IN PERSON & VIRTUAL BOARD MEETING



MAY 6, 2026 AT 8:45AM*

BOARD OF RETIREMENT MEETING

***This meeting will be held following the Committee scheduled prior.**

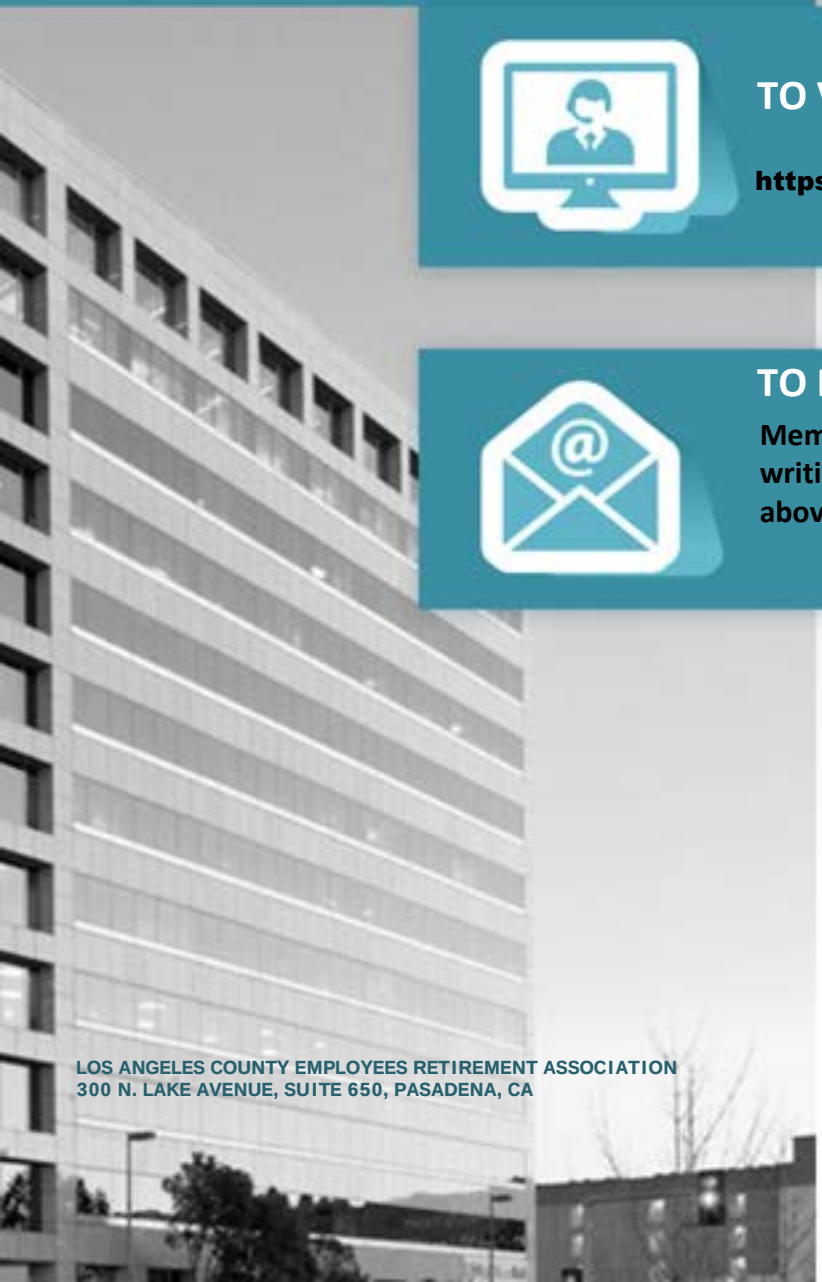
TO VIEW VIA WEB

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

TO PROVIDE PUBLIC COMMENT

Members of the public may address the Board orally and in writing. To provide Public Comment, please visit the above link and complete the request form.

Attention: If you have any questions, you may email PublicComment@lacera.gov



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

AGENDA

A REGULAR MEETING OF THE BOARD OF RETIREMENT

LOS ANGELES COUNTY EMPLOYEES RETIREMENT ASSOCIATION

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

8:45 A.M., WEDNESDAY, MAY 6, 2026*

This meeting will be conducted by the Board of Retirement both in person and by teleconference under California Government Code Section 54953.8.3.

Any person may view the meeting in person at LACERA's offices or online at https://LACERA.gov/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. PLEDGE OF ALLEGIANCE

III. PROCEDURE FOR TELECONFERENCE MEETING ATTENDANCE UNDER SB707

A. Just Cause (Section 54953.8.3)
B. Statement of Persons Present at SB707 Teleconference Locations

IV. APPROVAL OF THE MINUTES

A. Approval of the Minutes of the Regular Meeting of April 1, 2026.

V. PUBLIC COMMENT

(Members of the public may address the Board orally and in writing. To provide Public Comment, you should visit https://LACERA.gov/leadership/board-meetings and complete the request form.

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

V. PUBLIC COMMENT (Continued)

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

VI. EXECUTIVE SESSION

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

1. *LACERA v. County of Los Angeles*, California Supreme Court, Case No. S286264

VII. EXECUTIVE UPDATE

A. LACERA All Stars
B. Member Spotlight
C. Chief Executive Officer's Report

VIII. DISABILITY RETIREMENT APPLICATIONS ON CONSENT CALENDAR

IX. CONSENT ITEMS

A. **Ratification of Service Retirement and Survivor Benefit Application Approvals**
Recommendation that the Board approve the service retirements and survivor benefit applications received as April 28, 2026, along with any retirement rescissions and/or changes approved at last month's Board meeting. (Memo dated April 28, 2026)

B. **Appeals for the Board of Retirement's Meeting of May 6, 2026**
Recommendation as submitted by Tamara Caldwell, Division Manager, Disability Retirement Services: That the Board of Retirement grant the appeal and request for administrative hearing received from Hattie M. Collier and direct the Disability Retirement Services Manager to refer the case to a referee. (Memo dated April 20, 2026)

IX. CONSENT ITEMS (Continued)

C. **Service Provider Invoice Approval Request - Winet Patrick Creighton & Hanes**
Recommendation as submitted by Francis J. Boyd, Senior Staff Counsel, Disability Retirement Services: That the Board approve the service provider invoice for Winet Patrick Creighton & Hanes (Memo dated April 8, 2026 – Attachment is Non-Public and Exempt from Disclosure as Private Information and Exempt from Disclosure under California Government Code Sections 7927.700, 54957.5(a))

D. **Service Provider Invoice Approval Request - Perry Maloff M.D.**
Recommendation as submitted by Tamara Caldwell, Division Manager, Disability Retirement Services: That the Board approve the service provider invoice for Perry Maloff M.D. (Memo dated April 8, 2026 – Attachment is Non-Public and Exempt from Disclosure as Private Information and Exempt from Disclosure under California Government Code Sections 7927.700, 54957.5(a))

E. **Proposed Termination of Disability Retirement Service Invoice Threshold Approval Policy**
Recommendation as submitted by the Operations Oversight Committee: That the Board of Retirement approve the proposed termination of Disability Retirement Service Invoice Threshold Approval Policy. (Memo dated April 9, 2026)

F. **Assembly Bill 2780 - Public Employees' Retirement**
Recommendation as submitted by Les Robbins, Chair, Insurance, Benefits and Legislative Committee: That the Board adopt a "Support" position on Assembly Bill 2780, which would provide clarification and technical updates to the County Employees Retirement Law of 1937. (Memo dated April 21, 2026)

G. **Assembly Bill 1619 - Board Compensation**
Recommendation as submitted by Les Robbins, Chair, Insurance, Benefits and Legislative Committee: That the Board adopt a "Support If Amended" position on Assembly Bill 1619, which would authorize a board of retirement to increase the board compensation rate to a maximum of $320, if this authority is made operative by a board of supervisors. (Memo dated April 28, 2026)

IX. CONSENT ITEMS (Continued)

H. **Gateway Plaza- Reclassification from Investment to Capital Asset: Recommendation from JOGC**
Recommendation as submitted by Nicole Mi, Chair, Joint Organizational Governance Committee (JOGC): That the Committee recommend to the Board of Retirement and the Board of Investments approve the following: Approve Option 4 as the preferred approach for the future financial reporting and legal structuring of LACERA's headquarters building, Gateway Plaza (Property), and the title holding company, LACERA Gateway Property, Inc. (THC), in which the Property is currently held, such that the Property is reclassified from an investment asset to a capital asset, and in a subsequent year, the THC is dissolved and the asset is transferred to LACERA.
(Memo dated April 23, 2026)

I. **Recommendation to Approve Kirk Y. Chang M.D. (Internal Medicine) to the LACERA Panel of Physicians**
Recommendation as submitted by Tamara Caldwell, Division Manager, Disability Retirement Services: That the Board of Retirement approve the Application of Kirk Y. Chang M.D. - Internal Medicine, to the LACERA Panel of Examining Physicians. (Memo dated April 15, 2026)

J. **Recommendation to Approve Hamid R. Mir M.D. (Orthopedic Medicine) to the LACERA Panel of Physicians**
Recommendation as submitted by Tamara Caldwell, Division Manager, Disability Retirement Services: That the Board of Retirement approve the Application of Hamid R. Mir M.D. - Orthopedic Medicine, to the LACERA Panel of Examining Physicians. (Memo dated April 15, 2026)

K. **Recommendation to Approve Alexander Sones M.D. (Psychiatry-Forensic Psychiatry) to the LACERA Panel of Physicians**
Recommendation as submitted by Tamara Caldwell, Division Manager, Disability Retirement Services: That the Board of Retirement approve the Application of Alexander Sones M.D. - Psychiatry/Forensic Psychiatry, to the LACERA Panel of Examining Physicians. (Memo dated April 15, 2026)

IX. CONSENT ITEMS (Continued)

L. **Recommendation to Approve Nicole K. Ward D.O. (Rheumatology-Internal Medicine) to the LACERA Panel of Physicians**
Recommendation as submitted by Tamara Caldwell, Division Manager, Disability Retirement Services: That the Board of Retirement approve the Application of Nicole K. Ward D.O. - Rheumatology/Internal Medicine, to the LACERA Panel of Examining Physicians. (Memo dated April 15, 2026)

X. EXCLUDED FROM CONSENT ITEMS

XI. NON CONSENT ITEMS

A. **Updating LACERA's Code of Ethical Conduct**
Recommendation from the Joint Audit, Compliance, Risk, and Ethics Committee and submitted by Steven Rice, Chief Counsel, Allison Barrett, Senior Staff Counsel, and Jessica Rivas, Staff Counsel that the Board of Retirement approve the update to LACERA's Code of Ethical Conduct. (Presentation) (Memo dated April 22, 2026)

XII. REPORTS

A. **Disability Management & Compliance (DMC): Alternate Work Search Presentation; Rashae Walsh, Principal Analyst, Department of Human Resources**
RaShae Walsh, Principal Analyst
(Presentation)

B. **Contract Activity Report – March 2026**
Ricki Contreras, Administrative Services Division Manager
Elsy Gutierrez, Supervising Administrative Assistant II
(For Information Only) (Memo dated April 24, 2026)

C. **Monthly Status Report on Legislation**
Barry W. Lew, Legislative Affairs Officer
(For Information Only) (Memo dated April 22, 2026)

D. **Monthly Trustee Travel & Education Report – February March**
Ted Granger, Chief Financial Officer
(For Information Only) (Memo dated April 23, 2026)

XII. REPORTS

E. **April 2026 Fiduciary Counsel Contact and Billing Report**
Steven P. Rice, Chief Counsel
(For Information Only) (Memo dated April 27, 2026)
(Privileged and Confidential/Attorney-Client Communication/Attorney Work Product and Exempt from Disclosure under California Government Code Sections 7927.705, 54957.5(a))

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

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

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

XVI. DISABILITY RETIREMENT CASES TO BE HELD IN CLOSED SESSION

A. Applications for Disability

B. Recommendations

1. **E to D Application of Hong Mei**
Recommendation as submitted by Tamara Caldwell, Division Manager, Disability Retirement Services: That the Board of Retirement reject the application of Hong Mei. (Memo dated April 17, 2026 – Attached is Non-Public and Exempt from Disclosure under California Government Code Sections 7927.705, 54957.5(a))

XVI. DISABILITY RETIREMENT CASES TO BE HELD IN CLOSED SESSION (Continued)

2. **E to D Application of David W. Smith**
Recommendation as submitted by Tamara Caldwell, Division Manager, Disability Retirement Services: That the Board of Retirement reject the application of David W. Smith. (Memo dated April 17, 2026 – Attached is Non-Public and Exempt from Disclosure under California Government Code Sections 7927.705, 54957.5(a))

XVII. ADJOURNMENT

Although the meeting is scheduled for 8:45 a.m., it can start anytime thereafter, depending on the length of the Committee meeting preceding it.

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

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

MINUTES OF 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, APRIL 1, 2026

This meeting was conducted by the Board of Retirement both in person and by teleconference under California Government Code Section 54953.8.3.

TRUSTEES PRESENT:

Wayne Moore, Vice Chair

Les Robbins, Secretary

Nancy Durazo

Bobbie Fesler (Teleconference Due to Just Cause under Section 54953.8.3.)

Jason E. Green (Safety Alternate) (Teleconference Due to Just Cause under Section 54953.8.3.)

Shawn R. Kehoe

Aleen Langton

Ernesto J. Pantoja

Lisa Proft, Acting Ex-Officio

ABSENT:

JP Harris, Chair (Retired Alternate)

Elizabeth Ginsberg

David Ryu

STAFF ADVISORS AND PARTICIPANTS

Luis A. Lugo, Chief Executive Officer

JJ Popowich, Assistant Executive Officer

Jonathan Grabel, Chief Investment Officer

Steven P. Rice, Chief Counsel

Francis J. Boyd, Senior Staff Counsel

Allison Barrett, Senior Staff Counsel

Carly Ntoya, Director, Human Resources

Ricki Contreras, Administrative Services Division Manager

Tamara Caldwell, Disability Retirement Manager

Louis Gittens, Benefits Manager

Dr. Glenn Ehresmann, Medical Advisor

Nossaman LLP
Ashley Dunning, Fiduciary Counsel
Julia Botezatu, Associate

I. CALL TO ORDER

The meeting was called to order by Vice Chair Moore at 9:02 a.m. in the Board Room of Gateway Plaza.

II. PLEDGE OF ALLEGIANCE

Trustee Robbins led the Trustees and staff in reciting the Pledge of Allegiance.

III. PROCEDURE FOR TELECONFERENCE MEETING ATTENDANCE UNDER SB707

A. Just Cause (Section 54953.8.3)
B. Statement of Persons Present at SB707 Teleconference Locations

Trustee Fesler requested to participate in the meeting via teleconference for Just Cause, pursuant to Government Code Section 54953.8.3(c)(3) (SB 707). The reason for Just Cause was a need related to physical condition. A physical quorum was present at the noticed meeting location. Trustee Fesler confirmed that no individuals 18 years of age or older were present at the teleconference location.

Trustee Green requested to participate in the meeting via teleconference for Just Cause, pursuant to Government Code Section 54953.8.3(a)(3) (SB 707). The reason for Just Cause was a need for childcare. A physical quorum was present at the noticed meeting location. Trustee Green confirmed that no individuals 18 years of age or older were present at the teleconference location.

IV. APPROVAL OF THE MINUTES

A. Approval of the Minutes of the Regular Meeting of March 4, 2026.

Trustee Kehoe made a motion, Trustee Pantoja seconded, to approve the minutes of the Regular Meeting of March 4, 2026. The motion passed by the following roll call vote:

Yes: Durazo, Kehoe, Langton, Moore, Pantoja, Proft

Abstain: Fesler, Robbins

V. PUBLIC COMMENT

Mr. Eduardo Acosta addressed the Board regarding Disability Retirement Application No. 897E.

VI. EXECUTIVE UPDATE

A. LACERA All Stars

Mr. Popowich announced the winners for the month: Claro Lanting, Ngoc Vu, Vanessa Gonzalez and William Chuong. The web watcher winners were Moises Marroquin and Diana Luong and the Rideshare winner was Liping Li.

B. Member Spotlight

Mr. Popowich recognized LACERA member, Pamela Broom.

C. Chief Executive Officer's Report

Mr. Lugo provided a brief presentation on the Chief Executive Officer's Report and answered questions from the Board.

VII. DISABILITY RETIREMENT APPLICATIONS ON CONSENT CALENDAR

Safety Law Enforcement
Service-Connected Disability Applications

On a motion by Trustee Robbins, seconded by Trustee Pantoja, the Board of Retirement approved a service-connected disability retirement for the following named employees who met the burden of establishing permanent incapacity from the performance of their usual duties and a real and measurable connection between their incapacity and employment.

APPLICATION NO.	NAME
869E	AGUILERA, GEORGE L.
870E	TRIMARCHI, JOSEPH G.
871E*	BANKS, SEAN D.
872E	HODGE, CLARENCE A.
873E	WYCHE, BOBBY S.
874E	NEILL, PATRICK E.
875E*	RUELAS, RANDALL R.
876E	PARKER, RICHARD A.

*Granted SCD – Retroactive

VII. DISABILITY RETIREMENT APPLICATIONS ON CONSENT CALENDAR

Safety Law Enforcement (Continued)
Service-Connected Disability Applications

APPLICATION NO.	NAME
877E	TAPIA, ARTHUR P.
878E	JIRAK, ERIC W.
879E	OGLE, TRAVIS D.
880E*	RUBINO, STEPHAN P.
881E	AGUILERA, ALFRED B.
882E	GALANG, IAN TEODERIC S.
883E	TARIO, SONIA L.
884E	CANTU, OSCAR
885E	WILSON, RAYMUNDO T.
886E	RAMIREZ, EDWARD C., III
887E	OSEGUERA, HERIBERTO
888E	LIN, DONALD M.
889E	THORN, MARK A.
890E	MAMMOLITE, SIMON P.
891E	JOHNSON, KEITH D.
892E	MILLER, RICHARD J.
893E	DE LEON, DIANE M.
894E	BECKER, JOHN R.
895E	YELICK, JAY B.
896E	GARCIA, ARLENE
897E	ACOSTA, OLGA (DEC'D)

The motion passed by the following roll call vote:

Yes: Durazo, Fesler, Kehoe, Langton, Moore, Pantoja, Proft, Robbins

*Granted SCD – Retroactive

VII. DISABILITY RETIREMENT APPLICATIONS ON CONSENT CALENDAR

Safety Fire, Lifeguards
Service-Connected Disability Applications

On a motion by Trustee Green seconded by Trustee Robbins, the Board of Retirement approved a service-connected disability retirement for the following named employees who met the burden of establishing permanent incapacity from the performance of their usual duties and a real and measurable connection between their incapacity and employment.

APPLICATION NO.	NAME
1066C	PENA, VINCE A.
1067C	BALDWIN, MARVIN D.
1068C*	KAPU, EDWARD K., JR.
1069C	JOHNSON, WILLIAM H., JR.
1070C	EWALD, THOMAS C.
1071C	BENNETT, BRIAN D.
1072C	WELLS, RICHARD
1073C	PIERCE, EDWARD J.
1074C*	LEWIS, KEITH D.
1075C	ESCAMILLA, OSCAR E.
1076C	GROVES, CHARLES J.
1077C	BACKHAUS, RANDALL A.
1078C	CURTIS, WILLIAM A.
1079C	OTT, MARSHALL L.
1080C	CARTER, PATRICK J.
1081C	CABALLERO, DAVID B.
1082C	HURD, JEFFREY D.
1083C	DUNHAM, PATRICK L.
1084C	PEREZ, PATRICK T.
1085C	ROBERTSON, BRIAN T.
1086C	DAVIS, THOMAS W.

The motion passed by the following roll call vote:

Yes: Durazo, Fesler, Green, Langton, Moore, Pantoja, Proft, Robbins

*Granted SCD – Retroactive

VII. DISABILITY RETIREMENT APPLICATIONS ON CONSENT CALENDAR

General Members
Service-Connected Disability Applications

On a motion by Trustee Robbins, seconded by Trustee Kehoe, the Board of Retirement made a motion to approve a service-connected disability retirement for the following named employees who met the burden of establishing permanent incapacity from the performance of their usual duties and a real and measurable connection between their incapacity and employment.

APPLICATION NO.	NAME
2111D	BAKER, VERLEEN
2112D*	HOOKS, SANDRA
2113D*	STONE, DIANE L.
2114D**	SHEPPARD, DELSHAWN R.
2115D**	BEDOYAN, SOUREN S.
2116D***	CHEBISHYAN, ADRINA
2117D	RODRIGUEZ, ESTEBAN V.
2118D	MCKENZIE, ELAINE P.
2119D**	ALVAREZ, MARCOS J.
2120D***	JACKSON, KORTNEE L.
2121D*	BUSTOS-MONTES, ZARINA
2122D***	DONALD, PAMELA L.
2123D	THOMPSON, EDIE L.
2124D	TATLEY, ALDIN A.
2125D	BOOKER, ALMA T.
2126D***	WILLIAMS, DENISE G.
2127D***	HUERTA, ARTURO

The motion passed by the following roll call vote:

Yes: Durazo, Fesler, Kehoe, Langton, Moore, Pantoja, Proft, Robbins

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

VIII. CONSENT ITEMS

Trustee Kehoe made a motion, Trustee Robbins seconded, to approve consent items A-B. The motion passed by the following roll call vote:

Yes: Durazo, Fesler, Kehoe, Langton, Moore, Pantoja, Proft, Robbins

A. **Ratification of Service Retirement and Survivor Benefit Application Approvals**
Recommendation that the Board approve the service retirements and survivor benefit applications received as March 24, 2026, along with any retirement rescissions and/or changes approved at last month's Board meeting. (Memo dated March 24, 2026)

B. **Appeal(s) For the Board of Retirement's Meeting of April 1, 2026**
Recommendation as submitted by Tamara Caldwell, Division Manager, Disability Retirement Services: That the Board of Retirement grant the appeals and requests for administrative hearing received from Elijah D. Carder, Shaena D. Hall and Beverly A. La Cour and direct the Disability Retirement Services Manager to refer each case to a referee. (Memo dated March 19, 2026)

IX. EXCLUDED FROM CONSENT ITEMS

There were no items pulled for discussion.

X. NON CONSENT ITEMS

A. **Recommendation for Approval of (1) Klausner Kaufman Jensen & Levinson, (2) Nossaman LLP, and (3) Reed Smith LLP as Fiduciary Counsel Panel**
Recommendation as submitted by the Ad Hoc Fiduciary Counsel RFP Committee: That the Board approve the engagement of (1) Klausner Kaufman Jensen & Levinson; (2) Nossaman LLP; and (3) Reed Smith LLP as LACERA's fiduciary counsel panel for a five-year term. (Memo dated March 11, 2026)

A motion was made by Trustee Robbins, seconded by Trustee Kehoe to approve staff's recommendation. The motion passed by the following roll call vote:

X. NON CONSENT ITEMS (Continued)

Yes: Durazo, Fesler, Kehoe, Langton, Moore, Pantoja, Proft, Robbins

B. **Approval of LACERA and SEIU MOU Bargaining Units 850 and 851 – Tentative Agreements**
Recommendation as submitted by Luis A. Lugo, Chief Executive Officer: That the Board direct management to join the Represented Staff Members in signing the Memorandums of Understanding (MOU) incorporating the Tentative Agreements for LACERA Administrative, Technical, Clerical, and Blue-Collar Bargaining Unit (Unit 850) and LACERA Supervisory Bargaining Unit (Unit 851) and request administrative approval from the Los Angeles County Board of Supervisors. Upon LACERA Boards' approval, the MOUs will be effective January 1, 2026, through December 31, 2028. (Memo dated March 11, 2026)

A motion was made by Trustee Robbins, seconded by Trustee Kehoe to approve staff's recommendation. The motion passed by the following roll call vote:

Yes: Durazo, Fesler, Kehoe, Langton, Moore, Pantoja, Proft, Robbins

C. **Non-Represented and Management Staff Salary Adjustments**
Recommendation as submitted by Luis A. Lugo, Chief Executive Officer: That the Board approve salary adjustments for Non-Represented and Management Appraisal and Performance Plan (MAPP) classifications at levels consistent with those granted to Represented Staff Members, and direct management to request administrative approval from the Los Angeles County Board of Supervisors. This salary adjustment recommendation excludes LACERA's Chief Executive Officer classification, whose salary is determined independently by LACERA Boards. (Memo dated March 16, 2026)

A motion was made by Trustee Kehoe, seconded by Trustee Robbins to approve staff's recommendation. The motion passed by the following roll call vote:

Yes: Durazo, Fesler, Kehoe, Langton, Moore, Pantoja, Proft, Robbins

X. NON CONSENT ITEMS (Continued)

D. **Processing and Output Services Contract Renewal – CSG Systems, Inc.**
Recommendation as submitted by Cynthia Martinez, Chief, Communications: That the Board authorize LACERA to enter into a Processing and Output Services Agreement with CSG Systems, Inc. to continue critical print, mailing, and distribution services for retiree payroll warrants, statements, and annual benefit communications. This contract consolidates two previously expired CSG agreements into a single agreement and now exceeds the approval authority of the Chief Executive Officer, requiring Board approval. The total contract value is $600,000 over two years. (Memo dated March 19, 2026).

A motion was made by Trustee Langton, seconded by Trustee Pantoja to approve staff's recommendation. The motion passed by the following roll call vote:

Yes: Durazo, Fesler, Kehoe, Langton, Moore, Pantoja, Proft, Robbins

E. **Ratification of Reciprocal Disability Retirements**
Recommendation as submitted by Louis Gittens, Benefits Manager: That the Board approve the outgoing reciprocal disability retirement for the following named deferred members who were found to be disabled by the current reciprocal agency for the performance of their duties and have met the burden of proof (Memo dated March 16, 2026).

A motion was made by Trustee Kehoe, seconded by Trustee Robbins to approve staff's recommendation. The motion passed by the following roll call vote:

Yes: Durazo, Fesler, Kehoe, Langton, Moore, Pantoja, Proft, Robbins

XI. REPORTS

A. **Building a Culture of Excellence and Engagement**
Luis A. Lugo, Chief Executive Officer
(Presentation)

Mr. Lugo provided a presentation and answered questions from the Board. This item was received and filed.

B. **Contract Activity Report - February 2026**
Ricki Contreras, Administrative Services Division Manager
Elsy Gutierrez, Supervising Administrative Assistant II
(For Information Only) (Memo dated March 17, 2026)

This item was received and filed.

C. **Monthly Status Report on Legislation**
Barry W. Lew, Legislative Affairs Officer
(For Information Only) (Memo dated March 17, 2026)

This item was received and filed.

D. **Monthly Trustee Travel & Education Report – February 2026**
Ted Granger, Chief Financial Officer
(For Information Only) (Memo dated March 18, 2026)

This item was received and filed.

E. **March 2026 Fiduciary Counsel Contact and Billing Report**
Steven P. Rice, Chief Counsel
(For Information Only) (Memo dated March 23, 2026)
(Privileged and Confidential/Attorney-Client Communication/Attorney Work Product and Exempt from Disclosure under California Government Code Sections 7927.705, 54957.5(a))

This item was received and filed.

XII. ITEMS FOR STAFF REVIEW

There were no items for staff review.

XIII. ITEMS FOR FUTURE AGENDAS

There was nothing to report.

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

There was nothing to report.

XV. DISABILITY RETIREMENT CASES TO BE HELD IN CLOSED SESSION

A. Applications for Disability

APPLICATION NO. & NAME AND BOARD ACTION

5482B - BADALI, JOSEPH A.*

Trustee Moore made a motion, Trustee Pantoja seconded to deny a service-connected disability retirement, as the applicant is ineligible. The motion passed by the following roll call vote:

Yes: Durazo, Fesler, Kehoe, Moore, Pantoja, Proft, Robbins

Absent: Langton

APPLICATION NO. & NAME AND BOARD ACTION

5483B - GEISER SANTOS, WILLIAM G.

This item was pulled by staff for further development.

APPLICATION NO. & NAME AND BOARD ACTION

5484B - GUNN, ERIC J. (DEC'D)*

Trustee Kehoe made a motion, Trustee Durazo seconded to return to staff for further development. The motion passed by the following roll call vote:

Yes: Durazo, Fesler, Kehoe, Langton, Moore, Pantoja, Proft, Robbins

* Applicant Attorney Present

XV. DISABILITY RETIREMENT CASES TO BE HELD IN CLOSED SESSION

APPLICATION NO. & NAME AND BOARD ACTION

5309B - GANDY LOCKLIN, MALAYSIA L.

Trustee Moore made a motion, Trustee Pantoja seconded to continue a non-service connected disability supplemental disability allowance pursuant to government code sections 31720 and 31725.5. The motion passed by the following roll call vote:

Yes: Durazo, Fesler, Kehoe, Langton, Moore, Pantoja, Proft, Robbins

APPLICATION NO. & NAME AND BOARD ACTION

5333B - REYES, FRANCISCO J.

Trustee Kehoe made a motion, Trustee Pantoja seconded to grant a service connected disability with the option of an earlier effective date pursuant to government code sections 31720 and 31724. The motion passed by the following roll call vote:

Yes: Durazo, Fesler, Kehoe, Langton, Moore, Pantoja, Proft, Robbins

XVI. EXECUTIVE SESSION

A. **Conference with Legal Counsel – Anticipated Litigation**
(Significant exposure to litigation pursuant to paragraph (2) of subdivision (d) of Government Code Section 54956.9)

1. **Administrative Appeal of Charles Prosper**
JJ Popowich, Assistant Executive Officer
Steven P. Rice, Chief Counsel
(Memo dated March 12, 2026)

The Board received a report on the CEO's intended action with respect to this appeal.

XVI. EXECUTIVE SESSION (Continued)

B. **Report on Investigation of Complaint Against Public Employee**
(Pursuant to subdivision (b) of Government Code Section 54957)

Ashley Dunning, Nossaman LLP, Fiduciary Counsel
Chait Errande, Information Security Officer
(Memo dated March 25, 2026)

There is nothing to report.

XVII. ADJOURNMENT

There being no further business to come before the Board, the meeting was Adjourned in memory Los Angeles County Sheriff's Deputy, Levi Vargas at 11:30 a.m.

_____
LES ROBBINS, SECRETARY

_____
JP HARRIS, CHAIR

Recognizing Our Members' Service and Accomplishments

LACERA has over 120,000 active members working in dozens of L.A. County departments, many of whom dedicate their entire working lives to serving the community. Meet one of our long-serving members, who recently began enjoying his well-earned retirement .



MEMBER SPOTLIGHT

Retired Member

Richard Bendall

25+ YEARS OF SERVICE

Chief, Internal Audit Division

Years of Service: 38 (County), 31 (LACERA)

LACERA Career: Internal Audit Chief Richard Bendall retired in February after 38 years of service with the County. His County career included a stint at the Auditor Controller's Office along with an impressive 31-year tenure at LACERA. Under his leadership, the Internal Audit team served to provide independent and objective assurance and consulting services to improve LACERA's operations.

Proudest Accomplishments: Among his many career accomplishments, Richard is most proud of the role he played in helping make Internal Audit an integral part of LACERA's operations. He is also proud of the many staff members who began their LACERA careers in Internal Audit and went on to serve in management positions across the organization.

Retirement Plans: In his retirement, Richard is looking forward to spending more time with his children and grandkids. He is also planning to learn how to play guitar and get into photography.

LACERA

Los Angeles County Employees Retirement Association

Chief Executive Officer's Report

May 2026

Prepared for the Board of Retirement and Board of Investments

01

SECTION ONE

Organizational Updates

Board initiatives, hiring, and key events

LACERA Updates

Key initiatives and upcoming engagements across the organization

BOARD OF RETIREMENT OFFSITE

May 18–19, 2026 | Long Beach

Bringing the Future into Focus

CEO Focus & Initiatives, Artificial Intelligence and Cybersecurity, Retiree Healthcare Landscape, and Other Emerging and Forward-Looking Topics.

GENERAL ELECTIONS

Three-Year Term Effective January 1, 2027 – December 31, 2029

2026 Election Calendar

Election of the Second and Eighth Members and Alternate Retired Member of the Board of Retirement, and the Second and Eighth Members of the Board of Investments for LACERA.

Dates to Remember:

May 22 | Candidate Filing Period Begins

June 22 | Candidate Filing Period Ends

August 3 | Voting Begins

August 28 | Voting Ends

October 20 | Board of Supervisors Certifies Election Results

Hiring Update

Reporting Period: March 16, 2026 – April 15, 2026

RECRUITMENTS UNDERWAY

Active searches across divisions

Administrative Services	Document Processing Specialist
Investments	Finance Analyst II
Legal	Legal Analyst; Senior Staff Counsel
Systems	IT Manager I — App Development; IT Manager I — App Support
Various Divisions	Retirement Benefit Specialist III (Promotional); Sr. Retirement Benefit Specialist (Promotional); Section Head

ONBOARDING SOON

Executive Office	Assistant Executive Officer
Various Divisions	Retirement Benefit Specialist I (Trainees)

ADDITIONS TO THE TEAM

Welcome to LACERA

Judith Cajulis
Accountant
Financial & Accounting Services

Chona Labtic-Austin
Investment Accountant (Promotion)
Financial & Accounting Services

Edward Tomita
Investment Accountant (Promotion)
Financial & Accounting Services

March Madness | Retirements

Reporting Period: March 1–31, 2026 | Includes processed and pending retirements

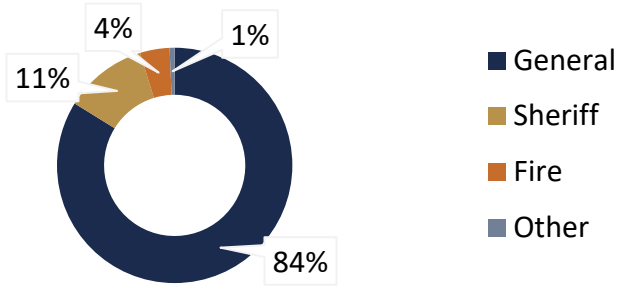
1,156
TOTAL RETIREMENTS

969
GENERAL PLANS

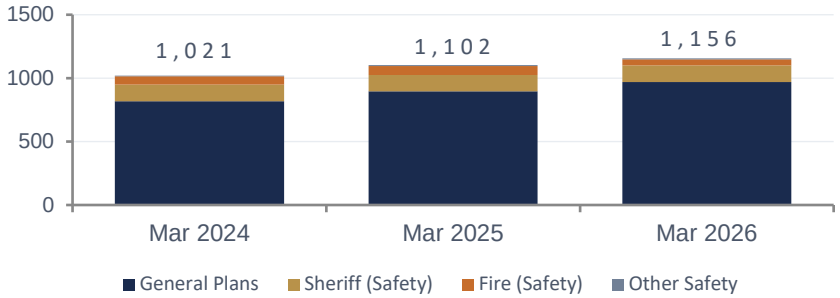
187
SAFETY PLANS

Sheriff
TOP DEPARTMENT | 198

RETIREMENT BREAKDOWN



YEAR-OVER-YEAR MARCH MADNESS



02

SECTION TWO

CEO Dashboard

Service metrics and operational performance

Disability Applications Snapshot

Reporting as of April 23, 2026

May Disability Agenda

KEY METRICS *Target: 12 months*

16.3 AVERAGE PROCESSING (MONTHS)

5% Processed in 12 months or less

98	553	0	12
APPLICATIONS PRESENTED TO BOARD	APPLICATIONS PRESENTED TO BOARD FYTD	APPEALS PRESENTED TO BOARD	APPEALS PRESENTED TO BOARD FYTD

Disability Application Status

APPLICATIONS

1,099 Pending in Process

100 New Applications

702 Received FYTD

APPEALS

65 Pending in Process

0 New Appeals

12 Received FYTD

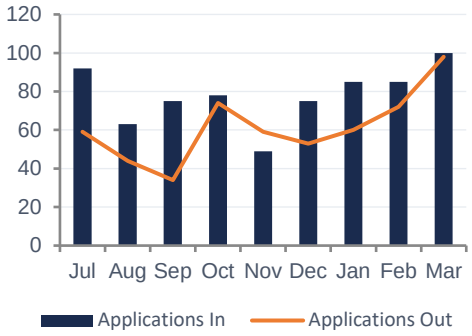
PENDING APPLICATION BY DEPARTMENT | TOP 3

Sheriff | 491 (45%)
Probation | 208 (19%)
Fire | 169 (15%)

PENDING APPLICATIONS BY MILESTONE

Intake Review	**82** (7%)
Records Request	**130** (12%)
File Indexing	**453** (41%)
Pending Interview	**105** (10%)
Drafting Report	**98** (9%)
Medical Review	**172** (16%)
Post Medical Review	**13** (1%)
Board Prep	**23** (2%)
Final Case Review	**23** (2%)

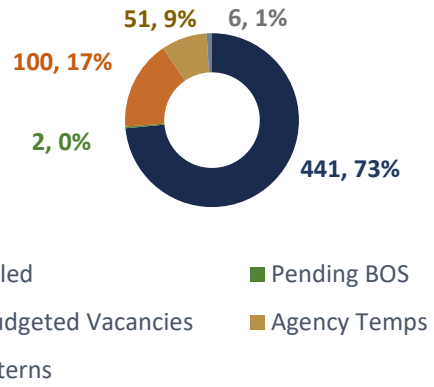
APPLICATIONS IN vs. OUT | FYTD



Human Resources Snapshot

Reporting Period: March 16, 2026 – April 15, 2026

POSITIONS BREAKDOWN

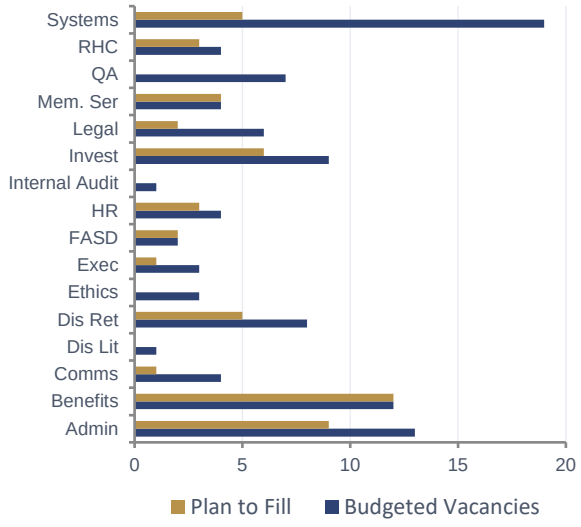


VACANCY RATE

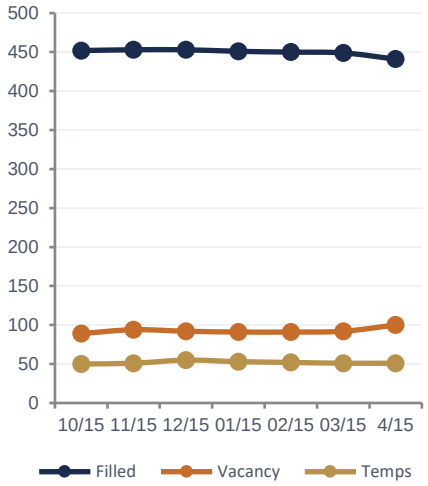
11%
PLAN TO FILL

18%
ALL BUDGETED

VACANCIES BY DIVISION



MONTH-TO-MONTH



Key Financial Information

Fiscal Year End: June 30, 2025

82.0%
FUNDED RATIO

7.0%
ASSUMED RATE OF RETURN

$86.2B
TOTAL NET ASSETS

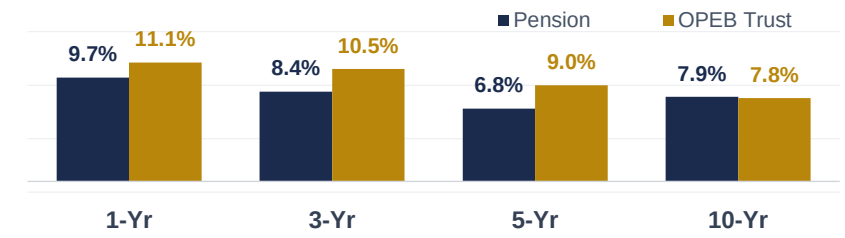
$99.7B
ACTUARIAL LIABILITY (AAL)

$17.9B
UNFUNDED LIABILITY (UAAL)

$607M
STAR RESERVE

ANNUALIZED INVESTMENT RETURNS

Net of Fees



LACERA PENSION DOLLAR

WHERE EACH PENSION DOLLAR COMES FROM



Membership Snapshot

Reporting Period: As of April 15, 2026

200,309

TOTAL MEMBERSHIP COUNT

$414.3M

MONTHLY PAYROLL

$3.69B FYTD | 98.7% Direct Deposit

361

NEW RETIRED PAYEES

March 2026

MEMBERSHIP BY STATUS

	General	Safety	Total
ACTIVE	87,178	12,095	99,273
RETIRED	63,757	15,328	79,085
INACTIVE	20,371	1,580	21,951

AVERAGE MONTHLY BENEFIT

MEMBER

General Plans

$4,598

Safety Plans

$10,161

SURVIVOR

General Plans

$3,969

MONTHLY AVERAGE (ALL PLANS)

$5,665

Member Services Snapshot

Reporting Period: March 31, 2026

MS CALL CENTER

Main Queue

9,703
Total Calls

Top Topics: Retirement Counseling, Taxes, MyLACERA

93% Answered

7% Abandoned

Avg Speed of Answer	**3 min**
Avg Duration	**16 min**

Callback Queue

955 | 99% Answered

RHC CALL CENTER

Retiree Healthcare

1,224
Total Calls

Top Topics: Medical/Dental Enrollments, Medicare Part B, General Benefit Inquiries

90% Answered

10% Abandoned

Avg Speed of Answer	**7 min**
Avg Duration	**13 min**

Callback Queue

76 | 97% Answered

MSC APPOINTMENTS

1,271	**10,406**
Month	FYTD

In-Person 645 | Virtual 607 | Phone 19

98% *MSC Satisfaction*

EVENTS & WEBINARS

Events/Webinar	**19** Month	**241** YTD
Attendance	**1,429** Month	**17,519** YTD

MS Member Emails 1,637

RHC Member Emails 1,042

Online Services | LACERA.gov & My LACERA

Reporting Period: March 31, 2026

128,350

TOTAL MEMBER ACCOUNTS

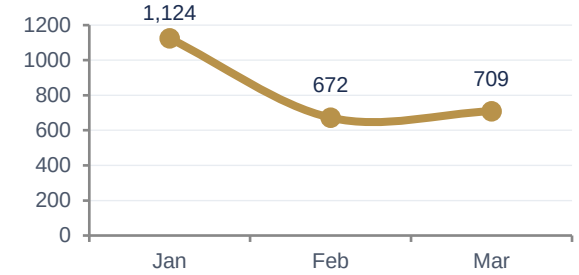
65%

PERCENTAGE OF TOTAL MEMBERS

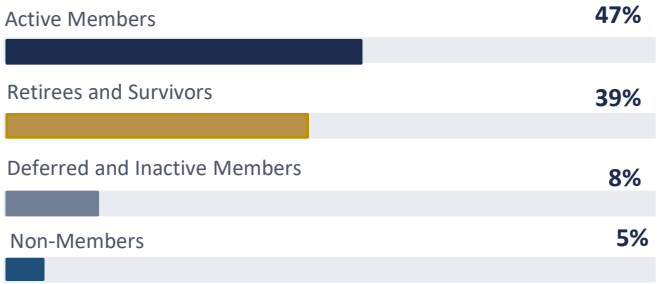
709

NEW ACCOUNTS IN MARCH

ANNUAL NEW MYLACERA ACCOUNTS



ACCOUNTS BY MEMBER TYPE



Retiree Healthcare

Reporting Period: March 31, 2026

RETIREE HEALTHCARE PROGRAM ENROLLMENTS

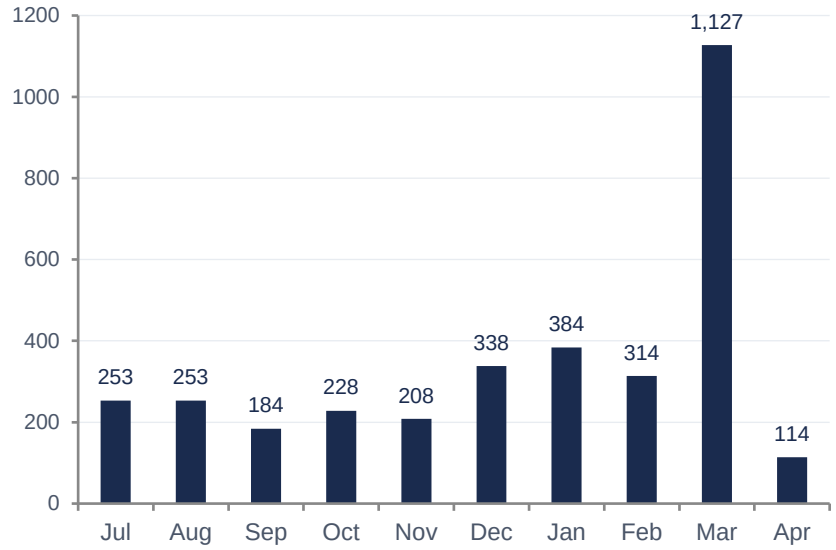
Dollars in millions | Employer Contribution, Member Contribution, and Enrollment count by benefit

BENEFIT	EMPLOYER CONTRIBUTION	MEMBER CONTRIBUTION	ENROLLMENTS
Medical	**$569.7**	$40.1	**57,993**
Dental	**$41.6**	$3.7	**60,500**
Part B	**$84.7**	—	**40,514**
Long Term Care	—	—	**56**
TOTAL	**$696.0**	**$43.8**	**159,063**

Retirements | Member Snapshot

Reporting as of April 15, 2026

MONTHLY RETIREMENTS



TOTAL RETIREMENTS BY TYPE | FYTD



FIRE RETIREMENTS | FYTD



SHERIFF RETIREMENTS | FYTD



03

SECTION THREE

Appendix

Additional reports and supporting information

Quiet List | Overview

Guidelines governing procurement communications

WHAT IS A QUIET PERIOD?

A quiet period is a period during which LACERA is prohibited from communicating with vendors about a specific procurement, typically to avoid conflicts of interest. The period begins when LACERA releases a solicitation (RFP, RFQ, etc.) and ends when the contract is awarded. During this time, trustees and staff are not allowed to have any contact with vendors — including phone calls, emails, or in-person meetings, other within permitted exceptions.

PERMITTED EXCEPTIONS

Trustees and staff may still communicate with vendors in these specific circumstances:

1 Clarifications

Responding in writing to authorized questions pursuant to the solicitation

2 Pre-Bid Conference

Pre-scheduled conferences with authorized LACERA personnel

3 Post-Award

Contract negotiations after the award has been made

4 Existing Business

Conducting other existing unrelated business

5 POC Studies

Conducting Proof of Concept studies

When in doubt, err on the side of caution or contact the LACERA Legal Office.

Quiet List | Administrative & Operations

*Reporting as of April 23, 2026 | *Subject to change*

Solicitation	Division	Released	Stage	Respondents
Auditing & Consulting Services Pool	Internal Audit	2/13/2025	Contract Execution	Eide Bailly
Chief Ethics and Compliance Officer Search Services	Human Resources	3/02/2026	Bid Review	CPS HR Consulting, Energy Search Associates, Leonid Group, Major, Lindsey & Africa, Sarmark Enterprises, The Forum Group, The SR Group, WBCP, Conselium
Digital Communications Governance & Compliance	Legal / InfoSec	12/1/2023	Contract Development	GlobalRelay, Smarsh
Fiduciary Counsel Legal Services	Legal Office	10/30/2025	Contract Development	Reed Smith LLP
Knowledge Management Solution	Disability Litigation	10/31/2025	Bid Review	Eccentex ,Quisitive LLC, Squirro Americas, Oxcyon Inc., Top Quadrant Inc., Work Methods Solutions Inc., Speridian Technologies LLC., Enterprise Knowledge LLC, Progress Federal Solutions, Upland RightAnswers.
Quality Assurance & Process Management Group Classification/Compensation Study	Human Resources	7/21/2025	Contract Execution	CBIZ Benefits & Insurance Services, Inc., CPS HR Consulting, Gallagher Benefits Services, Inc., Segal Western States, Transformance Consulting
Systems and InfoSec Classification and Compensation Study	Human Resources	1/26/2026	Bid Review	Ascension Strategic People Solutions, CBIZ Business & Insurance Services, Segal Western States, Transformance Consulting
SAAS Provider: Drupal Hosting	Systems	8/11/2025	Bid Review	AIM Tech, Amazee.io, ATZ, Datanetiix Solutions, Dynamics Federal Technologies, Exemplifai LLC, Pantheon Systems, Inc., Smashing Infolabs Private Limited

Quiet List | Investments

*Reporting as of April 23, 2026 | *Subject to change*

Solicitation	Division	Released	Stage	Respondents
Real Estate Consulting Services Search	Investments	2/27/2026	Bid Review	Albourne America, LLC, Mercer Investment Consulting, Inc., NEPC Investment Consulting, LLC RCLCO Fund Advisors, LLC, StepStone Group LP, Meketa Investment Group, Inc
Passive Cash Overlay Investment Manager Search	Investments	6/13/2025	Contract Development	Legal & General Asset Management, NISA Investment Advisors, Parametric Portfolio Associates, Russell Investments, State Street Investment Management

SEARCH CONTEXT

The Passive Cash Overlay Manager Search is in the Contract Development stage. Five qualified investment firms are under review, each offering institutional-grade passive overlay strategies. Final selection is expected to follow standard LACERA vendor award protocols.

Upcoming Conferences

Trustee development opportunities | April – Jul 2026

May 12-15	SACRS Spring Conference	*Olympic Valley, CA*
May 16-20	NCPERS Accredited Fiduciary (NAF) Program and Annual Conference & Exhibition (ACE)	*Las Vegas, NV*
May 18-19	IFEBP Washington Legislative Update	*Washington, D.C.*
May 19-20	Pacific Pension Institute (PPI) Seminar	*Paris, France*
May 29	CALAPRS Trustee Round Table	*Virtual*
Jun 2-3	PREA Institute	*Berkeley, CA*
Jun 8-10	NASP Annual Financial Services Conferences	*Detroit, MI*
Jun 9-10	AHIP Conference	*Las Vegas, NV*
Jun 12	CALAPRS Benefits Round Table	*Virtual*
Jun 15-16	NASP Master Class – Technology and Innovation Oversight	*Chicago, IL*
Jun 15-17	NCPERS Chief Officers Summit	*Orange County, CA*
Jul 7-8	TIDE SPARK – The Investment Diversity Exchange	*Rancho Palos Verdes, CA*
Jul 20-21	Pacific Pension Institute (PPI) Leadership Lab	*Toronto, Canada*

Report of Felony Forfeiture Cases

As of April 20, 2026



CURRENT REPORTING STATUS

**One new felony forfeiture case added to the report for the period ending April 20, 2026.*

ABOUT FELONY FORFEITURE

Under California Public Employees' Pension Reform Act (PEPRA) § 7522.72 and § 7522.74, public employees convicted of a felony arising from the performance of official duties may forfeit accrued pension benefits from the date of commission. LACERA monitors and reports such cases to the Board of Retirement. After LACERA decides that a forfeiture is warranted, the member has a right to appeal that decision to the Board.

FELONY FORFEITURE CASES (PENDING)

Member Name	Dept.	Conviction Date
*Tommy Trimble	Sheriff	3/12/2026
Toni Pittmon	Child and Family Services	2/17/2026
Michael D. Coberg	Sheriff	9/29/2025
Christopher Cadman	Sheriff	7/14/2025
David A. Rodriguez	Sheriff	7/14/2025

Member Name	Dept.	Conviction Date
Michael Meiser	Sheriff	7/10/2025
Dannie T. Kamack	Probation	3/3/2025
Eric C. Saavedra	Sheriff	1/16/2025
Joseph M. Benza	Sheriff	12/17/2024
**Mark Ridley-Thomas	BOS	3/31/2023

** Under Appeal

Public Records Requests

Information and Documents Requested under California Public Records Act
Reporting Period: March 15, 2026 – April 14, 2026

DATE	REQUESTOR	REQUEST SUMMARY
03-18-26	R. Renko, Individual	BLANK copies of the Deputies', Attorneys' application packet; with the dates of when the submission to obtain personnel files were implemented into the medical retirement application process.
03-23-26	J. Humphrey, FOIA	Copy of current contract(s) with proxy voting advisory service provider; any requests for RFP or RFI related to procurement of proxy voting advisory or research services from January 2021 to present; records showing total annual expenditures paid to proxy voting advisory service providers (FY 2023-2025), and fund's current proxy voting policy.
03-23-26	B. Schroeder, Individual	Listing in the investment reports showing calendar-year, net of fee and total plan returns, going back 15 years.
03-27-26	K. Simpson, Gain	Records of LACERA's private capital fund commitments quarterly from 2016 to the latest quarter available for Private Equity, Venture Capital, Real Estate, Infrastructure and Private Credit.
03-29-26	R. Renko, Individual	Copies of all disclosable records related to any executive or closed session discussions, or decisions, pertaining to my case, specifically 2018, with regards to Chair Kehoe and Legal Counsel Allison Barrett, Francis Boyd, and Vincent Lim.
04-01-26	E. Raasch, American Transparency	Electronic document which lists any and all retired employees (members) of LACERA and survivors which were paid a monthly pension annuity (payment) in fiscal or calendar year 2025.
04-02-26	R. Renko, Individual	Copy of December 6, 2023, and the title "Confidentiality-Control Policy" or "REVISED Summary of Evidence Procedures."
03-18-26	R. Renko, Individual	BLANK copies of the Deputies', Attorneys' application packet; with the dates of when the submission to obtain personnel files were implemented into the medical retirement application process.

Thank *You.*

Chief Executive Officer's Report | May 2026

Los Angeles County Employees Retirement Association

Questions and discussion

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

April 28, 2026

TO: Trustees, Board of Retirement

FOR: Board of Retirement Meeting on May 6, 2026

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 MAY 6, 2026

BENEFIT APPROVAL LIST

SAFETY MEMBER APPLICATIONS FOR: SERVICE RETIRMENT

NAME	DEPARTMENT	RETIRED	SERVICE
LOUIS A. COSTANZA JR	DISTRICT ATTORNEY Dept.# DA	03-28-2026	34 YR, 7 MO
STEPHEN C. SABOSKY	DISTRICT ATTORNEY Dept.# DA	04-30-2026	13 YR, 1 MO
ANDRES ALDANA	L A COUNTY FIRE DEPT Dept.# FR	05-31-2026	27 YR, 2 MO
DENNIS B. BRESHEARS	L A COUNTY FIRE DEPT Dept.# FR	03-28-2026	27 YR, 3 MO
JOE C. CARVALHO	L A COUNTY FIRE DEPT Dept.# FR	03-29-2026	26 YR, 10 MO
LYNN S. CLARK	L A COUNTY FIRE DEPT Dept.# FR	04-30-2026	27 YR, 3 MO
SCOTT E. DAVID	L A COUNTY FIRE DEPT Dept.# FR	03-31-2026	30 YR, 8 MO
TIMOTHY S. ESPARZA	L A COUNTY FIRE DEPT Dept.# FR	03-31-2026	26 YR, 5 1/5 MO
BRIAN G. FLEMING	L A COUNTY FIRE DEPT Dept.# FR	05-31-2026	25 YR, 5 MO
ERIC L. GOODRICH	L A COUNTY FIRE DEPT Dept.# FR	03-28-2026	32 YR, 8 MO
JOHN J. MULDOON	L A COUNTY FIRE DEPT Dept.# FR	03-30-2026	25 YR, 10 MO
KIMBERLY A. REYES	L A COUNTY FIRE DEPT Dept.# FR	03-30-2026	25 YR, 5 MO
PATRICK H. RICHARDSON	L A COUNTY FIRE DEPT Dept.# FR	03-31-2026	24 YR, 0 MO
ARON J. ROWE	L A COUNTY FIRE DEPT Dept.# FR	03-31-2026	25 YR, 2 1/2 MO
VIRGINIA M. RUPE	L A COUNTY FIRE DEPT Dept.# FR	03-31-2026	32 YR, 6 MO

BOARD OF RETIREMENT MEETING OF MAY 6, 2026

BENEFIT APPROVAL LIST

SAFETY MEMBER APPLICATIONS FOR: SERVICE RETIRMENT

NAME	DEPARTMENT	RETIRED	SERVICE
JAMES K. SOUKUP	L A COUNTY FIRE DEPT Dept.# FR	04-11-2026	24 YR, 2 1/2 MO
DAVID C. TRUJILLO	L A COUNTY FIRE DEPT Dept.# FR	03-31-2026	8 YR, 7 MO
PHILLIP C. VIRAMONTES	L A COUNTY FIRE DEPT Dept.# FR	03-31-2026	17 YR, 2 MO
GEORGE BOWERS JR.	SHERIFF Dept.# SH	03-28-2026	35 YR, 8 1/5 MO
STEPHEN M. CABRERA	SHERIFF Dept.# SH	06-26-2026	31 YR, 6 MO
ERIC M. CAPLINGER	SHERIFF Dept.# SH	03-28-2026	28 YR, 11 MO
LAURA P. CARRILLO	SHERIFF Dept.# SH	03-30-2026	29 YR, 3 MO
JOHN P. DORSTEN	SHERIFF Dept.# SH	03-28-2026	34 YR, 6 MO
KEVIN B. DUXBURY	SHERIFF Dept.# SH	05-31-2026	25 YR, 0 MO
ERIC R. GOMEZ	SHERIFF Dept.# SH	03-30-2026	30 YR, 8 MO
JESUS A. GUERRERO SANCHEZ	SHERIFF Dept.# SH	03-28-2026	31 YR, 1 MO
DOUGLAS L. KIMURA	SHERIFF Dept.# SH	06-30-2026	35 YR, 1 MO
RODNEY S. LOUGHRIDGE	SHERIFF Dept.# SH	03-28-2026	32 YR, 9 MO
EDWARD K. MAISANO	SHERIFF Dept.# SH	03-31-2026	33 YR, 11 MO
GARLAND E. MILLER	SHERIFF Dept.# SH	04-22-2026	31 YR, 6 MO

BOARD OF RETIREMENT MEETING OF MAY 6, 2026

BENEFIT APPROVAL LIST

SAFETY MEMBER APPLICATIONS FOR: SERVICE RETIRMENT

NAME	DEPARTMENT	RETIRED	SERVICE
JOSE M. NANQUIL	SHERIFF Dept.# SH	03-28-2026	36 YR, 7 MO
RIZALDY A. REANTASO	SHERIFF Dept.# SH	03-31-2026	29 YR, 4 MO
PAXTON A. REINECKER	SHERIFF Dept.# SH	03-31-2026	34 YR, 9 MO
TROY W. RODRIQUEZ	SHERIFF Dept.# SH	06-01-2026	25 YR, 7 MO
JACQUELINE H. SANCHEZ	SHERIFF Dept.# SH	03-28-2026	30 YR, 5 MO
SCOTT C. SHINAGAWA	SHERIFF Dept.# SH	03-31-2026	29 YR, 6 MO
ALEXANDER M. VALLOZZI	SHERIFF Dept.# SH	03-24-2026	29 YR, 5 MO

BOARD OF RETIREMENT MEETING OF MAY 6, 2026

BENEFIT APPROVAL LIST

GENERAL MEMBER APPLICATIONS FOR: SERVICE RETIRMENT

NAME	DEPARTMENT	RETIRED	SERVICE
ESTHER B. SAKO	AGING DEPARTMENT Dept.# AG	03-31-2026	25 YR, 0 MO
HSIU-HWA FU	AGRICULTURAL COMM./WTS & MEAS. Dept.# AW	04-30-2026	25 YR, 0 MO
PAWAN BHARDWAJ	AMBULATORY CARE NETWORK Dept.# HN	03-31-2026	13 YR, 0 MO
JENNIFER A. CASTILLO	AMBULATORY CARE NETWORK Dept.# HN	04-30-2026	28 YR, 9 MO
WINONA L. COWAN	AMBULATORY CARE NETWORK Dept.# HN	05-29-2026	20 YR, 1 MO
SUSANA DIAZ	AMBULATORY CARE NETWORK Dept.# HN	03-28-2026	25 YR, 6 MO
CARMEN A. GUERRERO	AMBULATORY CARE NETWORK Dept.# HN	03-27-2026	37 YR, 3 MO
EDITH J. HICKS	AMBULATORY CARE NETWORK Dept.# HN	03-30-2026	27 YR, 11 1/2 MO
OSCAR MEDRANO	AMBULATORY CARE NETWORK Dept.# HN	05-30-2026	25 YR, 1 MO
BERTHA O. MUNIVE	AMBULATORY CARE NETWORK Dept.# HN	05-30-2026	37 YR, 0 MO
SUZIE ORTIZ	AMBULATORY CARE NETWORK Dept.# HN	03-31-2026	37 YR, 7 MO
MARICELA C. PARRALES	AMBULATORY CARE NETWORK Dept.# HN	03-17-2026	25 YR, 2 1/2 MO
SUNDRA K. PHILLIPS	AMBULATORY CARE NETWORK Dept.# HN	05-30-2026	30 YR, 7 1/2 MO
SUSANA ROSS	AMBULATORY CARE NETWORK Dept.# HN	03-27-2026	25 YR, 5 MO

BOARD OF RETIREMENT MEETING OF MAY 6, 2026

BENEFIT APPROVAL LIST

GENERAL MEMBER APPLICATIONS FOR: SERVICE RETIRMENT

NAME	DEPARTMENT	RETIRED	SERVICE
DEMMIA T. SALARDA	AMBULATORY CARE NETWORK Dept.# HN	03-28-2026	27 YR, 4 MO
MARIA N. VALENZUELA	AMBULATORY CARE NETWORK Dept.# HN	05-30-2026	42 YR, 4 MO
LUCIANA VEGA	AMBULATORY CARE NETWORK Dept.# HN	04-30-2026	36 YR, 3 MO
ANGELINA BABCOCK	ANIMAL CONTROL Dept.# AN	05-31-2026	28 YR, 3 MO
DONATO LAPUZ	ANIMAL CONTROL Dept.# AN	03-31-2026	15 YR, 2 MO
ILDEFONSO DULAY	ASSESSOR Dept.# AS	03-25-2026	34 YR, 9 MO
ANDREW G. FURUTO	ASSESSOR Dept.# AS	03-31-2026	14 YR, 5 MO
REX HARTLINE	ASSESSOR Dept.# AS	05-01-2026	40 YR, 3 MO
LARRY J. SHORT	ASSESSOR Dept.# AS	03-31-2026	22 YR, 0 MO
ALGANESH TECLEMARIAM	ASSESSOR Dept.# AS	03-28-2026	18 YR, 9 MO
GABRIEL VALENCIA	ASSESSOR Dept.# AS	04-08-2026	37 YR, 9 1/2 MO
PAUL M. BERNAL	AUDITOR - CONTROLLER Dept.# AU	05-29-2026	42 YR, 1 MO
NORMA MARLE A. CANTA	AUDITOR - CONTROLLER Dept.# AU	03-31-2026	12 YR, 4 MO
SYLVESTER J. TOWNSEND	BEACHES & HARBORS Dept.# BH	05-30-2026	25 YR, 0 MO
ALAN V. NAIPO	BOARD OF SUPERVISORS Dept.# BS	05-09-2026	10 YR, 5 1/2 MO

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BENEFIT APPROVAL LIST

GENERAL MEMBER APPLICATIONS FOR: SERVICE RETIRMENT

NAME	DEPARTMENT	RETIRED	SERVICE
BRYAN C. WARD	BOARD OF SUPERVISORS Dept.# BS	05-26-2026	21 YR, 0 MO
FESIA A. DAVENPORT	CHIEF EXECUTIVE OFFICE Dept.# AO	05-01-2026	27 YR, 6 MO
LISA K. LEE	CHIEF EXECUTIVE OFFICE Dept.# AO	03-28-2026	42 YR, 3 13/16 MO
DAMION BUSHNELL	CHILD SUPPORT SERVICES Dept.# CD	05-13-2026	20 YR, 6 MO
FELICE R. MELWORM	CHILD SUPPORT SERVICES Dept.# CD	04-02-2026	25 YR, 8 1/2 MO
GABRIELLA N. MUNOZ	CHILD SUPPORT SERVICES Dept.# CD	03-28-2026	25 YR, 2 MO
CHERISE A. OLIVE	CHILD SUPPORT SERVICES Dept.# CD	04-30-2026	45 YR, 10 MO
RICHARD L. ROODZANT JR	CHILD SUPPORT SERVICES Dept.# CD	03-31-2026	25 YR, 4 1/2 MO
ASUNTA M. BARNES	CHILDREN & FAMILY SERVICES Dept.# CH	03-31-2026	27 YR, 3 1/2 MO
PATRICIA BARQUERA	CHILDREN & FAMILY SERVICES Dept.# CH	03-28-2026	23 YR, 6 MO
BERTHA A. BARRETO	CHILDREN & FAMILY SERVICES Dept.# CH	05-22-2026	17 YR, 10 MO
JOAN BECKET	CHILDREN & FAMILY SERVICES Dept.# CH	03-28-2026	33 YR, 2 MO
BERNADETTE D. BRAZAL	CHILDREN & FAMILY SERVICES Dept.# CH	03-25-2026	16 YR, 5 MO
FRANK J. CRUZ	CHILDREN & FAMILY SERVICES Dept.# CH	03-31-2026	33 YR, 1 MO
MARIA A. DE AVILA	CHILDREN & FAMILY SERVICES Dept.# CH	03-31-2026	39 YR, 2 MO

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GENERAL MEMBER APPLICATIONS FOR: SERVICE RETIRMENT

NAME	DEPARTMENT	RETIRED	SERVICE
SHELBY D. ELLIS	CHILDREN & FAMILY SERVICES Dept.# CH	04-30-2026	33 YR, 4 MO
ALMIRA M. GARZA	CHILDREN & FAMILY SERVICES Dept.# CH	05-29-2026	25 YR, 7 MO
ALEJANDRA GOMEZTAGLE	CHILDREN & FAMILY SERVICES Dept.# CH	06-27-2026	9 YR, 8 1/2 MO
LESLIE C. GRIFFITH	CHILDREN & FAMILY SERVICES Dept.# CH	03-28-2026	40 YR, 5 1/2 MO
MAYDA HERNANDEZ	CHILDREN & FAMILY SERVICES Dept.# CH	03-28-2026	30 YR, 2 MO
IRMA E. HERNANDEZ	CHILDREN & FAMILY SERVICES Dept.# CH	03-28-2026	33 YR, 6 MO
MARIA F. HERRERA	CHILDREN & FAMILY SERVICES Dept.# CH	03-28-2026	19 YR, 11 1/2 MO
SHEIRELLA A. JACKSON-GROSS	CHILDREN & FAMILY SERVICES Dept.# CH	04-30-2026	41 YR, 5 MO
GLENDA D. LEFLORE	CHILDREN & FAMILY SERVICES Dept.# CH	06-01-2026	30 YR, 5 MO
TIMOTHY J. LOVETT	CHILDREN & FAMILY SERVICES Dept.# CH	04-17-2026	12 YR, 10 MO
FELIPE D. MARTIN	CHILDREN & FAMILY SERVICES Dept.# CH	04-30-2026	27 YR, 2 1/2 MO
ZAHRA MISHEK	CHILDREN & FAMILY SERVICES Dept.# CH	03-31-2026	29 YR, 1 MO
ARMAND M. MONTIEL	CHILDREN & FAMILY SERVICES Dept.# CH	03-28-2026	37 YR, 0 MO
ANNIE M. MURRAY	CHILDREN & FAMILY SERVICES Dept.# CH	03-27-2026	9 YR, 11 MO
MARIA C. RAMIREZ	CHILDREN & FAMILY SERVICES Dept.# CH	03-28-2026	19 YR, 5 MO

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GENERAL MEMBER APPLICATIONS FOR: SERVICE RETIRMENT

NAME	DEPARTMENT	RETIRED	SERVICE
MICHAEL K. ROSS	CHILDREN & FAMILY SERVICES Dept.# CH	03-31-2026	28 YR, 0 MO
DAVID L. SALYERS	CHILDREN & FAMILY SERVICES Dept.# CH	04-30-2026	29 YR, 10 MO
RACHEL SIMON	CHILDREN & FAMILY SERVICES Dept.# CH	04-30-2026	41 YR, 5 MO
MALAK A. SOLIMAN	CHILDREN & FAMILY SERVICES Dept.# CH	03-28-2026	28 YR, 10 MO
ROBIN YOUNGER-HOLMES	CHILDREN & FAMILY SERVICES Dept.# CH	04-30-2026	33 YR, 9 MO
VIRGINIA A. ZOHRABIAN	CHILDREN & FAMILY SERVICES Dept.# CH	03-31-2026	26 YR, 0 MO
LOURDES N. AGUILAR GUZMAN	COASTAL CLUSTER-HARBOR/UCLA MC Dept.# HH	03-27-2026	40 YR, 4 1/2 MO
KATHY A. BENSON	COASTAL CLUSTER-HARBOR/UCLA MC Dept.# HH	05-27-2026	20 YR, 0 MO
DIEP H. BUI	COASTAL CLUSTER-HARBOR/UCLA MC Dept.# HH	03-29-2026	29 YR, 7 MO
ROWENA V. BUWALDA	COASTAL CLUSTER-HARBOR/UCLA MC Dept.# HH	03-25-2026	15 YR, 6 1/2 MO
LORENA L. CASTILLO LOPEZ	COASTAL CLUSTER-HARBOR/UCLA MC Dept.# HH	05-30-2026	25 YR, 6 MO
TRACY DAVENPORT	COASTAL CLUSTER-HARBOR/UCLA MC Dept.# HH	07-19-2026	21 YR, 0 MO
ROSALYN D. DOUGLAS	COASTAL CLUSTER-HARBOR/UCLA MC Dept.# HH	03-28-2026	33 YR, 2 MO

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GENERAL MEMBER APPLICATIONS FOR: SERVICE RETIRMENT

NAME	DEPARTMENT	RETIRED	SERVICE
ELDRIDGE A. LEWIS	COASTAL CLUSTER- HARBOR/UCLA MC Dept.# HH	04-30-2026	42 YR, 3 MO
REGINA R. MC CLENDON	COASTAL CLUSTER- HARBOR/UCLA MC Dept.# HH	03-28-2026	43 YR, 1 MO
MARY MCCOY	COASTAL CLUSTER- HARBOR/UCLA MC Dept.# HH	03-31-2026	20 YR, 2 MO
JOSEFINA MENDOZA	COASTAL CLUSTER- HARBOR/UCLA MC Dept.# HH	03-27-2026	22 YR, 11 1/2 MO
LAWRENCE E. NEAL	COASTAL CLUSTER- HARBOR/UCLA MC Dept.# HH	03-31-2026	38 YR, 9 1/2 MO
CHARLES PEOPLES	COASTAL CLUSTER- HARBOR/UCLA MC Dept.# HH	05-30-2026	51 YR, 0 MO
RANDY G. RAMIREZ	COASTAL CLUSTER- HARBOR/UCLA MC Dept.# HH	03-28-2026	25 YR, 6 1/2 MO
ANGELITA S. RAMIREZ	COASTAL CLUSTER- HARBOR/UCLA MC Dept.# HH	03-28-2026	26 YR, 8 MO
RENU SHARMA	COASTAL CLUSTER- HARBOR/UCLA MC Dept.# HH	03-31-2026	35 YR, 9 MO
ALFREDA WATKINS	COASTAL CLUSTER- HARBOR/UCLA MC Dept.# HH	04-30-2026	45 YR, 7 MO
JOVEN E. AGLIPAY	CORRECTIONAL HEALTH Dept.# HC	03-28-2026	16 YR, 8 1/2 MO
MARICAR BALABBO	CORRECTIONAL HEALTH Dept.# HC	06-30-2026	25 YR, 2 MO

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GENERAL MEMBER APPLICATIONS FOR: SERVICE RETIRMENT

NAME	DEPARTMENT	RETIRED	SERVICE
JENNY CHOI	CORRECTIONAL HEALTH Dept.# HC	05-30-2026	21 YR, 0 MO
HEYMI KIM	CORRECTIONAL HEALTH Dept.# HC	05-31-2026	18 YR, 0 1/3 MO
SCHOLAR C. NWOKE	CORRECTIONAL HEALTH Dept.# HC	05-30-2026	22 YR, 2 1/2 MO
LORETTA O. OGUNNAYA	CORRECTIONAL HEALTH Dept.# HC	03-31-2026	26 YR, 6 1/2 MO
NECITAS R. PABLICO	CORRECTIONAL HEALTH Dept.# HC	04-30-2026	36 YR, 1 MO
ANGELITA A. PEDRAJA	CORRECTIONAL HEALTH Dept.# HC	03-31-2026	10 YR, 8 MO
JUAN RENDON	CORRECTIONAL HEALTH Dept.# HC	03-31-2026	36 YR, 4 MO
JOSIE LOU L. SALAC	CORRECTIONAL HEALTH Dept.# HC	06-27-2026	21 YR, 0 MO
GEORGE VELASCO-LOPEZ	CORRECTIONAL HEALTH Dept.# HC	05-19-2026	21 YR, 0 MO
RICHARD GIRGADO	COUNTY COUNSEL Dept.# CC	06-06-2026	25 YR, 1 1/2 MO
EDWIN A. LEWIS	COUNTY COUNSEL Dept.# CC	05-30-2026	19 YR, 1 MO
VICTORIA MANSOURIAN	COUNTY COUNSEL Dept.# CC	03-31-2026	34 YR, 0 MO
ERICA P. GREENE	DEPARTMENT OF HUMAN RESOURCES Dept.# HM	03-28-2026	43 YR, 2 MO
DEANNA R. MARTINDALE	DEPARTMENT OF HUMAN RESOURCES Dept.# HM	06-27-2026	20 YR, 2 MO

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GENERAL MEMBER APPLICATIONS FOR: SERVICE RETIRMENT

NAME	DEPARTMENT	RETIRED	SERVICE
SEPIDEH A. SOURIS	DEPARTMENT OF HUMAN RESOURCES Dept.# HM	03-27-2026	33 YR, 0 MO
TRACEY K. REED	DEPT OF HOMELESS SERV & HOUSIN Dept.# DH	04-16-2026	30 YR, 10 1/2 MO
MARGARET G. AGHAJANIAN	DEPT OF PUBLIC SOCIAL SERVICES Dept.# SS	04-30-2026	25 YR, 0 MO
ARMINE AKOPYAN	DEPT OF PUBLIC SOCIAL SERVICES Dept.# SS	04-30-2026	25 YR, 0 MO
CLARENA ARNICK	DEPT OF PUBLIC SOCIAL SERVICES Dept.# SS	04-30-2026	25 YR, 0 MO
MARTHA ASCENCIO	DEPT OF PUBLIC SOCIAL SERVICES Dept.# SS	04-30-2026	31 YR, 2 MO
HASMIK AYDINDZHYAN	DEPT OF PUBLIC SOCIAL SERVICES Dept.# SS	04-30-2026	31 YR, 2 MO
JAIME E. BAQUERO	DEPT OF PUBLIC SOCIAL SERVICES Dept.# SS	06-30-2026	19 YR, 5 MO
SPADNAR K. BUTLER	DEPT OF PUBLIC SOCIAL SERVICES Dept.# SS	03-28-2026	26 YR, 3 MO
LUCIA CARINIO	DEPT OF PUBLIC SOCIAL SERVICES Dept.# SS	03-28-2026	32 YR, 0 MO
CHRIS S. CHAN	DEPT OF PUBLIC SOCIAL SERVICES Dept.# SS	06-01-2026	32 YR, 4 MO

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GENERAL MEMBER APPLICATIONS FOR: SERVICE RETIRMENT

NAME	DEPARTMENT	RETIRED	SERVICE
PHILLISTINE Y. CRAWFORD	DEPT OF PUBLIC SOCIAL SERVICES Dept.# SS	05-30-2026	32 YR, 9 MO
JESUS A. DAVILA	DEPT OF PUBLIC SOCIAL SERVICES Dept.# SS	04-30-2026	25 YR, 9 1/2 MO
MIGUEL E. DERAS	DEPT OF PUBLIC SOCIAL SERVICES Dept.# SS	05-30-2026	34 YR, 6 MO
MARTIN DOMINGUEZ	DEPT OF PUBLIC SOCIAL SERVICES Dept.# SS	03-28-2026	36 YR, 10 MO
SUSANNA DZHUGARYAN	DEPT OF PUBLIC SOCIAL SERVICES Dept.# SS	03-31-2026	26 YR, 4 MO
GLORIA ELIAS	DEPT OF PUBLIC SOCIAL SERVICES Dept.# SS	03-28-2026	26 YR, 4 MO
MANOOSH FARHADIANS	DEPT OF PUBLIC SOCIAL SERVICES Dept.# SS	04-30-2026	19 YR, 2 MO
CHERIE M. FRYMAN	DEPT OF PUBLIC SOCIAL SERVICES Dept.# SS	06-30-2026	12 YR, 0 MO
MIRTHA P. GALLEGOS	DEPT OF PUBLIC SOCIAL SERVICES Dept.# SS	03-27-2026	26 YR, 6 1/2 MO
OTILIA GAXIOLA	DEPT OF PUBLIC SOCIAL SERVICES Dept.# SS	05-05-2026	34 YR, 0 MO
PATRICIA W. GILKEY	DEPT OF PUBLIC SOCIAL SERVICES Dept.# SS	04-25-2026	25 YR, 0 MO

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GENERAL MEMBER APPLICATIONS FOR: SERVICE RETIRMENT

NAME	DEPARTMENT	RETIRED	SERVICE
PATRICIA GONZALEZ	DEPT OF PUBLIC SOCIAL SERVICES Dept.# SS	04-30-2026	25 YR, 0 MO
ARAKSI GRIGORIAN	DEPT OF PUBLIC SOCIAL SERVICES Dept.# SS	03-31-2026	25 YR, 0 1/2 MO
GLORIA C. HERNANDEZ	DEPT OF PUBLIC SOCIAL SERVICES Dept.# SS	03-28-2026	54 YR, 4 1/16 MO
SHIEN M. HO	DEPT OF PUBLIC SOCIAL SERVICES Dept.# SS	05-30-2026	35 YR, 7 MO
LINH T. HUYNH	DEPT OF PUBLIC SOCIAL SERVICES Dept.# SS	03-28-2026	36 YR, 3 MO
JULITA B. IBARRA	DEPT OF PUBLIC SOCIAL SERVICES Dept.# SS	06-20-2026	33 YR, 6 MO
ELIZABETH JACINTO	DEPT OF PUBLIC SOCIAL SERVICES Dept.# SS	04-11-2026	33 YR, 9 1/2 MO
SONYA KARAGEZYAN	DEPT OF PUBLIC SOCIAL SERVICES Dept.# SS	03-31-2026	26 YR, 4 MO
HASMIK KAZARYAN	DEPT OF PUBLIC SOCIAL SERVICES Dept.# SS	04-30-2026	24 YR, 8 MO
YANETH KEM	DEPT OF PUBLIC SOCIAL SERVICES Dept.# SS	03-28-2026	36 YR, 6 MO
PEGGY A. LIMONES	DEPT OF PUBLIC SOCIAL SERVICES Dept.# SS	03-31-2026	25 YR, 8 1/2 MO

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GENERAL MEMBER APPLICATIONS FOR: SERVICE RETIRMENT

NAME	DEPARTMENT	RETIRED	SERVICE
ELSIE C. LIN	DEPT OF PUBLIC SOCIAL SERVICES Dept.# SS	05-31-2026	14 YR, 0 MO
FARRAH LIU	DEPT OF PUBLIC SOCIAL SERVICES Dept.# SS	04-17-2026	26 YR, 7 MO
ALEJANDRA LUGO	DEPT OF PUBLIC SOCIAL SERVICES Dept.# SS	03-28-2026	35 YR, 8 MO
CANDICE LUI	DEPT OF PUBLIC SOCIAL SERVICES Dept.# SS	05-29-2026	31 YR, 3 MO
TONI L. LYNCH	DEPT OF PUBLIC SOCIAL SERVICES Dept.# SS	03-28-2026	25 YR, 0 MO
DEBRA L. MALDONADO	DEPT OF PUBLIC SOCIAL SERVICES Dept.# SS	03-28-2026	34 YR, 0 MO
MARY E. MARIANO	DEPT OF PUBLIC SOCIAL SERVICES Dept.# SS	04-30-2026	36 YR, 6 MO
KELLYE V. MILES	DEPT OF PUBLIC SOCIAL SERVICES Dept.# SS	03-27-2026	37 YR, 8 MO
VIVIAN MORAGA	DEPT OF PUBLIC SOCIAL SERVICES Dept.# SS	03-28-2026	45 YR, 11 MO
GINA L. MUNOZ	DEPT OF PUBLIC SOCIAL SERVICES Dept.# SS	03-25-2026	23 YR, 7 1/2 MO
COLIN E. NEAL	DEPT OF PUBLIC SOCIAL SERVICES Dept.# SS	05-27-2026	39 YR, 6 MO

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GENERAL MEMBER APPLICATIONS FOR: SERVICE RETIRMENT

NAME	DEPARTMENT	RETIRED	SERVICE
PING NG	DEPT OF PUBLIC SOCIAL SERVICES Dept.# SS	04-30-2026	37 YR, 4 MO
SON H. NGUYEN	DEPT OF PUBLIC SOCIAL SERVICES Dept.# SS	04-30-2026	25 YR, 0 MO
MOWELL G. OBONYANO	DEPT OF PUBLIC SOCIAL SERVICES Dept.# SS	05-29-2026	32 YR, 4 MO
LAURA P. PELAYO	DEPT OF PUBLIC SOCIAL SERVICES Dept.# SS	05-30-2026	25 YR, 3 MO
ROSE PEREGRINO	DEPT OF PUBLIC SOCIAL SERVICES Dept.# SS	03-28-2026	33 YR, 10 MO
RITA PEREZ	DEPT OF PUBLIC SOCIAL SERVICES Dept.# SS	03-28-2026	34 YR, 3 MO
SHOGIK PETROSYAN	DEPT OF PUBLIC SOCIAL SERVICES Dept.# SS	06-20-2026	32 YR, 3 MO
THEA S. QUEEN	DEPT OF PUBLIC SOCIAL SERVICES Dept.# SS	03-31-2026	27 YR, 6 MO
MARIA RAMIREZ	DEPT OF PUBLIC SOCIAL SERVICES Dept.# SS	05-31-2026	32 YR, 5 MO
ROSA M. RAMOS	DEPT OF PUBLIC SOCIAL SERVICES Dept.# SS	03-28-2026	34 YR, 4 MO
BENNIE REESE	DEPT OF PUBLIC SOCIAL SERVICES Dept.# SS	05-30-2026	31 YR, 11 MO

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GENERAL MEMBER APPLICATIONS FOR: SERVICE RETIRMENT

NAME	DEPARTMENT	RETIRED	SERVICE
MARIA G. RIVERA	DEPT OF PUBLIC SOCIAL SERVICES Dept.# SS	03-31-2026	25 YR, 5 1/2 MO
MARTHA ROBLES	DEPT OF PUBLIC SOCIAL SERVICES Dept.# SS	05-30-2026	25 YR, 6 MO
MARIA G. RODRIGUEZ	DEPT OF PUBLIC SOCIAL SERVICES Dept.# SS	03-28-2026	24 YR, 11 MO
PATRICIA RODRIGUEZ	DEPT OF PUBLIC SOCIAL SERVICES Dept.# SS	04-29-2026	28 YR, 0 MO
LUZ M. ROSS	DEPT OF PUBLIC SOCIAL SERVICES Dept.# SS	03-31-2026	26 YR, 9 MO
IBRAHIM SABA	DEPT OF PUBLIC SOCIAL SERVICES Dept.# SS	04-30-2026	34 YR, 6 1/2 MO
TOYIA M. SCALF	DEPT OF PUBLIC SOCIAL SERVICES Dept.# SS	05-30-2026	25 YR, 0 MO
SVETLANA SHEVEKHMAN	DEPT OF PUBLIC SOCIAL SERVICES Dept.# SS	04-30-2026	25 YR, 0 MO
SILVANA D. SIGUENZA	DEPT OF PUBLIC SOCIAL SERVICES Dept.# SS	03-28-2026	28 YR, 2 MO
TRACEY S. SIMPSON	DEPT OF PUBLIC SOCIAL SERVICES Dept.# SS	03-28-2026	40 YR, 2 MO
BETTY J. STARK	DEPT OF PUBLIC SOCIAL SERVICES Dept.# SS	04-30-2026	36 YR, 2 MO

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GENERAL MEMBER APPLICATIONS FOR: SERVICE RETIRMENT

NAME	DEPARTMENT	RETIRED	SERVICE
LA FRANCE TOLIVER	DEPT OF PUBLIC SOCIAL SERVICES Dept.# SS	04-30-2026	39 YR, 3 MO
SEDA TOLMOYAN	DEPT OF PUBLIC SOCIAL SERVICES Dept.# SS	04-30-2026	26 YR, 2 MO
HUI WEN TSENG	DEPT OF PUBLIC SOCIAL SERVICES Dept.# SS	03-31-2026	19 YR, 4 MO
KARINE VARDANYAN	DEPT OF PUBLIC SOCIAL SERVICES Dept.# SS	05-29-2026	19 YR, 3 MO
EILEEN VELASQUEZ	DEPT OF PUBLIC SOCIAL SERVICES Dept.# SS	03-28-2026	35 YR, 7 MO
ALFONSO S. VILLALPANDO	DEPT OF PUBLIC SOCIAL SERVICES Dept.# SS	02-27-2026	31 YR, 2 MO
MARTHA A. VIRGEN	DEPT OF PUBLIC SOCIAL SERVICES Dept.# SS	06-09-2026	26 YR, 0 1/2 MO
QUYNHHU T. VU	DEPT OF PUBLIC SOCIAL SERVICES Dept.# SS	03-27-2026	35 YR, 8 MO
JACQUELYNN WESTBROOKS	DEPT OF PUBLIC SOCIAL SERVICES Dept.# SS	03-31-2026	35 YR, 9 MO
MARC C. BEAART	DISTRICT ATTORNEY Dept.# DA	03-28-2026	34 YR, 2 MO
SERA BOYADJIAN	DISTRICT ATTORNEY Dept.# DA	03-04-2026	38 YR, 4 1/2 MO
KELLYJEAN M. CHUN	DISTRICT ATTORNEY Dept.# DA	05-30-2026	38 YR, 7 MO

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GENERAL MEMBER APPLICATIONS FOR: SERVICE RETIRMENT

NAME	DEPARTMENT	RETIRED	SERVICE
DONNA T. NAGAMINE	DISTRICT ATTORNEY Dept.# DA	03-28-2026	39 YR, 1 MO
CELIA POLITEO	DISTRICT ATTORNEY Dept.# DA	03-28-2026	37 YR, 7 MO
LINDA S. REISZ	DISTRICT ATTORNEY Dept.# DA	03-31-2026	40 YR, 1 MO
WAYMOND T. YEE	GRAND JURY Dept.# GJ	03-31-2026	31 YR, 7 MO
NORMA CASAS	HEALTH SERVICES ADMINISTRATION Dept.# HS	04-30-2026	17 YR, 2 MO
MIKAYEL CHOREKCHYAN	HEALTH SERVICES ADMINISTRATION Dept.# HS	05-30-2026	14 YR, 4 MO
LI-FARN HSIAO	HEALTH SERVICES ADMINISTRATION Dept.# HS	06-29-2026	24 YR, 1 MO
LAURA LEYMAN	HEALTH SERVICES ADMINISTRATION Dept.# HS	04-28-2026	5 YR, 0 MO
SU-LING LIN	HEALTH SERVICES ADMINISTRATION Dept.# HS	04-30-2026	18 YR, 8 MO
LUIS A. MARQUEZ	HEALTH SERVICES ADMINISTRATION Dept.# HS	05-11-2026	28 YR, 7 MO
RUTH D. MENDOZA	HEALTH SERVICES ADMINISTRATION Dept.# HS	03-28-2026	22 YR, 3 MO
LAURA RAMOS	HEALTH SERVICES ADMINISTRATION Dept.# HS	04-30-2026	46 YR, 0 MO

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NAME	DEPARTMENT	RETIRED	SERVICE
DAVIS TRUONG	HEALTH SERVICES ADMINISTRATION Dept.# HS	03-27-2026	32 YR, 8 MO
TOM T. VUONG	HEALTH SERVICES ADMINISTRATION Dept.# HS	05-29-2026	35 YR, 1 MO
YANCY J. ALMODOVAR	INTERNAL SERVICES Dept.# IS	05-29-2026	19 YR, 3 MO
VAHAN K. DEMIRJIAN	INTERNAL SERVICES Dept.# IS	05-21-2026	40 YR, 4 MO
TIMOTHY M. IRVIN	INTERNAL SERVICES Dept.# IS	06-27-2026	27 YR, 0 MO
LARRY W. LEW	INTERNAL SERVICES Dept.# IS	04-30-2026	47 YR, 4 MO
HA V. NGUYEN	INTERNAL SERVICES Dept.# IS	04-30-2026	24 YR, 0 1/2 MO
DANIEL P. SHRYNE	INTERNAL SERVICES Dept.# IS	03-28-2026	40 YR, 7 MO
JUMRIANGRATT HENRY	JUVENILE COURT HEALTH SERVICES Dept.# HJ	03-28-2026	26 YR, 3 MO
MARIO A. GUDINO	L A COUNTY FIRE DEPT Dept.# FR	04-30-2026	7 YR, 3 MO
TIMOTHY I. GULOY	L A COUNTY FIRE DEPT Dept.# FR	03-27-2026	27 YR, 7 MO
CLAUDIA P. SOIZA	L A COUNTY FIRE DEPT Dept.# FR	03-27-2026	33 YR, 11 MO
ADRIANA GOMEZ-ROMERO	MEDICAL EXAMINER Dept.# ME	03-23-2026	38 YR, 1 1/2 MO
ANAHIT GRIGORYAN	MEDICAL EXAMINER Dept.# ME	05-11-2026	13 YR, 3 1/2 MO

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GENERAL MEMBER APPLICATIONS FOR: SERVICE RETIRMENT

NAME	DEPARTMENT	RETIRED	SERVICE
HOUBI ARAKELIAN	MENTAL HEALTH Dept.# MH	04-30-2026	24 YR, 0 MO
PERCY H. ARREZA	MENTAL HEALTH Dept.# MH	06-12-2026	22 YR, 2 1/2 MO
CHAD D. BRINDERSON	MENTAL HEALTH Dept.# MH	03-28-2026	31 YR, 9 MO
MICHAEL A. COOK	MENTAL HEALTH Dept.# MH	05-30-2026	26 YR, 0 MO
GREGORY C. DOANE	MENTAL HEALTH Dept.# MH	03-28-2026	1 YR, 10 MO
CARRIE L. ESPARZA	MENTAL HEALTH Dept.# MH	05-29-2026	25 YR, 4 MO
CRYSTAL GAW	MENTAL HEALTH Dept.# MH	05-30-2026	26 YR, 3 MO
THOMAS KIRK	MENTAL HEALTH Dept.# MH	03-31-2026	25 YR, 1 1/2 MO
MARIAM NAHAPETYAN	MENTAL HEALTH Dept.# MH	03-28-2026	29 YR, 0 MO
DEBRA A. PRADO	MENTAL HEALTH Dept.# MH	04-02-2026	36 YR, 3 MO
MARIA ELENA SAEDEDDIN	MENTAL HEALTH Dept.# MH	06-27-2026	19 YR, 0 MO
SHIRIN SHARIFHA	MENTAL HEALTH Dept.# MH	04-30-2026	28 YR, 5 MO
LISA STRATFORD	MENTAL HEALTH Dept.# MH	04-30-2026	26 YR, 2 1/2 MO
TERRI L. WALTERS	MENTAL HEALTH Dept.# MH	03-23-2026	17 YR, 4 1/2 MO
CYNTHIA A. WHEATON	MENTAL HEALTH Dept.# MH	04-30-2026	41 YR, 2 MO

BOARD OF RETIREMENT MEETING OF MAY 6, 2026

BENEFIT APPROVAL LIST

GENERAL MEMBER APPLICATIONS FOR: SERVICE RETIRMENT

NAME	DEPARTMENT	RETIRED	SERVICE
BURLENA AYERS	NORTHEAST CLUSTER (LAC+USC) Dept.# HG	03-28-2026	43 YR, 11 MO
DOROTHY R. BLACK	NORTHEAST CLUSTER (LAC+USC) Dept.# HG	05-29-2026	6 YR, 1 MO
MONALEE BODDEN	NORTHEAST CLUSTER (LAC+USC) Dept.# HG	03-28-2026	37 YR, 4 MO
VELIA I. CALDERON	NORTHEAST CLUSTER (LAC+USC) Dept.# HG	04-15-2026	26 YR, 3 1/2 MO
HARRIETTE A. CALHOUN	NORTHEAST CLUSTER (LAC+USC) Dept.# HG	03-31-2026	41 YR, 6 MO
VICKIE L. CARTER	NORTHEAST CLUSTER (LAC+USC) Dept.# HG	05-22-2026	25 YR, 3 MO
TANYA L. CASTELLANOS	NORTHEAST CLUSTER (LAC+USC) Dept.# HG	06-01-2026	33 YR, 2 MO
MICHAEL DUARTE	NORTHEAST CLUSTER (LAC+USC) Dept.# HG	05-30-2026	10 YR, 5 MO
DIANA GALACHYAN	NORTHEAST CLUSTER (LAC+USC) Dept.# HG	05-28-2026	25 YR, 4 MO
DOLORES M. GIBBS	NORTHEAST CLUSTER (LAC+USC) Dept.# HG	04-30-2026	18 YR, 0 MO
ANGINE GYULAKUBYAN	NORTHEAST CLUSTER (LAC+USC) Dept.# HG	04-15-2026	20 YR, 0 MO

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BENEFIT APPROVAL LIST

GENERAL MEMBER APPLICATIONS FOR: SERVICE RETIRMENT

NAME	DEPARTMENT	RETIRED	SERVICE
YURI LEE	NORTHEAST CLUSTER (LAC+USC) Dept.# HG	05-29-2026	33 YR, 6 MO
MARIE A. LICATA	NORTHEAST CLUSTER (LAC+USC) Dept.# HG	04-30-2026	25 YR, 0 MO
BETTY N. LU	NORTHEAST CLUSTER (LAC+USC) Dept.# HG	03-28-2026	39 YR, 5 MO
PHYLLIS D. MIMS	NORTHEAST CLUSTER (LAC+USC) Dept.# HG	05-29-2026	19 YR, 1 MO
LAWRENCE OPAS	NORTHEAST CLUSTER (LAC+USC) Dept.# HG	03-31-2026	49 YR, 5 MO
ESTELITA V. RUTGER	NORTHEAST CLUSTER (LAC+USC) Dept.# HG	04-30-2026	25 YR, 0 MO
E'DWANDA V. SEYMORE	NORTHEAST CLUSTER (LAC+USC) Dept.# HG	05-30-2026	25 YR, 0 MO
LINDA J. WADE	NORTHEAST CLUSTER (LAC+USC) Dept.# HG	03-28-2026	44 YR, 0 MO
VIVIAN N. WAWORUNDENG	NORTHEAST CLUSTER (LAC+USC) Dept.# HG	03-28-2026	34 YR, 2 MO
JESUS SUAREZ	PARKS AND RECREATION Dept.# PK	03-31-2026	31 YR, 1 MO
BOB M. AKPONYE-OTUECHERE	PROBATION DEPARTMENT Dept.# PB	03-28-2026	25 YR, 10 MO
SISELEY A. ARROYO	PROBATION DEPARTMENT Dept.# PB	04-07-2026	19 YR, 8 1/2 MO

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BENEFIT APPROVAL LIST

GENERAL MEMBER APPLICATIONS FOR: SERVICE RETIRMENT

NAME	DEPARTMENT	RETIRED	SERVICE
GLORIA M. BETANCOURT	PROBATION DEPARTMENT Dept.# PB	03-27-2026	35 YR, 7 1/2 MO
EDWARD BONILLA	PROBATION DEPARTMENT Dept.# PB	05-29-2026	23 YR, 5 MO
TONYA F. CALAIS	PROBATION DEPARTMENT Dept.# PB	05-03-2026	25 YR, 8 MO
EDDIE J. CHISM	PROBATION DEPARTMENT Dept.# PB	05-31-2026	24 YR, 5 MO
TRACIE D. CHRETIEN	PROBATION DEPARTMENT Dept.# PB	05-13-2026	6 YR, 3 1/2 MO
MARGARET DURAN	PROBATION DEPARTMENT Dept.# PB	06-30-2026	10 YR, 11 MO
CELINA DURAZO	PROBATION DEPARTMENT Dept.# PB	03-28-2026	30 YR, 5 MO
WANDA S. FALLS	PROBATION DEPARTMENT Dept.# PB	03-31-2026	34 YR, 2 MO
KIMBERLY D. GOODWIN	PROBATION DEPARTMENT Dept.# PB	05-30-2026	18 YR, 2 MO
SCOTT M. HABERMAN	PROBATION DEPARTMENT Dept.# PB	03-14-2026	36 YR, 8 1/2 MO
BRIAN A. HARRIS	PROBATION DEPARTMENT Dept.# PB	04-30-2026	35 YR, 2 MO
ELVIRA HERNANDEZ	PROBATION DEPARTMENT Dept.# PB	04-16-2026	42 YR, 4 1/2 MO
LAWRENCE D. HORTON III	PROBATION DEPARTMENT Dept.# PB	03-31-2026	38 YR, 11 MO
KURT M. KELLER	PROBATION DEPARTMENT Dept.# PB	06-16-2026	39 YR, 7 1/2 MO
IRMA Y. LOPEZ	PROBATION DEPARTMENT Dept.# PB	03-28-2026	5 YR, 11 1/2 MO

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BENEFIT APPROVAL LIST

GENERAL MEMBER APPLICATIONS FOR: SERVICE RETIRMENT

NAME	DEPARTMENT	RETIRED	SERVICE
MARINE MANDJHYAN	PROBATION DEPARTMENT Dept.# PB	03-31-2026	27 YR, 2 MO
CHARLES MC DANIEL	PROBATION DEPARTMENT Dept.# PB	05-29-2026	43 YR, 2 MO
ELIA P. ORTEGA	PROBATION DEPARTMENT Dept.# PB	03-28-2026	23 YR, 10 MO
GLORIA A. PEREZ	PROBATION DEPARTMENT Dept.# PB	04-30-2026	21 YR, 11 MO
MONICA R. PIMENTELL	PROBATION DEPARTMENT Dept.# PB	04-30-2026	36 YR, 10 MO
MARIA A. PIZANO	PROBATION DEPARTMENT Dept.# PB	03-31-2026	27 YR, 5 1/2 MO
MARGIETTA ROBINSON	PROBATION DEPARTMENT Dept.# PB	05-30-2026	28 YR, 11 MO
LORENZO A. SANDOVAL	PROBATION DEPARTMENT Dept.# PB	05-20-2026	38 YR, 0 1/2 MO
MARIA E. SOTO	PROBATION DEPARTMENT Dept.# PB	03-28-2026	31 YR, 1 MO
DINEEN L. SUTTON-SMITH	PROBATION DEPARTMENT Dept.# PB	03-31-2026	28 YR, 0 1/2 MO
WANDA V. THARPE	PROBATION DEPARTMENT Dept.# PB	05-31-2026	37 YR, 3 MO
CATHERINE ZELAYA	PROBATION DEPARTMENT Dept.# PB	04-30-2026	25 YR, 8 1/2 MO
KEISHA C. HOLLAND	PUBLIC DEFENDER Dept.# PD	03-31-2026	26 YR, 0 1/10 MO
MARY E. TENNANT	PUBLIC DEFENDER Dept.# PD	03-31-2026	34 YR, 3 13/16 MO
MICHELLE ABRAM	PUBLIC HEALTH PROGRAM Dept.# PH	05-29-2026	25 YR, 0 MO

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GENERAL MEMBER APPLICATIONS FOR: SERVICE RETIRMENT

NAME	DEPARTMENT	RETIRED	SERVICE
RENEE S. BRACY	PUBLIC HEALTH PROGRAM Dept.# PH	03-28-2026	24 YR, 2 MO
MABEL I. CEDENO-GALE	PUBLIC HEALTH PROGRAM Dept.# PH	03-28-2026	36 YR, 4 MO
SUPREEDA M. DISPUN	PUBLIC HEALTH PROGRAM Dept.# PH	06-27-2026	12 YR, 0 MO
JOYSWORTH R. EYITAYO	PUBLIC HEALTH PROGRAM Dept.# PH	05-30-2026	20 YR, 4 MO
BARBARA J. FIERRO	PUBLIC HEALTH PROGRAM Dept.# PH	03-31-2026	25 YR, 7 1/2 MO
ELIZABETH GONZALEZ	PUBLIC HEALTH PROGRAM Dept.# PH	03-28-2026	37 YR, 5 MO
LIZA M. HERRERA	PUBLIC HEALTH PROGRAM Dept.# PH	05-29-2026	42 YR, 2 MO
RACHELLE D. JACKSON	PUBLIC HEALTH PROGRAM Dept.# PH	03-28-2026	38 YR, 5 MO
LINDA M. KIM-FUNG	PUBLIC HEALTH PROGRAM Dept.# PH	03-31-2026	42 YR, 9 MO
ELAINE A. MOORE	PUBLIC HEALTH PROGRAM Dept.# PH	03-28-2026	46 YR, 1 MO
BRIT K. OIULFSTAD	PUBLIC HEALTH PROGRAM Dept.# PH	03-31-2026	30 YR, 9 MO
ANNA L. SANCHEZ	PUBLIC HEALTH PROGRAM Dept.# PH	03-27-2026	39 YR, 11 MO
TONIA L. SMITH	PUBLIC HEALTH PROGRAM Dept.# PH	04-17-2026	34 YR, 8 MO
PINYEDA RENEE SRIVIRIYA BERNARDO	PUBLIC HEALTH PROGRAM Dept.# PH	03-31-2026	28 YR, 2 MO
LUTHER T. TERRELL	PUBLIC HEALTH PROGRAM Dept.# PH	03-31-2026	34 YR, 10 MO

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GENERAL MEMBER APPLICATIONS FOR: SERVICE RETIRMENT

NAME	DEPARTMENT	RETIRED	SERVICE
VANESSA G. TRAN	PUBLIC HEALTH PROGRAM Dept.# PH	03-14-2026	20 YR, 2 1/2 MO
KENT WEI	PUBLIC HEALTH PROGRAM Dept.# PH	03-31-2026	36 YR, 8 MO
RUTHANN ADAMS	PUBLIC LIBRARY Dept.# PL	03-28-2026	25 YR, 9 MO
SMITA A. LUHAR	PUBLIC LIBRARY Dept.# PL	05-16-2026	22 YR, 1 MO
CHARLOTTE NATALE	PUBLIC LIBRARY Dept.# PL	04-26-2026	13 YR, 10 MO
LUIS ALDRETE JR	PUBLIC WORKS Dept.# PW	03-27-2026	34 YR, 7 1/2 MO
CARLOS E. CLAYTON	PUBLIC WORKS Dept.# PW	04-30-2026	40 YR, 3 MO
CHRISTIAN L. GARCIA	PUBLIC WORKS Dept.# PW	03-27-2026	25 YR, 4 MO
ANOUSH A. HOVSEPIANS	PUBLIC WORKS Dept.# PW	03-31-2026	18 YR, 1 MO
JAGDISHBHAI R. PATEL	PUBLIC WORKS Dept.# PW	03-28-2026	25 YR, 3 MO
CHARLES M. RICHARDSON	PUBLIC WORKS Dept.# PW	05-09-2026	7 YR, 0 1/2 MO
HAMID R. SHALVIRI	PUBLIC WORKS Dept.# PW	05-30-2026	41 YR, 3 MO
ARIENNE E. TELIAS	PUBLIC WORKS Dept.# PW	04-24-2026	29 YR, 11 MO
VIKKI L. VALLES	PUBLIC WORKS Dept.# PW	03-27-2026	38 YR, 11 MO
ARTHUR VANDER VIS	PUBLIC WORKS Dept.# PW	04-30-2026	41 YR, 11 MO

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GENERAL MEMBER APPLICATIONS FOR: SERVICE RETIRMENT

NAME	DEPARTMENT	RETIRED	SERVICE
CYNTHIA L. ACHAY	RANCHO LOS AMIGOS HOSPITAL Dept.# HR	03-28-2026	17 YR, 10 MO
BOSUP JUNG	RANCHO LOS AMIGOS HOSPITAL Dept.# HR	03-31-2026	16 YR, 1 MO
SANDRA VERENICE LOPEZ-AREVALO	RANCHO LOS AMIGOS HOSPITAL Dept.# HR	03-28-2026	39 YR, 9 MO
LONNIE G. MCDANIEL	RANCHO LOS AMIGOS HOSPITAL Dept.# HR	04-09-2026	23 YR, 3 1/2 MO
SONIA J. NAVATO	RANCHO LOS AMIGOS HOSPITAL Dept.# HR	03-31-2026	33 YR, 9 MO
ISABEL OJEDA	RANCHO LOS AMIGOS HOSPITAL Dept.# HR	03-18-2026	10 YR, 3 MO
ESPERANZA G. POVEDA	RANCHO LOS AMIGOS HOSPITAL Dept.# HR	03-31-2026	9 YR, 7 MO
BERENICE RIVERA-CRUZ	RANCHO LOS AMIGOS HOSPITAL Dept.# HR	02-14-2026	10 YR, 4 1/2 MO
DENNIS Y. WONG	RANCHO LOS AMIGOS HOSPITAL Dept.# HR	05-30-2026	25 YR, 0 MO
EMMA J. MASON FARRIS	REG-RECORDER/COUNTY CLERK Dept.# RR	05-30-2026	10 YR, 9 MO
FATIMA A. MURILLO	REG-RECORDER/COUNTY CLERK Dept.# RR	03-31-2026	29 YR, 6 MO

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GENERAL MEMBER APPLICATIONS FOR: SERVICE RETIRMENT

NAME	DEPARTMENT	RETIRED	SERVICE
TONISHIA C. PATTERSON	REG-RECORDER/COUNTY CLERK Dept.# RR	01-30-2026	12 YR, 2 MO
YVONNE R. WHITE	REG-RECORDER/COUNTY CLERK Dept.# RR	03-31-2026	29 YR, 7 MO
LORI L. AVISHAY	SFV CLUSTER-OLIVE VIEW/UCLA MC Dept.# HO	05-30-2026	33 YR, 1 MO
ED L. BAUTISTA	SFV CLUSTER-OLIVE VIEW/UCLA MC Dept.# HO	03-31-2026	25 YR, 0 MO
MARYLOU C. GUDA	SFV CLUSTER-OLIVE VIEW/UCLA MC Dept.# HO	04-30-2026	17 YR, 0 MO
YOUNGIM KANG	SFV CLUSTER-OLIVE VIEW/UCLA MC Dept.# HO	04-29-2026	25 YR, 0 MO
LEVELL S. MARTIN	SFV CLUSTER-OLIVE VIEW/UCLA MC Dept.# HO	04-30-2026	21 YR, 3 MO
VIRGINIA C. MARTINEZ	SFV CLUSTER-OLIVE VIEW/UCLA MC Dept.# HO	04-30-2026	38 YR, 4 MO
YOLANDA NUNEZ	SFV CLUSTER-OLIVE VIEW/UCLA MC Dept.# HO	03-28-2026	38 YR, 3 MO
SHOU JU PAN	SFV CLUSTER-OLIVE VIEW/UCLA MC Dept.# HO	04-30-2026	25 YR, 0 MO
MARY SHAFER-MOYA	SFV CLUSTER-OLIVE VIEW/UCLA MC Dept.# HO	05-31-2026	33 YR, 3 1/2 MO

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BENEFIT APPROVAL LIST

GENERAL MEMBER APPLICATIONS FOR: SERVICE RETIRMENT

NAME	DEPARTMENT	RETIRED	SERVICE
DAMON D. WADE SR	SFV CLUSTER-OLIVE VIEW/UCLA MC Dept.# HO	05-16-2026	19 YR, 6 1/2 MO
HERBERT ABAD	SHERIFF Dept.# SH	04-30-2026	35 YR, 4 MO
LYDIA I. BRUCE	SHERIFF Dept.# SH	03-30-2026	28 YR, 11 MO
JANEE M. CARBAJAL	SHERIFF Dept.# SH	04-30-2026	25 YR, 11 MO
PATRICIA CASTILLO	SHERIFF Dept.# SH	03-28-2026	25 YR, 1 MO
LARRY CORTES	SHERIFF Dept.# SH	06-20-2026	27 YR, 8 MO
TINA Y. DARON	SHERIFF Dept.# SH	05-28-2026	41 YR, 3 MO
JOSE A. GODINEZ	SHERIFF Dept.# SH	05-30-2026	26 YR, 4 MO
VAZGEN KARAPETYAN	SHERIFF Dept.# SH	06-10-2026	13 YR, 8 1/2 MO
LU-CHIEH LEE	SHERIFF Dept.# SH	06-06-2026	24 YR, 0 1/2 MO
ANTHONY D. MATTHEWS	SHERIFF Dept.# SH	03-29-2026	35 YR, 6 MO
FRANK P. NUNEZ	SHERIFF Dept.# SH	03-31-2026	39 YR, 1 MO
JOANNE S. ORTIZ	SHERIFF Dept.# SH	04-30-2026	10 YR, 1 MO
PHILIP E. RODRIGUEZ	SHERIFF Dept.# SH	05-30-2026	34 YR, 11 MO
PAMELA J. ROSS	SHERIFF Dept.# SH	05-17-2026	38 YR, 10 MO

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GENERAL MEMBER APPLICATIONS FOR: SERVICE RETIRMENT

NAME	DEPARTMENT	RETIRED	SERVICE
PELENAKEKE SALESULU	SHERIFF Dept.# SH	03-31-2026	26 YR, 4 MO
MARIA I. SUDIK	SHERIFF Dept.# SH	05-26-2026	44 YR, 0 MO
SUZANNE M. TOMERAASEN	SHERIFF Dept.# SH	04-27-2026	25 YR, 7 1/2 MO
NNADI L. UDENGWU	SHERIFF Dept.# SH	03-31-2026	39 YR, 9 MO
ALEX ALDANA	SUPERIOR COURT/COUNTY CLERK Dept.# SC	06-08-2026	41 YR, 0 1/2 MO
JULIE L. BESINAIZ	SUPERIOR COURT/COUNTY CLERK Dept.# SC	03-31-2026	36 YR, 3 MO
SHANNON BOUSFIELD	SUPERIOR COURT/COUNTY CLERK Dept.# SC	05-15-2026	10 YR, 5 1/2 MO
NANCY E. BULLOCK	SUPERIOR COURT/COUNTY CLERK Dept.# SC	04-28-2026	35 YR, 6 MO
MARYANN K. CHING-TRAN	SUPERIOR COURT/COUNTY CLERK Dept.# SC	03-28-2026	32 YR, 9 MO
MARY D. CLARK	SUPERIOR COURT/COUNTY CLERK Dept.# SC	03-28-2026	34 YR, 3 MO
CARMEN CORTEZ	SUPERIOR COURT/COUNTY CLERK Dept.# SC	04-30-2026	38 YR, 11 MO
SANDRA D. FERGUSON	SUPERIOR COURT/COUNTY CLERK Dept.# SC	03-28-2026	27 YR, 2 MO

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BENEFIT APPROVAL LIST

GENERAL MEMBER APPLICATIONS FOR: SERVICE RETIRMENT

NAME	DEPARTMENT	RETIRED	SERVICE
DEBRA L. GONZALES	SUPERIOR COURT/COUNTY CLERK Dept.# SC	05-02-2026	3 YR, 8 1/2 MO
ANARUTH GONZALEZ	SUPERIOR COURT/COUNTY CLERK Dept.# SC	03-27-2026	11 YR, 1 MO
DENISE GRIMMETT	SUPERIOR COURT/COUNTY CLERK Dept.# SC	07-15-2026	28 YR, 0 1/2 MO
JAMIE L. JONES	SUPERIOR COURT/COUNTY CLERK Dept.# SC	05-30-2026	41 YR, 7 MO
SANDRA V. LISTER	SUPERIOR COURT/COUNTY CLERK Dept.# SC	04-30-2026	37 YR, 10 MO
RAYMOND LOW	SUPERIOR COURT/COUNTY CLERK Dept.# SC	03-28-2026	42 YR, 9 MO
BRENDA A. MATSUI	SUPERIOR COURT/COUNTY CLERK Dept.# SC	05-16-2026	27 YR, 9 1/2 MO
ANNE P. MCGINN	SUPERIOR COURT/COUNTY CLERK Dept.# SC	04-30-2026	22 YR, 7 MO
ROBERT T. SAIKI	SUPERIOR COURT/COUNTY CLERK Dept.# SC	03-28-2026	39 YR, 7 MO
MARGO WEBB	SUPERIOR COURT/COUNTY CLERK Dept.# SC	05-30-2026	31 YR, 6 MO
CHAU H. BANH	TREASURER AND TAX COLLECTOR Dept.# TT	03-31-2026	24 YR, 7 MO

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BENEFIT APPROVAL LIST

SAFETY SURVIVOR APPLICATIONS

NAME	DEPARTMENT	RETIRED	SERVICE
Darlene Almeria	SHERIFF Dept.# SH	02-15-2026	17 YR, 10 1/2 MO

SPOUSE of
John G. Almeria
dec'd on 02-14-2026
Sect. #31781.1

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BENEFIT APPROVAL LIST

GENERAL SURVIVOR APPLICATIONS

NAME	DEPARTMENT	RETIRED	SERVICE
Mr. Patrick A. Strattner	AMBULATORY CARE NETWORK Dept.# HN	02-20-2026	7 YR, 6 MO
HUSBAND of Michele A. Uglesich dec'd on 02-19-2026 Sect. #31781.1			
Tonda Frierson	PUBLIC WORKS Dept.# PW	01-13-2026	22 YR, 6 MO
WIFE of Steven D. Frierson dec'd on 01-12-2026 Sect. #31781.3			

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SAFETY MEMBER APPLICATIONS FOR: SERVICE RETIRMENT FROM DEFERRED

NAME	DEPARTMENT	RETIRED	SERVICE
LEONEL OCHOA	L A COUNTY FIRE DEPT Dept.# FR	04-01-2026	10 YR, 10 MO
CHRISTOPHE S. JOHNSON	SHERIFF Dept.# SH	03-31-2026	10 YR, 1 MO
BRIAN S. SCHLOTTACH	SHERIFF Dept.# SH	05-01-2026	4 YR, 8 MO

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GENERAL MEMBER APPLICATIONS FOR: SERVICE RETIRMENT FROM DEFERRED

NAME	DEPARTMENT	RETIRED	SERVICE
PATRICIA C. BALDERAS	AIDS PROGRAM Dept.# PP	03-31-2026	15 YR, 7 1/5 MO
RICARDO NUNEZ	AMBULATORY CARE NETWORK Dept.# HN	03-19-2026	7 YR, 6 1/2 MO
PERRY MITTLEMAN	ASSESSOR Dept.# AS	04-21-2026	12 YR, 7 MO
JOSE MATA	BEACHES & HARBORS Dept.# BH	04-08-2026	24 YR, 2 MO
PAMELA S. TSCHUMI	CALIFORNIA CHILDREN'S SERVICES Dept.# PS	03-31-2026	5 YR, 3 1/2 MO
JORDAN A. HARNISH	CHILD SUPPORT SERVICES Dept.# CD	03-06-2026	13 YR, 1 MO
CHUONG LA	CHILD SUPPORT SERVICES Dept.# CD	03-06-2026	6 YR, 8 MO
AVIS TOPPS	CHILD SUPPORT SERVICES Dept.# CD	03-28-2026	6 YR, 8 MO
JOE DEVINE	CHILDREN & FAMILY SERVICES Dept.# CH	03-31-2026	10 YR, 7 MO
ISMAEL HERNANDEZ	CHILDREN & FAMILY SERVICES Dept.# CH	04-08-2026	23 YR, 1 MO
PATRICIA RODRIGUEZ	CHILDREN & FAMILY SERVICES Dept.# CH	03-27-2026	10 YR, 5 MO
VICTORIA TORRES	CHILDREN & FAMILY SERVICES Dept.# CH	03-20-2026	9 YR, 6 MO
ROSLYN R. WATSON	CHILDREN & FAMILY SERVICES Dept.# CH	03-28-2026	12 YR, 7 1/2 MO
RONALD CROUCHET	COASTAL CLUSTER-HARBOR/UCLA MC Dept.# HH	04-09-2026	18 YR, 11 MO

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GENERAL MEMBER APPLICATIONS FOR: SERVICE RETIRMENT FROM DEFERRED

NAME	DEPARTMENT	RETIRED	SERVICE
MANETHA SAMS	COASTAL CLUSTER-HARBOR/UCLA MC Dept.# HH	03-01-2026	39 YR, 7 MO
CHERYL VAN DER ZAAG	CORRECTIONAL HEALTH Dept.# HC	06-08-2026	20 YR, 1 1/2 MO
SRPOOHI A. AGHAZARIAN	DEPT OF PUBLIC SOCIAL SERVICES Dept.# SS	05-10-2026	18 YR, 6 1/2 MO
HECTOR A. ARCE	DEPT OF PUBLIC SOCIAL SERVICES Dept.# SS	03-06-2026	13 YR, 10 MO
ROBERT G. BECK	DEPT OF PUBLIC SOCIAL SERVICES Dept.# SS	06-26-2026	23 YR, 7 1/2 MO
KAREN K. LEE	DEPT OF PUBLIC SOCIAL SERVICES Dept.# SS	05-02-2026	7 YR, 6 MO
LAURA E. LOZANO	DEPT OF PUBLIC SOCIAL SERVICES Dept.# SS	01-23-2026	13 YR, 6 MO
SHERI PALUS	DEPT OF PUBLIC SOCIAL SERVICES Dept.# SS	06-01-2026	6 YR, 9 MO
DEBORAH KNAAN	DISTRICT ATTORNEY Dept.# DA	03-03-2026	22 YR, 6 1/2 MO
KATHRYN A. SOLORZANO	DISTRICT ATTORNEY Dept.# DA	04-15-2026	17 YR, 4 MO
JACOB H. YIM	DISTRICT ATTORNEY Dept.# DA	03-31-2026	24 YR, 5 1/2 MO
ANGELA M. ROBSON	HEALTH SERVICES ADMINISTRATION Dept.# HS	03-11-2026	13 YR, 3 MO

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GENERAL MEMBER APPLICATIONS FOR: SERVICE RETIRMENT FROM DEFERRED

NAME	DEPARTMENT	RETIRED	SERVICE
KATHLEEN A. TORRES	HEALTH SERVICES ADMINISTRATION Dept.# HS	03-01-2026	4 YR, 4 MO
SONIA A. AJANG	INTERNAL SERVICES Dept.# IS	04-19-2026	27 YR, 11 MO
CINDY S. HEWITT	JUVENILE COURT HEALTH SERVICES Dept.# HJ	04-01-2026	29 YR, 0 MO
SARA J. MOORE	L A COUNTY FIRE DEPT Dept.# FR	04-15-2026	17 YR, 0 1/2 MO
CLAUDIA CONTRERAS	MENTAL HEALTH Dept.# MH	04-04-2026	14 YR, 9 1/2 MO
SUSAN D. DOMINGUEZ	MENTAL HEALTH Dept.# MH	04-04-2026	1 YR, 10 MO
RAYLETTE L. FELTON	MENTAL HEALTH Dept.# MH	06-26-2026	4 YR, 2 MO
HUONSIV LIM	MENTAL HEALTH Dept.# MH	03-10-2026	5 YR, 8 MO
BARBARA E. BROWN	NORTHEAST CLUSTER (LAC+USC) Dept.# HG	04-18-2026	6 YR, 4 1/2 MO
MICHELE D. HURLBUT	NORTHEAST CLUSTER (LAC+USC) Dept.# HG	04-23-2026	10 YR, 10 MO
LUIS A. PINEDA	NORTHEAST CLUSTER (LAC+USC) Dept.# HG	04-19-2026	20 YR, 0 MO
JUTARA SRIVALI TEAL	NORTHEAST CLUSTER (LAC+USC) Dept.# HG	05-30-2026	30 YR, 9 MO
BRADLEY W. HATTON	OFFICE OF PUBLIC SAFETY Dept.# SY	04-17-2026	11 YR, 1 MO

BOARD OF RETIREMENT MEETING OF MAY 6, 2026

BENEFIT APPROVAL LIST

GENERAL MEMBER APPLICATIONS FOR: SERVICE RETIRMENT FROM DEFERRED

NAME	DEPARTMENT	RETIRED	SERVICE
JUAN M. NUNEZ	OFFICE OF PUBLIC SAFETY Dept.# SY	03-10-2026	14 YR, 7 MO
RAUL I. BARRAZA	PROBATION DEPARTMENT Dept.# PB	04-10-2026	28 YR, 4 1/2 MO
SABA T. BOWERS	PROBATION DEPARTMENT Dept.# PB	04-06-2026	5 YR, 3 MO
GILDA M. GAYTAN	PROBATION DEPARTMENT Dept.# PB	03-24-2026	13 YR, 9 MO
TERRENCE L. HENDERSON	PROBATION DEPARTMENT Dept.# PB	05-13-2026	40 YR, 11 MO
RICHARD P. MADERO	PROBATION DEPARTMENT Dept.# PB	03-14-2026	22 YR, 0 MO
TIFFANY C. TISEN	PUBLIC DEFENDER Dept.# PD	03-10-2026	2 YR, 2 MO
AYDA GHEBREZGHI	PUBLIC HEALTH PROGRAM Dept.# PH	03-31-2026	12 YR, 6 1/2 MO
BARBARA L. HAMRICK	PUBLIC HEALTH PROGRAM Dept.# PH	04-01-2026	5 YR, 2 MO
DIOR K. HILDEBRAND	PUBLIC HEALTH PROGRAM Dept.# PH	03-11-2026	15 YR, 2 MO
AKIKO C. KIMURA	PUBLIC HEALTH PROGRAM Dept.# PH	05-01-2026	1 YR, 4 MO
JERRICK T. TORRES	PUBLIC HEALTH PROGRAM Dept.# PH	05-16-2026	7 YR, 0 MO
GREGORY JAQUEZ	PUBLIC WORKS Dept.# PW	03-30-2026	28 YR, 7 1/2 MO
IHEUKWUMERE H. NWACHUKU	PUBLIC WORKS Dept.# PW	03-25-2026	19 YR, 9 MO
GLENN R. TIMMONS	PUBLIC WORKS Dept.# PW	03-28-2026	27 YR, 11 MO

BOARD OF RETIREMENT MEETING OF MAY 6, 2026

BENEFIT APPROVAL LIST

GENERAL MEMBER APPLICATIONS FOR: SERVICE RETIRMENT FROM DEFERRED

NAME	DEPARTMENT	RETIRED	SERVICE
SUZANNE KNUTZEN	RANCHO LOS AMIGOS HOSPITAL Dept.# HR	04-22-2026	11 YR, 0 MO
KAREN M. LAI	RANCHO LOS AMIGOS HOSPITAL Dept.# HR	03-30-2026	5 YR, 11 MO
CHRISTINE E. NASSER	RANCHO LOS AMIGOS HOSPITAL Dept.# HR	03-25-2026	5 YR, 2 MO
LAURIE GELARDI	SFV CLUSTER-OLIVE VIEW/UCLA MC Dept.# HO	05-30-2026	25 YR, 4 MO
TED V. ALCANTARA	SHERIFF Dept.# SH	04-15-2026	25 YR, 10 1/2 MO
NNENNA N. BENSON	SHERIFF Dept.# SH	04-01-2026	12 YR, 9 1/2 MO
JULIET L. CAMACHO	SHERIFF Dept.# SH	03-13-2026	13 YR, 9 MO
ADRIANE E. COOK	SHERIFF Dept.# SH	05-10-2026	38 YR, 7 MO
STEPHEN R. COOPER	SHERIFF Dept.# SH	04-14-2026	21 YR, 4 1/2 MO
JANETH TENORIO	SHERIFF Dept.# SH	03-31-2026	14 YR, 7 1/2 MO
LISA M. RIGGINS	WORKFORCE DEV AGING & COMM SVC Dept.# CS	01-07-2026	13 YR, 11 MO

BOARD OF RETIREMENT MEETING OF MAY 6, 2026
RESCISSIONS/CHANGES FROM PRIOR BENEFIT APPROVAL LISTS

SAFETY MEMBER APPLICATIONS FOR SERVICE RETIRMENT

NAME	DEPARTMENT	UPDATE
STEVE A. OOSTERHOF	SHERIFF	CHANGE OF DATE TO May 12, 2026

BOARD OF RETIREMENT MEETING OF MAY 6, 2026
RESCISSIONS/CHANGES FROM PRIOR BENEFIT APPROVAL LISTS

GENERAL MEMBER APPLICATIONS FOR SERVICE RETIRMENT

NAME	DEPARTMENT	UPDATE
KIM CHAU	CHILDREN & FAMILY SERVICES	CHANGE OF DATE TO April 30, 2026
P ADRIANA M. VAN HEMERT	CHILDREN & FAMILY SERVICES	RESCISSION OF RETIREMENT
ANA R. AMEZCUA MORENO	COASTAL CLUSTER-HARBOR/UCLA MC	CHANGE OF DATE TO June 29, 2026
PANYAPON CHAIVEERA	COASTAL CLUSTER-HARBOR/UCLA MC	CHANGE OF DATE TO March 31, 2026
CESAR FELIX	DEPARTMENT OF HUMAN RESOURCES	RESCISSION OF RETIREMENT
SIMON ARSHARUNI	DEPT OF PUBLIC SOCIAL SERVICES	CHANGE OF DATE TO March 31, 2026
ALICIA B. GONZALEZ	DEPT OF PUBLIC SOCIAL SERVICES	CHANGE OF DATE TO March 28, 2026
BUSHRA B. HASSAN	DEPT OF PUBLIC SOCIAL SERVICES	CHANGE OF DATE TO June 30, 2026
CONNIE KWOK	DEPT OF PUBLIC SOCIAL SERVICES	RESCISSION OF RETIREMENT
MARY ELLEN RODRIGUEZ	DEPT OF PUBLIC SOCIAL SERVICES	CHANGE OF DATE TO April 30, 2026
VIRGINIA M. VEGA	DEPT OF PUBLIC SOCIAL SERVICES	RESCISSION OF RETIREMENT
MARIA TERESA J. QUIAOIT	L A COUNTY FIRE DEPT	CHANGE OF DATE TO March 28, 2026

BOARD OF RETIREMENT MEETING OF MAY 6, 2026
RESCISSIONS/CHANGES FROM PRIOR BENEFIT APPROVAL LISTS

GENERAL MEMBER APPLICATIONS FOR SERVICE RETIRMENT

NAME	DEPARTMENT	UPDATE
CHARLOTTE A. LUJAN	MENTAL HEALTH	CHANGE OF DATE TO March 31, 2026
EVANGELIA VITOGIANNIS	MENTAL HEALTH	RESCISSION OF RETIREMENT
CHARLES L. GARZA	NORTHEAST CLUSTER (LAC+USC)	RESCISSION OF RETIREMENT
MITCHELL BISHOP	PARKS AND RECREATION	CHANGE OF DATE TO March 27, 2026
JAIME E. ALVAREZ	PROBATION DEPARTMENT	CHANGE OF DATE TO May 30, 2026
LESLEY H. BOURNE	PROBATION DEPARTMENT	CHANGE OF DATE TO March 28, 2026
CARLOS F. CORONADO	PROBATION DEPARTMENT	CHANGE OF DATE TO April 30, 2026
SHIRRANE B. FRANKLIN	PROBATION DEPARTMENT	CHANGE OF DATE TO June 30, 2026
SHANNON P. GALLIEN	PROBATION DEPARTMENT	CHANGE OF DATE TO June 30, 2026
TYRONE O. HARLOW	PROBATION DEPARTMENT	CHANGE OF DATE TO March 27, 2026
EARNEST R. JOHNSON	PROBATION DEPARTMENT	RESCISSION OF RETIREMENT
PAYLIA S. KITTRELL	PROBATION DEPARTMENT	CHANGE OF DATE TO April 06, 2026
AI T. NGUYEN	PROBATION DEPARTMENT	RESCISSION OF RETIREMENT

BOARD OF RETIREMENT MEETING OF MAY 6, 2026
RESCISSIONS/CHANGES FROM PRIOR BENEFIT APPROVAL LISTS

GENERAL MEMBER APPLICATIONS FOR SERVICE RETIRMENT

NAME	DEPARTMENT	UPDATE
PAUL A. RAMIREZ	PROBATION DEPARTMENT	RESCISSION OF RETIREMENT
SONYA L. ROBERSON	PROBATION DEPARTMENT	CHANGE OF DATE TO June 28, 2026
LESLIE B. RINGOLD	PUBLIC DEFENDER	CHANGE OF DATE TO June 30, 2026
ROSE E. NATIVIDAD	PUBLIC HEALTH PROGRAM	CHANGE OF DATE TO March 27, 2026
EMY OKOHIRA	PUBLIC HEALTH PROGRAM	CHANGE OF DATE TO June 28, 2026
MARIA ELSIE D. AYEN	SFV CLUSTER-OLIVE VIEW/UCLA MC	CHANGE OF DATE TO May 09, 2026
JAMES G. CURRAN	SHERIFF	CHANGE OF DATE TO May 22, 2026
ANGELO P. TRAMONTANO	SHERIFF	CHANGE OF DATE TO June 26, 2026

April 20, 2026

TO: Each Trustee
Board of Retirement

FROM: Tamara Caldwell, Division Manager
Disability Retirement Services Division

SUBJECT: **APPEAL(S) FOR THE BOARD OF RETIREMENT'S MEETING OF MAY 6, 2026**

IT IS RECOMMENDED that the Board of Retirement grant the appeal(s) and request(s) for administrative hearing received from the following member(s), and direct the Disability Retirement Services Manager to refer this case to a referee:

5481B	Hattie M. Collier	In Pro Per	Deny SCD-Grant NSCD

TLC:kw

LACERA Los Angeles County Employees Retirement Association
300 N. Lake Ave., Pasadena, CA 91101 / PO Box 7060, Pasadena, CA 91109-7060 / www.lacera.gov / 626/564-6132 • 800/786-6464

April 8, 2026

TO: Each Trustee
Board of Retirement

FROM: Francis J. Boyd
Senior Staff Counsel

FOR: May 6, 2026, Board of Retirement Meeting

SUBJECT: SERVICE PROVIDER INVOICE APPROVAL REQUEST – WINET PATRICK CREIGHTON & HANES

On January 1, 2015, the Board of Retirement adopted a policy whereby staff is authorized to approve and pay vendor invoices up to a cumulative amount of $15,000.00 per vendor. Invoices from vendors exceeding $15,000.00 per case shall be submitted to the Board of Retirement for approval prior to payment.

Jennifer Creighton at Winet Patrick Creighton & Hanes was hired to investigate and process a disability-retirement application filed by a LACERA employee. This confidential file is identified as 2H2024K.

Ms. Creighton's firm has been paid $46,917.16 for services provided for this case.

Enclosed are her most recent invoices:

1. January 31, 2026, totaling $276.00;
2. February 28, 2026, totaling $207.00.

The total outstanding balance for both invoices is $483.00.

The charges are appropriate given the complexity of the issues presented in this disability-retirement application. This is the final invoice in this matter.

IT IS THEREFORE RECOMMENDED THAT the Board approve the service provider invoice for Winet Patrick Creighton & Hanes.

FJB:mc

Confidential Attachment

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

April 8, 2026

TO: Each Trustee
Board of Retirement

FROM: Tamara Caldwell, Division Manager
Disability Retirement Services

FOR: May 6, 2026, Board of Retirement Meeting

SUBJECT: SERVICE PROVIDER INVOICE APPROVAL REQUEST – PERRY MALOFF M.D.

On January 1, 2015, the Board of Retirement adopted a policy whereby staff is authorized to approve and pay vendor invoices up to a cumulative amount of $15,000.00 per vendor. Invoices from vendors exceeding $15,000.00 per case shall be submitted to the Board of Retirement for approval prior to payment.

Dr. Perry Maloff completed his initial report and record review for the application of Christopher A. Wilkins and is requesting approval for payment of the attached invoice. This was an extensive case with 26.10 hours of record review. The total outstanding balance is $15,905.50.

IT IS THEREFORE RECOMMENDED THAT the Board approve the service provider invoice for Perry Maloff, M.D.

TLC:mc

Confidential Attachment

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

April 9, 2026

TO: Each Trustee
Board of Retirement

FROM: Operations Oversight Committee
Nancy M. Durazo, Chair
Wayne Moore, Vice Chair
Bobbie Fesler, Trustee
Aleen Langton, Trustee
David Ryu, Alternate Trustee

FOR: May 6, 2026, Board of Retirement Meeting

SUBJECT: PROPOSED TERMINATION OF DISABILITY RETIREMENT SERVICES APPROVAL OF SERVICE PROVIDER INVOICE POLICY

RECOMMENDATION

At its April 1, 2026, meeting, the Operations Oversight Committee (OOC) reviewed the proposed recommendation and approved it for submission to the Board of Retirement for final consideration.

The Operations Oversight Committee recommends that the Board of Retirement:

1. Terminate the current Disability Retirement Services Approval of Service Provider Invoice Policy, which requires Board preapproval for invoices exceeding $15,000, per member/case, per vendor; and
2. Replace individual invoice approvals with quarterly reporting to the Board of Retirement of all invoices but increase the reporting threshold from $15,000 to $30,000 or another amount as determined by the Board.

EXECUTIVE SUMMARY

At the Board of Retirement meeting on January 7, 2026, Trustee Fesler requested that staff review the appropriateness of the Disability Retirement Services Approval of Service Provider Invoice Policy (“policy”) and the $15,000 threshold itself. The policy was established by the Board of Retirement (Board) on January 1, 2015, during a period when invoice oversight and approval practices at LACERA differed significantly from those in place today. At that time, the Board preapproved all invoices prior to payment. As part of an effort to streamline routine operations while preserving heightened oversight of higher

cost expenditures, the Board eliminated preapproval for most invoices and adopted a policy requiring Board approval only for DRS' invoices exceeding a defined threshold set at $15,000, per member/case and per vendor. The policy was intended to ensure continued Board visibility over high-cost invoices under the oversight framework that existed at that time.

The invoices subject to this policy involve services that are routinely incurred by Disability Retirement Services in the ordinary course of processing disability retirement applications and related proceedings. Covered expenses include panel physicians, hearing officers, copy services, job analysts, court reporters, investigative and database services, and outside legal counsel. These services are authorized through existing contracts and are budgeted annually as part of LACERA's formal budget approval process. They are necessary to support the statutory and fiduciary responsibilities associated with evaluating, adjudicating, and administering disability retirement applications, and therefore represent operational, non-discretionary expenses incurred as cases progress.

In connection with this request, DRS also reviewed historical invoice activity to assess whether the existing $15,000 threshold continues to reflect current operational realities. This review included an analysis of invoice frequency, dollar ranges, and escalation trends over the past decade, as well as consideration of inflation and changes in the cost and complexity of professional services supporting disability retirement cases processing.

ETHICS AND COMPLIANCE COMMITTEE (ECC) REVIEW

As part of LACERA's established governance framework and the development of the Ethics and Compliance Program, all new policies and substantive revisions to existing policies are reviewed by the ECC prior to internal adoption or submission to the Board, depending on the nature and scope of the policy. This review ensures that policies remain necessary, appropriate, and aligned with current organizational controls, compliance standards, and governance practices.

The ECC alongside DRS reviewed the existing policy to determine whether it continues to serve a meaningful compliance or oversight function under today's operating environment. The ECC considered how DRS' invoices are incurred, reviewed, approved, and paid under current practices. The ECC observed that invoices (even those previously above the Board approval limit) are considered covered and preapproved expenses, as they are defined by LACERA's annual formal budget planning and approval processes. These particular DRS invoices are tied to services that have already been authorized and contracted, and in practice, such invoices are consistently approved and are not subject to discretionary denial.

In conducting its review, the ECC specifically recognized that these invoices relate to services that are incurred in the ordinary course of Disability Retirement Services' work and are necessary to process member applications, rather than discretionary or exceptional expenditures.

As part of its review, the ECC also considered historical invoice trends, including the frequency and dollar amounts of invoices exceeding the current $15,000 threshold. This analysis showed that the real purchasing power of the threshold has eroded over time and that higher dollar invoices have become more common in recent years, largely due to increased case complexity and rising professional service costs. The review further demonstrated that invoices exceeding approximately $30,000 represent a clear inflection point, where costs are no longer routine and are typically associated with unusually complex or resource-intensive cases. In other words, the $30,000 figure reflects the trend analysis reviewed by the ECC (where invoice amounts become less frequent and more atypical) and is being used as a proposed quarterly reporting threshold, which is an increase from the existing $15,000 preapproval threshold.

Based on this review, it was determined that the existing policy no longer serves its original compliance purpose and that continued reliance on individual Board approvals for these invoices is unnecessary given current governance, controls, and budgetary safeguards.

CURRENT CONTROLS AND OVERSIGHT

Today, DRS' invoices are subject to reinforced checks and balances designed to ensure fiscal integrity and compliance, including:

- Verification by staff and (where applicable) legal counsel, that services were received as billed and are consistent with contract terms.
- Quality assurance review to identify and resolve discrepancies or irregularities.
- Management approval confirming that expenses are reasonable, necessary, and within the approved budget.
- Independent review by LACERA's Budget Unit and Financial and Accounting Services Divisions prior to payment.

These controls collectively provide a higher level of oversight than existed when the policy was first adopted, making a separate invoice-approval policy redundant and inefficient. These controls apply consistently to all invoices, regardless of amount, and provide assurance that high-cost expenditures are subject to meaningful review before payment.

RECOMMENDED GOVERNANCE APPROACH

While the ECC determined that the policy itself is no longer necessary, it emphasized the importance of maintaining transparency and Board visibility into high-cost expenditures. To that end, based on ECC's guidance, DRS recommends replacing individual invoice approvals with quarterly reporting to the Board of Retirement.

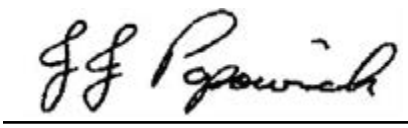
Under this approach, the Board would receive regular summaries of high-cost DRS invoices, allowing Trustees to monitor spending trends, ask questions, and request additional information as needed without delaying payment of properly reviewed and approved expenses. This approach preserves strong governance and accountability while aligning oversight with current operational realities and best practices.

For reporting purposes, it remains necessary to establish a defined threshold for identifying high-cost invoices. Based on the historical trend analysis reviewed by the ECC, DRS recommends establishing a reporting threshold of $30,000 per member/case, per vendor, which represents a clear point at which invoice amounts become atypical and warrant enhanced Board visibility. Under this governance approach, the existing preapproval requirement would be terminated and replaced with quarterly reporting of invoices exceeding the Board established threshold, preserving transparency and oversight while avoiding transaction-level delays for invoices that have already undergone rigorous internal review and budgetary approval.

The recommended approach reflects a deliberate shift from transaction-level preapproval to trend-based oversight, supported by strengthened internal controls and regular reporting to the Board. The DRS Approval of Service Provider Invoice Policy was appropriate and necessary when adopted in 2015. However, the governance environment, internal controls, and oversight mechanisms at LACERA have evolved substantially since that time.

Based on the Ethics and Compliance Committee's review, the policy is no longer required to ensure fiscal responsibility or accountability. Rescinding the policy, while maintaining quarterly reporting to the Board, reflects a modernized approach to governance that balances efficiency, transparency, and oversight.

Reviewed and Approved:



JJ Popowich, Assistant Executive Officer

c: Frank Boyd, Senior Staff Counsel
Allison E. Barrett, Senior Staff Counsel
Ted Granger, Chief Financial Officer
Ricki Contreras, Division Manager

TLC:mc

Attachment

LACERA POLICY STATEMENT

DISABILITY RETIREMENT SERVICES APPROVAL OF SERVICE PROVIDER INVOICE POLICY STATEMENT

(Effective January 1, 2015)

Purpose

Disability Retirement Services (DRS) routinely receives service provider invoices from various vendors in conjunction with the processing of applications for disability retirement. Service providers include panel physicians, hearing officers, copy services, job analysts, court reporters, investigative and database services, and outside legal counsel.

DRS has a robust checks and balances system to ensure any invoices received adhere to established contracts, procedures, and the costs charged for goods or services is reasonable based on the type and amount of work performed. DRS Investigative Staff, DRS Legal Counsel, and Disability Litigation Staff review the invoices to ensure services were provided in the prescribed manner and in compliance with the contract guidelines within the appropriate fee schedules and timelines. DRS Quality Assurance resolves any disputes related to invoices prior to submission to DRS Management for final review and payment authorization. DRS Administrative Staff processes the request and sends the payment request to Accounting for review and final payment.

This policy will authorize and direct LACERA staff to pay service provider invoices directly after they have been processed through the above described quality control process and approved by the DRS Division Manager. The DRS Division Manager, or their designated staff, will provide a quarterly report to the Board of Retirement for review and comment.

I. Statement of Policy

Staff is authorized to pay DRS Service Provider Invoices up to $15,000 upon receipt and after concurrence of DRS Investigative Staff or Disability Litigation Staff, DRS Quality Assurance Staff, DRS Administrative Staff, DRS Management, DRS Legal Counsel, and Financial and Accounting Services Division review and approval. Invoices over $15,000 will be submitted to the Board of Retirement for approval prior to payment. DRS will provide a quarterly report to the Board of Retirement for review and comment.

II. Implementation

This policy is established pursuant to the Board of Retirement's fiduciary responsibility to prudently administer the retirement plan in accordance with the

County Employees Retirement Law of 1937. This policy may be modified in the future by Board of Retirement action.

Adopted: December 3, 2014

LACERA

April 21, 2026

TO: Each Member
Board of Retirement

FROM: Insurance, Benefits and Legislative Committee
Les Robbins, Chair
Aleen Langton, Vice Chair
Ernesto J. Pantoja
Shawn R. Kehoe
Jason Green, Alternate

FOR: May 6, 2026 Board of Retirement Meeting

SUBJECT: **Assembly Bill 2780—Public Employees' Retirement**

Author: *Committee on Public Employment and Retirement*
Sponsor: *State Association of County Retirement Systems*
Amended: *April 20, 2026*
Introduced: *March 9, 2026*
Status: *Re-referred to Committee on Public Employment & Retirement. (04/21/2026)*

IBLC Recommendation: *Support*
Staff Recommendation: *Support*

RECOMMENDATION
That the Board of Retirement adopt a "Support" position on Assembly Bill 2780, which would provide clarification and technical updates to the County Employees Retirement Law of 1937.

LEGISLATIVE POLICY STANDARD
The Board of Retirement's legislative policy standard is to support proposals that provide clarification, technical updates, or conforming changes to the County Employees Retirement Law of 1937, the California Public Employees' Pension Reform Act of 2013, or other applicable provisions under California law related to public retirement systems (Legislative Policy, page 6).

SUMMARY
AB 2780 is an omnibus bill that provides clarifications, technical updates, and conforming changes to the County Employees Retirement of Law of 1937 (CERL). It also contains amendments to the Public Employees' Retirement Law and State Teachers' Retirement Law sponsored by CalPERS and CalSTRS, respectively.

ANALYSIS

Trustee Elections: Active Members (31520, 31520.1, 31520.2)

The second, third, seventh, and alternate seventh members of the Board of Retirement, and the second, third, and fourth members of the Board of Investments are elected by the active members of the retirement association.

There appears to be some ambiguity in the statutes to enable deferred members to elect the aforementioned board members. The proposed amendments will clarify that only active members, i.e., in active service of a county, district, or court, may vote for these board members.

Errors and Omissions (31540.5)

The CERL statutes on errors and omissions with respect to contributions and benefit payments are currently applicable only to LACERA.

The proposal will add a new section on errors and omissions that apply to the other 19 CERL systems. LACERA's statutes will remain unchanged.

The proposed section (31540.5) is identical to LACERA's section (31540) except that it does not contain the limitation of three years, which limits the retirement system's right to collect erroneous payments three years from the date of payment.

Compensation Earnable (31621.7, 31622, 31639.3, 31641, 31641.2, 31641.6, 31641.20, 31641.21)

Various CERL sections refer to "compensation earnable," which are pensionable pay items from which contributions and final compensation are calculated. However, there are several sections that use the term "earnable compensation." The amendments will ensure that the term "compensation earnable" is used consistently throughout CERL.

Burial Benefit (31789.6)

Various CERL sections provide payment of a burial benefit to a member's estate or named beneficiary after the death of the member. If a member has membership in more than one retirement system, generally the last retirement system in which the member rendered service and retired pays the burial benefit. However, the various sections are not consistent in specifying this requirement.

The proposed amendment will clarify for CERL's various sections on burial benefits that if a member retired from reciprocal retirement systems subsequently dies, their

beneficiary is only entitled to a lump-sum death benefit from the retirement system in which the member last rendered employment.

Concurrent Retirement (31835)
For various reasons that do not involve the member working at both reciprocal retirement systems at the same time, a member's retirement date at reciprocal systems might not be concurrent and might be different for a short period of time. The proposed amendment would provide for a difference not to exceed 30 calendar days for purposes of determining concurrent retirement. This would ensure that the member not be disqualified from using the highest final compensation from their reciprocal systems due to administrative technicalities. The proposed amendment is based on the California State Teachers' Retirement System's statute on concurrent retirement.

IT IS THEREFORE RECOMMENDED THAT THE BOARD adopt a "Support" position on Assembly Bill 2780, which would provide clarification and technical updates to the County Employees Retirement Law of 1937.

Attachments
Attachment 1—Board Positions Adopted on Related Legislation
Attachment 2—Support and Opposition
AB 2780 (Committee on Public Employment & Retirement) as amended on April 20, 2026

cc: Luis Lugo
JJ Popowich
Steven P. Rice
Jean Kim
Naomi Padron, MKP Government Relations

BOARD POSITIONS ADOPTED ON RELATED LEGISLATION

SB 853 (Chapter 239, Statutes of 2025) made various clarifications and technical updates as well as amendments for administrative flexibility to the County Employees Retirement Law of 1937. The Board of Retirement adopted a "Support" position.

AB 2474 (Chapter 108, Statutes of 2024) provided authorization for LACERA to establish a prepaid card program to disburse retirement allowances. The bill also provided for actions that the retirement system can undertake with respect to retired members who are employed after retirement in violation of specified statutes. The Board of Retirement adopted a "Support" position.

AB 2770 (Chapter 117, Statutes of 2024) made various clarifications and technical updates as well as amendments for administrative flexibility to the County Employees Retirement Law of 1937. The Board of Retirement adopted a "Support" position.

AB 1824 (Chapter 231, Statutes of 2022) made various clarifications and technical updates to the County Employees Retirement Law of 1937. The Board of Retirement adopted a "Support" position.

AB 1971 (Chapter 524, Statutes of 2022) made various amendments to the County Employees Retirement Law of 1937 to provide administrative flexibility and more efficient and effective service to members and stakeholders. The Board of Retirement adopted a "Support" position.

AB 2376 (Chapter 134, Statutes of 2016) clarified the definition of Plan D for purposes of a prospective plan transfer and the applicability of the reciprocal provision on nonconcurrent retirement to Plan E members. The Board of Retirement adopted a "Support" position.

AB 992 (Chapter 40, Statutes of 2015) clarified the ability of members to change their retirement option after being granted a disability retirement. The Board of Retirement adopted a "Support" position.

AB 2474 (Chapter 741, Statutes of 2014) made various amendments to the County Employees Retirement Law of 1937 to conform with the California Public Employees' Pension Reform Act of 2013. The Board of Retirement adopted a "Support" position.

AB 2473 (Chapter 740, Statutes of 2014) made various amendments to the County Employees Retirement Law of 1937 to conform with federal law. The Board of Retirement adopted a "Support" position.

SB 13 (Chapter 528, Statutes 2013) made various technical and clarifying amendments to the County Employees Retirement Law of 1937 and California Public Employees' Pension Reform Act of 2013. The Board of Retirement adopted a "Support" position.

AB 1380 (Chapter 247, Statutes 2013) amended various provisions of the County Employees Retirement Law of 1937 to conform with the California Public Employees' Pension Reform Act of 2013. The Board of Retirement adopted a "Watch" position.

SB 996 (Chapter 792, Statutes of 2012) clarified that for purposes of disability retirement the presumption of heart trouble is a rebuttable presumption. The Board of Retirement adopted a "Support" position.

AB 1902 (Chapter 86, Statutes of 2010) provided technical and clarifying amendments to the provisions of Plan E related to prospective plan transfers and disability retirement, reciprocity, and the crediting of service. The Board of Retirement adopted a "Support" position.

SB 1479 (Chapter 158, Statutes of 2010) provided technical and clarifying amendments to the County Employees Retirement Law of 1937 related to the commencement of membership, exclusion from membership based on monthly compensation rate, advance payments of employer contributions from districts, and compliance with Internal Revenue Service procedures. The Board of Retirement adopted a "Watch" position.

AB 1354 (Chapter 188, Statutes of 2010) amended the County Employees Retirement Law of 1937 to conform with federal law on tax qualification requirements and benefits related to deaths due to military service. The Board of Retirement adopted a "Support" position.

AB 1355 (Chapter 9, Statutes of 2009) updated cross-references related to the calculation of survivor allowances and made other technical changes. The Board of Retirement adopted a "Watch" position.

AB 399 (Chapter 778, Statutes of 2001) codified negotiated benefit enhancements set forth in a Memorandum of Understanding (MOU) between the County of Los Angeles and its labor organizations. The Board of Retirement adopted a "Support" position.

SUPPORT
State Association of County Retirement Systems (Co-*Sponsor*)
California Public Employees' Retirement System (Co-Sponsor)
California State Teachers' Retirement System (Co-Sponsor)

OPPOSITION
None on file.

AMENDED IN ASSEMBLY APRIL 20, 2026

CALIFORNIA LEGISLATURE—2025–26 REGULAR SESSION

ASSEMBLY BILL No. 2780

Introduced by Committee on Public Employment and Retirement (Assembly Members McKinnor (Chair), Boerner, Garcia, and Michelle Rodriguez)

March 9, 2026

An act to amend Sections ~~22156.07,~~ 22170.5, 22250, 22455.5, 24201.5, 24204, 24209, 24209.3, 24210, 25006, 25009, 26300, and 26606 of, and to amend, repeal, and add Sections 22164.5, 26004, 26113, 26135.7, 26139, and 26139.5 of, the Education Code, and to amend Sections 31520, 31520.1, 31520.2, 31621.7, 31622, 31639.3, 31641, 31641.2, 31641.6, 31641.20, 31641.21, and 31835 of, and to add Sections 31540.5 and 31789.6 to, the Government Code, relating to retirement, and making an appropriation therefor.

LEGISLATIVE COUNSEL'S DIGEST

AB 2780, as amended, Committee on Public Employment and Retirement. Public employees' retirement.

(1) Existing law, the Teachers' Retirement Law, establishes the State Teachers' Retirement System (STRS) 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. STRS is administered by the Teachers' Retirement Board. Existing law requires employers and employees to make contributions to the system based on the member's creditable compensation. Existing law defines terms for the purposes of STRS.

~~Existing law defines "position subject to membership" to include, among others, a position at a county office of education or school district, not including a charter school, that the governing body of the employer has designated in a resolution adopted at a public meeting as a position subject to membership for which the employer requires the holding of a valid credential, license, or certificate authorized by the Commission on Teacher Credentialing or the State Department of Health Care Services.~~

~~This bill would revise this definition to also include a position meeting the above-described criteria for which the employer requires the holding of a valid permit authorized by the Commission on Teacher Credentialing or the State Department of Health Care Services.~~

~~Existing law requires the board to determine a date based on when the retirement system has the capacity to implement specified statutory changes and requires the board to post that information on its internet website no later than July 1, 2027.~~

~~This bill would delete the above-described language and instead would require the above provision to be operative on July 1, 2027.~~

~~(2) Existing~~

Existing law defines "retired member activities" to mean one or more of specified identified activities within the California public school system and performed by a member retired for service under STRS, as prescribed.

This bill, commencing July 1, 2027, would redefine "retired member activities" to mean all service performed within the California public school system by a member retired for service under STRS when the member is employed in specified positions, including as an employee or independent contractor.

~~(3)~~

(2) Existing law defines "sick leave days," "basic sick leave day," and "excess sick leave days" for purposes of STRS. For specified standards concerning service credit that are expressed only in terms of hours, existing law requires the number of hours to be divided by 6 to determine the number of sick days.

This bill would delete the above provision on calculating the number of hours. The bill would instead provide that, when determining the number of days, including for those identified standards, one day shall be equivalent to the number of hours of creditable service performed in a day in that position on a full-time basis, but no less than 6 hours.

~~(4)~~

(3) Existing law requires the retirement board and employees of STRS to discharge their duties with respect to the system and the plan solely in the interest of the members and beneficiaries, as specified. This includes by diversifying the investments of the plan so as to minimize the risk of large losses unless under the circumstances it is clearly prudent not to do so.

This bill would revise that provision to instead require diversifying the investments of the plan so as to minimize the risk of loss and to maximize the rate of return unless under the circumstances it is clearly not prudent to do so.

~~(5)~~

(4) Existing law requires employers to make available criteria for membership, including optional membership, in a timely manner to all persons employed to perform creditable service subject to coverage by the Defined Benefit Program and to inform part-time and substitute employees, within 30 days of the date of hire, or by March 1, 1995, whichever is later, that they may elect membership in the plan's Defined Benefit Program at any time while employed.

This bill would shorten the above-described timeframe for notifying those employees to within 10 working days of the date of hire.

~~(6)~~

(5) Existing law establishes the circumstances in which a member who is eligible and applies for a disability allowance or retirement may apply to receive a service retirement allowance pending the determination of their application for disability. Under those provisions, a member who applies for service retirement in these circumstances does not receive service credit for each day of accumulated or unused leave of absence for illness or injury or for education, as specified.

This bill would also provide that a member who applies for retirement under those provisions shall not receive an additional 2 years of service credit granted in specified circumstances.

Existing law requires the retirement board to determine a date based on when the system has the capacity to implement specified changes to the above provisions. Existing law further requires the board to post that date on its website no later than January 1, 2026.

This bill would delete the above-described language.

~~(7)~~

(6) Existing law provides that a service retirement allowance becomes effective upon any date designated by the member, provided all of specified conditions are met. This includes a requirement that the

member file an application for service retirement on a form provided by STRS, executed no earlier than 6 months before the effective date of the member's retirement allowance.

This bill would also require the application for service retirement allowance to be received by STRS within 30 days after the date of the member's signature and, if applicable, the spouse's or registered domestic partner's signature.

Existing law permits a member who files an application for service retirement to change or cancel their retirement application if certain conditions are met. Existing law requires that the form provided by STRS be received by the system no later than 30 days from the date the member's initial benefit payment for the member's most recent retirement under the Defined Benefit Program is paid by the system.

This bill would also require that the form be received by STRS within 30 days after the date of the member's signature and, if applicable, the spouse's or registered domestic partner's signature. The bill would additionally authorize a member to elect to change a retirement annuity from the defined Benefit Supplement Program to a lump-sum payment any time after retirement, subject to using a form provided by the system and meeting other specified requirements.

Existing law requires the retirement board to determine a date based on when the system has the capacity to implement specified changes to these provisions and to post the date on its website no later than January 1, 2026.

This bill would delete the above-described language.

~~(8)~~

(7) Existing law specifies the amount a member is to receive upon retirement for service following reinstatement, which is based on specified factors. Existing law also specifies circumstances in which a member who reinstates and performs other creditable service is entitled to a service retirement allowance. Existing law also specifies the amount a member is entitled to receive upon retirement for service following a prior disability retirement, as prescribed.

This bill would require benefits calculated pursuant to the above provisions to be modified by an option if elected pursuant to that law.

~~(9)~~

(8) Existing law authorizes the retirement board to declare an additional earnings credit to be applied to Defined Benefit Supplement accounts for a plan year, subject to certain considerations by the board. Existing law requires the board to specify, for any plan year for which

it declares an additional earnings credit, the amount to be added to members' accounts as a percentage increase. Existing law prohibits additional earnings credit from being added to the balance of credits transferred from a member's Defined Benefit Supplement account to the Annuitant Reserve.

This bill would delete the above-described provision prohibiting additional earnings credit from being added to the balance of credits transferred.

~~(10)~~

(9) Existing law requires a member's retirement benefit under the Defined Benefit Supplement Program to be an amount equal to the balance of credits in the member's Defined Benefit Supplement account on the date the retirement benefit becomes payable. Existing law requires the retirement benefit to be a lump-sum payment or an annuity payable in monthly installments, or a combination thereof.

This bill would establish specified conditions if a member elects to change their retirement annuity from the Defined Benefit Supplement Program to a lump-sum payment, including providing for termination of payment of the annuity based on the balance of credits and making the election irrevocable.

~~(11)~~

(10) Existing law provides that benefits payable to participants or beneficiaries of STRS are subject to limits imposed by specified provisions of federal law and shall not exceed those limitations.

This bill, commencing July 1, 2027, for a STRS participant subject to the California Public Employees' Pension Reform Act of 2013, would specify those limits for participants whose service is included in federal social security and those whose service is not subject to social security. The bill would make those provisions subject to annual changes in the consumer price index and other conditions. The bill, commencing July 1, 2027, would also redefine various terms applicable to STRS and would make other related changes to those provisions.

~~(12)~~

(11) Existing law creates the Teachers' Retirement Fund, which is continuously appropriated for specified purposes, into which certain moneys are deposited, including employee contributions.

By ~~expanding the category of positions subject to membership under STRS and~~ affecting the contributions to the retirement fund, the bill would make an appropriation.

~~(13)~~

(12) Existing law, the County Employees Retirement Law of 1937, authorizes counties to establish retirement systems pursuant to its provisions in order to provide pension benefits to county, city, and district employees and their beneficiaries. Existing law sets forth the membership composition for boards of retirement and boards of investment, as specified. Existing law requires specified members of the retirement board to be active members of the association elected by it.

This bill would revise the above provisions to require those board members to be elected by those active members. The bill would also redefine "active member" to specify that it refers to a member in county service, as otherwise defined, and would make related changes to other definitions under that law.

Existing law, for the County of Los Angeles, establishes certain legal obligations of the retirement system to its members and their beneficiaries. Existing law specifies that, for purposes of payments into or out of the retirement fund for adjustment of errors or omissions, the period of limitation of actions is 3 years. Existing law also establishes a 10-year period of limitation for cases in which payment is erroneous because of the death of the retired member or beneficiary or because of remarriage or due to fraudulent reports of compensation, as specified.

This bill would establish similar obligations applicable for counties other than Los Angeles. The bill would specify that in cases in which payment is erroneous because of the death of the retired member or beneficiary or because of the remarriage of the beneficiary, the period of limitation of actions shall be 10 years. The bill would also provide a 10-year limitation period for cases in which payment has been made as a result of fraudulent reports, as specified. The bill would make various other related and conforming changes to these retirement provisions.

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

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

~~SECTION 1. Section 22156.07 of the Education Code is amended to read:~~

~~22156.07. (a) Except as otherwise provided under this part, "position subject to membership" means the following:~~

~~(1) A position at a county office of education or school district, not including a charter school, that the governing body of the employer has designated in a resolution adopted at a public meeting as a position subject to membership for which the employer requires the holding of a valid credential, license, permit, or certificate authorized by the Commission on Teacher Credentialing or the State Department of Health Care Services. The resolution must be in effect on the date of hire in the position or be effective retroactively to include the position as of the date of hire, whichever is later, but no earlier than the operative date of this section as determined by subdivision (c).~~

~~(2) A position at a county office of education or school district, including a charter school, that is included in a certificated bargaining unit represented by an exclusive representative, whether by agreement between the exclusive representative and the employer as reflected in a collective bargaining agreement or by written decision of the Public Employment Relations Board. The collective bargaining agreement must be in effect on the date of hire in the position or be effective retroactively to include the position as of the date of hire, whichever is later, but no earlier than the operative date of this section as determined by subdivision (c).~~

~~(3) A position at a charter school eligible to receive state apportionment where the position requires the holding of a Commission on Teacher Credentialing certificate, permit, or other document pursuant to subdivision (*l*) of Section 47605.~~

~~(4) A position at a community college district, that is any of the following:~~

~~(A) A faculty member, as defined in Section 87003, subject to the appropriate minimum standards adopted by the Board of Governors of the California Community Colleges pursuant to Section 87356.~~

~~(B) An academic position, as defined in subdivision (b) of Section 87001, subject to the appropriate minimum standards adopted by the Board of Governors of the California Community Colleges pursuant to Section 87356.~~

~~(C) An educational administrator, as defined in subdivision (b) of Section 87002, subject to the appropriate minimum standards adopted by the Board of Governors of the California Community Colleges pursuant to Section 87356.~~

~~(D) A position pursuant to a contract with the United States Department of Defense to provide vocational training as an employee of a community college employer.~~

~~(5) A position as a superintendent of a California public school.~~

~~(6) A position that would otherwise be subject to membership in a different public retirement system when held by a member who has elected coverage by the Defined Benefit Program pursuant to Chapter 10 (commencing with Section 22500).~~

~~(b) "Position subject to membership" does not mean and shall not include:~~

~~(1) A position that would otherwise be subject to coverage by the Defined Benefit Program when held by a member of the Public Employees' Retirement System who has elected coverage in the Public Employees' Retirement System pursuant to Chapter 10 (commencing with Section 22500).~~

~~(2) A position that is not employed by an employer or employing agency as defined in Section 22131.~~

~~(3) A position at a county office of education or school district, including a charter school, that is included in a noncertificated bargaining unit represented by an exclusive representative, whether by agreement between the exclusive representative and the employer as reflected in a collective bargaining agreement in effect on the date of hire in the position or by written decision of the Public Employment Relations Board.~~

~~(c) This section shall become operative on July 1, 2027.~~

~~SEC. 2.~~

SECTION 1. Section 22164.5 of the Education Code is amended to read:

22164.5. (a) "Retired member activities" means one or more activities identified in subdivision (b), (c), or (d) of Section 22119.5 or subdivision (b), (c), or (d) of Section 26113 within the California public school system and performed by a member retired for service under this part as one of the following:

(1) An employee of an employer.

(2) An employee of a third party, except as specified in subdivision (b).

(3) An independent contractor.

(b) The activities of an employee of a third party shall not be included in the definition of "retired member activities" if all of the following conditions apply:

(1) The employee performs an assignment of 24 months or less.

(2) The third-party employer does not participate in a California public pension system.

(3) The activities performed by the individual are not normally performed by employees of an employer, as defined in Section 22131.

(c) This section shall become inoperative on July 1, 2027, and, as of January 1, 2028, is repealed.

~~SEC. 3.~~

SEC. 2. Section 22164.5 is added to the Education Code, to read:

22164.5. (a) "Retired member activities" means all service performed within the California public school system by a member retired for service under this part when the member is employed as one of the following:

(1) An employee of an employer.

(2) An employee of a third party, except as specified in subdivision (b).

(3) An independent contractor.

(b) Service performed by an employee of a third party shall not be included in the definition of "retired member activities" if all of the following conditions apply:

(1) The employee performs an assignment of 24 months or less.

(2) The third-party employer does not participate in a California public pension system.

(3) The activities performed by the individual are not normally performed by employees of an employer, as defined in Section 22131.

(c) This section shall become operative on July 1, 2027.

~~SEC. 4.~~

SEC. 3. Section 22170.5 of the Education Code is amended to read:

22170.5. (a) "Sick leave days" means the number of days of accumulated and unused leave of absence for illness or injury granted by each employer.

(b) "Basic sick leave day" means the days of paid leave of absence due to illness or injury granted by each employer that are not excess sick leave days.

(c) "Excess sick leave days" means the day or total number of days of paid leave of absence due to illness or injury granted by each employer in excess of 12 days per school year.

(d) When determining the number of days pursuant to this section, including for those standards identified in Section 22138.5, one day shall be equivalent to the number of hours of creditable service performed in a day in that position on a full-time basis but shall be no less than six hours.

~~SEC. 5.~~

SEC. 4. Section 22250 of the Education Code is amended to read:

22250. The board and its officers and employees of the system shall discharge their duties with respect to the system and the plan solely in the interest of the members and beneficiaries of the Defined Benefit Program as well as the participants and beneficiaries of the Cash Balance Benefit Program as follows:

(a) For the exclusive purpose of the following:

(1) Providing benefits to members and beneficiaries of the Defined Benefit Program as well as the participants and beneficiaries of the Cash Balance Benefit Program.

(2) Defraying reasonable expenses of administering the plan.

(b) With the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent person acting in a like capacity and familiar with those matters would use in the conduct of an enterprise of a like character and with like aims.

(c) By diversifying the investments of the plan so as to minimize the risk of loss and to maximize the rate of return unless under the circumstances it is clearly not prudent to do so.

(d) In accordance with the documents and instruments governing the plan and the system insofar as those documents and instruments are consistent with this part and Part 14 (commencing with Section 26000).

~~SEC. 6.~~

SEC. 5. Section 22455.5 of the Education Code is amended to read:

22455.5. (a) The Legislature finds and declares that the federal Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508) requires all public employers to provide their employees with either social security coverage or membership in a qualified retirement plan.

(b) Employers shall make available criteria for membership, including optional membership, in a timely manner to all persons employed to perform creditable service subject to coverage by the Defined Benefit Program, and shall inform part-time and substitute employees, within 10 working days of the date of hire, or by March 1, 1995, whichever is later, that they may elect membership in the plan's Defined Benefit Program at any time while employed. Written acknowledgment by the employee shall be maintained in employer files on a form provided by this system.

(c) Employers shall be liable to the plan for employee and employer contributions and interest with respect to the Defined Benefit Program from the date of hire, or March 1, 1995, whichever is later, in addition to system administrative and audit costs, if an audit or a member's complaint reveals noncompliance. However, no employer shall be liable for employee contributions for service performed prior to January 1, 1995.

~~SEC. 7.~~

SEC. 6. Section 24201.5 of the Education Code is amended to read:

24201.5. (a) A member who is eligible and applies for a disability allowance or retirement pursuant to Section 24001 or 24101 may apply to receive a service retirement allowance pending the determination of their application for disability, subject to all of the following:

(1) The member is eligible to retire for service under Section 24201 or 24203.

(2) The member submits the application on a form provided by the system, subject to all of the following:

(A) The application is executed no earlier than the date the application for disability benefits is executed and no earlier than six months before the effective date of the retirement allowance.

(B) The effective date is no earlier than the first day of the month in which the application for disability benefits is received by the system, unless the application for disability benefits is denied or canceled and the member has indicated an earlier service retirement date on the application to use if denied or canceled. If the application for disability benefits is denied or canceled, the service retirement date of a member who submits an application for retirement pursuant to this section shall be no earlier than 270

calendar days prior to when the application for service retirement is received by the system.

(C) The effective date is later than the last day the member earned creditable compensation pursuant to Section 22119.2 or 22119.3.

(D) The effective date is no earlier than one year following the date on which a retirement allowance was terminated pursuant to Section 24208, unless the application for disability benefits is denied or canceled and the member has indicated an earlier service retirement date on the application to use if denied or canceled. If the application for disability benefits is denied or canceled, the service retirement date is no earlier than one day after the date on which a retirement allowance was terminated pursuant to Section 24208, provided that the retirement allowance is terminated no earlier than 270 calendar days prior to when the application for service retirement is received by the system.

(E) The effective date is no earlier than one year following the date on which a retirement allowance was terminated pursuant to subdivision (a) of Section 24117.

(3) The effective date of the service retirement allowance can be no earlier than the date upon and continuously after which the member is determined to the satisfaction of the board to have been mentally incompetent.

(4) A member who applies for service retirement under this section is not eligible to receive a lump-sum payment and an actuarially reduced monthly allowance pursuant to Section 24221.

(5) A member who applies for service retirement under this section is not eligible to receive an allowance calculated pursuant to Section 24205.

(6) A member who applies for service retirement under this section and elects to receive their retirement benefit pursuant to Section 25009 as a lump-sum payment is not eligible to elect a disability benefit pursuant to Section 25016 or 25018.1.

(7) (A) Except as described in subparagraph (B), a member who applies for service retirement under this section shall not receive service credit for each day of accumulated and unused leave of absence for illness or injury or for education pursuant to Section 22717 or 22717.5 or service credit granted pursuant to Section 22714.

(B) If the application for disability is denied or canceled, the member's service retirement allowance shall be adjusted to the effective date of the service retirement to include service credited pursuant to Section 22714, 22717, or 22717.5.

(8) If the application for disability is denied or canceled, a member who applies for a service retirement allowance under this section is subject to all of the following:

(A) Unless otherwise provided in this part, a member who, on their application for service retirement, elects an option pursuant to Section 24300.1 or 24307 may not change or revoke that option.

(B) If the member receives a modified service retirement allowance based on the election of an option pursuant to Section 24300.1 or 24307, that modified service retirement allowance shall continue in effect and unchanged.

(C) If the member did not elect an option pursuant to Section 24300.1 or 24307 and receives an unmodified service retirement allowance, that unmodified service retirement allowance shall continue in effect and unchanged.

(b) A member who applies for service retirement under this section may change or cancel their service retirement application pursuant to Section 24204, or may terminate their service retirement allowance pursuant to Section 24208.

(c) A member may not cancel their application for disability prior to a determination of that application unless they submit a written request to the system. If a member elects to cancel their service retirement application or elects to terminate their service retirement allowance as described in subdivision (b), that election shall not cancel the application for disability.

(d) (1) Subparagraph (C) of paragraph (1) of subdivision (a) of Section 24001 and paragraph (3) of subdivision (a) of Section 24101 shall not apply to a member who cancels an application for service retirement pursuant to Section 24204 or who terminates a service retirement allowance pursuant to Section 24208, if all of the following apply:

(A) The member earned at least one year of credited service subsequent to the most recent terminated service retirement allowance.

(B) The member's application for disability under this section is pending determination by the board.

(2) If the member's application for disability under this section is denied or canceled, subparagraph (C) of paragraph (1) of subdivision (a) of Section 24001 and paragraph (3) of subdivision (a) of Section 24101 shall apply if the member submits a new application for disability.

(e) (1) If the board approves the application for disability, and notwithstanding subdivision (f) of Section 24204, the board shall cancel the member's application for service retirement and shall authorize payment of a disability allowance or disability retirement.

(2) If the board approves the application for disability and the member has received service retirement allowance payments under this part, the effective date for the disability allowance or disability retirement shall be the same as the effective date of the service retirement allowance.

(f) If a member who applies for service retirement under this section dies prior to a determination by the board on the application for disability, the member shall be considered retired for service at the time of death, and any subsequent benefits shall be paid accordingly.

(g) If a member who applies for service retirement under this section dies after the board has approved the member's application for disability, the member shall be considered a disabled member, or retired for disability, at the time of death, and any subsequent benefits shall be paid accordingly, even if the member died prior to receiving notification of the approval of their application for disability.

(h) If the member changes or cancels their service retirement application or terminates their service retirement allowance as described in subdivision (b), the system shall make appropriate adjustments to the applicable service retirement allowance, disability allowance, or disability retirement allowance, retroactive to the effective date of the disability allowance or disability retirement allowance. Subdivision (a) of Section 24617 shall not apply.

(i) The system may recover a service retirement allowance overpayment made to a member by deducting that overpayment from any subsequent disability benefit payable to the member.

(j) Nothing in this section shall be construed to allow a member or beneficiary to receive more than one type of retirement or disability allowance for the same period of time.

~~SEC. 8.~~

SEC. 7. Section 24204 of the Education Code is amended to read:

24204. (a) A service retirement allowance under this part shall become effective upon any date designated by the member, provided all of the following conditions are met:

(1) An application for service retirement allowance is filed on a form provided by the system, which is executed no earlier than six months before the effective date of retirement allowance and received by the system within 30 days after the date of the member's signature and, if applicable, the spouse's or registered domestic partner's signature.

(2) The effective date of a member who files an application for retirement pursuant to Section 24201 is no earlier than 270 calendar days prior to when the application for service retirement is received by the system.

(3) The effective date is later than the last day the member earned creditable compensation pursuant to Section 22119.2 or 22119.3.

(4) The effective date is no earlier than one day after the date on which the retirement allowance was terminated under Section 24208.

(5) The effective date is no earlier than one year following the date on which the retirement allowance was terminated under subdivision (a) of Section 24117.

(6) The effective date is no earlier than the date upon and continuously after which the member is determined to the satisfaction of the board to have been mentally incompetent.

(7) The effective date is no earlier than one day after the date upon which the member completes payment of a service credit purchase pursuant to Section 22801, 22820, or 22826, or payment of a redeposit of contributions pursuant to Section 23200, except as provided in Section 22801 or 22829.

(b) A member who files an application for service retirement may change or cancel their retirement application if all of the following are met:

(1) The form provided by the system is received by the system no later than 30 days from the date the member's initial benefit payment for the member's most recent retirement under the Defined Benefit Program is paid by the system and received by the system

within 30 days after the date of the member's signature and, if applicable, the spouse's or registered domestic partner's signature.

(2) The member returns the total gross distribution amount of all payments for any canceled benefit, including a lump-sum payment being changed to an annuity, to the system no later than 45 days from the date of the member's initial benefit payment. The member shall be liable for any adverse tax consequences that may result from these actions.

(c) A member may elect to change a retirement annuity from the Defined Benefit Supplement Program to a lump-sum payment any time after retirement subject to Section 25009 using a form provided by the system. The form shall be received by the system within 30 days after the date of the member's signature and, if applicable, the spouse's or registered domestic partner's signature.

(d) Nothing in this section shall be construed to allow a member to receive more than one type of retirement or disability allowance for the same period of time by virtue of the member's own membership.

~~SEC. 9.~~

SEC. 8. Section 24209 of the Education Code is amended to read:

24209. (a) Upon retirement for service following reinstatement, the member shall receive a service retirement allowance equal to the sum of both of the following:

(1) An amount equal to the monthly allowance the member was eligible to receive immediately preceding the most recent reinstatement, exclusive of any amounts payable pursuant to Section 22714 or 22715, increased by the improvement factor that would have been applied to the allowance if the member had not reinstated.

(2) An amount calculated pursuant to Section 24202, 24202.5, 24202.6, 24203, 24203.5, or 24206 based on credited service accrued, including any service granted pursuant to Section 22717 or 22717.5, subsequent to the most recent reinstatement, the member's age on the last day of the month in which the retirement allowance begins to accrue, and final compensation.

(b) If the total amount of credited service accrued, other than that accrued pursuant to Sections 22714, 22715, 22717, 22717.5, and 22826, except as provided in subdivision (c) of Section 22121, is equal to or greater than 30 years, the amounts identified in

paragraphs (1), for members who initially retired on or after January 1, 1999, and (2) of subdivision (a) shall be calculated pursuant to Section 24203.5.

(c) If the total amount of credited service accrued, other than that accrued pursuant to Sections 22714, 22715, 22717, 22717.5, and 22826, except as provided in subdivision (c) of Section 22121, is equal to or greater than 30 years, upon retirement for service following reinstatement, a member who retired pursuant to Section 24213, and received the terminated disability allowance for the prior retirement, shall receive a service retirement allowance equal to the sum of the following:

(1) An amount based on the credited service accrued, including any service granted pursuant to Section 22717 or 22717.5, prior to the effective date of the disability allowance, the member's age at the prior retirement increased by the factor provided in Section 24203.5, and projected final compensation.

(2) An amount calculated pursuant to Section 24202, 24202.5, 24202.6, 24203.5, or 24206 based on credited service accrued, including any service granted pursuant to Section 22717 or 22717.5, subsequent to the reinstatement, the member's age on the last day of the month in which the retirement allowance begins to accrue, and final compensation using compensation earnable, or projected final compensation, or a combination of both.

(d) Benefits calculated pursuant to this section shall not take into consideration the benefit comparison described in Section 24203.8.

(e) Benefits calculated pursuant to this section shall be modified by an option if elected pursuant to this part.

~~SEC. 10.~~

SEC. 9. Section 24209.3 of the Education Code is amended to read:

24209.3. (a) Notwithstanding subdivision (a) of Section 24209, and exclusive of any amounts payable during the prior retirement for service pursuant to Section 22714, or 22715:

(1) A member who retired, other than pursuant to Section 24210, 24211, 24212, or 24213, and who reinstates and performs creditable service, as defined in Section 22119.5, after the most recent reinstatement, in an amount equal to two or more years of credited service, shall, upon retirement for service on or after the effective

date of this section, receive a service retirement allowance equal to the sum of the following:

(A) An amount calculated pursuant to this chapter based on credited service accrued, including any service granted pursuant to Section 22717 or 22717.5, prior to the most recent reinstatement, using the member's age at the subsequent service retirement, from which age shall be deducted the total time during which the member was retired for service, and final compensation.

(B) An amount calculated pursuant to this chapter based on credited service accrued, including any service granted pursuant to Section 22717 or 22717.5, subsequent to the most recent reinstatement, using the member's age on the last day of the month in which the retirement allowance begins to accrue, and final compensation.

(2) A member who retired pursuant to Section 24210 and who reinstates and performs creditable service, as defined in Section 22119.5, after the most recent reinstatement, in an amount equal to two or more years of credited service, shall, upon retirement for service on or after the effective date of this section, receive a service retirement allowance equal to the sum of the following:

(A) An amount calculated pursuant to this chapter based on credited service accrued, including any service granted pursuant to Section 22717 or 22717.5, prior to the effective date of the disability retirement, using the member's age at the subsequent service retirement, from which age shall be deducted the total time during which the member was retired for service, and indexed final compensation to the effective date of the initial service retirement.

(B) An amount calculated pursuant to this chapter based on the credited service accrued, including any service granted pursuant to Section 22717 or 22717.5, after termination of the disability retirement, excluding credited service accrued or granted subsequent to the most recent reinstatement, using the member's age at the subsequent service retirement, from which age shall be deducted the total time during which the member was retired for service, and final compensation.

(C) An amount calculated pursuant to this chapter based on credited service accrued, including any service granted pursuant to Section 22717 or 22717.5, subsequent to the most recent reinstatement, using the member's age on the last day of the month

in which the retirement allowance begins to accrue, and final compensation.

(3) A member who retired pursuant to Section 24211 and who reinstates and performs creditable service, as defined in Section 22119.5, after the most recent reinstatement, in an amount equal to two or more years of credited service, shall, upon retirement for service on or after the effective date of this section, receive a service retirement allowance equal to the sum of the following:

(A) The greater of (i) the disability allowance the member was eligible to receive immediately prior to termination of that allowance, excluding the children's portion, or (ii) an amount calculated pursuant to this chapter based on credited service accrued prior to the effective date of the disability allowance, excluding credited service accrued or granted pursuant to Section 22717 or 22717.5 or Chapter 14 (commencing with Section 22800) or Chapter 14.2 (commencing with Section 22820) or Chapter 19 (commencing with Section 23200), using the member's age at the subsequent service retirement, from which age shall be deducted the total time during which the member was retired for service, and final compensation using compensation earnable, or projected final compensation earnable, or a combination of both.

(B) An amount equal to either of the following:

(i) For a member who was receiving a benefit pursuant to subdivision (a) of Section 24211, an amount calculated pursuant to this chapter based on credited service accrued at the time of the retirement pursuant to Section 24211, excluding credited service accrued or granted prior to the effective date of the disability allowance or pursuant to Section 22717 or 22717.5 or Chapter 14 (commencing with Section 22800) or Chapter 14.2 (commencing with Section 22820) or Chapter 19 (commencing with Section 23200), the member's age at the subsequent service retirement, from which age shall be deducted the total time during which the member was retired for service, and final compensation using compensation earnable, or projected final compensation, or a combination of both.

(ii) For a member who was receiving a benefit pursuant to subdivision (b) of Section 24211, an amount calculated pursuant to this chapter based on projected service at the time of the retirement pursuant to Section 24211, excluding credited service accrued or granted prior to the effective date of the disability

allowance or pursuant to Section 22717 or 22717.5 or Chapter 14 (commencing with Section 22800) or Chapter 14.2 (commencing with Section 22820) or Chapter 19 (commencing with Section 23200), the member's age at the subsequent service retirement, from which age shall be deducted the total time during which the member was retired for service, and final compensation using compensation earnable, or projected final compensation, or a combination of both.

(C) An amount based on any credited service accrued or granted pursuant to Section 22717 or 22717.5 or Chapter 14 (commencing with Section 22800) or Chapter 14.2 (commencing with Section 22820) or Chapter 19 (commencing with Section 23200), at the time of the retirement pursuant to Section 24211, using the member's age at the subsequent service retirement, from which age shall be deducted the total time during which the member was retired for service, and final compensation using compensation earnable, or projected final compensation, or a combination of both.

(D) An amount calculated pursuant to this chapter based on credited service accrued subsequent to the most recent reinstatement, including credited service accrued or granted pursuant to Section 22714, 22715, 22717, or 22717.5 or Chapter 14 (commencing with Section 22800) or Chapter 14.2 (commencing with Section 22820) or Chapter 19 (commencing with Section 23200), using the member's age on the last day of the month in which the retirement allowance begins to accrue, and final compensation using compensation earnable, or projected final compensation, or a combination of both.

(4) A member who retired pursuant to Section 24212 or 24213 and who reinstates and performs creditable service, as defined in Section 22119.5, after the most recent reinstatement, in an amount equal to two or more years of credited service, shall, upon retirement for service on or after the effective date of this section, receive a service retirement allowance equal to the sum of the following:

(A) An amount calculated pursuant to this chapter based on the member's projected service at the time of the retirement pursuant to Section 24212 or 24213, including credited service accrued or granted pursuant to Section 22717 or 22717.5 or Chapter 14 (commencing with Section 22800) or Chapter 14.2 (commencing

with Section 22820) or Chapter 19 (commencing with Section 23200), using the member's age at the subsequent service retirement, from which age shall be deducted the total time during which the member was retired for service, and final compensation using compensation earnable, or projected final compensation, or a combination of both.

(B) An amount calculated pursuant to this chapter based on credited service accrued subsequent to the most recent reinstatement, including credited service accrued or granted pursuant to Section 22714, 22715, 22717, or 22717.5 or Chapter 14 (commencing with Section 22800) or Chapter 14.2 (commencing with Section 22820) or Chapter 19 (commencing with Section 23200), using the member's age on the last day of the month in which the retirement allowance begins to accrue, and final compensation using compensation earnable, or projected final compensation, or a combination of both.

(b) If the total amount of credited service, other than projected service, or service that accrued or was granted pursuant to Sections 22714, 22715, 22717, 22717.5, and 22826, except as provided in subdivision (c) of Section 22121, is equal to or greater than the number of years required to be eligible for an increased allowance pursuant to this chapter or Section 22134.5, the amounts identified in this section shall be calculated pursuant to the section authorizing the increased benefit.

(c) For members receiving an allowance pursuant to Section 24410.5 or 24410.6, the amount payable pursuant to this section shall not be less than the amount payable to the member as of the effective date of reinstatement.

(d) The amount payable pursuant to this section shall not be less than the amount that would be payable to the member pursuant to Section 24209.

(e) For purposes of determining an allowance increase pursuant to Sections 24415 and 24417, the calendar year of retirement shall be the year of the subsequent retirement if the final compensation used to calculate the allowance pursuant to this section is higher than the final compensation used to calculate the allowance for the prior retirement.

(f) The allowance paid pursuant to this section to a member receiving a lump-sum payment pursuant to Section 24221 shall be actuarially reduced to reflect that lump-sum payment.

(g) Benefits calculated pursuant to this section shall not take into consideration the benefit comparison described in Section 24203.8.

(h) Benefits calculated pursuant to this section shall be modified by an option if elected pursuant to this part.

~~SEC. 11.~~

SEC. 10. Section 24210 of the Education Code is amended to read:

24210. (a) Upon retirement for service following a prior disability retirement granted pursuant to Chapter 26 (commencing with Section 24100) that was terminated, the member shall receive a service retirement allowance calculated pursuant to Section 24202, 24202.5, 24202.6, 24203, 24203.5, 24203.6, or 24206 and equal to the sum of both of the following:

(1) An amount based on credited service accrued, including any service granted pursuant to Section 22717 or 22717.5, prior to the effective date of the disability retirement, the member's age on the last day of the month in which the retirement allowance begins to accrue, and indexed final compensation to the effective date of the service retirement.

(2) An amount based on the credited service accrued, including any service granted pursuant to Section 22717 or 22717.5, after termination of the disability retirement, the member's age on the last day of the month in which the retirement allowance begins to accrue, and final compensation.

(b) Benefits calculated pursuant to this section shall be modified by an option if elected pursuant to this part.

~~SEC. 12.~~

SEC. 11. Section 25006 of the Education Code is amended to read:

25006. (a) The board may declare an additional earnings credit to be applied to Defined Benefit Supplement accounts for a plan year. Prior to declaring an additional earnings credit, the board shall consider all of the following:

(1) Whether the plan's investment earnings with respect to the Defined Benefit Supplement Program for the plan year exceed the amount required to meet the liabilities identified in paragraphs (2), (3), and (4).

(2) The amount required for the plan year to credit interest on members' nominal accounts at the minimum interest rate.

(3) The amount of the plan's administrative expenses with respect to the Defined Benefit Supplement Program for the plan year.

(4) The sufficiency of the Gain and Loss Reserve and whether any additions must be made to that reserve.

(b) For any plan year that the board declares an additional earnings credit, the board shall specify the amount to be added to members' accounts as a percentage increase. The additional earnings credit shall be applied to the balance of credits in each member's nominal account as of the last day of the plan year and shall be applied as of the date specified by the board.

(c) The declaration of an additional earnings credit shall be made as a plan amendment adopted by the board with respect to the Defined Benefit Supplement Program upon recommendation of the actuary based on the actuarial valuation undertaken following the plan year pursuant to Section 22311.5, but no later than June 30 following the end of the plan year.

~~SEC. 13.~~

SEC. 12. Section 25009 of the Education Code is amended to read:

25009. (a) A member's retirement benefit under the Defined Benefit Supplement Program shall be an amount equal to the balance of credits in the member's Defined Benefit Supplement account on the date the retirement benefit becomes payable.

(b) A retirement benefit shall be a lump-sum payment, or an annuity payable in monthly installments, or a combination of both a lump-sum payment and an annuity, as elected by the member on the application for a retirement benefit. Any retirement benefit paid as an annuity under this chapter shall be subject to Section 25011 or 25011.1.

(c) If a member elects to change their retirement annuity from the Defined Benefit Supplement Program to a lump-sum payment pursuant to subdivision (c) of Section 24204, all of the following shall apply:

(1) Payment of the annuity based on the balance of credits that was transferred from the member's Defined Benefit Supplement account to the Annuitant Reserve shall terminate.

(2) The member's Defined Benefit Supplement account shall be credited with the balance of credits remaining in the member's Annuitant Reserve account as of the date the annuity is terminated,

and the Annuitant Reserve shall be reduced by the amount credited to the member's account.

(3) The lump-sum payment based on the remaining balance of credits in the member's Defined Benefit Supplement account at the time of the lump-sum payment shall become payable pursuant to this section, and no additional interest shall be issued.

(4) The election is irrevocable.

(d) Upon distribution of the entire retirement benefit in a lump-sum payment, no other benefit shall be payable to the member or the member's beneficiary under the Defined Benefit Supplement Program.

(e) A member may not apply a lump-sum payment made to the member pursuant to this section for any of the following purposes:

(1) Purchasing service credit pursuant to Chapter 14 (commencing with Section 22800), Chapter 14.2 (commencing with Section 22820), or Chapter 14.5 (commencing with Section 22850).

(2) Redepositing previously refunded retirement contributions pursuant to Chapter 19 (commencing with Section 23200).

~~SEC. 14.~~

SEC. 13. Section 26004 of the Education Code is amended to read:

26004. Notwithstanding any other provision of law:

(a) The benefits payable to any participant or beneficiary under this part shall be subject to the limitations imposed by Section 415 of Title 26 of the United States Code.

(b) The amount of compensation that is taken into account in computing benefits under this part for a plan year shall not exceed the annual compensation limit applicable to that plan year in accordance with Section 401(a)(17) of Title 26 of the United States Code as that section read on the effective date of this section and as that section may be amended after that date. The determination of compensation for a 12-month period shall be subject to the annual compensation limit in effect for the calendar year in which the 12-month period begins. In a determination of average compensation over more than one 12-month period, the amount of compensation taken into account for each 12-month period shall be subject to the respective annual compensation limit applicable to that period.

(c) Distributions from the plan under this part shall be made in accordance with Section 401(a)(9) of Title 26 of the United States Code, including the incidental death benefit requirements of Section 401(a)(9)(G) and the regulations thereunder. The required beginning date of benefit payments that represent the entire interest of the participant shall be as follows:

(1) In the case of a lump-sum distribution of a retirement benefit, disability benefit, or termination benefit, the lump-sum payment shall be made not later than April 1 of the calendar year following the later of (A) the calendar year in which the participant attains the age at which the Internal Revenue Code of 1986 requires a distribution of benefits or (B) the calendar year in which the participant terminates all employment subject to coverage by the plan.

(2) In the case of a retirement benefit or disability benefit that is to be paid in the form of an annuity, payment of the annuity shall begin not later than April 1 of the calendar year following the later of (A) the calendar year in which the participant attains the age at which the Internal Revenue Code of 1986 requires a distribution of benefits or (B) the calendar year in which the participant terminates employment in all positions subject to coverage by the plan, with the annuity to continue over the life of the participant or the life of the participant and the participant's option beneficiary, or over a period not to exceed the life expectancy of the participant or the life expectancy of the participant and the participant's option beneficiary.

(3) In the case of a death benefit, distributions shall commence as follows:

(A) The normal form of the benefit or other lump-sum distribution shall be paid in accordance with Section 401(a)(9) of Title 26 of the United States Code and the regulations thereunder.

(B) Annuity payments shall commence as follows:

(i) If the spouse is the sole beneficiary, not later than December 31 of the later of the calendar year in which the participant would have attained the age at which the Internal Revenue Code of 1986 requires a distribution of benefits or the calendar year following the calendar year of the participant's death.

(ii) If the spouse is not the sole beneficiary, not later than December 31 of the calendar year following the calendar year of the participant's death.

(d) If a person becomes entitled to a distribution from the plan under this part that constitutes an eligible rollover distribution within the meaning of Section 401(a)(31) of Title 26 of the United States Code, the person may elect under terms and conditions established by the board to have the distribution or a portion thereof paid directly to a plan that constitutes an eligible retirement plan within the meaning of Section 401(a)(31), as specified by that person. Upon the exercise of the election by a person with respect to a distribution or a portion thereof, the distribution from the plan of the amount so designated, once distributable under the terms of the plan, shall be made in the form of a direct rollover to the eligible retirement plan so specified.

(e) The amount of any benefit from the plan under this part that is determined on the basis of actuarial assumptions shall be based on actuarial assumptions adopted by the board pursuant to Section 26213 as a plan amendment with respect to the Cash Balance Benefit Program and those assumptions shall preclude employer discretion and comply with Section 401(a)(25) of Title 26 of the United States Code.

(f) This section shall become inoperative on July 1, 2027, and, as of January 1, 2028, is repealed.

~~SEC. 15.~~

SEC. 14. Section 26004 is added to the Education Code, to read:

26004. Notwithstanding any other provision of law:

(a) The benefits payable to any participant or beneficiary under this part shall be subject to the limitations imposed by Section 415 of Title 26 of the United States Code.

(b) The amount of compensation that is taken into account in computing benefits under this part for a plan year shall not exceed the following limitations:

(1) The annual compensation limit applicable to that plan year in accordance with Section 401(a)(17) of Title 26 of the United States Code as that section read on the effective date of this section and as that section may be amended after that date. The determination of compensation for a 12-month period shall be subject to the annual compensation limit in effect for the calendar year in which the 12-month period begins. In a determination of average compensation over more than one 12-month period, the amount of compensation taken into account for each 12-month

period shall be subject to the respective annual compensation limit applicable to that period.

(2) For a participant subject to the California Public Employees' Pension Reform Act of 2013:

(A) (i) One hundred twenty percent of the "contribution and benefit base," as determined under Section 430(b) of the Social Security Act (42 U.S.C. Sec. 430(b)), on January 1, 2013, for a participant whose service is not included in the federal system.

(ii) One hundred percent of the "contribution and benefit base," as determined under Section 430(b) of the Social Security Act (42 U.S.C. Sec. 430(b)), on January 1, 2013, for a participant whose service is included in the federal system pursuant to any changes in state or federal law enacted on or after January 1, 2013.

(B) The system shall adjust the limit based on the annual changes to the Consumer Price Index for All Urban Consumers: U.S. City Average, calculated by dividing the Consumer Price Index for All Urban Consumers: U.S. City Average for the month of February in the fiscal year preceding the adjustment by the Consumer Price Index for All Urban Consumers: U.S. City Average for the month of February of the previous year rounded to the nearest thousandth. Notwithstanding paragraph (1) of subdivision (d) of Section 7522.10 of the Government Code, the adjustment shall be effective annually on July 1, beginning July 1, 2014.

(C) The Legislature reserves the right to modify the requirements of this paragraph with regard to all participants subject to this subdivision, except that the Legislature shall not modify these provisions in a manner that would result in a decrease in benefits accrued before the operative date of the modification.

(c) Distributions from the plan under this part shall be made in accordance with Section 401(a)(9) of Title 26 of the United States Code, including the incidental death benefit requirements of Section 401(a)(9)(G) and the regulations thereunder. The required beginning date of benefit payments that represent the entire interest of the participant shall be as follows:

(1) In the case of a lump-sum distribution of a retirement benefit, disability benefit, or termination benefit, the lump-sum payment shall be made not later than April 1 of the calendar year following the later of (A) the calendar year in which the participant attains the age at which the Internal Revenue Code of 1986 requires a

distribution of benefits or (B) the calendar year in which the participant terminates all employment subject to coverage by the plan.

(2) In the case of a retirement benefit or disability benefit that is to be paid in the form of an annuity, payment of the annuity shall begin not later than April 1 of the calendar year following the later of (A) the calendar year in which the participant attains the age at which the Internal Revenue Code of 1986 requires a distribution of benefits or (B) the calendar year in which the participant terminates employment in all positions subject to coverage by the plan, with the annuity to continue over the life of the participant or the life of the participant and the participant's option beneficiary, or over a period not to exceed the life expectancy of the participant or the life expectancy of the participant and the participant's option beneficiary.

(3) In the case of a death benefit, distributions shall commence as follows:

(A) The normal form of the benefit or other lump-sum distribution shall be paid in accordance with Section 401(a)(9) of Title 26 of the United States Code and the regulations thereunder.

(B) Annuity payments shall commence as follows:

(i) If the spouse is the sole beneficiary, not later than December 31 of the later of the calendar year in which the participant would have attained the age at which the Internal Revenue Code of 1986 requires a distribution of benefits or the calendar year following the calendar year of the participant's death.

(ii) If the spouse is not the sole beneficiary, not later than December 31 of the calendar year following the calendar year of the participant's death.

(d) If a person becomes entitled to a distribution from the plan under this part that constitutes an eligible rollover distribution within the meaning of Section 401(a)(31) of Title 26 of the United States Code, the person may elect under terms and conditions established by the board to have the distribution or a portion thereof paid directly to a plan that constitutes an eligible retirement plan within the meaning of Section 401(a)(31), as specified by that person. Upon the exercise of the election by a person with respect to a distribution or a portion thereof, the distribution from the plan of the amount so designated, once distributable under the terms of

the plan, shall be made in the form of a direct rollover to the eligible retirement plan so specified.

(e) The amount of any benefit from the plan under this part that is determined on the basis of actuarial assumptions shall be based on actuarial assumptions adopted by the board pursuant to Section 26213 as a plan amendment with respect to the Cash Balance Benefit Program and those assumptions shall preclude employer discretion and comply with Section 401(a)(25) of Title 26 of the United States Code.

(f) This section shall become operative on July 1, 2027.

~~SEC. 16.~~

SEC. 15. Section 26113 of the Education Code is amended to read:

26113. (a) "Creditable service" means any of the activities described in subdivision (b) performed for any of the following employers:

(1) A prekindergarten through grade 12 employer in a position with certification qualifications authorized by the Commission on Teacher Credentialing pursuant to Section 44001.

(2) A community college employer by a faculty member, as defined in Section 87003, in an academic position, as defined in subdivision (b) of Section 87001, or by an educational administrator, as defined in subdivision (b) of Section 87002, subject to the appropriate minimum standards adopted by the Board of Governors of the California Community Colleges pursuant to Section 87356, or pursuant to a contract between a community college district and the United States Department of Defense to provide vocational training.

(3) A charter school employer under the provisions of an approved charter for the operation of a charter school for which the charter school is eligible to receive state apportionment.

(b) The types of activities are any of the following:

(1) The work of teachers, instructors, district interns, and academic employees employed in the instructional program for pupils, including special programs such as adult education, regional occupational programs, childcare centers, and prekindergarten programs pursuant to Section 22161.

(2) Education or vocational counseling, guidance, and placement services.

(3) The work of employees who plan courses of study to be used in California public schools, or research connected with the evaluation or efficiency of the instructional program.

(4) The selection, collection, preparation, classification, demonstration, or evaluation of instructional materials of any course of study for use in the development of the instructional program in California public schools, or other services related to California public school curriculum.

(5) The examination, selection, in-service training, mentoring, or assignment of teachers, principals, or other similar personnel involved in the instructional program.

(6) The work of nurses, physicians, speech therapists, psychologists, audiologists, and other California public school health professionals.

(7) Services as a California public school librarian.

(8) Activities connected with the enforcement of the laws relating to compulsory education, coordination of child welfare activities involving the school and the home, and the school adjustment of pupils.

(9) The work of employees who are responsible for the supervision of persons or administration of the duties described in this subdivision.

(c) "Creditable service" also means any of the activities described in subdivision (b) when they are performed for an employer by:

(1) Superintendents of California public schools, and presidents and chancellors of community college employers.

(2) Consulting teachers employed by an employer to participate in the California Peer Assistance and Review Program for Teachers pursuant to Article 4.5 (commencing with Section 44500) of Chapter 3 of Part 25 of Division 3 of Title 2.

(3) Audiometrists who hold a certificate of registration issued by the State Department of Health Care Services.

(d) "Creditable service" also means the performance of California public school activities related to, and an outgrowth of, the instructional and guidance program of the California public school when performed for the same employer for which the member is performing any of the activities described in subdivision (b) or (c).

(e) "Creditable service" also means trustee service as defined in Section 26144.5, if eligible pursuant to Section 26403.

(f) The board shall have final authority for determining creditable service to cover activities not already specified.

(g) This section shall become inoperative on July 1, 2027, and, as of January 1, 2028, is repealed.

~~SEC. 17.~~

SEC. 16. Section 26113 is added to the Education Code, to read:

26113. (a) "Creditable service" means service in a position subject to membership as defined in Section 22156.07.

(b) "Creditable service" also means trustee service as defined in Section 26144.5, if eligible pursuant to Section 26403.

(c) This section shall become operative on July 1, 2027.

~~SEC. 18.~~

SEC. 17. Section 26135.7 of the Education Code is amended to read:

26135.7. (a) "Retired participant activities" means one or more activities identified in subdivision (b), (c), or (d) of Section 22119.5 or (b), (c), or (d) of Section 26113 within the California public school system and performed by a participant retired for service under this part as one of the following:

(1) An employee of an employer.

(2) An employee of a third party, except as specified in subdivision (b).

(3) An independent contractor.

(b) The activities of an employee of a third party shall not be included in the definition of "retired participant activities" if all of the following conditions apply:

(1) The employee performs an assignment of 24 months or less.

(2) The third-party employer does not participate in a California public pension system.

(3) The activities performed by the individual are not normally performed by employees of an employer, as defined in Section 22131.

(c) This section shall become inoperative on July 1, 2027, and, as of January 1, 2028, is repealed.

~~SEC. 19.~~

SEC. 18. Section 26135.7 is added to the Education Code, to read:

26135.7. (a) "Retired participant activities" means all service performed within the California public school system by a participant retired for service under this part when the participant is employed as one of the following:

(1) An employee of an employer.

(2) An employee of a third party, except as specified in subdivision (b).

(3) An independent contractor.

(b) Service performed by an employee of a third party shall not be included in the definition of "retired participant activities" if all of the following conditions apply:

(1) The employee performs an assignment of 24 months or less.

(2) The third-party employer does not participate in a California public pension system.

(3) The activities performed by the individual are not normally performed by employees of an employer, as defined in Section 22131.

(c) This section shall become operative on July 1, 2027.

~~SEC. 20.~~

SEC. 19. Section 26139 of the Education Code is amended to read:

26139. (a) "Salary" means remuneration paid in cash by an employer to a participant for creditable service performed in that position subject to coverage under the Cash Balance Benefit Program. Salary shall include:

(1) Money paid in accordance with a publicly available written contractual agreement, including, but not limited to, a salary schedule, based on years of training and years of experience as specified in Section 45028 for creditable service performed.

(2) For participants not paid according to a salary schedule, money paid for creditable service performed in accordance with a publicly available written contractual agreement, including, but not limited to, a collective bargaining agreement or an employment agreement.

(3) Money paid for the participant's absence from performance of creditable service as approved by an employer, except as provided in paragraph (5) of subdivision (b).

(4) Employee contributions picked up by an employer pursuant to Section 26502.

(5) Amounts deducted by an employer from the participant's salary, including, but not limited to, deductions for participation in a deferred compensation plan; deductions for the purchase of an annuity contract, tax-deferred retirement plan, or other insurance program; and deductions for participation in a plan that meets the requirements of Section 125, 401(a), 401(k), 403(b), 457(b), or 457(f) of Title 26 of the United States Code.

(6) Money paid by an employer in addition to salary paid under paragraph (1) or (2) if paid to all employees in a class in the same dollar amount, the same percentage of salary, or the same percentage of the amount being distributed.

(7) Any other payments the board determines by plan amendment to be "salary."

(b) "Salary" does not mean and shall not include:

(1) Money paid for service that is not creditable service.

(2) Money paid by an employer in addition to salary paid under paragraph (1) or (2) if not paid to all employees in a class in the same dollar amount, the same percentage of salary, or the same percentage of the amount being distributed.

(3) Fringe benefits provided by an employer.

(4) Expenses paid or reimbursed by an employer.

(5) Money paid in exchange for the relinquishment of unused accumulated leave.

(6) Severance pay, including lump-sum and installment payments, or money paid in excess of salary or wages to a participant as compensatory damages or as a compromise settlement.

(7) Payments, including, but not limited to, those for participation in a deferred compensation plan; to purchase an annuity contract, tax-deferred retirement program, or other insurance program; and for participation in a plan that meets the requirements of Section 125, 401(a), 401(k), 403(b), 457(b), or 457(f) of Title 26 of the United States Code that are purchased by an employer for a participant.

(8) Any payments determined by the system to have been made by an employer to enhance a participant's benefits.

(9) Any other payments the board determines by plan amendment not to be "salary."

(c) Any employer or person who knowingly or willfully reports salary in a manner inconsistent with the provisions of subdivisions

(a) or (b) may be subject to prosecution for fraud, theft, or embezzlement in accordance with provisions of the Penal Code. The system may establish procedures to ensure that salary reported by an employer is in compliance with this section.

(d) For purposes of this section, remuneration shall be considered paid if distributed to any person in the same class of employees who meets the qualifications or requirements specified in a publicly available written contractual agreement, including, but not limited to, a collective bargaining agreement or an employment agreement, as a condition of receiving the remuneration.

(e) This section shall be deemed to have become operative on July 1, 1996.

(f) This section shall not apply to a participant subject to the California Public Employees' Pension Reform Act of 2013.

(g) This section shall become inoperative on July 1, 2027, and, as of January 1, 2028, is repealed.

~~SEC. 21.~~

SEC. 20. Section 26139 is added to the Education Code, to read:

26139. (a) "Salary" means remuneration paid in cash by an employer to a participant who performs creditable service in a position subject to coverage under the Cash Balance Benefit Program. Salary shall include any compensation except that which is specified in subdivision (c) of Section 22119.3.

(b) Salary in any fiscal year shall not exceed the limits described in subdivision (b) of Section 26004.

(c) Any employer or person who knowingly or willfully reports salary in a manner inconsistent with the provisions of subdivisions (a) or (b) may be subject to prosecution for fraud, theft, or embezzlement in accordance with provisions of the Penal Code. The system may establish procedures to ensure that salary reported by an employer is in compliance with this section.

(d) This section shall become operative on July 1, 2027.

~~SEC. 22.~~

SEC. 21. Section 26139.5 of the Education Code is amended to read:

26139.5. (a) "Salary," for participants subject to the California Public Employees' Pension Reform Act of 2013, means remuneration paid each pay period in cash by an employer to a

participant for creditable service performed in that position subject to coverage under the Cash Balance Benefit Program in accordance with a publicly available written contractual agreement, including, but not limited to, a salary schedule or employment agreement, based on years of training and years of experience as specified in Section 45028. Salary shall include:

(1) Money paid for the participant's absence from performance of creditable service as approved by an employer, except as provided in paragraph (5) of subdivision (b).

(2) Employee contributions picked up by an employer pursuant to Section 26502.

(3) Amounts deducted by an employer from the participant's salary, including, but not limited to, deductions for participation in a deferred compensation plan; deductions for the purchase of an annuity contract, tax-deferred retirement plan, or other insurance program; and deductions for participation in a plan that meets the requirements of Section 125, 401(a), 401(k), 403(b), 457(b), or 457(f) of Title 26 of the United States Code.

(4) Any other payments the board determines by plan amendment to be "salary."

(b) "Salary" does not mean and shall not include:

(1) Money paid for service that is not creditable service.

(2) Money not paid each pay period in which creditable service is performed for that position.

(3) Fringe benefits provided by an employer.

(4) Expenses paid or reimbursed by an employer.

(5) Money paid in exchange for the relinquishment of unused accumulated leave.

(6) Severance pay, including lump-sum and installment payments, or money paid in excess of salary to a participant as compensatory damages or as a compromise settlement.

(7) Payments, including, but not limited to, those for participation in a deferred compensation plan; to purchase an annuity contract, tax-deferred retirement program, or other insurance program; and for participation in a plan that meets the requirements of Section 125, 401(a), 401(k), 403(b), 457(b), or 457(f) of Title 26 of the United States Code that are purchased by an employer for a participant.

(8) Any payments determined by the system to have been made by an employer to enhance a participant's benefits under the plan.

(9) Money paid to the participant in lieu of benefits provided to the participant by the employer or paid directly by the employer to a third party other than the system for the benefit of the participant.

(10) Any one-time or ad hoc payments made to a participant.

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

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

(13) Any other payments the board determines by plan amendment not to be "salary."

(c) (1) Salary in any fiscal year shall not exceed:

(A) One hundred twenty percent of the "contribution and benefit base," as determined under Section 430(b) of the Social Security Act (42 U.S.C. Sec. 430(b)), on January 1, 2013, for a participant whose service is not included in the federal system.

(B) One hundred percent of the "contribution and benefit base," as determined under Section 430(b) of the Social Security Act (42 U.S.C. Sec. 430(b)), on January 1, 2013, for a participant whose service is included in the federal system pursuant to any changes in state or federal law enacted on or after January 1, 2013.

(2) The system shall adjust the limit based on the annual changes to the Consumer Price Index for All Urban Consumers: U.S. City Average, calculated by dividing the Consumer Price Index for All Urban Consumers: U.S. City Average for the month of February in the fiscal year preceding the adjustment by the Consumer Price Index for All Urban Consumers: U.S. City Average for the month of February of the previous year rounded to the nearest thousandth. Notwithstanding paragraph (1) of subdivision (d) of Section 7522.10 of the Government Code, the adjustment shall be effective annually on July 1, beginning July 1, 2014.

(3) The Legislature reserves the right to modify the requirements of this subdivision with regard to all participants subject to this subdivision, except that the Legislature may not modify these provisions in a manner that would result in a decrease in benefits accrued prior to the effective date of the modification.

(d) Any employer or person who knowingly or willfully reports salary in a manner inconsistent with the provisions of subdivisions (a) or (b) may be subject to prosecution for fraud, theft, or

embezzlement in accordance with provisions of the Penal Code. The system may establish procedures to ensure that salary reported by an employer is in compliance with this section.

(e) For purposes of this section, remuneration shall be considered paid if distributed to any person in the same class of employees who meets the qualifications or requirements specified in a publicly available written contractual agreement, including, but not limited to, a collective bargaining agreement or an employment agreement, as a condition of receiving the remuneration.

(f) This section shall become inoperative on July 1, 2027, and, as of January 1, 2028, is repealed.

~~SEC. 23.~~

SEC. 22. Section 26139.5 is added to the Education Code, to read:

26139.5. (a) "Service" means work performed for compensation, except as otherwise specifically provided in this part.

(b) This section shall become operative on July 1, 2027.

~~SEC. 24.~~

SEC. 23. Section 26300 of the Education Code is amended to read:

26300. (a) Within 10 working days following the later of the first day of employment, the date of the employer's governing board's action to provide the Cash Balance Benefit Program, or the effective date of the employer's governing board's action to provide the Cash Balance Benefit Program, the employer shall make available to the employee the following information:

(1) The employee's rights and responsibilities as a participant in the program, the employer's responsibilities under the program, and the benefits payable under the program.

(2) The employee's right to elect membership in the Defined Benefit Program in lieu of participation in the Cash Balance Benefit Program, the rights and responsibilities of a member and the employer under the Defined Benefit Program, and benefits payable under the Defined Benefit Program.

(b) Written acknowledgment by the employee that they have received the information specified in subdivision (a) shall be retained in the employer's files on a form prescribed by the system.

(c) If an employer's governing board's action to provide the Cash Balance Benefit Program gives employees the right to elect

other coverage in lieu of the Cash Balance Benefit Program pursuant to Section 26400, the employer shall, within 10 working days following the later of the first day of employment, the date of the employer's governing board's action to provide the program or the effective date of the employer's governing board's action to provide the program, notify existing employees of the following:

(1) The employee's right to elect other coverage if offered by the employer in lieu of participation in the Cash Balance Benefit Program.

(2) The rights and responsibilities of the employer and a participant in an alternative retirement plan if offered by the employer.

(3) The benefits payable under an alternative retirement plan if offered by the employer.

~~SEC. 25.~~

SEC. 24. Section 26606 of the Education Code is amended to read:

26606. Any additional earnings credit declared shall be determined as a specified percentage increase in the closing balance of each employee account and employer account with respect to the Cash Balance Benefit Program measured as of the last day of the plan year. The additional earnings credit shall be credited to employee account and employer account balances as of the date the board declares the additional earnings credit is to be applied.

~~SEC. 26.~~

SEC. 25. Section 31520 of the Government Code is amended to read:

31520. Except as otherwise delegated to the board of investment and except for the statutory duties of the county treasurer, the management of the retirement system is vested in the board of retirement, consisting of five members, one of whom shall be the county treasurer. The second and third members of the board shall be active members of the association elected by those active members within 30 days after the retirement system becomes operative in a manner determined by the board of supervisors. The fourth and fifth members shall be qualified electors of the county who are not connected with county government in any capacity, except one may be a supervisor and one may be a retired member, and shall be chosen by the board of supervisors. The first persons chosen as the second and fourth

members shall serve for two years from the date the system becomes operative and the third and fifth members shall serve for a term of three years from that date. Thereafter the terms of office of the four elected members are three years.

As used in this section "active member" means a member in county service pursuant to Section 31640 and a "retired member" means a member, including a member under former Section 31555, retired for service or disability.

~~SEC. 27.~~

SEC. 26. Section 31520.1 of the Government Code is amended to read:

31520.1. (a) In any county subject to Articles 6.8 (commencing with Section 31639) and 7.5 (commencing with Section 31662.2), the board of retirement shall consist of nine members and one alternate, one of whom shall be the county treasurer. The second and third members of the board shall be active members of the association, other than safety members, elected by those active members within 30 days after the retirement system becomes operative in a manner determined by the board of supervisors. The fourth, fifth, sixth, and ninth members shall be qualified electors of the county who are not connected with the county government in any capacity, except one may be a supervisor, and shall be appointed by the board of supervisors. A supervisor appointed as a member of the retirement board may not serve beyond their term of office as supervisor. The seventh member shall be a safety active member of the association elected by the safety active members. The eighth member shall be a retired member elected by the retired members of the association in a manner to be determined by the board of supervisors. The alternate member shall be that candidate, if any, for the seventh member from the group under Section 31470.2 or 31470.4, or any other eligible safety member in a county if there is no eligible candidate from the groups under Sections 31470.2 and 31470.4, which is not represented by a board member who received the highest number of votes of all candidates in that group, and shall be referred to as the alternate seventh member. If there is no eligible candidate there may not be an alternate seventh member. The first person chosen as the second and fourth members shall serve for a term of two years beginning with the date the system becomes operative, the third and fifth members shall serve for a term of three years beginning with that date, and the sixth,

seventh and alternate seventh members shall serve for a term of two years beginning on the date on which a retirement system established by this chapter becomes operative. The eighth and ninth members shall take office as soon as practicable for an initial term to expire concurrent with the expiration of the longest remaining term of an elected member. Thereafter, the terms of office of the elected, appointed, and alternate seventh members are three years, except as provided in Section 31523.

(b) The alternate seventh member provided for by this section shall vote as a member of the board only if the second, third, seventh, or eighth member is absent from a board meeting for any cause, or if there is a vacancy with respect to the second, third, seventh, or eighth member, the alternate seventh member shall fill the vacancy until a successor qualifies. The alternate seventh member shall sit on the board in place of the seventh member if a member of the same service is before the board for determination of their retirement.

(c) The alternate seventh member shall be entitled to both of the following:

(1) The alternate seventh member shall have the same rights, privileges, responsibilities, and access to closed sessions as the second, third, seventh, and eighth member.

(2) The alternate seventh member may hold positions on committees of the board independent of the second, third, seventh, or eighth member and may participate in the deliberations of the board or any of its committees to which the alternate seventh member has been appointed whether or not the second, third, seventh, or eighth member is present.

(d) As used in this section, "active member" means a member in county service pursuant to Section 31640 and a "retired member" means a member, including a member under former Section 31555, retired for service or disability.

~~SEC. 28.~~

SEC. 27. Section 31520.2 of the Government Code is amended to read:

31520.2. (a) In any county in which the assets of the retirement system exceed eight hundred million dollars ($800,000,000), the board of supervisors may, by resolution, establish a board of investments. The board shall consist of nine members, one of whom shall be the county treasurer. The second

and third members shall be general active members of the association elected by the general membership of the association for a three-year term. The fourth member shall be a safety active member elected by the safety membership of the association for a three-year term. The eighth member shall be a retired member of the association elected by the retired membership of the association for a three-year term. The fifth, sixth, seventh, and ninth members shall be qualified electors of the county who are not connected with county government in any capacity, and shall be appointed by the board of supervisors. They shall also have had significant experience in institutional investing, either as investment officer of a bank, or trust company; or as investment officer of an insurance company, or in an active, or advisory, capacity as to investments of institutional or endowment funds. The first person chosen as a fifth, sixth, or seventh member shall serve for a three-year term, the second person chosen shall serve a four-year term, and the third person chosen shall serve a two-year term. The first person appointed as the ninth member shall serve a one-year term. Thereafter, all terms of all appointed members shall be three years.

(b) The board of investments shall be responsible for all investments of the retirement system.

(c) As used in this section, "active member" means a member in county service pursuant to Section 31640 and a "retired member" means a member, including a member under former Section 31555, retired for service or disability.

~~SEC. 29.~~

SEC. 28. Section 31540.5 is added to the Government Code, to read:

31540.5. (a) The obligations of the retirement system to its members continue throughout their respective memberships, and the obligations of the retirement system to, and in respect to, retired members continue throughout the lives of the retired members, and thereafter until all obligations to the members' beneficiaries under optional settlements have been discharged. The obligations of the county or district to the retirement system with respect to members employed by them, respectively, continue throughout the memberships of the members, and the obligations of the county or district to the retirement system with respect to retired members formerly employed by them, respectively, continue until all of the

obligations of the retirement system to those retired members have been discharged. The obligations of any member to the retirement system continue throughout their membership, and thereafter until all of the obligations of the retirement system to that member have been discharged.

(b) In cases in which payment is erroneous because of the death of the retired member or beneficiary or because of the remarriage of the beneficiary, the period of limitation of actions shall be 10 years and that period shall commence with the discovery of the erroneous payment.

(c) If any payment has been made as a result of fraudulent reports for compensation made, or caused to be made, by a member for their own benefit, the period of limitation of actions shall be 10 years and that period shall commence either from the date of payment or upon discovery of the fraudulent reporting, whichever date is later.

(d) The board shall determine the applicability of the period of limitation in any case, and its determination with respect to the running of any period of limitation shall be conclusive and binding for purposes of correcting the error or omission.

(e) This section does not apply to a county of the first class.

~~SEC. 30.~~

SEC. 29. Section 31621.7 of the Government Code is amended to read:

31621.7. The normal rates of contribution for members covered by Section 31751 shall be such as will provide an average annuity at age 55 equal to one-three hundredth of the member's final compensation, according to the tables adopted by the board of supervisors, for each year of service rendered after entering the system.

Until revised pursuant to Sections 31453 and 31454, the normal rate of contribution of each member is that percentage of the member's compensation earnable, shown in the following table according to the member's age at the time of entry into the retirement system:

Age of entry into system	Percentage of contribution
16	2.93
17	2.93

18	2.93
19	2.93
20	2.93
21	2.93
22	2.93
23	2.94
24	2.94
25	2.95
26	2.96
27	2.97
28	2.98
29	3.00
30	3.02
31	3.04
32	3.06
33	3.08
34	3.10
35	3.12
36	3.15
37	3.17
38	3.20
39	3.22
40	3.25
41	3.28
42	3.31
43	3.34
44	3.37
45	3.40
46	3.43
47	3.46
48	3.50
49	3.54
50	3.57
51	3.61
52	3.65
53	3.69
54 and over	3.72

~~SEC. 31.~~

SEC. 30. Section 31622 of the Government Code is amended to read:

31622. Until revised pursuant to Sections 31453 and 31454, the rate of contribution of each member not covered by Article 6.8 is that percentage of the member's compensation earnable shown in the following tables according to age and sex at the time of entry into the retirement system:

Age of entry into system	Percentage of contribution, Male	Percentage of contribution, Female
16	6.55	7.02
17	6.59	7.07
18	6.63	7.13
19	6.67	7.19
20	6.71	7.25
21	6.75	7.31
22	6.80	7.38
23	6.85	7.45
24	6.90	7.52
25	6.96	7.61
26	7.01	7.69
27	7.07	7.78
28	7.14	7.87
29	7.20	7.96
30	7.27	8.06
31	7.34	8.16
32	7.42	8.26
33	7.49	8.37
34	7.58	8.48
35	7.66	8.58
36	7.75	8.69
37	7.84	8.80
38	7.93	8.92
39	8.02	9.03
40	8.12	9.15
41	8.22	9.27
42	8.33	9.38

43	8.43	9.51
44	8.54	9.63
45	8.64	9.75
46	8.75	9.88
47	8.86	10.00
48	8.97	10.13
49	9.08	10.26
50	9.20	10.39
51	9.31	10.52
52	9.42	10.65
53	9.54	10.79
54	9.65	10.93
55	9.76	11.07
56	9.88	11.21
57	10.00	11.35
58	10.12	11.49
59	10.25	11.64
60	_____	_____

~~SEC. 32.~~

SEC. 31. Section 31639.3 of the Government Code is amended to read:

31639.3. Until revised pursuant to Sections 31453 and 31454, the rate of contribution of each safety member is that percentage of the member's compensation earnable shown in the following tables according to age at the time of entry into the retirement system:

Age	Percentage
18	9.27
19	9.29
20	9.32
21	9.34
22	9.43
23	9.53
24	9.63
25	9.73
26	9.83
27	9.94
28	10.04

29	10.15
30	10.25
31	10.36
32	10.48
33	10.59
34	10.71
35	10.82
36	10.94
37	11.06
38	11.17
39	11.30
40	11.42
41	11.55
42	11.66
43	11.79
44	11.92
45	12.04
46	12.17
47	12.30
48	12.43
49 and over	12.56

~~SEC. 33.~~

SEC. 32. Section 31641 of the Government Code is amended to read:

31641. "Service" means uninterrupted employment of any person appointed or elected for that period of time:

(a) For which deductions are made from the person's compensation earnable *or pensionable compensation* from the county or district for such service while the person is a member of the retirement association.

(b) In military service for which the county or district or member is authorized by other provisions of this chapter to make, and does make, contributions.

(c) For which the member receives credit for county service or for public service or for both pursuant to the provisions of this article.

(d) Allowed for prior service.

~~SEC. 34.~~

SEC. 33. Section 31641.2 of the Government Code is amended to read:

31641.2. Any member of the retirement system who elects pursuant to Section 31641.1 to make contributions and receive credit as service for time for which the member claims credit because of public service shall contribute to the retirement fund, prior to the effective date of their retirement, by lump sum payment or by installment payments over a period not to exceed five years, an amount equal to the sum of:

(a) Twice the contributions the member would have made to the retirement fund if they had been a member during the same length of time as that for which they elected to receive credit as service, computed by applying the rate of contribution first applicable to them upon commencement of their membership in this system to the monthly compensation first earnable by them at the time as provided in Section 31641.3, multiplied by the number of months for which they elected to receive credit for county service, including time, if any, prior to the establishment of the system, and which will constitute current service under this system.

(b) The "regular interest" that would have accrued to the member contributions if they had been made on the date used to determine on what compensation earnable *or pensionable compensation* contributions pursuant to this section shall be based, from that date until the completion of payment of those contributions, computed at the current interest rate.

(c) Except as prohibited by Section 31640.7, the governing body by a four-fifths vote may provide that it shall make on behalf of officers and employees eligible to receive credit for prior service under this chapter, and who so elect prior to filing an application for retirement, part of the contributions specified in paragraphs (a) and (b) of this section. The contributions made by a governmental agency pursuant to this section shall be available only for purposes of retirement for service or for disability and a member resigning from county service shall be entitled to withdraw only that portion of their accumulated contributions made.

~~SEC. 35.~~

SEC. 34. Section 31641.6 of the Government Code is amended to read:

31641.6. An employee of a city who has become a county employee upon the assumption by the county of the functions of the city department in which they were employed, may, if the employee is not covered by the city under a contract with the Public Employees' Retirement System, elect to receive credit in the county retirement system for service for the city prior to the cessation of their employment by the city. When such person elects to receive credit, membership in the retirement system shall commence with the first day of the month in which credit is granted.

Any such person shall be entitled to credit in the county retirement system for service performed for the city when and if (a) the board of retirement receives certification from the city of the city service and compensation earnable *or pensionable compensation* of the employee; and (b) the employee deposits into the employees' retirement system the amount of contributions they would have made had they been a county employee during their city employment; and (c) there is also deposited in the employees' retirement system by the city, the employee, or both, the amount that the county would have been required to deposit to the employees' retirement fund based on the city salary paid to such employee.

Upon deposit of such funds, the employee's age at entry shall be considered to be their age at time of employment with the city or at the time this chapter was effective in the county whichever is later. Such money deposited under (b) above shall be considered as accumulated normal contributions of the employee and any such money deposited under (c) above shall be considered as contributions of the employer county.

If all of the money called for under (b) above is not paid within 90 days after employment by the county, only the part of city employment latest in date covered by such deposit shall be credited and the age at entry and the amount under (c) above shall be adjusted accordingly.

An employee shall receive credit for city employment prior to their employment by the county only for such service for which they are not entitled to receive a pension or retirement from such city.

This section shall become operative in any county on the first day of the calendar month after the board of supervisors adopts by four-fifths vote a resolution making it operative in the county.

~~SEC. 36.~~

SEC. 35. Section 31641.20 of the Government Code is amended to read:

31641.20. Any member of the retirement system who elects pursuant to Section 31641.1 to make contributions and receive credit as service for time for which they claim credit because of public service shall contribute to the retirement fund, prior to the effective date of their retirement, by lump-sum payment or by installment payments over a period not to exceed five years, an amount equal to the sum of:

(a) Twice the contributions they would have made to the retirement fund if they had been a member during the same length of time as that for which they have elected to receive credit as service, computed by applying the rate of contribution at the time of the election to the monthly compensation earnable *or pensionable compensation* by them at the time of the election pursuant to Section 31641.1, multiplied by the number of months for which they have elected to receive credit for county service, including time, if any, prior to the establishment of the system, and which will constitute current service under this system.

(b) The "regular interest" which would have accrued to the member contributions if they had been made on the date used to determine on what compensation earnable *or pensionable compensation* contributions pursuant to this section shall be based, from that date until the completion of payment of those contributions, computed at the current interest rate.

(c) The governing body by a four-fifths vote may provide that it shall make on behalf of officers and employees eligible to receive credit for prior service under this chapter, and who so elect prior to filing an application for retirement, part of the contributions specified in paragraphs (a) and (b) of this section. The contributions made by a governmental agency pursuant to this section shall be available only for purposes of retirement for service or for disability and a member resigning from county service shall be entitled to withdraw only that portion of their accumulated contributions made by them.

(d) This section shall only apply in counties of the third class, as established by Sections 28020 and 28024, as amended by Chapter 1204 of the Statutes of 1971, but it shall not apply in those

counties unless and until it is adopted by a majority vote of the board of supervisors.

~~SEC. 37.~~

SEC. 36. Section 31641.21 of the Government Code is amended to read:

31641.21. Regular interest computed at the current interest rate as used in subdivision (b) of Section 31641.2 shall mean that amount of interest which would have been credited to the account of the member on the amount to be deposited at the interest rates established for the system if the contribution required by that section had been on deposit from the date used to determine the compensation earnable *or pensionable compensation* on which such contributions are based until the amount required to be deposited has been paid.

~~SEC. 38.~~

SEC. 37. Section 31789.6 is added to the Government Code, to read:

31789.6. If the beneficiary of a member retired under this chapter or the California Public Employees' Pension Reform Act of 2013 established reciprocity and is entitled to receive a lump-sum death benefit from the reciprocal retirement system in which the person was a member in employment subsequent to their last employment in which the person was a member of a retirement system established under this chapter, no payment shall be made under Section 31789, 31789.01, 31789.1, 31789.12, 31789.13, 31789.2, 31789.3, 31789.5, or 31790 providing for payment of a lump-sum death benefit to a member's designated beneficiary.

~~SEC. 39.~~

SEC. 38. Section 31835 of the Government Code is amended to read:

31835. The average compensation during any period of service as a member of the Public Employees' Retirement System, a member of the Judges' Retirement System or Judges' Retirement System II, a member of a retirement system established under this chapter in another county, a member of the State Teachers' Retirement System, or a member of a retirement system of any other public agency of the state that has established reciprocity with the Public Employees' Retirement System subject to the conditions of Section 31840.2, shall be considered compensation

earnable or pensionable compensation pursuant to Section 7522.34, whichever is applicable, by a member for purposes of computing final compensation for that member provided:

(a) The period intervening between active memberships in the respective systems does not exceed 90 days, or 6 months if Section 31840.4 applies. That period shall not include any time during which the member was prohibited by law from becoming a member of the system of another county.

Notwithstanding anything in this chapter to the contrary, the 90-day or 6-month restriction referred to in this section or any other provision of this chapter affecting deferred retirement shall not be applicable to any members who left county or district service prior to October 1, 1949, and subsequently redeposited.

(b) The member retires concurrently under both systems and is credited with the period of service under that other system at the time of retirement.

(c) For the purposes of this section and Section 31835.02, "concurrently" means retiring on the same date or on different dates, not to exceed a difference of 30 calendar days, provided that the member does not perform service subject to coverage under the other system between the two retirement dates.

The provisions of this section shall be applicable to all members and beneficiaries of the system.

O

LACERA

April 28, 2026

TO: Each Member
Board of Retirement

FROM: Insurance, Benefits and Legislative Committee
Les Robbins, Chair
Aleen Langton, Vice Chair
Ernesto J. Pantoja
Shawn R. Kehoe
Jason Green, Alternate

FOR: May 6, 2026 Board of Retirement Meeting

SUBJECT: **Assembly Bill 1619—Board Compensation**

Author: *Valencia [D]*
Sponsor: *Orange County Employees' Retirement System*
Introduced: *January 21, 2026*
Status: *Referred to Committee on Public Employment & Retirement. (02/02/2026)*

IBLC Recommendation: *Support If Amended*
Staff Recommendation: *Support If Amended*

RECOMMENDATION
That the Board of Retirement adopt a "Support If Amended" position on Assembly Bill 1619, which would authorize a board of retirement to increase the board compensation rate to a maximum of $320 for appointed, retiree, and retiree alternate trustees, if this authority is made operative by a board of supervisors.

LEGISLATIVE POLICY STANDARD
The Board of Retirement's legislative policy standard is to support proposals that provide the BOR with increased flexibility in its administration of retirement plans and operations (page 6). AB 1619 would, if made operative by a board of supervisors, provide the BOR with the flexibility to increase the compensation rate for board meeting attendance.

SUMMARY
AB 1619 would, if made operative by a board of supervisors, authorize a board of retirement to increase the current compensation rate of $100 per meeting to a rate of not more than $320.

ANALYSIS
Existing Law
Government Code Section 31521 provides that in counties having a retirement board of nine members and an alternate retired member, the fourth, fifth, sixth, eighth, ninth, and

alternate retired members, and in counties having a board of investments, the fifth, sixth, seventh, eighth, and ninth members (which are the appointed, retiree, and retiree alternate trustees), shall receive compensation at a rate of not more than $100 per meeting, or for a meeting of a committee authorized by the board, for not more than five meetings per month.

Government Code Section 31521.1 provides for the same rate of compensation as specified in Section 31521. However, Section 31521.1 applies to LACERA only.

This Bill
AB 1619 proposes that the board compensation rate of $100 may be increased by a board of retirement to a rate of not more than $320, if the statute is adopted by a board of supervisors.

The current rate of $100 was established over 40 years ago and has not been subject to adjustment due to inflation. Providing the 20 retirement systems operating under the County Employees Retirement Law of 1937 with the flexibility to adjust the board compensation rate would reflect the wide-ranging diversity of these 20 systems in terms of workload for those members of the board of retirement who are not active employees receiving a salary from the plan sponsor.

Recommended Amendments

- Section 31521.1 should be amended with the same authority provided in Section 31521.

- Since a board of investments is also referenced in Sections 31521 and 31521.1, AB 1619's proposed change should be conformed to reference a board of investments as well.

IT IS THEREFORE RECOMMENDED THAT THE BOARD adopt a "Support If Amended" position on Assembly Bill 1619, which would authorize a board of retirement to increase the board compensation rate for appointed, retiree, and retiree alternate trustees to a maximum of $320, if this authority is made operative by a board of supervisors.

Attachments
Attachment 1—Board Positions Adopted on Related Legislation
Attachment 2—Support and Opposition
AB 1619 (Valencia) as amended on April 23, 2026

cc: Luis Lugo
JJ Popowich
Steven P. Rice
Jonathan Grabel
Naomi Padron, MKP Government Relations

BOARD POSITIONS ADOPTED ON RELATED LEGISLATION

AB 753 (Chapter 320, Statutes of 2007) provided that a board of supervisors may provide compensation to an alternate retired member serving on a board of retirement. It also provided that the fourth, fifth, sixth, eighth, ninth, and alternate retired members of the retirement board may receive compensation for the review of disability retirement cases. The Board of Retirement sponsored AB 753 and adopted a “Support” position.

SUPPORT
Orange County Employees' Retirement System (Sponsor)
Contra Costa County Employees Retirement Association
Orange County Employees Association

OPPOSITION
Unknown.

AMENDED IN ASSEMBLY APRIL 23, 2026

CALIFORNIA LEGISLATURE—2025–26 REGULAR SESSION

ASSEMBLY BILL No. 1619

Introduced by Assembly Member Valencia
(Coauthor: Assembly Member Chen)

January 21, 2026

An act to *amend Section 22223 of the Education Code, and to* amend ~~Section 31521~~ *Sections 20091, 31521, and 31521.1* of the Government Code, relating to public employees' retirement.

LEGISLATIVE COUNSEL'S DIGEST

AB 1619, as amended, Valencia. ~~County~~ *Public* employees' retirement: administration.

(1) Existing law, the Teachers' Retirement Law, establishes the State Teachers' Retirement System (STRS) 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, credited service, and age at retirement, subject to certain variations. STRS is administered by the Teachers' Retirement Board. Existing law also creates the Cash Balance Benefit Program, which is administered by the board, to provide a retirement plan for the benefit of participating employees who provide creditable service for less than 50% of full time. Existing law requires certain board members to receive $100 for attendance at board and committee meetings.

This bill would increase that rate to $320.

(2) Existing law, the Public Employees' Retirement Law (PERL), creates the Public Employees' Retirement System (PERS) for the purpose of providing pension benefits to state employees and employees of contracting agencies and prescribes the rights and duties of members

of the system and their beneficiaries. Existing law vests management and control of PERS in its board of administration. Existing law authorizes certain board members to receive $100 for attendance at a meeting of the board or committee thereof, as prescribed.

This bill would increase that rate to $320.

~~Existing~~

(3) Existing law, the County Employees Retirement Law of 1937, authorizes counties to establish retirement systems pursuant to its provisions in order to provide pension benefits to county, city, and district employees and their beneficiaries. Existing law sets forth the membership composition for boards of retirement and boards of investment, as specified. Existing law authorizes the board of supervisors for counties for which these provisions apply to provide that certain members of these boards shall receive compensation at a rate of not more than $100 for a meeting or for a meeting of a committee authorized by the entire board.

This bill would authorize the above-described compensation rate to be increased by the board of retirement to not more than $320 per meeting, and would provide that this provision would not be operative in any county until it is *publicly noticed and* adopted by a majority vote of the board of ~~supervisors.~~ *supervisors, as specified.*

Existing law, applicable to Los Angeles County, authorizes the board of supervisors to provide compensation to certain members of the board of retirement and board of investments at a rate of not more than $100 for a board or committee meeting, subject to certain limits.

This bill would authorize the above-described compensation rate to be increased by the board of retirement or board of investments to a rate of not more than $320 per meeting. The bill would prohibit this provision from becoming operative until it is publicly noticed and adopted by a majority vote of the board of supervisors, as specified.

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

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

SECTION 1. Section 22223 of the Education Code is amended to read:

22223. The members of the board who are not active members of the Defined Benefit Program or active participants of the Cash Balance Benefit Program and who are appointed by the Governor

pursuant to Section 22200 shall receive ~~one hundred dollars ($100)~~ *three hundred twenty dollars ($320)* for every day of actual attendance at meetings of the board or any meeting of any committee of the board of which the person is a member, and that is conducted for the purpose of carrying out the powers and duties of the board, together with their necessary traveling expenses incurred in connection with performance of their official duties.

SEC. 2. Section 20091 of the Government Code is amended to read:

20091. The members of the board appointed by the Governor pursuant to subdivision (e) of Section 20090, the public member appointed jointly by the Senate Committee on Rules and the Speaker of the Assembly pursuant to subdivision (f) of Section 20090, and any retired person serving on the board pursuant to subdivision (g) of Section 20090 shall receive ~~one hundred dollars ($100)~~ *three hundred twenty dollars ($320)* for every day or portion thereof of actual attendance at meetings of the board or any meeting of any committee of the board of which committee the person is a member and which meeting is conducted for the purpose of carrying out the powers and duties of the board, together with their necessary traveling expenses incurred in connection with performance of their official duties.

~~SECTION 1.~~

SEC. 3. Section 31521 of the Government Code is amended to read:

31521. (a) The board of supervisors may provide that the fourth and fifth members, and in counties having a board consisting of nine members or nine members and an alternate retired member, the fourth, fifth, sixth, eighth, ninth, and alternate retired members, and in counties having a board of investments under Section 31520.2, the fifth, sixth, seventh, eighth, and ninth members of the board of investments, shall receive compensation at a rate of not more than one hundred dollars ($100) for a meeting, or for a meeting of a committee authorized by the board, for not more than five meetings per month, together with actual and necessary expenses for all members of the board.

(b) The compensation rate established by the board of supervisors pursuant to subdivision (a) may be increased by the board of retirement to a rate of not more than three hundred twenty dollars ($320). This subdivision shall not be operative in any

county until it is *publicly noticed and* adopted by a majority vote of the board of ~~supervisors.~~ *supervisors, and shall not be adopted by a consent calendar.*

SEC. 4. Section 31521.1 of the Government Code is amended to read:

31521.1. (a) The board of supervisors may provide that in counties having a board consisting of nine members and an alternate retired member, the fourth, fifth, sixth, eighth, ninth, and alternate retired members, and in counties having a board of investments under Section 31520.2, the fifth, sixth, seventh, eighth, and ninth members of the board of investments, shall receive compensation at a rate of not more than one hundred dollars ($100) for a meeting, or for a meeting of a committee authorized by the board, for not more than five meetings per month, together with actual and necessary expenses for all members of the board.

(b) The compensation rate established by the board of supervisors pursuant to subdivision (a) may be increased by the board of retirement or board of investments to a rate of not more than three hundred twenty dollars ($320). This subdivision shall not become operative until it is publicly noticed and adopted by a majority vote of the board of supervisors, and shall not be adopted by a consent calendar.

~~(b)~~

(c) This section shall apply only in a county of the first class, as defined by Section 28020, as amended by Chapter 1204 of the Statutes of 1971, and Section 28022, as amended by Chapter 43 of the Statutes of 1961.

O

April 22, 2026

TO: Each Trustee –
Board of Retirement
Board of Investments

FROM: Nicole Mi, Chair
Joint Organizational Governance Committee

FOR: May 6, 2026 – Board of Retirement
May 13, 2026 – Board of Investments

SUBJECT: **JOGC Recommendation – Approval of Option 4 (Gateway Plaza)**

RECOMMENDATION

The Joint Organizational Governance Committee (JOGC) recommends to the Board of Retirement and the Board of Investments the following action:

> Approve Option 4 as the preferred approach for the future financial reporting and legal structuring of LACERA's headquarters building, Gateway Plaza (Property), and the title holding company, LACERA Gateway Property, Inc. (THC), in which the Property is currently held, such that the Property is reclassified from an investment asset to a capital asset, and in a subsequent year, the THC is dissolved and the asset is transferred to LACERA.

PURPOSE

This item is presented for Board action following review by the JOGC, to align the financial reporting classification of Gateway Plaza with its administrative use, while maintaining a thoughtful and controlled transition in accounting, operations, and legal structuring.

The information attached, including the staff memorandum, Crowe LLP reports, and privileged legal analysis, the result of a six-month long project to provide detailed analysis on operational, legal, and cost implications regarding the financial reporting treatment of the Gateway Plaza and the THC. Staff have summarized the reporting options evaluated by Crowe's Public Sector Consulting Group (Crowe) and are requesting the approval of Option 4.

EXECUTIVE SUMMARY

At its April 20, 2026 meeting, the JOGC reviewed alternatives for the long-term governance and reporting structure of the Gateway Plaza building. After evaluating fiduciary obligations under the California Constitution and CERL, applicable GASB guidance, administrative expense considerations, as well as audit and operational impacts, the JOGC determined that Option 4 provides the most appropriate and thoughtful path forward.

Since the purchase of the THC and LACERA's headquarters, LACERA's administrative use has increased over time. LACERA currently occupies about 50.6% of the rentable space, and renovations are underway for a new first-floor boardroom to improve accessibility and accommodate meeting attendance.

This increased administrative use is not aligned with the building's current investment classification and raises financial reporting questions under GASB guidance. It also relates to prior Board of Investment direction (2021 and 2025 Real Estate Structure Reviews) to reduce separate account real estate holdings where appropriate.

An internal working group (Executive, Investments, Financial & Accounting Services, Legal, and Administrative Services, in consultation with fiduciary and tax counsel) engaged Crowe to assess the accounting, reporting, tax, legal, audit, and operational implications of reclassifying Gateway Plaza as an administrative (capital) asset and to identify viable paths forward.

Based on Crowe's analysis in Attachment II, staff recommended Option 4 to the JOGC which:

1. Transition the THC from FASB to GASB reporting, allow the THC to reclassify Gateway Plaza from an investment to a capital asset, and treat the THC as a blended component unit effective July 1, 2026, on LACERA's financials while the THC remains in place.
2. In a subsequent year, dissolve the THC and transfer ownership to LACERA. Beginning July 1, 2026, transition THC administration of the Property from the Investment Division to the Administrative Services Division.

This item follows prior Executive Session discussions with the Board of Investments (October 8, 2025) and the Board of Retirement (November 5, 2025).

BACKGROUND

Gateway Plaza is held in LACERA's wholly owned THC, and was purchased in 1990. LACERA now occupies about 50.6% of the building, with the remainder leased to third-party tenants; for the fiscal year ended June 30, 2025, the THC generated approximately $9 million in net investment income. Because Gateway Plaza administrative use has increased, LACERA evaluated whether its classification and reporting should change; Crowe was engaged to review viable financial reporting and structural alternatives for the Boards' consideration.

Each option presents different implications related to financial reporting complexity, audit risk, administrative expense impacts under CERL's 21-basis-point limitation, legal considerations, and operational burden as detailed in the attached report.

LEGAL AUTHORITY

A privileged legal analysis is attached. The analysis concludes that a specific choice among the options presented is not legally mandated. The JOGC and the Boards may, after deliberation and consideration of all the information provided in this memo and its

attachments and the input of LACERA's staff and consultants, and weighing the advantages and risks of each option, prudently exercise their fiduciary duty to recommend and then approve an option from among those set forth in the analysis, including Option 4. The JOGC conducted such a deliberation before making its recommendation.

DISCUSSION

The analysis provided by Crowe demonstrates that LACERA is proceeding with a solution that provides the same level of compliance with GASB standards, consistency with CERL fiduciary duties, and transparency for financial reporting.

The JOGC's recommendation is based on the following considerations:

- Fiduciary Alignment: Option 4 is consistent with the Boards' exclusive benefit obligations and fiduciary oversight responsibilities.
- Accounting and Reporting Clarity: Provides a clearer long-term reporting framework aligned with applicable GASB guidance.
- Governance Simplicity: Reduces structural complexity associated with maintaining a separate legal entity.
- Administrative Cost Transparency: Allows clearer identification and monitoring of administrative and operating costs.
- Operational Practicality: Supports continued use of the building as LACERA's administrative headquarters with appropriate controls.

Based on this review, the JOGC concluded that Option 4 best balances fiduciary, financial, operational, and compliance considerations. This approach is consistent with prior Board direction regarding thoughtful reduction of separate account real estate assets where appropriate while maintaining fiscal discipline and minimizing financial reporting and legal risks.

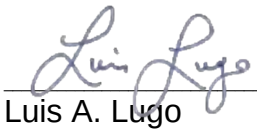
NEXT STEPS

Upon Board approval, staff will proceed with implementation and execute the necessary changes to administration of the building, accounting and reporting, and legal structure.

Attachments:

A. Staff Memo (including Attachments below) dated April 9, 2026 for the April 20, 2026 JOGC meeting
    I. Crowe, LLP's Slide Deck
    II. Crowe, LLP's Final Analysis with recommended Options
    III. Crowe, LLP's January Preliminary Analysis
    IV. CLA Letter
    V. LACERA's Legal Analysis (Privileged and Confidential – Not for Public Distribution)

REVIEWED AND APPROVED:



04/28/2026

Luis A. Lugo
Chief Executive Officer

Date

LAL:TG, JT

c: JJ Popowich Jonathan Grabel Steven P. Rice

LACERA Los Angeles County Employees Retirement Association

April 9, 2026

TO: Trustees – Joint Organizational Governance Committee

FROM: Luis A. Lugo
Chief Executive Officer

Ted Granger
Chief Financial Officer

FOR: April 20, 2026 – JOGC Meeting

SUBJECT: **Gateway Plaza – Reclassification from Investment to Capital Asset: Options and Related Financial Reporting Analysis**

RECOMMENDATION
Staff recommend that the Joint Organizational Governance Committee (JOGC):

(1) Review and recommend that the Board of Retirement and Board of Investments approve Option 4 as the preferred approach for the future financial reporting and legal structuring of the LACERA's headquarters building, Gateway Plaza (Property), and the title holding company, LACERA Gateway Property, Inc. (THC), in which the Property is currently held such that the Property is reclassified from an investment asset to a capital asset.

PURPOSE
Presented for JOGC consideration are the results of a comprehensive evaluation performed by Crowe LLP (Crowe) in coordination with the internal working group, to evaluate financial reporting and legal structure options related to the LACERA headquarters, Gateway Plaza, and the wholly-owned THC, LACERA Gateway Property, Inc., that currently owns the building. Crowe is a public accounting and consulting firm engaged to provide assistance in evaluating the accounting and financial reporting options available with respect to the characterization of the Property as a capital asset. Crowe was selected due to the firm's experience in performing the financial statement audit of another large Californian public pension system with similar reporting for capital assets, and Crowe is a member of the audit pool approved by the Audit Compliance Risk and Ethics Committee.

Crowe's report, following this memorandum, is the result of a six-month long project to provide detailed analysis on accounting, operational, legal, and cost implications regarding the financial reporting treatment of the Gateway Plaza and the THC. Staff have summarized the reporting options evaluated by Crowe and are requesting the Joint Organizational Governance Committee (JOGC) to recommend Option 4.

EXECUTIVE SUMMARY

LACERA's internal space needs have grown, due to the increase in workforce and retiree population in response to Los Angeles County's growth over the last 30 years, and the cost of customizing space for business administration purposes. This growth has led to rising tension between managing the THC, and its asset, Gateway Plaza, as investments of the pension fund versus the Property's use and operation as an administrative asset. LACERA recently executed a new lease in January 2026 that increased LACERA's occupancy to approximately 50.6% of rentable square footage consisting of office and storage space. Additionally, renovation is underway on the first floor for the new boardroom to increase accessibility and to accommodate the meeting attendees, both public and LACERA staff.

Continuing to hold individually owned real estate investment assets, including Gateway Plaza, does not align with the direction set by the 2021 and 2025 Real Estate Structure Reviews, and approved by the Board of Investments, which established a policy preference to reduce separate account real estate holdings in favor of real estate commingled fund investments, where appropriate.

To support an informed governance decision, an internal working group (composed of Executive, Investments, Financial & Accounting Services, Legal, and Administrative Services, in consultation with fiduciary and tax counsel) initiated a formal analysis and engaged Crowe to evaluate accounting, reporting, tax, legal, audit, and other implications associated with reclassifying Gateway Plaza from an investment to an administrative asset, and to identify viable paths forward for LACERA's JOGC and Boards' consideration.

By this memo, staff recommends Crowe's Option 4, which calls for the THC to be treated, under Governmental Accounting Standards Board (GASB) standards as a blended component unit of the Pension Fund for financial reporting purposes effective July 1, 2026, with the Property reported as a capital asset on LACERA's financial statements, and for the THC to be dissolved in a future year such that LACERA will become the direct owner of the Property at that time. Administration of the THC and the Property will be transferred beginning July 1, 2026 from the Investment Division to administrative staff.

This presentation follows Executive Session discussion about these matters with the Board of Investments at its October 8, 2025 meeting and the Board of Retirement at its November 5, 2025 meeting.

BACKGROUND

Gateway Plaza is held by a THC, that is wholly owned by LACERA and was purchased as an investment asset by the pension plan in 1990. As LACERA grew both in terms of assets and staff, LACERA's occupancy of the building increased from 28% to 50.6% and the property continues to function as LACERA's administrative headquarters with the remaining 49% serving as an incoming producing investment asset occupied by third-party tenants. For the fiscal year ended June 30, 2025, the THC provided net annual

investment income of approximately $9 million after deducting the cost of maintaining the building of $4 million from lease revenue of $13 million.

Given this increase in LACERA's proportionate share of the building's occupancy, the current investment classification and accounting treatment of the building has become misaligned with actual use. This misalignment raised questions regarding the appropriate financial reporting framework for the THC under recent applicable GASB guidance (GASB 72 and 90), as detailed in Crowe's attached report. In considering the change in reporting framework for the THC, other potential impacts on audit complexity, compliance with CERL's administrative expense limitation, and long-term operational flexibility were also assessed in the options presented below.

Crowe conducted a formal review, consistent with the October/November 2025 Board discussions and strategic plan of reducing the separate account real estate holdings of LACERA, to evaluate viable financial reporting and structural alternatives for Gateway Plaza.

SUMMARY OF OPTIONS

Staff and key stakeholders from the internal working group evaluated five potential options for reporting and structuring Gateway Plaza. These options range from LACERA's financial statement presentation changes based on materiality, to changes in the THC's reporting framework to be reported as a component unit of LACERA, to dissolution of the THC, and to the sale of Gateway Plaza. Each option presents trade-offs related to:

- Financial statement presentation and audit effort
- Timing and recognition of depreciation and other administrative costs
- Compliance with County Employees Retirement Law of 1937 (CERL's) 21 basis points administrative expense limitation
- Legal structure and risk exposure
- Implementation complexity and operational burden

The five potential options for reporting and structuring Gateway Plaza are summarized below by staff and detailed discussion of each option is provided in the attached analysis by Crowe. At a high level, the options are:

<u>Option 1 – Reclassify the Asset Due to Immateriality for Financial Statement Reporting</u>
Reclassify Gateway Plaza from an investment to a capital asset in LACERA's financial statements based on plan-wide materiality, while retaining the existing THC structure.

<u>Option 2 – Report the THC as a Blended Component Unit</u>
Transition the THC from Financial Accounting Standards Board (FASB) to GASB reporting and blend the THC into LACERA's financial statements, with the building reported as a capital asset.

Option 3 – Dissolve the THC and Transfer the Asset to LACERA
Fully dissolve the THC and transfer Gateway Plaza directly to LACERA, recording the asset at its carrying value and recognizing associated depreciation and administrative costs.

Option 4 – Report the THC as a Blended Component Unit, with Planned Dissolution in a Future Year
This Option includes a combination of both Options 2 and 3 above. Transition the THC to GASB reporting and treat it as a blended component unit in the near term, allowing capital asset reporting and depreciation to occur within the THC structure. In year 2, the THC would be dissolved and the asset transferred to LACERA.

Option 5 – Sell Gateway Plaza and Lease Comparable Space
Sell the property, reinvest the proceeds in accordance with LACERA's investment strategy, and lease administrative space as a tenant.

Each option presents different implications related to financial reporting complexity, audit risk, administrative expense impacts under CERL's 21 basis-points limitation, legal considerations, and operational burden as detailed in the attached report. Reclassifying Gateway Plaza from an investment asset to a capital asset will result in a non-cash write-down of approximately $30 million to the investment book of record, reflecting a reduction from the reported fair value to the accounting value of the asset. This write-down will impact investment performance by an estimated 8 basis points and has a de minimus effect on the Plan's funded status. Overall, this accounting change does not affect the Fund's cash flows, liquidity, or ability to meet benefit obligations.

LEGAL AUTHORITY

A privileged legal analysis is attached. The analysis concludes that a specific choice among the options presented is not legally mandated. The JOGC and the Boards may, after deliberation and consideration of all the information provided in this memo and its attachments and the input of LACERA's staff and consultants, and weighing the advantages and risks of each option, prudently exercise their fiduciary duty to recommend and then approve an option from among those set forth above, including Option 4.

CONCLUSION

The internal working group and LACERA's external auditor, CliftonLarsonAllen, LLP (CLA) has evaluated multiple reporting alternatives for Gateway Plaza presented by Crowe and has selected the most technically sound, legally defensible, and operationally aligned solution for LACERA. The analysis provided by Crowe demonstrates that LACERA is proceeding with a solution that provides the same level of compliance with GASB standards, consistency with CERL fiduciary duties, and transparency for financial reporting. Proceeding with this solution supports clear, compliant reporting; aligns with longstanding fiduciary obligations; and reflects how LACERA currently uses its headquarters.

Staff Recommendation and Rationale

After evaluating the accounting guidance, audit implications, administrative cost impacts, and implementation risks, staff recommend Option 4 as the most balanced and prudent approach to explore reporting changes that will align with LACERA's operations and investment objectives.

Option 4 provides a phased transition that:

- Aligns financial reporting with Gateway Plaza's growing administrative use
- Allows the necessary accounting transition to occur in a controlled manner
- Limits near term impacts on LACERA's administrative expense limitation (21 basis-points) by initially retaining changes in reporting within the THC structure; and
- Preserves flexibility to dissolve the THC and transfer the asset directly to LACERA in year 2, once the reporting transition has stabilized.

This approach is consistent with prior Board direction regarding thoughtful reduction of separate account real estate assets where appropriate while maintaining fiscal discipline and minimizing financial reporting and legal risks.

NEXT STEPS

If the recommended option is endorsed by the JOGC, staff will prepare and present Option 4 to both the Board of Retirement and the Board of Investments for their independent consideration and approval.

Attachments:

I. Crowe, LLP's Slide Deck
II. Crowe, LLP's Final Analysis with recommended Options
III. Crowe, LLP's January Preliminary Analysis
IV. CLA Letter – LACERA Gateway Plaza
V. LACERA's Legal Analysis (Privileged and Confidential – Not for Public Distribution)

REVIEWED AND APPROVED:

Luis A. Lugo — 04/12/2026

Luis A. Lugo
Chief Executive Officer

Date

LAL:TG:JT
Gateway Plaza – Reclassification from Investment to Capital Asset: Options and Related Financial Reporting Analysis.doc

c: Board of Retirement and Board of Investments, LACERA

Jonathan Grabel	Jude Perez	Steven P. Rice
JJ Popowich	Bonnie Nolley	Terri Herubin
Judy Tran	Christine Roseland	Ricki Contreras

Leisha Collins
Ashley K. Dunning, Nossaman, Fiduciary Counsel
Jenni Krengel, Buchalter, LLP, Tax Counsel

ATTACHMENT I

LACERA Gateway Plaza Reporting Options

April 20, 2026

Smart decisions. Lasting value.™



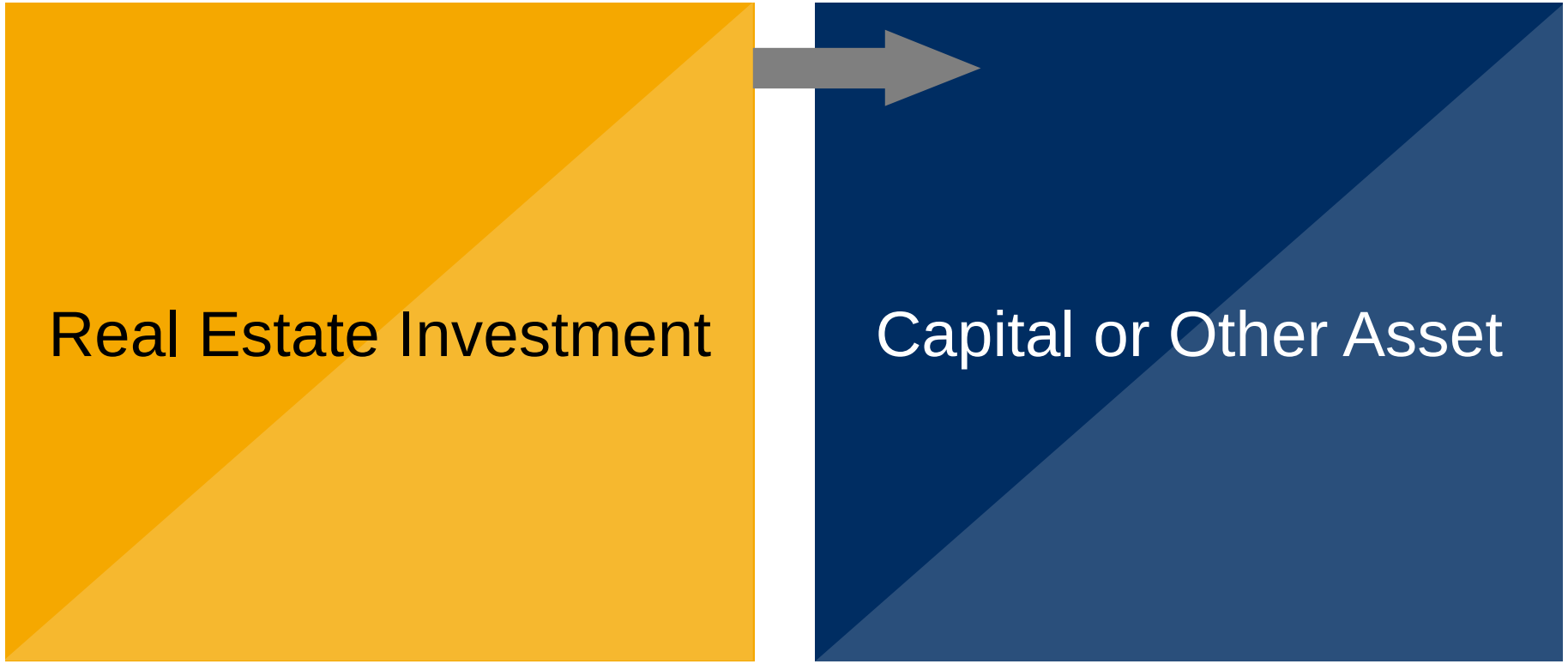
Background on Gateway Plaza

- Gateway Plaza was purchased in 1990 for approximately $66.8M.
- Valuation of the property has fluctuated over time – 2025 valuation totaled $77.9 million.
- The property has been held and operated as an investment asset, through a wholly-owned Title Holding Company consistent with LACERA's legacy real estate strategy and for liability protection.
- LACERA’s occupancy of the building has increased over time, with occupancy of 50.6% in 2026.
- The remaining 49% of the property is leased to other tenants, representing an income stream for LACERA.
- The THC is a California corporation. The THC's Board of Directors consists of a LACERA executive, elected by the sole shareholder, with officers appointed from LACERA staff. The THC holds annual meetings, makes required state filings, and respects other corporate formalities..



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Analysis – Are there reporting options?



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Methodology

- Crowe worked with LACERA to develop an understanding of how the Gateway Plaza is currently being reported by LACERA, including the structure of the Gateway Plaza THC.
- Through review of published annual financial statements, Crowe developed an understanding of how other retirement systems, including California systems, are reporting their system headquarters properties.
- Crowe reviewed current authoritative guidance (such as Government Accounting Standards Board (GASB) Pronouncements) and held conversations with GASB to determine reporting options.
- LACERA's legal team and outside fiduciary and tax counsel analyzed and provided perspective on various legal aspects of changing the THC structure.
- LACERA executives and Crowe have collaborated on reporting options with a goal of understanding impact to financial reporting, operations, and legal exposure.



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Key Takeaways

- **Other Systems**
  Most CERL systems (five out of eight) reported leasing their headquarters. Many non-CERL systems are reporting their owned headquarters as a capital asset. Few are reporting as an investment.
- **GASB 72**
  GASB 72 is clear that once reported as an investment or capital asset, the classification should not be changed.
- **Materiality**
  To be calculated by LACERA, including both qualitative and quantitative factors. Range of 2-5% of assets. 2% as of June 30, 2025 would be $1.7B. As confirmed with the LACERA auditors, the Gateway Plaza is immaterial to LACERA's financial reporting.
- **Legal Protections**
  LACERA's legal team concluded the THC provides an element of legal protection to LACERA. If the THC were to dissolve, LACERA should evaluate the need for additional insurance coverage for losses. Both THC and LACERA should have statutory immunity from property-based claims.



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Accounting – Gateway Plaza THC

- **Current Financial Reporting:**
  - The Gateway Plaza THC currently presents their financial statements aligned with Financial Accounting Standards Board (FASB) framework.
    - The Gateway Plaza property is reported as an investment at fair value in the THC financial statements.
    - The net income of the THC flows through to the LACERA financial statements as investment income.
- **Authoritative Guidance on THC Reporting Framework:**
  - The AICPA State and Local Government Audit Guide provides context for when entities should report under a Government Accounting Standards Board (GASB) framework.
  - One of the criterion outlined by the AICPA is “The potential for unilateral dissolution by a government with the net assets reverting to a government.” In this case, the net assets of the THC would revert to LACERA (a government) upon dissolution and the criterion is met.
- **Avenue for Changing the Asset for Financial Reporting:**
  - Since the THC should be reporting under a GASB framework, it provides an opportunity to reclassify the Gateway Plaza property from an investment to a capital asset through implementation of GASB 72, an option that would not otherwise be available.
  - The THC would report an error correction in their financial statements upon implementation of the change. The error correction would essentially represent the difference between the fair value of the investment property (today) and the depreciated value of the capital asset property (future).

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Accounting – LACERA

- **Current Financial Reporting:**
  - LACERA currently reports the Gateway Plaza THC as an investment in the LACERA financial statements aligned with the majority equity interest provisions of GASB 90.
    - LACERA reports the Gateway Plaza THC as a real estate investment asset.
    - The net income of the THC flows through to the LACERA financial statements as investment income.
- **Authoritative Guidance for LACERA's Reporting of the Gateway Plaza THC:**
  - GASB 90, issued in 2018 and effective for fiscal year 2020, clarified scenarios where governments have 100% ownership of separate organizations that are not being held as investments. The Gateway Plaza is being used by LACERA and would not be considered solely an investment property.
  - GASB 90 goes on to explain these ownership situations should be evaluated for blended component unit reporting. The Gateway Plaza THC meets the blended component unit criteria outlined in GASB.
    - Note: Other THCs held solely for investment purposes do not apply.
- **Impact to LACERA's Financial Statements:**
  - **THC Remains Intact:** The impact to LACERA's financial statements would be driven by the financial reporting change in the THC. If the THC changes their financial reporting to GASB and classifies the Gateway Plaza property as a capital asset, LACERA would report the same through the component unit blending exercise.
  - **THC Dissolves:** LACERA would report a transfer in of assets from the dissolved THC which would trigger an opportunity for LACERA to classify the Gateway Plaza property as a capital asset.
  - Both options present different impact on LACERA's administrative expense which will be discussed.

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Options

1

Reclassify Asset – Immaterial

- GASB need not be applied to immaterial items.
- Auditor involvement to align with materiality considerations.

2

Report THC as Blended Component Unit

- The THC would change to reporting under GASB framework.
- LACERA would blend the THC into financial reporting.
- THC and LACERA would report a capital asset.

3

Dissolve THC

- Dissolution of THC would result in asset reverting to LACERA.
- THC would report a transfer out of assets.
- LACERA would report a transfer in of assets.
- Upon dissolution, LACERA could report the asset as a capital asset under GASB 72.

4

Year 1 – THC Component Unit Year 2 – Dissolve THC

- In year 1, the THC would change to reporting under GASB framework and LACERA would blend the THC into LACERA financial reporting.
- In year 2, the THC would dissolve and transfer all assets to LACERA.
- The THC structure absorbs the financial reporting change limits impact on LACERA admin expense.

5

Sell Gateway Plaza

- The THC would market and sell the Gateway Plaza.
- Upon receipt of sale proceeds, the THC would dissolve and transfer assets to LACERA.
- LACERA would invest the sale proceeds in other investment vehicles.
- LACERA would lease office space, which may require relocation.

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Impact Overview

Area	Option 1 (Immaterial)	Option 2 (THC Component Unit)	Option 3 (Dissolve THC)	Option 4 (THC Component Unit Y1 – Dissolve THC Y2)	Option 5 (Sell the Gateway Plaza)
Financial Statements – LACERA	Low A simple reclassification in the LACERA financials would be low effort.	High LACERA would blend the THC to their financial statements resulting in multiple adjustments to the LACERA financial statements.	High LACERA would record a transfer of assets from the THC upon dissolution of the THC. LACERA would also reclassify the Gateway Plaza asset. This would require multiple adjustments to the LACERA financial statements.	High In year 1, LACERA would have multiple financial statement adjustments to blend the THC into the LACERA financial statements. Effort would continue in year 2 to record the transfer of assets upon dissolution of the THC.	Low The reallocation of cash proceeds from the sale to other investments within the portfolio has limited impact on LACERA financial reporting activities.
Financial Statements – Gateway Plaza THC	Low There would be no change to the THC financial statements.	High The THC would change their financial reporting from FASB to GASB reporting framework resulting in multiple adjustments to the THC financial statements.	Moderate The THC would record a transfer of assets to LACERA upon dissolution of the THC.	High The THC would have significant reporting changes covering two years. In year 1, to change from FASB to GASB reporting structure. In year 2, to record a transfer of assets to LACERA upon dissolution of the THC.	Low Upon sale of the property, the THC would record a transfer of assets to LACERA and dissolve the THC.

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Impact Overview

Area	Option 1 (Immaterial)	Option 2 (THC Component Unit)	Option 3 (Dissolve THC)	Option 4 (THC Component Unit Y1 – Dissolve THC Y2)	Option 5 (Sell the Gateway Plaza)
External Audit – LACERA	Moderate The audit will have ongoing materiality considerations resulting from the immaterial reclassification. If the fair value of the Gateway Plaza increases significantly over time, it could warrant a passed audit adjustment which would be noted but not impact the overall audit opinion.	Moderate The auditors will review the blending of the component unit to the LACERA financials.	High The auditors will review the transfer of assets from the THC and perform procedures over LACERA's change to capital assets reporting for the Gateway Plaza.	Moderate The auditors will review the blending of the component unit to the LACERA financials. The transfer of assets upon THC dissolution in year 2 likely would not warrant substantial audit procedures.	Low There would be little impact to LACERA's external audit. The sale of the property may be tested within the investment procedures performed by the auditors.
External Audit – Gateway Plaza THC	Low There would be no impact to the THC audit.	High The THC would need to select a new auditor and there would likely be significant audit procedures performed in the initial year of change to the THC financial statements.	Low Once the THC is dissolved, there would be no annual audit of the THC.	Moderate In year 1, the THC would need to select a new auditor and there would likely be significant procedures performed over the change in THC reporting. Upon dissolution of the THC, there would be no annual audit necessary.	Low Once the property is sold and the THC is dissolved, there would be no annual audit of the THC.

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Impact Overview

Area	Option 1 (Immaterial)	Option 2 (THC Component Unit)	Option 3 (Dissolve THC)	Option 4 (THC Component Unit Y1 – Dissolve THC Y2)	Option 5 (Sell the Gateway Plaza)
Operations	Moderate Internal operational structure for THC may require refinement to move operational aspects out of investments team to LACERA administrative operations.	High Internal operational structure for THC may require refinement to move operational aspects out of investments team to LACERA administrative operations	High Internal operational structure for THC would no longer be required by LACERA since THC will no longer exist.	High With the goal of this option being eventual dissolution of the THC, the internal operational structure for the THC would no longer be required by LACERA.	High Internal operational structure changes may be necessary as LACERA would move from building ownership to property lease activities.
CERL 21 Basis Point Compliance	Low There would be no change to the administrative costs factored into LACERA's CERL 21 basis points compliance calculation.	Low There would be no change to the administrative costs factored into LACERA's CERL 21 basis points compliance calculation.	High Dissolution of the THC would result in LACERA taking over the annual THC expenses which would be factored into LACERA's administrative expense budget (CERL 21 basis points). Additionally, LACERA may need to absorb a large error correction ($30M+) in a single year.	Low This option limits impact on CERL 21 basis points compliance as the financial reporting change (moving the Gateway Plaza from an Investment to a Capital Asset) occurs within the THC structure.	Low There would be minimal impact to administrative costs factored into CERL 21 basis points compliance. The lease payment LACERA makes to the THC today would approximate the lease payment LACERA would continue to make in order to lease property.

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Impact Overview

Area	Option 1 (Immaterial)	Option 2 (THC Component Unit)	Option 3 (Dissolve THC)	Option 4 (THC Component Unit Y1 – Dissolve THC Y2)	Option 5 (Sell the Gateway Plaza)
Legal Risk	Low There would be no change to the legal structure of the THC.	Low There would be no change to the legal structure of the THC.	Moderate The THC legal structure would dissolve. LACERA would need to mitigate any legal exposure perhaps through insurance coverage.	Moderate The THC legal structure would ultimately dissolve. LACERA would need to mitigate any legal exposure perhaps through insurance coverage.	Low LACERA would no longer be owner of the Gateway Plaza property.
Implementation Complexity	Moderate There would be required ongoing monitoring for audit materiality concerns and additional reporting/audit requirements with higher asset valuation.	High Going through the first-year audit for the THC would require additional efforts. Effort required to adjust LACERA's reporting of a component unit is minimal, with updates being made to various LACERA financial statement accounts to blend the THC reporting to LACERA's reporting.	High Dissolution of the THC would require operational changes including short-term impact of managing the dissolution. Long-term, LACERA will absorb the administrative components of managing the building.	High Dissolution of the THC would require operational changes including short-term impact of managing the dissolution. Long-term, LACERA will absorb the administrative components of managing the building.	High Selling the Gateway Plaza would have short-term impact of managing the sale of the building. Additionally, if LACERA were to lease space in a different building, there would be effort associated with relocation. Long-term, managing a lease is less complex.

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Overview of Financial Impact

- **Option 1: Reclassify Asset – Immaterial**
  - LACERA Assets: Decrease due to change from investment to depreciated asset
  - LACERA Administrative Expense: No change
- **Option 2: Report the THC as a Component Unit**
  - LACERA Assets: Decrease due to change from investment to depreciated asset
  - LACERA Administrative Expense: No change due to error correction occurring within the THC.
- **Option 3: Dissolve the THC**
  - LACERA Assets: Decrease due to change from investment to depreciated asset
  - LACERA Administrative Expense: Will be impacted by error correction and absorption of THC expenses
- **Option 4: Y1 – THC Component Unit / Y2 – Dissolve THC**
  - LACERA Assets: Decrease due to change from investment to depreciated asset
  - LACERA Administrative Expense: No change for year 1 due to error correction occurring within the THC. In year 2, variability in administrative expenses for LACERA's operation of building.
- **Option 5: Y1 – Sell Gateway Plaza**
  - LACERA Assets: No change (or relatively consistent depending on sale price)
  - LACERA Administrative Expense: No change (or relatively consistent if space can be leased for a similar cost to what LACERA is paying the THC today.



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Management Recommendation

Option 4:

- Year 1: Report Gateway Plaza Inc. as a component unit of LACERA.
- Year 2: Dissolve Gateway Plaza Inc. and transfer assets to LACERA.

- **Benefits:**
  - Aligns with investment strategy – Gateway Plaza will be reported as a capital asset instead of real estate investment.
  - Consistency of administrative expenses – Reduces impact to LACERA administrative expenses due to the change in year 1 being reported through the THC structure.

- **Challenges:**
  - Liability protections – Dissolving the legal form of the THC exposes trust assets to residual risk above statutory immunity and insurance coverage.
  - New THC auditor – LACERA will need to select a new auditor to audit the THC under GASB framework.
  - Accounting complexity – Will impact the financial reporting team over a two-year period.

- **Implementation Timeline:**
  - If approved, year 1 implementation effective July 1, 2026. Would require additional planning efforts to commence by May 2026.

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Questions

Thank you.



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Background

Background on Gateway Plaza

Gateway Plaza, located in Pasadena, California, serves as the headquarters for the Los Angeles County Employees Retirement Association (LACERA). The property was purchased in April 1990 for approximately $66.88 million, including related fees, improvement reserve, and closing costs, through LACERA Gateway Property, Inc., a title-holding company (THC) established to manage the asset as an investment under LACERA's real estate investment program. The building comprises about 274,000 square feet of rentable office space across 13 floors, along with 14,000 square feet of storage and an attached 10-level parking structure. Originally managed by Heitman Financial, LACERA assumed direct management in 1998, gradually expanding its occupancy from 28% in 1991 to 50.6% in early 2026.

Historical and Structural Context

Gateway Plaza's THC structure was designed to mitigate liability and streamline operations by isolating real estate risks at the entity level. LACERA created many similar legal structures primarily for the purpose of holding wholly-owned real estate assets as part of LACERA's investment portfolio. The THC is a corporation wholly-owned by LACERA and organized under Internal Revenue Code Section 501(c)(25) to hold and operate real property on behalf of governmental retirement systems. It is a legally separate and tax-exempt entity and mainly functions as a special purpose investment vehicle within LACERA's real estate investment program. In accordance with GASB Statement No. 90, *Majority Equity Interests — an amendment of GASB 14 and GASB 61* (GASB 90), paragraph 6, and GASB Statement No. 72, *Fair Value Measurement and Application* (GASB 72), paragraph 64, LACERA currently reports its 100-percent ownership interest in the corporation at fair value within the fiduciary fund (LACERA's financial statements), rather than as a blended or discretely presented component unit. The reported amount represents the fair value of the THC, which, because the entity's only significant asset is Gateway Plaza, effectively equals the property's appraised value net of the company's working-capital accounts. The THC holds a minimal amount of other assets. Gateway Plaza is its sole property and operating activity. As is discussed below, GASB 90, which was issued in 2018, required governmental entities to evaluate situations in which they hold a majority equity interest in other legal structures to determine proper reporting. At the time of implementing GASB 90, LACERA Management determined the impact to be immaterial to LACERA.

The THC is solely directed by LACERA's Chief Investment Officer, with other officers drawn from LACERA executive and legal teams. Over the years, the property has undergone capital improvements (about $40 million in total), including lobby renovations, HVAC replacements, elevator upgrades, and substantial tenant improvements to suit LACERA's administrative needs. Despite these investments, the building's valuation has declined from a peak of $126 million in 2022 to $77.9 million in 2025. This was exacerbated by the COVID-19 pandemic and resulting prevalence of hybrid working models.

Current Efforts and Next Steps

To explore reporting changes that will align with LACERA's operations and investment objectives, LACERA formed an internal working group with representatives from its Executive, Investments, Legal, Accounting, and Administrative Services divisions to evaluate reclassifying Gateway Plaza from an investment to an administrative or capital asset. Crowe LLP was selected to lead the accounting and financial analysis, including a review of Governmental Accounting Standards Board (GASB) guidance, audit and tax implications, and procedural steps for reclassification.

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Accounting Analysis

Rationale for the Potential Accounting Change

As LACERA's internal occupancy and customization of the building grew, the distinction between Gateway Plaza as an investment property and as an operational headquarters became increasingly blurred. The dual purpose of the asset—serving both as a tenant investment and as a workspace—created accounting and fiduciary challenges. Moreover, LACERA's 2021 and 2025 Real Estate Structure Reviews established a policy preference for divesting from individually held real estate title holding companies in favor of commingled funds. Continuing to treat Gateway Plaza as an investment is inconsistent with this policy and with the asset's administrative usage profile.

Guidance on Future Reporting by the THC

As described above, the THC is a corporation wholly-owned by LACERA and organized under Internal Revenue Code Section 501(c)(25) to hold and operate real property on behalf of governmental retirement systems. The THC has historically reported its financial statements in accordance with the financial reporting framework required by the Financial Accounting Standards Board (FASB).

The AICPA State and Local Government Audit Guide, Chapter 1, Section 1.01, states that governmental organizations are subject to generally accepted accounting principles (GAAP) for state and local governments if one of more of the following characteristics exist:

1. Popular election of officers or appointment (or approval) of a controlling majority of the members of the organization's governing body by officials of one or more state or local governments;
2. The potential for unilateral dissolution by a government with the net assets reverting to a government; or
3. The power to enact and enforce a tax levy.

Based upon the structure of the THC, criterion number 2 above applies, as dissolution of the THC would result in any net assets reverting to LACERA. Meeting this criterion would require the THC to report financial statements in accordance with the GASB financial reporting framework. A change in the reporting framework of the THC would likely result in restatement of the THC financial statements through an error correction.

If a change to the financial reporting framework of the THC is enacted, the THC would be required to adopt GASB 72, *Fair Value Measurement and Application*, thus enacting a requirement to determine whether the Gateway Plaza asset should be reported as a capital asset or as an investment.

Guidance on Future Reporting by LACERA

GASB 90, paragraphs 5 and 6, provides that if the majority equity interest is held solely for investment purposes, it should be measured at fair value and reported as an investment under GASB 72.

LACERA owns 100 percent of LACERA Gateway Property, Inc., which exists to hold and operate Gateway Plaza within LACERA's real-estate investment portfolio. As noted in the previous section, a portion of the Gateway Plaza is being occupied by LACERA and should be treated as a capital asset under a GASB reporting model, as it would not be held solely for investment purposes. Use of the balance of the building is driven in large part by LACERA's administrative interests, such as the recently approved conversion of remaining space on the ground floor into a board room. Under GASB 72, LACERA classified the THC as an investment, a decision made by the Board of Investments in 1990, which locked in the classification at acquisition and later changes in use will not change the original classification. The proposed change in guidance and classification came about as a result of a review of the THC under GASB 90 that, if implemented, will allow for the THC to change its reporting framework from FASB to GASB. Thus, creating an opportunity to reclassify the asset under GASB 72 as a capital asset.

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Because the ownership interest is 100 percent, rather than a majority, the provisions of GASB 90, paragraph 9, should be considered for reporting the THC in the LACERA financial statements. Paragraph 9 states that governments acquiring a 100% equity interest in a legally separate entity such as the THC should report the entity as a component unit on LACERA's financial statements.

It is important to recognize LACERA currently maintains several additional THC's to hold real estate investment properties. As these THC's are holding properties that are only for investment purposes (i.e. LACERA does not occupy/use any of the real estate), reporting of these properties as investments will not change.

Guidance on Potential Capital Asset Valuation

Based upon the guidance described above, if the THC were to report a capital asset under GASB framework, the THC would need to determine a carrying value for the capital asset. Reflecting on historical activity impacting the cost of the asset as well as the useful life of the asset will be necessary in order to determine the carrying value.

Guidance on Dissolution of THC and Transfer of Asset to LACERA

Should LACERA ultimately decide to dissolve the THC, a transfer of the capital asset from THC into the LACERA financial statements would be required. LACERA would apply the provisions of GASB 48, *Sales and Pledges of Receivables and Future Revenues and Intra-Entity Transfers of Assets and Future Revenues*, which provides authoritative guidance for transfers of assets within the same financial-reporting entity.

Paragraph 15 specifies that when a capital asset is transferred between related funds, departments, or component units of a single reporting entity, the transfer is reported by the transferring entity as a transfer (rather than a sale) and by the receiving entity at the carrying amount of the asset as reported by the transferring entity at the time of the transfer.

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Reporting Options

As described in the attached January Preliminary Analysis prepared by Crowe, four options for reporting the Gateway Plaza were initially identified. LACERA Management reviewed the options and collaborated through a series of discussions with relevant parties including their external auditor, CliftonLarsonAllen, LLP. LACERA Management ultimately determined five viable options for reporting, as described below.

Option 1 – Reclassify the Asset due to Immateriality for Financial Statement Reporting

Although GASB 72, paragraph 68, indicates that asset classification is determined at acquisition and ordinarily retained, GASB's conceptual framework recognizes that materiality governs the application of all financial-reporting requirements. Because Gateway Plaza's fair value of approximately $77.9 million represents less than 0.1 percent of LACERA's total plan assets of $85 billion, any difference between investment accounting at fair value and capital-asset accounting at cost less depreciation would likely be considered immaterial to LACERA's consolidated financial statements.

Under this approach, LACERA would reclassify its equity interest in the THC from "Investments – Real Estate" to "Capital Assets – Buildings and Improvements." The fair value of the property on the reclassification date would establish the new cost basis for capitalization and depreciation would begin prospectively over the building's remaining useful life. The THC could continue to hold legal title and maintain its own books, but LACERA would treat the building as an administrative capital asset for administrative operations because its primary function is to support LACERA's internal operations rather than to generate investment income. This option would result in no change to the THC's current financial reporting.

This change would likely be immaterial in the context of total plan assets and therefore would not require restatement of prior financial statements. LACERA should prepare a materiality assessment, both quantitative and qualitative, and obtain auditor concurrence that the reclassification does not materially affect the plan's financial position or results of operations. The change would be accounted for prospectively, with no note disclosure required since the change would be considered immaterial.

Because this approach relies on materiality, implementation would focus on documenting Management's judgment and auditor concurrence, updating financial-statement presentation, and disclosing the rationale for reclassification. No legal transaction or new fund structure would be required, but LACERA would begin recognizing depreciation of the capital asset.

Option 2 – Report THC as a Blended Component Unit

Based upon the analysis above, the THC meets the criteria outlined in the AICPA State and Local Government Audit Guide for reporting their financial statements in accordance with the GASB financial reporting framework. The THC could revise their financial reporting in line with GASB requirements and thus, would apply the provisions of GASB 72 and report the Gateway Plaza asset as a capital asset, either wholly or bifurcated, in the THC financial statements. This change in reporting would likely flow through an error correction reported in the THC financial statements. This error correction would represent the difference between the current fair value of the investment vs. the depreciated value of the capital asset upon the change in reporting.

Subsequent to the THC revising their financial reporting, LACERA could consider reporting the THC as a blended component unit in the LACERA financial statements. In doing so, LACERA would blend the THC financial reporting into LACERA's financial statements, with appropriate accounting eliminations. If determined to be immaterial, this would not require an error correction to the LACERA financial statements and would be reported prospectively.

Option 3 – Dissolve the THC and Transfer Asset to LACERA

Dissolution of the THC would likely result in THC assets being transferred to LACERA. Should LACERA seek formal dissolution of the THC, the THC would report a transfer out of the Gateway Plaza building and

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other assets (for example, cash). LACERA would apply the provisions of GASB 48 to report a transfer in of assets from the THC at the carrying value of the assets as reported by the THC. In doing so, LACERA would implement the provisions of GASB 72 in identifying how the Gateway Plaza building would be reported on the LACERA financial statements. LACERA could report the Gateway Plaza as a capital asset, either wholly or bifurcated, in the LACERA financial statements. If the Gateway Plaza were to be reported as a capital asset, the difference between the current fair value of the investment vs. the depreciated value of the capital asset would be considered an error correction but likely determined to be immaterial to the LACERA financial statements.

Option 4 – Report the THC as a Blended Component Unit / Dissolve the THC and Transfer Asset to LACERA in Future Year

In consideration of options 2 and 3, this option represents a combination of the two. An advantage to initially maintaining the separate legal structure of the THC includes the budgeting and incurrence of expenses in the THC legal structure and still treating the THC as a blended component unit and reflecting the building as a capital asset in LACERA's financial statements. In keeping this process within the THC structure, it limits the impact on the LACERA administrative expenses threshold. In changing the financial reporting of the Gateway Plaza building from an investment asset to a capital asset, the difference between the current fair value of the investment vs. the depreciated value of the capital asset will be an adjustment in the year of change. Keeping this adjustment within the THC structure may be preferable to limit impact on LACERA administrative expenses, while maintaining transparency of reporting. In a future year, LACERA could dissolve the THC and transfer the asset to LACERA, with limited impact to LACERA administrative expenses.

Option 5 – Sell the Gateway Plaza and Lease Similar Space

As was noted in the Crowe analysis, many other retirement systems lease administrative as an alternative to ownership. LACERA may consider selling the Gateway Plaza building and investing the proceeds in an investment vehicle aligned with the LACERA investment strategy. LACERA could enter into a lease agreement for similar space, perhaps even within the same space, and would incur administrative lease expense at a rate similar to what LACERA is paying to lease space from the THC today.

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Legal Analysis

Analysis provided by the LACERA legal division, the analysis concludes there is no legally mandated outcome between maintaining the existing THC ownership structure or dissolving it in favor of direct ownership by LACERA; rather, the decision is fundamentally a business judgment. Fiduciary duty requires that LACERA's Boards and Management be fully informed, deliberate the options and risks, and act prudently in the best interests of members and beneficiaries.

Operational and administrative implications represent a key differentiator between the options. Dissolving the THC introduces complexities related to property tax notifications and communication with tenants, while also eliminating ongoing corporate maintenance costs. Retaining the THC avoids disruption to existing leases and preserves continuity but maintains ongoing compliance obligations. If the building is treated as a capital asset, wholly or in part, LACERA's legal division has identified issues related to the transfer of responsibility that administrative staff must be prepared to address and manage on an ongoing basis.

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Financial Statement Audit Impact

Financial Statement Audit Materiality

Audit materiality is a consideration of the maximum financial statement misstatement that would not reasonably influence financial statement users' decisions. Materiality is set using a benchmark (e.g., total assets, revenue, or net position) and adjusted for qualitative factors such as volatility, risks, and public interest.

If LACERA were to pursue any change in the financial-reporting treatment of Gateway Plaza through a presentation change based on materiality, auditors would focus on whether the accounting and disclosures comply with GASB 72 and GASB 34. Their review would include evaluation of the underlying transaction, evidence supporting fair-value measurement, and the completeness of journal entries and note disclosures. If the change were immaterial at the plan-wide level, the audit focus would be on Management's documentation of its materiality analysis.

Discussions with Financial Statement Auditors

LACERA Management has held meetings with the current auditors of both the Gateway Plaza THC and LACERA.

KPM & Associates (KPM) audited the Gateway Plaza THC financial statements for the fiscal year ended June 30, 2025. LACERA Management discussed the potential change in financial reporting framework from FASB to GASB reporting with KPM. The representative from KPM explained that they do not currently perform GASB financial statement audits and would not be equipped to perform the audit of Gateway Plaza THC if the financial statements move to a GASB reporting framework. The Gateway Plaza THC would need to select a new audit firm to perform the financial statement audit.

For the fiscal year ended June 30, 2026, Clifton Larson Allen (CLA) will audit the financial statements of LACERA. LACERA Management discussed the impact of change on the LACERA financial statements with CLA. As is noted in the attached communication from CLA, the auditors are aligned with the options but noted LACERA Management should consider the ongoing materiality impact of moving forward with option 1.

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Expense Impact to LACERA

The table below evaluates the five options and their related impact to the 21 basis-points administrative expense limitation as well as the overall impact to LACERA's net income.

	Today	Option 1 (Immaterial)		Option 2 (THC Component Unit)		Option 3 (Dissolve THC)		Option 4 (THC Component Unit)	(Dissolve THC)	Option 5 (Building Sale)	
		Year 1	Year 2	Year 1	Year 2	Year 1	Year 2	Year 1	Year 2	Year 1	Year 2
Administrative Expenses (21 BPS Limitation)											
Annual lease payment from LACERA to THC (estimated)	(6,400,000)	(6,400,000)	(6,400,000)	(6,400,000)	(6,400,000)	-		(6,400,000)		(6,400,000)	(6,400,000)
Future capital improvements to Gateway Plaza for LACERA space (estimated)	(1,500,000)	(1,500,000)	(1,500,000)	(1,500,000)	(1,500,000)	(1,500,000)	(1,500,000)	(1,500,000)	(1,500,000)	(1,500,000)	(1,500,000)
Annual expenses incurred by THC (real estate taxes, property management fees, adminsitrative and other operating expenses) (estimated)						(4,200,000)	(4,200,000)		(4,200,000)		
Additional expenses related to THC dissolution						TBD	TBD		TBD		
Annual depreciation of the Gateway Plaza building (estimated)						(1,000,000)	(1,000,000)		(1,000,000)		
THC financial reporting error correction (estimated)						(30,000,000)					
Total Administrative Expenses	**(7,900,000)**	**(7,900,000)**	**(7,900,000)**	**(7,900,000)**	**(7,900,000)**	**(36,700,000)**	**(6,700,000)**	**(7,900,000)**	**(6,700,000)**	**(7,900,000)**	**(7,900,000)**
Expenses for financial reporting only											
THC net income (estimated)	9,000,000	9,000,000	9,000,000								
THC lease income (other building tenants) (estimated)				6,800,000	6,800,000	6,800,000	6,800,000	6,800,000	6,800,000		
Elimination of lease payment from LACERA to THC for CU blending				6,400,000	6,400,000			6,400,000	-		
Annual expenses incurred by THC (real estate taxes, property management fees, adminsitrative and other operating expenses) (estimated)				(4,200,000)	(4,200,000)			(4,200,000)			
Annual depreciation of the Gateway Plaza building (estimated)		(1,000,000)	(1,000,000)	(1,000,000)	(1,000,000)			(1,000,000)			
THC financial reporting error correction (estimated)		(30,000,000)		(30,000,000)				(30,000,000)			
Total Non-Administrative Financial Reporting Net Revenue/Expense	**9,000,000**	**(22,000,000)**	**8,000,000**	**(22,000,000)**	**8,000,000**	**6,800,000**	**6,800,000**	**(22,000,000)**	**6,800,000**	**-**	**-**
Total LACERA Income Statement Impact	**1,100,000**	**(29,900,000)**	**100,000**	**(29,900,000)**	**100,000**	**(29,900,000)**	**100,000**	**(29,900,000)**	**100,000**	**(7,900,000)**	**(7,900,000)**

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Level of Effort and Risk Analysis

This heat map summarizes the level of effort required from the LACERA and THC teams as related to the five options.

Area	Option 1 (Immaterial)	Option 2 (THC Component Unit)	Option 3 (Dissolve THC)	Option 4 (THC Component Unit Y1 – Dissolve THC Y2)	Option 5 (Sell the Gateway Plaza)
Financial Statements – LACERA	Low *A simple reclassification in the LACERA financials would be low effort.*	High *LACERA would blend the THC to their financial statements resulting in multiple adjustments to the LACERA financial statements.*	High *LACERA would record a transfer of assets from the THC upon dissolution of the THC. LACERA would also reclassify the Gateway Plaza asset. This would require multiple adjustments to the LACERA financial statements.*	High *In year 1, LACERA would have multiple financial statement adjustments to blend the THC into the LACERA financial statements. Effort would continue in year 2 to record the transfer of assets upon dissolution of the THC.*	Low *The reallocation of cash proceeds from the sale to other investments within the portfolio has limited impact on LACERA financial reporting activities.*
Financial Statements – Gateway Plaza THC	Low *There would be no change to the THC financial statements.*	High *The THC would change their financial reporting from FASB to GASB reporting framework resulting in multiple adjustments to the THC financial statements.*	Moderate *The THC would record a transfer of assets to LACERA upon dissolution of the THC.*	High *The THC would have significant reporting changes covering two years. In year 1, to change from FASB to GASB reporting. In year 2, to record a transfer of assets to LACERA upon dissolution of the THC.*	Low *Upon sale of the property, the THC would record a transfer of assets to LACERA and dissolve the THC.*
External Audit – LACERA	Moderate *The audit will have ongoing materiality considerations resulting from the immaterial reclassification. If the fair value of the Gateway Plaza increases significantly over time, it could warrant a passed audit adjustment which would be noted but not impact the overall audit opinion.*	Moderate *The auditors will review the blending of the component unit to the LACERA financials.*	High *The auditors will review the transfer of assets from the THC and perform procedures over LACERA's change to capital assets reporting for the Gateway Plaza.*	Moderate *The auditors will review the blending of the component unit to the LACERA financials. The transfer of assets upon THC dissolution in year 2 likely would not warrant substantial audit procedures.*	Low *There would be little impact to LACERA's external audit. The sale of the property may be tested within the investment procedures performed by the auditors.*
External Audit – Gateway Plaza THC	Low	High	Low	Moderate	Low

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Area	Option 1 (Immaterial)	Option 2 (THC Component Unit)	Option 3 (Dissolve THC)	Option 4 (THC Component Unit Y1 – Dissolve THC Y2)	Option 5 (Sell the Gateway Plaza)
	There would be no impact to the THC audit.	*The THC would need to select a new auditor and there would likely be significant audit procedures performed in the initial year of change to the THC financial statements.*	*Once the THC is dissolved, there would be no annual audit of the THC.*	*In year 1, the THC would need to select a new auditor and there would likely be significant procedures performed over the change in THC reporting. Upon dissolution of the THC, there would be no annual audit necessary.*	*Once the property is sold and the THC is dissolved, there would be no annual audit of the THC.*
Operations	🟡 Moderate *Internal operational structure for THC may require refinement to move operational aspects out of investments team to LACERA administrative operations.*	🔴 High *Internal operational structure for THC may require refinement to move operational aspects out of investments team to LACERA administrative operations.*	🔴 High *Internal operational structure for THC would no longer be required by LACERA since THC will no longer exist.*	🔴 High *With the goal of this option being eventual dissolution of the THC, the internal operational structure for the THC would no longer be required by LACERA.*	🔴 High *Internal operational structure changes may be necessary as LACERA would move from building ownership to property lease activities.*
CERL 21 Basis-Points Compliance	🟢 Low *There would be no change to the administrative costs factored into LACERA's CERL 21 basis-points compliance calculation.*	🟢 Low *There would be no change to the administrative costs factored into LACERA's CERL 21 basis-points compliance calculation.*	🔴 High *Dissolution of the THC would result in LACERA taking over the annual THC expenses which would be factored into LACERA's administrative expense budget (CERL 21 basis-points). Additionally, LACERA may need to absorb a large error correction ($30M+) in a single year.*	🟢 Low *This option limits impact on CERL 21 basis-points compliance as the financial reporting change (moving the Gateway Plaza from an Investment to a Capital Asset) occurs within the THC structure, including the error correction.*	🟢 Low *There would be minimal impact to administrative costs factored into CERL 21 basis-points compliance. The lease payment LACERA makes to the THC today would approximate the lease payment LACERA would continue to make in order to lease property.*
Legal Risk	🟢 Low *There would be no change to the legal structure of the THC.*	🟢 Low *There would be no change to the legal structure of the THC.*	🟡 Moderate *The THC legal structure would dissolve. LACERA would need to mitigate any legal exposure perhaps through insurance coverage.*	🟡 Moderate *The THC legal structure would ultimately dissolve. LACERA would need to mitigate any legal exposure perhaps through insurance coverage.*	🟢 Low *LACERA would no longer be owner of the Gateway Plaza property.*

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Area	Option 1 (Immaterial)	Option 2 (THC Component Unit)	Option 3 (Dissolve THC)	Option 4 (THC Component Unit Y1 – Dissolve THC Y2)	Option 5 (Sell the Gateway Plaza)
Implementation Complexity	🟡 Moderate *There would be required ongoing monitoring for audit materiality concerns and additional reporting/audit requirements with higher asset valuation.*	🔴 High *Going through the first-year audit for the THC would require additional efforts. Additional effort required to adjust LACERA's reporting of a component unit is minimal.*	🔴 High *Dissolution of the THC would require operational changes including short-term impact of managing the dissolution. Long-term, LACERA will absorb the administrative components of managing the building.*	🔴 High *Dissolution of the THC would require operational changes including short-term impact of managing the dissolution. Long-term, LACERA will absorb the administrative components of managing the building.*	🔴 High *Selling the Gateway Plaza would have short-term impact of managing the sale of the building. Additionally, if LACERA were to lease space in a different building, there would be effort associated with relocation. Long-term, managing a lease is less complex.*

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Conclusion

Based upon the analysis described above, LACERA Management determined **Option 4 – Report the THC as a Blended Component Unit with Dissolution in a Future Year** to be the most balanced and strategically prudent approach. This option aligns with proper stewardship, improves transparency, and allows the Board and Management to thoughtfully manage legal, financial, and operational risks over time rather than through an immediate structural change through dissolution of the THC. Option 4 preserves the existing THC structure in the near term, maintaining limited liability protections and operational continuity. This will position LACERA for an eventual THC dissolution that is deliberate and well controlled. With option 4, LACERA will ultimately budget for and control the administrative costs of operating the Gateway Plaza, which is a consideration for the 21 basis-points limitation imposed by CERL.

From a financial and administrative perspective, Option 4 provides a phased approach that mitigates key risks identified across the analysis. By initially retaining the THC, LACERA can absorb significant accounting changes within the THC structure, thereby minimizing immediate pressure on LACERA's administrative expense cap. The subsequent dissolution in a future year allows for a more manageable transfer of assets and operational responsibilities once financial reporting impacts have stabilized. This approach balances compliance with accounting standards, reduces implementation risk, and supports long-term alignment with LACERA's investment strategy.

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Introductory Background

Background on Gateway Plaza

Gateway Plaza, located in Pasadena, California, serves as the headquarters for the Los Angeles County Employees Retirement Association (LACERA). The property was purchased in April 1990 for approximately $68 million through LACERA Gateway Property, Inc., a title-holding company (THC), established to manage the asset as an investment under LACERA's real estate investment program. The building comprises about 274,000 square feet of rentable office space across 13 floors, along with 14,000 square feet of storage and an attached 10-level parking structure. Originally managed by Heitman Financial, LACERA assumed direct management in 1998, gradually expanding its occupancy from 28% in 1991 to an anticipated 52% by early 2026.

Historical and Structural Context

Gateway Plaza's THC structure was designed to mitigate liability and streamline operations by isolating real estate risks at the entity level. LACERA created many similar legal structures primarily for the purpose of holding wholly-owned real estate assets as part of LACERA's investment portfolio. The THC is a corporation wholly owned by LACERA and organized under Internal Revenue Code Section 501(c)(25) to hold and operate real property on behalf of governmental retirement systems. It is a legally separate and tax-exempt entity, and mainly functions as a special purpose investment vehicle within LACERA's real-estate investment program. In accordance with GASB Statement No. 90, *Majority Equity Interests — an amendment of GASB 14 and GASB 61*, paragraph 6, and GASB Statement No. 72, *Fair Value Measurement and Application*, paragraph 64, LACERA currently reports its 100-percent ownership interest in the corporation at fair value within the fiduciary fund, rather than as a blended or discretely presented component unit. The reported amount represents the fair value of the THC, which, because the entity's only significant asset is Gateway Plaza, effectively equals the property's appraised value net of the company's working-capital accounts. The THC holds a minimal amount of other assets. Gateway Plaza is its sole property and operating activity.

The THC is solely directed by LACERA's Chief Investment Officer, with other officers drawn from LACERA executive and legal teams. Over the years, the property has undergone capital improvements (about $40 million in total) including lobby renovations, HVAC replacements, elevator upgrades, and substantial tenant improvements to suit LACERA's administrative needs. Despite these investments, the building's valuation has declined from a peak of $126 million in 2022 to $77.9 million in 2025.

Rationale for the Potential Accounting Change

As LACERA's internal occupancy and customization of the building increased, the distinction between Gateway Plaza as an investment property and as an operational headquarters became increasingly blurred. The dual purpose of the asset—serving both as a tenant investment and as a workspace—created accounting and fiduciary challenges. Moreover, LACERA's 2021 and 2025 Real Estate Structure Reviews established a policy preference for divesting from individually held real estate title holding companies in favor of commingled funds. Continuing to treat Gateway Plaza as an investment is inconsistent with this policy and with the asset's administrative usage profile.

Current Efforts and Next Steps

To address these issues, LACERA formed an internal working group with representatives from its Executive, Investments, Legal, Accounting, and Administrative Services divisions to evaluate reclassifying Gateway Plaza from an investment to an administrative or capital asset. Crowe LLP was selected to lead the accounting and financial analysis, including a review of Governmental Accounting Standards Board (GASB) guidance, audit and tax implications, and procedural steps for reclassification.

Accounting Background

Current Accounting Treatment

LACERA prepares its financial statements on a fiduciary-fund basis, consistent with GASB Statement No. 84*, Fiduciary Activities*. As a public employee retirement system established under the County Employees Retirement Law of 1937 (CERL), LACERA's activities are reported within a pension (and other post-retirement employee benefit) trust fund, which is a type of fiduciary fund. The fiduciary-fund financial statements present only the plan's

assets, liabilities, and changes in fiduciary net position and are separate from the County of Los Angeles' government-wide and governmental-fund financial reporting.

Gateway Plaza is currently reported as an investment within the Gateway Plaza THC financial statements which are separate from LACERA. LACERA's financial statements report an investment in the Gateway Plaza THC as a real estate investment within the LACERA financial statements, consistent with GASB Statement No. 72, *Fair Value Measurement and Application,* and GASB 90 The property is measured at fair value, with changes in value recognized through investment income. As the asset is held in a THC structure within LACERA's real estate program, no depreciation is recorded under the fair value model.

Asset Investment Value (FY 2025 Financial Reporting)

The Gateway Plaza THC June 30, 2025 financial statements reported net assets of $74,942,902, including a net unrealized loss on real-estate investments of $46,664,307. In LACERA's fiduciary-fund financial statements, LACERA reports its 100% ownership interest in this entity as a real-estate investment measured at fair value. This has historically believed by LACERA to be consistent with GASB 72 and GASB 90, which require majority-owned entities held solely for investment purposes to be reported as investments rather than blended component units.

Lease Asset and Liability

LACERA has evaluated the applicability of GASB Statement No. 87, *Leases*, to its occupancy of Gateway Plaza and concluded that recognition of a lease asset and liability is not required. The arrangement, in which LACERA leases space from a title-holding company it controls, meets the definition of a lease under GASB 87. However, management performs an annual analysis of all organizational leases to assess materiality and disclosure requirements. Based on that review, the lease activity is immaterial to LACERA's financial statements.

Accordingly, no leases or related disclosures are presented in LACERA's financial statements.

Guidance on Future Reporting by THC

As described above, the THC is a corporation wholly owned by LACERA and organized under Internal Revenue Code Section 501(c)(25) to hold and operate real property on

behalf of governmental retirement systems. The THC has historically reported its financial statements in accordance with the financial reporting framework required by the Financial Accounting Standards Board (FASB).

The AICPA State and Local Government Audit Guide, chapter 1, section 1.01, states governmental organizations are subject to generally accepted accounting principles (GAAP) for state and local governments if one of more of the following characteristics exist:

1. Popular election of officers or appointment (or approval) or a controlling majority of the members of the organization's governing body by officials of one or more state or local governments;
2. The potential for unilateral dissolution by a government with the net assets reverting to a government; or
3. The power to enact and enforce a tax levy.

Based upon the structure of the THC, dissolution of the THC would result in any net assets reverting to LACERA. Meeting this criterion would require the THC to report financial statements in accordance with the GASB financial reporting framework. A change in the reporting framework of the THC would likely result in restatement of the THC financial statements through an error correction.

If a change to the financial reporting framework of the THC is enacted, the THC would be required to adopt GASB 72, *Fair Value Measurement and Application*, thus enacting a requirement to determine whether the Gateway Plaza asset should be reported as a capital asset or as an investment.

GASB 72, paragraph 64, defines an investment as "a security or other asset that the government holds primarily for the purpose of income or profit and has a present service capacity based solely on its ability to generate cash or to be sold to generate cash." Based upon this definition, the THC would likely conclude that the Gateway Plaza property, as a whole, does not meet the definition of an investment.

GASB 72, paragraph B47, describes the evaluation governments should perform when determining reporting for "mixed-use" assets. This paragraph is relevant to the THC as the Gateway Plaza building is used both for government office space and revenue generating leases. Since the Gateway Plaza's usage by LACERA is gradually increasing and expected to exceed 50% in 2026, the THC may conclude that the Gateway Plaza should be a capital asset. However, the THC would also have the ability to analyze usage of the Gateway Plaza

and bifurcate the building to be reported as both capital asset and investment. Once this determination is made, the THC is not permitted, under GASB 72 guidance, to change the reporting of the asset. A change in reporting would not limit LACERA's ability to sell the Gateway Plaza.

Guidance on Future Reporting by LACERA

As described above, in accordance with GASB 90, paragraph 6, LACERA has historically reported its 100-percent ownership interest in the THC at fair value within their fiduciary fund, rather than as a blended or discretely presented component unit.

GASB 90, paragraphs 5 and 6, provides that if the majority equity interest is held solely for investment purposes, it should be measured at fair value and reported as an investment under GASB 72.

LACERA owns 100 percent of LACERA Gateway Property, Inc., which exists to hold and operate Gateway Plaza within LACERA's real-estate investment portfolio. As noted in the previous section, a portion of the Gateway Plaza is being occupied by LACERA and should be treated as a capital asset under a GASB reporting model as it would not be held solely for investment purposes.

Because the ownership interest is 100 percent, rather than a majority, the provisions of GASB 90, paragraph 9, should be considered for reporting the THC in the LACERA financial statements. Paragraph 9 states that governments acquiring a 100% equity interest in a legally separate entity such as the THC should report the entity as a component unit.

GASB Codification 2600.15 discusses instances in which a government holds a majority equity interest in a legally separate organization that does not meet the definition of an investment and requires reporting of the separate organization as a component unit.

GASB Codification 2600.12 discusses when a component unit should be blended into a reporting entity's financial statements. Blending is required when a component unit exclusively (or almost exclusively) benefits the reporting entity even though it does not provide services directly to it. This would provide for LACERA reporting the THC as a blended component unit in the LACERA financial statements.

If blending the THC into the LACERA financial statements, LACERA would report the financial statement balances of the THC in the LACERA financial statements, with necessary eliminations occurring for activity between the two entities.

Guidance on Potential Capital Asset Valuation

Based upon the guidance described above, if the THC were to report a capital asset under GASB framework, the THC would need to determine a carrying value for the capital asset. Reflecting on historical activity impacting the cost of the asset as well as the useful life of the asset will be necessary in order to determine the carrying value.

Guidance on Dissolution of THC and Transfer of Asset to LACERA

Should LACERA ultimately decide to dissolve the THC, a transfer of the capital asset from THC into the LACERA financial statements would be required. LACERA would apply the provisions of GASB 48, *Sales and Pledges of Receivables and Future Revenues and Intra-Entity Transfers of Assets and Future Revenues*, which provides authoritative guidance for transfers of assets within the same financial-reporting entity.

Paragraph 15 specifies that when a capital asset is transferred between related funds, departments, or component units of a single reporting entity, the transfer is reported by the transferring entity as a transfer (rather than a sale) and by the receiving entity at the carrying amount of the asset as reported by the transferring entity at the time of the transfer.

Additional GASB Guidance

Under GASB 72, paragraph 68, the determination of whether an asset is an investment is made at the time of acquisition, based on management's intent and actions. Once that determination is made, the classification should be retained, even if usage changes. Accordingly, the property remains an investment measured at fair value if determined upon implementation of GASB 72.

If the THC changes to a GASB reporting model and decides to change the reporting of Gateway Plaza to a capital asset, the accounting treatment would shift from fair value measurement to the historical-cost model under GASB 34, *Basic Financial Statements – and Management's Discussion and Analysis for State and Local Governments*. GASB 34, paragraph 18, states that "capital assets should be reported at historical cost," including all ancillary charges necessary to place the asset into its intended location and condition for use. Should the Gateway Plaza THC change to a GASB reporting model, the capital asset should be evaluated to determine the initial cost with application of depreciation over the life of the asset (for example, if the capital asset were purchased in 1990, depreciation

would begin on that date). Any historical improvement costs should be considered in determining the net book value of the asset as of the date of the change in reporting.

LACERA management should make a determination regarding the useful life of the asset. Historical depreciation would be reflected in the beginning error correction adjustment within the THC financial statements. With the blending of the THC financial statements to LACERA, the annual capital asset depreciation expense would be reported in the LACERA financial statements as administrative expense.

Subsequent accounting follows the capital-asset model under GASB 34. The building is reported at cost (or fair value on the acquisition date, if applicable) and depreciated systematically, and no longer subject to annual fair-value measurement if reported as a capital asset instead of an investment. Consistent with GASB 34, paragraphs 22–23, depreciation should begin over the asset's estimated remaining useful life, based on its present condition and expected future service.

GASB 34 requires depreciation over estimated useful lives using a systematic and rational method but does not prescribe specific lives; management establishes useful lives based on professional judgment, considering the asset's condition, expected period of service, maintenance practices, and experience with comparable assets, and applies depreciation prospectively.

GASB Materiality and Reporting Considerations

GASB's conceptual literature does not prescribe numeric thresholds for materiality and offers limited explicit guidance. The clearest statement appears in GASB Concepts Statement No. 1, paragraph 64, which requires that "nothing material should be omitted … nor should anything be included that would cause the information to be misleading." Consistent with GASB's principles-based framework and the GAAP hierarchy in GASB Statement No. 76, *The Hierarchy of Generally Accepted Accounting Principles for State and Local Governments*, (which makes GASB Statements and Implementation Guides authoritative), materiality remains a matter of professional judgment applied to recognition, measurement, presentation, and disclosure. Accordingly, standards are applied to the extent the outcome is material to the financial statements; immaterial differences need not be adjusted or disclosed. Where a reclassification is immaterial at the plan-wide level, management may apply this principle to justify presentation changes that

better reflect operational reality, provided the treatment and rationale are documented and reviewed with the external auditor.

Financial Statement Audit Implications

Audit materiality is a consideration of the maximum financial statement misstatement that would not reasonably influence financial statement users' decisions. Materiality is set using a benchmark (e.g., total assets, revenue, or net position) and adjusted for qualitative factors such as volatility, risks, and public interest).

Auditors assess financial statement materiality by considering what magnitude and nature of misstatements could reasonably influence the decisions of financial statement users. They typically establish an overall materiality threshold using relevant benchmarks (for example, a percentage of total assets, revenue, or net position), then refine it for the entity's context, volatility, users' needs, and qualitative factors.

From there, auditors set lower levels such as performance materiality (to reduce the risk that undetected misstatements aggregate to a material amount) and tolerable misstatement at the account or assertion level to design procedures. Materiality is not static: auditors reassess it as they learn more during the engagement, and they may set specific materiality levels for particular classes of transactions or disclosures, as well as component-level thresholds in group audits. Ultimately, the evaluation of identified misstatements—both individually and in the aggregate—considers quantitative size and qualitative aspects before concluding whether the financial statements are fairly presented.

While each government and audit firm will have their own perspective of qualitative factors impacting materiality, a typical range for quantitative consideration would be 2-5% of total assets. As of June 30, 2024, the Pension Plan had assets totaling $85,171,212,000. A 2% materiality assessment would be $1,703,424,000.

Assessing materiality at an individual account level, as of June 30, 2024 total real estate investments were $4,406,609,000. A 2% materiality assessment would be $88,132,000.

If LACERA were to pursue any change in the financial-reporting treatment of Gateway Plaza through a presentation change based on materiality, auditors would focus on whether the accounting and disclosures comply with GASB 72 and GASB 34. Their review would include

evaluation of the underlying transaction, evidence supporting fair-value measurement, and the completeness of journal entries and note disclosures. If the change were immaterial at the plan-wide level, the audit focus would be on management's documentation of its materiality analysis.

California Employee Retirement Law (CERL) Implications

CERL limits annual administrative expenses to 21 basis points. Footnote L of the 2025 LACERA financial statements describes the annual LACERA budgeting process considers the 21 basis point limitation in CERL and that both budgeted and actual administrative expenditures were less than the 21 basis point limitation. LACERA should continue considering annual rent payments and other cash expenditures to the THC relative to the 21 basis point CERL limitation.

Other Public Retirement System Research

To support the evaluation of how public retirement systems account for and disclose their headquarters properties, research was conducted on a range of comparable public retirement systems. This analysis focused on identifying the reporting methods used in financial statements and accompanying disclosures, particularly regarding classification within fiduciary funds. The table below summarizes the reporting approaches of various systems, providing a benchmark for assessing current practices and informing potential updates to reporting practices.

California Systems		Other US Systems	
System	Accounting Treatment	System	Accounting Treatment
CalPERS (California Public Employees' Retirement System)	Capital Asset	New York State Teachers' Retirement System (NYSTRS)	Capital Asset
CalSTRS (California State Teachers' Retirement System)	Capital Asset	NYC Employees' Retirement System (NYCERS)	Lease
LAFPP (Los Angeles Fire & Police Pensions)	Capital Asset	Teacher Retirement System of Texas (TRS)	Capital Asset
LACERS (Los Angeles City Employees' Retirement System)	Capital Asset	State of Wisconsin Investment Board (SWIB)	Lease
SFERS (San	Lease	Pennsylvania Public	Investment

California Systems		Other US Systems	
System	**Accounting Treatment**	**System**	**Accounting Treatment**
Francisco Employees' Retirement System)		School Employees' Retirement System (PSERS)	
SDCERA (San Diego County Employees Retirement Association)	Investment / Lease	New York State Common Retirement Fund (NYS CRF)	Lease
SDCERS (San Diego City Employees' Retirement System)	Lease	Colorado Public Employees' Retirement Association (PERA)	Capital Asset
OCERS (Orange County Employees Retirement System)	Capital Asset	Arizona State Retirement System (ASRS)	Capital Asset
SBCERA (San Bernardino County Employees' Retirement Association)	Lease	Oregon Public Employees Retirement System (PERS)	Capital Asset
ACERA (Alameda County Employees' Retirement Association)	Lease	Minnesota State Retirement System (MSRS)	Capital Asset
CCCERA (Contra Costa County Employees' Retirement Association)	Lease	Minnesota Public Employees Retirement Association (PERA MN)	Capital Asset
VCERA (Ventura County Employees' Retirement Association)	Lease	Minnesota Teachers Retirement Association (TRA MN)	Capital Asset
SCERS (Sacramento County Employees' Retirement System)	Lease	Maryland State Retirement & Pension System (SRPS)	Lease
KCERA (Kern County Employees' Retirement Association)	Capital Asset	Indiana Public Retirement System (INPRS)	Capital Asset
TCERA (Tulare County Employees' Retirement	Capital Asset	Virginia Retirement System (VRS)	Capital Asset

California Systems		Other US Systems	
System	Accounting Treatment	System	Accounting Treatment
Association			
MCERA (Marin County Employees' Retirement Association)	Capital Asset	Ohio Public Employees Retirement System (OPERS)	Capital Asset
		State Teachers Retirement System of Ohio (STRS Ohio)	Capital Asset
		Retirement Systems of Alabama (RSA)	Capital Asset

Next Steps

As LACERA looks ahead with the next steps for reporting the THC, four options have been identified.

Option – Reclassify the Asset due to Immateriality

Although GASB 72 paragraph 68 indicates that asset classification is determined at acquisition and ordinarily retained, GASB's conceptual framework recognizes that materiality governs the application of all financial-reporting requirements. Because Gateway Plaza's fair value of approximately $74 million represents less than 0.1 percent of LACERA's total plan assets of $85 billion, any difference between investment accounting at fair value and capital-asset accounting at cost less depreciation would likely be considered immaterial to LACERA's consolidated financial statements.

Under this approach, LACERA would reclassify its equity interest in the THC from "Investments – Real Estate" to "Capital Assets – Buildings and Improvements." The fair value of the property on the reclassification date would establish the new cost basis for capitalization and depreciation would begin prospectively over the building's remaining useful life. The THC could continue to hold legal title and maintain its own books, but LACERA would treat the building as an administrative capital asset for administrative operations because its primary function is to support LACERA's internal operations rather than to generate investment income.

This change would likely be immaterial in the context of total plan assets and therefore would not require restatement of prior financial statements. LACERA should prepare a materiality assessment, both quantitative and qualitative, and obtain auditor concurrence that the reclassification does not materially affect the plan's financial position or results of operations. The change would be accounted for prospectively, with no note disclosure required since the change would be considered immaterial.

This option would achieve the objective of removing Gateway Plaza from the investment portfolio and reporting it as a capital asset on LACERA's books, while avoiding a legal transfer or dissolution of the THC. However, management would need to monitor the administrative-expense ratio annually to ensure continued compliance with the 21-basis-point statutory limit in CERL.

Gateway Plaza would become a non-investable operational asset, which changes the composition of plan assets but does not impair LACERA's ability to pay benefits. Similar to other CERL systems (e.g., CalPERS, OCERS), the building would simply appear as an administrative capital asset with depreciation included in administrative costs. A simple footnote disclosure should clarify that plan assets include property used for administrative purposes.

Because this approach relies on materiality, implementation would focus on documenting management's judgment and auditor concurrence, updating financial-statement presentation, and disclosing the rationale for reclassification. No legal transaction or new fund structure would be required, but LACERA would begin recognizing depreciation and related administrative costs subject to the CERL Section 31580.2 limit.

Additionally, as described above, the THC is currently reporting their financial statements using a FASB model. Based upon the structure of the THC with dissolution reverting assets back to LACERA, the THC is required to report their financial statements using a GASB model. This is likely a material reporting issue for the THC and should be considered in evaluation of options.

Option – Report THC as a Blended Component Unit

Based upon the analysis above, the THC meets the criteria outlined in the AICPA State and Local Government Audit Guide for reporting their financial statements in accordance with

the GASB financial reporting framework. The THC could revise their financial reporting in line with GASB requirements and thus, would apply the provisions of GASB 72 and report the Gateway Plaza asset as a capital asset, either wholly or bifurcated, in the THC financial statements. This change in reporting would likely flow through an error correction reported in the THC financial statements.

Subsequent to the THC revising their financial reporting, LACERA could consider reporting the THC as a blended component unit in the LACERA financial statements. In doing so, LACERA would blend the THC financial reporting into LACERA's financial statements, with appropriate eliminations. If determined to be immaterial, this would not require an error correction to the LACERA financial statements and would be reported prospectively.

See Appendix A for an example financial statement related to this option.

Option – Report THC as a Blended Component Unit with Materiality Considerations

Aligned with options 1 and 2, LACERA could consider reporting the THC as a blended component unit in the LACERA financial statements. In doing so, LACERA would blend the THC financial reporting into LACERA's financial statements, with appropriate eliminations. Should the THC choose to report the Gateway Plaza as a capital asset, either wholly or bifurcated, LACERA could apply the materiality concepts discussed in option 1 to report the capital asset within another asset class that does not align with investments or capital assets. For example, LACERA could choose to report the capital asset as an "other asset" as it would likely be considered immaterial.

Option – Dissolve the THC and Transfer Asset to LACERA

Dissolution of the THC would likely result in THC assets being transferred to LACERA. Should LACERA seek formal dissolution of the THC, the THC would report a transfer out of the Gateway Plaza building and other assets (for example, cash). LACERA would apply the provisions of GASB 48 to report a transfer in of assets from the THC at the carrying value of the assets as reported by the THC. In doing so, LACERA would implement the provisions of GASB 72 in identifying how the Gateway Plaza building would be reported on the LACERA financial statements. LACERA could report the Gateway Plaza as a capital asset, either wholly or bifurcated, in the LACERA financial statements.

Appendix A

Example financial statement changes. See supplemental notes.

	LACERA Financial Statements	
	Previous	**Updated**
Real estate investment	$ 76,210	$ 40,667
Capital asset	-	35,000
Cash	-	1,549
Prepaid and other assets	-	261
Net appreciation in fair value of investments	$ (8,567)	TBD
Rental income	-	6,833
Administrative expenses	(6,364)	(5,100)

Depreciation Calculation	
Asset Balance	$ 35,000
Annual Depreciation (40 years)	875

Administrative Expenses	
LACERA lease payment to THC	$ 6,364
Blending elimination	(6,364)
THC expenses	4,225
THC depreciation	875
Total	$ 5,100

Notes:

1. *The example financial statements included above assume the THC will choose to bifurcate the Gateway Plaza asset.*
2. *The figures above are presented as an example only and may not reflect actual financial statement balances post-change.*
3. *The THC will likely report an error correction for the change from FASB to GASB reporting in the initial year of change.*

CliftonLarsonAllen LLP
CLAconnect.com

April 9, 2026

Mr. Ted Granger, CPA, CFO
Los Angeles County Employees Retirement Association (LACERA)
300 N Lake Avenue
Pasadena, CA 91109-7060

Mr. Granger:

As you know, CliftonLarsonAllen (CLA) was recently engaged to perform LACERA's annual financial statement audit beginning June 30, 2026. CLA is aware of LACERA's consideration of potential changes in financial reporting for Gateway Plaza and participated in several discussions with LACERA management and Crowe LLP.

We have reviewed the options with management as identified in Crowe LLP's memorandum to the Board for the April 20, 2026, Joint Organizational Governance Committee meeting, and do not have any concerns with the approaches identified.

Sincerely,

Christian J. Rogers

Christian J. Rogers, CPA
Managing Principal
CLA

Cc: LACERA Management

CLA (CliftonLarsonAllen LLP) is an independent network member of CLA Global. See CLAglobal.com/disclaimer.

April 15, 2026

TO: Each Trustee
Board of Retirement

FROM: Tamara Caldwell, Division Manager
Disability Retirement Services Division

Patty Silva, DRS Interim Supervisor
Disability Retirement Services Division

FOR: May 6, 2026, Disability Board of Retirement Meeting

SUBJECT: RECOMMENDATION TO APPROVE KIRK Y. CHANG, M.D. (INTERNAL MEDICINE) TO THE LACERA PANEL OF PHYSICIANS

RECOMMENDATION

To support timely, high-quality medical-legal evaluations and maintain a geographically accessible and appropriately credentialed panel of examining physicians, staff recommends that the Board of Retirement approve the application of Kirk Y. Chang, M.D., for appointment to LACERA's Panel of Examining Physicians.

DISCUSSION

Certifications & Licensure

Dr. Kirk Y. Chang is board certified by the American Board of Internal Medicine (1998–2028) and the American Board of Cardiovascular Disease (2003–present) and holds an active California medical license (A75580) and Washington State medical license (35504).

Education & Training

He earned a B.S. in Biochemistry from the University of California, Los Angeles (1991, cum laude) and an M.D. from the University of Southern California, Keck School of Medicine (1995, highest distinction). He completed residency training in Internal Medicine at Virginia Mason Medical Center (1995–1998) and served as Chief Medical Resident (1998–1999), followed by a cardiology fellowship at UCLA/West Los Angeles VA Medical Center (2000–2003) where he served as Chief Cardiology Fellow (2002–2003).

Professional Experience

Dr. Chang's professional experience includes work as a hospitalist and founding member at Virginia Mason Medical Center (1999–2000), and he has served as a

Staff Physician at Cedars-Sinai Medical Center (2002–present) within the Smidt Heart Institute/Center of Excellence while also maintaining a private practice in Los Angeles (2003–present).

Medical-Legal Experience
He is a Qualified Medical Evaluator (QME) (November 2021–present) and passed the QME Competency Examination in October 2021.

Honors, Affiliations & Community Service
Dr. Chang is a Fellow of the American College of Cardiology and a member of multiple professional associations, has received honors including Cedars-Sinai Circle of Friends (2018) and Alpha Omega Alpha (1995), has participated in community service roles with the City of Beverly Hills (including Chairman of the Health and Safety Commission, 2022–2023), and speaks English (native) and Mandarin Chinese (fluent).

Panel Onboarding & Compliance
If approved, Disability Retirement Services (DRS) will provide an orientation for Dr. Chang and his practice team covering LACERA's Panel Physician Guidelines, evaluation standards under applicable disability retirement law, report requirements and timelines, fee and billing procedures, and ongoing quality-control processes. DRS will also confirm continuing compliance with licensing, board certification, and insurance requirements.

Medical Advisor Review
On April 1, 2026, Board Medical Advisor Glenn Ehresmann, M.D., reviewed Dr. Chang's application and credentials and concurred with forwarding the application to the Board of Retirement for consideration.

TLC:PS/mc

Attachments

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 02/24/2026
Physician Name: KIRK CHANG	Group Name: KIRK Y CHANG MD INC
Primary Address: 8635 W. 3RD ST #1050W LOS ANGELES ca 90048	
Primary Contact: KIRK CHANG	Title: MD
Telephone: 310-659-4026	Email: KYC@KIRKCHANGMD.COM
Secondary Address:	
Telephone:	Email:

PHYSICIAN BACKGROUND	
Field of Specialty: INTERNAL MEDICINE Board Certification ☒ Yes ☐ No	Subspecialty: CARDIOLOGY Board Certification ☒ Yes ☐ No
License # A75580 Expiration Date: 02/28/2027	
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	3	Treatment	85
IME	3	Evaluations	15
QME	4	Research	0
Workers' Compensation Evaluations	4	Teaching	0
Disability Evaluations	3		100 %
Med-Legal Reports	4		

Performing Medical Evaluations for Public Organizations	☒ Yes ☐ No
Performing Medical Evaluations for Private Organizations	☒ Yes ☐ No
Please Names of Organizations: SBCERA VCERA OCERS	
Estimated Time from Appointment to Examination: ◉ 2 weeks ○ 3-4 Weeks ○ Over a month	Able to Submit a Final Report and Invoice in 30 days: ☒ Yes ☐ No

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

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

What is you Cancellation Policy? (Attach policy, if applicable).

IF CANCELLATION WITHIN 6 BUSINESS DAYS

Cancelled Exams that do not adhere to your stated policy:	Fee: $ 503.75
Cancelled Hearings that do not adhere to your stated policy:	Fee: $ 375

Name of person completing this form:

Print Name:	Title:
KIRK CHANG	MD
Physician Signature:	Date
	02/25/26

You may attach additional pages if necessary.

Revised: 12/8/21

KIRK Y. CHANG

8635 W. 3rd. St, Ste 1050W Los Angeles, CA 90048 | (310)659-4026 | kyc@kirkchangmd.com

EDUCATION

University of California, Los Angeles
Bachelor of Science, Biochemistry — 1991
cum laude

University of Southern California, Keck School of Medicine
M.D. — 1995
Highest distinction

POSTGRADUATE TRAINING

Virginia Mason Medical Center
Seattle, Washington
Residency in Internal Medicine — 1995-1998
Chief Medical Resident — 1998-1999

UCLA/West Los Angeles VA Medical Center
Fellow, Division of Cardiology — 2000-2003
Chief Cardiology Fellow, 2002-2003

WORK EXPERIENCE

Hospitalist, Department of Internal Medicine — 1999-2000
Virginia Mason Medical Center
Founding Member

Staff Physician, Cedars-Sinai Medical Center — 2002- present
Smidt Heart Institute, Center of Excellence

Private Practice — 2003- present
Los Angeles, California

Qualified Medical Evaluator — Nov 2021- present

BOARD CERTIFICATION

American Board of Internal Medicine — 1998-2028
American Board of Cardiovascular Diseases — 2003-present

MEDICAL LICENSURE

California	A75580
Washington State	35504
QME Competency Examination – PASS	October 2021

PROFESSIONAL SOCIETIES

Fellow, American College of Cardiology
American Medical Association
American Academy of Anti-Aging Medicine
Los Angeles County Medical Association

AWARDS/HONORS

Cedars Sinai Medical Center, Circle of Friends, *Honors*	2018
Alpha Omega Alpha Honor Medical Society	1995
Pathology Honors Society	1993
Hugh Edmondson Fellow, USC	1986

COMMUNITY SERVICE/ORGANIZATIONAL AFFILIATIONS

City of Beverly Hills Health and Safety Commission	2019-2025
Chairman	2022-2023
City of Beverly Hills Medical Advisory Task Force	2020-present
City of Beverly Hills Team Beverly Hills	2019
Rotary Club of Beverly Hills	2019-present

PUBLICATIONS AND PAPERS

McLeod SD. Chang KY. Flowers CW. Irvine J. Rao NA. Smith RE. McDonnell PJ. *Iris sutured posterior chamber lens dislocation after penetrating keratoplasty*. Arch Ophthal 1996;114(8):1032-1033.

Flowers CW. Chang KY. McLeod SD. Irvine J. McDonnell PJ. Rao NA. Smith RE. *Changing indications for penetrating keratoplasty, 1989-1993*. Cornea 1997;16(1):120-121.

Chang KY. Chang GY. *A case of chronic uveitis preceding CNS lymphoma by 7 years in an immunocompetent patient*. Ann Ophthal 1997;29:309-311.

Chang, K.Y., Ebrahimi, R., Bersohn, M.M. (2003) Ventricular fibrillation resulting from acute right ventricular infarction from isolated occlusion of a right ventricular branch artery. *J Cardiovasc Pharmacol Ther*, 8(1): 5-8

ABSTRACTS AND PRESENTATIONS

Chang KY. Yo C. Rostamian K. Chong LP. "Utility of fundoscopic examination in patients without fungemia." Supplement to Investigative Ophthalmology & Visual Science, 1995;36:s631 (Presented May 1995 ARVO, Sarasota, Florida)

Chang KY. Mecklenburg RS. Rosoff L. "Hypercalcemia and Sarcoid." American College of Physicians Associates' Competition, Clinical Vignette, Seattle 1996

Lui K. **Chang KY**. Fredlund P. "Thyroid Storm and Myasthenia Gravis." American College of Physicians Associates' Competition, Clinical Vignette, Seattle 1997

Fowler JV. **Chang KY**. "A case of fatal thrombocytopenic thrombotic purpura secondary to ticlopidine." American College of Physicians Associates' Competition, Clinical Vignette, Seattle 1998

LANGUAGES

English– native language
Mandarin Chinese– speak fluently

American Board of Internal Medicine®

510 Walnut Street | Suite 1700 | Philadelphia, PA | 19106-3699 | 800.441.2246 | www.abim.org | request@abim.org

Verification of Certification Status

Furman S. McDonald, MD
President
Chief Executive Officer

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February 26, 2026

Dr. Kirk Yuen Chang
BLDG
8635 W 3rd St STE 1050W
Los Angeles, CA 90048-6105

Below is the certification status of this physician as of February 26, 2026. In addition to reporting board certification, ABIM reports whether or not ABIM Board Certified physicians are participating in Maintenance of Certification (MOC). Because ABIM's MOC program requires continuous activities to maintain certification, we no longer issue certificates with end dates; however, we recognize that some entities may still require current certification status to complete primary-source verification.

Our website, www.abim.org/verify, is the primary verification source for ABIM Board Certification. We will update this status on an annual basis. Therefore, we encourage credentialers to use the **ABIM's annual re-verification date of April 1** to verify your physician's status. By using the annual re-verification date suggested, you will have accurate information about a physician's current certification status. Visit www.abim.org/moc to review ABIM's Maintenance of Certification policies.

If you have questions, please call 1 (800) 441-ABIM (2246), Mon. - Fri., 8:30 a.m. to 6 p.m. ET, or email us at request@abim.org.

Name: **Dr. Kirk Yuen Chang**

Internal Medicine: **Certified**
Cardiovascular Disease: **Certified**

Participating in MOC: **Yes**

INITIAL CERTIFICATION
Internal Medicine: 1998
Cardiovascular Disease: 2003

American Board of Internal Medicine

A MEMBER BOARD OF THE AMERICAN BOARD OF MEDICAL SPECIALTIES (ABMS)

Kirk Y. Chang, M.D., F.A.C.C.

Cardiovascular Diseases
Diplomate of the American Board of Internal Medicine
Diplomate of the American Board of Internal Medicine,
Cardiovascular Diseases
Qualified Medical Examiner
790 Leeward Way • Costa Mesa, California 92627
(949) 333-1586 Fax (818) 838-3749

[redacted]

[redacted]

[redacted]

Date of Injury: [redacted]
Date of Birth: xxxxxxxx
Employer: [redacted]
Date of Exam: [redacted]

INDEPENDENT MEDICAL EVALUATION

Dear Sir or Madam:

This is a Cardiologist INDEPENDENT MEDICAL EVALUATION performed in the [redacted]

INTRODUCTION

Ms. Redacted Redacted is a [redacted]-year-old female who was employed as a [redacted] Ms. Redacted claims that heart condition and hypertension limits her ability to perform the duties of her position.

PRESENT COMPLAINTS

While working in the office [redacted] applicant reports she did not feel well- something did not feel right. She felt like she was going to have a headache, but none came. She felt a bit woozy. She asked the nurse across the hall to check her blood pressure, which she reports was high. She cannot recall the exact reading. She finished her report, and told her supervisor, requested evaluation by employee health, and went there later that day.

A QME from [redacted], who opined a 30% WPI based on LVH/LVMI and diastolic dysfunction.

[redacted]

On [redacted] Dr. [redacted] noted applicant was evaluated [redacted] with left jaw and ear pain, left sided facial numbness. Diagnosed with Bell's Palsy. CT and MR imaging were reportedly negative.

She reports her date of retirement was [redacted]

She denies ER visits or hospitalizations for hypertension. She reports no time off due to blood pressure issues. She reports no history of heart failure or stroke.

She reports now that she is retired, she is active, exercising, trying to spend more effort on her health.

WORK HISTORY

Applicant began work in [redacted] She reports having a pre-employment examination which she passed. She worked 6am-2pm shift with occasional nights. She did not actively seek overtime.

OCCUPATIONAL REQUIREMENTS

The job description and the Physical Requirements of the Position/Occupational Title have been reviewed under the Record Review section of the report, including a discussion with Ms. Redacted as to the job description after she read the enclosed "job analysis".

SUBSEQUENT EMPLOYMENT HISTORY

Applicant is retired.

PAST HISTORY:

1. Diabetes mellitus
2. Hypertension

SURGERIES:

Lumpectomy x 2
Acute gastroenteritis with AKI. Hospitalized 4-5 days about 5 years ago. [redacted]

MEDICATIONS:

Lumpectomy x 2
Acute gastroenteritis with AKI. Hospitalized 4-5 days about 5 years ago. [redacted]

ALLERGIES: NKDA

FAMILY HISTORY:

Sister with diabetes.

HABITS:

Smoked a ppd for 2 years, quit two years ago. This was during a very stressful period when certain inmates were assaulting staff.

REVIEW OF SYSTEMS:
GENERAL: negative
HEENT: rare headaches
CARDIOVASCULAR: no chest pain
GASTROINTESTINAL:
GENITOURINARY: none
EXTREMITIES: no swelling

PHYSICAL EXAMINATION:

GENERAL:
VITAL SIGNS:
Height [redacted]
Weight [redacted]
BODY MASS INDEX: [redacted]

BLOOD PRESSURE: **126/82**
HEART RATE: **80 bpm**
General: No acute distress, awake and alert.
HEENT: NCAT, sclerae anicteric, PERRL, EOMI, throat clear.
Neck: Supple, no significant jugular venous distention.
Carotid: Normal carotid upstrokes, no carotid bruit.
Lungs: Good inspiratory effort, no accessory muscle use, clear to auscultation bilaterally.
Heart: Regular rate and rhythm, normal S1/S2, no murmurs/rub/gallop.
Abdomen: Soft, nontender, nondistended. Normoactive bowel sounds.
Extremities: No edema. 3+ pedal pulses.
Skin: No cyanosis, no clubbing.
Neuro: A&O x 3. Cranial nerves II through XII were intact and symmetric bilateral.
Psych: Alert and cooperative with interview.

DIAGNOSES:

HYPERTENSION
DIABETES MELLITUS

DISCUSSION AND CONCLUSION

This [redacted]-year-old woman worked [redacted] years as a [redacted]. In [redacted] she felt unwell and was diagnosed with hypertension. Her blood pressure is well controlled with two medications. She denies missed days, ER visits, or hospitalizations due to hypertension. Internal Medicine Qualified Medical Examination did not note any periods of disability for her hypertension.

QUESTIONS FROM [redacted]

1. Does the member have an actual and present cardiological (hypertension) impairment that arises to the level of substantial incapacity to perform their usual duties?

No, there were no periods of disability or impairment due to hypertension that prevented the applicant from performing her work duties.

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? Please explain fully.

She denies missed days, ER visits, or hospitalizations due to hypertension. Internal Medicine Qualified Medical Examination did not note any periods of disability for her hypertension.

3. If you find the member to be substantially incapacitated, is the incapacity permanent or temporary? As specified in California Public Employees' Retirement Law G.C. 20026, if temporary, will the incapacity last longer than 12 months? Please explain in detail.

Applicant is not substantially incapacitated due to hypertension.

4. Please list the specific Job Duties and/or Physical Requirements of Position the member is unable to perform for each substantially incapacitated body part/condition.

The applicant may perform all job duties, with no restrictions due to hypertension.

5. As of what date did the member's condition become "substantially incapacitating"? What objective medical evidence leads you to your conclusion the member is substantially incapacitated based on the date provided?

Applicant is not and has not been substantially incapacitated due to hypertension.

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

Yes, she was cooperative with examination and gave an honest history.

REVIEW OF RECORDS:

Job Description. [redacted] Job Title: [redacted].
Essential Duties and Responsibilities: 1) 30% Supervises, trains, and develops subordinate staff, ensures that subordinate staff and inmates are diligent in the performance of their duties and comply with department and institutional rules, regulations, and procedures. 2) 20% Conducts daily accountability of staff, accounting for all custodial personnel assigned. Ensures that coverage is provided when necessary to cover vacant posts due to custodial staff utilizing leave credits or during emergency situations. Ensure accuracy and timely processing of paperwork, inmate grievances, and Rules Violation Reports. 3) 20% Ensures that appropriate procedures and specific post orders are developed, maintained, and enforced. Supervises and monitors regular updates of unit procedures and post orders. 4) 20% Conducts regular health, safety, and security inspections, also logging and signing all required inspection/tool logs. Ensures staff are completing inventories (key, tool, personal protective equipment, and perpetual). Ensures staff are completing logs appropriately (including cell search and building). Ensure staff have necessary equipment as noted in their designated post orders. 5) 05% Conduct investigative interviews as necessary, maintain employee discipline at appropriate levels and ensure compliance with employee contracts in all areas of responsibility. 6) 05% Maintain a system for timely and appropriate maintenance of supervisory files, to include regular and accurate completion of probationary and annual reports of subordinate staff. Physical Demands: 1) Standing: Occasionally - must be able to stand in a confined space for long periods of time while speaking or giving prepared lectures to staff, observing inmate and staff activities, and performing inspections. 2) Walking: Occasionally - walks to other offices to attend meetings, or to the various facilities to perform inspections, or to speak with staff. 3) Running: Occasionally - must be able to run in an all-out effort while responding to an alarm or serious incidents. Distances vary from a few yards up to 400 yards. May include up and/or down stairs, across grass with sprinkler heads and gopher holes, cement, dirt, and asphalt in wet and dry conditions. 4) Sitting: Frequently to Constantly - sits at meetings and while performing paperwork. There is flexibility for movement on a frequent basis to break sitting with standing and walking. 5) Lifting/Carrying: Occasionally - lifts paperwork and files weighing up to five pounds. He/she will occasionally lift binders of information. Emergency situations may involve lifting and/or physically restraining an individual, including wrestling them to the floor. Must be able to drag or carry items weighing between 80 and 400 pounds in very cramped spaces with the assistance of other individuals working simultaneously. Mental Demands: [redacted] must be alert and must have the ability to sustain their alertness over an 8-hour workday or longer if overtime is required. [redacted] are at risk of physical violence at all times in a correctional institution, by aggressive or combative inmates, including physical attacks, verbal abuse, harassment, or violence between inmates. [redacted] must be able to make rapid and correct decisions and respond in life-threatening situations. They must also be able to shoot to stop the threat in accordance with the [redacted]. [redacted] may be exposed to unpleasant situations, including dealing with inmates who have attempted or committed suicide, gassings, or having body fluids thrown on them. They must be able to perform the full range of duties and assignments described herein and cannot rely on the same daily routine of duties. Work Environment: The work environment characteristics described here are representative of those an employee encounters while performing the essential functions of this job. Reasonable accommodation may be made to enable individuals with

disabilities to perform the essential functions. May be exposed to contagious life-threatening diseases such as AIDS/HIV, Hepatitis, Tuberculosis, and other communicable diseases. Frequently works in a temperature-controlled office space with fluorescent lighting, linoleum-covered flooring. While performing inspections, he/she may occasionally be exposed to fumes, outdoor weather conditions, temperature extremes, high noise levels, significant vibration, and moving mechanical parts.

[redacted] **Medical Clinic, Inc,** [redacted] **MD, Qualified Medical Examination.** [redacted] History of Present Illness: Patient still works at C[redacted] as a [redacted] which she has been doing for [redacted] years. The last [redacted] years she has been working as a sergeant. Before that, she was a [redacted] Her promotion occurred [redacted] years ago and put more stress on her life and her job. Past Medical History: 1) Diagnosed with hypertension and diabetes mellitus about a year and a half ago. 2) Food poisoning about five years ago. She was dehydrated. Her kidneys shut down. She was hospitalized for five days and then improved and was sent home. 3) She had a lumpectomy of her right breast [redacted] years ago and another one [redacted] years ago. Family History: Her father died young of unknown causes. She has five brothers, one died of stomach cancer, one died from complications of Down's Syndrome. She has one sister who is diabetic. Social History: She smoked a pack a day for about two years and quit about a year and a half ago. Before that, she smoked rarely but on and off. Medications: Metformin 500 mg which she splits and takes half in the morning and half in the evening. Lisinopril /hydrochlorothiazide 20/125 mg daily, Crestor unknown dosage. Review of Systems: Chest pain, visual disturbances, headaches, dizziness, arm pain, heartburn, diarrhea, and constipation. Vital Signs: BP: 128/87. Pulse: 61. Temperature: 98.2. Height: [redacted] weight: [redacted] Pulse Oximetry: 98%. Physical Examination: Low-grade systolic murmur. Left sternal border. Abdomen: Moderately obese. Diagnoses: 1) Hypertension industrial-related. 2) Diabetes mellitus non-industrial. Diagnostic Data: 1) EKG (Electrocardiogram): Showed normal sinus rhythm with a heart rate of 61 beats per minute. 2) Echocardiogram: Showed increased intraventricular thickening and a left ventricular mass index of 95.7 grams/meter squared. Indicated decreased left ventricular compliance by mitral flow pattern, suggesting diastolic dysfunction. 3) Carotid Doppler: Showed intimal media thickening of both common carotids with no plaque or flow disturbances. Described as an unremarkable study. 4) Lower Extremity Venous Doppler: Showed no evidence of deep vein thrombosis or venous valvular insufficiency. Described as a normal study. 5) Lower Extremity Arterial Doppler: Revealed normal real-time imaging and Doppler at all levels on both the right and left sides. Described as a normal study. 6) Ankle/Brachial Index: Revealed a value of 1.5 on the right and a value of 1.2 on the left, both within normal limits. 7) Event Recorder: Showed the patient presented in normal sinus rhythm. Detected rare PACs (Premature Atrial Contractions) and PVCs (Premature Ventricular Contractions). Impairment Rating: Permanent impairment due to hypertensive cardiovascular disease, this patient fits into Class 3 category since she does have increased left ventricular mass and she does have diastolic dysfunction. She is assigned 30% impairment of the whole person. Permanent and Stationary: The patient is permanent and stationary and maximally medically improved. The patient is maximally medically improved but her diastolic blood pressure could be better. She needs some medication adjustment. Apportionment: She gets the benefit of the presumption. There is no apportionment for her

hypertension. Future Medical Treatment: She needs ongoing medical care because she is a diabetic and is hypertensive. She has to follow up with her internist or cardiologist.

[redacted] **MD, Ankle Brachial Index Assessment.** [Redacted_redacted_[redacted] Referring Physician: [redacted]. Impression: 1) Trace tricuspid regurgitation with RVSP 23 mmHg. 2) Trace mitral regurgitation. 3) Increased interventricular septal thickening. 4) Left ventricular mass index is 95.7 g/m². Decreased left ventricular compliance by mitral flow pattern. Normal left ventricular function.

[redacted] **MD, Color Flow Doppler Report**. [Redacted_redacted_[redacted] Referring Physician: [redacted] Impression: 1) Trace tricuspid regurgitation with RVSP 23 mmHg. 2) Trace mitral regurgitation. 3) Increased interventricular septal thickening. 4) Left ventricular mass index is 95.7 g/m². 5) Decreased left ventricular compliance by mitral flow pattern. 6) Normal left ventricular function.

[redacted] **MD, Carotid Duplex Scan.** [Redacted_redacted_[redacted] Referring Physician: [redacted]. Impression: Right: Mild minimal thickening in CCA. Moderate internal thickening in DST CCA. Doppler normal. Left: Mild internal thickening in CCA. Moderate internal thickening in DST CCA. Doppler normal.

[redacted] **MD, Peripheral Vascular Venous Evaluation.** [Redacted_redacted_[redacted] Referring Physician: [redacted] Current Complaints: Leg pain/soreness, edema -both, inflammation, varicose veins, stasis disease, chest pain, dyspnea, hemoptysis, fever. Past History: Phlebitis, stasis, emboli, edema, varices, previous support, previous vein stripping, anticoagulation. Impression: No evidence of deep vein thrombosis seen in veins assessed. Imaged right and left common femoral veins, superficial femoral veins, popliteal veins, and posterior tibial veins. No evidence of venous valvular insufficiency present.

[redacted] **MD, Lower Extremity Arterial Duplex Final Report.** [Redacted_[redacted] Referring Physician: [redacted] Impression: Right: Real-time normal at all levels. Doppler normal at all levels. Left: Real-time normal at all levels. Doppler normal at all levels.

[redacted] **MD, End of Study MCT Report [Handwritten].** [Redacted_redacted_[redacted] Referring Physician: [redacted] MD. Impression: During 3-day study no significant symptoms were documented during these study period.

[redacted] **, M.D., Progress Note.** [Redacted_redacted_[redacted] Current Complaints: Patient followed up requesting FreeStyle Libre sensor. Was sent to a Qualified Medical Evaluator from work to address the hypertension. Diabetes mellitus (DM) is well controlled. Averages for blood glucose levels: 7 days = 117; 14 days = 115; 30 days = 115; and 90 days = 115. Sigmoid

colonoscopy confirmed both internal and external hemorrhoids as the reason for bright red blood per rectum (BRBPR). Was given Anusol supplement and recommended to do Sitz baths. The bleeding for now is controlled. Current Medications: Lidocaine 5% cream, Lisinopril hydrochlorothiazide 20 12.5 mg, metformin HCL 500 mg, Rosuvastatin Calcium 10 mg. Diagnoses: 1) Type 2 diabetes mellitus with hyperglycemia – previous A1C 7.6. 2) Essential (primary) hypertension - stable. 3) Mixed hyperlipidemia. 4) First degree hemorrhoids – internal and external, stable for now. Treatment Plan: 1) Level 4 established. 2) Ordered labs. 3) FreeStyle Libre 14-day sensor. 4) Advised low salt, low carb, low fat, low cholesterol diet, and daily exercise. 5) Continue same medications. 6) Request consult note from Dr. Mani's office. 7) Screening for breast cancer with screening mammogram. Work Status: Not noted.

[redacted], **Laboratory Report**. [Redacted_[redacted]]. Results: CBC with differential platelets was within normal limits. Comprehensive metabolic panel showed glucose high at 102, triglycerides high at 228, and hemoglobin A1c high at 6.1.

[redacted], **Progress Note**. [Redacted_redacted_[redacted] Current Complaints: Presented to discuss lab results. Requested work excuse for today's visit. Vital Signs: BP: 122/76 mmHg. Respiratory Rate: 18. Temperature: 97.2 F. Height: [redacted] inches. Weight [redacted] O2: 99%. Diagnoses: 1) Type 2 diabetes mellitus with hyperglycemia. 2) Essential (primary) hypertension - stable. 3) Mixed hyperlipidemia. Treatment Plan: 1) Level 3 established. 2) Labs ordered. 3) Advised low salt, low carb, low fat, low cholesterol diet, and daily exercise. 4) Continue same medications. 5) Advised to schedule follow-up appointment in 6 months to review results. 6) Given work excuse today. 7) Discharged by MM. Work Status: Not noted.

[redacted]
Progress Note. [Redacted_redacted_[redacted] Current Complaints: Follow-up after PMH admission due to CVA/neuro referral. Seen on [redacted] for left jaw and ear pain. Severe pain, with associated numbness of the left face. Symptoms worsened on [redacted] and discharged [redacted] Discharged on Acyclovir 800 mg, t.i.d. x 7 days and Prednisone 20 mg q.d. for 12 days. Final diagnosis was Bell's Palsy. She was informed the imaging studies were negative. Reviewed a CT head, CTA head, and MRI of the brain, all were negative without acute findings. She was still having some pain on the left side of the face. Vital Signs: BP: 147/79. HR: 88/min. Rest of the report is illegible.: 18/min. Oxygen Sat: 99%. BMI: [redacted] Weight: [redacted] Height: [redacted] Temperature: 98.8 F. Physical Examination: General Appearance: Notable flaccid nasolabial fold. Normal movement of the forehead with limited movement of the 7th cranial nerve. Diagnoses: 1) Bell's palsy. 2) Type 2 diabetes mellitus without complication, without long-term current use of insulin. 3) Essential (primary) hypertension - notes elevated today. 4) Body mass index (BMI) 30.0-30.9, adult. Treatment Plan: 1) Finish Acyclovir and Prednisone as directed. 2) Instill over-the-counter lubricating eye drops to the left eye at least 6 times per day. 3) Instructed to be careful with diet, to avoid sugary high-carb foods, and walk daily for exercise. To take medications as directed. 4) Monitor blood pressure. Work Status: Off work for next two weeks.

[redacted] **Progress Note**. [Redacted_redacted_[redacted] Current Complaints: Left side face pain in office for follow-up of Bell's palsy. She is still complaining of pain on the left side of the face, ear problems, twitches of the left side, and patient still cannot whistle. She did finish her medications as prescribed and wants to clarify insurance forms for work purposes. Diagnoses: 1) Bell's palsy – much improved. 2) Type 2 diabetes mellitus without complication, without long-term current use of insulin. 3) Essential (primary) hypertension – well controlled. 4) Body mass index (BMI) 30 0-30 9, adult. Treatment Plan: 1) Continue patching her eye for comfort as needed. 2) Continue Metformin HCL 500 mg. 3) Continue Lisinopril-HCTZ. 4) Daily exercise. Work Status: Not noted.

[redacted] **Physical Requirements of Position/Occupational Title.** [Redacted_redacted_[redacted]. Job Title: [redacted] Job Activity: 1) 8 hours work per day. 2) Constantly (>5 hours): Interacting/communicating, supervising staff, sitting. 3) Frequently (2.5-5 hrs.): Interacting/communicating, supervising staff, bending (neck), bending (waist), twisting (neck), reaching (below shoulder). 4) Occasionally (31 min - 2.5 hrs.): Lifting/carrying 0-50 lbs, standing, walking, running, crawling, kneeling, climbing, squatting, bending (neck), bending (waist), twisting (neck), twisting (waist), reaching (above shoulder). 5) Infrequently (5-30 min): Lifting/carrying 50 lbs.

[redacted] **MD, Progress Note**. [Redacted_redacted_[redacted]]. Current Complaints: Presented to discuss lab results. Vital Signs: BP: 111/67. HR: 83. Temperature: 98.6. Weight: [redacted] Height: [redacted] Oxygen Saturation: 98%. BMI: 30.07. BSA: 189. Labs: HbA1c was high at 6.4. Lipid panel showed high triglycerides at 306, low HDL at 38, high VLDL at 50. CMP showed glucose high at 122. Diagnoses: 1) Type 2 diabetes mellitus without complication, without long-term current use of insulin. 2) Essential (primary) hypertension. 3) Hypertriglyceridemia. Treatment Plan: 1) Continue metformin HCL 500 mg, Lisinopril-hydrochlorothiazide 20-125 mg, Rosuvastatin Calcium 10 mg. 2) Start Icosapent Ethyl 1 gm. 3) Lipids are not well controlled with elevated TG, will add Fish Oil to statin. 4) Continue diet and exercise. 5) Mammogram screening. 6) Order Cologuard. 7) Stop Ciprofloxacin-dexamethasone suspension 0.3-0.1%, 4 drops into the affected ear. Work Status: Not noted.

[redacted] **Laboratory Report.** [Redacted_redacted_[redacted] Results: Lipid panel showed triglycerides high at 254, VLDL cholesterol calculated high at 42. Comprehensive metabolic panel showed glucose high at 122.

Undated, ECG Report. [Redacted_redacted_[redacted]]. Impression: Sinus rhythm. Normal ECG.

Undated, [redacted] **Disability Retirement Election Application.** [Redacted_redacted_[redacted] Job Title: [redacted] Disability Retirement Type: Service pending industrial disability retirement. Employment Status: Last day on payroll was [redacted]. Retirement date was [redacted]. Disability Information: Reported specific disability of heart,

hypertension. Onset on [redacted]. Reported not feeling well, blood pressure was high. Effect on Job Duties: Reported no preclusions due to illness. Illness did not affect her ability to perform the duty. She is currently retired, not working in any capacity.

Office visit note from [redacted] County Physicians Medical Group Clinic was reviewed as it pertains to the treatment of acute otitis externa and seasonal allergies ([redacted]).

MISCELLANEOUS RECORDS:

Authorization to disclose protected health information was reviewed but not summarized.

SOURCE OF ALL FACTS AND DISCLOSURE

The source of all facts was the history given by the patient and review of the previous examiner's medical reports. I personally interviewed the patient, performed the physical examination, reviewed the history with the patient, 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, are 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 notes herein, that I believe it to be true.

Should you have any further questions concerning this patient, please do not hesitate to contact me.

Sincerely,



KIRK Y. CHANG, M.D., F.A.C.C.
Cardiovascular Diseases
Diplomate of the American Board of Internal Medicine
Diplomate of the American Board of Internal Medicine, Cardiovascular Diseases
Qualified Medical Examiner

KC/ACU/

Kirk Y. Chang, M.D., F.A.C.C.

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[redacted]

Job Title:
DOI: CT
Claim No.:
Soc. Sec. No.: xxxxxxxxxx
DOB: xxxxxxxxxx
[redacted]

AGREED MEDICAL EVALUATION IN INTERNAL MEDICINE

ML-201-94– This is a Comprehensive Medical-Legal Evaluation.
Number of pages of records reviewed in preparation of this report = 528
Subtract 200 pages for MLPRR = 328

Dear Parties:

The applicant, Redacted REDACTED, presents to my [redacted] located at 8[redacted] for the purposes of an Agreed Medical Evaluation in Internal Medicine-Cardiovascular Disease on [redacted]

Prior to the evaluation, I explained the claimant their rights under Title 8 CCR 40. I gave them the opportunity to ask questions. I answered all questions prior to proceeding with the evaluation.

The following history, physical examination, and review of medical records were performed by myself. Please note, I spent 1.0 hours in face-to-face time with this applicant.

HISTORY OF INJURY

This [redacted]-year-old man began working for the [redacted] as a [redacted] in [redacted]. The Joint Cover Letter notes a cumulative trauma claim involving the back, neck, heart/high blood pressure, bilateral feet, bilateral knees, and gastrointestinal system/acid reflux. There is also a right lower extremity claim in the form of varicose veins. Applicant retired [redacted]

The applicant entered employment with the [redacted] on [redacted] completing a [redacted] followed by [redacted] at the [redacted] Division, [redacted] Division, and subsequently the [redacted] Division, where he remained until retirement in [redacted]. For the majority of his career the applicant worked [redacted] and reported working evening and overnight shifts.

Medical records document a longstanding cumulative trauma history beginning during his tenure as a [redacted] Prior stipulated awards reflect industrial injury to the circulatory system, gastrointestinal system, spine, knees, feet, and other body parts over multiple cumulative trauma periods dating back to [redacted]. A prior AME by Dr. [redacted] formed the basis for a 45% permanent disability award related to the circulatory system with provision for future medical care.

Following a specific low back injury on [redacted], the applicant underwent orthopedic AME with [redacted]. Dr. [redacted] diagnosed lumbar ligamentous strain, degenerative disc disease, and lumbar spondylosis with radiculopathy. The applicant was found permanent and stationary, and a 13% WPI was opined, with apportionment of 90% industrial and 10% nonindustrial.

In [redacted], the applicant underwent internal medicine QME with Dr. [redacted] for obstructive sleep apnea. CPAP therapy initiated in [redacted] resulted in symptomatic improvement. A supplemental report dated [redacted] assigned 10% whole person impairment, with apportionment of 60% industrial and 40% nonindustrial due to obesity. Ongoing CPAP management was recommended. Subsequent stipulations in [redacted] awarded 0% permanent disability but preserved future medical care.

An internal medicine AME by Dr. [redacted] on [redacted] addressed a claim of hemorrhoids. Dr. [redacted] found the applicant permanent and stationary, assigned a 15% whole person impairment under Table 6-4 Class II, and apportioned 100% to industrial factors, including prolonged sitting and weight gain. Conservative treatment and potential procedural intervention were recommended.

The applicant underwent an AME for hearing loss and tinnitus with Dr. [redacted] on [redacted]. Diagnoses included bilateral sensorineural noise-induced hearing loss and tinnitus, apportioned 100% industrial. Hearing aids were recommended, along with laboratory screening. A 5% permanent disability award was later issued for bilateral hearing loss and tinnitus.

Pain management evaluations by Dr. [redacted] from [redacted] onward consistently documented cervical radiculopathy, lumbar radiculopathy, spinal stenosis, bilateral knee pain, and bilateral plantar fasciitis. Treatments included topical NSAIDs, oral anti-inflammatories, home exercise programs, physical therapy, and interventional procedures. A lumbar intralaminar epidural steroid injection was performed on [redacted] with reported benefit, followed by repeat injections on [redacted] with limited relief. A cervical epidural steroid injection on [redacted] produced good symptomatic and functional improvement.

An internal medicine AME by Dr. [redacted] addressed hypertension and gastroesophageal reflux disease. Dr. [redacted] noted ongoing use of NSAIDs 3-4 times weekly. Both conditions were found permanent and stationary and industrial in causation. GERD was rated at 7% whole person impairment with 100% industrial apportionment. Hypertension impairment and apportionment were deferred pending additional records. Lifelong medical management was recommended for both conditions.

Orthopedic AME by Dr. [redacted] on [redacted] diagnosed cervical disc disease, lumbar disc disease with stenosis, bilateral knee chondromalacia, bilateral plantar fasciitis, bilateral carpal tunnel syndrome, and right cubital tunnel syndrome. Dr. [redacted] opined that the cumulative trauma from [redacted] was a substantial contributing factor. He assigned combined regional impairments totaling 41% whole person impairment, with apportionment predominantly industrial, and recommended ongoing orthopedic, pain management, podiatric, and hand specialty care.

JOB DESCRIPTION:

The applicant's job duties include, but are not limited to enforcing local, state and federal laws, patrolling assigned geographic zones and responding to calls, driving a patrol car, apprehending and transporting suspects, interviewing victims, witnesses and suspects, gathering and logging evidence, writing citations, delivering warrants, and testifying in court, preparing reports documenting incidents and activities, responding to emergency and non-emergency situations, preventing and investigating illegal activities, domestic disturbances and accidents, participating in training activities. The applicant is required to use a gun belt, bullet proof vest, flashlights, batons, tasers, firearms and other equipment.

The physical requirements of the applicant's daily duties entailed prolonged standing and walking, repetitive bending, twisting, stooping, climbing, and descending stairs and ladders, repetitive movement of the upper and lower extremities, repetitive hand movement, gripping, grasping, pushing/pulling, and lifting and carrying up to 200+ pounds.

CONCURRENT EMPLOYMENT:

Applicant denies concurrent employment.

CURRENT WORK STATUS:

The applicant retired from employment with the [redacted] in [redacted]. He works as on-set security 2-3 times a month.

CURRENT COMPLAINTS:

The applicant reports a history of hypertension managed with medication and ongoing gastroesophageal reflux symptoms, including nocturnal reflux and dietary intolerance to spicy and acidic foods. He reports taking a 14-pack of Omeprazole about every month

He reports developing varicose veins in his right distal thigh and leg about 5-6 years ago. Primarily a cosmetic issue, he denies pain, bleeding or bruising, denies swelling.

The applicant reports episodes of palpitations 2-3 times a month, occur suddenly and last up to two minutes. He reports previous 24-hour and 72-hour monitoring did not reveal significant findings, but they are ongoing and sometimes associated with dizziness but no pre-syncope.

INDUSTRIAL INJURIES:

The records document multiple cumulative trauma industrial injuries during the applicant's employment with the [redacted], including injuries to the circulatory system/heart/high blood pressure, gastrointestinal system/acid reflux, spine, bilateral knees, and bilateral feet, with cumulative trauma periods dating back to [redacted]

NON-INDUSTRIAL INJURIES/AUTO/MOTORCYCLE ACCIDENTS:

Applicant denies.

PAST MEDICAL HISTORY:

1. Hypertension.
2. Hemorrhoids.
3. Gallstones.
4. Kidney stones.
5. Hiatal hernia.
6. Spinal stenosis.
7. Sleep apnea on CPAP

SURGERIES/HOSPITALIZATIONS:

1. Kidney stone surgery in the past.

SOCIAL HISTORY:

The applicant was born in [redacted]
Highest level of education is [redacted]
The applicant was in the [redacted] for [redacted] prior to [redacted]
The applicant is [redacted]
The applicant rarely consumes alcoholic beverages.
The applicant is a never smoker.

FAMILY HISTORY:

The applicant's father died at the age of [redacted] and had a history of diabetes mellitus, hypertension and coronary artery disease.

CURRENT MEDICATIONS:

1. Olmesartan 20mg
2. HCTZ 25mg
3. Aspirin 81mg
4. Omeprazole 20mg as needed (about every other day)
5. Ibuprofen as needed (2-3 times per week)

ALLERGIES: No known drug allergies.

ACTIVITIES OF DAILY LIVING:

Self-care and personal hygiene:	**Has difficulty**	**No difficulty**	**Description by Applicant**
Urinating		X	
Defecating		X	
Brushing teeth		X	
Combing hair		X	
Bathing		X	
Dressing oneself		X	
Eating		X	
Communication			
Writing		X	
Typing		X	
Hearing		X	
Speaking		X	
Physical Activity:			
Standing		X	
Sitting	X		
Squatting	X		
Walking		X	

Climbing stairs	X		
Sensory Function:			
Hearing	X		
Seeing		X	
Tactile feelings		X	
Tasting		X	
Smelling		X	
Nonspecialized hand functions:			
Grasping		X	
Gripping		X	
Lifting	X		
Carrying	X		
Travel:			
Riding		X	
Driving		X	
Flying		X	
Sexual Function:		X	
Orgasm			
Lubrication			
Ejaculation			
Erection			
Sleep			
Restful, nocturnal pattern		X	Sleeps well with CPAP
Other activities:			
Bending	X		
Stooping	X		
Reaching		X	
Kneeling		X	
Balancing		X	
Pushing		X	
Pulling		X	

REVIEW OF SYSTEMS:

Head: None
Eyes: None
Respiratory: No cough or asthma
Cardiovascular: No chest pain. Reports abnormal coronary calcium scan [redacted] years ago, told to take aspirin by his PCP.
Gastrointestinal: GERD as described, hemorrhoids claim previous settled, stable.
Genitourinary: None
Musculoskeletal: reports orthopedic pain
Neurological: None
Skin: None

PHYSICAL EXAMINATION:

Height: [redacted] Weight: [redacted] BMI: [redacted]
Vital signs: Blood pressure 142/76 right arm; Heart rate 80 bpm, Respirations 12/min
General: No acute distress, awake and alert.
HEENT: NCAT, sclerae anicteric, PERRL, EOMI, throat clear.

Neck: Supple, no significant jugular venous distention.

Carotid: Normal carotid upstrokes, no carotid bruit.

Lungs: Good inspiratory effort, no accessory muscle use, clear to auscultation bilaterally.

Heart: Regular rate and rhythm, normal S1/S2, no murmurs/rub/gallop.

Abdomen: Soft, nontender, nondistended. Normoactive bowel sounds.

Extremities: No edema. 3+ pedal pulses. Prominent, tortuous varicose veins noted along the right distal medial thigh extending into the proximal medial calf. No associated erythema, warmth, ulceration, or tenderness. Left with minimal spider veins but no varicosity.

Skin: No cyanosis, no clubbing.

Neuro: A&O x 3. Cranial nerves II through XII were intact and symmetric bilateral. No facial droop was noted. Able to move all extremities.

Psych: Alert and cooperative with interview.

REVIEW OF RECORDS:

528 pages of medical records were reviewed. I have included the salient features in my Review of Records section, which is appended to this report.

DOCUMENTED VITAL SIGNS AND INTERVENTIONS:

Date	Provider	BP	Weight	Medications/ Comments
[redacted]	[redacted]		[redacted]	Tramadol, ibuprofen, lisinopril, HCTZ, aspirin
[redacted]	[redacted]	128/74	[redacted]	IM QME: Sleep apnea dx 10/14/16. CPAP since February 2017
[redacted]	[redacted]	130/80	[redacted]	
[redacted]	[redacted]	114/79	[redacted]	97

[redacted]		[redacted]		112/72	[redacted]	96

EKG performed at [redacted]:

Normal sinus rhythm, non-specific intraventricular conduction delay; no acute ST T changes

Transthoracic Echocardiogram Performed at [redacted]

Demographics:

Height: [redacted]
Weight [redacted]

Structure	Dimension	Normal Value	Structure	Dimension	Normal Value
LVDd (mm)	45	< 58	LA (cm)	3.7	< 4
LVDs (mm)	31		Ao Root (cm)	2.9	< 4
IVSd (mm)	12	8-11	EF (%)	70	> 55
LVPWd (mm)	13	8-11	E/A	0.90	
RWT	0.56	(<0.42)			

Conclusion:

1. Left ventricle cavity is normal in size. Normal left ventricular wall thickness. Normal global wall motion. Visual EF is 60-65%.
2. Doppler evidence of grade I (impaired) diastolic dysfunction, normal left atrial pressure.
3. Normal valvular structures.
4. No pericardial effusion

Calculated from above data:

Left ventricular mass: 210 grams
Left ventricular mass index: 92 gm/m^2 (normal 49-115 gm/m^2) (1).

1. Lang, RM., et al. (2015). Recommendations for Cardiac Chamber Quantification by Echocardiography in Adults: An Update from the American Society of Echocardiography and the European Association of Cardiovascular Imaging. J Am Soc Echocardiogr. 281:1.

IMPRESSION:

1. HYPERTENSION
2. GERD
3. VARICOSE VEINS RIGHT LOWER EXTREMITY

4. PALPITATIONS

DISCUSSION:

This [redacted] year-old man began working for the [redacted] as a [redacted] in [redacted]. The Joint cover letter notes a cumulative trauma claim involving the back, neck, heart/high blood pressure, bilateral feet, bilateral knees, and gastrointestinal system/acid reflux.

There is a high blood pressure claim. The applicant denies pre-existing high blood pressure. Medical records document a diagnosis of hypertension requiring ongoing medical management. Normal to Stage 1 hypertension was noted while taking two blood pressure medications.

The applicant reports a history of gastroesophageal reflux symptoms extending over approximately [redacted] years, including heartburn, painless regurgitation, and worsening of symptoms in the recumbent position, with exacerbation from spicy foods and caffeine. In his Agreed Medical Evaluation dated [redacted] Dr. [redacted] diagnosed gastroesophageal reflux disease and concluded, within reasonable medical probability, that the condition was industrial in causation, attributing it primarily to prolonged occupational stress and chronic nonsteroidal anti-inflammatory medication use associated with the applicant's law enforcement duties. Dr. [redacted] further found the applicant permanent and stationary from an internal medicine standpoint, assigned a 7% whole person impairment pursuant to Table 6-3 of the AMA Guides, Fifth Edition, and recommended ongoing access to acid-suppressive therapy. These conclusions are consistent with the applicant's longitudinal symptom history, therapeutic response to antacid medication, and reported prior upper gastrointestinal endoscopy.

With respect to contributing risk factors for GERD, the applicant's daily aspirin use represents a non-industrial factor. The record reflects that aspirin was not prescribed for an accepted industrial condition, but rather appears to have been self-initiated due to an abnormal coronary calcium scan and family history of myocardial infarction and coronary artery disease in the applicant's father. While aspirin can contribute to upper gastrointestinal irritation, its use in this case is prophylactic and non-industrial in origin. When considered in totality, the applicant's GERD remains predominantly attributable to industrial factors identified by Dr. [redacted] including occupational stress and long-term NSAID exposure, with acknowledgment of limited non-industrial contribution from aspirin use. This distinction does not alter the diagnosis, MMI status, or need for future medical care, but is relevant when evaluating apportionment.

There is a varicose veins claim. The applicant denies pre-existing peripheral vascular disease or varicose veins. The applicant reports developing varicose veins in the right distal thigh and leg approximately five to six years ago. He describes this as primarily a cosmetic issue and denies associated pain, bleeding, bruising, or lower extremity swelling. On physical examination, prominent, tortuous varicose veins are noted along the distal medial aspect of the right thigh extending into the proximal medial calf. The varicosities are soft, compressible, and non-tender, without overlying skin changes, edema, stasis dermatitis, ulceration, or evidence of thrombophlebitis.

The applicant reports intermittent palpitations occurring approximately two to three times per month, with sudden onset and duration of up to two minutes. He reports prior 24-hour and 72-hour ambulatory monitoring without significant findings. Symptoms persist intermittently and are sometimes associated with dizziness, without syncope or near-syncope. To further evaluate these ongoing symptoms, a 14-day ambulatory cardiac monitor has been placed. **A supplemental medical-legal report will be issued upon completion and review of the monitoring results**.

Based on the available history, examination, and medical records, there is sufficient information to render medical-legal determinations regarding the applicant's hypertension, gastroesophageal reflux disease, and varicose veins. The following opinions are offered within a reasonable degree of medical probability.

CAUSATION:

Hypertension:

It **is** within a reasonable degree of medical probability that the applicant's hypertension injury was caused and/or aggravated by the work activities and job demands associated with his employment as a [redacted] with the [redacted]

The applicant denies pre-existing hypertension prior to his employment. The medical records document prolonged exposure to occupational stress, irregular and overnight shift work, and sustained physiologic stressors inherent in [redacted] over more than [redacted] decades. These factors are recognized contributors to the development and progression of hypertension and are consistent with the chronology and clinical findings documented in the Agreed Medical Evaluation performed by Dr. [redacted]

AOE/COE (Lab. Code, § 3600). The applicant's injury of hypertension arose out of employment and was caused by employment and **is AOE/COE**.

Gastroesophageal Reflux Disease (GERD)

It **is** within a reasonable degree of medical probability that the applicant's gastroesophageal reflux disease was caused and/or aggravated by the work activities and job demands associated with his employment as a [redacted] with the [redacted]

The applicant denies pre-existing GERD prior to his employment. The medical records document onset of reflux symptoms during his patrol assignment at the [redacted] Division, with symptoms temporally associated with occupational stress, irregular work hours, and chronic use of nonsteroidal anti-inflammatory medications for industrial orthopedic conditions. These factors are known to contribute to GERD and are consistent with the findings of the Agreed Medical Evaluation performed by Dr. [redacted]

AOE/COE (Lab. Code, § 3600). The applicant's injury of GERD arose out of employment and was caused by employment and **is AOE/COE**.

Varicose veins:

The applicant was found to have peripheral vascular disease to include varicose veins in the right lower extremity only.

Any conditions which would impair the return of blood from the extremities to the heart could aggravate or accelerate this condition. In this case, the applicant's daily duties, characterized by prolonged standing, ambulation, and sustained carrying load, constitute occupational exposures that aggravated his underlying venous pathology and accelerated the progression to chronic peripheral venous disease.

I opine within a reasonable degree of medical probability that the applicant's varicose veins disease was **aggravated by the physical demands and stresses of his employment as a** [redacted]

AOE/COE (Lab. Code, § 3600). The applicant's injury of varicose veins arose out of employment and was caused by employment and **is AOE/COE**.

PERMANENT AND STATIONARY:

Hypertension:

The applicant's hypertension is permanent and stationary for purposes of industrial disability. The applicant has reached maximum medical improvement as of [redacted] consistent with Dr. [redacted] Agreed Medical Evaluation.

GERD:

The applicant's gastroesophageal reflux disease is permanent and stationary for purposes of industrial disability. The applicant has reached maximum medical improvement as of [redacted] consistent with Dr. [redacted] Agreed Medical Evaluation.

Varicose veins:

The applicant was at MMI as of my evaluation and he is P&S on [redacted]

IMPAIRMENT:

Recent case law, Almaraz-Guzman II charges the rating physician with providing a Whole Person Impairment rating utilizing any chapter, table or method in the AMA Guides 5th Edition that most accurately reflects the injured claimant's impairment. The AMA Guides state, "impairment percentages or ratings developed by medical specialists are consensus derived, estimated to reflect

the severity of the medical condition and the degree to which the impairment decreases an individual's ability to perform common Activities of Daily Living, excluding work".

I opine that the Whole Person Impairment rating given in this report adequately addresses the legitimate objective medical factors in pathology and constitutes substantial medical evidence using the AMA Guides 5th Edition and taking into account Almaraz-Guzman II.

Hypertension:

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

There are no periods of disability related to hypertension.

Table 4-1 Classification of Hypertension in Adults

	Blood Pressure Categories			**Hypertension Categories**		
Blood Pressure	**Optimal**	**Normal**	**High Normal**	**Stage 1**	**Stage 2**	**Stage 3**
Systolic	<120	<130	130-139	140-159	160-179	≥180
	and	and	or	or	or	or
Diastolic	<80	<85	85-89	90-99	100-109	≥110

Adapted from the Sixth Report of the Joint National Committee on Prevention, Detection, Evaluation and Treatment of High Blood Pressure. *Arch Intern Med.* 1997;157:2413-2446.

Table 4-2 Criteria for Rating Permanent Impairment Due to Hypertensive Cardiovascular Disease

Class 1 0%-9% Impairment of the Whole Person	**Class 2** 10%-29% Impairment of the Whole Person	**Class 3** 30%-49% Impairment of the Whole Person	**Class 4** 50%-100% Impairment of the Whole Person

Asymptomatic; stage 1 or 2 hypertension without medication **or** normal blood pressure on anti-hypertensive medication **and** No evidence of end-organ damage	Asymptomatic; stage 1 or 2 hypertension despite multiple medications **or** anti-hypertensive medication with any of the following: (1) proteinuria, urinary sediment abnormalities, no renal function impairment as measured by the blood urea nitrogen (BUN) and serum creatinine; (2) definite hypertensive changes on fundoscopic examination in arterioles, e.g., "copper" or "silver wiring," or arteriovenous crossing changes with or without hemorrhages and exudates; either abnormality suggests end-organ damage	Asymptomatic; stage 3 hypertension despite multiple medications **or** anti-hypertensive medication with any of the following: (1) proteinuria, urinary sediment abnormalities, renal function impairment as measured by the BUN and serum creatinine, and a decreased creatinine clearance of 20% to 50% normal; (2) LV hypertrophy by ECG or echocardiography but no symptoms of HF; either abnormality suggests more extensive end-organ damage	Antihypertensive medication with stages 1-3 and any of the following abnormalities: (1) proteinuria, urinary sediment abnormalities, renal function impairment as measured by the BUN and serum creatinine, and a creatinine clearance < 20% normal; (2) hypertensive cerebrovascular damage or episodic hypertensive encephalopathy; (3) LV hypertrophy, systolic dysfunction, and/or signs and symptoms of HF due to hypertension.

5th Edition AMA Guides to the Evaluation of Permanent Impairment, page 66.

The applicant is noted to have normal-Stage 1 blood pressure while taking two blood pressure medications. Class 1 (0-9% WPI) includes hypertensive patients not taking blood pressure medications, or patients taking medications who have normal blood pressure and no evidence of end-organ damage. A strict interpretation of Class 2 (10-29% WPI) would include patients with uncontrolled hypertension taking multiple medications, or patient taking an anti-hypertensive medication who exhibit renal or retinal evidence of end-organ damage. Based upon a strict interpretation of the above table, the applicant would best fall into Class 2.

However, a strict Class 1 does not appear to accurately assess the true level of whole person impairment. The applicant is noted to have Stage 1 hypertension while taking two medications, and is noted to have evidence of hypertensive end-organ damage in the form of Grade 1 diastolic dysfunction. Diastolic dysfunction reflects myocardial stiffness which results in elevated filling pressures that can result in symptoms and in extreme cases progress to heart failure. Diastolic dysfunction is recognized by a consensus of opinion among cardiologists to represent the first manifestation of the impact of hypertension on the heart [JACC HF 2017. 5(8):543].

Another potential sign of hypertensive end-organ damage would be concentric remodeling or eccentric hypertrophy. The relative wall thickness is 0.56, which is elevated. An elevated relative wall thickness signifies that the left ventricle has undergone concentric remodeling or hypertrophy, typically as an adaptive response to chronic pressure overload such as from hypertension. Chronic pressure overload increases the afterload on the heart, prompting the left ventricle to thicken its walls inwardly (concentrically) to normalize wall stress and maintain cardiac output, leading to an elevated relative wall thickness. The applicant's echocardiogram report was reviewed. Left ventricular wall was interpreted as non-hypertrophied, making the echo findings most consistent with concentric remodeling.

An appropriate alternative methodology of rating would be to utilize Table 4-2, in a non-strict manner, and place the applicant in Class 2, given the presence of hypertensive end-organ damage in the form of diastolic dysfunction and concentric remodeling. There are no other tables in the AMA Guides 5th Edition that would more accurately address the true level of WPI.

Applicant does not meet Class 3 criteria, given the absence of LVH or renal dysfunction.

He is not Class 4 as he has no evidence of congestive heart failure or cerebrovascular impairment.

I opine with reasonable medical probability that a whole person impairment rating of 20% is accurate and reflective of the applicant's condition.

The presence of diastolic dysfunction and concentric remodeling does constitute "heart trouble" as pertains to LC 3212.

Gastroesophageal Reflux Disease (GERD)

The applicant's gastroesophageal reflux disease remains appropriately rated at 7% Whole Person Impairment, as previously determined by Dr. [redacted]. There is no medical basis to alter or increase this impairment rating.

Varicose veins:

There are no periods of disability related to the applicant's varicose veins.

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

Table 4-5 Criteria for Rating Permanent Impairment of the Lower Extremity Due to Peripheral Vascular Disease

Class 1 0%-9% Impairment of the Lower Extremity	Class 2 10%-39% Impairment of the Lower Extremity	Class 3 40%-69% Impairment of the Lower Extremity	Class 4 70%-89% Impairment of the Lower Extremity	Class 4 90%-100% Impairment of the Lower Extremity

Neither intermittent claudication nor pain at rest **or** only transient edema **and** on physical examination, not more than the following findings are present: loss of pulses; minimal loss of subcutaneous tissue; calcification of arteries as detected by radiographic examination; asymptomatic dilation of arteries or of veins, not requiring surgery and not resulting in curtailment of activity	Intermittent claudication on severe usage of the lower extremity **or** persistent edema of a moderate degree, controlled by elastic supports **or** vascular damage evidenced by a sign such as a healed, painless stump of an amputated digit showing evidence of persistent vascular disease, or a healed ulcer	Intermittent claudication on walking as few as 25 yards and no more than 100 yards at average pace **or** marked edema that is only partially controlled by elastic supports **and** vascular damage evidenced by a sign such as healed amputation of two or more digits of one extremity, with evidence of persisting vascular disease or superficial ulceration	Intermittent claudication on walking less than 25 yards, or intermittent pain at rest **or** marked edema that cannot be controlled by elastic supports **or** vascular damage as evidenced by signs such as an amputation at or above an ankle, or amputation of two or more digits of two extremities with evidence of persistent vascular disease; or persistent widespread or deep ulceration involving one extremity	Severe and constant pain at rest **or** vascular damage evidenced by signs such as amputation at or above the ankles of two extremities, or amputation of all digits of two or more extremities with evidence of persistent, widespread, or deep ulceration involving two or more extremities

5th Edition AMA Guides to the Evaluation of Permanent Impairment, page 76.

According to the above chart, the applicant's right lower extremity would be most accurately placed into Class 1. The applicant is noted to have large varicosities involving the right distal thigh and leg/calf; however, there is no evidence of intermittent claudication, pain at rest, ulceration, or activity curtailment. Importantly, there is no persistent or marked edema documented, and the venous dilation does not require surgical intervention. The presence of varicosities alone, despite their large size, in the absence of functional vascular compromise, falls within the criteria for asymptomatic dilation of veins as described in Class 1. Given the extent and prominence of the varicosities involving both the distal thigh and proximal calf, placement at the upper end of the Class 1 range is medically reasonable despite the absence of functional limitation.

The applicant does not meet criteria for Class 2, as there is no documentation of intermittent claudication even with severe usage of the lower extremity, nor is there persistent edema of a moderate degree requiring control with elastic supports. Additionally, there is no evidence of healed ulcers or vascular damage indicative of more advanced disease.

The applicant does not meet criteria for Class 3, as there is no history of intermittent claudication occurring at distances of 25 to 100 yards, no marked edema partially controlled by elastic supports, and no evidence of vascular damage such as digit amputation or superficial ulceration.

The applicant does not meet criteria for Class 4, as there is no intermittent claudication at distances less than 25 yards, no pain at rest, no marked edema that is unresponsive to elastic supports, and no vascular damage such as amputations or persistent ulceration.

In accordance with the AMA Guides, Fifth Edition, vascular impairment due to chronic venous insufficiency is assessed separately for each lower extremity using Table 4-5. Each lower extremity impairment percentage is then converted to whole person impairment using Table 17-3 on page 527.

I opine within a reasonable degree of medical probability that a 9% impairment of the right lower extremity is accurate and reflective of the applicant's condition.

Lower extremity impairment is converted to whole person impairment using Table 17-3 on page 527. The applicant's right lower extremity varicose veins condition, rated at **9% lower extremity impairment**, converts to **4% whole person impairment.**

APPORTIONMENT:

Hypertension:

From a medical perspective and in my apportionment determination, I have considered a number of conditions as they apply to the applicant including the absence of pre-existing hypertension, presence of family history of hypertension, work duties, work hours and shift work.

The guidelines for the detection, evaluation and treatment of hypertension have been revised and published in the past 10 months and have been reviewed and incorporated in this report [Hypertension 2018;71(6): e113–e115]. Although these guidelines comport a lower level of optimal blood pressure control, The AMA Guides, 5th edition have been employed in the analysis of the applicant and the rating of his impairment.

In considering the specific contribution of the occupation of the applicant as a [redacted] Kales and colleagues reviewed the prevalence of hypertension in [redacted] and comparing that data to the NHANES data cited above suggests that the risk of hypertension in [redacted] may be as much as 15-20% higher than [redacted] comparably aged in the general population [Am J Hyperten. 2009;22(1), 11-20].

One study showed people who worked more than 40 hours per week had an increased risk for both masked and sustained hypertension. The risk climbed even higher for those who worked more than 49 hours a week (Hypertension 2020: 75(2), 532-538).

I apportion 80% of the applicant's hypertension impairment to industrial conditions which include his work duties and work hours, shift work and industrial obstructive sleep apnea.

I apportion 20% of the applicant's hypertension impairment to non-industrial conditions which include his family history and obesity.

The presence of diastolic dysfunction and concentric remodeling does constitute "heart trouble" as pertains to LC 3212.

GERD:

From a medical perspective and in my apportionment determination, I have considered the factors relevant to the applicant's gastroesophageal reflux disease. The applicant denies any history of gastroesophageal reflux disease prior to his employment. The medical records document the onset of reflux symptoms during his patrol assignment at the [redacted] Division, with contributing industrial factors including prolonged occupational stress, irregular and overnight work hours, duty belt use, and chronic use of nonsteroidal anti-inflammatory medications for treatment of accepted industrial orthopedic conditions. These are recognized contributors to the development and persistence of gastroesophageal reflux disease and are temporally and clinically consistent with the applicant's longitudinal symptom history.

I agree with the apportionment analysis and conclusions reached by Dr. [redacted] in his Agreed Medical Evaluation dated [redacted] who found the applicant's gastroesophageal reflux disease to be predominantly industrial in nature. However, I have additionally considered the applicant's daily aspirin use as a distinct non-industrial contributing factor.

The medical records reflect that aspirin was prescribed for primary cardiovascular risk reduction in the setting of an abnormal coronary calcium scan, in the absence of established coronary artery disease. As such, the aspirin use represents non-industrial preventive medical management rather than treatment of an accepted or industrially caused cardiac condition. Aspirin is independently associated with gastrointestinal mucosal irritation and reflux symptoms and therefore represents a non-industrial contributing factor to the applicant's gastroesophageal reflux disease.

I apportion 90% of the applicant's GERD impairment to industrial conditions which include his work duties, work hours, duty belt use, and industrial NSAID use.

I apportion 10% of the applicant's GERD impairment to non-industrial conditions which include his non-industrial aspirin use.

Varicose veins:

From a medical perspective and in my apportionment determination, I have considered a number of conditions as they apply to the applicant's peripheral vascular disease/varicose veins. The applicant demonstrates large varicosities involving the right distal thigh and leg/calf. I have considered non-industrial factors, including pre-existing obesity, which is a recognized risk factor for venous disease.

I have also considered industrial factors related to the applicant's cumulative trauma employment as a [redacted] including prolonged standing duties, prolonged duty hours, and sustained gravitational venous loading of the lower extremities over the course of more than [redacted] years of service. These occupational factors are known contributors to the development, progression, and clinical manifestation of venous insufficiency and varicosities over time.

I apportion 80% of the applicant's varicose veins disease impairment to the cumulative trauma related to his employment as a [redacted] and specifically to the prolonged standing duties and prolonged duty hours over [redacted] years of service.

I apportion 20% of the varicose veins disease disability to non-industrial conditions to include his pre-existing obesity.

WORK RESTRICTIONS:

There are no restrictions in regard to the applicant's hypertension, GERD, or varicose veins.

FUTURE MEDICAL CARE

The applicant should have a provision for his medications and medical management with periodic visits with his primary treating physician to treat his hypertension.

The applicant will require future medical care for gastroesophageal reflux disease on an industrial basis. This includes access to an internist, gastroenterologist, or family physician, continued use of acid-suppressive medications such as H2 blockers or proton pump inhibitors, dietary counseling as needed, and follow-up evaluations should symptoms worsen or change.

The applicant should be afforded follow-up on an industrial basis to include periodic visits and any diagnostic testing as determined by his treating physician to treat the varicose veins condition found in the lower extremity. The applicant should have a provision for any medications and medical management to treat varicose veins condition found in the lower extremities.

BASIS FOR OPINION:

The opinions expressed in this report are based upon the applicant's history, the physical examination; the medical records reviewed, and the training, knowledge, and experience of this examiner with over 27 years of experience as a board-certified internist and 23 years as a board-certified cardiologist. All opinions expressed were based on a reasonable degree of medical probability and are subject to amendment in the event that new information is brought forward.

DISCLOSURE

I hereby declare under penalty of perjury that I have not violated Labor Code Section 139.3 and that the contents of this report are true to the best of my information and belief. 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.

In compliance with Labor Code Section 5703(A)(1), I, Kirk Y. Chang, M.D., F.A.C.C., the consulting physician, 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. I declare under penalty of perjury that I did not discriminate in any way against the parties to the action or the injured worker in the evaluation process or in the content of the report.

I have addressed the issues of apportionment within the body of this report in accordance with Labor Code 4663(c). If I have assigned disability caused by factors other than the industrial injury, that level of disability constitutes the apportionment. The ratio of nonindustrial disability, if any, to all described disability represents my best medical judgment as to the percentage of disability caused by the industrial injury and the percentage of disability caused by other factors, as defined in Labor Code Section 4663 and 4664.

In compliance with Workers' Compensation legislation (Labor Code Section 4628 (b)): I declare that the history was obtained by Daniela Ferrario, medical historian, by virtue of her training and experience. The report was edited for formatting, grammar and spelling by [redacted] *Medical Editor. Summary of medical records were done by* [redacted] *Review of history with the patient, review of medical records, physical examination, reading of x-rays, medical dictation/review of final report by myself in compliance with the guidelines established by the Industrial Medical Council or the Administrative Director pursuant to paragraph (5) of subdivision (j) of Section 139.2.*

The undersigned further declares under penalty of perjury that to the best of their knowledge and belief they did not discriminate in any way against the parties to the action or the injured worker in the evaluation process or in the content of the report.

I further declare and verify under penalty of perjury, pursuant to 8 C.C.R. §9795 that ***528 pages of records*** *were reviewed by myself as part of the medical-legal evaluation and preparation of this report.*

This report is prepared and signed in the County of Los Angeles, California on January 6, 2026.

Sincerely,

CHANG MD

KIRK Y. CHANG, M.D., F.A.C.C.
Cardiovascular Diseases
Diplomate of the American Board of Internal Medicine
Diplomate of the American Board of Internal Medicine, Cardiovascular Diseases
Qualified Medical Examiner

KC/ACU/

REVIEW OF RECORDS

ATTESTATIONS/DECLARATIONS:

[redacted] Declaration.
Attesting to 528 pages of records being forwarded for review.

COVER LETTERS:

[redacted] Joint AME Letter.

MEDICAL RECORDS:

[redacted] Stipulations with Request for Award.
DOI: CT: [redacted]
The patient was employed by the [redacted] as a [redacted] The parties stipulated that the cumulative injury end date was [redacted] 45% permanent disability was awarded for the Circulatory System. Per the AME report of Dr [redacted] there is a need for future medical treatment. Comments: 1) The patient's disability is based on the report of AME Dr [redacted] Dated [redacted]: Disability is contemplated as follows- 04.01.00 00-30[5)38-4901-47-45. 2) The patient is entitled to future medical care. 3) The date of injury is amended to a cumulative trauma period from [redacted] ending on [redacted].

[redacted]. Award.
The award is made in favor of the patient against the [redacted] /Tristar [redacted].

[redacted] Agreed Medical Examination. THE GREATER [redacted] ORTHOPAEDIC SURGICAL AND MEDICAL GROUP
DOI: [redacted].
Chief Complaint: Low back pain that radiates down the right lower extremity at times reaching his ankle, with intermittent numbness and tingling in the right lower extremity.
History of Present Illness: The patient is a [redacted] who needs to perform all the duties related to law enforcement. The patient states that his pain relates to work related injury that happened while getting ready to put on a [redacted] He describes twisting and turning while donning his duty belt, experiencing an acute onset of low back pain that was sharp in nature and radiating to the right lower extremity.
Diagnosis: 1) Lumbar spine ligamentous strain. 2) Lumbar spine degenerative disc disease. 3) Lumbar spine spondylosis with radiculopathy.
Comments: At this time, the patient's condition has stabilized and is maximally medically improved and permanent and stationary as of the date of this examination.
Work Restrictions: The patient may continue working his regular duties without restrictions.

Causation/Apportionment: According to the examiner's opinion, 10% of the patient's current disability causation is apportioned to the natural history and progression of organic disease of the lumbar spine, including degenerative disc disease and facet disease. The remaining 90% of causation of his current level of disability is apportioned to the industrial injury as described.
Disability: The patient is rated using the AMA Guides to the Evaluation of Permanent Impairment, 5th Edition, using the lumbar DRE Category III with a 13% Impairment of the Whole Person for findings of radiculopathy including pain in a dermatomal distribution in the right lower extremity and reproducible pain, numbness and tingling symptoms in the right lower extremity in the dermatomal distribution consistent with lumbar spine disc injury. Therefore, the patient's signs and symptoms place him in the DRE Lumbar Category III on Table 15-3, page 384.
Future Medical Care: If the patient's condition worsens patient would be referred to orthopedic evaluation and treatment, which include use of anti-inflammatories, analgesics, antispasmodics, injections in the form of epidural steroid injections, facet blocks or rhizotomies, physical therapy, chiropractic, acupuncture, lumbar bracing and the provision for lumbar spine surgery.

[redacted] Stipulations with Request for Award.
DOI: CT: [redacted] and still ongoing.
Injury: The patient was employed by the [redacted] as a [redacted] 23% permanent disability was awarded for the low back. Comments: The parties agree to resolve this case based on the medical reporting of Dr [redacted] report dated [redacted]

[redacted] Award.
The award is made in the favor of the patient against the [redacted].

[redacted], MD
[redacted]. Panel Qualified Medical Evaluation in Internal Medicine.
DOI: [redacted]
Subjective Complaint: The patient reports that his primary complaint related to his sleep apnea is the discomfort he has when using the machine. Occasionally, he has a dry throat and a bloody nose.
History of Present Illness: The patient states that he was diagnosed with sleep apnea as he was having a snoring problem that worsened over the last few years. The patient has been on CPAP since [redacted], due to which he feels less tired.
Diagnosis: Obstructive sleep apnea, industrial, related to a prior industrial musculoskeletal injury.
Causation: The patient's obstructive sleep apnea is considered an industrial condition.
Disability: The examiner defers determining permanent and stationary status until he has detailed reports of obstructive sleep apnea and specific dates of when he started CPAP treatment.
Impairment Rating/Apportionment: The examiner defers rating impairment and apportionment until he have further medical records detailing a recent sleep study.
Future Medical Care: The patient should follow up with his primary care physician for continued management of the obstructive sleep apnea.

[redacted] MD

[redacted] Agreed Medical Examination in Internal Medicine.
Comments: The patient has reached the status of maximal medical improvement with regard to his internal medical health. He has had no periods of temporary total disability based on his hemorrhoidal condition.
Impairment Rating: The patient would be best classified within Class II of Table 6-4 and specifically with a 15% permanent impairment rating.
Apportionment: The patient's lower GI tract condition/hemorrhoids would be seen to be 100% industrial in nature due to a combination of industrial weight gain as well as a history of prolonged sitting. Each and both of these are causative in the development of a hemorrhoidal condition. Therefore, 100% of the patient's impairment per Table 6-4 would be apportioned to industrial causation absent evidence to the contrary.
Future Medical Care: The patient should be treated conservatively with Sitz baths, topical creams/ointments, or he may require some form of procedure, such as banding or surgery.

[redacted] Agreed Medical Examination. [redacted]
DOI: CT: [redacted]
Chief Complaints: The patient's primary complaint is that he has difficulty understanding people when they speak to him in crowds, meetings and restaurants. He further indicates ringing/buzzing in both ears
History of Present Illness: The patient complains of constant ringing in both ears that began two to three years ago. He reported there was no specific incident that caused the ringing to start. When it starts, it lasts all day. He has had noise for one and a half years. The sound has changed over time. The sound becomes louder. He describes this as occurring constantly and sounding like a low-pitched ringing/buzzing noise. Nothing seems to make the ringing better. The patient noted loud noises make the ringing worse. He experienced the feeling of fullness or pressure in both ears. He experienced pain in both ears. He did experience itching in both ears.
Diagnoses: 1) Sensorineural noise-induced hearing loss. 2) Tinnitus.
Discussion: The patient needs to be fitted with aids to improve his communication abilities.
Apportionment: It is the examiner's further opinion that the hearing loss as it now exists in both ears is (100%) related to this employment. (0%) is non-industrial. The approximate percentage directly resulting from the industrial exposure is (100%).
[redacted] The examiner is trying to confirm what the actual impairment is in this patient's activities of daily living. The examiner would look at the complaints and offer a 2% overall impairment for hearing.
Future Medical and Monitoring: It is the examiner's recommendation that the patient have testing done to include serum zinc, lead, magnesium, B12, folate, vitamin D, iron and thyroid function studies. If any of these are abnormal, proper treatment should be given, and the hearing and tinnitus should be retested afterwards. However, if no abnormalities are noted, the patient will be considered permanent and stationary at that time.
Work Restrictions: The patient should always use the hearing aids in the workplace. In the event there is potential for loud noise exposure, he should use large earmuffs over the hearing aids.
Rehabilitation: Rehabilitation is not an issue in this case.

[redacted]. Stipulations with Request for Award.
DOI: [redacted]
The patient was employed by the [redacted] as a [redacted] The parties stipulated that the specific injury occurred on [redacted]. 28% permanent disability was awarded for hemorrhoids. The period of temporary disability was from NLT through [redacted]. Per the AME report of Dr, there is a need for medical treatment.

[redacted] Award.
Award is made in favor of the patient against the [redacted] PS1.

[redacted] Qualified Medical Evaluator's Supplemental Report in Internal Medicine .
Discussion: The examiner's diagnostic impression is unchanged from his initial report, and the examiner still considers his obstructive sleep apnea to be an industrially related condition.
Impairment Rating: The examiner assigns him a 10% whole person impairment.
Apportionment: For his issue of obstructive sleep apnea, the examiner approves 60% to industrial causation and 40% to nonindustrial causation due to his body habitus and pre-existing obesity.
Future Medical Care: The patient should continue to follow up with his primary treatment physician for continued management of his obstructive sleep apnea.

[redacted] Stipulations with Request for Award.
DOI: [redacted]
The patient was employed by the [redacted] as a [redacted] The parties stipulated that the cumulative injury end date was [redacted]. 5% permanent disability was awarded for bilateral hearing loss and tinnitus. The period of temporary disability was from N/A through N/A. Per the AME report of Dr, there is a need for medical treatment.

[redacted] Award.
Award is made in favor of the patient against [redacted] PS1.

[redacted] Stipulations with Request for Award.
DOI: [redacted]
The patient was employed by the [redacted] as a [redacted] The parties stipulated that the cumulative injury end date is [redacted] 0 % permanent disability was awarded for obstructive sleep apnea. The period of temporary disability was adequately compensated. Per the AME report of Dr, there is a need for medical treatment.

[redacted] Award.
Award is made in favor of the patient against [redacted] PS1.

[redacted] MRI of Lumbar Spine without Contrast. DYNAMIC UPRIGHT MRI

Impression: 1) Mild levoconvex scoliosis of the lumbar spine. 2) Disc desiccations noted at all lumbar levels. 3) There is grade I anterolisthesis of L4 over L5. 4) Grade I retrolisthesis of L5 over S1. 5) Reduced intervertebral disc space noted at all lumbar segments. 6) Modic type II endplate degenerative changes noted at L1-2 through L5-S1. 7) Schmorl's nodes noted at L1 to L5. 8) Posterior annular tear noted at L2-3 and L4-5. 9) L2-L1 level: A 4.3 mm broad-based disc protrusion with moderate bilateral facet joint arthropathy. It is associated with hypertrophy of the ligamentum flavum. Together, these findings are causing mild spinal canal stenosis. Lateral recesses are stenosed. There is moderate bilateral neural foraminal stenosis causing compression over the exiting and transiting nerve roots. 10) L1-L2 level: A 2.2 mm broad-based disc protrusion with moderate bilateral facet joint arthropathy. It is associated with hypertrophy of the ligamentum flavum. Together, these findings are causing mild spinal canal stenosis. Lateral recesses are stenosed. There is moderate bilateral neural foraminal stenosis causing compression over the exiting and transiting nerve roots. 11) L2-L3 level: A 6.6 mm broad-based disc protrusion with moderate bilateral facet joint arthropathy. It is associated with hypertrophy of the ligamentum flavum. Together, these findings are causing severe spinal canal stenosis. Lateral recesses are stenosed. There is severe bilateral neural foraminal stenosis causing compression over the exiting and transiting nerve roots. 12) L3-L4 level: A 4.4 mm broad-based disc protrusion with moderate bilateral facet joint arthropathy. It is associated with hypertrophy of the ligamentum flavum. Together, these findings are causing mild spinal canal stenosis. Lateral recesses are stenosed. There is moderate bilateral neural foraminal stenosis causing compression over the exiting and transiting nerve roots. 13) L4-L5 level: A 6.2 mm broad-based disc protrusion with moderate bilateral facet joint arthropathy. It is associated with hypertrophy of the ligamentum flavum. Together, these findings are causing severe spinal canal stenosis. Lateral recesses are stenosed. There is severe bilateral neural foraminal stenosis causing compression over the exiting and transiting nerve roots. 14) L5-S1 level: A 4.3 mm broad-based disc protrusion with moderate bilateral facet joint arthropathy. It is associated with hypertrophy of the ligamentum flavum. Together, these findings are causing moderate to severe spinal canal stenosis. Lateral recesses are stenosed. There is moderate to severe bilateral neural foraminal stenosis causing compression over the exiting and transiting nerve roots.

[redacted] Initial Pain Management Evaluation. PAIN & WELLNESS CENTERS OF [redacted]

DOI: [redacted]

Chief Complaint: The patient is a [redacted] year-old male. He is here today for a new patient consultation.

Injury/Accident Description: The patient reports repetitive motion trauma is associated with his work duties during [redacted] which caused pain to the neck radiating to both upper extremities and to the lower back radiating to both lower extremities.

Subjective Complaints: Neck pain: The neck pain occurs frequently. The pain radiates to the bilateral upper extremities. The patient's pain is accompanied by tingling and numbness. The patient describes the pain as aching, pins and needles, shooting, sharp, and stabbing with moderate severity. The pain is aggravated by flexion/extension and rotation. Low back pain: The low back pain is frequent. The pain radiates to the bilateral lower extremities, R>L. The patient's pain is accompanied by tingling and numbness. The patient described the pain as

aching, sharp, pins and needles, and shooting with moderate severity. The pain is aggravated by bending, lifting, rotation, and twisting. Lower extremity pain: both feet, both knees, the same. The pain is intermittent. The pain is aggravated by flexion/extension and prolonged walking. The patient described the pain as aching, dull, and sharp with moderate severity. Pain level today is 5/10. Onset of Pain: The onset of pain was insidious. The frequency of pain is frequent, worse after activity and worse during an activity. The pain has occurred for 8 years. The associated symptoms are awakening from sleep, insomnia, and leg numbness. Activities that aggravate the pain include all movement, bending forward, exercise, lifting objects, rotating the neck, standing for long periods, and walking long distances. Activities that relieve pain include lying flat, resting, and sitting.
Past Medical History: Patient has a history of hypertension and chronic pain.
Past Surgical History: The patient's surgical history includes kidney stone removal.
Diagnoses: 1) Cervical radiculitis. 2) Cervicalgia. 3) Cervical strain/sprain. 4) Lumbar radiculitis. 5) Lumbar disc degeneration. 6) Lumbar disc displacement. 7) Spinal stenosis. 8) Lumbago. 9) Bilateral foot pain. 10) Bilateral knee pain. 11) Plantar fasciitis bilateral.
Treatment Plan: Procedure Request: LESI (Lumbar intralaminar epidural steroid injection. Open MRI Request: cervical spine without contrast, left knee and right knee. The patient will follow up for an appointment in 6 weeks.
Medications: Diclofenac gel 1%.
Work Status: Retired.

[redacted] Pain Management Re-Evaluation. PAIN & WELLNESS CENTERS [redacted]
DOI: [redacted]
Subjective Complaints: Pain level is usually a 6/10. Severe pain level: 9/10. Pain level today is 8/10.
Interval History: Referral for epidural pending. The patient reports low back pain with numbness/tingling that radiates to both lower extremities and both feet. Pain is worse with prolonged standing and relieved with rest. The patient had a previous epidural injection in [redacted] with good improvement and requests another injection. The patient has a GI problem with ibuprofen and will trial Celebrex. He has tried conservative treatment, including physical therapy and chiropractic therapy, in the past. The patient states the epidural was most effective, and he had good relief from the last injection.
Diagnoses: Essentially unchanged.
Treatment Plan: Procedure Request: LESI (Lumbar intralaminar epidural steroid injection. Open MRI Request: cervical spine without contrast, left knee and right knee. The patient will follow up for an appointment in 6 weeks.
Medications: Diclofenac gel 1%. Celebrex 100 mg.
Work Status: Essentially unchanged.

[redacted]. Agreed Medical Evaluator's Medical Legal Report.
DOI: CT [redacted].

Job Description: The patient began his career with the [redacted] on [redacted]. That was the date he entered the [redacted] program. Following the successful completion of his training, the patient was assigned to [redacted] at the [redacted] for his probationary year. After one year, he was reassigned to the [redacted] Division, also on [redacted] for the following year. In [redacted], he was again redeployed as a [redacted] at the [redacted] Division and remained at the [redacted] Division for the rest of his career, until his retirement in [redacted]. He has served as a [redacted] during that entire period of time. Over the years, he generally worked from 6:00 p.m. to 6:00 a.m. He had this shift for over [redacted] years of his career. He retired from the [redacted] in [redacted].

History of Injury: The patient states that as a result of his [redacted] for the [redacted], in [redacted], he began to experience cervical and lumbar pain as well as bilateral knee pain. He states these issues were not the result of a specific injury, but rather due to the wear and tear of being an [redacted] officer for such a prolonged period of time. Over the years, he has had numerous MRIs of his cervical and lumbar spine as well as his bilateral knees. He has also been offered physical therapy sessions and acupuncture treatments. Over the years, he has either been prescribed or taken over-the-counter anti-inflammatory medication in an effort to control his orthopedic issues. He continues to require ibuprofen three to four times a week. The patient has hypertension. He cannot recall exactly when he was diagnosed with high blood pressure. He states he has reflux symptoms. He states his reflux began when he began as a [redacted] at the [redacted] Division. He is occasionally awakened at night with reflux symptoms. He will avoid spicy and acidic foods as these items will aggravate his reflux symptoms.

Past Medical History: 1) Hypertension. 2) GERD.

Family History: The father of the patient died at the age of [redacted]. He had diabetes mellitus and coronary artery disease.

Vitals: Weight [redacted] Height: [redacted] BMI: [redacted]

Diagnoses: 1) Orthopedic injuries not addressed. 2) Hypertension. 3) Gastroesophageal reflux disease.

Discussion: Hypertension: Disability Status: The patient is permanent and stationary for industrial disability rating purposes from an internal medicine standpoint. He has reached the point of maximal medical improvement. Causation: It is, therefore, with reasonable medical probability that the hypertensive disorder of the patient has been caused on an industrial basis. Impairment Rating: At the present time, an impairment rating for the patient hypertensive disorder is being deferred pending receipt of the medical records from his primary physician, Dr. [redacted]. Apportionment: Apportionment is similarly being deferred pending the receipt of the above study. Future Medical Care: The patient requires care by an internist, cardiologist or family physician skilled in the care of hypertension. He should see his doctor between four and six times per year, depending on the level of hypertensive control. He requires annual cardiovascular testing (including labs). He requires lifelong access to antihypertensive medication. Gastroesophageal Reflux Disease: Disability Status: The patient is permanent and stationary for industrial disability rating purposes from an internal medicine standpoint. He has reached the point of maximal medical improvement. Impairment Rating: The patient has 7% whole person impairment. Apportionment: Apportionment is 100% industrial. Future Medical Care: The patient requires access to a gastroenterologist, internist or family physician skilled in

the care of gastrointestinal issues. He requires acid-suppressing medications, such as H2 blockers or proton pump inhibitors, and should have access to these medications indefinitely on an industrial basis.

[redacted]. MRI of Cervical Spine without contrast. DYNAMIC UPRIGHT MRI
Impression: 1) Marked straightening of cervical lordotic curvature without segmental malalignment, denoting spastic muscles, acute in etiology. 2) Slight grade anterolisthesis of C5 over C6 vertebra is noted, acute to indeterminate in etiology. 3) Disc desiccation at all cervical levels with preserved heights, chronic in etiology. 4) Small anterior and posterior osteophytes at C3-4, C4-5, C5-6, and C6-7 levels, chronic in etiology. 5) There are focal T2W hyperintense signals in the posterior annular fibers of the C4-C5 disc, suggesting an annular tear, which may cause severe pain, acute in etiology. 6) Perineural cysts noted in bilateral neural foramina at the C6-7 level, a larger one on the right measures about 10.7 x 7.2 mm, indeterminate in etiology. 7) C3-4 level: A 2.1 mm diffuse disc bulge with mild facet joint arthropathy effacing the ventral thecal sleeve. There is mild right neural foraminal stenosis resulting in impingement of the right-sided nerve roots. There is no compromise of the lateral recesses or traversing nerve roots. 8) C4-5 level: A 2.4 mm diffuse disc bulge with mild facet joint arthropathy effacing the ventral thecal sleeve. There is minimal bilateral neural foraminal narrowing without compromise of the nerve roots. There is no compromise of the lateral recesses or traversing nerve roots. 9) C5-6 level: A 2.7 mm diffuse disc bulge with mild facet joint arthropathy effacing the ventral thecal sleeve. There is minimal bilateral neural foraminal narrowing without compromise of the nerve roots. There is no compromise of the lateral recesses or traversing nerve roots. 10) C6-7 level: A 3.2 mm diffuse disc bulge with mild facet joint arthropathy effacing the ventral thecal sleeve. There is minimal bilateral neural foraminal narrowing without compromise of the nerve roots. There is no compromise of the lateral recesses or traversing nerve roots. 11) The disc bulges at all levels are indeterminate in etiology.

[redacted] Pain Management Re-Evaluation. PAIN & WELLNESS CENTERS [redacted]
DOI: [redacted]
Subjective Complaints: Pain level today: 8 (L/S) 8 (BLE); 8 (C/S) 8 (BUE); 7 (R I knee); 6 (L knee)/10.
Interval History: The patient returns to care; the patient is unsure if the claim has been officially accepted yet. AME from [redacted] by D[redacted] found an industrial injury, and the patient is not MMI. AME had recommended updated testing and referral to the podiatrist for orthotics due to bilateral plantar fasciitis. Per the patient, both AME ordered tests have been completed: MRI C/S [redacted] completed, Dynamic MRI [redacted] EMG/NCV completed in [redacted] will obtain to review. The patient has been told in the past that he is not a surgical candidate for L/S, and the patient is not interested in pursuing surgery anyway. The patient has received good benefit from the previous epidural injection provided by the previous PM doctor. Now that the claim has been approved, will re-request LESI.
Diagnoses: Essentially unchanged.

Treatment Plan: Procedure Request: LESI (Lumbar intralaminar epidural steroid injection. Open MRI Request: cervical spine without contrast, left knee and right knee. The patient will follow up for an appointment in 6 weeks.
Podiatrist request for evaluation and treatment.
Medications: Diclofenac gel 1%. Discontinue Celebrex 100 mg.
Work Status: Retired. Per AME/QME, the patient can perform modified work duties with no heavy lifting, no repetitive bending, no prolonged sitting, and no above shoulder-level work.

[redacted]
DOI: [redacted]
Subjective Complaints: The patient complains of pain in the bottom of both heels, which occurs with pressure and when on foot for long periods of time. Pain also occurs with the first steps following a period of rest. The patient relates that he was previously treated on a private basis with over-the-counter inserts, which he continues to use.
Diagnosis: 1) Plantar fascial fibromatosis. 2) Calcaneal spurs right foot. 3) Calcaneal spurs left foot.
Treatment: Requested Physical therapy. Advised to continue over-the-counter inserts. Advised to continue normal daily activities as tolerated.
Work Status: As per the primary care physician.

[redacted] Televisit Note. PAIN & WELLNESS CENTERS
DOI: [redacted]
Subjective Complaints: Neck pain, low back pain, lower extremity pain. Pain level today is 8 (L/S); 8 (BLE); 8 (C/S); 8 (BUE); 7 (R knee); 6 (L knee)/10. The recent change is the same.
Interval History: The patient is endorsing lower back pain with associated radicular symptoms of the bilateral lower extremities.
Diagnosis: 1) Cervicalgia. 2) Lumbago with sciatica, unspecified side. 3) Other intervertebral disc degeneration, lumbar region. 4) Other intervertebral disc displacement, lumbar region. 5) Pain in the right knee. 6) Pain in the left knee. 7) Pain in the unspecified knee. 8) Spinal stenosis, lumbar region without neurogenic claudication. 9) Radiculopathy, cervical region. 10) Radiculopathy, lumbar region. 11) Pain in the unspecified foot. 12) Sprain of ligaments of the cervical spine.
Treatment: Requested physical therapy. Prescribed Diclofenac gel 1%.
Work Status: Retired. Per AME/QME, the patient can perform modified work duties with no heavy lifting, no repetitive bending, no prolonged sitting, and no above shoulder-level work.

[redacted] Office Visit. [redacted]
DOI: [redacted]
Subjective Complaints: The patient states still having ongoing pain in the bottom of the feet and in the arch area. The patient has completed physical therapy sessions, and did not helped with the pain.

Diagnosis: 1) Plantar fascial fibromatosis. 2) Calcaneal spur, right foot. 3) Calcaneal spur left foot.
Treatment: Requested cortisone injection. Advised to continue over-the-counter inserts. Advised to continue normal daily activities as tolerated. Advised to continue range of motion exercises, warm Epsom salt soaks, and icing.
Work Status: As per the primary care physician.

[redacted]. Orthopedic Supplemental Agreed Medical-Legal Report. [redacted]
MANAGEMENT
DOI: CT [redacted]
Discussion: The electrodiagnostic study report of the bilateral upper extremities, dated [redacted] reveals evidence of moderate to severe bilateral carpal tunnel syndrome as well as ulnar neuropathy at the right elbow. The undersigned recommends that the patient be seen by a hand specialist for evaluation and treatment of bilateral upper extremity peripheral nerve entrapment syndrome.

[redacted] MRI of Left Knee without Contrast. DYNAMIC UPRIGHT MRI
Impressions: 1) Grade I injury (sprain) of the medial and lateral collateral ligaments. 2) Grade II chondromalacia patellae. 3) Mild tricompartmental degenerative changes. 4) Mild knee joint effusion.

[redacted]. MRI of Right Knee without Contrast. DYNAMIC UPRIGHT MRI
Impressions: 1) Grade II tear of the body and posterior horn of the medial meniscus. 2) Grade I injury (sprain) of the medial and lateral collateral ligaments. 3) Grade I chondromalacia patellae. 4) Mild tricompartmental degenerative changes. 5) Mild knee joint effusion. 6) Few collateral vessels within the subcutaneous soft tissues of the knee joint along its medial aspect.

[redacted]. Office Visit. [redacted]
DOI: [redacted]
Subjective Complaints: The patient states he is still having pain in the bottom of both feet, especially after being on them for long periods of time. The patient is here for his 1st cortisone injection.
Diagnosis: 1) Plantar fascial fibromatosis. 2) Calcaneal spurs right foot. 3) Calcaneal spurs left foot.
Plan: Administered cortisone. Advised to continue range of motion exercises, warm Epsom salt soaks, and icing. Advised to continue normal daily activities as tolerated.
Work Status: As per the primary care physician.

[redacted] Procedure Note. PAIN AND WELLNESS CENTERS [redacted]

Operation: Lumbar intralaminar epidural steroid injection, Midline L4-L5, L5-S1 with Fluoroscopic guidance.
Pre-op Diagnosis: Lumbar radiculopathy, Lumbar disc herniation, Lumbar spondylosis without myelopathy.
Post-op Diagnosis: Lumbar radiculopathy, Lumbar disc herniation, Lumbar spondylosis without myelopathy.

[redacted]
DOI: [redacted]
Subjective Complaints: Present Status: Tennis shoes. Recheck B/L foot: The patient states his heels are feeling better. The patient relates that the first cortisone injection was helpful as he is having less pain. However, the patient states he is still having some pain with prolonged standing/walking. Overall, he feels approximately 20% improved. The patient has also completed 12 out of 12 physical therapy sessions, which he felt were not very helpful.
Diagnosis: 1) Plantar fascial fibromatosis. 2) Calcaneal spur, right foot. 3) Calcaneal spur left foot.
Plan: Cortisone injection x 2 B/L heels. Advised to continue normal daily activities as tolerated. Advised to continue range of motion exercises, warm Epsom salt soaks, and icing. Follow up in 2 weeks.
Work Status: Work status per PCP.

[redacted] Office Visit. PAIN AND WELLNESS CENTERS [redacted]
DOI: [redacted]
Subjective Complaints: Neck pain: The neck pain occurs frequently. The pain radiates to the bilateral upper extremities. The patient's pain is accompanied by tingling and numbness. The patient describes the pain as aching, pins and needles, shooting, sharp, and stabbing with moderate severity. The pain is aggravated by flexion/extension and rotation. Low back pain: The low back pain is frequent. The pain radiates to the bilateral lower extremities. The patient's pain is accompanied by tingling and numbness. The patient described the pain as aching, sharp, pins and needles, and shooting with moderate severity. The pain is aggravated by bending, lifting, rotation, and twisting. Lower extremity pain: both feet, both knees the same. The pain is intermittent. The pain is aggravated by flexion/extension and prolonged walking. The patient described the pain as aching, dull, and sharp with moderate severity. Complaint Details: Pain level is usually a 6/10. Severe pain level: 9/10. Pain level today is 8 (L/S); 8 (BLE); 8 (C/S); 8 (BUE); 7 (R knee); 6 (L knee). Pain recent change is the same.
History of Present Illness: The patient's pain has been reduced from 9/10 to 6-7/10; functional benefits have been noted with today's report. The patient was approved for 12 sessions of C/S and 2 sessions remaining; the patient is reporting limited benefits. The patient reports shooting pain radiating down both upper extremities and affecting the fingers: index, middle, ring, and thumb. The patient has radicular symptoms corresponding to C5, C6 dermatomal distribution; the patient is amenable to CESI. EMG/NCV of both upper extremities on [redacted] report exhibited moderate to severe bilateral CTS and ulnar neuropathy of the right elbow.

Diagnosis: 1) Cervicalgia. 2) Lumbago with sciatica, unspecified side. 3) Other intervertebral disc degeneration, lumbar region. 4) Other intervertebral disc displacement, lumbar region. 5) Pain in right knee. 6) Pain in left knee. 7) Pain in unspecified knee. 8) Spinal stenosis, lumbar region without neurogenic claudication. 9) Radiculopathy, cervical region. 10) Radiculopathy, lumbar region. 11) Pain in unspecified foot. 12) Sprain of ligaments of cervical spine. 13) Cervical facet arthropathy. 14) Cervical strain/sprain. 15) Lumbago. 16) Bilateral foot pain. 17) Plantar fasciitis, bilateral.
Plan: Home exercise program. Prescription: Diclofenac sodium 1% gel.
Work Status: Retired. Per AME/QME, the patient can perform modified work duties with no heavy lifting, no repetitive bending, prolonged sitting, and no above shoulder-level work.

[redacted] Office Visit.
Chief Complaints: Follow-up.
History of Present Illness: The patient is presenting in the office for a routine follow-up.
Vitals: BP: 114/79. Resp. Rate: 16. Temp: 98.3. Heart Rate: 100. Pulse Ox: 97. Height: [redacted] Weight: [redacted] BMI: [redacted]
Diagnoses: 1) Essential hypertension. 2) Mixed hyperlipidemia. 3) Subclinical hyperthyroidism. 4) Weight loss. 5) Prediabetes.
Plan: Lab were order, lifestyle modification.

[redacted] Office Visit. [redacted]
DOI: [redacted].
Subjective Complaints: Tennis shoes. Recheck B/L Foot: The patient states he is feeling improved. The patient relates that his heels feel approximately 25% improved, but they are still painful, especially in the morning. The patient is here for the 2nd cortisone injection.
Diagnosis: 1) Plantar fascial fibromatosis. 2) Calcaneal spur, right foot. 3) Calcaneal spur, left foot.
Plan: Cortisone injection x 2 B/L heels. Advised to continue normal daily activities as tolerated. Advised to continue range of motion exercises, warm Epsom salt soaks, and icing. Follow up in 2 weeks.
Work Status: The patient is retired. Next appointment scheduled on [redacted].

[redacted]. Office Visit. [redacted]
DOI: [redacted]
Subjective Complaints: Present Status: Tennis shoes. Recheck B/L Foot: The patient states the 2nd cortisone injection was helpful as it decreased his pain significantly. However, the patient still relates to pain, especially in the morning, which is rated at a 2-3 on a scale of 1-10.
Diagnosis: 1) Plantar fascial fibromatosis. 2) Calcaneal spur, right foot. 3) Calcaneal spur, left foot.
Plan: Request: Custom Functional Orthotics x 1 pair: Patient has had conservative treatment including physical therapy, cortisone injections, over-the-counter inserts, NSAIDs (oral and topical), home stretching and icing regimen. Advised to continue normal daily activities as

tolerated. Advised to continue range of motion exercises, warm Epsom salt soaks, and icing. Follow up in 4 weeks.
Work Status: The patient is retired. Next appointment scheduled on [redacted]

[redacted] Pain Management Re-Evaluation/Tele visit. PAIN & WELLNESS CENTERS [redacted]
DOI: [redacted]
Subjective Complaints: Frequent pain in the neck and lower back, which radiates to the bilateral upper extremities for the neck and radiates to the bilateral lower extremities for the lower back. The patient described the pain as aching, sharp, pins and needles, and shooting with moderate severity. The aggravating factors for the lower back are bending, lifting, rotation, and twisting, and for the neck are flexion/extension and rotation. Lower extremity intermittent pain in both feet and knees is the same. The pain is aggravated by flexion/extension and prolonged walking. The patient described the pain as aching, dull, and sharp with moderate severity.
Interval History: CESI was denied; will submit an appeal. The patient has failed conservative measures for the C/S and is indicated for a diagnostic CESI to address his neck pain and radicular symptoms that are affecting his ADLs. MRI reports of the bilateral knees discussed; the patient has bilateral tricompartmental OA in addition to a meniscus tear of the right knee; will trial viscosupplementation for the right knee.
Diagnoses: 1) Cervical: Cervical Radiculitis. Cervicalgia. Disc displacement. Cervical Facet. Arthropathy. Cervical Strain/sprain. 2) Lumbar: Radiculitis. Disc degeneration. Disc displacement. Spinal stenosis. Lumbago. 3) Localized pain dx: Bilateral foot pain, bilateral knee pain. Right knee derangement. 4) Bursitis/itis: plantar fasciitis bilateral.
Plan: Procedure request. Knee joint injection. Bilateral Gen Visc 850 times three. Home Exercise. Consider steroid vs viscosupplementation vs PRP for bilateral knees. Procedure requested: Cervical ESI entry level at C7-T1 with a catheter upto (Bilateral C5-7) levels. Refill Diclofenac gel 1%.

[redacted] Office Visit. [redacted]
DOI: [redacted]
Subjective Complaints: The patient relates that his pain has decreased overall. However, the patient states he will still experience pain in his feet, especially after being on foot for long periods of time. The patient is here to be cast for orthotics.
Diagnoses: 1) Plantar fascial fibromatosis. 2) Calcaneal spur, right foot. 3) Calcaneal spur, left foot.
Plan: The patient today was cast in neutral for regular poly orthotics with no post and full length spenco top cover to decrease pain and biomechanically support feet. Dispense in 4 weeks. Advised to continue range of motion exercises, warm Epsom salt soaks, and icing. Advised to continue normal daily activities as tolerated.
Work Status: The patient is retired.

[redacted] Office Visit. PAIN & WELLNESS CENTERS [redacted]

[redacted]
Subjective Complaints: Essentially unchanged.
Interval History: The patient is approved and scheduled for bilateral knee Genvisc injections. The patient reports his L/S pain is returning, but is still slightly better than before LESI. The patient will hold repeat LEST until he completes knee injections. CESI's appeal was denied again. Will continue to appeal. Discussed trialing Meloxicam when pain is more severe, and the patient agrees. He has failed ibuprofen. The patient uses diclofenac gel when the pain is milder.
Diagnoses: Essentially unchanged.
Plan: Home exercise recommended. Procedure: Cervical Epidural Appeal. Epidural injections are recommended to lower inflammation at the source of the pain. Diclofenac and meloxicam are also prescribed.

[redacted]. Procedure Note. PAIN & WELLNESS CENTERS [redacted]
Procedure: Bilateral knee injection under Fluoroscopic guidance.
Preoperative Diagnoses: Osteoarthritis of the knee, Knee pain.
Postoperative Diagnoses: Osteoarthritis of the knee, Knee pain.

[redacted] Pulmonary/Sleep Consultation Note. [redacted] HEALTH
Chief Complaint: Follow-up. HTN. Nephrolithiasis/renal cysts. Hepatic steatosis.
Interval History: Overall, doing well. The patient sleeps very well with the device. The patient is getting supplies from Breathe Medical. The patient does use a heated tube. The filter door is falling off the current machine.
Vital: BP: 112/72. Pulse: 55. Resp: 20. Temp: 98. SpO2: 96%. Weight: [redacted] Height: [redacted]. BMI: [redacted]
Assessment: 1) Sleep apnea, obstructive. 2) Encounter for counselling on the use of CPAP. 3) Difficulty using a continuous positive airway pressure (CPAP) device.
Plan: Will prescribe a new device. Metformin 500 mg tablet was ordered. Return in about 1 year (around [redacted]) for routine follow-up.

[redacted] Office Visit.
DOI: [redacted]
Recheck B/L Foot: The patient states his feet have been doing well. The patient rates his current pain level at a 2 on a scale of 1 to 10.
Diagnoses: 1) Plantar fascial fibromatosis. 2) Calcaneal spur, right foot. 3) Calcaneal spur, left foot.
Treatment Plan: Dispensed orthotics - noted good fit and feel. Instructed in a slow break-in period. continue range of motion exercises, warm Epsom salt soaks, and icing. Advised to continue normal daily activities as tolerated. Follow up in 4 weeks.
Work Status: The patient is retired.

[redacted] Office Visit.

DOI: [redacted]
Chief Complaints: Consult bilateral wrists only, KW.
Assessment: 1) Cervical radiculopathy. 2) Severe carpal tunnel syndrome of both wrists.
Treatment Plan: 1) Cortisone injection (1 cc Lidocaine with 1 cc Dexamethasone). 2) Follow up in 4 weeks.
Work Status: The patient is retired.

[redacted]. Procedure Note. PAIN & WELLNESS CENTERS [redacted]
Procedure: Bilateral knee injection under Fluoroscopic guidance. GenVisc 850 - hyaluronic acid (25mg) x2 (50mg total).
Pre-operative diagnosis: Osteoarthritis of the knee, Knee pain.
Post-operative diagnosis: Same.

[redacted] Office Visit. PAIN AND WELLNESS CENTERS [redacted]
DOI: [redacted]
Subjective Complaints: Neck Pain: The neck pain occurs frequently. The pain radiates to the bilateral upper extremities. The patient's pain is accompanied by tingling and numbness. The patient describes the pain as aching, pins and needles, shooting, sharp, and stabbing with moderate severity. The pain is aggravated by flexion/extension and rotation.
Low Back Pain: The low back pain is frequent. The pain radiates to the bilateral lower extremities. The patient's pain is accompanied by tingling and numbness. The patient described the pain as aching, sharp, pins and needles, and shooting with moderate severity. The pain is aggravated by bending, lifting, rotation, and twisting.
Lower Extremity Pain: Both feet and knees are the same. The pain is intermittent. The pain is aggravated by flexion/extension and prolonged walking. The patient described the pain as aching, dull, and sharp with moderate severity.
Interval History: The patient is pending 3/3 genvisc on [redacted] The patient endorses some improvement in ROM, but continues to endorse moderate pain with prolonged walking/stair climbing. CESI now approved; expires [redacted] The patient reports increased LS pain and requests a repeat LESI. Low back neck pain.
Diagnoses: 1) Cervicalgia. 2) Lumbago with sciatica, unspecified side. 3) Other intervertebral disc degeneration, lumbar region. 4) Other intervertebral disc displacement, lumbar region. 5) Unspecified internal derangement of the right knee. 6) Pain in the right knee. 7) Pain in the left knee. 8) Pain in the unspecified knee. 9) Spinal stenosis, lumbar region without neurogenic claudication. 10) Radiculopathy, cervical region. 11) Radiculopathy, lumbar region. 12) Pain in the unspecified foot. 13) Sprain of ligaments of the cervical spine. 14) Other tear of unspecified meniscus, current injury, unspecified knee, initial encounter.
Work Status: The patient is retired. Per AME/QME, the patient can perform modified work duties with no heavy lifting, no repetitive bending, prolonged sitting, and no above shoulder-level work.
Treatment Plan: Lumbar intralaminar epidural steroid injection. Home exercise program, stretches and dynamic exercise. Follow up for an appointment in 6 weeks. Meloxicam 7.5 mg.

[redacted] Procedure Note. PAIN & WELLNESS CENTERS [redacted]
Procedure: Bilateral knee injection under fluoroscopic guidance: GenVisc 850 - hyaluronic acid (25 mg) x 2.
Pre-operative diagnosis: Osteoarthritis of the knee, Knee pain.
Post-operative diagnosis: Same.

[redacted]. Office Visit.
DOI: [redacted].
Recheck B/L Foot: The patient states he feels 90% improved. The patient has adjusted well to his orthotics and has been wearing them full-time.
Diagnoses: Essentially unchanged.
Treatment Plan: 1) WPI.
Work Status: The patient is retired.

[redacted] Office Visit. [redacted] ORTHOPEDICS & SPORTS MEDICINE
DOI: [redacted]
Subjective Complaints: The patient has nerve pain that runs from his c/s to his bilateral wrists. lots of shock pain near his bilateral wrists.
History of Present Illness: The patient comes into the clinic to re-check on the bilateral wrists. He received a cortisone injection for his right wrist, and that relieved the pain and discomfort from his right wrist. His left wrist still has some numbness and tingling at times. Will get cortisone for the left wrist if possible.
Assessment: Essentially unchanged.
Treatment Plan: Follow-up in 4 weeks. Post-op OT 3 x 4 w (12 sessions) @ BCO for right wrist.

[redacted] Televisit Note. PAIN & WELLNESS CENTERS [redacted]
DOI: [redacted].
Interval History: [redacted] - The patient states that Genvisc bilateral knees have been very helpful. The patient is appreciative and able to walk further distances. The patient is approved for both CESI and LESI. The patient prefers to schedule CESI first, then LESI. Will schedule 4-6 weeks apart, the patient continues with medication management, and will refill medications today.
Work Status: Retired. Per AME/QME, the patient can perform modified work duties with no heavy lifting, no repetitive bending, prolonged sitting, and no above shoulder-level work.
Diagnoses: 1) Cervical: Cervical Radiculitis, Cervicalgia, Disc displacement, Cervical Facet Arthropathy, and Cervical Strain/sprain. 2) Lumbar: Radiculitis, Disc degeneration, Disc displacement, Spinal stenosis, and Lumbago. 3) Localized pain diagnoses: Bilateral foot pain, bilateral knee pain, and right knee derangement, meniscal tear. 4) Bursitis/itis: Plantar fasciitis bilateral.

Treatment Plan: Conservative Treatment: Home Exercise Program. Progressive walking, strength training, and stretching improved functional status, self-efficacy, and other key symptoms in fibromyalgia patients. Pool or aquatherapy has been effective and is highly recommended for fibromyalgia patients. This was found to be cost-effective in terms of health and societal costs. 2) Stretches and Dynamic exercise: Educated the patient regarding the benefits of exercises and stretches.
Follow Up: The patient will follow up for an appointment in 6 weeks, and the patient is awaiting a procedure pending appointment scheduling.
Additional Treatment Recommendations: Repeat LESI pain. Consider repeat viscosupplementation vs PRP for bilateral knees.
Prescription: 1) Diclofenac Sodium 1% Gel 2) Meloxicam 7.5 mg.

[redacted] Pain Management Re-Evaluation. PAIN & WELLNESS CENTERS [redacted]
DOI: [redacted]
Interval History: [redacted] - The patient continues to benefit from refills requested. The patient is encouraged to continue the home exercise program. Scheduled [redacted] LESI to follow. No medication.
Work Status: Retired. Per AME/QME, the patient can perform modified work duties with no heavy lifting, no repetitive bending, prolonged sitting, and no above shoulder-level work.
Diagnoses: 1) Cervical Radiculitis. 2) Cervicalgia. 3) Disc displacement. 4) Cervical Facet Arthropathy. 5) Cervical Strain/sprain. 6) Lumbar Radiculitis. 7) Disc degeneration. 8) Disc displacement. 9) Spinal stenosis. 10) Lumbago. 11) Bilateral foot pain. 12) Bilateral knee pain. 13) Right knee derangement. 14) Meniscal tear. 15) Bilateral plantar fasciitis.
Treatment Plan: Conservative treatment: Home exercise program: (Stretches & Dynamic exercise)
Follow-up: The patient will follow up for an appointment in 6 weeks.
Additional Treatment Recommendations: Repeat LESI. Consider repeat viscosupplementation vs PRP for bilateral knees.
Prescription: 1) Diclofenac Sodium 1% Gel. 2) Meloxicam 7.5 mg.

[redacted]. Pain Management Re-Evaluation. PAIN & WELLNESS CENTERS [redacted]
DOI: [redacted]
Interval History: The patient reports no acute changes; continues to benefit from visco injections. CESI rescheduled to [redacted]. The patient continues HEP; no refills today.
Diagnoses: 1) Cervical Radiculitis. 2) Cervicalgia. 3) Disc displacement. 4) Cervical Facet Arthropathy. 5) Cervical Strain/sprain. 6) Radiculitis. 7) Disc degeneration. 8) Disc displacement. 9) Spinal stenosis. 10) Lumbago. 11) Bilateral foot pain. 12) Bilateral knee pain. 13) Right knee derangement. 14) Meniscal tear. 15) Plantar fasciitis, bilateral.
Treatment Plan: Home Exercise Program, stretches, and dynamic exercise: Educated the patient regarding the benefits of exercises and stretches. The patient will follow up in 6 weeks.

Additional Treatment Recommendations: Repeat LESI. Consider repeat viscosupplementation vs PRP for bilateral knees.
Prescription: 1) Diclofenac Sodium 1% Gel. 2) Meloxicam 7.5 mg.

[redacted]. Procedure Note. PAIN & WELLNESS CENTERS [redacted]
Procedure: Cervical epidural steroid injection with fluoroscopic guidance, bilateral C5-7.
Preoperative Diagnosis: 1) Cervical radiculopathy. 2) Cervical disc herniation. 3) Cervical spondylosis without myelopathy.
Postoperative Diagnosis: Same.

[redacted] Office Visit. PAIN & WELLNESS CENTERS [redacted]
DOI: [redacted]
Interval History: The patient is status post cervical epidural steroid injection on [redacted], with good benefit; functional benefits documented. The patient continues to benefit from bilateral knee visco injections. The patient would like to proceed with approved LESI; expires [redacted]; will request extension of authorization. The patient is interested in returning to work to a new security job; requests that any restrictions be removed to trial return to work. The patient is to continue the home exercise program and medications PM; requests a refill of diclofenac gel.
Diagnoses: Cervical: Cervical Radiculitis, Cervicalgia, Disc displacement, Cervical Facet Arthropathy, and Cervical Strain/sprain. Lumbar: Radiculitis, Disc degeneration, Disc displacement, Spinal stenosis, and Lumbago. Localized pain diagnoses: bilateral foot pain, bilateral knee pain, and right knee derangement, meniscal tear. Bursitis/itis: plantar fasciitis bilateral.
LESI (Lumbar intralaminar epidural steroid injection) - Home Exercise Program: Stretches & Dynamic exercise: Educated the patient regarding the benefits of exercises and stretches.
Follow-up: The patient will follow up for an appointment in 6 weeks.
Additional Treatment Recommendations: Repeat LESI. Consider repeat viscosupplementation vs PRP for bilateral knees. Diclofenac Sodium 1% Gel. Meloxicam 7.5 mg.
Prescription: 1) Diclofenac Sodium 1% Gel.

[redacted] Televisit Note. PAIN & WELLNESS CENTERS [redacted]
DOI: [redacted]
Interval History: The patient continues to benefit from CESI and B/L knee visco injections; LBP has also subsided and is manageable at this time; the patient wishes to defer LESI; the patient is aware of expiration. The patient has started new work and is tolerating well. The patient continues HEP and medications as needed; no refills requested.
Diagnosis: 1) Cervical radiculitis. 2) Cervicalgia. 3) Disc displacement. 4) Cervical facet arthropathy. 5) Cervical strain/sprain. 6) Radiculitis. 7) Disc degeneration. 8) Disc displacement. 9) Spinal stenosis. 10) Lumbago. 11) Bilateral foot pain. 12) Bilateral knee pain. 13) Right knee derangement. 14) Meniscal tear. 15) Plantar fasciitis, bilateral.
Work Status: Retired. No restrictions.

Treatment Plan: Conservative Treatment: Home exercise program: Stretches and dynamic exercise: Educated the patient regarding the benefits of exercises and stretches.
Follow-Up: The patient will follow up for an appointment in 6 weeks.
Additional Treatment Recommendations: Repeat LESI as needed. Consider repeat viscosupplementation versus PRP for bilateral knees.
Prescription: 1) Diclofenac Sodium 1% Gel. 2) Meloxicam 7.5 mg.

[redacted] Televisit Note. PAIN & WELLNESS CENTERS
DOI: [redacted].
Interval History: The patient reports that overall pain remains stable. The patient continues to experience benefits from CESI and Trivisc. The patient reports he is not using meds as often. The patient will continue to defer LESI as the low back pain is also doing well. No refills.
Diagnoses: 1) Cervical radiculitis. 2) Cervicalgia. 3) Disc displacement. 4) Cervical facet arthropathy. 5) Cervical strain/sprain. 6) Lumbar radiculitis. 7) Disc degeneration. 8) Disc displacement. 9) Spinal stenosis. 10) Lumbago. 11) Bilateral foot pain. 12) Bilateral knee pain. 13) Right knee derangement. 14) Meniscal tear. 15) Bilateral plantar fasciitis.
Treatment Plan: Conservative treatment: Home exercise program: Stretches and dynamic exercise: Educated the patient regarding the benefits of exercises and follow-up. The patient will follow up for an appointment in 6 weeks.
Additional Treatment Recommendations: Repeat LESI. Consider repeat viscosupplementation vs PRP for bilateral knees.
Prescription: 1) Diclofenac Sodium 1% Gel. 2) Meloxicam 7.5 mg.

[redacted]. Televisit Note. PAIN & WELLNESS CENTERS [redacted]
DOI: [redacted]
Subjective Complaints: The patient describes pain level today as 9 (L/S); 9 (BLE); 3 (C/S); 3 (BUE); 2 (R knee); 2 (L knee)/10. Pain recent changes is increased (L/S).
Interval History: The patient reports increased frequency of L/S pain with radicular symptoms radiating to the RLE. LESI approved, and the patient is ready to move forward - will schedule. The patient reports continued benefit from CESI and Trivisc. Continue med mgt.
Diagnoses: 1) Cervical radiculitis. 2) Cervicalgia. 3) Disc displacement. 4) Cervical facet arthropathy. 5) Cervical strain/sprain. 6) Radiculitis. 7) Disc degeneration. 8) Disc displacement. 9) Spinal stenosis. 10) Lumbago. 11) Bilateral foot pain. 12) Bilateral knee pain. 13) Right knee derangement. 14) Meniscal tear. 15) Plantar fasciitis bilateral.
Plan: Home exercise program, stretches and Dynamic exercise. Additional treatment Repeat LESI prn. Consider repeat Viscosupplementation vs PRP for bilateral knees. Medication: Diclofenac gel 1%. Meloxicam 7.5 mg.

[redacted] Comprehensive Orthopedic Agreed Medical Legal Evaluation. [redacted] HEALTH MANAGEMENT
DOI: CT: [redacted]

History of Injury: The patient was initially evaluated by the undersigned on [redacted], at which time he was evaluated for a continuous trauma injury he stated occurred during his course of employment for [redacted] where he worked from [redacted] He stated that most of his career was spent in [redacted] and the latter part of his career was spent in Training. According to the patient, he had back pain since [redacted] as a result of a work-related injury. He stated at that time he experienced pain in his back from putting on his [redacted] He stated he underwent diagnostic studies and was diagnosed with lumbar disc disease. Per the patient, his low back pain would radiate down his right lower extremity. He stated he received treatment from different physicians including pain management. The patient stated his symptoms were persistent. The patient also stated that over the last several years of his employment, he was experiencing progressive neck pain with symptoms radiating to his upper extremities pain in both knees and feet, treatment. He stated he also experienced something for which he did not receive.

Present Complaints: The patient complains today of pain and tightness in his neck, with restriction of motion of his neck. He states he has a cracking sensation in his neck. He states at times he has symptoms at night. He states that at times he feels weakness in his upper extremities and numbness in his arms.

The patient complains today of pain in his right elbow that increases with activity and numbness and tingling in both wrists and hands, with loss of strength in his hands. He states his symptoms increase with pushing or twisting.

The patient complains today of pain in his lower back that increases with prolonged sitting or standing. He states he has symptoms at night that make it difficult to sleep at night. He states that at times he has numbness radiating to his legs.

The patient complains today of pain and stiffness in both knees. He states his knee symptoms increase with weight-bearing. He states he has difficulty kneeling or squatting.

The patient complains today of pain in both feet that increases with activity. The patient states he has difficulty getting up from low seating.

Other Industrial Injuries: The patient states that in [redacted], he was involved in a work-related motor vehicle accident, and he injured both knees. The patient states that on [redacted], he injured his lower back while at work.

Past Surgeries: The patient underwent kidney stone surgery.

Vitals: Height: [redacted] Weight: [redacted]

Diagnoses: 1) Cervical disc disease. 2) Right cubital tunnel syndrome. 3) Carpal tunnel syndrome, bilaterally. 4) Lumbar disc disease/stenosis. 5) Bilateral knee chondromalacia. 6) Bilateral plantar fasciitis.

Causation: With the information available today, it is within the realm of reasonable medical probability that the continuous trauma claim of [redacted] is proven to be a causal agent in the patient's present condition referable to the cervical spine, lumbar spine, bilateral knees, and bilateral feet as diagnosed today. With the information available today, there may be basis for industrial continuous trauma injury to these bodily components.

Impairment Rating: Combining Multiple Regional WP Impairments: 20% Whole person impairment (lumbar spine). 14% Whole person impairment (BLEs). 9% Whole person impairment (BUEs). 7% Whole person impairment (cervical spine). Total whole person impairment for the patient case: 41%.

Future Medical Care: The patient should have access to medical care in the future consisting of periodic orthopedic evaluations, oral anti-inflammatory medications, oral analgesics, and abbreviated courses of physical therapy modalities not to exceed three or four weeks in length at a frequency no greater than three times per week, at which time the patient should be re-evaluated by the treating physician. Future medical care should also include the continuation with pain management for injections to the cervical spine and lumbar spine. With regard to both knees, future medical care should also include periodic viscosupplementation injections if the symptoms persist, MR arthrogram of the bilateral knees, and possible knee arthroscopies. For both feet, future medical care should also include periodic evaluation by a podiatrist for replacement of orthotics and a limited number of injections. Future medical care for both upper extremities should also include periodic evaluations by a hand specialist for possible peripheral nerve decompression to the right elbow and bilateral wrists.
Work Status: The patient states today that he is currently not working.
Apportionment: Cervical spine: Apportionment is 10% to activities of daily living and 90% to the [redacted] continuous trauma. Bilateral wrists & Right elbow: Apportionment is 10% to activities of daily living and 85% to the [redacted] continuous trauma. Lumbar spine: Apportionment is 10% to activities of daily living and 30% to the [redacted] continuous trauma. Bilateral knees & Bilateral feet: Apportionment is 10% to activities of daily living and 90% to the [redacted] continuous trauma.

[redacted] Procedure Note. PAIN & WELLNESS CENTERS [redacted]
Procedure: Lumbar intralaminar epidural steroid injection midline L4-L5, L5-S1 with fluoroscopic guidance.
Preoperative Diagnosis: Lumbar radiculopathy, lumbar disc herniation, lumbar spondylosis without myelopathy.
Postoperative Diagnosis: Same.

[redacted] Televisit Note. PAIN & WELLNESS CENTERS [redacted]
DOI: [redacted]
Subjective Complaint: Essentially unchanged.
Interval History: The patient s/p LESI on [redacted] Too soon to determine benefits, will monitor. Continue medication management, no refills needed.
Diagnoses: Essentially unchanged.
Plan: Home exercise program, stretches and Dynamic exercise. Additional treatment Repeat LESI prn. Consider repeat Viscosupplementation vs PRP for bilateral knees. Medication: Diclofenac gel 1%. Meloxicam 7.5 mg.

[redacted]. Primary Treating Physician's Initial Report. [redacted] MEDICAL GROUP
DOI: [redacted]
Job Description: The patient's work hours per day were 12 hours. The patient worked 36 hours per week. The patient was employed on the job from [redacted] The patient states

that the job duties involved [redacted] duties. According to the patient, this position always required the patient to sit, stand, bend from the waist, climb, crawl, twist from the waist, finely manipulate materials, reach above shoulder level, walk, bend from the neck, squat, kneel, twist from the neck, use the hands repetitively, power grasp, push, pull, reach below shoulder level, lift, and carry. The patient carried up to 30 pounds on the job.
History of Injury: The patient appears to be reasonably cooperative with providing information concerning the above-captioned work injury. The following history is obtained from the patient to the best of the patient recollection. According to the patient, he was performing his usual and customary duties on the date of injury. The patient states that he was injured as the result of repetitive work. Due to continuing complaints, the patient presents todays for an initial orthopedic evaluation.
Major Medical Illness: The patient notes hypertension.
Current Complaints: Cervical Spine: The patient reports slight (2/10) neck pain. Lumbar Spine: The patient reports slight (2/10) lower back pain with numbness and tingling at the bilateral lower extremities. The patient notes radiating pain from the lumbar spine to the bilateral lower extremities that is worse on the right. Knee Patella (Left): The patient reports slight (2/10) left knee pain. Knee Patella (Right): The patient reports slight (2/10) right knee pain. Ankle Malleolus (Left): The patient reports slight (2/10) left ankle pain. Ankle Malleolus (Right): The patient reports slight (2/10) right ankle pain.
Vitals: Height: [redacted] Weight: [redacted] BMI: [redacted]
Diagnoses: 1) Sprain of ligaments of cervical spine. 2) Sprain of ligaments of lumbar spine. 3) Sprain of unspecified site of right knee. 4) Sprain of unspecified site of left knee. 5) Plantar fascial fibromatosis.
Plan: The examiner is requesting authorization for chiropractic therapy and consultation with pain management specialist Dr. [redacted]. The examiner also advised the patient to continue home exercise. The examiner request patient prior medical records, including in particular any MRI reports, X-ray reports, NCV/EMG reports, and QME reports for further comment and review. The patient will return on [redacted] for re-evaluation.
Causation: The patient's medical findings are consistent with his description of the work-related injuries that occurred on [redacted]. Therefore, it is my opinion that causation is related to the industrial accident.
Work Status: The patient is currently retired.

[redacted]. Office Visit. PAIN & WELLNESS CENTERS OF SOUTHERN CALIFORNIA
DOI: [redacted].
Subjective Complaints: The patient describe pain level today is 8 (L/S); 9 (BLE); 3 (C/S); 3 (BUE); 2 (R knee); 2 (L knee)/10. Pain recent change is decreased (L/S).
Interval History: The patient LESI on 09/10/25. He reports no to minimal benefit. The patient's main concern is radicular pain radiating to BLE, right greater than left. Discussed 2nd diagnosis TFESI, will submit. The patient has trialed gabapentin and lyrica with no benefit, will send amitriptyline to trial, continue medication management.
Diagnoses: Same as previous report [redacted]

Plan: Procedure request TFESI lumbar transforaminal epidural steroid injection. Home exercise, stretches and dynamic exercise. Medication prescribed Diclofenac gel 1%, Meloxicam 7.5 mg, Amitriptyline HCL 50 mg.

[redacted]. Primary Treating Physician's Follow Up Report. [redacted] MEDICAL GROUP
DOI: [redacted]
Subjective Complaints: The patient has only been authorized on this claim for the neck, back, bilateral knees, and bilateral feet. At the neck, he describes 7/10 pain which radiates to the shoulders. He indicates 7/10 pain at the low back with radiation of pain to both feet and numbness at the plantar right foot. He indicates 5/10 pain at the knees and 4/10 pain at the feet. He also mentions elbow and wrist pain with numbness and tingling from the shoulders to the fingers of both hands.
Vitals: Height: [redacted] Weight: [redacted] BMI: [redacted]
Diagnoses: Essentially unchanged.
Plan: The examiner recommended acupuncture treatment.
Work Status: Essentially unchanged.

[redacted] Application for Adjudication of Claim.
DOI: [redacted]
Injury: The patient alleged that while employed with [redacted] as a [redacted] he sustained a cumulative trauma injury that began on [redacted] He states that due to repetitive stress and strain of job duties. Application amended to include right lower extremity (varicose veins).

MISCELLANEOUS RECORDS:

Letter, Employee's disability questionnaire, and qualified medical evaluator's findings summary form were reviewed but not summarized.

Kirk Y. Chang, M.D., F.A.C.C.

Cardiovascular Diseases
Diplomate of the American Board of Internal Medicine
Diplomate of the American Board of Internal Medicine,
Cardiovascular Diseases
Qualified Medical Examiner
8635 W. 3rd St. Ste 1050W • Los Angeles, California 90048
(310) 564-0060 Fax (800) 659-2084

[redacted]

[redacted]

[redacted]

[redacted]

RE:	REDACTED, Redacted
Employer:	[redacted]
Job Title:	[redacted]
DOI:	CT 0[redacted]
Claim No.:	xxxxxxxxxx
Soc. Sec. No.:	xxxxxxxxxxxx
DOB:	xxxxxxxxxxx
DOS:	[redacted]

SUPPLEMENTAL MEDICAL-LEGAL EVALUATION

This report is for a **Supplemental Medical-Legal Evaluation** which includes a review of records and preparation of a medical-legal report.

This report is billed as an **ML-203-94**

ML-203-95 – This is a Supplemental Medical-Legal Evaluation.
Number of pages of records reviewed in preparation of this report = 10
Subtract 50 pages for MLPRR = 00

****This is a medical-legal report and does not qualify for a PPO/Network discount.**

Dear Parties:

This supplemental medical report is provided in response to monitor results I received 0[redacted] from Bardy Diagnostics.

By way of review, I evaluated the applicant on [redacted]. Applicant is a [redacted]-year-old [redacted] with heart/hypertension, varicose veins and upper GI claims. I made my determination for the hypertension, varicose veins and GERD and placed an ambulatory cardiac monitor.

My assessments and opinions are based on the information provided. If necessary, I can issue another supplemental report should any additional information be provided for review.

INTERVAL INFORMATION:

10-day Bardy CAM was worn 0[redacted] Basic underlying rhythm was normal sinus. No significant arrhythmias were noted. No atrial fibrillation was seen, and no arrhythmias were seen during all patient triggered events.

REVIEW OF RECORDS:

MEDICAL RECORDS:

[redacted]

Summary of findings: Avg heart rate 78bpm; min HR 50 bpm; max HR 172 bpm; no pauses >2.5s. Predominant rhythm: NSR. Rare PAC 0.5 %, not associated with symptoms. Rare PVC <0.1%, not associated with symptoms. No significant runs or pauses noted. No atrial fibrillation seen. During patient triggered events (4), no arrhythmia was noted.

DOCUMENTED VITAL SIGNS AND INTERVENTIONS:

Date	Provider	BP	Weight	Medications/ Comments
[redacted]	[redacted]		[redacted]	Tramadol, ibuprofen, lisinopril, HCTZ, aspirin
[redacted]	[redacted]	128/74	[redacted]	IM QME: Sleep apnea dx [redacted] CPAP since [redacted]
[redacted]	[redacted]	130/80	[redacted]	
[redacted]	[redacted]	114/79	[redacted]	
[redacted]	[redacted]	112/72	[redacted]	
[redacted]	[redacted]		[redacted]	

[redacted]	[redacted]		[redacted]	
[redacted]	[redacted]		[redacted]	
[redacted]	[redacted]	142/76	[redacted]	My QME evaluation

EKG performed at [redacted]

Normal sinus rhythm, non-specific intraventricular conduction delay; no acute ST T changes

Transthoracic Echocardiogram Performed at [redacted] **(amended):**

Demographics:

Height: [redacted]
Weight [redacted]

Structure	Dimension	Normal Value	Structure	Dimension	Normal Value
LVDd (mm)	45	< 58	LA (cm)	3.7	< 4
LVDs (mm)	31		Ao Root (cm)	2.9	< 4
IVSd (mm)	12	8-11	EF (%)	60-65	> 55
LVPWd (mm)	13	8-11	E/A	0.90	
RWT	0.56	(<0.42)			

Conclusion:

1. Left ventricle cavity is normal in size. Concentric remodeling of the left ventricle. Normal global wall motion. Visual EF is 60-65%.
2. Doppler evidence of grade I (impaired) diastolic dysfunction, normal left atrial pressure.
3. Normal valvular structures.
4. No pericardial effusion

Calculated from above data:

Left ventricular mass: 210 grams
Left ventricular mass index: 92 gm/m^2 (normal 49-115 gm/m^2) (1).

1. Lang, RM., et al. (2015). Recommendations for Cardiac Chamber Quantification by Echocardiography in Adults: An Update from the American Society of Echocardiography and the European Association of Cardiovascular Imaging. J Am Soc Echocardiogr. 281:1.

IMPRESSION (amended):

1. HYPERTENSION, INDUSTRIAL
2. GERD, INDUSTRIAL
3. VARICOSE VEINS RIGHT LOWER EXTREMITY, INDUSTRIAL
4. PALPITATIONS WITHOUT OBJECTIVE ARRHYTHMIA, NO INDUSTRIAL INJURY

DISCUSSION:

This [redacted]-year-old man began working for the [redacted]. The Joint cover letter notes a cumulative trauma claim involving the back, neck, heart/high blood pressure, bilateral feet, bilateral knees, and gastrointestinal system/acid reflux.

The applicant reports intermittent palpitations occurring approximately two to three times per month, with sudden onset and duration of up to two minutes. He previously underwent both 24-hour and 72-hour ambulatory monitoring, neither of which demonstrated significant arrhythmia. His symptoms have persisted intermittently and are at times associated with subjective dizziness, though he denies syncope or near-syncope. In order to further evaluate these ongoing complaints, a 10-day ambulatory cardiac monitor was obtained.

Review of the 10-day [redacted] demonstrates a predominant normal sinus rhythm with an average heart rate of 78 beats per minute, a minimum nocturnal rate of 50 beats per minute, and a maximum rate of 172 beats per minute during sinus tachycardia. The study shows rare premature atrial contractions with a burden of approximately 0.5 percent and rare premature ventricular contractions with a burden of less than 0.1 percent. There were no episodes of atrial fibrillation, no supraventricular tachycardia, no ventricular tachycardia, no clinically significant pauses, and no conduction abnormalities. During the four patient-triggered events, no arrhythmia was documented.

When considered together with the prior 24-hour and 72-hour monitoring studies, which were likewise unrevealing, the cumulative objective data strongly supports a benign rhythm profile. The presence of rare isolated atrial and ventricular ectopy at this low burden is common in the general population and is not indicative of a pathologic arrhythmia, particularly in the setting of a structurally normal heart. The applicant has previously undergone cardiac evaluation with echocardiogram demonstrating no cardiomyopathy, no significant valvular disease, and no structural substrate for malignant arrhythmia.

Although the applicant perceives intermittent palpitations, the absence of correlation between symptoms and any documented arrhythmic event indicates that his complaints are not reflective of a diagnosable cardiac electrical injury. The findings are most consistent with benign ectopy and intermittent sinus tachycardia or heightened cardiac awareness rather than a sustained or clinically significant arrhythmia. Based on three ambulatory monitoring studies, there is no objective evidence of atrial fibrillation, sustained tachyarrhythmia, ventricular arrhythmia, or conduction disease.

Accordingly, the current monitor results do not alter my prior opinions. There is no basis for assignment of whole person impairment attributable to an arrhythmia, and no additional electrophysiologic evaluation is medically indicated at this time. The applicant's reported symptoms are not supported by objective evidence of a cardiac arrhythmia injury.

DISCLOSURE

I hereby declare under penalty of perjury that I have not violated Labor Code Section 139.3 and that the contents of this report are true to the best of my information and belief. 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.

In compliance with Labor Code Section 5703(A)(1), I, Kirk Y. Chang, M.D., F.A.C.C., the consulting physician, 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. I declare under penalty of perjury that I did not discriminate in any way against the parties to the action or the injured worker in the evaluation process or in the content of the report.

I have addressed the issues of apportionment within the body of this report in accordance with Labor Code 4663(c). If I have assigned disability caused by factors other than the industrial injury, that level of disability constitutes the apportionment. The ratio of nonindustrial disability, if any, to all described disability represents my best medical judgment as to the percentage of disability caused by the industrial injury and the percentage of disability caused by other factors, as defined in Labor Code Section 4663 and 4664.

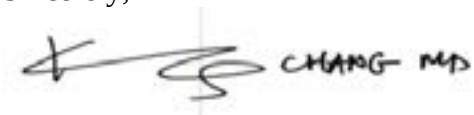
In compliance with Workers' Compensation legislation (Labor Code Section 4628 (b)): I declare that the history was obtained by Daniela Ferrario, medical historian, by virtue of her training and experience. The report was edited for formatting, grammar and spelling by [redacted]*, Medical Editor. Summary of medical records were done by* [redacted]*, Review of history with the patient, review of medical records, physical examination, reading of x-rays, medical dictation/review of final report by myself in compliance with the guidelines established by the Industrial Medical Council or the Administrative Director pursuant to paragraph (5) of subdivision (j) of Section 139.2.*

The undersigned further declares under penalty of perjury that to the best of their knowledge and belief they did not discriminate in any way against the parties to the action or the injured worker in the evaluation process or in the content of the report.

I further declare and verify under penalty of perjury, pursuant to 8 C.C.R. §9795 that ***10 pages of records*** *were reviewed by myself as part of the medical-legal evaluation and preparation of this report.*

This report is prepared and signed in the County of [redacted]

Sincerely,



KIRK Y. CHANG, M.D., F.A.C.C.
Cardiovascular Diseases
Diplomate of the American Board of Internal Medicine
Diplomate of the American Board of Internal Medicine, Cardiovascular Diseases
Qualified Medical Examiner

KC/ACU/

April 15, 2026

TO: Each Trustee
Board of Retirement

FROM: Tamara Caldwell, Division Manager
Disability Retirement Services Division

Patty Silva, DRS Interim Supervisor
Disability Retirement Services Division

FOR: May 6, 2026, Disability Board of Retirement Meeting

SUBJECT: RECOMMENDATION TO APPROVE HAMID R. MIR, M.D. (ORTHOPEDIC MEDICINE) TO THE LACERA PANEL OF PHYSICIANS

RECOMMENDATION

To support timely, high-quality medical-legal evaluations and maintain a geographically accessible and appropriately credentialed panel of examining physicians, staff recommends that the Board of Retirement approve the application of Hamid R. Mir, M.D., for appointment to LACERA's Panel of Examining Physicians.

DISCUSSION

Certifications & Licensure

Dr. Hamid R. Mir is a board-certified orthopedic spine surgeon licensed to practice medicine in the State of California. He holds an active California medical license and is authorized to practice orthopedic surgery with a sub-specialty in spine surgery.

Education & Training

Dr. Mir received his Doctor of Medicine degree from the State University of New York, Health Science Center at Brooklyn, College of Medicine, graduating *cum laude*. He completed his internship in general surgery and residency in orthopedic surgery at the University of Illinois at Chicago, followed by a combined orthopedic and neurosurgical spine surgery fellowship at Cedars-Sinai Medical Center, where he received advanced training in complex spinal evaluation and treatment. In addition to his medical education, Dr. Mir earned a Master of Business Administration (MBA) from the UCLA Anderson School of Management, Fully Employed MBA Program.

Professional Experience

Dr. Mir has extensive clinical experience in the evaluation and treatment of spinal conditions involving the cervical, thoracic, and lumbar spine, including degenerative conditions, spinal stenosis, trauma-related injuries, and complex spinal disorders. He maintains multiple Southern California practice locations in Tustin, Long Beach, and

Riverside, providing geographic accessibility across Los Angeles, Orange, and Riverside Counties.

Academic & Professional Contributions
Dr. Mir is affiliated with DISC Surgery Center (Newport Beach), St. Joseph Hospital (Orange), Chapman Medical Center (Orange), and Foothill Medical Center (Tustin). He has been recognized by Super Doctors, an independent private publisher and research organization, as a Southern California Super Doctor (2015–2023), Los Angeles Super Doctor, Rising Star, and has received a Patient's Choice Award from Vitals.com. He is also a member of the Alpha Omega Alpha Honor Medical Society and Phi Beta Kappa.

Dr. Mir has over 20 years of experience performing medical-legal evaluations, including service as an Agreed Medical Examiner (AME), Independent Medical Examiner (IME), and Qualified Medical Evaluator (QME). His current practice includes both treatment and evaluation services, with a substantial portion of his professional time dedicated to the preparation of comprehensive medical-legal reports.

Panel Onboarding & Compliance
If approved, Disability Retirement Services (DRS) will provide an orientation for Dr. Mir and his practice team covering LACERA's Panel Physician Guidelines, evaluation standards under applicable disability retirement law, report requirements and timelines, fee and billing procedures, and ongoing quality-control processes. DRS will also confirm continuing compliance with licensing, board certification, and insurance requirements.

Medical Advisor Review
On April 1, 2026, Board Medical Advisor Glenn Ehresmann, M.D., reviewed Dr. Mir's application and credentials and concurred with forwarding the application to the Board of Retirement for consideration.

TLC:PS/mc

Attachments

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 02/02/2026
Physician Name: HAMID MIR MD	Group Name: Evolve Orthopedics and Spine Institute
Primary Address: 17631 E. 17TH STREET, STE 200, TUSTIN, CA	
Primary Contact: Kimberly Ha	Title: Patient Coordinator
Telephone: 949-749-0055	Email: kimberly@hamidmirmd.com CC: info@hamidmirmd.com
Secondary Address: 2880 Atlantic Ave Ste 250 Long Beach, CA 90806 3421 Arlington Ave STE 105, Riverside, CA 92506	
Telephone: 949-749-0055	Email: kimberly@hamidmirmd.com CC: info@hamidmirmd.com

PHYSICIAN BACKGROUND	
Field of Specialty: [x] orthopedics Board Certification ☑ Yes ☐ No	Subspecialty: all ortho body parts Board Certification ☐ Yes ☐ No n/a
License # A84242 Expiration Date: 08/31/2027	
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	20 years	Treatment	90 %
IME	20 years	Evaluations	10 %
QME	20 years	Research	0 %
Workers' Compensation Evaluations	20 years	Teaching	0 %
Disability Evaluations	20 years		100 %
Med-Legal Reports	20 years		

Performing Medical Evaluations for Public Organizations ☑ Yes ☐ No

Performing Medical Evaluations for Private Organizations ☑ Yes ☐ No

Please Names of Organizations: American Academy of Orthopedic Surgeons
American Board of Orthopedic Surgeons

Qualified Medical Evaluator , Ortho Expert Work for civil case

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.

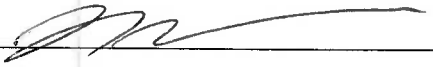
What is you Cancellation Policy? (Attach policy, if applicable).

$750 dollars for cancellations made within 5 days of the appointment + the cost of completed medical record review

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

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

Name of person completing this form:

Print Name:	Title:
Hamid Mir	MD
Physician Signature: 	Date 02/12/2026

You may attach additional pages if necessary.

Revised: 12/8/21

HAMID R. MIR, M.D.,QME

BOARD-CERTIFIED ORTHOPEDIC SPINE SURGEON

Phone: (949) 749-0055
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Practice Locations:

17631 E. 17 St. Suite 200
Tustin, CA 92780

2880 Atlantic Ave Ste. 250
Long Beach, CA 90806

3421 Arlington Ave, Suite 105
Riverside, CA 92506

Hospital Affiliations:

DISC Surgery Center, Newport, CA
St. Joseph Hospital, Orange CA
Chapman Medical Center
Foothill Medical Center, Tustin CA

EDUCATION

8/2017-9/2020 *M.B.A.*

UCLA Anderson, School of Management
Fully Employed, MBA
Los Angeles, CA

9/03-9/04 *Spine Fellowship:* Combined Orthopedic/Neurosurgical Spinal Surgery Fellowship
Cedars-Sinai Medical Center

6/99-6/03 *Residency:* Orthopedic Surgery
University of Illinois at Chicago
Chicago, IL

6/98-6/99 *Internship:* General Surgery
University of Illinois at Chicago
Chicago, IL

Graduate Education:

8/94-5/98 *M.D.*
State University of New York
HSCB
College of Medicine
Brooklyn, NY Cum Laude

Undergraduate Education:

8/91-6/94	*B.S.*	University of California at San Diego La Jolla, CA Major: Biochemistry & Cell Biology Honors with Distinction Magna Cum Laude

AWARDS

- Southern California Super Doctors: 2015-2023
- 2013 Los Angeles Super Doctor and Rising Stars
- 2013 Patient's Choice Award, Vitals.
- 2003 "Dedicated to the Advancement of Spinal Sciences"
- Christopher Pavildes Award for "Excellence in Orthopedic Surgery"
- Alpha Omega Alpha Honor Medical Society
- Phi Beta Kappa

BOOK CHAPTERS

1. "SLIM-LOC Anterior Cervical System". *Surgical Techniques in Spinal Instrumentation,* edited by Kim DH, Vaccaro AR, Fessler RG. Thieme Medical Publishing, 2005.

2. "The Unconstrained Implant: Charité Artificial Disc ™." *Non-Fusion Techniques for the Spine,* edited by James Maxwell. Quality Medical Publishing, 2006.

ABSTRACTS:

1. Addition of Cross-link to the C1 Lateral Mass/C2 Pedicle Screw Fixation Constructs: A Biomechanical Study. *Cervical Spine Research Society, Annual Meeting.* December of 2005.

2. The Charité Artificial Disc: Our Initial Experience with Surgical Complications in the Early Postoperative Period. Submitted to *Spine Arthroplasty Society.*

3. C1-2 Fusion Using Facet Arthrodesis without Posterior Structural Bone Grafting: Clinical Results on a New Technique.
    - *American Association of Neurological Surgeons/Congress of Neurological Surgeons, Annual Meeting,* March, 2005.
    - *Cervical Spine Research Society, Annual Meeting,* December 2005.

4. Transforaminal Lumbar Interbody Fusion for correction and maintenance of segmental coronal balance in degenerative scoliosis. Buenos Aires, Argentina, *Scoliosis Research Society*, Sept 2004.

5. Cantilever Transforaminal Lumbar Interbody Fusion for correction and maintenance of sagittal lordosis with clinical, radiological and functional outcome. *International Meeting for Advanced Spinal Technology*, Bermuda, July 2004.

6. Ender Rod Fixation for Pediatric Femur Fractures

   American Academy of Orthopedic Surgeons, 66th Annual Meeting, Anaheim, CA. Feb 7, 1999.

7. Insulin-like Growth Factor-1 enhances ventricular hypertrophy and function during onset of experimental cardiac failure
   American Heart Association, 67th Scientific Session. Dallas, Texas. November 15, 1994.

PUBLICATIONS:

- Cantilever TLIF With Structural Allograft and RhBMP2 for Correction and Maintenance of Segmental Sagittal Lordosis: Long-Term Clinical, Radiographic, and Functional Outcome. Spine September 2006. E748-753

- Ender Rod Fixation of femoral Shaft Fractures in Children" Clinical Orthopedics and Related Research. July 2000, 376: 119-123

- Secundum-Type Atrial Septal Defects with Failure to Thrive in First Year of Life Journal of Cardiac Surgery. March 1996. 11: 116-120.

- Insulin-like Growth Factor-1 enhances ventricular hypertrophy and function during onset of experimental cardiac failure Journal of Clinical Investigation. Feb 1995, 95: 619-6*27.*

MEDICAL LICENSURE:

- State of California: A84242

ORGANIZATION MEMBERSHIP/CREDENTIALS

- American Academy of Orthopedic Surgeons, Fellow
- American Board of Orthopedic Surgeons, Diplomate
    - Board Certification in Orthopedic Surgery, July 2007
    - Board Recertification in Orthopedic Surgery, June 2027

American Board of Orthopaedic Surgery

Verify Certification

Search Again **Record Count: 1.** (Note that result sets are limited to 200 records.)

Mir, Hamid Reza

Newport Beach, CA 92660

Orthopaedic Surgery Board Certification

Initially Certified: 07/13/2007 - 12/31/2017

Recertified: 01/01/2018 - 12/31/2027

Participating in MOC: Yes

Why Didn't I Find What I Was Looking For?

HAMID R. MIR, M.D.
BOARD CERTIFIED ORTHOPEDIC SPINE SURGEON
Minimally Invasive Spine Surgery
Scoliosis and Reconstructive Spine Surgery

949-988-7848 phone - 949-988-7801 fax
Newport Beach | Long Beach | Riverside
www.hamidmirmd.com

[redacted]

APPLICANT ATTORNEY

INSURANCE COMPANY

Employee: LASTNAME, FirstName
Employer: Employer
Occupation: Police Officer
DOI: CT [redacted]
Claim No: ******
WCAB No: ******
DOB: [redacted]
DOE:

ORTHOPEDIC AGREED MEDICAL EXAMINATION AND REPORT

To Whom It May Concern:

FirstName LastName is a 56-year-old left-handed male who was seen in my [redacted] located at [redacted] for the purposes of this Agreed Medical Examination on June 25, 2024.

This examination fulfills the criteria for ML201-94, Med-Legal Evaluation. A total of 322 pages of records were received and reviewed for this evaluation.

JOB DESCRIPTION:

He began working for Employer as a police officer on [redacted]

His job duties as a police officer included wearing a uniform and Sam Browne belt that held his gun, baton, handcuffs, pepper spray, magazine, taser, microphone device and radio that weighed about 25-30 pounds. In addition, he would wear bulletproof vest. He would have to drive a police patrol vehicle. In addition, he notes that periodically he would do foot patrol. He would make traffic stops, respond to police 911 emergencies, subdue, restrain and arrest suspects, which could be disorderly, drunk or uncooperative. Perform search and seizure activities, write citations and reports, deal with the public disturbances and mediate disputes, seize and handle evidence,

conducting booking procedures, search and chase suspects over various terrain and obstacles, render emergency first aid or CPR, communicate with the community, and service agencies. He would qualify for weapons once per month, as well as qualified for shot gun and hand gun and in between training days. He was a mountain bike instructed for 14 years in the academy; he would ride a bicycle in full gear over various terrains. He was an Urban Police Riffle Cadre for about 10 years. In addition to his full gear, he would wear a ballistic helmet while carrying a riffle with a first aid kit with ammunition to perform his job duties.

The physical requirements consisted of prolonged sitting, standing and walking; running over various terrain and jumping over fences; repetitive bending, stooping and squatting; repetitive twisting, turning, pushing, pulling and reaching; repetitive arm and hand movement, simple and forceful grasping, torquing motions and fine finger manipulation. He lifted and carried up 100-200 pounds. He worked a 3 4/10 schedule.

CURRENT WORK STATUS:

Mr. LastName last worked for the subject employer on [redacted], at which time he retired from employment.

PRIOR WORK HISTORY:

Prior to working for the EMPLOYER, he was a student in college and worked part-time in retail.

MECHANISM OF INJURY AND TREATMENT:

The applicant sustained a cumulative trauma from [redacted], involving his neck, back and bilateral knees. He started to experience pain in his neck, back and knees in [redacted] which slowly progressed over time. He attributed the onset of pain as a result of wearing a heavy Sam Brown belt and bullet-proof vest. He performed activities that had included repetitive flexion/extension of the neck, repetitively getting in and out of patrol vehicle, foot pursuits, climbing walls and fences, as well as bending, stooping, squatting, climbing, running, jumping, pushing, pulling, lifting of heavy objects and other physical activities.

On [redacted], he filed an incident report and a referral for medical treatment made. He was referred to Dr. ******. He was examined and x-rays were obtained. The applicant was prescribed medication. He was placed on temporary total disability.

He received physical therapy neck, back and knees. The applicant underwent MRI studies of the neck, back and bilateral knees. The applicant was advised that he had compressed discs causing pinched nerves in the neck. There were positive findings on the MRI of the low back. There was a tear in the meniscus of the right knee.

He was referred to pain management specialist Dr. ***** approximately in early [redacted] regarding his neck. He was examined and medication was prescribed. He was recommended epidurals for

his cervical spine but they were not initially authorized until the appeal process. By that time, his condition had improved to the point that he did not feel it was necessary to receive the injections.

The applicant received additional physical therapy for his neck, low back and bilateral knees. He received PRP injections for his bilateral knees. The injections provided temporary relief of his symptoms. He indicates that right knee surgery was recommended.

On [redacted], Mr. LastName underwent right knee surgery. He used his crutches for about 2-3 weeks to ambulate. He was dispensed a cold therapy unit for at home treatment. He received postoperative physical therapy for the right knee. He states that following surgery and treatment his condition in his right knee improved. But he continued to experience residual pain.

He remained under the care of Dr. ****** through [redacted] at which time he was released from care permanent and stationary. He was instructed to return to the clinic on an as needed basis during flare ups.

Mr. LastName remains under the care of Dr. *****. He follows up with this physician every 4 months and receives medication refills. The applicant does not recall seeing any other physicians or undergoing any other diagnostic testing or treatment. He performs home exercise daily. He performs hot/cold therapy and applies topical ointment to his affected areas as needed. The applicant takes medication for the pain as needed.

PRESENT COMPLAINTS:

NECK: Currently, Mr. LastName complains of slight to moderate constant pain in his neck. He rates his pain as an average of 4-5 on a scale of 1-10. The pain radiates into his left shoulder arm, hand and fingers. He experiences constant numbness and tingling in his left hand fingers. He notices cracking and popping in his neck with turning of his head. His neck symptoms are increased by repetitive flexion / extension of his neck, turning his head to the right, turning his head to the left, prolonged positioning of his head and neck.

LOWER BACK: Currently, Mr. LastName complains of slight to moderate constant pain in his low back. He rates his pain as an average of 4-5 on a scale of 1-10. The pain radiates into his left hip, buttock up to the thigh. He experiences constant numbness and tingling in his left out thigh and in intermittent in the left inner thigh. He limps intermittently. He does not use a cane. His low back symptoms are increased by bending, stooping, squatting, kneeling, using stairs, prolonged sitting over 15-30 minutes, prolonged standing over 15-30 minutes, prolonged walking over 15-30 minutes and heavy lifting and carrying.

RIGHT KNEE: Currently, Mr. LastName complains of moderate pain in his right knee. He rates his pain as an average of 5 on a scale of 1-10. He has intermittent swelling. He does experience popping and cracking intermittently. He experiences occasional locking. He does occasional experience right knee buckling. He limps intermittently. He does not use a cane. His right knee symptoms are increased by repetitive flexion, repetitive extension, stooping, squatting, kneeling,

using stairs, prolonged standing over 15-30 minutes, prolonged walking over 15-30 minutes and heavy lifting and carrying.

LEFT KNEE: Currently, Mr. LastName complains of moderate pain in his left knee. He rates his pain as an average of 5 on a scale of 1-10. He has intermittent swelling. He does experience popping and cracking intermittently. He experiences occasional locking. He does occasional experience right knee buckling. He limps intermittently. He does not use a cane. His left knee symptoms are increased by repetitive flexion, repetitive extension, stooping, squatting, kneeling, using stairs, prolonged standing over 15-30 minutes, prolonged walking over 15-30 minutes and heavy lifting and carrying.

MEDICAL HISTORY:

Past Medical History:

Hypertension.
Hyperlipidemia.

Past Surgical History:

Jaw surgery in [redacted].
Right knee surgery in [redacted]

Medications:

He is presently taking prescribed medications Gabapentin 300 mg, Meloxicam 15 mg and Methocarbamol 750 mg all as needed. As well as Olmesartan 40-25 mg daily, Amlodipine 5 mg daily, Rosuvastatin 10 mg daily, Nebivolol 10 mg daily and Tadalafil 5 mg daily.

Allergies:

The applicant suffers from seasonal allergies.

Prior Industrial/Non-Industrial Injuries:

None reported.

SOCIAL HISTORY:

The applicant is married and has 3 adult children.

REVIEW OF SYSTEMS:

GENERAL: The applicant suffers from post-Covid fatigue. He denies any recent weight loss or weight gain, fever and chills.
EYES: The applicant denies any eye pain or blurred vision.
HEENT: The applicant denies any ear pain or sore throat.
CARDIOVASCULAR: The applicant suffers from high blood pressure. He denies any history of cardiovascular disease.
RESPIRATORY: The applicant suffers from post-Covid related respiratory issues such as shortness or sporadic coughing attacks. He denies asthma or hemoptysis.
GI: The applicant denies any nausea, vomiting, diarrhea or abdominal pain.
GU: The applicant denies any dysuria, urinary frequency or nocturia.
ENDOCRINOLOGY: The applicant suffers from hyperlipidemia. He denies any history of thyroid disease and diabetes.
HEMATOLOGY: The applicant suffers from anemia. She denies easy bruising or blood disorders.
MUSCULOSKELETAL: The applicant is experiencing pain in her neck, lower back and bilateral knees due to the ongoing injury.
NEUROLOGICAL: The applicant suffers from headaches due to his neck pain. He denies any history or seizure or stroke.
PSYCHIATRY: The applicant denies depression, anxiety and stress.

ACTIVITIES OF DAILY LIVING:

As a result of the subject injury the applicant reports:

He has difficulty with dressing such as putting on his pants, socks and shoes.

He has difficulty with household chores such as sweeping, mopping, dusting, cooking, washing dishes, laundry and grocery shopping.

He used to play baseball and bike ride. He refrains from these activities.

He has difficulty with social activities that require prolonged standing and walking.

He has difficulty working on his cars due to his ongoing symptoms.

ADLS – ANSWERS TO QUESTIONS:

SELF CARE, PERSONAL HYGEINE

Urinating	No difficulty
Defecating	No difficulty
Brushing teeth	Mild difficulty
Combing hair	Mild difficulty
Bathing	Moderate difficulty
Dressing yourself	Moderate difficulty
Eating	No difficulty

COMMUNICATION

Writing	Mild difficulty
Typing	Moderate difficulty
Speaking	No difficulty
Hearing	No difficulty

SENSORY FUNCTION

Hearing	No difficulty
Seeing	No difficulty
Tactile feeling	Mild difficulty
Smelling	No difficulty

PHYSICAL ACTIVITIES

Standing	Mild difficulty

Sitting Mild difficulty

Reclining Mild difficulty

Walking Moderate difficulty

Climbing Stairs Moderate difficulty

NON-SPECIALIZED HAND ACTIVITES

Grasping Mild difficulty

Lifting Moderate difficulty

Tactile discrimination Mild difficulty

TRAVEL

Riding Moderate difficulty

Driving Moderate difficulty

Flying Moderate difficulty

SEXUAL FUNCTION

Orgasm Moderate difficulty

Ejaculation Moderate difficulty

Erection Moderate difficulty

Lubrication Mild difficulty

SLEEP

Restful Moderate difficulty

Nocturnal sleep patterns Mild difficulty

PHYSICAL EXAMINATION:

Height: 6'2" Weight: 240 pounds

Hand dominance: Left

Gait/Stance: Normal

Reflexes:	Right	Left	Normal
Biceps	2+	2+	2+
Triceps	2+	2+	2+
Patella	2+	2+	2+
Ankle	2+	2+	2+

Sensory:	Right	Left
C5	Normal	Decreased
C6	Normal	Decreased
C7	Normal	Normal
C8	Normal	Normal
T1	Normal	Normal

Motor Strength:	Right	Left
Deltoid	5/5	5/5
Biceps	5/5	5/5
Triceps	5/5	5/5
Wrist F/E	5/5	5/5
Intrinsics	5/5	5/5
Hip Flex	5/5	
Quads	5/5	
Hamstrings	5/5	
Anterior Fib	5/5	5/5
Plantar Flexors	5/5	5/5

CERVICAL SPINE:

Inspection:

Spinal alignment is normal.

Skin is intact.

Palpation:

There is tenderness on palpation over the paravertebral muscles on the right and on the left.

Range of Motion:	Normal (degrees)	Measured
Flexion	50°	40°
Extension	60°	50°
Left lateral bending	45°	35°
Right lateral bending	45°	45°
Left rotation	80°	60°
Right rotation	80°	80°

Special Tests:	Right	Left
Spurling's maneuver	Normal	Positive

THORACIC/LUMBAR SPINE:

Inspection:

There are no scars
There is no deformity.

Palpation:

There is tenderness to palpation of the paraspinal muscles with increased muscular tone at L4-5 and L5-S1.

Special Tests:

Straight Leg Raise Within normal limits, bilaterally

KNEES:

Palpation:

There is tenderness to palpation on the medial and lateral joint lines bilaterally.

Range of Motion:	Right	Left	Normal
Flexion	120°	120°	110°

Flexion contracture	0°	0°	0°

Special Tests:	Right	Left
McMurray's	Negative	Negative
Anterior drawer	Negative	Negative
Posterior drawer	Negative	Negative
Varus stress test	Negative	Negative
Valgus tress test	Negative	Negative
Lachman's	Negative	Negative

MEDICAL RECORD REVIEW:

[redacted] **DOI:** [redacted] **HX OF INJ:** Fell and braced himself with his left hand, palm flat and fractured left radial head. Seen at ***** ***** where x-ray were taken, showing a fracture of the left radial head. **CC:** Left elbow pain. (Remarkably failed to motion MVA of [redacted] with some residual subjective complaints, related to vehicular accident). DX: 1) [redacted], fracture, left radial head. 2) [redacted], vehicular accident with cervical, thoracic and lumbar sprain/strain. 3) Subjective radiculopathy left upper extremity, ulnar nerve distribution. **PLAN:** Medical records were reviewed. Request EMG/NCV of left upper extremity. **MMI:** Permanent and Stationary regarding cervical spine, minus and EMG/NCV of the left upper extremity. **WORK STAT:** None necessary for cervical spine. Elbow: No heavy lifting, no repetitive throwing activities, no repetitive flexion, extension, or athletic activities. May continue to work self modifying how he does his activities for the Employer as a Police Officer. **APPORTIONMENT:** Neck to the auto accident of [redacted] Left elbow apportioned to incident of [redacted]. **VOC REHAB:** Not indicated based on neck and/or elbow complaints. **FUT MED CARE:** Allowed access for cervical spine and left elbow, including determination by the EMG/NCV. If abnormal, suggest MRI of cervical spine for further evaluation. Left elbow: Occasional anti-inflammatories or analgesics. Does not believe surgery would be indicated. Might benefit from a simple injection of Xylocaine and Corticosteroid.

[redacted] **DOI:** [redacted] **HPI:** Seen for AME on [redacted], for left elbow pain. Advised for EMG/NCV. **DX:** 1) [redacted], fracture, left radial head. 2) [redacted] vehicular accident with cervical, thoracic and lumbar sprain/strain. 3) Probable left ulnar neuropathy at the elbow. **PLAN:** Reviewed report of Dr. ********, dated [redacted]. Final rating of disability remains essentially unchanged. Occasional anti-inflammatories or analgesics. **WORK STAT:** Has been working, self-modifying

how he does the job, and can continue. **FUT MED CARE:** Should be allowed access through appropriate Board Certified Orthopaedic Surgeon. May require some type of ulnar nerve release at the elbow. May become surgical candidate for ulnar nerve transposition type procedure.

[redacted] **DOI:** [redacted].**HPI:** Using a rescue inhaler of Albuterol. Released to go back to from COVID on [redacted] but is on TTD from an orthopedic condition, as per der Dr. ******. Has been diagnosed with hypertension and is on Losartan. **HX OF INJ:** On or about [redacted] started developing fatigue and shortness of breath. Was working in close quarters with other coworkers that were unknowingly infected with COVID, and later diagnosed with COVID-19. **CC:** Persistent shortness of breath, cough and fatigue, under the care of Dr. ******** in [redacted]. Headaches, occasional indigestion and shortness of breath. **PMH:** Hypertension. Hyperlipidemia. Orthodontic surgery in [redacted] **CURRENT MEDS:** Losartan 50 mg. Crestor 20 mg. Albuterol inhaler, as needed. DX: 1) Status post COVID-19 infections. Hypertension. 3) Orthopedic injuries, deferred to appropriate provider. **PLAN:** Continue regimen of using Albuterol rescue inhaler, as needed. Continue to follow-up with Dr. ********. Any TTD days lost from work due to COVID, is industrial in nature, and needs to be covered on an industrial basis. **CAUSATION:** With reasonable medical probability, hypertension is industrially related due to years of repetitive stress/strain of work in active duty law enforcement and chronic pain from duty related orthopedic injuries. **Rx:** Losartan with RFA. **FU VISIT:** 3 months.

[redacted] **DOI:** [redacted]. **CC:** Cervical (3/10), lumbar (5-6/10) and bilateral knee (5-6/10) pain. DX: 1) Chronic cervical strain. 2) Chronic lumbar strain. Bilateral knee chronic strain. 4) Bilateral knee chronic patellofemoral chondromalacia. **PLAN:** Recommend MRI studies of cervical and lumbar spine and right knee on [redacted], as scheduled and EMG/NCS of bilateral upper extremities, as scheduled on [redacted] Considered a good candidate for platelet injections. Continue HEP. OTC medications, as needed. **WORK STAT:** TTD. **FU VISIT:** 4-5 weeks.

[redacted]) Electrodiagnostic Study of Bilateral Upper Extremities. **IMPRESSION:** Chronic left C7 radiculopathy.

[redacted]. **** ********. M.D. (Radiology) at ****** ****** Advanced Imaging. MRI of Cervical Spine Without. **IMPRESSION:** 1) Congenitally short pedicles and superimposed degenerative changes of cervical spine with moderate

spinal stenosis and ventral indentation on the spinal cord at C4-C5, mild to moderate spinal canal stenosis at C5-C6 and mild spinal canal stenosis at the adjacent levels. 2) Multilevel neuroforaminal stenosis, including severe left and moderate right neuroforaminal stenosis at C4-C5 and C6-C7, severe right and moderate to severe left neuroforaminal stenosis at C5-C6, as well as moderate to severe right and moderate left neuroforaminal stenosis at C7-Tl.

[redacted]. **** ********. M.D. (Radiology) at ****** ****** ****** Imaging. MRI of Lumbar Spine without Contrast. **IMPRESSION:** 1) Transitional lumbosacral anatomy with partial sacralization of the L5 vertebral body which will be designated as LS for the purposes of this study. 2) Degenerative changes of the lumbar spine, most pronounced at L4-L5 where there is mild spinal canal stenosis and narrowing of the lateral recesses with mild posterior displacement of the descending left L5 nerve roots as well as moderate bilateral neural foraminal stenosis with possible contract of the exiting L4 nerve roots as well as moderate bilateral neural foraminal stenosis with possible contact of the exiting L4 nerve root. 3) Mild narrowing of the lateral recesses at L3-L4 with possible contact of the descending L4 nerve roots as well as mild to moderate bilateral neural foraminal stenosis without significant spinal canal stenosis.

[redacted]. ***** *. ***. M.D. (Radiology) at ****** ***** ***** Imaging. MRI of Right Knee without Contrast. **IMPRESSION:** 1) Oblique increased signal within the posterior horn of the medial meniscus with inferior surface fraying/defect peripherally tracking to the body junction. 2) Subtle free edge fraying of the body of the lateral meniscus. 3) Proximal patellar tendinosis. 4) Chondromalacia as described with small effusion and 8 mm posterior loose body and 1.6 cm corticated body along the popliteus muscle belly.

[redacted] *. ******. M.D. (Ortho) Telemedicine PTP Progress Report (PR-2). **DOI:** CT [redacted] **CC:** Cervical (3/10), lumbar (6/10), right knee (6/10) and left knee (3/10) pain. DX: 1) Chronic cervical strain. 2) Chronic lumbar strain. 3) Bilateral knee chronic strain. 4) Bilateral knee chronic patellofemoral chondromalacia. **RECORD REVIEW:** 1) MRI Cervical spine, as noted above. 2) MRI Lumbar spine dated 05/13/21-IMP: Transitional lumbosacral anatomy with partial sacralization of the L5 vertebral body which will be designated at L5. Degenerative changes, most pronounced at L4-L5 nerve root and moderate bilateral neuroforaminal stenosis with possible contact of the exiting L4 nerve roots. Mild narrowing of the lateral recess at L3-L4 with possible contact of descending L4 nerve root and mild to moderate bilateral neuroforaminal stenosis without significant spinal canal stenosis. 3) MRI of Right knee, dated [redacted]-IMP: Oblique increased signal within the posterior horn of the medial meniscus with inferior surface faying/defect peripherally tracking to the body junction. Subtle free edge fraying of

the body of the lateral meniscus. Proximal patellar tendinosis. Chondromalacia. 4) EMG of BUE, dated [redacted]-IMP: Chronic left C7 radiculopathy. **PLAN:** MRI studies of cervical and lumbar spine and right knee and EMG/NCS of bilateral upper extremities reviewed. Request physical therapy 2x6 for cervical and lumbar spine with RFA, dated [redacted] Request PRP injection for right knee with RFA, dated [redacted] Good candidate for epidural injection. **WORK STAT:** TTD. **FU VISIT:** 4 weeks.

[redacted] ********. PA-c/***** *. ******. M.D. (Ortho) PTP Progress Report (PR-2). **DOI:** CT [redacted] **HPI:**
Started PT and completed 2/12 sessions. **CC:**
Cervical (7/10), lumbar (7/10), right knee (7/10) and left knee (5-6/10) pain. DX: 1) Chronic cervical strain. 2) Chronic lumbar strain. 3) Bilateral knee chronic strain. 4) Bilateral knee chronic patellofemoral chondromalacia. 5) Chronic left C7 radiculopathy EMG.6) Severe-moderate neuroforaminal stenosis at C4-C5, C5-C6 and C6-C7. **PLAN:** Recommended PRP injection for the right knee on [redacted], as scheduled. Discontinue all anti-inflammatory medications 1 week prior and for 6 weeks after the injection. Recommended for neurosurgical consultation with RFA, dated [redacted]. Continue remaining physical therapy. **Rx:** Gabapentin 300 mg, Diclofenac 75 mg and Tylenol No. 3 with RFA, dated 07/28/21. **FU VISIT:** 4 weeks.

[redacted] *******, PA/***** *. ******. M.D. (Ortho) Telemedicine PTP Progress Report (PR-2). **DOI:** CT [redacted]. **CC:** Cervical (7-8/10), lumbar (7-8/10) and bilateral knee pain. DX: 1) Chronic cervical strain. 2) Chronic lumbar strain. 3) Bilateral knee chronic strain. 4) Bilateral knee chronic patellofemoral chondromalacia. 5) Chronic left C7 radiculopathy EMG. 6) Severe-moderate neuroforaminal stenosis at C4-C5, C5-C6 and C6-C7. **PLAN:** Increase Gabapentin 300 mg, 2x per day, if no benefit, increase to 3x per day. Neurosurgeon consult approved, pending scheduling. Recommended PRP injection for the right knee on [redacted], as scheduled. Discontinue all anti-inflammatory. Continue HEP program. **FU VISIT:** 2 weeks.

[redacted] ***** *. ******. M.D. (Ortho) PTP Progress Report (PR-2). **DOI:** CT [redacted]. **CC:** Cervical (8/10), lumbar (6/10), right knee (5/10) and left knee (4/10) pain. DX: 1) Chronic cervical strain. 2) Chronic lumbar strain. 3) Bilateral knee chronic strain. 4) Bilateral knee chronic patellofemoral chondromalacia. 5) Chronic left C7 radiculopathy EMG. 6) Severe-moderate neuroforaminal stenosis at C4-C5, C5-C6 and C6-C7.**PLAN:** Neurosurgeon consult approved, continue pending scheduling. Administered PRP injection, right knee. **Rx:** Neurontin 300 mg. **WORK STAT:** TTD.

[redacted] **** *******, MD. [redacted] Surgeon) Initial Consult Report with RFA. **DOI:** CT 0[redacted] **HX OF INJURY:** Due to cumulative injury to the neck. **CC:** Neck and arm pain. **PMH:** High blood pressure. Jaw surgery in the 2000's. **CURRENT MEDS:** Gabapentin. Tylenol No. 4. **DX:** 1) Cervical disc displacement with radiculopathy. 2) Cervical spondylosis. **PLAN:** MRI studies of the cervical spine reviewed. Treatment options discussed. If symptoms of neck and arm pain persist, the patient requires surgery, an anterior cervical discectomy and fusion of C5-C6 and C6- C7. Request authorization for physical therapy 2x per week for 6 weeks with RFA, dated [redacted] Request authorization for cervical spine epidural steroid injections with RFA, dated [redacted]. **WORK STAT:** Deferred to PTP. **FU VISIT:** As needed.

[redacted] ********. PA-c/***** *. ******, M.D. (Ortho) Telemedicine PTP Progress Report *(PR-2)*. **DOI:** CT [redacted] **HPI:** Completed physical therapy 12/12. **CC:** Cervical (6/10), lumbar (4-5/10), left knee (4/10) and right knee (5-6/10) pain. Problems sleeping. **DX:** 1) Chronic cervical strain. 2) Chronic lumbar strain. 3) Bilateral knee chronic strain. 4) Bilateral knee chronic patellofemoral chondromalacia. 5) Chronic left C7 radiculopathy EMG. 6) Severe-moderate neuroforaminal stenosis at C4-C5, C5-C6 and C6-C7. **PLAN:** Recommend neurosurgeon consult on [redacted], as scheduled. **Rx:** Gabapentin 300 mg with RFA, dated [redacted]. Tylenol with codeine #4 with RFA, dated [redacted]. **WORK STAT:** TTD. **FU VISIT:** 4-6 weeks.

[redacted]. ****** *. ******, M.D. (Internal Medicine) PTP Progress Report. **DATE OF VISIT:** [redacted]. **DOI:** 04/27/2020. **HPI:** Seen for Covid 19 and hypertension. Under care of pulmonologist for Covid. **CC:** Slowly getting better, off bronchodilators, still feels SOB with external activity due to Covid. Still ongoing hypertension. Continued having orthopedic problems with back and knee problems. DX: 1) Hypertension, rule out hypertensive heart disease. 2) Status post COVID still with residual symptomatology. 3) Questionable cardiac murmur, etiology to be determined. 4) Orthopedic injuries, deferred to appropriate provider. **PLAN:** Higher dose of Losartan. 2D echocardiogram with RFA. Continue to see Dr. ********, pulmonologist. Records from Dr. ******** will be requested. **Rx:** Losartan 100 mg with RFA. **WORK STAT:** TTD deferred to orthopedic specialist. **FU VISIT:** 3 months.

[redacted] ********, PA-c/***** *. ******, M.D. (Ortho) PTP Progress Report (PR-2). **DOI:** CT [redacted] **CC:** Cervical (5-6/10), lumbar (4-5/10), left knee (4-5/10) and right knee pain. Right knee pain has improved with the PRP injection. Locking/weakness of the right knee. **CURRENT MEDS:** Tylenol No. 4. Gabapentin. **DX:** 1) Chronic cervical strain. 2) Chronic lumbar strain. 3) Bilateral knee chronic strain. 4) Bilateral knee chronic patellofemoral chondromalacia. 5) Chronic left C7 radiculopathy EMG. 6) Severe-moderate neuroforaminal stenosis at C4-C5, C5-C6 and C6-C7. **PLAN:** Recommend cervical traction and physical

therapy, as well as epidural injections. Future anterior cervical discectomy and fusion of C5-C6 and C6-C7 if fails conservative treatment. Pain management report from Dr. ***** requested for review with RFA, dated [redacted]. **Rx:** Gabapentin with RFA, dated [redacted] and Tylenol #4 with RFA, dated [redacted]. **WORK STAT:** TTD. **FU VISIT:** 4-6 weeks.

[redacted] ********, PA-c/***** *, ******, M.D. (Ortho) PTP Progress Report (PR-2). **DOE:** [redacted] **DOI:** CT [redacted] **CC:** Cervical spine (5/10) pain, radiating to left upper extremity to hand. Lumbar spine (4-5/10) pain, that radiates into left lower extremity/thigh. Constant bilateral knee pain 5/10. **CURRENT MEDS:** Tylenol No. 4. Gabapentin 300 mg. DX: 1) Chronic cervical strain. 2) Chronic lumbar strain. 3) Bilateral knee chronic strain. 4) Bilateral knee chronic patellofemoral chondromalacia. 5) Chronic left C7 radiculopathy EMG. 6) Severe-moderate neuroforaminal stenosis at C4-C5, C5-C6 and C6-C7. **PLAN:** Request 6 additional sessions of physical therapy to neck and lumbar spine with RFA, dated [redacted]. Recommended pain management consult with Dr. *****, as scheduled on [redacted], and request Dr. *****'s report for review. **Rx:** Gabapentin with RFA, dated [redacted]. **WORK STAT:** TTD. **FU VISIT:** 4-6 weeks.

[redacted] ***** *, *****, M.D. (Pain Medicine) Initial Interventional Pain Management Consultation. **DOI:** [redacted] **HX OF INJURY:** Cumulative trauma injury to neck, lower back and right and left knees which he attributes to strenuous and repetitive nature of job as a police officer. **CC:** Neck pain (6-8/10) with pain shooting into LUE. **PMH:** Mandible surgery. Hypertension. **CURRENT MEDS:** Losartan. Gabapentin. Meloxicam. Methocarbamol. **DX:** Cervical radiculopathy at C6. Cervical radiculopathy at C7. Myofascial pain syndrome. Chronic pain syndrome. **PLAN:** MRI of cervical spine obtained. Multiple treatment options discussed. Recommend C6 and C7 selective nerve root block on the left side with RFA, dated [redacted]. Covid-19 testing 3 days prior to procedure, with RFA, dated [redacted] **Rx:** Gabapentin 300 mg, Meloxicam 15 mg and Methocarbamol 750 mg with RFA, dated [redacted] **WORK STAT:** Per PTP. **FU VISIT:** 1 month.

[redacted] ********, PA-c/***** *, ******, M.D. (Ortho) PTP Progress Report *(PR-* 2)/Telemedicine Visit. **DOE:** [redacted] **DOI:** CT [redacted] **HPI:** Currently in physical therapy for cervical and lumbar spine, completed 2/6 sessions. Seen by Neurosurgeon, Dr. *******, who recommended pain management evaluation and physical therapy for the neck. Had pain management consultation for possible injections with Dr. ***** at SCOI [redacted], who recommended injections. Authorized for 7 additional physical therapy sessions to cervical spine. Status post right knee PRP injection in [redacted]. **CC:** Constant

cervical spine pain (5/10). Constant back pain (4/10). Constant bilateral knee pain (5/10). **CURRENT MEDS:** Tylenol No. 4. Gabapentin 300 mg. DX: 1) Chronic cervical strain. 2) Chronic lumbar strain. 3) Bilateral knee chronic strain. 4) Bilateral knee chronic patellofemoral chondromalacia. 5) Chronic left C7 radiculopathy EMG. 6) Severe-moderate neuroforaminal stenosis at C4-C5, C5-C6 and C6-C7, [redacted]. **PLAN:** MRI of Right knee, dated [redacted] reviewed. Recommend a repeat IA PRP injection to right knee with RFA. Continue Tylenol with Codeine. Obtain Dr. ***** report, from [redacted], for review. **Rx:** Gabapentin 300 mg with RFA. **WORK STAT:** TTD, per Work Status Form. **FU VISIT:** 4-6 weeks; [redacted]

[redacted] ***** *. *****. M.D. (Pain Medicine) Secondary Treating: Physician's Progress Report/Progress Notes. **DOI:** [redacted] **BPI:** Had physical therapy and medical management for 6 weeks during last 6 months without benefit. CC: Neck pain (6-8/10) with pain shooting into LUE. Numbness, tingling and muscle spasms. **CURRENT MEDS:** Losartan. Gabapentin. Meloxicam. Methocarbamol. **DX:** Cervical radiculopathy at C6 and C7. Chronic pain syndrome. Myofascial pain syndrome. **PLAN:** MRI of cervical spine reviewed with patient today. Recommend C6 and C7 selective nerve root block on the left side. **Rx:** Losartan 12.5 mg. Gabapentin 300 mg. Meloxicam 15 mg. Methocarbamol 750 mg. **WORK STAT:** Per PTP. FU **VISIT:** 1 month.

[redacted] ********. PA-c/***** *. ******. M.D. (Ortho) PTP Progress Report *(PR-* 2)/Telemedicine. **DOE:** [redacted] 2022. **DOI:** CT [redacted] **HPI:** Had follow-up with Dr. ***** on approximately 03/2022. Currently pending lumbar epidural steroid injection authorization with pain management. Scheduled for PRP injection to right knee on [redacted] Has completed 3/6 physical therapy to cervical and lumbar spine. Seen by Dr. ******* who recommended evaluation with pain management and course of physical therapy for neck. Cervical spine epidural injection denied and referred to IMR, awaiting response. CC: Constant cervical spine pain (6/10), worsened since last visit. Pain radiates down to the left upper extremity. Constant lumbar spine pain (5/10), worsened since last visit. Constant bilateral knee pain (5/10) slightly worsened on right knee. **CURRENT MEDS:** Tylenol with Codeine. Gabapentin 300 mg. DX: 1) Chronic cervical strain. 2) Chronic lumbar strain. 3) Bilateral knee chronic strain. 4) Bilateral knee chronic patellofemoral chondromalacia. 5) Chronic left C7 radiculopathy EMG. 6) Severe-moderate neuroforaminal stenosis at C4-C5, C5-C6 and C6-C7, per MRI of [redacted] **PLAN:** Cont physical therapy and approved PRP injection, right knee. **Rx:** Gabapentin and Tylenol #3 with RFA, dated [redacted]. **WORK STAT:** Remain TTD from [redacted] per Work Status Sheet. **FU VISIT:** 4-6 weeks; [redacted]

[redacted]. ***** *. ******, M.D. (Ortho) PTP Progress Report (PR-2). **DOE:** [redacted] **DOI:** CT [redacted]. **HPI:** Completed 6/6 physical therapy sessions to neck and lower back. CC: Neck/thoracic spine pain, same as last visit. Low back pain (5/10). Right knee pain (5-6/10). Left knee pain (5/10). **CURRENT MEDS:** Tylenol with Codeine. Gabapentin 300 mg. **DX:** Unchanged. **PLAN:** Will request 12 sessions of physical therapy, 2x6 for cervical and lumbar spine with RFA. Will proceed with the authorized platelet rich plasma injection for right knee. **Rx:** Tylenol #3 with RFA. **WORK STAT:** Remain TTD. **FU VISIT:** 6 weeks.

[redacted] ***** *. *****, M.D. (Pain Medicine) Secondary Treating Physician's Progress Report (PR-2)/Progress Notes/Office Visit. **DOI:** [redacted] CC: Dull achy neck pain (6-8/10) with occasional sharp shooting pain that does down the LUE. Pain accompanied by numbness and tingling. **CURRENT MEDS:** Losartan. Gabapentin. Meloxicam. Methocarbamol. **DX:** 1) Cervicalgia. 2) Cervical radiculopathy at C6. 3) Cervical radiculopathy at C7. 4) Chronic pain syndrome. 5) Myofascial pain syndrome. **PLAN:** Continue to recommend C6 and C7 selective nerve root block on the left side, when patient is ready. Continue meds. **WORK STAT:** Per PTP. **FU VISIT:** 1 month.

[redacted] ****. PA-c/***** *. ******. M.D. (Ortho) PTP Progress Report (PR-2). **DOE:** [redacted] **DOI:** CT [redacted] **HPI:** Had PRP injection to right knee on [redacted] with 25%-30% benefit. Completed 12/12 sessions of physical therapy to cervical and lumbar spine with benefit. **CC:** Cervical spine pain (5-6/10) with pain radiating down to left arm, hand and numbness and tingling in the hand with burning sensation. Lumbar spine pain (4-5/10) with pain radiating to left hip, leg with stabbing and burning sensation. Constant left knee pain (5-6/10). Right knee pain (4-5/10). Increased pain in left knee. **CURRENT MEDS:** Tylenol No. 4. Gabapentin 300 mg. **DX:** Unchanged. **PLAN:** Requesting MRI left knee with RFA. Request add'l physical therapy for cervical and lumbar spine with RFA. Cont follow-up with Dr. ***** for Pain Mgmt. **Rx:** Tylenol No. 4. **WORK STAT:** TTD. **FU VISIT:** 4-6 weeks.

[redacted] *******, PA/***** *. ******. M.D. (Ortho) PTP Progress Report (PR-2). **DOE:** [redacted] **DOI:** CT [redacted] **HPI:** Continues to follow-up with pain management, Dr. *****, who is appealing the denial of the CESI. **CC:** Constant cervical spine pain (6/10) with pain radiating down to the left shoulder and symptoms of numbness and tingling down to the left upper extremity. Constant lumbar spine pain (5/10). Constant bilateral knee pain (6/10), with right knee worsening pain. DX: 1) Chronic cervical strain. 2) Chronic lumbar strain. 3) Bilateral knee chronic strain. 4) Bilateral knee chronic patellofemoral chondromalacia. 5) Chronic left C7 radiculopathy EMG. 6) Severe-moderate neuroforaminal stenosis at C4-C5, C5-C6 and C6-C7, per MRI of [redacted]

Right knee oblique increased signal within the posterior horn of the medical meniscus with inferior surface fraying/defect peripherally tracking to the body junction, subtle free edge fraying of the body of the lateral meniscus, proximal patellar tendinosis, chondromalacia, as described with small effusion and 8 mm posterior loose body and 1.6 cm corticated body along with the popliteus muscle belly, per MRI [redacted] **PLAN:** Will appeal denial for the updated MRI of left knee. Request authorization for physical therapy 2x6 to bilateral knees. **Rx:** Gabapentin 300 mg. **WORK STAT:** TTD.

[redacted] ********, PA-c/***** *. ******, M.D. {Ortho) PTP Progress Report (PR-2). **DOI:** CT [redacted]. **CC:** Cervical spine and knee pain (6/10). Lumbar spine pain (5/10). **DX:** Unchanged. **PLAN:** Continue home exercise. Completed MRI of left knee as scheduled on [redacted] Schedule authorized 12 sessions of physical therapy to bilateral knees. Continue to follow-up with pain management specialist, Dr. *****. **Rx:** Gabapentin 300 mg. **WORK STAT:** TTD.

[redacted]. Incomplete Report/Not Noted (Radiology) at Advanced Imaging Center. MRI of the Left Knee Without. **IMPRESSION:** 1) Insertional tendinopathy and enthesopathy changes of the superomedial aspect of the quadriceps attachment to the superior patella with mild reactive edema in the adjoining soft tissues and prepatellar region. Reactive marrow edema along the superomedial aspect of the patella also seen. The patella is also borderline high riding in position and demonstrates mild lateral subluxation with minimal grade 3/grade 5 chondral changes along the central trochlea. 2) Intrinsic signal within the periphery of the mid body of the medial meniscus may represent degenerative changes. No definite displaced meniscal tear seen. 3) Interstitial degenerative signal is noted along the ACL. No acute tear.

[redacted] *****. PA/***** *. *****, M.D. (Ortho) Office Visit/Primary Treating Physician's Progress Report (PR-2). **DOI:** [redacted]. CC: Chronic cervical pain (6- 8/10). Pain remained unchanged. Continues to have radicular symptoms down the left upper extremity. **CURRENT MEDS:** Gabapentin. Losartan. Meloxicam. Methocarbamol. **DX:** 1) Cervicalgia. 2) Cervical radiculopathy at C6. 3) Cervical radiculopathy at C7. 4) Chronic pain syndrome. 5) Myofascial pain syndrome. **PLAN:** Cervical spine epidural injection has been approved, but will hold on scheduling. Recommend C6-C7 selective nerve root block on the left. **Rx:** Mobic 15 mg. Gabapentin 300 mg. **WORK STAT:** Per PTP. **FU VISIT:** 3 months.

[redacted] ********, PA-c/***** *. ******, M.D. (Ortho) PTP Progress Report {PR-2). **DOI:** CT [redacted] **HPI:** Currently attending physical therapy for bilateral knees and completed 7-8/12 sessions. **CC:** Constant cervical spine pain (6/10). Constant lumbar spine pain (5/10). Constant bilateral knee pain (6/10). **DX:**

Unchanged. **PLAN:** MRI of left knee reviewed with patient. Continue home exercise. Recommend PRP injection to left knee with RFA. Continue and complete remaining sessions of physical therapy. Continue to follow-up with pain management specialist, Dr. *****. Continue with Gabapentin. **WORK STAT:** TTD.

[redacted] ********, PA-c/***** *, ******, M.D. (Ortho) PTP Progress Report (PR-2). **DOI:** CT [redacted] **HPI:** Completed 12/12 physical therapy to bilateral knees, with improvement of pain, ROM, and strength. **CC:** Constant cervical spine pain (6/10) with pain radiating into the left upper extremity, with associated numbness and tingling on the left first, second, as well as third digits of the hand. Constant lumbar spine pain (5/10), about the same as last visit. Constant left knee pain (5/10) and right knee pain (6/10). **DX:** Unchanged. **PLAN:** Continue home exercise. Recommend updated MRI of right knee with RFA. Continue to follow-up with pain management specialist, Dr. *****. Continue with Gabapentin. **WORK STAT:** TTD.

[redacted] ******* *******, M.D. (Radiology) Advanced Imaging Center. MRI of the Right Knee with and Without. **IMPRESSION:** 1) Degenerative tear of the posterior horn and posterior mid-body of the medial meniscus with extruded inferior articular fragment in the medial recess. 2) Multiple loose bodies seen within the posterior intercondylar region of the knee. Grade 3/Grade 2 chondral. Degeneration of the central trochlea seen. Otherwise, articular cartilage in the medial and lateral compartments relatively well preserved. 3) Minimal free edge blunting and fraying of the lateral meniscus seen without acute meniscal tear.

[redacted] ***** *, ******, M.D. (Ortho) PTP Progress Report (PR-2). **DOI:** CT [redacted] **HPI:** Authorized for PRP injection to left knee. **CC:** Cervical spine pain (6/10) radiating down the left arm. Lumbar spine pain (4-5/10). Right knee pain (6/10). Left knee pain (5/10). **DX:** Unchanged. **PLAN:** Provided with left knee PRP injection. Would benefit from another round of physical therapy, 12 sessions to cervical and lumbar spine with RFA. Right knee MRI reviewed with patient. Recommended arthroscopy of the right knee with partial meniscectomy and postop therapy with RFA. **WORK STAT:** If restricted duty not available, patient considered TTD.

[redacted] *****, PA/***** *, *****, M.D. (Ortho) Office Visit/Primary Treating Physician's Progress Report (PR-2). **DOI:** [redacted] CC: Pain has remained unchanged. **CURRENT MEDS:** Gabapentin. Losartan. Meloxicam. Methocarbamol. **DX:** Unchanged. **PLAN:** Cervical spine epidural injection has been approved, but will still hold on scheduling. Recommend C6-C7 selective nerve root block on the left. **Rx:** Mobic 15 mg. Gabapentin 300 mg. **WORK STAT:** Per PTP. **FU VISIT:** 3 months.

[redacted]. ********. PA-c/***** *. ******. M.D. (Ortho) PTP Progress Report (PR-2). **DOI:** CT [redacted] **HPI:** Received PRP injection to left knee last visit, which helped pain mildly. CC: Constant cervical spine pain (6/10) radiating down the left upper extremity, causing numbness and tingling in the left hand. Constant lumbar spine pain (5/10) with numbness and tingling, along with burning, pins-and-needles in the left thigh. Constant left knee pain (4/10). Constant right knee pain (5/10). **DX:** Unchanged. **PLAN:** Will continue to track progress. Recommended right knee arthroscopy with partial meniscectomy and postop therapy. Pending authorization for physical therapy 12 sessions of cervical and lumbar spine. **WORK STAT:** TTD. **FU VISIT:** 4 weeks.

[redacted]. ********, PA-c/***** *. ******, M.D. (Ortho) PTP Progress Report (PR-2). **HPI:** Left knee PRP injection on 1[redacted] helped decrease pain by 25-30%. Completed 4/12 physical therapy sessions to lumbar spine, with little relief. **CC:** Constant cervical spine pain (6/10). Constant lumbar spine pain (4/10), improved since last visit. Constant left knee pain (4/10). Constant right knee pain (5/10). Symptoms of right knee giving away, have subsided tremendously since last visit. **DX:** Unchanged. **PLAN:** Authorized for right knee surgery and scheduled on [redacted] Pending auth for neck physical therapy. Cont physical therapy for lumbar spine and meds with pain management. **Rx:** Tylenol #3 for postop pain. **WORK STAT:** TTD. **FU VISIT:** 4-6 weeks.

[redacted] *****. PA/***** *. *****. M.D. (Ortho) Office Visit/Progress Notes/Primary Treating Physician's Progress Report (PR-2). **DOI:** [redacted] **CC:** Pain remains unchanged. Continues to have radicular symptoms down doing the left upper extremity. **CURRENT MEDS:** Gabapentin. Losartan. Meloxicam. Methocarbamol. DX: 1) Cervicalgia. 2) Cervical radiculopathy at C6. 3) Cervical radiculopathy at C7. 4) Chronic pain syndrome. 5) Myofascial pain syndrome. **PLAN:** Cervical spine epidural injection has been approved, but will still hold on scheduling. Will benefit from selective nerve root block on the left at C6-C7. **Rx:** Mobic 15 mg. Gabapentin 300 mg. **WORK STAT:** Per PIP. **FU VISIT:** 4 months.

[redacted]. ***** *. ******, M.D. (Ortho) Operative Report. **PROCEDURE:** Arthroscopic partial medial meniscectomy and removal of multiple loose bodies over 2.0 cm from the Intercondylar notch. Right knee extensive hemorrhagic synovectomy.

[redacted]. ********, PA-c/***** *. ******, M.D. (Ortho) PTP Progress Report (PR-2). **DOI:** CT [redacted] **HPI:** Status post right knee arthroscopic surgery [redacted] **CC:** Constant bilateral knee pain (4/10). Right knee pain improved since last visit. Lumbar spine pain (4/10). Constant cervical spine pain (5-6/10). **DX:** Remains unchanged. **PLAN:** Sutures removed in office. Postop

protocol discussed. Cleared to start postop physical therapy. **WORK STAT:** TTD. **FU VISIT:** 4-6 weeks.

[redacted] ********, PA-c/***** *, ******, M.D. (Ortho) PTP Progress Report (PR-2). **DOI:** CT [redacted] **HPI:** Completed 7-8/12 sessions of right knee postop physical therapy. Taking OTC pain medication. **CC:** Frequent bilateral knee pain (3/10). Constant cervical spine pain (6-7/10). Constant lumbar spine pain (4/10), similar since last visit. Doing well postoperatively. **DX:** Unchanged. **PLAN:** Recommend additional set of postop physical therapy with RFA. Continue Gabapentin as Rx by Dr. *****. **WORK STAT:** TTD. **FU VISIT:** 4 weeks.

[redacted] ****** *, ******, M.D. Ont Med) Primary Treating Physician Progress Report and RFA/PR-4. **DOI:** [redacted] **HPI:** Follow-up for blood pressure and long COVID symptoms. Recuperating from knee surgery done around [redacted]. **CC:** Nonspecific symptoms of fatigue, attributed to COVID. Blood pressure better. **CURRENT MEDS:** Carvedilol. Losartan. Meloxicam. Gabapentin. Crestor. **DX:** 1) Hypertension/hypertensive heart disease. 2) History of COVID, with some long COVID symptoms of fatigue. 3) Persistent systolic heart murmur. **PLAN:** Cardiology consultation with RFA, due to persistent murmur. MMI for COVID. **CAUSATION:** COVID is industrial due to workplace exposures. **IMPAIRMENT:** 3% WPI for COVID. **FUT MED CARE:** Follow-up with an internist 1-2x per year, periodic diagnostic lab testing. **WORK STAT:** None based on COVID.

[redacted] ********, PA-c/***** *, ******, M.D. (Ortho) PTP Progress Report (PR-2). **DOI:** CT [redacted]. CC: Frequent bilateral knee pain (3-4/10). Constant cervical spine pain (5/10) which radiates into the left shoulder and travels down into the left upper extremity and fingers, causing numbness and tingling. Constant lumbar spine pain (4/10). Burning in the left thigh and tingling. **DX:** Unchanged. **PLAN:** Continue with recently approved additional postop physical therapy, to begin on [redacted] Continue under care of Dr. ***** and with Gabapentin. **WORK STAT:** TTD, but permitted to proceed with firearm qualification. **FU VISIT:** 4 weeks.

[redacted] ********, PA-c/***** *, ******, M.D. (Ortho) PTP Progress Report (PR-2). **HPI:** Completed 7/12 of postop physical therapy. **CC:** Constant cervical spine pain (5/10), similar to last visit and that pain radiates into the left upper extremity, to forearm and 1st and 2nd digits of the left hand. Constant lumbar spine pain (4/10), similar to last visit. Constant bilateral knee pain (3/10). **DX:** Unchanged. **PLAN:** Cont physical therapy and home exercise. Cont under care of Dr. ***** and Gabapentin. **WORK STAT:** TTD, but permitted to proceed with firearm qualification. **FU VISIT:** 4 weeks.

[redacted] *****, PA/***** *. *****, M.D. (Ortho) Office Visit/Progress Notes/Primary Treating Physician's Progress Report (PR-2). **DOI:** [redacted] **HPI:** Last seen on [redacted] CC: Pain continues to be well controlled. Cervical spine pain (3-6/10). **CURRENT MEDS:** Gabapentin. Losartan. Meloxicam. Methocarbamol. **DX:** Unchanged. **PLAN:** Cervical spine epidural injection is approved, but will still hold on scheduling. Would benefit from selective nerve root block on the left at C6-C7. **Rx:** Mabie 15 mg. Gabapentin 300 mg. **WORK STAT:** Per PTP. **FU VISIT:** 4 months.

[redacted] ***** *. ******, M.D. (Ortho) PTP Permanent and Stationary Report. **DOI:** CT [redacted]. **CC:** Neck pain with radiation down the left arm (4/10). Low back pain with radiation to the left thigh (4/10). Bilateral knee pain (3/10). **DX:** 1) Chronic cervical strain. 2) Severe-moderate neuroforaminal stenosis at C4-C5, C5-C6 and C6-C7, per MRI 05/21/21. 3) Chronic left C7 radiculopathy EMG. 4) Chronic lumbar strain. 5) Bilateral knee chronic strain. 6) Bilateral knee chronic patellofemoral chondromalacia. 7) Right knee oblique increased signal within the posterior horn of the medical meniscus with inferior surface fraying/defect peripherally tracking to the body junction, subtle free edge fraying of the body of the lateral meniscus, proximal patellar tendinosis, chondromalacia, as described with small effusion and 8 mm posterior loose body and 1.6 cm corticated body along with the popliteus muscle belly, per MRI [redacted] **MMI:** Permanent and Stationary. **IMPAIRMENT:** Cervical spine 18% WPI. Lumbar spine 13% WPI. Right knee 3% WPI. Left knee 2% WPI. Pain 3% WPI. **APPORTIONMENT:** 100% to industrial injury from [redacted] l. **WORK STAT:** Precluded from climbing, squatting or lifting over 15 pounds. If restrictions not able to be accommodated, patient would be an excellent candidate for Supplemental Job Displacement Voucher. **FUT MED CARE:** Provided with access to an orthopedic primary treating physician for monitoring of appropriate medications, short courses of physical therapy for bilateral knees, as well as massage therapy for cervical and lumbar spine with utilization per the MTUS guidelines for flare-ups. Allowed surgery for cervical spine and lumbar spine. Allowed platelet rich plasma injections and viscosupplementation injections to the bilateral knees.

[redacted] ****** *. ******. M.D. (Int Med) Primary Treatin2: Physician Progress Report. Telemedicine. **DOI:** [redacted]. **HPI:** Follow-up for blood pressure medications. Saw a cardiologist, Dr. ******* *****, who made modifications in medications, discontinued Carvedilol substituted it with Nebivolol and added Hydrochlorothiazide. Had episode of dizziness, light headedness with some nausea that persisted for about 1 week, which occurred approx 1 month ago. Patient concerned about some pre stroke-type symptoms and went to urgent care, with work up inconclusive and unclear may have had a viral syndrome, eventually resolved. Taking blood pressure regularly and has been satisfactory. Scheduled for further cardiac testing this week, per Dr. ****. **CURRENT MEDS:**

Nebivolol. Losartan. Hydrochlorothiazide. Crestor. DX: 1) Hypertension. 2) Hyperlipidemia. 3) Cardiac workup in progress. **PLAN:** Continue workup with Dr. ****. Continue exercise program and medications. Get blood tests through PCP, Dr. ********. **FU VISIT:** [redacted]

[redacted] ******* *****, PA-c/***** *. *****, M.D. (Ortho) Office Visit/Progress Notes/Primary Treating Physician's Progress Report (PR-2). **DOI:** [redacted] CC: Pain continues to be stable. Pain level about 3-6/10. **CURRENT MEDS:** Gabapentin. Losartan. Meloxicam. Methocarbamol. **DX:** Unchanged. **PLAN:** Submit C6-C7 cervical intralaminar epidural steroid injection with RFA, dated [redacted] **Rx:** Gabapentin 300 mg, Robaxin 750 mg and Meloxicam 15 mg with RFA, dated 10/11/23. **WORK STAT:** Per PTP. **FU VISIT:** 4 months.

[redacted] *****, PA-c/***** *. *****, M.D. (Ortho) Office Visit/Progress Notes/Primary Treating Physician's Progress Report (PR-2). **DOI:** [redacted] **CC:** Pain level about 3-8/10. Cervical spine pain with radicular symptoms going down the left upper extremity with numbness and tingling. **CURRENT MEDS:** Gabapentin 300 mg. Losartan 12.5 mg. Meloxicam 15 mg. Methocarbamol 750 mg. DX: 1) Cervicalgia. 2) Cervical radiculopathy at C6. 3) Cervical radiculopathy at C7. 4) Chronic pain syndrome. 5) Myofascial pain syndrome. **PLAN:** Will re-submit for C6- C7 cervical intralaminar steroid injection. **Rx:** Gabapentin 300 mg. Mobic 15 mg. **WORK STAT:** Per PTP. **FU VISIT:** 4 months; around [redacted]

MISCELLANEOUS

- [redacted] Worker's Compensation Appeals Board. Award; Stipulations with Request for Award. DOI: [redacted] 24% permanent disability, payable at $160 per week beginning [redacted] in the sum of [redacted] and Award with Medical.
- [redacted] Medata. Request from ***** ********, M.D. Utilization Review: Approved for Carvedilol and Losartan/HCT.
- [redacted] Health Insurance Claim Form. ******* *, ********, M.D. Charge: [redacted]
- [redacted] Letter to [redacted] M.D. for agreeing to be an AME in Orthopedic, from ***** ***** ***** ***** & *****, [redacted] with Schedule of Records/Medical Index.
- [redacted] ******* *, *******, M.D.: [redacted], Amount [redacted] Amount: [redacted]; and [redacted]

End of Medical Record Review
322 Pages Reviewed

IMAGING STUDIES:

Cervical spine MRI dated [redacted] has revealed C4-5 disc herniation with central canal stenosis and C5-6 disc herniation with central canal stenosis.

Lumbar spine MRI has revealed L4-5 disc herniation with central canal stenosis.

MRI of the right knee has revealed significant chondromalacia, and medial meniscal tear.

MRI of the left knee has revealed significant chondromalacia.

DIAGNOSES:

1) Cervical radiculopathy, left-sided, C4-5, C5-6 disc herniation with stenosis.

2) Lumbar radiculopathy, left-sided; L4-5 disc herniation, 7 mm, left-sided.

DISCUSSION:

Officer FirstName LastName presents with complaints involving his neck and low back that he attributes to a period of cumulative trauma from [redacted] during the course of his employment as a Police Officer for the Employer Police Department.

The examinee states he started to experience pain in his neck, back and knees in 2010, which slowly progressed over time. He indicates he performed activities that had included repetitive flexion/extension of the neck, repetitively getting in and out of patrol vehicle, foot pursuits, climbing walls and fences, as well as bending, stooping, squatting, climbing, running, jumping, pushing, pulling, lifting of heavy objects and other physical activities. He also attributes the onset of pain as a result of wearing a heavy Sam Brown belt and bullet-proof vest.

He states that on [redacted] he filed an incident report and was referred for medical treatment. He was then referred to Dr. ****** who examined him and obtained x-rays. He states he was prescribed medication and was placed on temporary total disability.

Treatment was reported as having included physical therapy for his neck, back and knees.

He states he had MRI studies of the neck, back and bilateral knees, and was advised that he had compressed discs causing pinched nerves in the neck, positive findings on the MRI of the low back and a tear in the meniscus of the right knee.

After referral to Dr. ***** for pain management he was recommended epidurals for his cervical spine but they were not initially authorized until the appeal process. He indicates that by that time

his neck condition had improved to the point that he did not feel it was necessary to receive the injections.

He received additional physical therapy for his neck, low back and bilateral knees. He also received PRP injections for his bilateral knees, which provided temporary relief of symptoms.

He states that right knee surgery was recommended, which he underwent on [redacted] followed by postoperative physical therapy for the right knee. He states that following surgery and treatment his right knee improved; however, he continues to experience residual right knee pain.

He states that on [redacted] Dr. ****** released him from care as permanent and stationary.

He remains under the care of Dr. *****, whom he follows up with every 4 months and receives medication refills.

Review of the medical records includes an orthopedic report by Dr. ******* dated [redacted] indicating he was in an auto accident on [redacted] and was diagnosed with injury to the cervical, thoracic and lumbar sprain/strain. He also had a left elbow radial head fracture on [redacted] At that time he was noted to have subjective radiculopathy in the left upper extremity ulnar nerve distribution. He was considered to be permanent and stationary regarding the cervical spine minus an EMG/NCV of the left upper extremity. There were no work restrictions for the cervical spine. He was given restrictions for the elbow.

There appears to be no ratable disability for the cervical spine pertaining to the [redacted] auto accident.

Dr. ******* subsequently received a report of Dr. ******** dated [redacted], after the request for EMG/NCV studies, and noted the final rating of disability remained essentially unchanged.

The progress report dated [redacted] notes he was being treated for the cumulative trauma injury from [redacted], with diagnoses that included chronic cervical strain, chronic lumbar strain, bilateral knee chronic strain, and bilateral knee chronic patellofemoral chondromalacia.

He then underwent diagnostic studies including MRI scans of the cervical spine and lumbar spine and EMG/NCV studies of the upper extremities in [redacted].

The electrodiagnostic study on [redacted] has indicated chronic left C7 radiculopathy.

The MRI of the cervical spine on [redacted] is remarkable for moderate spinal stenosis at C4-5 and mild to moderate canal stenosis at C5-6, with disc herniation and neuroforaminal stenosis at these levels.

An MRI of the lumbar spine on [redacted] has revealed mild spinal canal stenosis with disc herniation, mild posterior displacement of the descending left L5 nerve roots as well as moderate bilateral neural foraminal stenosis.

An MRI of the right knee on [redacted] was remarkable for increased signal within the posterior horn of the medial meniscus with inferior surface fraying/defect peripherally tracking to the body junction, chondromalacia and loose bodies.

On [redacted] his treating physician, Dr. ******, reviewed the results of the EMG and MRI scans and recommended physical therapy for the cervical and lumbar spine, and PRP injection for the right knee. He was also noted to be a good candidate for an epidural injection.

When seen on [redacted] he was recommended a neurosurgical consultation, and was to continue with physical therapy and his medications.

On [redacted] a PRP injection was administered to the right knee.

A neurosurgical consultation report by Dr. ******* dated [redacted] indicates MRI studies were reviewed and authorization was requested for cervical spine epidural steroid injections.

When seen by Dr. ****** on [redacted] it was noted that his right knee pain had improved with a PRP injection; however, he was complaining of locking and weakness of the right knee. Cervical traction was recommended, as well as physical therapy and he was continued on medications. He was also recommended epidural injections, and if he failed conservative treatment future anterior cervical discectomy and fusion of C5-6 and C6-7.

On [redacted] he was recommended a pain management consult with Dr. *****.

A pain management report by Dr. ***** dated [redacted] indicates the diagnoses included cervical radiculopathy at C6, cervical radiculopathy at C7, myofascial pain syndrome, and chronic pain syndrome. Multiple treatment options discussed and he was recommended C6 and C7 selective nerve root block on the left side.

A repeat PRP injection to the right knee was recommended by Dr. ****** on [redacted].

On [redacted] Dr. ***** again recommended C6 and C7 selective nerve root block on the left side.

When seen by his treating physician on [redacted] it was noted that he had completed six physical therapy sessions to the neck and low back. The plan was 12 sessions of physical therapy, 2x6 for cervical and lumbar spine, and he was to proceed with the authorized platelet rich plasma injection for right knee.

He reported 25-30% benefit after a PRP injection to the right knee on [redacted].

On [redacted] an MRI of the left knee was requested by his treating physician. Additional physical therapy for the cervical and lumbar spine, and pain management followup were recommended.

Physical therapy for both knees was requested by the treating physician on [redacted].

An MRI of the left knee on [redacted] was remarkable for tendinopathy and minimal grade 3 changes of the patella and grade 5 chondral changes along the central trochlea.

A PRP injection to the left knee was recommended on [redacted].

An updated MRI of the right knee was requested on [redacted].

An MRI of the right knee on [redacted] revealed a degenerative tear of the posterior horn and posterior mid-body of the medial meniscus with extruded inferior articular fragment in the medial recess, multiple loose bodies within the posterior intercondylar region of the knee, and Grade 2-3 chondromalacia.

A left knee PRP injection was provided on [redacted].

Arthroscopy of the right knee was recommended by the treating physician on [redacted], after reviewing the updated MRI of the right knee.

He saw Dr. ***** on multiple occasions who again recommended C6 and C7 selective nerve root block on the left side.

On [redacted] his treating physician, Dr. ******, performed arthroscopic surgery to the right knee with partial medial meniscectomy and removal of multiple loose bodies over 2.0 cm from the Intercondylar notch, and right knee extensive hemorrhagic synovectomy.

He subsequently received postoperative physical therapy for the right knee and followed up with his treating physician.

A permanent and stationary report by Dr. ****** on [redacted] indicates there was 18% whole person impairment for the cervical spine, lumbar spine 13% WPI, right knee 3% WPI and left knee 2% WPI, as well as 3% for pain. No apportionment was indicated. Future medical care was addressed, as well as restrictions and he was considered an excellent candidate for Supplemental Job Displacement Voucher.

On [redacted] Dr. ***** recommended a C6-C7 cervical intralaminar epidural steroid injection.

When seen by Dr. ***** on [redacted] a C6-C7 cervical intralaminar steroid injection was again recommended.

CAUSATION:

His job duties included repetitive bending, stooping and squatting; repetitive twisting, turning, pushing and pulling, prolonged sitting, standing and walking, running over various terrain, jumping over fences, and lifting and carrying up to 100 to 200 pounds, which are activities that

can cause and contribute to neck, low back and bilateral knee complaints and findings over time, on a cumulative trauma basis. He also wore Sam Browne belt while working and has a presumption for the back on a work related basis.

The medical records are supportive of work related injury to his neck, low back and bilateral knees, for which he has undergone treatment.

Based on the information available to me he sustained an industrial cumulative trauma injury to his cervical spine, lumbar spine and bilateral knees from [redacted], during the course of his employment as a Police Officer for the Employer Police Department.

DISABILITY STATUS:

The cervical spine, lumbar spine and bilateral knees reached maximum medical improvement on [redacted] when found to be permanent and stationary by his treating physician.

RECOMMENDED FUTURE MEDICAL TREATMENT:

Future medical care includes courses of physical and/or chiropractic therapy to treat the cervical spine, lumbar spine and both knees.

He can return to his treating orthopedic surgeon for evaluation and treatment of the cervical spine, lumbar spine and both knees.

He is indicates for return visits to his treating pain management physician for prescriptions of appropriate medications, and cervical and lumbar epidural steroid injections.

He also has provisions for additional PRP injections for the bilateral knees, limited to two per year for each knee.

PERIODS OF TEMPORARY DISABILITY:

He has had an appropriate period of temporary total disability from [redacted] when found to be permanent and stationary by his treating physician.

PERMANENT IMPAIRMENT:

Cervical Spine: There is tenderness on palpation over the paravertebral muscles on the right and on the left. Range of motion of the cervical spine is slightly restricted. Spurling's test is positive for cervical radiculopathy on the left. Sensation is decreased in the C5 and C6 dermatomes on the left. The cervical spine MRI has revealed C4-5 disc herniation with central canal stenosis and C5-6 disc herniation with central canal stenosis, supportive of cervical radiculopathy. The electrodiagnostic study on [redacted] has indicated chronic left C7 radiculopathy. The objective findings are supportive of DRE Cervical Category III, 17% whole person impairment, which includes difficulties with activities of daily living involving the cervical spine.

Lumbar Spine: There is tenderness to palpation of the paraspinal muscles with increased muscular tone at L4-5 and L5-S1. Straight leg raising test is negative bilaterally, and motor and sensory examinations of the lower extremities are normal. The MRI of the lumbar spine has revealed L4-5 disc herniation with central canal stenosis. There are complaints pain radiating into his left hip, buttock up to the thigh, and constant numbness and tingling in his left out thigh and intermittent in the left inner thigh, consistent with the MRI revealing L4-5 disc herniation with stenosis which is supportive of lumbar radiculopathy. The objective findings are supportive of DRE Lumbar Category III, lower range, 10% whole person impairment.

Right Knee: There is tenderness to palpation on the medial and lateral joint lines. The right knee is status post partial medial meniscectomy for which there is 2% lower extremity impairment with reference to Table 17-33. The MRI of the right knee has revealed significant, Grade 2-3 chondromalacia, supportive of 7% lower extremity impairment for decreased cartilage interval with reference to Table 17-31. With reference to Table 17-2, combining the 2% and 7% results in 9% lower extremity impairment, converting to 4% whole person impairment for the right knee utilizing Table 17-3.

Left Knee: There is tenderness to palpation on the medial and lateral joint lines. The MRI of the left knee has revealed, minimal grade 3 chondromalacia of the patella and also significant grade 5 chondral changes along the central trochlea of the left knee, supportive of 7% lower extremity impairment for decreased cartilage interval with reference to Table 17-31, converting to 3% whole person impairment for the left knee utilizing Table 17-3.

APPORTIONMENT:

There is no history of any prior or non-industrial injury to the cervical spine, lumbar spine and bilateral knees, and considering the arduous nature of his job duties it would be speculative to state that there would be any significant degenrative change absent the long period of cumulative trauma. Based on the information available to me I would apportion 100% of the impairment for the cervical spine, lumbar spine and bilateral knees to the industrial cumulative trauma injury from

[redacted], during the course of his employment as a Police Officer for the Employer Police Department.

WORK RESTRICTIONS:

Work restrictions are not applicable as the patient is retired.

WORK STATUS

He is retired.

VOCATIONAL REHABILITATION

As he has retired he is not indicated for supplemental job displacement benefits.

Please do not hesitate to contact me if you have any questions or concerns regarding this case.

My opinions stated in this report are based on reasonable medical probability and substantial medical evidence.

Any additional records that may be provided will be reviewed and discussed in a supplemental report.

PHYSICIAN DISCLOSURE

The above report is not to be construed as a complete physical examination for general health purposes. Only those symptoms which are believed to have been involved in the injury, or might relate to the injury, have been assessed. Regarding the general health of this patient, it is advisable to have a physical examination for general purposes with the patient's personal physician.

The above assessment, diagnosis, and treatment recommendations are based on the available medical records, patient's self-reported history, physical exam, and review of diagnostics studies. I reserve the right to make changes to this report should additional information or documentation is provided to me at any time in the future.

I declare under penalty of perjury that I, the signing physician, have actually performed this examination, and the time spent in performing this evaluation is in compliance with the IMC guidelines (section 53 07.1 and 5307.6).

STATEMENT OF COMPLIANCE:

Let it be known that over eighty percent (80%) of this physician's time is annually devoted to medical treatment.

DECLARATION PURSUANT TO LABOR CODE SECTION 4628(J):

"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 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 have not violated Labor Code Section 139.3 and the contents of the report are true and correct to the best of my knowledge. This statement is made under penalty of perjury.

Executed on [redacted] in the County of Orange County, California.



HAMID R. MIR, M.D.

Orthopedic Surgeon, Board Certified

Fellowship Trained in Spine Surgery

Qualified Medical Examiner

[redacted]

HAMID R. MIR, M.D.

BOARD CERTIFIED ORTHOPEDIC SPINE SURGEON
Minimally Invasive Spine Surgery
Scoliosis and Reconstructive Spine Surgery

949-688-1216 phone · 949-988-7801 fax
Newport Beach | Marina Del Rey | Riverside
www.hamidmirmd.com

Applicant Attorney

Defense Attorney

Examinee's Name:	*****, *****
Date of Exam:	[redacted]
Date of Birth:	***** **, ****
Employer:	City of ***** *****
Date of Injury:	1) CT [redacted]
	2) [redacted]
	3) CT [redacted]
Claim No.:	1) ******
	2) ******
	3) ******

ORTHOPEDIC AGREED MEDICAL EVALUATION AND REPORT

To whom it may concern:

The examinee was seen in my Riverside office today, [redacted], for an Orthopedic Agreed Medical Evaluation. All historical data was obtained directly from the examinee and any available medical records.

This evaluation includes a comprehensive history, a comprehensive physical examination and complex medical decision making. This examination fulfills the criteria for ML201-94, Medical-Legal Agreed Medical Evaluation. Total of 474 pages of records were received and reviewed for this evaluation.

CHIEF COMPLAINTS

- Occasional right shoulder pain.
- Frequent lower back pain.
- Radiating lower back pain into the bilateral legs, buttocks, hips and thighs.
- Occasional left hip pain.
- Constant right knee pain.
- Radiating right knee pain into the upper inner thigh and down into the calf, sides of the lower leg and back of knee.
- Constant right ankle pain.
- Internal complaints of acid reflux.

EMPLOYMENT HISTORY

Ms. ***** started working for ***** ***** Police Department as a police officer, initially in [redacted] Training in [redacted] and the in academy on [redacted]. She was responsible for enforcing laws and ordinances, protecting life and property, issuing citations, making arrests, possessing and carrying a firearm, wearing a Sam Brown, collecting evidence, patrolling, preparing reports, working as a team member, providing information to the public and performing administrative and payroll duties

According to the examinee, this position physically required her to sit, stand, walk, run, drive, bend, stoop, twist, chase, climb, reach above shoulder level, reach below shoulder level, squat, kneel, crawl, crouch, ascend or descend stairs, use a firearm, perform take-downs, tactical duties, push, pull, and lift and carry up to approximately and adult size male. There were also repetitive arm and hand movements, using her hands for fine manipulation, gripping, grasping, pinching, and repetitive motions, which included writing, data entry and typing.

The examinee reported that for the last 4 years of her employment with ***** ***** Police Department, she worked a 3/12 schedule, graveyard shift, various hours per day and various days per week, on a rotating basis. Prior to that, she worked a 4/10 schedule for several years, various hours per day, various days per week, on a rotating basis.

The examinee was employed by City of ***** ***** Police Department for a little over [redacted] years.

CURRENT WORK STATUS

Ms. ***** is no longer employed by City of ***** ***** Police Department. She last worked on [redacted], at which time she was placed on temporary total disability by her treating physician. She subsequently retired as of [redacted].

She is currently not working and is not currently receiving workers compensation benefits.

HISTORY OF INJURY

CT [redacted]

Ms. ***** is claiming injury on a continuous trauma basis from [redacted], through [redacted], and states that during the course of her employment with City of ***** ***** Police Department, she was performing her usual and customary job duties when she developed the gradual onset of pain to her right shoulder, right knee and left hip, and internal complaints of acid reflux. She attributes her pain and complaints to continuous and repetitive job duties and also as a consequence to specific other industrial injuries throughout the years, as noted below. She also attributes her left hip complaints to overcompensation of her right knee pain.

Ms. ***** reports that she had a specific injury to her neck and bilateral shoulders in [redacted], as well as right knee work injury in [redacted]. She was treated for these injuries, with surgeries and various therapies and was place on permanent work restrictions, which placed her in the office and in administrative duties in which she performed time keeping and payroll. As she began working in office duties, she developed the gradual onset of right shoulder pain, which she attributes to prolonged and repetitive extensive writing and typing. She also reported experiencing another industrial injury of bilateral carpal tunnel syndrome, right trigger thumb and right cubital tunnel syndrome, which was treated under a separate claim with right thumb, wrist/hand and elbow surgeries in [redacted]

Ms. ***** believes she may have reported her right shoulder, left hip and right knee complains in [redacted] and believes she may have received physical therapy. But at the time, does not believe anything was really for her left hip, or at that time for her right knee.

Over the years she did report undergoing many MRI studies of her right shoulder which did report a tear. She did not recall when her MRI studies were done. Eventually surgery to the right should was recommended and she underwent right shoulder surgery on

approximately [redacted] She was treated with some postoperative physical therapy, but the dates and number of treatments could not be remembered. She continued to remain symptomatic with right shoulder pain and complaints.

Ms. ***** did report a prior industrial injury to her right knee in [redacted], which was treated under a separate claim. Under this separate claim, she reported being treated with physical therapy and medications, which caused acid reflux, as well as 3 different surgeries to her right knee, in [redacted], and again in [redacted]

The examinee reports that she has continued to remain symptomatic with right knee pain. After her 3rd right knee surgery in [redacted], Ms. ***** was advised that she would eventually require right knee replacement surgery.

As she continued to remain symptomatic with right knee pain, after her retirement in June [redacted], Ms. ***** was seen and examined at *****-*****. She was recommended for right knee replacement surgery, which was performed on [redacted]. Postoperatively, she continued to treat at *****-***** with follow-up visits and physical therapy. She reported undergoing 24 sessions of postoperative physical therapy to her right knee in [redacted] The exact dates of her physical therapy treatments were unknown.

In [redacted], due to ongoing right knee pain, additional physical therapy to her right knee was recommended and 12 sessions were eventually approved. She reports starting her additional physical therapy again in [redacted] 2x per week, which has caused increased pain. She last attended physical therapy to her right knee on [redacted] and reports that she has 5 more sessions of physical therapy to go. She is scheduled to be seen at *****-***** again in late [redacted]

As noted above, Ms. ***** attributes her left hip pain to over compensation of her right knee pain and injury. She denies receiving any treatment for her left hip pain. She has continued to remain symptomatic with left hip pain.

[redacted]

Ms. ***** states that on [redacted], during the course of her employment with City of ***** ***** Police Department, she was performing her usual and customary job duties when she sustained injury to her back. She reports that it was during the riots and they were put on 12 hour shifts with no days off. She reports that she got out of her chair,

after prolonged sitting and experienced the immediate onset of sharp lower back pain. The injury was reported to her supervisor and she was sent to the company clinic.

At the company clinic, Ms. ***** underwent x-rays of her lumbar spine and after a few weeks she underwent an MRI of her lumbar spine, which reported some abnormalities. She reports that she was treated with physical therapy, 24 sessions and also believes she had some chiropractic treatment. She was unable to recall the exact number of physical therapy and chiropractic treatments received, or the dates of her treatments. She believes she last received treatment and/or therapy in late [redacted].

Ms. ***** believes she was treated for her lower back pain by ****** ******, M.D. with physical therapy, chiropractic treatments and follow-up visits. She was considered Permanent and Stationary by Dr. ****** in [redacted]. She believes she was last seen by Dr. ****** in approximately [redacted] or [redacted]

CT [redacted]

Ms. ***** is claiming injury on a continuous trauma basis from [redacted], through [redacted], and states that during the course of her employment with City of ***** ***** Police Department, she was performing her usual and customary job duties when she developed the gradual onset of pain to her right ankle. She attributes her right ankle pain and complaints to continuous and repetitive job duties, including walking up and down stairs, walking in the parking garage, walking on hard surfaces and working in the kit room, going up and down a step stool and down onto the hard surface floor.

Ms. ***** reports that she was initially seen at ***** in [redacted]. She was seen by a podiatrist and was given a brace for her right ankle. She also reports that she may have had diagnostic studies performed at *****, x-rays and/or an MRI, but was unable to recall. Physical therapy was recommended, but she declined physical therapy through *****.

In approximately [redacted], the examinee reports that she was seen by Dr. ******* at *****-*****, who did recommended PRP injections to her right ankle, but they were denied by the insurance. She denies receiving any treatment for her right ankle. She believes she was last seen by Dr. ******* in [redacted].

The examinee remains symptomatic with right shoulder, lower back, left hip and right knee and ankle/foot pain, as well as complaints of acid reflux and radiating lower back pain into the bilateral legs, buttocks, hips and thighs and right knee pain radiating into the

upper inner thigh and into the calf, sides of the lower leg and into the back of the knee. She self-treats with medications, heat, ice and home stretching and exercises.

The examinee could not recall having consulted any other physicians or having been provided with any further course of treatment when she presented in my office today for examination.

TREATMENT TO-DATE

- Physical therapy to right shoulder in [redacted]. The exact number and/or dates unknown.
- Right shoulder surgery on approximately [redacted]
- Postoperative physical therapy to right shoulder in [redacted] The exact number and/or dates unknown.
- Three (3) different surgeries to the right knee, [redacted], again in [redacted], and a 3rd right knee surgery in [redacted] (under separate claim).
- Various and multiple pre and post physical therapy to the right knee (under separate claim).
- Right knee replacement surgery on [redacted].
- Postoperatively physical therapy, 24 sessions in [redacted]. The exact dates of her physical therapy treatments were unknown.
- Additional right knee physical therapy (12 sessions, 2x per week approved) she has received 7 out of 12 sessions. She does not know the dates of her treatments, but last received therapy on [redacted] She reports that she has 5 more sessions of physical therapy to go.
- Physical therapy, 24 sessions and some chiropractic treatment to the lower back in [redacted] The exact number of physical therapy and chiropractic treatments were unknown. She believes she last received treatment and/or therapy in late [redacted].

PRIOR INDUSTRIAL INJURIES

The examinee states that in approximately [redacted] while employed by ***** ***** Police Department, she was involved in a "shooting" work related injury and sustained injuries to her neck, as well as bilateral shoulders. As a result, treatment was required and received. She reports she was treated with medications, physical therapy and surgery to

her neck, with plates and screws, in [redacted] and surgery to her left shoulder in [redacted]. She was unable to recall the dates she was off work. She has continued to remain symptomatic.

The examinee states that in approximately [redacted] while employed by ***** ***** Police Department, she was involved in a work related injury and sustained injury to her right knee. As a result, treatment was required and received. She reports she was treated with medications, physical therapy, 3 different surgeries to her right knee, in [redacted], again in [redacted], and with a 3rd right knee surgery in [redacted] and with postoperative physical therapy. She was unable to recall when she was off work for treatments. She has continued to remain symptomatic.

The examinee states that in approximately [redacted] while employed by ***** ***** Police Department, she was involved in a work related injury and sustained injury to her bilateral upper extremities, elbows, wrists, hands and fingers. She was diagnosed with bilateral carpal and cubital tunnel, right trigger thumb and right cubital tunnel. As a result, treatment was required and received. She reports that she was treated with medications, physical therapy, and underwent right trigger thumb release, right carpal tunnel release and right cubital tunnel release. She continues to remain symptomatic.

PRIOR NON-INDUSTRIAL INJURIES

The examinee denies past non-industrial pain, accidents and/or injuries.

PRESENT COMPLAINTS

RIGHT SHOULDER: Ms. ***** complains of experiencing occasional sharp, dull, aching, stabbing, burning pain in her shoulder. She describes her pain as a 4-5 on a pain scale from 1 to 10 with 10 being the most severe. Her shoulder pain is increased upon lifting, carrying, pushing, pulling, and reaching at and above shoulder level. The pain is decreased with ice, heat, stretching and with over-the-counter Advil or Tylenol. She experiences stiffness and popping of the joints. She experiences difficulty sleeping due to pain.

LUMBAR SPINE: Ms. ***** complains of frequent sharp, dull, aching, stabbing, spasming and burning pain in her lower back. She describes her pain as a 2-8 on a pain scale from 1 to 10 with 10 being the most severe. The pain is located across her waist and radiates down into her legs to the feet. The pain is increased upon sitting, standing, walking for any length of time, crossing her legs, bending at her waist, twisting, stooping,

pushing, pulling and lifting and/or carrying of 10 pounds weight. The pain is decreased with heating pad, ice and with over-the-counter Advil or Tylenol. She experiences stiffness, weakness and popping of the joints. She reports difficulty with ambulation. She experiences difficulty sleeping due to pain. There is increased frequency in urination and increased back pain with bowel movements and straining.

There is no numbness or tingling in her legs. She denies increased back pain upon coughing or sneezing.

LEFT HIP: Ms. ***** complains of experiencing occasional sharp, dull, aching, stabbing and burning pain in her hip. She describes her pain as a 2-6 on a pain scale from 1 to 10 with 10 being the most severe. The pain is increased upon standing and walking for any length of time, walking on even or uneven terrain, squatting, bending, stooping, ascending and descending stairs, pushing, pulling and lifting and/or carrying of any weight. The pain is decreased with heat, ice, over-the-counter Advil or Tylenol and with not lying on her left side. She experiences stiffness and weakness. She experiences difficulty sleeping due to pain.

RIGHT KNEE: Ms. ***** complains of experiencing constant sharp, dull, aching, stabbing, burning pain in her knee. She describes her pain as a 2-9 on a pain scale from 1 to 10 with 10 being the most severe. The pain radiates up into the thigh and down into the calf and sides of the lower leg and behind the knee. The pain is increased upon standing and walking for any length of time, walking on even or uneven terrain, squatting, bending, stooping, ascending and descending stairs, pushing, pulling and lifting and/or carrying of weight. The pain is decreased with elevation of her knee, heat, ice and over-the-counter Advil or Tylenol. She experiences stiffness, weakness, swelling and popping, locking, giving way and buckling of the knee. She experiences difficulty sleeping due to pain.

RIGHT ANKLE/FOOT: Ms. ***** complains of experiencing constant sharp, dull, aching, stabbing, burning pain in her foot, ankle and Achilles. She describes her pain as a 1-5 on a pain scale from 1 to 10 with 10 being the most severe. The pain is increased upon wearing the wrong shoes, standing and walking for any length of time, walking on even or uneven terrain, squatting, bending, stooping, ascending and descending stairs, pushing, pulling and lifting and/or carrying of any weight. The pain is decreased with elevation of her ankle/foot and ice. She experiences stiffness, weakness, swelling and cracking of the joints. She experiences difficulty sleeping due to pain.

ACTIVITIES OF DAILY LIVING

Ms. ***** experiences increased pain with self-care and personal hygiene, including taking a shower or bath, washing or drying her face/body, turning on/off faucets, brushing her teeth, combing/brushing her hair, self-dressing, putting on or taking off her socks/shoes, opening a carton of milk or jar, making a meal, getting on or off the toilet and with the ability to urinate or defecate. There is increased pain with physical activities that involves sitting, standing, walking, reclining, rising from a chair, getting in and out of bed, ascending or descending stairs, working outdoors, performing light housework, shopping, running errands, carrying groceries or anything over 10 pounds, caring for children/parents, engaging in hobbies and with sexual activity. There is increased pain and difficulty with communication, including writing a note, typing a message on a computer/keyboard and watching television. She experiences increased pain with travel, including getting in or out of a vehicle, driving or riding in a vehicle, riding a bicycle or flying in a plane.

Please see the attached Activities of Daily Living Sheet as completed by the examinee.

DIAGNOSTIC STUDIES

No diagnostic studies films are available for review.

PAST MEDICAL/SOCIAL HISTORY

Past Illnesses: The examinee has a history of seasonal allergies, high cholesterol and thyroid disease and takes medications for control. She denies high blood pressure, diabetes mellitus, lung disease, epilepsy, tuberculosis, collagen disease or cancer. She denies any other serious illnesses.

Past Surgeries: The examinee has undergone a tonsillectomy when she was 18-years-old; Wisdom teeth removal as a teen; D&C on [redacted] and again in approximately [redacted] Gall bladder removal on [redacted] Right knee surgeries in [redacted] and [redacted] Tubal ligation in [redacted] Cosmetic surgery in [redacted]; Neck surgery with plates and screws in [redacted] Hysterectomy and prolapse bladder surgery on [redacted]; Right trigger thumb and carpal tunnel, and cubital tunnel release surgeries in [redacted] Left shoulder surgery in [redacted]; right shoulder surgery in [redacted]; and right knee replacement surgery in June [redacted]

Medication(s): The examinee is currently taking a statin for high cholesterol and medication for her thyroid disease; Lasix for edema; Climara for estrogen; a vaginal cream; Trazodone; Phentermine, a diet pill; Over-the-counter Tylenol or Advil; Over-the-Counter Omeprazole; Vitamin B12; Estroven; Flax seed; Neuriva; A multivitamin; Vitamin C; Vitamin D; Magnesium: Turmeric; Zyrtec; and Flonase.

Allergies: The examinee has no known allergies to medications, but reports a possible sensitivity to Iodine.

Social History: The examinee drinks alcoholic beverages "once in a while". The examinee denies smoking cigarettes, and reports quitting in [redacted]. The examinee denies use of illegal drugs.

PHYSICAL EXAMINATION

The examinee is a 62-year-old female. She is 5 feet, 03 inches tall and weighs 160 pounds. The examinee is right hand dominant.

LUMBAR SPINE:

Inspection:

There is no sagittal kyphotic deformity. Skin is intact.

Palpation:

There is tenderness on palpation over the paraspinal muscles

Range of Motion:	Normal	Measured
Flexion	60°	60°
Extension	30°	30°
Right lateral flexion	30°	30°
Left lateral flexion	30°	30°

Special Tests:	Right	Left

Straight Leg Raise	Negative	Negative

LOWER EXTREMITIES:

Motor Examination:	Right	Left
Knee Extension	5/5	5/5
Knee Flexion	5/5	5/5
Ankle Dorsiflexion	5/5	5/5
Ankle Plantarflexion	5/5	5/5

Sensation to light touch:	Right	Left
L-3	Normal	Normal
L-4	Normal	Normal
L-5	Normal	Normal
S-1	Normal	Normal

Deep Tendon Reflexes:	Right	Left
Patella	2+	2+

SHOULDER EXAM:

Inspection:

There are no rashes, bruises, abrasions, lacerations or ecchymosis noted.
There is no erythema or swelling.

Palpation (tenderness):	Right	Left
Acromioclavicular joint	Normal	Normal
Sternoclavicular joint	Normal	Normal

Subacromial space	Normal	Normal

Shoulder Muscle Strength:	Right	Left
Abduction	5/5	5/5
Adduction	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

Range of Motion:	Right	Left	Normal (deg.)
Abduction	180	180	180
Adduction	50	50	50
Forward flexion	180	180	180
Extension	50	50	50
Internal rotation	90	90	90
External rotation	90	90	90

Orthopedic Tests:	Right	Left
Supraspinatus test	Normal	Normal
Impingement test	Normal	Normal

HIP EXAM:

Inspection:

There is no deformity. Skin is intact.

Palpation:

There is no tenderness

Range of Motion:	Normal	Right	Left
Flexion	110°	110°	110°
Extension	10°	10°	10°
Internal Rotation	30°	30°	30°
External Rotation	40°	40°	40°
Abduction	45°	45°	45°
Adduction	15°	15°	15°

Motor Examination:	Right	Left
Hip Flexion	5/5	5/5
Hip Extension	5/5	5/5
Hip Abduction	5/5	5/5
Hip Adduction	5/5	5/5

KNEE EXAM:

Inspection:

Inspection revealed no deformity with normal alignment. There is no evidence of effusion.

Palpation:

There is tenderness on palpation of the **right knee medial joint line.** There is popping of the patellofemoral joint with flexion and extension

Range of Motion

	Right	Left	Normal (deg.)
Flexion	**110**	130	150
Extension	0	0	0

Knee Motor Strength:	Right	Left
Flexion	5/5	5/5
Extension	5/5	5/5

Orthopedic Tests:

	Right	Left
Drawer, Anterior	Normal	Normal
Drawer, Posterior	Normal	Normal
Lachman's test	Normal	Normal
McMurray	Normal	Normal
Valgus stress test	No instability	No instability
Varus stress test	No instability	No instability

ANKLE/FOOT:

Inspection:

There are no rashes, bruises, lacerations, ecchymosis or abrasions. There is no erythema or gross swelling.

Palpation:

There is tenderness on palpation over the posterior Achilles tendon

Range of Motion:	Right	Left	Normal (deg.)
Ankles			
Dorsiflexion	15	15	15
Plantar flexion	50	50	50
Subtalar			
Inversion	35	35	35
Eversion	20	20	20
Great Toe			
Flexion	25	25	25
Extension	40	40	40

Ankle/Foot Muscle Strength:	Right	Left
ANKLE		
Dorsiflexion	5/5	5/5
Plantar flexion	5/5	5/5
Inversion	5/5	5/5
Eversion	5/5	5/5

MEDICAL RECORD REVIEW

Received 474 pages of records for review. The total length of time for review of these records was 14 hours.

******* *******, MD.
[redacted] **Primary Treating Physician's Permanent and Stationary Report with Review of Medical Records. DOI**: [redacted] [redacted] **Chief Complaints (Subjective)**: Cervical spine pain, right knee pain, left knee. There is no pain in the left knee. **Final Diagnoses**: 1) 2 to 3 mm annular disc bulges C4 through C7, per MRI times two, with congenital narrowing of the spinal canal and positive discogram C5-C6. 2) Status post arthroscopic partial medial meniscectomy and lateral release, right knee by history, significantly improved. **Causation**: Absent evidence to the contrary, based on the information available to me at this time, it does appear that the patient's complaints are related to the industrial injury. **Work Restrictions**: Cervical spine: The

patient has a work restriction precluding repetitive motions of the neck, heavy lifting, lifting, pushing, pulling, forward reaching, and working at or above the shoulder level. Right knee: The patient has a work restriction precluding prolonged walking, prolonged sitting, repetitive squatting, repetitive kneeling, repetitive ascending and descending stairs, working at unprotected heights and very heavy lifting. **Vocational Rehabilitation**: She should not be considered a qualified injured worker for vocational rehabilitation purposes. **Apportionment**: The increased disability for the cervical spine above the 20% previously awarded should be considered secondary to the natural progression of the industrially related trauma of September 4, 1997 and should be obtained via the subtraction method. **Future Medical Care**: The patient should have access to future medical care in the form of orthopedic evaluation and conservative measures of treatment as needed for increased symptoms which may occur spontaneously or following vigorous activity. She may require the reinstitution of a conservative treatment program to alleviate any increased discomfort she may experience and this should be provided. The patient has been advised to use moist heat application and over-the-counter anti. inflammatory and analgesic medication for pain relief. She was also advised to work on an exercise program at home. In the future patient also may need epidural injections to the cervical spine as well as possible cervical spine surgery. This should all be provided to the patient on an industrial basis. Patient will continue on a course of therapeutic modalities three times a week to maintain her permanent and stationary condition and allow her to continue working. Examiner provided the patient with a prescription for an alpha stimulator. No further appointments have been scheduled for this patient.

******** ********, MD.

[redacted] **Qualified Medical Examination. DOI**: [redacted] **Chief Complaint**: Neck, bilateral shoulder and right knee pain. **Diagnoses**: 1) Cervical spine strain superimposed upon degenerative disc disease. 2) Status post arthroscopy/arthroscopic partial medial meniscectomy and lateral release, right knee. **Work Capacity**: With respect to the right knee, the patient avoids very heavy lifting, repetitive kneeling/squatting/ascending/descending stairs. **Future Medical Treatment**: Anticipated future medical treatment includes oral anti-inflammatory and analgesic medication as well as orthopaedic surgical follow up on an intermittent and as needed basis for flares of symptomatology. **Apportionment**: The patient cervical disability is apportioned 100% to the [redacted] specific injury. The patient's right knee disability is apportioned 100% to the [redacted] specific injury.

[redacted] **Stipulations with Request for Award.** The patient was employed by City of ***** ***** as a Police Officer. The parties stipulated that the cumulative

injury date was [redacted] 25% permanent disability was awarded for neck and shoulder.

[redacted] **Award.** Award is made in favor of ***** ***** against City of ***** *****.

Unknown Provider.
[redacted] **Procedure Report.** **Procedure**: C4-7 anterior cervical decompression with cervical total disc replacement and or anterior cervical decompression fusion with instrumentation and iliac crest aspiration. They also could go up to C3 or down to T1. **Diagnosis**: C4-7 herniated nucleus pulpous kyphosis radiculopathy.

****** ****, MD.
[redacted] **MRI of the Left Shoulder without Contrast.** **Impression**: 1) No evidence for full-thickness or retracted tear involving the rotator cuff. Partial-tear/tendinosis is noted within the distal supraspinatus and infraspinatus tendons as described above with more focal high-grade signal abnormality noted along the articular-sided fibers of the distal supraspinatus tendon. Mild fatty atrophy of the supraspinatus musculature is seen. 2) Hypertrophic changes of the acromioclavicular joint as well as a laterally downs loping acromion which can narrow the acromiohumeral interval and predispose to the clinical findings of impingement. 3) Minimal subacromial/subdeltoid bursal fluid/bursitis. 4) Soft tissue inflammatory changes within the lateral soft tissues overlying the shoulder as well as a thin linear fluid collection noted within the superficial muscle substance of the deltoid, correlate to traumatic injury in this region as this can be seen in the setting of a muscle tear or small hematoma. 5) No evidence for labral tear.

****** ******, DO.
[redacted] **Primary Treating Physician's Progress Report (PR-2).** **History of Present Illness (Subjective)**: There is constant pain in the left shoulder that is aggravated by forward reaching lifting pushing, pulling, working at or above the shoulder level. The pain is characterized as burning. The patient's pain is worsening. The pain is 8. **Diagnosis**: Shoulder Region DIS NEC. **Treatment Plan**: Request authorization for an MRI of the left shoulder. **Work Status**: This patient has been instructed to return to modified work.

****** ******, DO.
[redacted] Primary Treating Physician's Re-Evaluation and Progress Report with Request for Surgical Authorization. **DOI**: [redacted] [redacted]
Chief Complaint (Subjective): There is intermittent pain in the cervical spine. There is constant pain in the left shoulder. There is persistent pain in the right wrist and elbow. There is persistent pain in the left elbow and hand. There is intermittent pain in the right knee. **Diagnoses**: 1) Status post C4 to C7 hybrid reconstruction. 2) Left shoulder impingement. 3) Status post right trigger thumb/de Quervain's release. 4) Status post right carpal/cubital tunnel release. 5) Left carpal / cubital tunnel syndrome. 6) Right elbow medial epicondylitis. 7) Status post right knee arthroscopic surgery with degenerative joint disease. **Treatment Plan**: As such, a recommendation has been made and a surgical request submitted for diagnostic/therapeutic left shoulder arthroscopy with subacromial arch decompression and Mumford resection as well as possible rotator cuff repair if deemed necessary intra-operatively. Together with authorization for surgery, there is a need for preapproval for DME and postoperative medication and physical therapy. The patient has been advised to follow up with me in several weeks for orthopedic re. evaluation and confirmation of the proposed surgical plan. The patient can take the appropriate pharmacological agents for symptomatic relief. **Work Status**: The patient is currently working and may continue to do so. She will require a brief period of temporary total disability postoperatively. The patient should follow up in two weeks.

****** ******, DO.
[redacted] Primary Treating Physician's Progress Report (PR-2). **History of Present Illness (Subjective)**: There is constant pain in the left shoulder that is aggravated by forward reaching lifting pushing, pulling, working at or above the shoulder level. The pain is characterized as burning. The patient's pain is worsening. The pain is 8. **Diagnosis**: Shoulder Region DIS NEC. **Treatment Plan**: The patient has been advised there are no guarantees or outcomes of the scheduled surgery. A postoperative appointment has been provided. **Work Status**: This patient has been instructed to return to modified work.

****** ******, DO.
[redacted] Primary Treating Physician's Progress Report (PR-2). **History of Present Illness (Subjective)**: There is constant pain in the left shoulder that is aggravated by forward reaching lifting pushing, pulling, working at or above the shoulder level. The pain is characterized as burning. The pain is 6. **Diagnosis**: Shoulder region status post left shoulder surgery. **Treatment Plan**: Request authorization for a course of physical therapy to the left shoulder at a rate of three times a week for the ensuing six

weeks. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. **Work Status**: This patient has been instructed to return to modified work.

****** ******, DO.
[redacted] Primary Treating Physician's Progress Report (PR-2). **History of Present Illness (Subjective)**: There is intermittent pain in the left shoulder. There is intermittent pain in the right shoulder. There is constant pain in the right knee. **Diagnoses**: 1) Shoulder region status post left shoulder surgery. 2) Internal derangement knee NOS. **Treatment Plan**: Request authorization for an MRI of right knee. Request authorization for a course of physical therapy to the right knee at a rate of 2 times a week for the ensuing 4 weeks. Using a sterile and aseptic technique, an intra-articular injection of Celestone with lidocaine and Marcaine was administered into the right knee. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process. **Work Status**: This patient has been instructed to remain off-work until today only and return to modified work.

**** ****, MD.
[redacted] **Impression**: 1) There is increased signal in the anterior horn of the lateral meniscus with extension to the superior articular surface, which may represent a complex grade III tear versus postsurgical changes. Correlation with surgical history is recommended. This finding is stable since the prior examination. 2) Stable degenerative changes in the posterior horn of the medial meniscus. No medial meniscal tears are demonstrated. 3) Increased size of the popliteal cyst. 4) Stable lateral patellar tilt with lateral patellar tracking. (Incomplete Report)

****** ******, DO.
[redacted] Primary Treating Physician's Progress Report (PR-2). **DOI:** [redacted]. **History of Present Illness (Subjective)**: There is intermittent pain in the left shoulder. There is intermittent pain in the right shoulder. There is constant pain in the right knee. Developed left greater than right hip pain. The patient is here for pre-operative evaluation #2. Patient is complaining of difficulty sleeping. **Diagnoses**: 1) Shoulder region status post left shoulder surgery. 2) Internal derangement knee status post arthroscopy with DJD. **Treatment Plan**: Using a sterile and aseptic technique, an intra-articular injection of Celestone with lidocaine and Marcaine was administered into the left hip greater trochanter. A postoperative appointment has been provided. **Work Status**: This patient has been instructed to remain off-work and return to modified work.

****** ******, DO.

[redacted] **Primary Treating Physician's Progress Report (PR-2). DOI:** [redacted] **History of Present Illness (Subjective)**: The patient has undergone right knee arthroscopy. There is intermittent pain in the left shoulder. There is intermittent pain in the right shoulder. Developed left greater than right hip pain. Patient is complaining of difficulty sleeping. **Diagnoses**: 1) Shoulder region status post left shoulder surgery. 2) Internal derangement knee status post arthroscopy with DJD. **Treatment Plan**: Pending authorization for a series of three Synvisc injection to the right knee. Using a sterile and aseptic technique, an intra-articular injection of Celestone with lidocaine and Marcaine was administered into the right knee. Request authorization for an MRI of the lumbar spine. **Work Status**: This patient has been instructed to remain off-work.

****** ******, DO.

[redacted] **Primary Treating Physician's Re-Evaluation and Progress Report with Request for Authorization. DOI:** [redacted] **Chief Complaint (Subjective)**: The patient is scheduled to undergo surgery on June 21, 2016, to her right knee. There is constant pain in the right knee that awakens patient frequently at night. The patient reports locking, catching and giving way with resultant pain occurring in the left knee and right hip. There is constant pain in the cervical spine that is aggravated by repetitive motions of the neck, pushing, pulling, lifting, forward reaching and working at or above the shoulder level. The pain is characterized as sharp. There is radiation of pain into the upper extremities. There are associated headaches that are migrainous in nature as well as tension between the shoulder blades. There is frequent pain in both shoulders that is aggravated by forward reaching, lifting, pushing, pulling and working at or above the shoulder level. There is intermittent pain in the elbows, wrists, hands and thumbs that is aggravated by repetitive motions, gripping, grasping, pushing, pulling, torquing and lifting. The pain is characterized as dull and achy. There is occasional nighttime paresthesia in the left hand. The patient has sleep difficulties due to chronic pain. **Diagnoses**: 1) Status post C4 to C7 hybrid reconstruction. 2) Bilateral shoulder impingement. 3) Status post right trigger thumb/de Quervain's release. 4) Status post right carpal/cubital tunnel release. 5) Left carpal / cubital tunnel syndrome. 6) Right elbow medial epicondylitis. 7) Left de Quervain's syndrome. 8) Status post right knee arthroscopic surgery with degenerative joint disease and new linear oblique tear of medial meniscus, per MRI of [redacted] **Treatment Plan**: The patient has been advised there are no guarantees on outcomes of the scheduled surgery. A postoperative appointment has been provided. **Work Status**: The patient can continue working up

until surgery. She has been provided a postop appointment for [redacted] Examiner requesting authorization for the patient to return to examiner office for re-evaluation.

****** ****, MD.
[redacted] **Consultation Report. Chief Complaint**: Right knee pain. The patient was injured at her right knee, neck and shoulder at her job. **Assessment**: Knee sprain and internal derangement status post job injury, cervical spine degenerative disk disease and radiculopathy status post fusion and patient is better, right and left shoulder arthroscopy surgery. The patient is improved. **Plan**: Examiner will give the patient a prescription for Norco 5/325 mg.

Unknown Provider.
[redacted] **Progress Record.**

****** ******, DO.
[redacted] **Operative Report. Preoperative Diagnosis**: Recurrent internal derangement right knee. **Postoperative Diagnoses**: 1) Large grade III/tear/avulsion medial femoral condyle. 2) Tear posterior horn of medial meniscus. 3) Grade II chondromalacia trochlea. 4) Free floating loose chondral body. **Procedures Performed**: 1) Diagnostic/therapeutic arthroscopy with extensive synovectomy/debridement. 2) Extensive chondroplasty medial femoral condyle. 3) Removal of large chondral fragments. 4) Medial meniscectomy. 5) Injection of local anesthetic, right knee.

****** ******, DO.
[redacted] **Operative / Invasive Procedure Report. Pre / Post-Operative Diagnosis**: Right knee internal derangement. **Procedure**: Right knee arthroscopy with repair of internal derangement.

****** ******, DO.
[redacted] **Primary Treating Physician's Re-Evaluation and Postoperative Report with Request for Authorization. DOI**: [redacted] **Chief Complaint (Subjective)**: The patient underwent a right knee arthroscopy on June 21, 2016 and presents today for her post op evaluation. Already she is noticing improvement in her symptoms. She presents in no apparent acute distress. **Diagnoses**: 1) Status post C4 to C7 hybrid reconstruction. 2) Bilateral shoulder impingement. 3) Status post right trigger thumb/de Quervain's release. 4) Status post right carpal/cubital tunnel release. 5) Left carpal / cubital tunnel syndrome. 6) Right elbow medial epicondylitis. 7) Left de Quervain's syndrome. 8) Status post right knee arthroscopic surgery x 2. **Treatment Plan**: The patient will be

referred for a course of postoperative physical therapy for the right knee at a rate of three times a week for the ensuing four weeks. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. **Work Status**: The patient is temporarily totally disabled. The patient should follow up in two weeks.

****** ******, DO.

[redacted] Primary Treating Physician's Progress Report (PR-2). **DOI:** [redacted]

History of Present Illness (Subjective): The patient has undergone right knee arthroscopy. There is intermittent pain in the left shoulder. There is intermittent pain in the right shoulder. Developed left greater than right hip pain. Patient is complaining of difficulty sleeping. **Diagnoses**: 1) Shoulder region status post left shoulder surgery. 2) Internal derangement knee status post arthroscopy with DJD. **Treatment Plan**: Under sterile conditions, the sutures were removed and steri-strip applied to the wound. Using a sterile and aseptic technique, an intra-articular injection of Toradol mixed with Marcaine as well as an intramuscular injection of vitamin B-12 complex was given to the patient. Request authorization for a course of P.O physical therapy to right knee be at a rate of three times a week for the ensuing four weeks. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. **Work Status**: This patient has been instructed to remain off-work next visit.

****** ******, DO / **** ****, DC.

[redacted] Primary Treating Physician's Progress Report (PR-2). **DOI:** [redacted]

History of Present Illness (Subjective): The patient has undergone right knee arthroscopy. There is intermittent pain in the left shoulder. There is intermittent pain in the right shoulder. Developed left greater than right hip pain. Patient is complaining of difficulty sleeping. **Diagnoses**: 1) Internal derangement knee status post arthroscopy with DJD. 2) Shoulder region status post left shoulder surgery. **Treatment Plan**: Continue P.O physical therapy to right knee. Continue HEP. **Work Status**: This patient has been instructed to remain off-work.

****** ******, DO.

[redacted] Primary Treating Physician's Progress Report (PR-2). **DOI:** [redacted]

History of Present Illness (Subjective): The patient has undergone right knee arthroscopy. There is intermittent pain in the left shoulder. There is intermittent pain in the right shoulder. Developed left greater than right hip pain. Patient is complaining of difficulty sleeping. **Diagnoses**: 1) Internal derangement right knee status post arthroscopy with DJD. 2) Shoulder region status post left shoulder surgery. 3)

Impingement syndrome of unspecified shoulder. 4) Other specified postprocedural states. **Treatment Plan**: Request authorization for a course of physical therapy to the right shoulder at a rate of two times a week for the ensuing four weeks. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Pending for an MRI of the right shoulder results. Examiner provided the patient with a prescription for a right knee unloaded brace to take some pressure off the joint. **Work Status**: This patient has been instructed to remain off-work.

****** ******, DO.

[redacted] **Primary Treating Physician's Progress Report (PR-2). DOI:** [redacted] **History of Present Illness (Subjective)**: The patient has undergone right knee arthroscopy. Still has swelling and crepitus. There is intermittent pain in the left shoulder. There is intermittent pain in the right shoulder. Developed left greater than right hip pain. Patient is complaining of difficulty sleeping. **Diagnoses**: 1) Internal derangement right knee status post arthroscopy with DJD. 2) Shoulder region status post left shoulder surgery. 3) Impingement syndrome of unspecified shoulder. 4) Other specified postprocedural states. **Treatment Plan**: The patient has decided to undergo a series of three Synvisc injections. Examiner will request authorization for a series of three Synvisc injections to the right knee. Celebrex 200 mg and Prevacid 15 mg were prescribed. **Work Status**: This patient has been instructed to return to modified work.

****** ******, DO.

[redacted] **Primary Treating Physician's Progress Report (PR-2). DOI:** [redacted] **History of Present Illness (Subjective)**: The patient has undergone right knee arthroscopy. Still has swelling and crepitus. There is intermittent pain in the left shoulder. There is intermittent pain in the right shoulder. Developed left greater than right hip pain. Patient is complaining of difficulty sleeping. **Diagnoses**: 1) Internal derangement right knee status post arthroscopy with DJD. 2) Shoulder region status post left shoulder surgery. 3) Impingement syndrome of unspecified shoulder. 4) Other specified postprocedural states. **Treatment Plan**: Using a sterile and aseptic technique, a second Synvisc injection in a series of 3 was administered to the right knee. The patient tolerated this procedure well with no adverse local or systemic reactions. **Work Status**: This patient has been instructed to return to modified work.

****** ******, DO.

[redacted] **Primary Treating Physician's Progress Report (PR-2). DOI:** [redacted] **History of Present Illness (Subjective)**: The patient has undergone right knee arthroscopy. Still has swelling and crepitus. There is intermittent pain in the left

shoulder. There is intermittent pain in the right shoulder. Developed left greater than right hip pain. She has increased right arm numbness. Patient is complaining of difficulty sleeping. **Diagnoses**: 1) Internal derangement right knee status post arthroscopy with DJD. 2) Shoulder region status post left shoulder surgery. 3) Impingement syndrome of unspecified shoulder. 4) Other specified postprocedural states. 5) Lesion of ulnar nerve, unspecified upper limb. 6) Medial epicondylitis, right elbow. **Treatment Plan**: Neurontin 300 mg were prescribed. Request authorization for an EMG/NCV studies of the bilateral upper extremities. **Work Status**: This patient has been instructed to return to modified work. Released to light duty assignment with the work restrictions listed below from [redacted] Recovery Limitations/Work Restrictions: Driving never (0 hours), pushing / pulling: occasionally (up to 3 hours) > 10lbs. Additional Work Restrictions: No weightbearing right lower extremity, no duty belt, employee parking no more than 100feet. Five minutes break every hour.

[redacted] **Worker's Compensation Claim Form (DWC-1). DOI:** CT [redacted] **Injury:** The patient alleged that while working for City of ***** *****, she sustained a cumulative trauma injury that began on [redacted] and ended on [redacted] She states she injured at right shoulder, right knee and left hip during the course and scope of employment injured right shoulder, right knee and left hip.

****** ******, DO.

[redacted] **Primary Treating Physician's Progress Report (PR-2). DOI:** [redacted] **History of Present Illness (Subjective)**: The patient has undergone right knee arthroscopy. Still has swelling, weakness and crepitus. There is intermittent pain in the left shoulder. There is intermittent pain in the right shoulder. Developed left greater than right hip pain. She has increased right arm numbness. Patient is complaining of difficulty sleeping. **Diagnoses**: 1) Internal derangement right knee status post arthroscopy with DJD. 2) Shoulder region status post left shoulder surgery. 3) Impingement syndrome of unspecified shoulder. 4) Other specified postprocedural states. 5) Lesion of ulnar nerve, unspecified upper limb. 6) Medial epicondylitis, right elbow. **Treatment Plan**: Celebrex 200 mg were prescribed. Examiner provided the patient with a prescription for a right knee unloader brace. **Work Status**: This patient has been instructed to return to modified work. Released to light duty assignment with the work restrictions listed below from [redacted] Recovery Limitations/Work Restrictions: Driving never (0 hours), pushing / pulling: occasionally (up to 3 hours) > 10lbs. Additional Work Restrictions: No weightbearing right lower extremity, no duty belt, employee parking no more than 100feet. Five minutes break every hour.

****** ******, DO.

[redacted] Primary Treating Physician's Progress Report (PR-2). **DOI:** [redacted]. **History of Present Illness (Subjective)**: The patient has undergone right knee arthroscopy. Still has swelling, weakness and crepitus. There is intermittent pain in the left shoulder. There is intermittent pain in the right shoulder. Developed left greater than right hip pain. She has increased right arm numbness. Patient is complaining of difficulty sleeping. **Diagnoses**: 1) Internal derangement right knee status post arthroscopy with DJD. 2) Shoulder region status post left shoulder surgery. 3) Impingement syndrome of unspecified shoulder. 4) Other specified postprocedural states. 5) Lesion of ulnar nerve, unspecified upper limb. 6) Medial epicondylitis, right elbow. **Treatment Plan**: Neurontin 600 mg and Prilosec 20 mg were prescribed. Scheduled for an EMG/NCV studies of the bilateral upper extremities. **Work Status**: This patient has been instructed to return to modified work. Released to light duty assignment with the work restrictions listed below from [redacted] Recovery Limitations/Work Restrictions: Driving never (0 hours), pushing / pulling occasionally (up to 3 hours) > 10lbs. Additional Work Restrictions: No weightbearing right lower extremity, no duty belt, employee parking no more than 100feet. Five minutes break every hour.

***** *********, MD.

[redacted] Electrodiagnostic Studies of the Upper Extremities. **Impressions**: Normal Study. 1) No electrophysiological evidence of entrapment neuropathy on the median, ulnar and radial nerves. 2) No electrophysiological evidence to support motor radiculopathy in the upper extremities. 3) No electrophysiological evidence to support distal peripheral neuropathy in the upper extremities.

****** ******, DO.

[redacted] Primary Treating Physician's Progress Report (PR-2). **DOI:** [redacted] **History of Present Illness (Subjective)**: The patient has undergone right knee arthroscopy. Still has swelling, weakness and crepitus. There is intermittent pain in the left shoulder. There is constant pain in the right shoulder. Developed left greater than right hip pain. She has increased right arm numbness. Patient is complaining of difficulty sleeping. **Diagnoses**: 1) Internal derangement right knee status post arthroscopy with DJD. 2) Shoulder region status post left shoulder surgery. 3) Impingement syndrome of unspecified shoulder. 4) Other specified postprocedural states. 5) Lesion of ulnar nerve, unspecified upper limb. 6) Medial epicondylitis, right elbow. **Treatment Plan**: Using a sterile and aseptic technique, an intra-articular injection of Celestone with Lidocaine and Marcaine was administered into the right

shoulder with immediate relief of pain. Pending for an EMG/NCV studies of the bilateral upper extremities. **Work Status**: This patient has been instructed to return to modified work.

****** ******, DO.

[redacted] **Primary Treating Physician's Initial Complex Orthopedic Evaluation with Request for Authorization. DOI**: [redacted]

Current Complaints: There is constant pain in the right shoulder. There is frequent pain in the left hip. There is intermittent pain in the right knee. There is intermittent pain in the left shoulder. There is constant pain in the right greater than left elbow. There is intermittent pain in the wrists, hands and thumbs. There is occasional nighttime paresthesia. There is intermittent pain in the cervical spine with occasional slight headaches. The pain is aggravated by prolonged positioning of the neck. There is mild paresthesia in the upper extremities. The patient has sleep difficulties due to chronic pain. **Diagnoses**: 1) Internal derangement right shoulder. 2) Internal derangement right knee. 3) Left greater trochanteric bursitis/internal derangement left hip. 4) Status post C4 to C7 hybrid reconstruction. 5) Status post left shoulder surgery. 6) Bilateral shoulder impingement. 7) Status post right trigger thumb/de Quervain's release. 8) Status post right carpal/cubital tunnel release. 9) Left carpal / cubital tunnel syndrome. 10) Right elbow medial epicondylitis. 11) Left de Quervain's syndrome. 12) Status post right knee arthroscopic surgery x 2. **Causation**: It is within reasonable medical probability the patient's symptoms and diagnoses are a direct result of the continuous trauma that occurred from [redacted] while working for the City of ***** ***** as a police officer. **Recommendations**: The patient will be referred for a course of physical therapy at a rate of three times a week for four weeks. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement. The patient will follow up in several weeks. Examiner requesting authorization for the patient to return to examiner office for re-evaluation. **Work Status**: The patient is currently working light duty and may continue to do so. Released to light duty assignment with the work restrictions listed below from [redacted] Additional Work Restrictions: No weightbearing right lower extremity, no duty belt, employee parking no more than 100feet. Five minutes break every hour.

****** ******, DO.

[redacted] **Primary Treating Physician's Progress Report (PR-2). DOI:** [redacted] **History of Present Illness (Subjective)**: The patient has undergone right knee arthroscopy. Still has swelling, weakness and crepitus. There is intermittent

pain in the left shoulder. There is constant pain in the right shoulder. Developed left greater than right hip pain. She has increased right arm numbness. Patient is complaining of difficulty sleeping. **Diagnoses**: 1) Internal derangement right knee status post arthroscopy with DJD. 2) Shoulder region status post left shoulder surgery. 3) Impingement syndrome of unspecified shoulder. 4) Other specified postprocedural states. 5) Lesion of ulnar nerve, unspecified upper limb. 6) Medial epicondylitis, right elbow. **Treatment Plan**: Mobic 15 mg was prescribed. Pending for MRI and AME reports. **Work Status**: This patient has been instructed to return to modified work. Released to light duty assignment with the work restrictions listed below from [redacted] Recovery Limitations/Work Restrictions: Repetitive hand motions occasionally (up to 3 hours) for 7-10 pounds. Additional Work Restrictions: No weightbearing right lower extremity, no duty belt, employee parking no more than 100feet. Five minutes break every hour.

****** ******, DO.

[redacted] **Primary Treating Physician's Progress Report (PR-2). DOI:** [redacted] **History of Present Illness (Subjective)**: The patient has undergone right knee arthroscopy. Still has swelling, weakness and crepitus. There is intermittent pain in the left shoulder. There is constant pain in the right shoulder. Developed left greater than right hip pain. She has increased right arm numbness. Patient is complaining of difficulty sleeping. **Diagnoses**: 1) Internal derangement right knee status post arthroscopy with DJD. 2) Shoulder region status post left shoulder surgery. 3) Impingement syndrome of unspecified shoulder. 4) Other specified postprocedural states. 5) Lesion of ulnar nerve, unspecified upper limb. 6) Medial epicondylitis, right elbow. **Treatment Plan**: Request authorization for a course of physical therapy to the shoulder, knee, hip at a rate of three times a week for the ensuing four weeks. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Pending for AME reports. **Work Status**: This patient has been instructed to return to modified work.

***** *****, MD.

[redacted] **Consultation Note. Subjective**: The patient is seen for consultation and evaluation regarding specifically her right shoulder and knee. **Assessment**: 1) Right shoulder impingement bursitis. 2) History of right knee arthroscopic surgery x 3 with residual pain. 3) Left hip bursitis and tendinitis. **Recommendations**: Examiner would highly recommend a course of therapy and conservative measures for the right shoulder. With regard to her right knee, because she has had 3 knee surgeries, examiner do not recommend any further surgical intervention at

this time, conservative measures should be entertained. Follow up is within the next 6 to 8 weeks.

****** ******, DO.
[redacted] Primary Treating Physician's Progress Report (PR-2). **DOI:** [redacted] **History of Present Illness (Subjective)**: The patient has undergone right knee arthroscopy. Still has swelling, weakness and crepitus. There is intermittent pain in the left shoulder. There is constant pain in the right shoulder. Developed left greater than right hip pain. She has increased right arm numbness. Patient is complaining of difficulty sleeping. **Diagnoses**: 1) Internal derangement right knee status post arthroscopy with DJD. 2) Shoulder region status post left shoulder surgery. 3) Impingement syndrome of unspecified shoulder. 4) Other specified postprocedural states. 5) Lesion of ulnar nerve, unspecified upper limb. 6) Medial epicondylitis, right elbow. **Treatment Plan**: Request authorization for a course of physical therapy to the shoulder, knee, hip at a rate of three times a week for the ensuing four weeks. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Follow up with Dr. *****. **Work Status**: This patient has been instructed to return to modified work.

***** *****, MD.
[redacted] Consultation Note. **Subjective**: The patient is seen for re-evaluation. She brought in the MRI studies which examiner had requested to review. She has downs loping of the acromion with a large spur digging into the rotator cuff. She has subchondral cystic changes of the greater tuberosity with impingement. The glenohumeral ligaments are intact. There was a large area of cluster of microcystic changes over the greater tuberosity consistent with chronic impingement. **Assessment**: Right shoulder impingement with weakness, pain, discomfort, chronic. **Recommendations**: Examiner has reviewed her MRI studies of the right shoulder. Examiner would recommend authorization be obtained for diagnostic operative right shoulder arthroscopy. The patient is seen today for a preoperative visit. Examiner will see the patient back on a routine basis following surgery.

***** *****, MD / ********* *******, PA.
[redacted] History and Physical Note. **Subjective**: The patient is seen today for an orthopedic evaluation regarding her right shoulder. **Assessment**: 1) History of industrial injury to the right shoulder while employed by *****. 2) MRI studies of the right shoulder completed at *****-***** Oncology which show rotator cuff impingement. 3) Previous knee arthroscopies, Dr. ******. **Recommendations**: Recommend patient continue conservative modalities of rest, ice, anti-inflammatory and

analgesics. Recommend conservative treatments for her knee. Recommend Synvisc-One or viscosupplementation for her right knee. She has had previous knee arthroscopies and has evidence of arthritis. Recommend viscosupplementation be authorized for her right knee. Examiner will recommend right shoulder diagnostic arthroscopy to be authorized. Recommend MRI study to be authorized. Examiner also recommend surgery be authorized. Examiner will reassess the patient in 4 to 6 weeks once surgery is authorized. **Work Status**: Consult only. Primary treating physician is Dr. ******.

****** ******, DO.

[redacted] Primary Treating Physician's Progress Report (PR-2). **DOI:** [redacted] **History of Present Illness (Subjective)**: The patient has undergone right knee arthroscopy. Still has swelling, weakness and crepitus. There is intermittent pain in the left shoulder. There is constant pain in the right shoulder. Developed left greater than right hip pain. She has increased right arm numbness. Patient is complaining of difficulty sleeping. **Diagnoses**: 1) Internal derangement right knee status post arthroscopy with DJD. 2) Shoulder region status post left shoulder surgery. 3) Impingement syndrome of unspecified shoulder. 4) Other specified postprocedural states. 5) Lesion of ulnar nerve, unspecified upper limb. 6) Medial epicondylitis, right elbow. **Treatment Plan**: Request authorization for a course of physical therapy to the shoulder, knee, hip at a rate of three times a week for the ensuing four weeks. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Follow up with Dr. *****. Mobic 15 mg was prescribed. **Work Status**: This patient has been instructed to return to modified work. Released to light duty assignment with the work restrictions listed below from [redacted] Climbing: Occasionally (up to 3 hours) limited stairs. Pushing / Pulling: Occasionally (up to 3 hours) no repetitive activity. Additional Work Restrictions: Needs to work at ergonomic work station, no overhead work, no duty belt, no shot gun qualification.

****** *****, MD.

[redacted] Operative Report. **Pre / Post Operative Diagnoses**: Bursal sided partial rotator cuff tear of the right shoulder with chronic subacromial and subdeltoid bursitis, impingement and acromioclavicular osteoarthritis with labral tear right shoulder. **Procedure Performed**: Right shoulder arthroscopy with arthroscopic extensive debridement with bursectomy decompression acromioplasty and arthroscopic Mumford/distal clavicle resection with arthroscopic capsulorrhaphy of the right shoulder.

***** *****, MD.

[redacted] **Consultation Note. Subjective**: The patient is first postoperative visit. She has undergone arthroscopy of the right shoulder on [redacted] Examiner has recommended we begin her on range of motion gradual strengthening with physical therapy at Select PT. Examiner anticipate she will need 12-24 weeks of physical therapy for her right shoulder. Follow up 6 weeks. The patient is seen post-operatively. A follow up appointment is given.

***** *****, MD / ****** ***, PA-C.

[redacted] **Progress Note. Subjective**: The patient is here today for orthopedic evaluation and first postoperative visit. Patient is status post right shoulder diagnostic and operative arthroscopy on [redacted] **Assessment**: 1) History of injury to the right shoulder while employed by *****. 2) Status post right shoulder diagnostic and operative arthroscopy, [redacted] **Recommendations**: Recommend patient continue conservative modalities of rest, ice, anti-inflammatory and analgesics as needed. Patient initiated with 12 visits of physical therapy. The patient given prescription of 20 Norco. Examiner will reassess the patient in 6 weeks. **Work Status**: Patient to remain temporarily totally disabled.

****** ******, DO.

[redacted] **Primary Treating Physician's Progress Report (PR-2). DOI:** [redacted] **History of Present Illness (Subjective)**: The patient has undergone right knee arthroscopy. Still has swelling, weakness and crepitus. There is intermittent pain in the left shoulder. There is constant pain in the right shoulder. Developed left greater than right hip pain. She has increased right arm numbness. Patient is complaining of difficulty sleeping. She has right side neck pain with stiffness. **Diagnoses**: 1) Internal derangement right knee status post arthroscopy with DJD. 2) Shoulder region status post left shoulder surgery. 3) Impingement syndrome of unspecified shoulder. 4) Other specified postprocedural states. 5) Lesion of ulnar nerve, unspecified upper limb. 6) Medial epicondylitis, right elbow. 7) Arthrodesis status. 8) Cervicalgia. **Treatment Plan**: Follow up with Dr. ***** and continue P.O physical therapy. **Work Status**: This patient has been instructed to return to modified work. Released to light duty assignment with the work restrictions listed below from [redacted] Climbing: Occasionally (up to 3 hours) climb stairs. Pushing / Pulling: Occasionally (up to 3 hours) no repetitive activity, 7-10 pounds. Additional Work Restrictions: No weight bearing right lower extremity, no duty belt, employee parking no more than 100ft. 5 minutes break every hour. no shot gun qualification.

****** ******, DO.

[redacted] **DOE: April 3, 2018. Primary Treating Physician's Re-Evaluation and Progress Report with Request for Authorization. DOI:** [redacted] **Chief Complaint (Subjective)**: There is intermittent pain in the cervical spine with occasional slight headaches. The pain is aggravated by prolonged positioning of the neck. There is mild paresthesia in the upper extremities. There is intermittent pain in the left shoulder. There is constant pain in the right greater than left elbow. There is associated numbness in the right arm. There is intermittent pain in the wrists, hands and thumbs. There is occasional nighttime paresthesia. There is frequent pain in the left hip. There is intermittent pain in the right knee with some residual swelling, weakness and crepitus. The patient has sleep difficulties due to chronic pain. **Diagnoses**: 1) Status post-surgery right shoulder, [redacted] 2) Internal derangement right knee. 3) Left greater trochanteric bursitis/internal derangement left hip. 4) Status post C4 to C7 hybrid reconstruction. 5) Status post left shoulder surgery. 6) Status post right trigger thumb/de Quervain's release. 7) Status post right carpal/cubital tunnel release. 8) Left carpal / cubital tunnel syndrome. 9) Right elbow medial epicondylitis. 10) Left de Quervain's syndrome. 11) Status post right knee arthroscopic surgery x 2. **Treatment Plan**: The patient has been advised to continue with the postoperative therapy. She should also continue with therapy to the left hip as before. Examiner suggested a corticosteroid injection to the left hip. **Work Status**: The patient can continue working light duty as before. The patient should follow up in two weeks.

***** *****, MD / ****** ****, PA-C.

[redacted] **Progress Notes. Subjective**: The patient is here today for orthopedic evaluation regarding her right shoulder. **Assessment**: 1) History of injury to the right shoulder while employed by *****. 2) Status post right shoulder diagnostic and operative arthroscopy, [redacted] **Recommendations**: Recommend patient continue conservative modalities of rest, ice, anti-inflammatory and analgesics as needed. Patient recommended to be authorized to receive a prescription of naproxen. Patient recommended to be authorized for an additional 12 sessions of physical therapy. Examiner will reassess the patient in 6 weeks. **Work Status**: Patient to remain temporarily totally disabled.

****** ******, DO.

[redacted] **Primary Treating Physician's Re-Evaluation and Progress Report with Request for Authorization. DOI:** [redacted] **Chief Complaint (Subjective)**: The patient has continued symptomatology in her left hip. She

is diagnosed with greater trochanteric bursitis. There is frequent pain in the left hip. There is intermittent pain in the cervical spine with stiffness and occasional slight headaches. The patient has undergone a right shoulder arthroscopy. There is intermittent pain in the left shoulder. There is constant pain in the right greater than left elbow. There is intermittent pain in the wrists, hands and thumbs. There is intermittent pain in the right knee with some residual swelling, weakness and crepitus. The patient has sleep difficulties. **Diagnoses**: 1) Internal derangement right shoulder. 2) Internal derangement right knee. 3) Left greater trochanteric bursitis/internal derangement left hip. 4) Status post C4 to C7 hybrid reconstruction. 5) Status post left shoulder surgery. 6) Bilateral shoulder impingement. 7) Status post right trigger thumb/de Quervain's release. 8) Status post right carpal/cubital tunnel release. 9) Left carpal / cubital tunnel syndrome. 10) Right elbow medial epicondylitis. 11) Left de Quervain's syndrome. 12) Status post right knee arthroscopic surgery x 2. **Treatment Plan**: The patient is advised to continue with heat and ice. She can take over-the-counter anti-inflammatory. Consideration for injections has been given. Examiner requesting authorization for the patient to return for re-evaluation. The patient will follow up in several weeks. **Work Status**: The patient can continue working light duty. Released to light duty assignment with the work restrictions listed below from [redacted] Climbing: Occasionally (up to 3 hours) climb stairs. Pushing / Pulling: Occasionally (up to 3 hours) no repetitive activity, 7-10 pounds. Additional Work Restrictions: No weight bearing right lower extremity, no duty belt, employee parking no more than 100ft. 5 minutes break every hour. no shot gun qualification.

***** *****, MD / ****** ****, PA-C.

[redacted] **Progress Notes**. **Subjective**: The patient is here today for orthopedic evaluation regarding her right knee. **Assessment**: 1) History of work-related injury to the right knee and right shoulder. 2) Previous history of right knee arthroscopic surgery 3 times with residual pain, discomfort and well-documented osteoarthritis. 3) MRI studies of the right knee done at *** ***** Imaging [redacted] showing tear of the anterior horn of the medial meniscus with Baker cyst. No osteoarthritis. 4) Status post right shoulder diagnostic and operative arthroscopy, [redacted] 5) Synvisc-One viscosupplementation of the right knee [redacted] **Recommendations**: Recommend patient continue conservative modalities of rest, ice, anti-inflammatory and analgesics as needed. The patient recommended to proceed and continue with authorized Synvisc-One viscosupplementation injection of the right knee today. The patient advised to avoid strenuous activity for the next 2 to 3 days. The patient advised to use conservative measures should post injection flare occur. Should the patient continue to receive significant benefit from these injections, she should receive them on a 6 to 12-month basis. Examiner will reassess the patient in 6 weeks. The patient to continue with

physical therapy for her shoulder at this time. **Work Status**: Patient to remain temporarily totally disabled until next visit.

****** ****, PA-C.
[redacted] Progress Notes. **Procedure Orders**: Arthrocentesis. Joint injection. **Post-procedure Diagnosis**: Arthritis of knee.

****** ******, DO.
[redacted] Primary Treating Physician's Progress Report (PR-2). **DOI:** [redacted] **History of Present Illness (Subjective)**: The patient has undergone right knee arthroscopy. Still has swelling, weakness and crepitus. There is intermittent pain in the left shoulder. There is constant pain in the right shoulder. Developed left greater than right hip pain. She has increased right arm numbness. Patient is complaining of difficulty sleeping. She has right side neck pain with stiffness. **Diagnoses**: 1) Internal derangement right knee status post arthroscopy with DJD. 2) Shoulder region status post left shoulder surgery. 3) Impingement syndrome of right shoulder status post-surgery. 4) Other specified postprocedural states. 5) Lesion of ulnar nerve, unspecified upper limb. 6) Medial epicondylitis, right elbow. 7) Arthrodesis status. 8) Cervicalgia. **Treatment Plan**: Follow up with Dr. ***** and continue P.O physical therapy. Request authorization for a course of physical therapy to the cervical spine at a rate of two times a week for the ensuing four weeks. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. **Work Status**: This patient has been instructed to return to modified work.

***** *****, MD / **** ********, PA-C.
[redacted] Progress Notes. **Subjective**: The patient is here today for orthopedic evaluation regarding her right knee and right shoulder. **Assessment**: 1) History of industrial injury to the right knee and right shoulder. 2) Previous right knee arthroscopic surgery x 3. 3) MRI studies of the right knee done at *** ***** Imaging [redacted] which show medial meniscal tear and Baker cyst with arthritis. 4) Right shoulder diagnostic and operative arthroscopy on [redacted] 5) Synvisc-One viscosupplementation [redacted] **Recommendations**: Recommend patient continue conservative modalities of rest, ice, anti-inflammatory and analgesics. Recommend the patient continue therapy for her shoulders. Recommend she back off on the weights until she feels more comfortable. She would also benefit from a medial unloader brace for her right knee. Examiner will reassess the patient in 6 weeks. **Work Status**: Patient is temporarily disabled for the next 6 weeks.

[redacted] Primary Treating Physician's Progress Report (PR-2). **DOI:** [redacted] **History of Present Illness (Subjective)**: The patient has undergone right knee arthroscopy. Still has swelling, weakness and crepitus. There is intermittent pain in the left shoulder. There is constant pain in the right shoulder. Developed left greater than right hip pain. She has increased right arm numbness. There is constant pain in the cervical spine. Patient is complaining of difficulty sleeping. **Diagnoses**: 1) Internal derangement right knee status post arthroscopy with DJD. 2) Shoulder region status post left shoulder surgery. 3) Impingement syndrome of right shoulder status post-surgery. 4) Other specified postprocedural states. 5) Lesion of ulnar nerve, unspecified upper limb. 6) Medial epicondylitis, right elbow. 7) Arthrodesis status. 8) Cervicalgia. **Treatment Plan**: Follow up with Dr. ***** and continue P.O physical therapy. Request authorization for a course of physical therapy to the cervical spine at a rate of two times a week for the ensuing four weeks. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. **Work Status**: This patient has been instructed to return to modified work. Released to light duty assignment with the work restrictions listed below from [redacted] Climbing: Occasionally (up to 3 hours) climb stairs. Pushing / Pulling: Occasionally (up to 3 hours) no repetitive activity, 7-10 pounds. Additional Work Restrictions: No weight bearing right lower extremity, no duty belt, employee parking no more than 100ft. 5 minutes break every hour. No shot gun qualification.

****** ******, DO.

[redacted] Primary Treating Physician's Progress Report (PR-2). **DOI:** [redacted]. **History of Present Illness (Subjective)**: The patient has undergone right knee arthroscopy. Still has swelling, weakness and crepitus. There is intermittent pain in the left shoulder. There is constant pain in the right shoulder. Developed left greater than right hip pain. She has increased right arm numbness. There is constant pain in the cervical spine. Patient is complaining of difficulty sleeping. **Diagnoses**: 1) Internal derangement right knee status post arthroscopy with DJD. 2) Shoulder region status post left shoulder surgery. 3) Impingement syndrome of right shoulder status post-surgery. 4) Other specified postprocedural states. 5) Lesion of ulnar nerve, unspecified upper limb. 6) Medial epicondylitis, right elbow. 7) Arthrodesis status. 8) Cervicalgia. **Treatment Plan**: Follow up with Dr. ***** and continue P.O physical therapy. Start for a course of physical therapy to the cervical spine. **Work Status**: This patient has been instructed to return to modified work. Released to light duty assignment with the work restrictions listed below from [redacted] Climbing: Occasionally (up to 3 hours) climb stairs. Pushing / Pulling: Occasionally (up to 3 hours) no repetitive

activity, 7-10 pounds. Additional Work Restrictions: No weight bearing right lower extremity, no duty belt, employee parking no more than 100ft. 5 minutes break every hour. No shot gun qualification.

****** ******, DO.
[redacted] Primary Treating Physician's Progress Report (PR-2). **DOI:** [redacted] **History of Present Illness (Subjective)**: The patient has undergone right knee arthroscopy. Still has swelling, weakness and crepitus. There is intermittent pain in the left shoulder. There is constant pain in the right shoulder. Developed left greater than right hip pain. She has increased right arm numbness. There is constant pain in the cervical spine. Patient is complaining of difficulty sleeping. **Diagnoses**: 1) Internal derangement right knee status post arthroscopy with DJD. 2) Shoulder region status post left shoulder surgery. 3) Impingement syndrome of right shoulder status post-surgery. 4) Other specified postprocedural states. 5) Lesion of ulnar nerve, unspecified upper limb. 6) Medial epicondylitis, right elbow. 7) Arthrodesis status. 8) Cervicalgia. **Treatment Plan**: Follow up with Dr. ***** and continue P.O physical therapy. Continue for a course of physical therapy to the cervical spine. **Work Status**: This patient has been instructed to return to modified work. Released to light duty assignment with the work restrictions listed below from [redacted] Climbing: Occasionally (up to 3 hours) climb stairs. Pushing / Pulling: Occasionally (up to 3 hours) no repetitive activity, 7-10 pounds. Additional Work Restrictions: No weight bearing right lower extremity, no duty belt, employee parking no more than 100ft. 5 minutes break every hour. No shot gun qualification.

***** *****, MD / ***** ****, PA-C.
[redacted] Progress Notes. **DOI:** [redacted] **Subjective**: The patient is here today for orthopedic evaluation regarding her right shoulder. **Assessment**: 1) History of industrial injury to the right shoulder while employed by *****. 2) Status post right knee arthroscopy, [redacted] **Recommendations**: Recommend patient continue conservative modalities of rest, ice, anti-inflammatory and analgesics. She will continue physical therapy. Recommend patient be authorized for additional 12 sessions of physical therapy. Examiner will reassess the patient in 8 weeks. **Work Status**: Restricted duties only.

****** ******, DO.
[redacted] Primary Treating Physician's Progress Report (PR-2). **DOI:** [redacted] **History of Present Illness (Subjective)**: The patient has undergone right knee arthroscopy. Still has swelling, weakness and crepitus. There is intermittent pain in the left shoulder. There is constant pain in the right shoulder. Developed left

greater than right hip pain. She has increased right arm numbness. There is constant pain in the cervical spine. Patient is complaining of difficulty sleeping. **Diagnoses**: 1) Internal derangement right knee status post arthroscopy with DJD. 2) Shoulder region status post left shoulder surgery. 3) Impingement syndrome of right shoulder status post-surgery. 4) Other specified postprocedural states. 5) Lesion of ulnar nerve, unspecified upper limb. 6) Medial epicondylitis, right elbow. 7) Arthrodesis status. 8) Cervicalgia. **Treatment Plan**: Continue HEP and meds. Follow up with other specialists. **Work Status**: This patient has been instructed to return to modified work.

***** *****, MD / ***** ****, PA-C.

[redacted] Progress Notes. **DOI:** [redacted] **Subjective**: The patient is here today for orthopedic evaluation regarding her right shoulder. She also reports she has pain that continues in her right knee as well as her left hip. **Assessment**: 1) History of industrial injury to the right shoulder and right knee while employed by ***** ***** Police Department. 2) Status post right knee arthroscopy, [redacted] 3) Left hip pain. 4) Continued right knee pain, rule out meniscal tear. **Recommendations**: Recommend patient continue conservative modalities of rest, ice, anti-inflammatory and analgesics. Recommend patient be authorized for MR arthrogram studies of the right knee to rule out internal derangement. Recommend patient continue physical therapy strengthening in regard to her shoulder and recommend patient be authorized for evaluation with Dr. **** **** for her left hip. Examiner will reassess the patient in 10-12 weeks. **Work Status**: Restricted duties only.

****** ******, DO.

[redacted] Primary Treating Physician's Progress Report (PR-2). **DOI:** [redacted] **History of Present Illness (Subjective)**: The patient has undergone right knee arthroscopy. Still has swelling, weakness and crepitus. There is intermittent pain in the left shoulder. There is constant pain in the right shoulder. Developed left greater than right hip pain. She has increased right elbow and arm numbness. There is constant pain in the cervical spine. Patient is complaining of difficulty sleeping. **Diagnoses**: 1) Internal derangement right knee status post arthroscopy with DJD. 2) Shoulder region status post left shoulder surgery. 3) Impingement syndrome of right shoulder status post-surgery. 4) Other specified postprocedural states. 5) Lesion of ulnar nerve, unspecified upper limb. 6) Medial epicondylitis, right elbow. 7) Arthrodesis status. 8) Cervicalgia. **Treatment Plan**: Continue HEP and meds. Follow up with other specialists. Voltaren 1% gel 100 mg was prescribed. Pending authorization for acupuncture. Request authorization for right elbow brace. **Work Status**: This patient has been instructed to return to modified work.

****** ******, DO.

[redacted] Primary Treating Physician's Progress Report (PR-2). **DOI:** [redacted] **History of Present Illness (Subjective)**: The patient has undergone right knee arthroscopy. Still has swelling, weakness and crepitus. There is intermittent pain in the left shoulder. There is constant pain in the right shoulder. Developed left greater than right hip pain. She has increased right elbow and arm numbness. There is constant pain in the cervical spine. Patient is complaining of difficulty sleeping. **Diagnoses**: 1) Internal derangement right knee status post arthroscopy with DJD. 2) Shoulder region status post left shoulder surgery. 3) Impingement syndrome of right shoulder status post-surgery. 4) Other specified postprocedural states. 5) Lesion of ulnar nerve, unspecified upper limb. 6) Medial epicondylitis, right elbow. 7) Arthrodesis status. 8) Cervicalgia. **Treatment Plan**: Continue HEP and meds. Follow up with other specialists. Voltaren 1% gel 100 mg was prescribed. **Work Status**: This patient has been instructed to return to modified work.

Dr. **** *******.

[redacted] MRI of Right Knee Post Arthrogram. **Impression**: Degenerative osteoarthritis with tricompartmental chondromalacia of the knee, with severe grade III-IV chondromalacia of the weightbearing femoral medial condyle and grade II-III changes involving the weightbearing lateral tibial plateau and overlying deep inner femoral lateral condyle. Status post partial lateral meniscectomy with free edge blunting of its posterior horn and root. Minimal degenerative fraying at the apical free edge margin at the mid body extending into the anterior horn. Status post partial medial meniscectomy with extensive free edge resection of the posterior horn and most of the inner mid body. Degenerative signal throughout the posterior horn remnant without evidence of gross re-tear or displaced fragment. Congenitally shaped Wiberg type II patella with a dominant lateral facet and severe medial facet hypoplasia. Severe irregular grade III-IV chondromalacia patella from its apex mostly over its lateral facet as well as grade III chondromalacia of the ventral femoral lateral condyle. Chronic synovitis with synovial proliferation within the suprapatellar bursa. No significant postsurgical arthrofibrosis or cyclops lesion formation. Intact cruciate and collateral ligaments with slight bowing of the MCL secondary to medial extrusion of the small remaining mid body remnant of the medial meniscus.

***** *****, MD / **** ***, PA-C.

[redacted] Progress Notes. **DOI:** [redacted] **Subjective**: The patient is here today for orthopedic evaluation regarding her right knee. **Assessment**: 1) History of industrial injury to the right knee, the left hip, right shoulder. 2) Previous right shoulder diagnostic and operative arthroscopy on [redacted] 3) Previous MRI

studies of the right knee completed at ***** **** imaging which show areas of grade 3 to 4 chondromalacia arthritis. 4) Previous Synvisc-One viscosupplementation on [redacted] **Recommendations**: Recommend patient continue conservative modalities of rest, ice, anti-inflammatory and analgesics. Recommend Synvisc-One viscosupplementation to be authorized for her right knee. Examiner will reassess patient in 6 weeks for the Synvisc injection. **Work Status**: Restricted duties only for her knee.

****** ******, DO.
[redacted] **Primary Treating Physician's Progress Report (PR-2). DOI:** [redacted] **History of Present Illness (Subjective)**: The patient has undergone right knee arthroscopy. Still has swelling, weakness and crepitus. There is intermittent pain in the left shoulder. There is constant pain in the right shoulder. Developed left greater than right hip pain. She has increased right elbow and arm numbness. There is constant pain in the cervical spine. Patient is complaining of difficulty sleeping. **Diagnoses**: 1) Internal derangement right knee status post arthroscopy with DJD. 2) Shoulder region status post left shoulder surgery. 3) Impingement syndrome of right shoulder status post-surgery. 4) Other specified postprocedural states. 5) Lesion of ulnar nerve, unspecified upper limb. 6) Medial epicondylitis, right elbow. 7) Arthrodesis status. 8) Cervicalgia. **Treatment Plan**: Continue HEP and meds. Request authorization for acupuncture treatment to the cervical spine at a rate of 2 x a week for four weeks. Follow up with other specialists. **Work Status**: This patient has been instructed to return to modified work. Released to light duty assignment with the work restrictions listed below from [redacted] Climbing: Occasionally (up to 3 hours) climb stairs. Pushing / Pulling: Occasionally (up to 3 hours) no repetitive activity, 7-10 pounds. Additional Work Restrictions: No weight bearing right lower extremity, no duty belt, employee parking no more than 100ft. 5 minutes break every hour. No shot gun qualification.

****** ******, DO.
[redacted] **Primary Treating Physician's Progress Report (PR-2). DOI:** [redacted] **History of Present Illness (Subjective)**: The patient has undergone right knee arthroscopy. Still has swelling, weakness and crepitus. There is intermittent pain in the left shoulder. There is constant pain in the right shoulder. Developed left greater than right hip pain. She has increased right elbow and arm numbness. There is constant pain in the cervical spine. Patient is complaining of difficulty sleeping. **Diagnoses**: 1) Internal derangement right knee status post arthroscopy with DJD. 2) Shoulder region status post left shoulder surgery. 3) Impingement syndrome of right shoulder status post-surgery. 4) Other specified postprocedural states. 5) Lesion of ulnar nerve, unspecified upper limb. 6) Medial epicondylitis, right elbow. 7) Arthrodesis status. 8) Cervicalgia.

Treatment Plan: Continue HEP and meds. Continue for acupuncture treatment to the cervical spine. Follow up with other specialists. Request authorization for an MRI of the cervical spine. **Work Status**: This patient has been instructed to return to modified work. Released to light duty assignment with the work restrictions listed below from [redacted] Climbing: Occasionally (up to 3 hours) climb stairs. Pushing / Pulling: Occasionally (up to 3 hours) no repetitive activity, 7-10 pounds. Additional Work Restrictions: No weight bearing right lower extremity, no duty belt, employee parking no more than 100ft. 5 minutes break every hour. No shot gun qualification.

****** ******, DO.

[redacted] Primary Treating Physician's Progress Report (PR-2). **DOI:** [redacted] **History of Present Illness (Subjective)**: The patient has undergone right knee arthroscopy. Still has swelling, weakness and crepitus. There is intermittent pain in the left shoulder. There is constant pain in the right shoulder. Developed left greater than right hip pain. She has increased right elbow and arm numbness. There is constant pain in the cervical spine. Patient is complaining of difficulty sleeping. **Diagnoses**: 1) Internal derangement right knee status post arthroscopy with DJD. 2) Shoulder region status post left shoulder surgery. 3) Impingement syndrome of right shoulder status post-surgery. 4) Other specified postprocedural states. 5) Lesion of ulnar nerve, unspecified upper limb. 6) Medial epicondylitis, right elbow. 7) Arthrodesis status. 8) Cervicalgia. **Treatment Plan**: Continue HEP and meds. Follow up with other specialists. X-ray of the cervical spine upon return. **Work Status**: This patient has been instructed to return to modified work.

***** *****, MD / ***** ****, PA-C.

[redacted] Progress Notes. **DOI:** [redacted] **Subjective**: The patient is here today for orthopedic evaluation regarding her right knee and right shoulder. **Assessment**: 1) History of industrial injury to the right knee, the left hip and right shoulder. 2) Previous right shoulder arthroscopy on [redacted] 3) MRI studies of the right knee show chondromalacia and arthritis. 4) Synvisc-One right knee on [redacted] **Recommendations**: Recommend patient continue conservative modalities of rest, ice, anti-inflammatory and analgesics. Will recommend patient proceed with Synvisc-One injection today. He should avoid strenuous activities for 2-3 days. If these injections prove to benefit them, they should repeat these injections every 6-12 months. Will continue to recommend patient to be authorized for treatment and evaluation by Dr. **** in regard to her hip. Reassess patient in about 12 weeks. **Work Status**: Restricted duties only.

****** ******, DO.

[redacted] Primary Treating Physician's Progress Report (PR-2). **DOI:** [redacted] **History of Present Illness (Subjective)**: The patient has undergone right knee arthroscopy. There is intermittent pain in the left shoulder. There is constant pain in the right shoulder. Developed left greater than right hip pain. She has increased right elbow and arm numbness. There is intermittent pain in the cervical spine. Patient is complaining of difficulty sleeping. **Diagnoses**: 1) Internal derangement right knee status post arthroscopy with DJD. 2) Shoulder region status post left shoulder surgery. 3) Impingement syndrome of right shoulder status post-surgery. 4) Other specified postprocedural states. 5) Lesion of ulnar nerve, unspecified upper limb. 6) Medial epicondylitis, right elbow. 7) Arthrodesis status. 8) Cervicalgia. **Treatment Plan**: Continue HEP and meds. Follow up with other specialists. X-ray of the cervical spine upon return. **Work Status**: This patient has been instructed to return to modified work. Released to light duty assignment with the work restrictions listed below from [redacted] Climbing: Occasionally (up to 3 hours) climb stairs. Pushing / Pulling: Occasionally (up to 3 hours) no repetitive activity, 7-10 pounds. Additional Work Restrictions: No weight bearing right lower extremity, no duty belt, employee parking no more than 100ft. 5 minutes break every hour. No shot gun qualification.

****** ******, DO.

[redacted] Primary Treating Physician's Progress Report (PR-2). **DOI:** [redacted] **History of Present Illness (Subjective)**: The patient has undergone right knee arthroscopy. There is intermittent pain in the left shoulder. There is constant pain in the right shoulder. Developed left greater than right hip pain. She has increased right elbow and arm numbness. There is intermittent pain in the cervical spine. There are associated headaches that are migrainous in nature as well as tension between the shoulder blades. **Diagnoses**: 1) Internal derangement right knee status post arthroscopy with DJD. 2) Shoulder region status post left shoulder surgery. 3) Impingement syndrome of right shoulder status post-surgery. 4) Other specified postprocedural states. 5) Lesion of ulnar nerve, unspecified upper limb. 6) Medial epicondylitis, right elbow. 7) Arthrodesis status. 8) Cervicalgia. **Treatment Plan**: Continue HEP and meds. Follow up with other specialists. **Work Status**: This patient has been instructed to return to modified work. Released to light duty assignment with the work restrictions listed below from [redacted] Climbing: Occasionally (up to 3 hours) climb stairs. Pushing / Pulling: Occasionally (up to 3 hours) no repetitive activity, 7-10 pounds. Additional Work Restrictions: No weight bearing right lower extremity, no duty belt, employee parking no more than 100 feet. 5 minutes break every hour. No shot gun qualification.

***** *****, MD / ***** ****, PA-C.
[redacted] Progress Notes. **DOI:** [redacted] **Subjective**: The patient is here today for orthopedic evaluation regarding her right knee, left hip and right shoulder. **Assessment**: 1) History of industrial injury to the right knee, the left hip and right shoulder. 2) Status post right shoulder arthroscopy on [redacted] 3) MRI studies of the right knee show chondromalacia and arthritis most recently [redacted] **Recommendations**: Recommend patient continue conservative modalities of rest, ice, anti-inflammatory and analgesics. Examiner recommend the patient continue physical therapy. If viscosupplementation continues to benefit her she should repeat these injections every 6-12 months.

****** ******, DO.
[redacted] Primary Treating Physician's Progress Report (PR-2). **DOI:** [redacted] **History of Present Illness (Subjective)**: The patient has undergone right knee arthroscopy. There is intermittent pain in the left shoulder. There is constant pain in the right shoulder. Developed left greater than right hip pain. She has increased right elbow and arm numbness. There is intermittent pain in the cervical spine. There are associated headaches that are migrainous in nature as well as tension between the shoulder blades. Has recent increased stiffness/pain. **Diagnoses**: 1) Internal derangement right knee status post arthroscopy with DJD. 2) Shoulder region status post left shoulder surgery. 3) Impingement syndrome of right shoulder status post-surgery. 4) Other specified postprocedural states. 5) Lesion of ulnar nerve, unspecified upper limb. 6) Medial epicondylitis, right elbow. 7) Arthrodesis status. 8) Cervicalgia. **Treatment Plan**: Continue HEP and meds. Follow up with other specialists. Pending AME re-eval. **Work Status**: This patient has been instructed to return to modified work.

***** *****, MD / ***** ****, PA-C.
[redacted] Progress Notes. **DOI:** [redacted] **Subjective**: The patient is seen for evaluation regarding her right knee. **Assessment**: 1) History of industrial injury to the right knee and right shoulder while employed by *****. 2) Status post right shoulder diagnostic and operative arthroscopy on [redacted] 3) MRI studies of the right knee shows osteoarthritis and chondromalacia. 4) Synvisc-One right knee [redacted] **Recommendations**: Recommend patient to continue conservative modalities of rest, ice, anti-inflammatory and analgesics. Recommend patient to be authorized for additional Synvisc be authorized for her right knee. Reassess patient for next injection.

****** ******, DO.
[redacted] Primary Treating Physician's Progress Report (PR-2). **DOI:** [redacted] **History of Present Illness (Subjective)**: The patient has undergone

right knee arthroscopy. There is intermittent pain in the left shoulder. There is constant pain in the right shoulder. Developed left greater than right hip pain. She has increased right elbow and arm numbness. There is intermittent pain in the cervical spine. There are associated headaches that are migrainous in nature as well as tension between the shoulder blades. Has recent increased stiffness/pain. **Diagnoses**: 1) Internal derangement right knee status post arthroscopy with DJD. 2) Shoulder region status post left shoulder surgery. 3) Impingement syndrome of right shoulder status post-surgery. 4) Other specified postprocedural states. 5) Lesion of ulnar nerve, unspecified upper limb. 6) Medial epicondylitis, right elbow. 7) Arthrodesis status. 8) Cervicalgia. **Treatment Plan**: Continue HEP and meds. Follow up with other specialists. **Work Status**: This patient has been instructed to return to modified work. Released to light duty assignment with the work restrictions listed below from [redacted] Climbing: Occasionally (up to 3 hours) climb stairs. Pushing / Pulling: Occasionally (up to 3 hours) no repetitive activity, 7-10 pounds. Additional Work Restrictions: No weight bearing right lower extremity, no duty belt, employee parking no more than 100 feet. 5 minutes break every hour. No shot gun qualification.

***** *****, MD / ***** ****, PA-C.
[redacted] **Progress Notes. DOI:** [redacted] **Subjective**: The patient is seen for orthopedic evaluation regarding her right knee. **Assessment**: 1) History of industrial injury to the right knee and right shoulder. 2) Right shoulder arthroscopy on March 2018. 3) Right knee osteoarthritis and chondromalacia. 4) Synvisc-One right knee most recently [redacted] **Recommendations**: Recommend patient to continue conservative modalities of rest, ice, anti-inflammatory and analgesics. Recommend patient proceed with authorized Synvisc-One injection today. Recommend nonstrenuous activities for the next 2 days. If these injections provide a benefit her, she should repeat these injections every 6 to 10 months. Reassess patient in 12 weeks or on a prn basis. **Work Status**: Restricted duties only.

****** ******, DO.
[redacted] **Primary Treating Physician's Re-Evaluation and Progress Report with Request for Authorization. DOI:** [redacted] **Chief Complaint (Subjective)**: The patient has increasing symptomatology in her right knee and shoulder. She also has some increasing symptomatology in the right elbow. There is constant pain in the right knee with some residual swelling, weakness and crepitus. There is constant pain in the right shoulder. There is constant pain in the right greater than left elbow. There is associated numbness in the right arm. There is frequent pain in the bilateral hips, left greater than right. There is intermittent pain in the cervical spine

with stiffness and occasional slight headaches. There is intermittent pain in the left shoulder. There is intermittent pain in the wrists, hands and thumbs. The pain is characterized as dull and achy with associated numbness. There is occasional nighttime paresthesia. The patient has sleep difficulties due to chronic pain. **Differential Diagnoses**: 1) Status post right shoulder surgery. 2) Internal derangement right knee. 3) Left greater trochanteric bursitis/internal derangement left hip. 4) Status post C4 to C7 hybrid reconstruction. 5) Status post left shoulder surgery. 6) Bilateral shoulder impingement. 7) Status post right trigger thumb/de Quervain's release. 8) Status post right carpal/cubital tunnel release. 9) Left carpal / cubital tunnel syndrome. 10) Right elbow medial epicondylitis. 11) Left de Quervain's syndrome. 12) Status post right knee arthroscopic surgery x 2. **Treatment Plan**: Examiner recommending authorization for PRP injection to the right knee. As such, authorization is also being requested for this injection to be completed at an ASC facility which will assess appropriate facility fees. Preauthorization for payment of these fees must also be included in the certification. Examiner requesting authorization for the patient to return to examiner office for re-evaluation. The patient will follow up in several weeks. **Work Status**: The patient can continue working light duty. Released to light duty assignment with the work restrictions listed below from [redacted] Climbing: Occasionally (up to 3 hours) climb stairs. Pushing / Pulling: Occasionally (up to 3 hours) no repetitive activity, 7-10 pounds. Additional Work Restrictions: No weight bearing right lower extremity, no duty belt, employee parking no more than 100 feet. 5 minutes break every hour. No shot gun qualification.

****** ******, DO.

[redacted] **Primary Treating Physician's Re-Evaluation and Procedure Report with Request for Authorization. DOI:** [redacted] **Chief Complaint (Subjective)**: There is constant pain in the right knee with some residual swelling, weakness and crepitus. **Procedure Performed**: Using sterile and aseptic technique, 30 cc of blood was drawn by our medical assistant from the right antecubital fossa and processed for platelet-rich plasma. After processing, 4 to 5 cc platelet-rich plasma was isolated and mixed with 3 cc Marcaine and using sterile and aseptic technique, the combination of the above was injected into the right knee. The patient was discharged in stable and satisfactory condition. **Differential Diagnosis**: Status post platelet-rich plasma injection, right knee. **Work Status**: The patient should be temporarily totally disabled for today.

[redacted] Worker's Compensation Claim Form (DWC-1). **DOI:** [redacted] **Injury:** The patient alleged that while working for City of ***** *****, she sustained an injury on [redacted] She states she injured at back.

[redacted] Worker's Compensation Claim Form (DWC-1). **DOI:** CT [redacted] **Injury:** The patient alleged that while working for City of ***** *****, she sustained a cumulative trauma injury that began on [redacted] and ended on [redacted] She states she injured at right ankle during course and scope of employment.

Miscellaneous:

Lab reports dated [redacted] noted.

This completes the review of submitted medical records.

Summary of medical records were done by * ****** *****,** [redacted]

DIAGNOSIS

- RIGHT ACHILLES TENDINITIS
- RIGHT KNEE TENDINITIS
- RIGHT SHOULDER TENDINITIS
- LEFT HIP PAIN
- LUMBAR RADICULITIS

DISCUSSION

Ms. ***** presents for evaluation of her right shoulder, left hip and right knee pain due to a continuous trauma injury from [redacted] through [redacted] evaluation of her lower back pain due to her injury on [redacted] and evaluation of her right ankle/foot pain due to a continuous trauma injury from [redacted] secondary to her employment as a police officer for the City of ***** *****.

Ms. ***** attributes her right shoulder and right knee pain and complaints to continuous and repetitive job duties and as a consequence of other industrial related injuries, treated

under separate claims; and her left hip pain as a consequence to her right knee pain. She believes her injuries and complaints were reported in [redacted], and she was treated with physical therapy and many MRI studies of her right shoulder. She reported undergoing right shoulder surgery in March [redacted] and was treated postoperatively with physical therapy. She denies receiving any treatment for her left hip.

Ms. ***** did report a prior injury to her right knee in [redacted], which was treated under a separate claim and which she underwent 3 different right knee surgeries in [redacted] and in [redacted]. She continued to remain symptomatic.

The examinee subsequently retired on [redacted] Post retirement, as she continued to remain symptomatic with right knee pain she was seen at *****-*****. Right knee replacement was recommended and performed on [redacted] Postoperatively, she underwent 24 sessions of physical therapy in [redacted] In [redacted] due to ongoing right knee pain, 12 additional sessions of physical therapy were requested and approved. In [redacted], she began physical therapy, 2x per week and has received 7 out of 12 sessions. She has 5 sessions of physical therapy left and last received therapy to her right knee on [redacted] She continues to treat at *****-***** with follow-up visits and is scheduled to be seen again in late [redacted]

The examinee's industrial injury of [redacted] occurred while she was getting out of her chair after having worked for multiple 12 hours shifts, without time off, during Covid 19. The injury was reported and she was sent to the company clinic where she was treated with x-rays and an MRI of her lumbar spine. She was with treated physical therapy, 24 sessions and possibly some chiropractic treatment. She believes she last received treatment and/or therapy in late [redacted] She was treated by ****** ******, M.D. and reports she was considered Permanent and Stationary in approximately [redacted]

Ms. ***** attributes her right ankle/foot pain to continuous and repetitive job duties, walking on hard surfaces, ascending and descending stairs and having to go down from a step ladder onto a hard surface. She reports that her right ankle/foot pain was reported and she was sent to *****, where x-rays and possibly other diagnostic studies were obtained. She was treated with bracing of her right foot/ ankle. Physical therapy was recommended, but the examinee declined. She reports that she was also seen at *****-***** in approximately [redacted] where a PRP injection was recommended to her right ankle, but it was denied by the insurance company.

At the time of her evaluation in this office today, [redacted] Ms. ***** presents as a 62-year-old female, with complaints of occasional right shoulder and left hip pain, frequent lower back pain and constant right knee and ankle/foot pain, as well as radiating lower back pain into the bilateral legs, buttocks, hips and thighs and radiating right knee pain into the upper inner thigh and down into the calf, sides of the lower leg and back of knee.

CAUSATION:

She has described her required job duties as including standing, walking, running, driving, bending, stooping, twisting, climbing, reaching above shoulder level, reaching below shoulder level, squatting, kneeling, crawling, crouching, ascending and descending stairs, pushing, pulling, lifting and carrying up to approximately and adult size male, which are activities that can cause and contribute to complaints and findings in the right shoulder, right knee and left hip over time, including development of left hip compensatory complaints while favoring the industrially injured right knee, on a cumulative trauma basis.

Based on the information available to me she sustained an industrial cumulative trauma injury to the right shoulder, right knee and left hip from [redacted] during the course of her employment as a police officer for the ***** ***** Police Department.

She describes having developed the gradual onset of pain in her right ankle, which she attributes to continuous and repetitive job duties, including walking up and down stairs, walking in the parking garage, walking on hard surfaces and working in the kit room, going up and down a step stool and down onto the hard surface floor. Based on the information available to me she sustained an industrial cumulative trauma injury to the right ankle from [redacted] during the course of her employment as a police officer for the ***** ***** Police Department.

According to her history, she sustained injury to her low back on [redacted] during the riots and working 12 hour shifts with no days off, and when she got out of her chair after prolonged sitting she experienced the immediate onset of sharp lower back pain. Based on the information available to me, she sustained an industrial injury to the lumbar spine on [redacted] during the course of her employment as a police officer for the ***** ***** Police Department.

DISABILITY STATUS:

Her right knee pops and she has pain over the medial right knee. She states she does not want to have any more surgery right now. As she is declining further surgery the right shoulder, lumbar spine, left hip, right knee and right ankle have reached maximum medical improvement at the time of examination on [redacted]

She has had appropriate periods of temporary total disability when she was off work while receiving treatment for the industrial injuries.

IMPAIRMENT / DISABILITY:

Right shoulder: There is no tenderness to palpation. Muscle strength is full. Range of motion of the right shoulder is unrestricted. Orthopedic testing of the right shoulder is normal. The right shoulder is status post Mumford procedure, distal clavicle resection for which there is 10% upper extremity impairment with reference to Table 16-27, converting to 6% whole person impairment for the right shoulder.

Lumbar Spine: There is tenderness on palpation over the lumbar paraspinal muscles. Range of motion of the lumbar spine is unrestricted. Straight leg raising test is negative bilaterally and motor, sensory and reflex examinations of the lower extremities are all normal, ruling out lumbar radiculopathy clinically. For the complaints of lower back radiating pain into the bilateral lower extremities, non-verifiable lumbar radicular complaints, DRE Lumbar Category II is appropriate for 5% whole person impairment.

Left Hip: Examination reveals no tenderness to palpation, full muscle strength and unrestricted range of motion, bilaterally, consistent with 0% whole person impairment for the left hip.

Right Knee: Examination reveals tenderness on palpation of the right knee medial joint line. There is popping of the right patellofemoral joint with flexion and extension. Orthopedic testing of the right knee is normal, and knee muscle strength is full. Range of motion of the right knee is slightly restricted on flexion. The right knee is status post total knee replacement. Referring to Table 17-35, totaling the points, 10, 22, 10 and 15 results in 57, referring to Table 17-33 indicating fair result, there is 20% whole person impairment for the right knee.

Right Ankle: There is tenderness on palpation over the posterior Achilles tendon. Right ankle range of motion is unrestricted. Right ankle/foot muscle strength is full bilaterally.

The objective findings are consistent with 0% whole person impairment for the right ankle.

APPORTIONMENT:

Ms. ***** reports that she had a specific injury to her neck and bilateral shoulders in [redacted], as well as right knee work injury in [redacted]

The Stipulations with Request for Award, and Award, dated [redacted] indicate 25% permanent disability was awarded for neck and shoulder for the cumulative injury date of [redacted] while employed by the City of ***** ***** as a Police Officer. However, a report on which the shoulder impairment was based is unavailable and this is requested for review.

There is no history of any other specific injury to the right shoulder and no history of any non-industiral injury to the right shoulder. As a result of worsening right shoulder complaints she underwent shoulder diagnostic and operative arthroscopy on [redacted] including Mumford procedure, distal clavicle resection, which appears to have been as a result of the cumulative trauma injury. Based on the information available to me, lacking a report for review on which the prior Award for the right shoulder was based, I would be inclined to apportion 15% of the right shoulder impairment and disability to the [redacted] cumulative injury for which she received an Award, and 85% is apportioned to the industrial cumulative trauma injury to the right shoulder from [redacted] during the course of her employment as a police officer for the ***** ***** Police Department.

She provides a history of right knee surgeries in [redacted] and right total knee replacement surgery in [redacted] which appears to have been as treatment on an industrial basis, beginning with treatment for the [redacted] industrial injury to the right knee. However, a prior Award for the right knee [redacted] injury is currently unavailable for review. The records also indicate she had degenerative changes in the right knee, which can be expected with the arduous work activities she performed, and accelerated by the surgical procedures to the right knee which appear to been performed on an industrial basis. It would be speculative to state that she would have any significant degenrative changes in the right knee absent the long period of cumulative trauma on an industrial basis. Based on the information available to me I would apportion 15% of the right knee impairment and disability to the 2001 specific right knee work related injury, and 85% of the right knee impairment and disability is apportioned to the industrial cumulative

trauma injury to the right knee from [redacted] during the course of her employment as a police officer for the ***** ***** Police Department.

There is no history of any prior specific injury to the low back and no history of any non-industrial injury to the low back. Based on the information available to me I would apportion 100% of the lumbar spine impairment and disability to the lumbar spine on [redacted] when she was performing prolonged standing while wearing a Sam Brown gun belt, and then prolonged sitting also while wearing a Sam Brown gun belt, then stood up with the acute onset low back pain, during the course of her employment as a police officer for the ***** ***** Police Department.

As there is no impairment for the left hip and right ankle, discussion of apportionment is moot.

FUTURE MEDICAL CARE:

Future medical care for flare-ups of the right shoulder, lumbar spine, left hip, right knee and right ankle includes short courses of physical therapy, limited 12 sessions per year, each, for three years, and prescriptions of appropriate analgesic and nonsteroidal anti-inflammatory medications. She can also perform home exercises, take over-the-counter analgesic and non-steroidal anti-inflammatory and use heat and cold applications at home to help decrease the discomfort.

For the lumbar spine, should a flare-up of lower back and lower extremity symptoms persist despite additional conservative treatment she would be indicated for an MRI scan and EMG/NCV studies and depending on the findings consideration may be given for referral for pain management, with potential treatment options that may include medications and injections for pain.

For the right knee, should the complaints of popping and pain, including over the medial aspect of the right knee, and should the condition progress she has provisions for appropriate injections. Should the right knee condition deteriorate and develop positive orthopedic tests at the right knee, she would be indicated for a CT scan, with treatment as needed based on the findings, which may include re-do right total knee replacement as a potential possibility, followed by an appropriate course of postoperative physical therapy.

For the right ankle, should symptoms persist or worsen, she may benefit from PRP injections to her right ankle.

For flare-ups of the right shoulder that persist despite more conservative treatment she would be indicated local cortisone injections, limited to two per year.

For flare-ups of the left hip that persist despite more conservative treatment she would be indicated for local corticosteroid injections to the left hip greater trochanter, limited to two per year.

RESTRICTIONS:

She is capable of working with restrictions of no lifting more than 20 pounds, and no excessive bending, stooping or squatting.

As she states she has retired as of [redacted] she is not considered a candidate for supplemental job displacement benefits.

Any additional records that may be provided will be reviewed and discussed in a supplemental report.

PHYSICIAN DISCLOSURE

The history was taken by [redacted] and was reviewed and verified by the undersigned.

The above report is not to be construed as a complete physical examination for general health purposes. Only those symptoms which are believed to have been involved in the injury, or might relate to the injury, have been assessed. Regarding the general health of this patient, it is advisable to have a physical examination for general purposes with the patient's personal physician.

The above assessment, diagnosis, and treatment recommendations are based on the available medical records, patient's self-reported history, physical exam, and review of diagnostics studies. I reserve the right to make changes to this report should additional information or documentation is provided to me at any time in the future.

I declare under penalty of perjury that I, the signing physician, have actually performed this examination, and the time spent in performing this evaluation is in compliance with the IMC guidelines (section 53 07.1 and 5307.6).

STATEMENT OF COMPLIANCE:

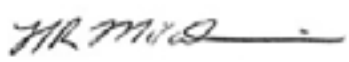
Let it be known that over eighty percent (80%) of this physician's time is annually devoted to medical treatment.

DECLARATION PURSUANT TO LABOR CODE SECTION 4628(J):

"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 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 have not violated Labor Code Section 139.3 and the contents of the report are true and correct to the best of my knowledge. This statement is made under penalty of perjury.

Executed on 5/17/2023 in the [redacted] California.



_____

HAMID R. MIR, M.D.
Orthopedic Surgeon, Board Certified
Fellowship Trained in Spine Surgery
Qualified Medical Examiner
[redacted]

April 15, 2026

TO: Each Trustee
Board of Retirement

FROM: Tamara Caldwell, Division Manager
Disability Retirement Services Division

Patty Silva, DRS Interim Supervisor
Disability Retirement Services Division

FOR: May 6, 2026, Disability Board of Retirement Meeting

SUBJECT: RECOMMENDATION TO APPROVE ALEXANDER SONES, M.D. (PSYCHIATRY/FORENSIC PSYCHIATRY) TO THE LACERA PANEL OF PHYSICIANS

RECOMMENDATION

To support timely, high-quality medical-legal evaluations and maintain a geographically accessible and appropriately credentialed panel of examining physicians, staff recommends that the Board of Retirement approve the application of Alexander Sones, M.D., for appointment to LACERA's Panel of Examining Physicians.

DISCUSSION

Certifications & Licensure

Dr. Alexander Sones is board-certified by the American Board of Psychiatry and Neurology in Psychiatry (January 2023) and Forensic Psychiatry (October 2023). He holds active California and New York medical licenses. He is also a Qualified Medical Evaluator with the California Division of Workers' Compensation and is certified to conduct forensic health examinations for asylum seekers.

Education & Training

Dr. Sones earned a B.A. in Psychology (College Honors) from Washington University in St. Louis (2013) and an M.D. from the David Geffen School of Medicine at UCLA (2018). He completed an internship at Harbor-UCLA Medical Center (2018–2019), a psychiatry residency at UCLA Neuropsychiatric Institute, Harbor Track (2019–2022), and a forensic psychiatry fellowship at UCLA Neuropsychiatric Institute (2022–2023).

Professional Experience

His experience includes private practice in general and forensic psychiatry in Santa Monica, California, providing medication management, psychotherapy, and expert witness services. He has served as a Qualified Medical Evaluator, Agreed Medical

Evaluator, and Independent Medical Evaluator in psychiatric matters, including panel-appointed independent medical examinations for county retirement systems. Dr. Sones currently serves as an Attending Psychiatrist at the UCLA Mood Clinic and has held clinical and forensic psychiatry roles within Los Angeles County programs.

Academic & Professional Contributions
Dr. Sones has held academic leadership roles, including Chief Resident of Inpatient Psychiatry and Chief Resident of Forensic Psychiatry in the Department of Psychiatry and Biobehavioral Science at the David Geffen School of Medicine at UCLA He has contributed to peer-reviewed publications, book chapters, lectures, and professional presentations on psychiatry and forensic psychiatry, including ethics, disability evaluations, and standards of care.

Panel Onboarding & Compliance
If approved, Disability Retirement Services (DRS) will provide an orientation for Dr. Sones and his practice team covering LACERA's Panel Physician Guidelines, evaluation standards under applicable disability retirement law, report requirements and timelines, fee and billing procedures, and ongoing quality-control processes. DRS will also confirm continuing compliance with licensing, board certification, and insurance requirements.

Medical Advisor Review
On April 1, 2026, Board Medical Advisor Glenn Ehresmann, M.D., reviewed Dr. Sones' application and credentials and concurred with forwarding the application to the Board of Retirement for consideration.

TLC:PS/mc

Attachment

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 2/14/2026
Physician Name: Alexander Sones	Group Name: Alexander Sones, MD, Inc.
Primary Address: 2730 Wilshire Blvd, Suite 325, Santa Monica, CA 90403	
Primary Contact: Alex Sones	Title: Psychiatrist
Telephone: 310 439 9749	Email: a.sones@ucla.edu
Secondary Address:	
Telephone: 310 948 0010	Email: asones@sonesmd.com

PHYSICIAN BACKGROUND	
Field of Specialty: Psychiatrist Board Certification [X] Yes [ ] No	Subspecialty: Forensic Psychiatry Board Certification [X] Yes [ ] No
License # A163339 Expiration Date: 7/31/2027	
Has your license been suspended in the last 3 years? [ ] Yes [X] No Has there been any disciplinary actions filed against you in the last 3 year? [ ] Yes [X] 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	2	Treatment	53
IME	2	Evaluations	35
QME	2	Research	2
Workers' Compensation Evaluations	2	Teaching	10
Disability Evaluations	1		100 %
Med-Legal Reports	3		

Performing Medical Evaluations for Public Organizations [x] Yes [ ] No

Performing Medical Evaluations for Private Organizations [ ] Yes [x] No

Please Names of Organizations:

Orange County Employee Retirement System, Santa Barbara County Employee Retirement System, California State Teachers Retirement System, Los Angeles Department of Water & Power Retirement Plan Office, California Division of Workers' Compensation

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	[x] Yes [ ] No

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

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

What is you Cancellation Policy? (Attach policy, if applicable).

Appointments must be canceled in writing at least six business days prior to the evaluation or hearing.

Cancelled Exams that do not adhere to your stated policy:	Fee: $ 503.75
Cancelled Hearings that do not adhere to your stated policy:	Fee: $ 503.75

Name of person completing this form:

Print Name:	Title:
Alexander Sones	Psychiatrist
Physician Signature: Alexander Sones, MD	Date 2/14/2026

You may attach additional pages if necessary.

Revised: 12/8/21

ALEXANDER SONES, MD

2730 Wilshire Blvd, Suite 325
Santa Monica, CA 90403
a.sones@ucla.edu
Phone: (310) 439-9749
Website: www.sonesmd.com

EDUCATION & TRAINING

Washington University in St. Louis
St. Louis, MO
Bachelor of Arts in Psychology with College Honors
May 2013

David Geffen School of Medicine at UCLA
Los Angeles, CA
Doctor of Medicine
June 2018

Harbor-UCLA Medical Center
Los Angeles, CA
Internship in Psychiatry
2018-2019

UCLA Neuropsychiatric Institute
Los Angeles, CA
Residency in Psychiatry, Harbor Track Resident
2019-2022

UCLA Neuropsychiatric Institute
Los Angeles, CA
Fellowship in Forensic Psychiatry
2022-2023

ACADEMIC APPOINTMENTS

Voluntary Clinical Instructor of Psychiatry
Department of Psychiatry and Biobehavioral Science
David Geffen School of Medicine at UCLA
Los Angeles, CA
2024 – Present

Chief Resident of Inpatient Psychiatry
Department of Psychiatry and Biobehavioral Science
David Geffen School of Medicine at UCLA
Los Angeles, CA
2021-2022

Chief Resident of Forensic Psychiatry
Department of Psychiatry and Biobehavioral Science
David Geffen School of Medicine at UCLA
Los Angeles, CA
2020-2021

LICENSURE & CERTIFICATION

- **Diplomate, Psychiatry, American Board of Psychiatry and Neurology**, January 2023 - Present
- **Diplomate, Forensic Psychiatry, American Board of Psychiatry and Neurology**, October 2023 - Present
- **California State Medical License**, July 2019 - Present, #A163339
- **New York State Medical License,** January 2023 - Present, #321178
- **Qualified Medical Evaluator**, California Division of Workers' Compensation, May 2024 - Present
- **Forensic Health Exams for Asylum Seekers Certification,** March 2019

HONORS & AWARDS

- Rappeport Fellowship, awarded by The American Academy of Psychiatry and the Law to the most outstanding residents with interests in psychiatry and the law (2021-2022)
- Alpha Omega Alpha Honor Medical Society, David Geffen School of Medicine at UCLA Delta Chapter (2018)

PROFESSIONAL EXPERIENCE

Private Practice of General Psychiatry and Forensic Psychiatry
Santa Monica, CA (7/2022-Present)

- Full-service outpatient psychiatrist in West Los Angeles providing psychiatric medication management and psychotherapy
- Provide expert witness services across a wide range of legal matters, including standards of care, disability, fitness-for-duty, and risk assessments

Qualified Medical Evaluator, State of California, Division of Workers' Compensation
Southern California (5/2024-Present)

- Serve as Qualified Medical Evaluator, Agreed Medical Evaluator, and Independent Medical Evaluator in psychiatric matters within the California workers' compensation system
- Panel-appointed expert for Independent Medical Examinations for Santa Barbara and Orange Counties' Retirement Systems

Attending Psychiatrist, UCLA Mood Clinic
Los Angeles, CA (10/2024-Present)

- Supervise UCLA resident psychiatrists in provision of outpatient psychiatric services in UCLA specialty mood disorders clinic

Forensic Psychiatrist, ThNK Consultants
Los Angeles, CA (7/2023-12/2024)

- Consultant for wide variety of forensic psychiatric topics and litigation, including *Tarasoff* duties, standards of care, licensing, and disability evaluations

Contract Psychiatrist, Office of Diversion and Reentry
Los Angeles, CA (8/2020-10/2023)

- Provided field-based primary psychiatric care for clients diverted from prison and jail in integrative, intensive Assertive Community Treatment (ACT) team in Los Angeles

Contract Psychiatrist, The People Concern
Los Angeles, CA (7/2020-6/2022)

- Provided field-based primary psychiatric care for forensic and high-risk clients in integrative, intensive Assertive Community Treatment (ACT) team in Los Angeles

BIBLIOGRAPHY

Book Chapters

- **Sones AC**, Darby WC, Weinstock R. The Tarasoff Duty to Protect: Unintended Consequences and New Liability Concerns. In: Forensic Neuropsychiatric Ethics: Balancing Competing Duties In and Out of Court, edited by WC Darby and R Weinstock. Washington, DC: American Psychiatric Association Publishing (2025).
- **Sones AC**, Krasnoff M, Vicari M, Ames D. Assessment and Behavioral Change Strategies in Clinical Practice. In: Lifestyle Psychiatry: Using Exercise, Diet and Mindfulness to Manage Psychiatric Disorders, edited by D.L. Noordsy. Washington DC: American Psychiatric Publishing (2019):303-322.

Original Publications

- Cornwell J, Smith C, Lucarelli K, **Sones AC**, Rootman D. Critical pre- and postoperative factors in evaluating ptosis. Frontiers in Ophthalmology. 2025 Aug;1609113.
- MacIntyre M, **Sones AC**, Li J, Darby WC, Weinstock R. From posts to protection: Ethical considerations regarding forensic psychiatrists and a duty to warn based on social media. Behavioral Sciences & the Law. 2024 Feb;2024:1-19.
- **Sones AC**, Fogelson DL, Glick ID, Shader RI. Untreated mental illness has created a national tragedy: A pandemic of homelessness. Journal of Clinical Psychopharmacology. 2022 Mar;42(2):115-117.
- Ames D, Erickson Z, Geise C, Tiwari S, Sakhno S, **Sones AC**, Tyrrell CG, Mackay CRB, Steele CW, Van Hoof T, Weinreich H, Koenig HG. Treatment of moral injury in U.S. veterans with PTSD using a structured chaplain intervention. Journal of Religion and Health. 2021 Oct;60(5):3052-3060.
- MacIntyre MR, Darby WC, **Sones AC**, Li J, Leong GB, Weinstock R. Voluntary intoxication, homicide, and mens rea: Past, present, and future. Behavioral Sciences & the Law. 2021 Apr;39(2):150-169.
- **Sones AC**, Weinstock R, Darby WC, Shauer A. (2021, February 19). Therapists need clarity on duty to warn of patients' violent threats. *Daily Journal*. https://dailyjournal.com.
- Ames D, Erickson Z, Youssef NA, Arnold I, Adamson S, **Sones AC**, Yin J, Haynes K, Volk F, Teng EJ, Oliver JP, Koenig HG. Moral injury, religiosity, and suicide risk in US veterans and active duty military with PTSD symptoms. *Military Medicine*. 2019;184(3-4):e271-e278.
- **Sones AC**, Masters C, Kang MR. Effort thrombosis: Venous thrombosis triggered by exercise. *Proceedings of UCLA Healthcare*. 2016;20.
- Baker MR, Tessier JM, Meyer HB, **Sones AC**, Sachinvala N, Ames D. Yoga-based classes for veterans with severe mental illness: Development, dissemination, and assessment. *Federal Practitioner*. 2015;32(10):19-25.
- Ketch RA, Rubin RT, Baker MR, **Sones AC**, Ames D. Art appreciation for veterans with severe mental illness in a VA Psychosocial Rehabilitation and Recovery Center. *Arts & Health*. 2015, DOI: 10.1080/17533015.2015.1019700.
- Meyer HB, Katsman A, **Sones AC**, Auerbach DE, Ames D, Rubin RT. Yoga as an ancillary treatment for neurological and psychiatric disorders: A review. *J Neuropsychiatry Clin Neurosci*. 2012;24(2):152-64.

Lectures and Oral Presentations

- **Sones AC**. Testifying for Wrists. Presented annually during core didactics series for medical student and first year psychiatry residents at UCLA-Semel and West LA VA Psychiatry Residency programs, 2020-Present, most recently 7/22/2025

- **Sones AC**. LPS [Lantermann-Petris-Short] Training. Presented annually at new resident orientation for UCLA-Semel and West LA VA Psychiatry Residency programs, 2020-Present, most recently 6/17/2025
- **Sones AC**. New frontiers in Tarasoff. Presented annually at UCLA-Semel core Forensics Psychiatry Fellowship didactics, 2022-Present, most recently 2/12/2025.
- **Sones AC**. Duty to protect or duty to warn? Presented at UCLA-Semel core Forensics Psychiatry Fellowship didactics, 4/20/2022.
- **Sones AC**. Malingering psychosis. Presented at UCLA-Semel core Forensics Psychiatry Fellowship didactics, 4/21/2021.
- **Sones AC**. Combined index response for ptosis surgery: Nominal group technique. Oral presentation at: American Society of Ophthalmic Plastic and Reconstructive Surgery Spring Scientific Symposium; 6/23/2017; Vancouver, BC, Canada.

Abstracts Accepted for Poster Presentation

- Bui AL, **Sones AC**, Dy LS, Tse L, Shaw L, Talley M, Marfisee M. "Creating a Student-Run Haven for Homeless College Students in Los Angeles: Bruin Shelter and a New Medical and Social Case Management Model." *Society of Student Run Free Clinics.* Anaheim, CA. February 11, 2017.
- **Sones AC**, Rootman D. "Critical pre-operative and post-operative factors in evaluating ptosis." *ASOPRS 47th Annual Fall Scientific Symposium.* Chicago, IL. October 13, 2016.
- **Sones AC,** Masters C, Kang MR. "Effort Thrombosis: Venous Thrombosis Triggered by Exercise." *Society of Hospital Medicine: Hospital Medicine 2016*. San Diego, CA. March 7, 2016.
- **Sones AC**, Masters C, Kang MR. "Effort Thrombosis: Venous Thrombosis Triggered by Exercise." *Society of General Internal Medicine: 2016 California-Hawaii Regional Meeting.* San Francisco, CA. January 15, 2016.
- **Sones AC,** Tran A, Moreno T, Rootman D, Goldberg R. "Creating a Combined Response Index for Ptosis Surgery Outcomes." *2014 Josiah Brown Poster Fair.* Los Angeles, CA. July 24, 2014.
- Tran A, **Sones AC**, Moreno T, Rootman D, Goldberg R. "Effect of induced facial nerve palsy on eyelid position." *2014 Josiah Brown Poster Fair.* Los Angeles, CA. July 24, 2014.
- Erickson Z, **Sones AC**, Ames D. "Management of Antipsychotic Medication Associated Obesity." *Department of Psychiatry, November Grand Rounds*. West Los Angeles VA Medical Center, Los Angeles CA. November 14, 2013.
- **Sones AC**, Meyer H, Ames D. "The Effects of Yoga on Biopsychosocial Parameters." *2013 VA Mental Health Summit.* VA Greater Los Angeles Healthcare System, Los Angeles, CA. August 21, 2013.
- Todorov A, **Sones AC**, Lynskey M, Krasteva D, Lazarov P, Nesheva E, Gergov G, Galabova A, Yankova E, Llujebova A, Nikolov M, Beltcheva O, Mitev V, Kaneva R, Kremensky I. "Genetic Epidemiology of Heroin Dependence in Bulgaria." *Initiative for Health Foundation.* Sofia, Bulgaria. September 6, 2011.

Pending Submissions

- Moral injury: early interventions and prevention of severe mental illness in veterans
- Ethics of AI Use in Forensic Psychiatry

American Board of Psychiatry and Neurology, Inc.

A Member Board of the American Board of Medical Specialties (ABMS)

Certifies that

Alexander Cera Sones, M.D.

is complying with the standards for continuing certification in
Psychiatry and Forensic Psychiatry
from ***January 01, 2026*** *to* ***December 31, 2028***

As a Diplomate of the American Board of Psychiatry and Neurology,
ongoing certification is contingent upon meeting the Continuing Certification program requirements.

Jeffrey M. Lyness, M.D., President and CEO

The current and official status of this certificate should be verified online in the ABPN ***verifyCERT*** *directory at ABPN.org since certification status is dependent on many ongoing requirements. The ABPN cannot guarantee the certification status resulting from the loss or restriction of medical licensure if the loss or restriction has not been reported to the ABPN.*

Printed 2/14/2026

Alexander C. Sones, M.D.
Qualified Medical Examiner
Diplomate, American Board of Psychiatry and Neurology, Psychiatry
Diplomate, American Board of Psychiatry and Neurology, Forensic Psychiatry
2730 Wilshire Blvd, Suite 325, Santa Monica, California 90403
Tel: (310) 439-9749
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Orange County Employee Retirement System
2223 E Wellington Ave #100
Santa Ana, CA 92701

DISABILITY INDEPENDENT MEDICAL EVALUATION

Member name: [redacted] (Date of Birth: [redacted])
Soc. Sec number: xxx-xx-[redacted]
Employer: [redacted]
Occupation: [redacted]
Examination Date: [redacted]

IDENTIFICATION:

The member is a [redacted]-year-old female employed by [redacted] as a [redacted]. The member last worked on [redacted] Per the Employee's Statement of Disability dated [redacted] the member reported inability to perform her job duties. She attributed this to limited use of the upper extremities and inability to tolerate prolonged sitting or standing. She reported acute anxiety and depression.

She reported right carpal tunnel syndrome with severe pain in the upper extremities, primarily on the right. Symptoms were worsened by repetitive typing, writing, computer mouse use, and holding objects. She described weakness and numbness in the hands.

She reported severe headaches and sharp, stabbing pain involving both sides of the neck and the upper to mid back. She described back aches and muscle spasms. She reported lower extremity numbness after sitting longer than 20 minutes.

She reported fibromyalgia and myofascial pain syndrome with painful and tender areas involving the arms, legs, buttocks, calves, and tops of the feet. She described fatigue and headaches during flare-ups. She reported a sensation of throat closing during periods of stress. She was evaluated by an ENT physician through Kaiser Permanente in Corona and underwent endoscopy. She was advised that this symptom was stress related.

She reported acute anxiety, panic attacks, and depression.

She reported costochondritis with severe chest pain, chest tightening, and tenderness of the rib cage and clavicular areas bilaterally.

[redacted]

She reported sciatica with sharp, shooting pain in the buttocks and numbness radiating down the legs with prolonged sitting. She also described burning pain along the thighs.

The applicant was evaluated through HIPAA-compliant videoconference. The applicant consented to be examined through videoconference. A physical examination was not necessary to perform this evaluation.

At the start of the examination the applicant was informed that the evaluation was in connection with her [redacted] disability claim and that no treatment relationship existed. It was explained to her that she had the right to terminate the examination at any time no matter what the reason. The applicant was also made aware that any communication would not be confidential. She was notified that any information provided, as well as the results of psychological testing and my conclusions regarding the evaluation, would be included in the report and that this report would be read by others involved in her claim. She was informed that she was permitted to ask questions at any time during the evaluation. The applicant indicated that she understood the aforementioned and agreed to proceed with the evaluation. If the applicant wishes to review this report, I would prefer that she review it under the supervision of a physician or mental health professional since this report could be easily misinterpreted.

The applicant resides in a condo. She has been residing at this location for the past five years. She moved five years ago after her daughter was assaulted by a neighbor's son. She lives with her spouse.

The applicant is currently not employed. The applicant last worked on approximately [redacted] for the [redacted] as a [redacted] She resigned on [redacted]. This was her employer at the time of her industrial injuries.

ABSTRACT:

1. **Is the member currently incapacitated? Yes**
2. **Is the member continuously incapacitated? Yes**
3. **If so, date continuous incapacity commenced?** [redacted]
4. **Is the member permanently incapacitated? No**
5. **If so, which claimed injury (injuries) do you find as permanently incapacitating? N/A**
6. **If so, is the incapacity service connected? N/A**
7. **Can the member return to work with treatment? From a psychiatric perspective, she will likely be able to return to work after treatment.**

RECOMMENDATION:

Based on my review of the records/documents and my examination of [redacted]. I recommend the applicant obtain treatment for her service-connected incapacity. At this time, change in her psychiatric condition is medically probable with treatment, and therefore her incapacity is not permanent.

HISTORY OF INDUSTRIAL INJURY:

The applicant began working for the [redacted] in [redacted]. Her last day of work was [redacted] as a [redacted] She resigned on [redacted]. She worked full-time for approximately 40 hours per week. When she last worked, she earned approximately $41 per hour.

[redacted]

When she started working at the [redacted], she earned approximately $18 per hour. She has had no concurrent employment or schooling while working for the [redacted].

The applicant was hired by the [redacted] as a [redacted]. She was promoted to [redacted] in approximately [redacted]. She was promoted to [redacted] in approximately [redacted]. She was promoted to [redacted] in approximately [redacted]. She was promoted to [redacted] in approximately [redacted]. She was promoted to [redacted] in approximately [redacted]

In her role as a [redacted], her primary duties involved [redacted] assigned to [redacted]. She conducted case reviews and reviewed documentation submitted by social workers providing services to [redacted] clients. She prepared performance evaluations and coordinated work assignments for [redacted].

In [redacted], she transferred to a different [redacted]. She remained a [redacted], but her duties changed. She managed [redacted] fraud complaints and coordinated with the [redacted] in the investigation of suspected fraud. She conducted trainings for [redacted] al [redacted]. She drafted policies and procedures for [redacted] staff. She also continued to conduct case reviews.

In approximately [redacted], she received a Summary of Conference and a Memorandum of Expectations indicating that certain performance expectations were not being met. These actions are discussed in detail below. Other than these actions, the applicant did not receive any formal reprimands, suspensions, or disciplinary actions.

During the initial phase of her employment, the applicant "loved" her job. She did not initially experience any work-related difficulties that adversely affected her psychological condition. From a psychological standpoint, she felt "good." She was neither depressed nor anxious. She remained calm, relaxed, and content most of the time. She got along well with coworkers and supervisors.

The applicant reported that in approximately [redacted] her supervisors "began to throw me under the bus so they didn't look bad." She stated that supervisors would "dump their work or make me clean up their mess." She reported that "for two years I was doing the job of two workers because my co-worker was out for maternity leave."

The applicant reported that in approximately [redacted] she was called into the office of a supervisor, [redacted], after her performance in preparing a learning plan for a specific employee was questioned. During the meeting, the applicant reported that she repeatedly tapped her finger on the desk while asking not to be assigned more difficult employees. She stated that this behavior was perceived as inappropriate or confrontational. She reported that [redacted] informed her she would be issued a Memorandum of Expectations indicating that certain performance expectations were not being met. The applicant reported that "for six weeks I was waiting for this Memo."

Following this meeting, the applicant was transferred to a fraud detection role under two new supervisors. She reported that she performed well in that position until [redacted], one of the supervisors, was promoted to [redacted].

[redacted], [redacted]
[redacted]

The applicant reported that [redacted] initially "left me alone for six months" while on probation. After [redacted] completed probation, the applicant reported that [redacted] began micromanaging her work. She stated that [redacted] questioned her out-of-office status despite her time having been approved. She reported that [redacted] alleged she was not completing her work assignments, which required the applicant to provide screenshots as proof that she was working.

She reported that a required form was not functioning properly, requiring her to re-type information, which she stated was difficult due to her physical injuries. She reported that [redacted] accused her of mis-typing a client's name on a log in an email copied to her manager. The applicant reported that she took a screenshot demonstrating that the name was correct and sent it to [redacted]. She stated that she copied union staff and Human Resources on the email because she felt she was being harassed. She reported that a supervisor then stated that she had violated client confidentiality.

The applicant reported that she became "shaking" and "crying" and stated that she had to leave work.

The applicant reported that she then worked on an internal protocol document for [redacted] procedures. She stated that the document was previously one page but was expanded to approximately seven pages. She reported that [redacted] repeatedly changed decisions related to the document, requiring multiple rewrites. [redacted] then wrote in an email notice to supervisors that [redacted] and the applicant had a video conference to discuss the document. "I was livid. I had all the evidence to show we switched everything to the evening before, and I was this close to being done." She reported that she went to her manager and described what occurred. She stated that thereafter [redacted] "really cracked down on me," including stating that she should not be out of the office for approved medical appointments.

The applicant reported that she contacted Human Resources and stated that she felt she was "going to have a nervous breakdown." She reported that Human Resources sent [redacted] for additional training.

The applicant was subsequently assigned a newly transferred employee who was involved in litigation against the [redacted] She reported that because she performed well managing this employee, she was subsequently assigned additional employees with performance or disciplinary issues. She stated that she was assigned approximately four such employees and was required to "constantly document," which she reported was difficult due to her hand and wrist injuries.
She reported that employees she supervised made false accusations against her. She stated that these employees had poor performance and required daily meetings, in addition to her other supervisory duties. She reported that she was required to complete case corrections and provide ongoing training to veteran staff who she believed should not have required such training.

The applicant estimated that between [redacted] and [redacted] she took "at least a year" off work in total due to mental health reasons. She reported multiple one-day leaves of absence. She reported one leave of absence of approximately two weeks in [redacted] due to stress and pain.

The applicant reported two Temporary Work Assignments. The first occurred in approximately [redacted]. During this assignment, unannounced home visits were removed from her duties, which she described as "my favorite part of the job." This Temporary Work Assignment lasted approximately three months.

[redacted]

A second Temporary Work Assignment occurred in approximately [redacted]. She was found to be unable to perform the essential functions of her position due to anxiety and stress. She was reassigned to [redacted] in the lobby for approximately six months. She reported that she was unable to return to her regular position and subsequently retired.

The applicant reported that she did not want to retire and that she enjoyed working. She stated that she needed to work an additional five years to feel financially secure. She reported that the cumulative stress and the mental and physical toll of her work led to her retirement.

She reported experiencing physical symptom flare-ups one to two times per week. She described being severely depressed and stated that she felt she had "lost my identity." She reported loss of motivation and energy. She described poor sleep with frequent nighttime awakenings and nightmares. She reported episodes of numbness in her arms and legs. She stated that it was difficult to enjoy activities. She reported feeling ashamed and avoiding discussion of her work.

She reported that she has not applied for any employment since retiring.

She reported that she has thought about returning to work and stated, "I could be a greeter at Walmart." She reported that she is working on managing her emotional reactivity and stated that she does not want to "be angry and pop off." She reported that she feels "still always angry." She stated that psychotherapy treatment has helped somewhat and that she hopes to reach a point where she can return to work. She reported that medications have worsened her symptoms.

The applicant reported that she feels unable to work at this time. She stated that she becomes easily overwhelmed. She reported that even receiving a group text from family can cause her to freeze, begin ruminating, and become unable to focus. She reported that she recognizes this reaction but remains unable to concentrate or engage in productive activity. She stated that she would experience these reactions frequently in a work environment and described feeling constantly inundated.
She reported that she would be open to participating in an Intensive Outpatient Program.

CURRENT ACTIVITIES:
The applicant was performing her duties as a [redacted] for the [redacted] prior to her resignation on [redacted]. She reported that she had been performing her job well. In her last performance evaluation in [redacted], she was rated as "meeting expectations."

In response to direct questioning, the applicant described the following work-related functional abilities and limitations.

Activities she was able to perform included arriving to work on time and maintaining regular attendance. She reported that she did not distract coworkers working near her and did not provoke altercations. She did not require special supervision. She reported that she was able to respond appropriately to changes in the work setting. She was aware of normal workplace hazards and was able to take appropriate precautions.

Activities she was not able to perform included responding appropriately to criticism from supervisors due to stress, pain, and anxiety. She reported difficulty interacting appropriately with supervisors and coworkers. She reported that she was distracted at work, including by a coworker who "was constantly

asking me for assistance even though I trained her multiple times." She reported inability to maintain attention and concentration on assigned tasks. She reported inability to carry out detailed instructions and difficulty understanding and remembering short, simple instructions. She reported that she could not make simple work-related decisions, which she attributed to perceived harassment by her supervisor causing her to question herself. She reported that she was not completing her work on schedule. She reported that she was unable to complete a normal workday or workweek without interruption from psychologically based symptoms. She reported difficulty remembering work procedures and stated that she was "constantly having to document and screenshot everything," which caused intense anxiety and fear.

The applicant spends approximately four hours per day using her smartphone, tablet, or computer to correspond in email and texts, play games, browse the web, make phone calls, use social media, and take photos. She spends approximately four hours per day watching movies and television and does not spend any time reading books.

The applicant spends one hour per week going to church or other religious institutions. She spends four hours per week dining at restaurants. She does not spend any time going to the gym or volunteering.

The applicant goes to the park for approximately two hours per week. At home the applicant performs her usual chores including washing dishes, preparing meals, sweeping, mopping, dusting, laundry, taking out the trash, gardening, taking care of her pet dog and cat, cleaning the kitchen, performing household repairs, and maintaining her vehicles for approximately two hours per day on three days per week. For approximately six hours per week, she runs her routine errands to the market, car parts store, gas station, bank, pet store, home improvement store, warehouse store, or department store.

The applicant spends approximately two hours per week traveling to and attending medical appointments. She does not spend any time going to casinos, concerts, or bars.

The applicant states that a typical day includes feeding her dog and cat, checking her emails and phone for messages, preparing food, watching television, going for a walk if she is feeling well enough, speaking on the phone with her mother or friends, and possibly running errands.

The applicant is independent in all activities of daily living, including bathing, dressing, toileting, transferring, continence, feeding, standing, sitting, seeing, hearing, feeling, sexual arousal, and sleep.

The applicant is independent in the following instrumental activities of daily living: traveling by car, using the Internet, using the telephone, and administering medications. She requires assistance for the following instrumental activities of daily living: food preparation, doing the laundry, writing and typing, shopping, managing housekeeping duties, and managing household finances. She requires assistance in these instrumental activities of daily living due to inability to use her hands, lift objects, or initiate and maintain fine motor movements due to pain in various areas of her body.

The applicant has not attended school since she last worked for the [redacted]. She traveled in [redacted] for two days to Phoenix, Arizona to visit an ailing family member.

PAST PSYCHIATRIC HISTORY

[redacted], [redacted]
[redacted]

The applicant reported attending one group therapy session in approximately [redacted]. This was recommended by a workers' compensation physician who believed her pain symptoms had a psychosomatic component. She did not continue treatment due to not finding it helpful.

Following her father's death in [redacted], she met with a psychotherapist through Kaiser Permanente whose name she cannot recall. She attended approximately two to three sessions. She reported feeling that the therapist was dismissive and stated the therapist remarked, "well they've all gotten past it, why haven't you?" She discontinued treatment because she felt unsupported and did not find it helpful.

She reported that she has seen two psychiatrists through Kaiser Permanente, each on one occasion, both around [redacted]. She cannot recall the name of either psychiatrist. She was prescribed Xanax, an antianxiety medication, for an unknown diagnosis. She reported taking half of one dose, which "made me so depressed," and she discontinued the medication. She was also prescribed Zoloft, which she took for approximately two and a half days before discontinuing due to increased anxiety and pacing. She was prescribed Lexapro, which she took for approximately one day and believed caused increased anxiety. She was prescribed buspirone, which she took for approximately one day before discontinuing due to increased anxiety. She reported that she is not interested in medication treatment and stated, "sometimes I think about it, but if it means I have to go through that where it's more anxiety, I don't want it."

Since [redacted], the applicant estimated that she has met with approximately six psychotherapists. With five of these therapists, she attended fewer than three sessions. One therapist treated her weekly for approximately six months before the therapist left their position for another job. One therapist was provided through the Kaiser pain clinic for a time-limited period of approximately six weeks. One therapist, described above, made a statement that the applicant found offensive, and she terminated treatment after two to three sessions. Another therapist stated she would not be helpful and saw the applicant approximately three times before referring her to a therapist who practices Eye Movement Desensitization and Reprocessing. This is her current therapist. She reported that she cannot recall why treatment ended with the sixth therapist.

Her current treatment consists of weekly psychotherapy for the past four months with [redacted] through Kaiser Permanente. She believes her diagnosis may include depression and anxiety. She has not yet started Eye Movement Desensitization and Reprocessing.

She is not currently under the care of a psychiatrist.

She reported emergency room visits for stress and anxiety following her father's death in [redacted] and believes she went approximately two times that year. She reported approximately three emergency room visits in [redacted] for stress and anxiety. She denied any psychiatric hospitalizations. She denied any history of sober living or substance use treatment. She denied any history of residential treatment, partial hospitalization, or intensive outpatient programs.

Regarding suicidality, she reported passive suicidal ideation beginning in [redacted] when her work injuries first started and again in [redacted] prior to retirement. She described thoughts such as, "I'm in so much pain and I'm so depressed, maybe I should just not wake up." She also reported a thought in [redacted] of driving into traffic. She estimated experiencing suicidal thoughts approximately two times over a two-year period. She denied any suicide attempts, self-injurious behaviors, or preparatory behaviors.

[redacted]

The applicant has no recollection of contact with any other specialists in psychiatry or mental health professionals except as stated. She has never used psychotropic medications except as mentioned. She has never received treatment for problems regarding the use of drugs or alcohol, including at a sober living or a drug and alcohol treatment center.

PAST MEDICAL HISTORY

The applicant has a medical history significant for fibromyalgia, diagnosed at approximately [redacted] years of age; hypertension, diagnosed at approximately [redacted] years of age; migraine headaches, diagnosed at approximately [redacted] years of age; myofascial pain syndrome, diagnosed at approximately [redacted] years of age; right carpal tunnel syndrome, diagnosed at approximately [redacted] years of age; lumbar and cervical strain, diagnosed at approximately [redacted] years of age; radial styloid tenosynovitis, diagnosed at approximately [redacted] years of age; cervical disc degeneration, diagnosed at approximately [redacted] years of age; and cervical radiculopathy, diagnosed at approximately [redacted] years of age.

The applicant reported two prior industrial injuries. The first occurred when she was approximately [redacted] years of age and involved overuse of the bilateral wrists, headaches, neck pain, shoulder pain, and back spasms. She reported being on disability for approximately 18 months. She reported receiving a settlement of approximately $12,000 for permanent disability.

The second industrial injury occurred when she was approximately [redacted] years of age and involved carpal tunnel syndrome, myofascial neck pain, shoulder strain, cervical radiculopathy, radial styloid tenosynovitis, lateral epicondylitis, and cervical disc degeneration. She was unable to estimate the total time she was off work. She reported being reassigned to temporary work assignments, including greeting duties. She reported receiving a settlement of approximately $100,000 for permanent disability.

Her surgical history includes right anterior cruciate ligament and meniscus repair in [redacted], hysterectomy in [redacted] due to fibroids and vaginal bleeding, and tonsillectomy in [redacted].
The applicant is currently prescribed tizanidine 5 mg, which she takes approximately one to two times per week for muscle spasms; hydroxyzine 25 mg, which she takes approximately one to two times per week for anxiety; cyclobenzaprine 10 mg, which she takes approximately one to two times per week for muscle spasms; meloxicam 15 mg, which she takes approximately one to two times per week for muscle pain; and rizatriptan 5 mg, which she takes approximately once every six months for migraine headaches. She also uses vitamin D and turmeric supplements.

She estimated that she has visited the emergency room approximately 10 times in her lifetime for reasons including a sprained ankle, a broken ankle, chest pain, and anxiety.

She reported one overnight hospitalization for routine childbirth in [redacted].

The applicant has no prior industrial injuries except as stated. She reports no history of serious head injury or loss of consciousness. She has never been placed on medications for an extended period of time except as described. There is no history of neurological disease, thyroid disease, hypertension, hypercholesterolemia, anemia, or any other chronic medical illnesses except as mentioned.

CURRENT PHYSICAL COMPLAINTS

The applicant currently reports headaches rated at 9 out of 10, with 10 representing the worst pain imaginable. These headaches occur approximately once every two weeks and last for about two hours. She reported that the pain is aggravated by stress and alleviated by migraine medication and ice packs.

She also reported pain involving the top of her head, bilateral jaw regions, and the cervical spine. This pain is rated at 7 out of 10. It occurs for approximately four hours on one to two days per week. She reported that the pain is aggravated by pushing, pulling, stress, and repetitive use, and is alleviated by pain medication and breathing exercises.

She reported pain in the right forearm and fingers, rated at 9 out of 10. This pain occurs for approximately 10 hours per day on seven days per week. She reported that the pain is aggravated by repetitive use, lifting, carrying, and writing, and is alleviated by medication and rest.

She reported back spasms and lower back pain rated at 6 out of 10. This pain occurs for approximately five hours per day on two to three days per week. She reported that the pain is aggravated by lifting, carrying, and pushing, and is alleviated by rest and medication.

REVIEW OF CURRENT PSYCHIATRIC SYMPTOMATOLOGY

I reviewed the applicant's psychiatric symptomatology through direct questioning. The applicant described her current mood as: "anxious and depressed."

1. Anxiety. The applicant states that she feels anxious on a daily basis for approximately 12 hours per day. On a scale from 0-10 with 0 being the absence of anxiety and 10 being the worst level of anxiety she can possibly imagine, the applicant rates her level of anxiety during these episodes as 8. She worries about her coworkers not being held accountable and family's health. Her anxiety is worsened by being in pain and people lying to her and is relieved by spending time with her pet dog and cat, breathing exercises, and prayer. She has been experiencing restlessness. She has not been experiencing obsessions, rituals, chills, chest pain, lightheadedness, derealization, or depersonalization.
2. Mood. The applicant states that her mood is low on a daily basis for approximately six hours per day. On a scale from 0-10 with 0 being the absence of depression and 10 being the worst level of depression she can possibly imagine, the applicant rates her level of depression during these episodes as 7. Her mood is worsened by her pain and talking about work and is improved when she spends time with her husband, daughter, and pets. She complains of disordered sleep, feelings of guilt and hopelessness, low energy, difficulty concentrating, appetite problems, and lack of enjoyment of activities she previously found enjoyable. She has not experienced suicidal thoughts since 2024, when she thought of driving into oncoming traffic. She has not attempted suicide. She has not experienced homicidal thoughts. She does not report episodes of persistently elevated mood.
3. Psychosis. The applicant does not report any delusions or hallucinations. She does not believe that her thoughts can be heard by others. She does not believe that her mind can be controlled by others.
4. Trauma- and Stressor-Related. The applicant does not report nightmares, avoidance, hypervigilance, intrusive memories, or flashbacks. Although she reports threatened death and serious injury such as her ex-spouses threats to kill her and her daughter, she does not report psychological symptoms associated with these stressors.

5. Appetite. The applicant reports disturbances in her appetite such that she eats significantly more than usual. Since the onset of her low mood, the applicant has gained approximately 11 pounds. She currently weighs [redacted] pounds and is [redacted] feet [redacted] inches tall.
6. Sleep. The applicant falls asleep at approximately 11 PM and wakes up at approximately 8 AM. The applicant reports that her sleep has been restorative. She has difficulty falling asleep and wakes up throughout the night approximately twice per night due to neck pain. The applicant does not report waking up earlier than usual.
7. Sexual Functioning. The applicant does not report a change in her sexual functioning or desire.
8. Social Functioning. The applicant reports significant problems in social functioning. She stated that she was previously very social but now limits social activity. She reported that she does not go out often and experiences significant anxiety when she does. She stated that she feels people are "fake" and that she avoids situations in which she may be asked about work. She reported interacting with her husband, best friend, daughter, and mother approximately two times per week. These interactions include going to the beach, walking, and going out to eat with her husband on weekends. She reported that prior to the onset of her symptoms, she socialized with friends approximately three to five times per week and with family approximately two times per week. She reported that she is able to initiate social contact. She denied provoking altercations. She reported current hobbies and activities including listening to music, going to the park, and kicking a soccer ball. She identified as Catholic and reported attending church weekly.
9. Alcohol. The applicant reports she drinks one to two beers per month with dinner. She has never had problematic alcohol use. She denies binge drinking or DUIs.
10. Tobacco. The applicant reports she has never smoked cigarettes or any other tobacco-containing products.
11. Recreational Substance Use. The applicant reported a history of marijuana use. She stated that she first used marijuana at approximately [redacted] years of age. She reported that her peak marijuana use occurred at approximately [redacted] years of age, during which time she used marijuana approximately two times on weeknights and four to five times on weekends. Over the past month, she reported using marijuana approximately one to two times daily, typically by smoking joints. She denies any historical use of cocaine, methamphetamine, PCP, hallucinogens, ketamine, narcotics, sedatives, or any other recreational substances.

FAMILY PSYCHIATRIC HISTORY

The applicant has two cousins who have committed suicide. The first was in his [redacted]'s and may have been related to a possible domestic dispute. The applicant was [redacted] years old at the time of his death. The second suicide was a cousin who was approximately [redacted] years old and was abusing methamphetamine. The applicant was in her [redacted]'s at the time of this cousin's death. She is not aware of any other history of psychiatric illness within her family.

SOCIAL HISTORY

The applicant was born in Los Angeles, California. She was healthy at birth. The emotional climate of her home was stable, and there were no unusual circumstances surrounding her birth. She is not aware of the specific ages at which she achieved developmental milestones but does not believe there were any developmental delays. During childhood, she denied significant problems with bedwetting, temper tantrums, stuttering, nightmares, head banging, rocking behaviors, or phobias.

[redacted], [redacted]
[redacted]

She described her childhood as “very blessed.” Both parents were “hard-working and employed.” She lived in Pico Rivera until approximately age [redacted], after which the family moved to Placentia for what she described as a “better life” and a more suburban environment. She was the youngest of three siblings and stated that the “older kids got all the good stuff.” She attended Catholic school until the fifth grade and was transferred to public school when tuition became unaffordable due to her brother attending the [redacted]. The family later moved to Chino Hills so her mother could help care for her grandfather. After his death, her parents downsized and moved to Riverside. She reported rare physical discipline during childhood, occurring approximately once every three years during major conflicts. She described occasional spanking, slapping, or hair pulling. She provided examples such as her mother gently pulling her hair when she spoke during church and slapping her on one occasion when she spoke up. She estimated this occurred possibly once during her childhood.

The applicant was raised by both parents and did not live with other individuals for a significant period during childhood. She described her parents’ marriage as close and loving, without known infidelity or separation. She reported being treated well by both parents.

She reported that two cousins died by suicide. The first occurred when she was approximately [redacted] years old; the cousin was in his [redacted]. She was not close to him and saw him at family gatherings. She reported that the family spoke briefly about the incident and then avoided discussion. The cousin shot his wife and then himself. She does not recall experiencing significant depressive symptoms following this event. The second suicide occurred when the applicant was in her early [redacted]. This cousin was approximately [redacted] years old and was seen two to three times per year. She reported feeling sad but tried not to think about it and did not take time off from work or school. She attended the funeral and described the family response as “hush hush.” The cousin died by suicide using his grandfather’s firearm.

The applicant reported having an adopted sister whom she described as “bipolar” and “the crazy one.” During childhood, they were somewhat close. In her forties, the applicant began avoiding this sister after learning that the man her sister married was a “pedophile.” This was discovered in approximately [redacted] when family members noted concerning behavior around children and later learned through an internet search that the man had prior arrests for prostitution and possession and distribution of child pornography. The sister later divorced him but continued to bring him to family gatherings. The applicant reported that family members were aware of this history but did not inform her, which she stated “broke the trust.” She also reported ongoing family conflict, including accusations that her siblings exposed her father to COVID and blamed her for this exposure. Her father later died from COVID-related illness.

She reported significant conflict with her siblings regarding the care of her mother following her father’s death. She stated that her siblings wanted to sell the family home and place her mother in a care facility. She reported that despite their financial means and available living space, none offered for their mother to live with them.

At approximately [redacted] years of age, the applicant discovered that her sister’s boyfriend was “illegally tapping” her phone and the phones of other family members, which she explained meant accessing their phones and taking photographs from the devices without their knowledge or consent. She reported that he stole approximately $100 from her and stole her car, which was later found overturned on the freeway. He was arrested and incarcerated. She reported feeling severely violated and anxious

[redacted]

but did not take time off from school.

The applicant reported terminating a pregnancy at age [redacted]. She became pregnant during a four-year relationship. She described feeling sad and conflicted, stating, "I didn't want to do it, but I was afraid," citing her age and Catholic family background. She described intense guilt, crying, and emotional distress. She did not take time off from school.

She denied any other exposure during childhood to physical, emotional, sexual, or verbal abuse, neglect, domestic violence, substance abuse in the household, mental illness in the household, parental separation, incarceration of a family member, or gang involvement.

The applicant's father died when the applicant was [redacted] old; he was [redacted] years old at the time of death. He died from COVID-related pneumonia. He previously worked as an auto body repairman at Ford Motor Company. Prior to his death, he was in fair health with a history of diabetes, knee pain, and multiple myocardial infarctions. The applicant described their relationship as good, with weekly contact prior to his death.

The applicant's mother is [redacted] old and resides in Corona, California. She is retired and previously worked as an electrocardiogram technician at a local hospital. Her health is fair. She has a history of hypertension and neuropathy related to breast cancer, which is in remission. She also has a history of melanoma and kidney cancer, both in remission. The applicant described their relationship as good and reported speaking with her mother approximately three times per week.

The applicant is one of five siblings. She has a brother, age [redacted], who lives in Corona, California, and works as a [redacted]. She has a sister, age [redacted] who lives in Chino Hills, California, and works as a [redacted]. She has a sister, age [redacted] who lives in Corona, California, and works for the [redacted] in [redacted]. She has a sister, age [redacted] who lives in Tustin, California, and works for the [redacted]. She reported that all siblings are in good health. She described having poor relationships with all of her siblings.

The applicant has been married twice. Her first marriage occurred in [redacted] following a four-year courtship and ended in [redacted]. Her former spouse is approximately [redacted] years old. He previously worked as a sales associate at a major retailer and was later employed as a truck driver. She reported that the marriage ended due to his increasing insecurity, depression, and controlling behavior. She reported verbal threats, including threats to kill her and their daughter. She described two incidents of physical aggression, including being flung across a room by her hand and being placed on a table during an argument. During the final four years of the marriage, they agreed to see other people. When he learned she was dating someone else, he took their daughter without permission. Law enforcement was contacted, and the child was returned. She later obtained a restraining order and temporarily lived with her mother. They shared custody of their daughter. She reported no contact with her former spouse for several years. He currently resides in Kansas.

The applicant married her current spouse in [redacted] after a courtship of approximately [redacted] years. They were introduced by mutual friends. Her spouse is [redacted] years old, works as a [redacted], and is in good health. She described the relationship as good and denied any history of abuse, domestic violence, infidelity, or law enforcement involvement during this marriage.

[redacted]

The applicant has one child, a [redacted]-year-old daughter who lives in Rancho Santa Margarita and works as a [redacted]. She reported that her daughter is in good health and described their relationship as good.

The applicant reported no difficulties starting school and denied any school phobias. She graduated from [redacted] in [redacted] and completed some college coursework. She did not repeat any grades and reported earning mostly A and B grades. She reported appropriate peer relationships, no significant problems with teachers, and participation in extracurricular activities, including soccer. She recalled receiving detention up to three times for skipping class. She denied any suspensions, expulsions, learning disabilities, or special education services.

She discontinued college after obtaining what she described as "a really good job" at [redacted] She initially applied for a mailroom position but was hired as an [redacted] following a successful interview.

The applicant began working at approximately age [redacted]. She worked as a [redacted] at an animal hospital from approximately ages [redacted]. She worked as a [redacted] for approximately six months at age [redacted]. She worked as an [redacted] at [redacted] for approximately four years beginning at age [redacted] and later developed a repetitive-use hand injury, resulting in approximately [redacted] months of disability. She then worked for the [redacted] as a [redacted] from approximately ages [redacted] to [redacted] and remained employed by the [redacted] until approximately age [redacted]. During this time, she was promoted to [redacted], [redacted], [redacted], and [redacted] She reported that she enjoyed her work, performed well, and left positions to pursue improved pay or scheduling. She denied any history of termination.

She reported current income of approximately $3,600 per month from a [redacted] pension.

The applicant does not identify any recent non-industrial stressors except as mentioned. In response to direct questioning, the applicant states that she has never served in the military, never faced any legal problems, never been arrested or faced criminal charges, and never faced the death of a close friend or family member except as mentioned. Her daughter has never faced serious illness. She has never faced a foreclosure of her home or experienced homelessness. She has never changed her religious beliefs. Neither she nor anyone close to her has had any problems with government agencies. There have been no burglaries, robberies, or similar crises. No one close to her has been involved in any situations of domestic violence or child abuse. No one close to her has been incarcerated except as mentioned. She has never experienced a miscarriage.

MENTAL STATUS EXAMINATION

The applicant presented on time for the appointment. She states she had no difficulty finding the location or navigating the check-in process. She was casually dressed, well groomed, and neatly attired. She appeared her stated age. She maintained appropriate eye contact. There were no unusual facial expressions or gestures.

The applicant maintained a pleasant and cooperative attitude. She was neither evasive nor guarded. She was a fair informant although had difficulty remembering specific details of historical events. She was

able to express her feelings freely. Her subjective report of her psychological condition was consistent with the objective findings.

The applicant remained seated during the examination and did not appear to be experiencing any physical discomfort. There was no evidence of tics, tremors, pacing, grimacing, nail biting, wringing of the hands, tapping of the foot, chewing movements, or any other abnormal psychomotor activity.

There was no evidence of any significant disturbance in her speech. Her speech was fluent without aphasia.

The applicant's affect and mood were depressed. She demonstrated a limited range of affect that was appropriate to the content of the interview; her affect was neither blunted nor elevated. She did not become tearful when discussing the onset of her work-related psychological difficulties. She smiled occasionally.

The applicant's thought processes were logical, coherent, goal-directed, and productive. There was no paucity of ideas, over-abundance of ideas, loosening of associations, flight of ideas, circumstantiality, tangentiality, thought blocking, derailment, nor neologisms.

The applicant's thought content was without any suicidal nor homicidal ideation. There were no ideas of reference, thought broadcasting, thought insertion, bizarre ideas, delusions, nor excessive suspiciousness.

The applicant did not report any disturbances in her sensory perception. She did not appear to be responding to internal stimuli. There was no evidence of depersonalization or derealization.

The applicant remained attentive and alert throughout the examination. There were no fluctuations in her level of consciousness. Her fund of knowledge was commensurate with her level of education. Her intelligence was estimated to be in the average range. She was alert and oriented in all spheres. Concentration was intact. Her memory for distant events was poor, but there were no significant disturbances in recent or immediate memory. Her judgment and insight were fair.

PSYCHOLOGICAL TESTING

Psychological testing has been administered and interpreted as an aid in the diagnosis and therapeutic planning and for evaluation of intellectual strength, psychopathology, psychodynamics, mental health risk, insight, motivation and other factors influencing treatment and prognosis.

The purpose of this examination is to determine the presence or signs of a mental illness for which psychological testing is indicated as an aid in the diagnosis, disability, and therapeutic planning. These tests are not being utilized solely as a screening procedure. Each test that has been performed is medically necessary. These tests are not being performed solely for Medical Legal purposes.

The interpretation of psychological testing which has been administered has been integrated with the information obtained from other sources and incorporated in the conclusions of the psychiatric report giving further meaning to the psychological testing and results.

It must be pointed out that psychological testing is only one aspect of a comprehensive psychiatric examination. Psychodiagnostic testing, in and of itself, can never provide a conclusive diagnostic picture and this is regardless of the number of tests administered. Test findings must be integrated with various other forms of data including mental status examination and history. The various aspects of the testing may suggest a clinical diagnosis, whereas the final determination is that the diagnosis is either different than that suggested by the testing or there is no clinical condition. Some tests are highly subjective and their value is for the examiner to gain a picture of the individual's perceived condition and symptomatology. Sometimes this is highly discrepant with their actual state. Psychological testing is also vulnerable to various forms of bias, and these must also be considered in terms of the final clinical determination.

The following psychological tests were performed:

1. Minnesota Multiphasic Personality Inventory-3 (MMPI-3)
2. Millon Clinical Multiaxial Inventory-IV (MCMI-IV)
3. Brief Symptom Inventory (BSI)
4. Beck Depression Inventory, Second Edition (BDI-II)
5. Beck Anxiety Inventory, Second Edition (BAI)

1. The **Minnesota Multiphasic Personality Inventory-3 (MMPI-3)** was scored using a computer application provided by Pearson. This MMPI interpretation can serve as a useful source of hypothesis about clients. This report is based on objectively derived scale indexes and scale interpretations that have been developed in diverse groups of patients. The personality descriptions, inferences and recommendations contained herein need to be verified by other sources of clinical information since individual clients may not fully match the prototype. The following is a summary of the applicant's clinical profile interpretation:

> *Scores on the MMPI-3 Validity Scales raise concerns about the possible impact of over-reporting (specifically, of cognitive and possibly somatic symptoms) on the validity of this protocol. With that caution noted, scores on the Substantive Scales indicate somatic and cognitive complaints, problematic eating behaviors, and emotional, behavioral, and interpersonal dysfunction. Somatic complaints include preoccupation with poor health, malaise, and neurological symptoms. Cognitive complaints include difficulties in memory and concentration. Emotional internalizing findings include suicidal ideation, demoralization, lack of positive emotions, perceived inefficacy, negative emotionality, worry, anxiety, anger, and compulsivity. Behavioral-externalizing problems include substance abuse and family problems. Interpersonal difficulties include social avoidance and social anxiety.*
>
> *The test taker produced scorable responses to all the MMPI-3 items. She also responded relevantly to the items on the basis of their content.*
>
> *The test taker provided an unusual combination of responses that is associated with non-credible reporting of somatic and/or cognitive symptoms. This combination of responses may occur in individuals with substantial medical problems who report credible symptoms, but it could also reflect exaggeration. She also provided an unusual combination of responses that is associated with non-credible memory complaints. This combination of responses may occur in individuals with significant emotional dysfunction*

[redacted]

MMPI-3 T SCORES (BY DOMAIN)

PROTOCOL VALIDITY

Content Non-Responsiveness	0 CNS	48 CRIN	47 VRIN	50 TRIN				
Over-Reporting	69 F	58 Fp		75 Fs	78 **FBS**	76 **RBS**		
Under-Reporting	36 L	44 K						

SUBSTANTIVE SCALES

Somatic/Cognitive Dysfunction	**72 RC1**	**68 MLS**	**71 NUC**	**75 EAT**	**81 COG**			
Emotional Dysfunction	**76 EID**	**67 RCd**	**58 SUI**	51 HLP	59 SFD	**66 NFC**		
		82 RC2	77 INTR					
		75 RC7	59 STR	**72 WRY**	**65 CMP**	**77 ARX**	**74 ANP**	63 BRF	**72 NEGE**
Thought Dysfunction	58 THD	63 RC6						
		59 RC8						
		52 PSYC						
Behavioral Dysfunction	54 BXD	58 RC4	**75 FML**	52 JCP	**65 SUB**			
		46 RC9	52 IMP	46 ACT	49 AGG	43 CYN		
		55 DISC						
Interpersonal Functioning	44 SFI	45 DOM	41 AGGR	52 DSF	**77 SAV**	**69 SHY**		

who report credible symptoms, but it could also reflect exaggeration. Scores on the Somatic Complaints (RC1), Malaise (MLS), Neurological Complaints (NUC), and Cognitive Complaints (COG) scales should be interpreted in light of this caution.

There are no indications of under-reporting in this protocol.

The test taker reports multiple somatic complaints including head pain complaints and vague neurological complaints. She likely perceives her physical problems as life-interfering. She also likely is prone to developing physical symptoms in response to stress. She also reports experiencing poor health and feeling weak or tired. Indeed she is likely preoccupied with poor health and complains of sleep disturbance, fatigue, low energy, and sexual dysfunction.

She reports problematic eating behaviors and likely experiences some combination of concerns about weight and body shape, restricted eating, and loss of control over eating.

The test taker reports a diffuse pattern of cognitive difficulties including memory problems, difficulties with attention and concentration, and possible confusion. Indeed she very likely complains about memory problems, does not cope well with stress, and experiences difficulties in attention and/or concentration.

The test taker responded to one of the seven Suicidal/Death Ideation (SUI) scale items in the keyed direction. The content of this item is provided in the Critical Responses section later in this report. She may be at risk for self-harm, preoccupied with suicide and death, and at risk for current suicidal ideation and attempts. This possible risk may be exacerbated by substance abuse.

Her responses indicate significant and pervasive emotional distress. More specifically, she reports a significant lack of positive emotional experiences and a marked lack of interest. She very likely presents with anhedonia and displays vegetative symptoms of depression.

The test taker reports various negative emotional experiences and likely is self-critical and guilt-prone. In particular, she reports multiple anxiety-related experiences, including generalized anxiety and reexperiencing and/or panic. She indeed likely experiences significant anxiety and anxiety-related problems, PTSD features including intrusive ideation and nightmares, and panic. She also reports being anger-prone. She indeed likely has problems with anger, irritability, and low tolerance for frustration; holds grudges; has temper tantrums; and is hostile, argumentative, and abusive. In addition, she reports excessive worry, including worries about misfortune and finances, as well as preoccupation with disappointments. She indeed likely worries excessively and ruminates. She reports engaging in compulsive behavior. She indeed likely engages in compulsive behavior such as repeated checking, experiences obsessions, and is rigid and perfectionistic.

She reports feeling sad and unhappy and being dissatisfied with her current life circumstances. She likely complains of feeling depressed and experiences sadness and

despair. More specifically, she reports being indecisive and inefficacious. She likely experiences subjective incompetence and shame and lacks perseverance and self-reliance.

There are no indications of disordered thinking in this protocol.

The test taker reports conflictual family relationships and lack of support from family members. She indeed likely has family conflicts and experiences poor family functioning, has strong negative feelings about family members, and blames family members for her difficulties. She also reports significant past and current substance abuse, and indeed likely has a history of problematic use of alcohol or drugs, including misuse of prescription medication, is sensation-seeking, and has had legal problems as a result of substance abuse.

The test taker reports not enjoying social events and avoiding social situations, including parties and other events where crowds are likely to gather. She very likely is socially introverted, has difficulty forming close relationships, and is emotionally restricted. She also reports being shy, easily embarrassed, and uncomfortable around others. She is likely to be socially inhibited, anxious and nervous in social situations, and viewed by others as socially awkward.

DIAGNOSTIC CONSIDERATIONS

This section provides recommendations for psychodiagnostic assessment based on the test taker's MMPI-3 results if her score reaches or exceeds the recommended cutoff in the MMPI-3 Manual for Administration, Scoring, and Interpretation. It is recommended that she be evaluated for the following, bearing in mind possible threats to protocol validity noted earlier in this report:

Somatic/Cognitive Disorders
- Somatic symptom disorder, if physical origins for malaise and neurological complaints have been ruled out
- Eating disorder
- Disorders related to attention difficulties

Emotional-Internalizing Disorders
- Major depression and other anhedonia-related disorders
- Features of personality disorders involving negative emotionality such as Dependent and Obsessive-Compulsive
- Anxiety-related disorders including PTSD
- Anger-related disorders
- Disorders involving excessive worry
- Obsessive-compulsive disorder

Behavioral-Externalizing Disorders
- Substance-related disorders

[redacted]

Interpersonal Disorders
- Features of personality disorders involving detachment
- Disorders associated with social avoidance such as avoidant personality disorder
- Social anxiety disorder (social phobia)

TREATMENT CONSIDERATIONS

This section provides inferential treatment-related recommendations based on the test taker's MMPI-3 scores. The following recommendations need to be considered in light of cautions noted earlier about possible threats to protocol validity.

Areas for Further Evaluation
- Risk for suicide should be assessed immediately.
- May require inpatient treatment because of significant depression.
- Need for antidepressant medication.
- Extent to which genuine physical health problems contribute to the scores on the Somatic Complaints (RC1)
and Neurological Complaints (NUC) scales.
- Origin of malaise complaints.
- Origin of cognitive complaints, bearing in mind possible over-reporting. May require a neuropsychological evaluation.

Psychotherapy Process Issues
- Likely to reject psychological interpretations of somatic complaints.
- Malaise may impede her willingness or ability to engage in treatment.
- Emotional difficulties may motivate her for treatment.
- Indecisiveness may interfere with establishing treatment goals and progress in treatment.

Possible Targets for Treatment
- Problematic eating behaviors
- Pronounced anhedonia
- Dysfunctional negative emotions
- Anxiety
- Anger management
- Excessive worry and rumination
- Obsessive-compulsive thoughts and behaviors
- Demoralization as an initial target
- Family problems
- Substance abuse
- Difficulties associated with social avoidance
- Anxiety in social situations

Comment: This profile is of questionable validity due to the applicant's tendency to respond to the test items in an exaggerated fashion. While this response pattern is frequently seen in malingering, during the examination I was not left with the impression that the applicant was being intentionally deceptive.

The test results confirm my impression that the applicant is experiencing significant psychological symptomatology.

2. The **Millon Clinical Multiaxial Inventory-IV (MCMI-IV)** was scored using a computer application provided by Pearson. The MCMI- IV reports are normed on patients who were in the early phases of assessment or psychotherapy for emotional discomfort or social difficulties. Respondents who do not fit this normative population or have inappropriately taken the MCMI-IV for nonclinical purposes may have distorted reports. The MCMI-IV report cannot be considered definitive. It should be evaluated in conjunction with additional clinical data. The following is a summary of the applicant's MCMI-IV clinical profile interpretation:

> *Scores for scales 2B (Melancholic), 8B (Masochistic), and C (Borderline) have been adjusted to compensate for the potential over reporting of symptoms based on the elevated scores from scales A (Generalized Anxiety) and CC (Major Depression).*
>
> *Additional score adjustments have also been made on scores for scales 2A (Avoidant) and S (Schizotypal).*
>
> *The following paragraphs refer to those enduring and pervasive personality traits that underlie this woman's emotional, cognitive, and interpersonal difficulties. Rather than focus on the largely transitory symptoms that make up clinical syndromes, this section concentrates on her more habitual and maladaptive methods of relating, behaving, thinking, and feeling.*
>
> *The MCMI-IV profile of this woman suggests marked dependency needs, an anxious seeking of reassurance from others, and an expectation that she will lose the support of those who have provided it. Significant relationships in her life have become increasingly insecure and unreliable. In response, she has become erratically moody and withdrawn, and now experiences prolonged periods of futility and dejection that are interspersed with occasional impulsive and angry outbursts.*
>
> *Typically compliant and hesitant, she is occasionally sullen, irritable, and pessimistic. She vacillates between being pleasant and agreeable and passively aggressive and withdrawn. To complicate matters, she frequently complains of being treated unfairly, which keeps others on edge, not knowing if she will react in an agreeable or a sulky manner. Although she attempts to be obliging, she has learned to expect disappointment and often provokes it by testing the behavior of others and by questioning their sincerity. These erratic behaviors have exasperated and alienated those on whom she leans and, as a consequence, she has begun to give up hope that she can ever regain their support. She often expresses guilt and self-condemnation for her moodiness, but increasingly she has resorted to passive withdrawal and social isolation.*
>
> *This woman increasingly feels a sense of helplessness and has anxious and depressive moods. Although she recognizes that others have begun to grow weary of her unpredictable behavior, she still cannot help but alternate between voicing self-deprecation and remorse, and withdrawing into a shell of protective indifference. There remains a struggle between dependent acquiescence to others and a desire to assert her*

[redacted], [redacted]
[redacted]

MILLON CLINICAL MULTIAXIAL INVENTORY-IV

PROFILE SUMMARY

HIGH-POINT CODE = 8A 3 2A
BR ADJUSTMENTS = A/CC

INVALIDITY (V) = 0
INCONSISTENCY (W) = 4

VALIDITY		Score Raw	Score BR	Profile of BR Scores 0 35 75 100
Modifying Indices				Low / Average / High
Disclosure	X	34	54	
Desirability	Y	4	20	
Debasement	Z	15	72	

PERSONALITY		Score Raw	Score PR	Score BR	Profile of BR Scores 0 60 75 85 115
Clinical Personality Patterns					Style / Type / Disorder
AASchd	1	10	64	66	
SRAvoid	2A	12	67	75	
DFMelan	2B	10	53	66	
DADepn	3	11	77	76	
SPHistr	4A	3	10	16	
EETurbu	4B	1	6	6	
CENarc	5	0	3	0	
ADAntis	6A	1	19	20	
ADSadis	6B	11	86	73	
RCComp	7	10	19	43	
DRNegat	8A	14	82	77	
AAMasoc	8B	4	37	44	
Severe Personality Pathology					
ESSchizoph	S	5	43	58	
UBCycloph	C	4	37	36	
MPParaph	P	9	75	71	

PSYCHOPATHOLOGY		Score Raw	Score PR	Score BR	Profile of BR Scores 0 60 75 85 115
Clinical Syndromes					Present / Prominent
GENanx	A	9	73	85	
SOMsym	H	9	69	72	
BIPspe	N	1	8	12	
PERdep	D	17	73	74	
ALCuse	B	0	14	0	
DRGuse	T	7	83	75	
P-Tstr	R	10	81	75	
Severe Clinical Syndromes					
SCHspe	SS	7	50	60	
MAJdep	CC	12	71	80	
DELdis	PP	2	63	62	

independence. Unfortunately, her inability to regulate her emotional controls and her feeling of being misunderstood only produce further erratic moodiness that adds to her tension and depression.

By examining the elevated Grossman Facet Scale scores for the Clinical Personality Patterns and Severe Personality Pathology scales, it is possible to identify a patient's most troublesome or clinically-significant functional and structural domains (e.g., self-image, interpersonal conduct). A careful analysis of this individual's facet scale scores suggests the following characteristics are among her most prominent personality features.

Most notable are her broad-based social anxiety and fearful guardedness. These characteristics stem from a desire to be accepted by others that is countered by a deep fear of humiliation and rejection, which results in withdrawal and feelings of personal exclusion. She may be characteristically shy and apprehensive, display awkwardness and discomfort in social situations, and actively recoil from the give-and-take of interpersonal relations.

Also salient is her lack of mature confidence and her tendency to act helpless and seek nurturance from others in a childlike manner. Characteristically withdrawing from adult responsibilities, she is docile and passive, displays few functional competencies, and avoids self-assertion.

Also worthy of attention are her expressions of purposeful inefficiency, her gratification in undermining the pleasures and expectations of others, and her overt displays of intentionally contrary and oppositional behavior. Although nearly everyone behaves resentfully at times, what distinguishes this individual is the ease with which she can be provoked into acting in a resentful manner and the regularity with which she manifests procrastination, inefficiency, and obstinate behavior.

Early treatment efforts are likely to produce optimal results if they are oriented toward modifying these personality features.

The following diagnostic assignments should be considered judgments of personality and clinical prototypes that correspond conceptually to formal diagnostic categories. The diagnostic criteria and items used in the MCMI-IV differ somewhat from those in the DSM-5, but there are sufficient parallels in the MCMI-IV items to recommend consideration of the following assignments. It should be noted that several DSM-5 clinical syndromes are not assessed in the MCMI-IV. Definitive diagnoses must draw on biographical, observational, and interview data in addition to self-report inventories such as the MCMI-IV.

Before each disorder name, ICD-9-CM codes are provided, followed by ICD-10-CM codes in parentheses.

Clinical Syndromes

The major complaints and behaviors of the patient parallel the following clinical syndrome diagnoses, listed in order of their clinical significance and salience.
296.33 (F33.2) Major Depression (recurrent, severe)
300.02 (F41.1) Generalized Anxiety Disorder
309.81 (F43.10) Posttraumatic Stress Disorder

Course: The clinical syndromes described previously tend to be relatively transient, waxing and waning in their prominence and intensity depending on the presence of environmental stress.

Personality Disorders
Deeply ingrained and pervasive patterns of maladaptive functioning underlie clinical syndromal pictures. The following personality prototypes correspond to the most probable DSM-5 diagnoses that characterize this patient.

Personality configuration composed of the following:
Unspecified Personality Disorder (Negativistic) Type
Dependent Personality Type
Avoidant Personality Style
and Unspecified Personality Disorder (Sadistic) Style

Course: The major personality features described previously reflect long-term or chronic traits that are likely to have persisted for several years prior to the present assessment.

Comment: This profile is of questionable validity due to the applicant's tendency to respond to the test items in an exaggerated fashion. While this response pattern is frequently seen in malingering, during the examination I was not left with the impression that the applicant was being intentionally deceptive. The test results corroborate my impression that the applicant is experiencing significant psychological symptomatology and that the applicant is suffering from Major Depressive Disorder as well as an Anxiety Disorder. There is insufficient historical or corroborative data to substantiate the diagnosis of Posttraumatic Stress Disorder or a Personality Disorder within reasonable medical probability.

3. The **Brief Symptom Inventory (BSI)** was scored using a computer application provided by Pearson. This test is a 53 item symptom inventory designed to reflect psychological symptoms patterns. Each item of the BSI is rated on a five point scale of distress (0 to 4) ranging from “not at all” (0) at one pole to “extremely” (4) at the other. The BSI is scored and profiled in terms of nine primary symptom dimensions and three global indices of distress. The following is a summary of the applicant’s BSI clinical profile interpretation:

The respondent's BSI symptom profile reveals a pattern and magnitude to be considered in the clinical range, and qualifies her as a positive clinical case.

Her symptomatic distress levels are clearly defined as being in the clinical range, which suggests that a more intensive and detailed evaluation of mental status is called for.

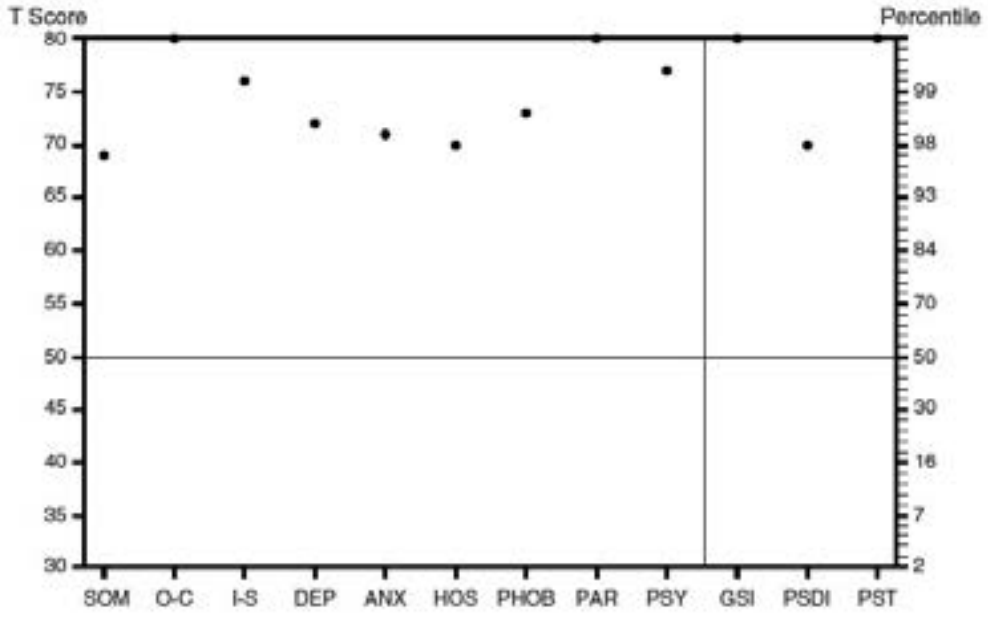
Overall intensity of distress is clinical in nature and she has endorsed a large number of clinical

[redacted], [redacted]
[redacted]

symptoms.

The respondent reveals scores on multiple primary symptom dimensions that are elevated and in the clinical range. With an extremely large number of syndromes elevated, such as in this case, it is very difficult to interpret score patterns unless one or more dimension scores are unusually high. It is clear that the respondent is experiencing significant psychological difficulties, and she should be more intensively evaluated.

BSI CLINICAL PROFILE



	SOM	O-C	I-S	DEP	ANX	HOS	PHOB	PAR	PSY	GSI	PSDI	PST
Nonpatient T Score:	69	80	76	72	71	70	73	80	77	80	70	80
Raw Score:	1.71	3.33	3.50	2.67	2.33	1.60	2.20	3.20	2.00	2.40	2.54	50
Outpatient T Score:	59	65	67	56	55	55	62	68	58	63	55	68
Inpatient T Score:	59	67	68	56	56	57	59	66	58	60	56	67

Comment: The results of this test confirm my impression the applicant is experiencing significant psychological symptomatology.

4. The **Beck Depression Inventory, Second Edition (BDI-II)** was scored using a computer application provided by Pearson. This is a 21 item inventory for measuring the severity of depression. The BDI-II was developed as an indicator of the presence and degree of depressive symptoms consistent with the DSM-IV, not as an instrument for specifying a clinical diagnosis. The BDI-II

should be used cautiously as the sole diagnostic measure because depression may accompany a variety of primary diagnostic disorders. The BDI-II is scored by summing the ratings for the 21 items. Each item is rated on a four point scale range from 0 to 3. The maximum total score is 63. Total scores from 0 to 13 points are considered to reflect a minimal level of depressive symptoms; scores from 14 to 19 indicate mild depressive symptoms; scores of 20 to 28 reflect moderate depressive symptoms; and scores of 29 to 63 indicate severe depressive symptoms.

Comment: The applicant scored 32 on this test, placing her at the 99th percentile, indicating a severe level of depression. The results of this test confirm my impression the applicant is experiencing significant depressive symptomatology.

5. The **Beck Anxiety Inventory (BAI)** was scored using a computer application provided by Pearson. This is a 21 item scale that measures the severity of anxiety. The scale consists of 21 descriptive statements of anxiety symptoms which are rated on a four point scale from 0 ("Not at all") to 3 ("I could barely stand it"). The BAI total score is the sum of the ratings for the 21 symptoms. The maximum total score is 63. Total scores from 0 to 7 points are considered to reflect a minimal level of anxiety; scores from 8 to 15 indicate mild anxiety; scores of 16 to 25 reflect moderate anxiety; and scores of 26 to 63 indicate severe anxiety.

Comment: The applicant scored 25 on this test, placing her at the 98.4th percentile, indicating a moderate level of anxiety. The results of this test confirm my impression the applicant is experiencing significant anxious symptomatology.

Psychiatric Diagnosis

The *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision* (*DSM-5-TR*) diagnosis that is most consistent with the applicant's presentation is:

F33.9, Major Depressive Disorder
F41.9 Unspecified Anxiety Disorder

IMPRESSION AND RECOMMENDATIONS:

The member is a [redacted]-year-old female employed by [redacted] as a [redacted]. The member last worked on [redacted].

The applicant reported that beginning in approximately [redacted] she experienced increasing workplace stress related to perceived unfair treatment, excessive workload, and supervisory conflict, including performance scrutiny, micromanagement, and allegations of misconduct. She described repeated disputes with supervisors, involvement of Human Resources and union staff, and escalating assignments involving employees with disciplinary or performance issues, which required extensive documentation and were difficult due to her physical injuries. She reported episodes of acute emotional distress at work, multiple leaves of absence between [redacted] and [redacted] for mental health reasons, and two Temporary Work Assignments that removed her from core job duties. She stated that she was ultimately unable to return to her regular position due to anxiety and stress and retired despite a desire to continue working for an additional five years for financial reasons.

At the present time, the applicant reports feeling "anxious and depressed." A review of her psychiatric symptomatology is significant for high amounts of anxiety regarding her ability to work, her family's

[redacted]

health, and her own health status. She also described a low mood, disordered sleep, feelings of guilt and hopelessness, low energy, difficulty concentrating, appetite problems, and lack of enjoyment of activities she previously found enjoyable. These symptoms are consistent with diagnoses of Major Depressive Disorder and Unspecified Anxiety Disorder. A battery of psychological tests was administered, and the results of these tests confirm my clinical impression that the applicant is experiencing significant psychological symptomatology. The diagnoses are consistent with those made by clinical providers, including [redacted], PhD who evaluated the applicant beginning in [redacted] and [redacted], PhD who evaluated the applicant beginning in [redacted].

RESPONSES TO QUESTIONS:

1. Is the applicant incapacitated from performing his or her usual job duties? Please explain your opinion.

Yes, the applicant is incapacitated from performing her usual job duties. The applicant is psychiatrically incapacitated from performing her usual job duties as a [redacted]. She has ongoing Major Depressive Disorder and Unspecified Anxiety Disorder that result in impaired concentration, reduced cognitive efficiency, and diminished ability to sustain attention on complex supervisory tasks. She is unable to tolerate ordinary workplace stressors, particularly supervisory feedback, interpersonal conflict, time pressure, and high documentation demands. Her symptoms include persistent anxiety, depressed mood, low energy, decreased motivation, emotional reactivity, and difficulty making work-related decisions. These symptoms have led to an inability to complete tasks on schedule, difficulty interacting appropriately with supervisors and staff, and an inability to complete a normal workday or workweek without interruption from psychologically based symptoms. This level of psychiatric impairment is consistent with her clinical presentation, longitudinal treatment history, functional reports, and psychological testing results, and renders her incapable of performing her usual job duties at this time.

2. Is the applicant capable of performing each of the duties described in the class specification for the applicant's occupation? Describe which duties the applicant can and cannot perform. Please explain your opinion.

No. The applicant is not capable of performing each of the duties described in the class specification for her occupation. Due to her depression and anxiety, ordinary workplace stressors result in emotional dysregulation, impaired concentration, and reduced functional capacity. She is unable to plan, organize, assign, or review the workload of [redacted] or supporting staff due to difficulty sustaining attention, impaired decision-making, and low stress tolerance. She is unable to evaluate subordinate performance or recommend disciplinary action because interpersonal conflict, criticism, and [redacted] judgment trigger significant anxiety and emotional reactivity. She is unable to consistently review and confer with staff regarding case plans, case records, and required documentation due to impaired focus, cognitive inefficiency, and difficulty completing tasks in a timely manner. She is also unable to reliably maintain and communicate up-to-date knowledge of governing laws, regulations, policies, and procedures to subordinate staff due to reduced cognitive endurance, impaired concentration, and difficulty tolerating the cognitive and emotional demands of the role. As a result, she is functionally incapable of performing the essential duties of her usual occupation at this time.

[redacted], [redacted]
[redacted]

3. Is the applicant's incapacity permanent? (Refer to the Legal Standards, above, for the meaning of "permanent.") Please explain your opinion.

No. The applicant's incapacity is not permanent. In this case, the applicant's incapacity is due to depression and anxiety, which are treatable psychiatric conditions. She has not yet received an adequate course of reasonable medical treatment, including structured psychiatric care and sustained medication management, that is likely to result in clinical improvement. As further improvement in her psychiatric condition is medically probable with appropriate treatment, her incapacity does not meet the definition of permanent.

4. Has the applicant received appropriate treatment for the stated injury/disease?

No. The applicant has not received appropriate treatment for the stated psychiatric conditions. While she has participated in psychotherapy, her treatment has been fragmented and insufficient in duration and intensity to constitute an adequate therapeutic course. She has not completed adequate psychiatric medication trials, as prior medications were discontinued after brief exposure due to perceived side effects. She has not participated in a higher level of care such as an Intensive Outpatient Program. Additional structured treatment, including intensive psychotherapy and a sustained trial of psychiatric medication, is reasonably medically necessary and likely to improve her condition.

5. In your opinion does the applicant require additional medical treatment? If so, describe the treatment, the timeframe, and the anticipated results.

Yes. The applicant requires additional medical treatment. Recommended treatment includes participation in an Intensive Outpatient Program for depression and anxiety, psychiatric medication management, and ongoing individual psychotherapy. An Intensive Outpatient Program is a structured treatment program that typically involves attendance at least three days per week for a minimum of three hours per day and includes a combination of group therapy, individual psychotherapy, skills-based interventions, and psychiatric oversight. The expected duration of an Intensive Outpatient Program is at least 30 days and often ranges from 30 to 90 days, depending on clinical response. With completion of this level of care and concurrent medication management and psychotherapy, significant improvement in depressive and anxiety symptoms is medically probable, and the applicant is likely to regain functional capacity and the ability to return to work.

6. Was the applicant <u>continuously incapacitated</u> from the date that they last worked to the date that the disability retirement application was filed? If, in your opinion, the applicant became incapacitated after they last worked, please state when the incapacity began. Please explain how the medical records support your conclusion.

Yes. The applicant was continuously incapacitated from the date she last worked, [redacted] through the date the disability retirement application was filed on [redacted]. Medical records document ongoing psychiatric incapacity during this period. She was evaluated and treated by [redacted], PhD on four occasions between [redacted] and [redacted] and was found to be totally temporarily disabled due to her psychiatric condition. She was also treated by [redacted], PhD between [redacted] and [redacted] and remained temporarily totally disabled throughout that period. There is no evidence in the medical records or in the applicant's report that she received the recommended Intensive Outpatient Program or

sustained psychiatric medication management during this timeframe. Accordingly, the available contemporaneous medical documentation supports continuous psychiatric incapacity from her last date of work through the filing of the disability retirement application.

7. Based on your evaluation and medical history, please state what permanent work restrictions, if any, you would recommend for the applicant. Please specify what injury/body part requires the work restrictions. Please explain your opinion. Please provide the applicant's weight limitations in pounds/ounces and time limits in terms of consecutive hours/minutes, as well as total hours/minutes in a defined workday. Also, please include the length of any required breaks.

At this time, no permanent work restrictions are recommended. The applicant has not yet received adequate treatment for her psychiatric conditions, and further improvement in her condition is medically probable with appropriate care. She is currently not capable of working in any capacity due to active psychiatric symptoms. As no permanent psychiatric restrictions can be determined prior to completion of recommended treatment, no specific permanent limitations regarding hours, breaks, or work capacity are assigned at this time. Determination of weight limitations and other physical restrictions is deferred to the appropriate physical medicine physicians.

8. Is the applicant able to perform other job duties within the restrictions you have indicated? Identify which duties the applicant is still able to perform.

No. The applicant is not able to perform other job duties within the restrictions indicated. Due to the severity of her current psychiatric symptoms, she is not capable of performing any work duties in a competitive work environment at this time.

9. Is the applicant's incapacity service-connected – i.e., did employment contribute substantially to the applicant's incapacity? Identify and explain in detail the "real and measurable connection" between the employment and applicant's incapacity.

Yes, the applicant's incapacity is service-connected. In this case, the applicant's [redacted] employment contributed substantially to her psychiatric incapacity. The record documents a prolonged period of escalating work-related stress beginning in approximately [redacted], characterized by excessive workload, repeated assignment of complex and high-risk [redacted] responsibilities, and ongoing conflict with supervisors. She experienced persistent performance scrutiny, micromanagement, disputed allegations of misconduct, and repeated changes in expectations that required extensive documentation and rework. These conditions directly precipitated and exacerbated symptoms of depression and anxiety, including emotional dysregulation, impaired concentration, panic symptoms, and inability to tolerate routine workplace stressors. The applicant required multiple leaves of absence, Temporary Work Assignments removing her from essential job duties, and was ultimately unable to return to her usual position. The temporal relationship between these employment stressors and the onset and progression of her psychiatric symptoms establishes a real and measurable connection between her [redacted] employment and her incapacity. While other factors may be present, her employment was a substantial contributing cause of her psychiatric incapacity. The incapacity may arise from lawful, nondiscriminatory, and good faith personnel actions; however, the cumulative effect of these employment conditions nonetheless contributed substantially to her inability to function psychiatrically at work.

[redacted], [redacted]
[redacted]

10. If it is your opinion that the applicant is permanently incapacitated for nonservice- connected reasons, please identify and explain all factors that caused or contributed to the applicant's incapacity.

It is not my opinion that the applicant is permanent incapacitated for nonservice-connected reasons.

11. Is applicant's incapacity the result of a permanent aggravation or acceleration of a pre-existing or nonindustrial medical condition? If so, did employment contribute substantially to this permanent aggravation or acceleration? Please explain your opinion.

No. The applicant's incapacity is not the result of a permanent aggravation or acceleration of a pre-existing or nonindustrial medical condition. The psychiatric conditions giving rise to her incapacity developed during the course of her employment and were not permanently worsened versions of a prior psychiatric disorder. Her symptoms emerged and progressed in temporal association with work-related stressors and demands and are partially attributable to her employment. Further, as improvement in her psychiatric condition is medically probable with appropriate treatment, there is no evidence of a permanent aggravation or acceleration of a pre-existing or nonindustrial condition.

12. Even if you do not find applicant to be permanently incapacitated, please provide your opinion regarding the cause of applicant's alleged injuries or illnesses. Are those injuries/illnesses service-connected – i.e., did employment contribute substantially to those injuries/illnesses? Please explain.

Yes. The applicant's psychiatric injuries and illnesses are service-connected, and her employment contributed substantially to their development. The record demonstrates that her depression and anxiety arose during the course of her [redacted] employment and in temporal association with prolonged and escalating workplace stressors. These included excessive workload demands, repeated assignment of complex supervisory responsibilities involving high-risk and disciplinary staff, persistent supervisory conflict, micromanagement, disputed allegations of misconduct, and repeated changes in expectations requiring extensive documentation. These employment conditions precipitated and exacerbated psychiatric symptoms including anxiety, panic reactions, depressed mood, emotional dysregulation, impaired concentration, and reduced functional capacity. The applicant required multiple leaves of absence, Temporary Work Assignments that removed essential job duties, and ultimately was unable to sustain her usual work role. The cumulative effect of these work-related stressors establishes a real and measurable connection between her employment and the development of her psychiatric conditions. While other nonindustrial factors may exist, her employment was a substantial contributing cause of her psychiatric injuries.

DSM-V-TR Question set:

1. *Answer the following if the individual has a mental disorder(s), as defined in DSM-V-Text Revision. Identify the disorder and list elements of the disorder(s) utilizing DSM. State facts that support your findings of the elements of DSM disorder(s). Discuss when this disorder first came into existence. Discuss the cause(s) of the disorder.*

The applicant meets criteria for Major Depressive Disorder and Unspecified Anxiety Disorder as defined in DSM-V-Text Revision. With respect to Major Depressive Disorder, she exhibits a persistently depressed mood, markedly diminished interest or pleasure in previously enjoyed activities, low energy, impaired concentration, feelings of guilt and hopelessness, disordered sleep, appetite

disturbance with weight gain, and reduced motivation, resulting in clinically significant distress and functional impairment. These symptoms have been present on a near-daily basis for extended periods and are supported by longitudinal clinical records, psychological testing, and her reported decline in occupational functioning. Her depressive disorder first came into existence during the course of her employment, with clear worsening beginning approximately between [redacted] and [redacted] and progressing thereafter in the context of escalating workplace stressors.

The applicant also meets criteria for Unspecified Anxiety Disorder. She experiences excessive and persistent anxiety, heightened emotional reactivity, panic-like symptoms, restlessness, difficulty concentrating, and inability to tolerate ordinary workplace stressors. Her anxiety is associated with physiological symptoms and cognitive impairment and has resulted in significant occupational dysfunction. These anxiety symptoms developed during her employment and intensified in parallel with increased workload, supervisory conflict, and perceived harassment.

The causes of both disorders are multifactorial; the evidence demonstrates that prolonged work-related stress, excessive job demands, interpersonal conflict with supervisors, and repeated performance-related stressors were substantial contributing causes to the onset and progression of her depressive and anxiety disorders. Other contributing causes of the applicant's Major Depressive Disorder and Unspecified Anxiety Disorder include chronic physical pain conditions, recurrent medical illnesses, family conflict, bereavement related to her father's death, and limited tolerance of psychotropic medications. Individual vulnerability factors such as histrionic personality traits also have contributed.

2. *State present recommended treatment, including type of treatment, anticipated results and time frame.*

The applicant's current recommended treatment consists of a higher level of structured psychiatric care, including an Intensive Outpatient Program focused on depression and anxiety, ongoing psychiatric medication management, and regular individual psychotherapy. An Intensive Outpatient Program provides organized, multimodal treatment and generally requires participation multiple days per week for several hours per day, with a combination of group-based interventions, individual therapy sessions, skills training, and psychiatric monitoring. The anticipated duration of this level of care is typically between 30 and 90 days based on clinical progress. With completion of this treatment and continued medication management and psychotherapy, meaningful improvement in psychiatric symptoms is expected, with a corresponding increase in functional capacity and a likely ability to return to work.

3. *If you found a mental disorder at Question 1, and the mental disorder(s) affects ability to work, discuss the following:*

a. *Describe any psychiatric limitations of applicant's ability to work. Describe specific tasks that cannot be performed, if any, due to the mental disorder.*

Her depression and anxiety result in poor stress tolerance, impaired concentration, reduced cognitive efficiency, and emotional reactivity in response to ordinary workplace demands. She is unable to effectively plan, organize, assign, or oversee the work of subordinate staff due to difficulty sustaining attention, slowed decision-making, and limited ability to manage competing demands. She is unable to conduct performance evaluations or make disciplinary recommendations because supervisory conflict, criticism, and judgment provoke significant

anxiety and interfere with appropriate professional functioning. She is unable to reliably review, analyze, and discuss case plans, case records, and required documentation due to impaired focus, reduced mental stamina, and difficulty completing tasks within expected timeframes. She is also unable to consistently maintain and convey required knowledge of applicable laws, regulations, policies, and procedures to staff due to diminished concentration and inability to tolerate the cognitive and emotional demands of the position. Consequently, her psychiatric conditions prevent her from performing the essential functions of her usual occupation at this time.

b. *If you identified any limitations above, state facts and reasons that support your opinion.*

The identified psychiatric limitations are supported by longitudinal clinical history, contemporaneous treatment records, psychological testing, and the applicant's consistent functional reports. The applicant demonstrated persistent symptoms of depression and anxiety, including impaired concentration, low energy, emotional dysregulation, and reduced stress tolerance, which were documented over an extended period. She required multiple leaves of absence and Temporary Work Assignments that removed her from essential job duties and was ultimately unable to return to her usual supervisory role. [redacted] [redacted], PhD evaluated the applicant on multiple occasions between [redacted] and *April* [redacted] and found her to be temporarily totally disabled due to her psychiatric condition. [redacted], PhD treated the applicant between [redacted] and [redacted] and likewise documented that she remained temporarily totally disabled throughout that period. Psychological testing administered during the evaluation demonstrated clinically significant depressive and anxiety symptoms with associated cognitive inefficiency. The temporal relationship between escalating workplace demands and the onset and progression of her symptoms, combined with consistent medical opinions of total temporary disability, supports the conclusion that her psychiatric conditions resulted in the work-related functional limitations described above.

c. *State the expected duration of any limitation(s) described above with and without treatment discussed above.*

Without appropriate treatment, the applicant's psychiatric limitations are likely to persist on a long-term basis and may become effectively permanent. With completion of the recommended treatment, including an Intensive Outpatient Program, psychiatric medication management, and ongoing psychotherapy, significant improvement is medically probable, and the functional limitations described above would be expected to resolve within approximately six months from the beginning of the Intensive Outpatient Program.

4. *If you stated any limitations at Question 3 above, answer the following:*
a. *What is the natural course of the mental disorder stated in Question 1 above?*

The natural course of depressive and anxiety disorders is variable and may be episodic or chronic in the absence of treatment. Symptoms commonly fluctuate in severity and may worsen over time with ongoing psychosocial stressors, medical comorbidity, and functional impairment. Without appropriate intervention, individuals may experience persistent low mood, anxiety, cognitive inefficiency, reduced stress tolerance, and progressive occupational and

social dysfunction. With timely and adequate treatment, including psychotherapy and pharmacologic intervention, symptoms frequently improve, and functional recovery is common, with many individuals returning to their prior level of functioning.

b. *What has been the course of the individual's life up to the time at which her work activities became subject to limitations?*

The course of this individual's life is described in detail above in the Social History section. In brief, she was raised in a stable household and functioned well academically, socially, and occupationally into adulthood, with long-term, successful employment and career advancement. Over the course of her life, she was exposed to several significant psychosocial stressors. These included the deaths of two cousins by suicide during her childhood and early adulthood. She experienced significant family conflict after learning that her adopted sister married an individual later identified as having a history of child sexual offenses, which led to estrangement and loss of trust within the family. She also reported substantial and ongoing conflict with her siblings following accusations that she exposed her father to COVID, culminating in strained relationships and lack of familial support after her father's death when the applicant was [redacted] years old. She reported a pregnancy termination at age [redacted] that was associated with guilt and emotional distress. Of particular significance, she experienced a highly stressful and traumatic first marriage marked by verbal threats to kill her and their daughter, two incidents of physical aggression, and an episode in which her former spouse took their daughter without permission, requiring law enforcement involvement and the issuance of a restraining order. Despite these cumulative stressors, she maintained functional independence and sustained employment until her work activities became subject to psychiatric limitations in the context of escalating occupational stress.

REVIEW OF MEDICAL RECORDS: Total pages: 4,102

[redacted] **KAISER PERMANENTE. [redacted]. Psych Social Worker Note. (Final Premed-[redacted] – Page 1978-1983). Total Sessions**: 1. **Diagnoses**: 1) Anxiety. 2) Depressive disorder, other specified.

[redacted]**. KAISER PERMANENTE. [redacted] Progress Note. (Final Premed-[redacted] - Page 1990-1990). Subjective:** The member was seen for intake by [redacted]. The member was given a Med Eval at Orange Psych. Scheduled for [redacted]. The member is calling back because she is having anxiety attacks, stressed out, chest pains, dizzy, pounding heart. She went to Urgent Care 2 weeks ago and was given Xanax. She cannot function without taking Xanax. The member wants to be seen ASAP.

[redacted]**. KAISER PERMANENTE. Psych Social Worker Notes. (Final Premed-[redacted] – Page 1309-1309, 1867-1874, 1994-1998, 2016-2016, 2021-2027, 2040-2042, 2054-2056). Total Sessions:** 5. **Diagnosis**: Major depressive disorder and anxiety disorder.

[redacted]**. INLAND PSYCHIATRIC MEDICAL GROUP. [redacted] Psych Initial Visit Note. (Final Premed- [redacted] – Page 2435-2435). Subjective**: The member was prescribed medication for depression and anxiety after her father passed away. She was having extreme panic attacks, where she went to the hospital because she was having chest pain and thought

[redacted], [redacted]
[redacted]

she was having a heart attack or something. **Diagnoses**: 1) Adjustment disorder with mixed emotional features. 2) Adjustment disorder with mixed anxiety and depressed mood. **Plan**: Continue current medication as prescribed by PCP. Continue individual therapy. Follow-up as needed.

[redacted]. [redacted], LCSW. Individual Psychotherapy Notes. (Final Premed-[redacted] - Page 3191-3218, 3222-3231, 3263-3272, 3352-3361, 3368-3377, 3381-3390, 3398-3407, 3411-3420, 3437-3460, 3473-3484, 3554-3565, 3569-3580, 3584-3595, 3602-3613, 3623-3634, 3641-3652, 3665-3676). Number of Sessions: 19. **Diagnoses**: 1) Generalized Anxiety. 2) Major Depression, recurrent, mild.

[redacted]. [redacted] PSYCHOLOGY INC. [redacted], PhD. Panel Qualified Medical Evaluation in Psychology. (Final Premed-[redacted] – Page 3485-3553). DOI: [redacted] - [redacted] **History of Injury**: The member reports a toxic interaction with her current supervisor, [redacted], that occurred between [redacted]. Her supervisor is very difficult to communicate with. She explains that the final blow to her mental stability was a final evaluation from [redacted] in which her supervisor claimed there had been a video conference that never happened. This apparently was the straw that broke the camel's back so in [redacted], things came to a head for her and she filed her claim. However, this perceived injury has been preceded by a long history of job stress that goes back to at least [redacted]. The stress began for The member when she became an [redacted] 4 years ago. She was given three or four problem trainees who required a training program and extensive documentation. In addition to the trainees, she had a department to run as well as other normal supervisory duties. Her primary complaint is that her job is incredibly stressful and due to being overloaded with too many responsibilities, she has become overwhelmed and can no longer cope with them. As a result, her coping skills are inadequate and she describes numerous situations in which she becomes extremely anxious, starts shaking, feels her throat closing up, feels her face going numb and starts having chest pains. At these times, which usually are during meetings or in discussions with her managers, she can feel her mind racing and lose her train of thought. She gives many examples of situations that cause these reactions, but they generally involve her supervisor and managers. The member reports that her supervisor and managers continue to fail to learn what she understands that the excessive and unrealistic demands of her job and her work restrictions may result in her being out of work with no pay. She claims that the office has been in complete disarray during COVID, leaving her with so many unsolvable personnel situations that she has essentially gotten closer and closer to a complete nervous breakdown. **Current Complaints**: **Physical**: Her primary complaint is disabling pain in her hands, right worse than left. She also complains of tension headaches, neck and shoulder tension, stomach distress and general malaise. **Psychological**: **Sleep:** The member reports she does have insomnia that she rates as intermittently severe. She has all three types of insomnia. **Fatigue:** Positive, along with insomnia, daytime fatigue, exhaustion and cognitive impairments. **Mood Instability:** Positive. She reports severe levels of anxiety and moderate levels of depression. Sometimes she gets chest pain. She is having a much harder time holding back on lashing out verbally at work. If someone asks her how she is doing, she starts crying or it is very difficult to hold back from crying. **Memory/Concentration:** The member has concentration and memory difficulties both at home and at work that she rates as at least moderate. **Social Life:** Positive. She had been a moderately social person but no longer enjoys social gatherings and stays in her house. **Concentration/Attention/Memory:** Positive. She notes that she is often confused and has trouble with her memory, a problem that she has never had before. **Social History:** The member has no history of drug/alcohol abuse. She does not smoke cigarettes and drinks alcohol infrequently. She does smoke marijuana a few times a week. **Mental Health History:** The member's

[redacted], [redacted]
[redacted]

anxiety and depression appeared between [redacted] and [redacted], predominantly due to job stress. She reports that she was also struggling with family problems in early [redacted], when her mother contracted breast cancer and her father became ill. She was seen for psychiatric and psychological care on [redacted] by [redacted], LCSW. At that time, she was diagnosed with anxiety, depressive disorder, other specified. At this time, it was noted that she was seeking service due to stress. She reported having panic attacks X 3 weeks. She went to Urgent Care and was prescribed Xanax, which made her drowsy. She reported that in November, there were a lot of changes at work. She moved in [redacted] due to her [redacted]-year-old daughter being assaulted. She moved in with her parents. In December, her mother was diagnosed with breast cancer. Her father is beginning to have signs of Parkinson's. She recognized in the past 4 months, she has experienced a lot of stressors. She was provided with referrals but did not follow through on a regular basis and has continued to have an increasingly difficult time with the demands of work. Currently, she has been seeing [redacted], LCSW and has a referral to a Dr. [redacted], a psychiatrist for a psychiatric medication evaluation. While she admits that she was disappointed by a number of other counselors, she finds [redacted] to be extremely helpful. **Personal History:** The member was previously divorced but has been with her current fiancé for [redacted] years. **Job Description:** The member is employed by the [redacted], currently working modified duty 5 hours per day due to orthopedic limitations. She has worked for this bureau for [redacted] years; her current position is [redacted]. In this capacity her job entails multiple duties as a [redacted] She works both in the office and makes unannounced home visits in order to triage fraud referrals. She reviews policies and procedures and updates and reformats processing guidelines in her job. She conducts training presentations for program integrity protocols, updates training materials and assist with special projects. Part of her job is evaluating and training new hires. She describes her job as, "extremely stressful". **Diagnosis**: **Axis I**: 1) Adjustment disorder with mixed anxiety and depressed mood, severe, both industrial and nonindustrial. 2) Somatic symptom disorder with predominant pain, industrial. **Axis II**: The member does not have a personality disorder but does have situationally induced persecutory and paranoid traits, industrial. **Axis III:** Per the medical records. **Axis IV**: Psychosocial and Environmental Problems: Problems with primary support group-Slight. Problems related to the social environment—Moderately Severe. Occupational problems- Severe. Economic Problems: Slight. Problems with access to health care services-Moderate. Other psychosocial and environmental problems- Moderate. **Axis V**: GAF = 59, slight to moderate symptoms, WPI equals 17%. . **AOE Determination**: It is opined that the actual events of employment are predominant in causing her the psychological symptoms. Industrial event 1 - 40%: Conflict with her manager [redacted], escalating to a supervisory meeting that ended in The member experiencing uncontrollable panic and anxiety symptoms. Industrial event 2 – 40%: Work stresses dating from [redacted] to the present, causing functional overload and emotional dyscontrol. Nonindustrial event 3 – 20%: Predisposing events that include the death of her father from Covid, the development of cancer in her mother and a necessary relocation due to danger to her daughter in [redacted]. **Disability Status**: The member should be considered temporarily partially disabled at this time. She continues to work modified duty, five hours per day, on an orthopedic limitation. She can work full-time without limitations so long as she is receiving psychiatric treatment and psychotherapy. . **Treatment Recommendations**: Continue ongoing psychotherapy on a weekly basis. She will need a more aggressive medication program on an industrial basis. **Apportionment**: Not yet relevant.

[redacted]. INLAND PSYCHIATRIC MEDICAL GROUP. [redacted], PMHNP. Initial Note. (Final Premed- [redacted] - Page 3618-3619). Subjective: For more than 7 months, The member has been feeling anxious, overwhelmed and tense. She reports worried thoughts, racing

[redacted], [redacted]
[redacted]

thoughts, flight of ideas, and has trouble relaxing. She is currently fighting a workers' compensation case and has multiple psych providers. She is in therapy with [redacted] and has a psychiatrist whom she will be working with in a month. She reports depressed mood. She reports anergia, anhedonia and amotivation. Her stressors are her job, financial situation, and health. **Diagnosis**: Generalized anxiety disorder. **Plan**: Started Buspirone. Consider Lexapro/Cymbalta at next visit.

[redacted]. [redacted] PSYCHOLOGY, INC. [redacted] [redacted], PhD. Supplemental Report. (Final Premed- [redacted] - Page 3760-3774). Discussion: Following the guidelines, after careful consideration, the examiner believes The member meets the Rolda Criteria. The percentage contributions to her injury are: Event No 1-40%: CT conflicts with her manager [redacted], escalating to a supervisory meeting that ended in The member experiencing uncontrollable panic and anxiety symptoms. Event No 2-40%: CT work stresses dating from 2020 to the present, causing functional overload and emotional dyscontrol. Event No 3-20% Predisposing events that include the death of her father from Covid, the development of cancer in her mother and a necessary relocation due to danger to her daughter in [redacted]. Total-100%. The examiner believes that The member has been able to demonstrate that she meets the above criteria for a compensable claim in this case. She does have a diagnosis that currently requires treatment. This is not a post-termination claim. In summary, within a reasonable level of medical probability, while the examiner defers to the Trier of Fact regarding the issue of AOE/COE, it is the examiner's opinion that actual events of employment are predominant in causing The member's adjustment disorder with mixed anxiety and depression and somatic symptom disorder and need for treatment.

[redacted]. MANAGEDMED, INC . [redacted] [redacted], PhD. Initial Comprehensive Psychological Evaluation with Associated Psychodiagnostics Testing. (Final Premed- [redacted] - Page 3788-3803). DOI: [redacted]. **History of Injury:** The member reports that on [redacted], severe workplace stress triggered acute physical symptoms, including shaking, nausea, diarrhea, facial pain, muscle tension, inflammation, and chest pain. She describes ongoing interpersonal conflict with her supervisor and coworkers, particularly [redacted], [redacted], and [redacted], which escalated over time. Attempts to address communication issues through meetings or mediation were unsuccessful and interactions often left her distressed. She reports repeated incidents that caused emotional upset, including being ignored, criticized, confronted, or yelled at, leading to increased stress reactions. She also reports that she has a history of overuse syndrome diagnosed in [redacted], resulting from physically demanding work involving lifting and moving heavy boxes. Since then, she has suffered chronic pain in her hands, neck, upper and lower back, bilateral arms, and sciatic pain in both legs, along with fatigue and weakness. She has undergone multiple treatments, including medication, physical therapy, chiropractic care, and acupuncture. Due to persistent pain, she currently works reduced hours. She reports that ongoing workplace conflict and perceived harassment continue to worsen her stress, causing her to feel unsafe, anxious, and emotionally overwhelmed, prompting her to file complaints and document incidents. Despite significant distress, she continues to work but states she is "barely getting through" her limited work hours. She filed an [redacted] complaint on Friday because of the bullying and harassment. **Associated Physical Symptoms**: The member continues to experience neck pain, bilateral shoulder pain, arm pain, upper, mid, and lower back pain. She has headaches for four days out of the week. **Associated Emotional Symptoms**: The member presents with agitated depression. She is irritable and agitated and breathless with exacerbation and anxiety. She states her supervisor continues to harass her. She had chest pain and had to go to [redacted]. She feels helpless and hopeless. She has nightmares and a mouth guard. She sleeps at most 4 hours at night and feels tired during the day. She has difficulty concentrating. She reported a blunted libido,

[redacted]

which is becoming a problem. She is nervous, anxious, insecure, and worried. She is constantly shaking, cannot think and focus. She is nervous, constantly replaying everything that has happened at work. She is going to get fired, lose her job, and her home. **Pertinent Psychiatric-Medical History:** The member denies any psychiatric hospitalizations. She does report some prior outpatient psychotherapy from [redacted] to the present and continuing. She is seeing LCSW [redacted] due to stress-related psychological states at Pacific Medical Group. She also saw Dr. [redacted], the Qualified Medical Evaluator for her workers' compensation claim. **Non-Industrial Stressors:** The member states that her father passed away in [redacted] at the age of [redacted] years due to pneumonia. Presumably, she was able to attend the funeral but continues to mourn the loss. **Prior Workers' Compensation Claims/Legal History:** The member filed a prior workers' compensation claim against the [redacted] in [redacted]. In fact, she states she has filed many claims. She is unable to recall them all. She states, "It's too much information." Upon discussion, it turns out that the [redacted] claim is a physical/mental claim and she continues being treated for both physical and psychological injury. **Diagnoses**: **Axis I**: 1) Unspecified depressive disorder, agitated. 2) Anxiety disorder not otherwise specified. 3) Insomnia disorder. **Axis II**: Prominent histrionic personality traits. **Axis III**: 1) Neck pain (mild to moderate to severe). 2) Bilateral shoulder and arm pain (mild to severe). 3) Upper, mid, and lower back pain (mild to severe). 4) Headaches (four times a week). **Axis IV**: Current level of stressors: moderate. **Axis V**: Global assessment of functioning past year: 56. **Plan**: Recommended initial six sessions of cognitive behavioral psychotherapy and with evidence of objective functional improvement, up to 13-20 sessions over the course of 13-20 weeks. **Discussion**: On this occasion, The member presents as temporarily partially disabled from a psychological point of view. She warrants a course of cognitive behavioral psychotherapy with focus on the reduction of anxiety and management of agitated depression. She warrants psychotropic medication. She has been prescribed a course of Lexapro and Atarax by a Kaiser physician, [redacted] MD. **Apportionment**: The member appears to have been fully functional on her job for [redacted] years prior to sustaining a recent industrial injury there. At this point, the predominance threshold of greater than 50% of her current psychiatric claims has been met. The predominant cause of all causes has been The member's industrial injury reaching and exceeding the necessary predominance threshold. This applies to both mental/mental claims as well as physical/mental ones. **Medical Causality**: There is a clear, causal connection between symptoms that have developed, the need for mental health evaluation, the treatment course, and the need to assess permanent disability. Stated in the most traditional way but for this job, she would not have had any need for mental health services, and the entire issue of permanent disability would be moot. Here as well though, should additional information be presented to the examiner, who would be happy to consider it and to alter his view accordingly.

[redacted]. [redacted] **PSYCHOLOGY, INC.** [redacted], **PhD.**
Supplemental Psychiatric QME Report. (Final Premed- [redacted] **- Page 3827-3832).**
DOI: [redacted]. **Discussion**: The member claims that the office has been in complete disarray during COVID, leaving her with so many unsolvable personnel situations that she has essentially gotten closer to a complete nervous breakdown. She gives many examples citing supervisees that were unqualified; reports that she was forced to retype by hand; contentious meetings with [redacted] and other supervisors that left her unsatisfied, angry, and resentful. Regarding the issue of good faith personnel actions, for an extensive face-to-face examination of The member and review of all records, the examiner's opinion is that the actions of [redacted] did not fall in the category of good faith personnel actions. From The member's perspective, when she desperately needed [redacted]'s backing, [redacted] either withdrew or became argumentative/adversarial enough that it exacerbated The member's psychological deterioration.

[redacted], [redacted]
[redacted]

[redacted], [redacted] PSYCHOLOGY, INC. [redacted] [redacted], PhD.
Panel Qualified Medical Re-evaluation in Psychology. (Final Premed- [redacted] - Page 3922-3939). DOI: [redacted] **History of Present Illness**: The member relates an increasing and ongoing set of crises. Although she had various treatments, including pain management, chiropractic, psychiatric and physical therapy, her condition has continued to worsen. She is at the point where even talking about her problems causes pain and anxiety. Going back several months, The member describes efforts to seek accommodations for her right upper extremity, right hand and back problems, asking for an electric standup desk. She has had one at home, but was denied being able to work from home, "even though others get it". She had also requested voice-to-text software, but the desk and the software were delayed for several months. She describes going to a supervisor one level above [redacted], [redacted], and telling him that in [redacted], she told him, "I'm going to have a nervous breakdown if I can't get these accommodations." Another incident occurred during this time when according to The member, her supervisor [redacted] corrected her for misspelling a person's name in a fraud report. The member responded, and copied [redacted], but as it turned out was written up for breaking privacy regulations on the name. There was a big row and The member was investigated and was about to be disciplined when it turned out that it was [redacted] who had gotten the name wrong. This incident and others like it just reinforced The member's claim that it was always [redacted] coming down on her and causing her additional emotional instability. With all the problems The member was having with her hands, shoulder, neck and back, she was transferred in [redacted] to work in the lobby. Her job there was to greet and assist clients looking for help from the [redacted] [redacted]. There were benefits to this position because she did not have to constantly use her right hand for typing. The job was often stressful, but The member enjoyed working with the clients, knowing how to deal with them after many years she had worked in [redacted]. However, in [redacted], the work became a lot worse because a flood of clients started coming in looking to add [redacted]. The member started to have increased problems with aggressive and violent clients and in [redacted] almost passed out, having to go to urgent care because of her blood pressure. The member had briefly attended group therapy, although there are no notes in the medical file. She did not find the group therapy helpful her saying. She reports she has also seen a psychiatrist, [redacted], and tried Lexapro but did not find it helpful. Additionally, according to her, in [redacted], she was notified that she cannot be accommodated and was taken off work without pay. This is causing a financial crisis for her. **Present Complaints**: **Physical**: The member's primary complaints are disabling pain in her hands, right worse than left. She also complains of tension headaches, neck and shoulder tension, stomach distress, and general malaise. **Psychological**: **Sleep:** The member reports she does have insomnia that she rates as intermittently severe. She has all three types of insomnia. **Fatigue:** Positive, along with insomnia, daytime fatigue, exhaustion and cognitive impairments. **Mood Instability:** Positive. She continues to report severe levels of anxiety and moderate levels of depression. **Memory/Concentration:** The member has concentration and memory difficulties both at home and at work that she rates as at least moderate. **Social Life:** Positive.
Concentration/Attention/Memory: Positive. She notes that she continues to be confused and has trouble with her memory. **Diagnoses**: **Axis I**: 1) Adjustment disorder with mixed anxiety and depressed mood, severe both industrial and nonindustrial. 2) Somatic symptoms disorder with predominant pain, industrial. **Axis II**: The member does not have a personality disorder but does have situationally induced persecutory and paranoid traits, industrial. **Axis III**: Per the medical records. **Axis IV**: Psychosocial and environmental problems: 1) Problems with primary support group: slight. 2) Problems related to the social environment: moderately severe. 3) Occupational problems: severe. 4) Economic problems: slight. 5) Problems with access of health care services: moderate. 6) Other

[redacted]

psychosocial and environmental problems: moderate. **Axis V**: GAF=59, slight to moderate symptoms, WPI equals 17%. **Plan**: The member should be enrolled in intensive outpatient psychotherapy with Dr. [redacted] and with a psychiatrist. **Disability Status**: On a psychological basis, The member should be considered totally temporarily disabled. **Work Limitations**: The member is unable to work in any capacity at this time. Considering her psychological condition, it is the examiner's opinion that she should be taken off work for a period of 90 to 180 days so that she can put all her energy into intensive psychological and psychiatric treatment. **AOE Determination**: The examiner opined that actual events of employment are predominant in causing The member's adjustment disorder with mixed anxiety and depression and somatic symptom disorder and need for treatment. **Apportionment**: Not yet relevant. The examiner anticipates there will be an apportionment to non-industrial factors discussed in this report.

[redacted] **PhD. Primary Treating Physician's Progress Report (PR-2). (Final Premed-** [redacted] **- Page 3957-3958).** (Handwritten report, partially illegible). **DOI**: [redacted]. **Subjective:** The member continues to struggle with increased symptoms of depression and anxiety. **Diagnoses:** 1) Major depressive disorder, single episode, unspecified. 2) Anxiety disorder, unspecified. 3) Insomnia disorder. **Plan:** Recommended behavioral psychotherapy and psychotropic medication management. **Work status**: Remain off work until [redacted].

[redacted] **MANAGEDMED, INC.** [redacted] **PhD. Disability Certificate. (Final Premed-** [redacted] **- Page 3961-3961). DOI:** [redacted] **Comments**: This is to certify that The member is temporarily totally disabled from [redacted]. **Diagnoses:** 1) Major depressive disorder, single episode, unspecified. 2) Anxiety disorder, unspecified.

[redacted]. **MANAGEDMED, INC.** [redacted] **PhD. Disability Certificate. (Final Premed-** [redacted] **- Page 3981-3981). DOI:** [redacted]. **Comments**: This is to certify that The member is temporarily totally disabled from 05/13/24 to 06/30/24. **Diagnoses:** 1) Major depressive disorder, single episode, unspecified. 2) Anxiety disorder, unspecified.

[redacted]. [redacted] **PSYCHOLOGY, INC.** [redacted] **PhD. Panel Qualified Medical Supplemental Report in Psychology. (Final Premed-** [redacted] **- Page 4006-4008). DOI:** [redacted] **Discussion**: The examiner has no psychiatric or psychological reports after [redacted] and it is unclear about the factors involved in this current issue, which is to be addressed. The member is aware that her deteriorating condition has a long list of complicating causes that she has a treatment-resistant psychological injury. The best course of action is to allow her to spend 30 minutes with her via telehealth to sort out the factors that would potentially lead to an improved condition, all the while taking work-related causation into account. If she is able to comprehend the issues involved and clarify her willingness to participate in the treatment authorized for psychiatry and psychology per office or if she comprehends but declines and if there are any further reports available to the examiner. The examiner would be able to give a more well-informed opinion about her disability status.

NON-PSYCH RECORDS:

[redacted], [redacted]
[redacted]

[redacted]. **KAISER PERMANENTE. Prenatal Record. (Final Premed-** [redacted] **- Page 35-35).** (Handwritten reports, largely illegible)

[redacted]. **KAISER PERMANENTE.** [redacted]**. History and Physicals Report. (Final Premed-** [redacted] **- Page 47-48). Chief Complaint**: Fetal deceleration and flat tracing. **Present Illness**: The member was brought in for induction. **Past History**: Operations: Tonsillectomy. Serious illnesses: Pyelonephritis seven years ago. **Family History**: Diabetes in her father. Hypertension in her mother. **Diagnosis**: Fetal intolerance to labor.

[redacted]. **KAISER PERMANENTE.** [redacted]**. Operative Procedure Record. (Final Premed-** [redacted] **- Page 77-77, 116-117). Operation**: Primary low transverse cesarean operation. **Pre-operative Diagnoses**: 1) Fetal intolerance to labor. 2) A 42-week intrauterine pregnancy. **Post-operative Diagnoses**: Same as the pre-op diagnoses.

[redacted]. **KAISER PERMANENTE. Progress Sheet. (Final Premed-** [redacted] **- Page 72-72).** (Handwritten report, largely illegible)

[redacted]. **KAISER PERMANENTE. Progress Sheet. (Final Premed-** [redacted] **- Page 72-72).** (Handwritten report, largely illegible)

[redacted]. **KAISER PERMANENTE. Progress Sheet. (Final Premed-** [redacted] **- Page 73-73).** (Handwritten report, largely illegible). **Comments:** Post-partum day #2.

[redacted]. **KAISER PERMANENTE.** [redacted]**. Discharge Summary. (Final Premed-** [redacted] **– Page 131-132). Admission Date:** [redacted]. **Hospital Course**: The member was admitted, with treated with Prostin gel and within 7 hours was 2 cm. Eight hours after admission, she was 3.5 cm dilated, and an internal pressure catheter and scalp electrode were applied. Pitocin was begun eleven hours after admission and The member then received an epidural. The baseline of the fetal electronic monitoring increased and then flattened. Vaginal examination provoked a 3 to 4 minute prolonged fetal bradycardic episode. Occasional lates were noted. At this point, the cervix was 6 cm, 0 station, 80% and there appeared to be swelling of the cervical lips. No evidence of meconium. The member was taken to the operating room, where epidural was reinjected. A low transverse cesarean operation was accomplished, delivering a [redacted] pound, [redacted] ounce newborn, with very thick meconium. Apgar scores were 8/9 to the male newborn. Cord pH was 7.327 and 7.208. There were no surgical complications. Postoperatively, The member did well, being discharged on postoperative day #2. She was afebrile. She was breast-feeding. . **Discharge Diagnosis**: Prolonged fetal bradycardia.

[redacted]. **KAISER PERMANENTE.** [redacted]**. Progress Note. (Final Premed-** [redacted] **– Page 135-136). Subjective:** The member reports left ear itching. **Diagnosis**: Otitis externa (primary encounter diagnosis).

[redacted]. **KAISER PERMANENTE.** [redacted] **Progress Note. (Final Premed-** [redacted] **– Page 139-140). Subjective:** The member reports upper abdomen cramping, nausea, and back cramping. She reports mild HA and fever.

[redacted], [redacted]
[redacted]

[redacted]. **KAISER PERMANENTE. A[redacted] PA. Progress Note. (Final Premed-[redacted] – Page 142-143). Subjective:** The member reports urinary urgency, frequency and burning. She also complains of sore throat. **Diagnosis**: 1) Urinary tract infection (primary encounter diagnosis). 2) Pharyngitis.

[redacted]. **KAISER PERMANENTE[redacted], MD. Progress Note. (Final Premed-[redacted] – Page 156-159). Subjective:** The member is seen for routine pelvic. **Diagnosis**: 1) STD screening (primary encounter diagnosis). 2) Never smoked. 3) Pelvic examination, periodic.

[redacted]. **KAISER PERMANENTE. [redacted], NP. Progress Note. (Final Premed-[redacted] - Page 176-177). Subjective Complaints:** The member is seen for gynaecological exam, pap smear, and STD check. She is concerned because her HPV test was positive. She also wants STDs checked, as her ex-spouse had extramarital affairs. **Assessment:** Physical exam is notable for: GYN exam.

[redacted]. **KAISER PERMANENTE. PAP Test Report. (Final Premed-[redacted] – Page 177-178). Comment**: Positive for human papilloma virus high/intermediate risk group.

[redacted]. **KAISER PERMANENTE. [redacted] PA. Progress Note. (Final Premed-[redacted] - Page 185-187). Subjective:** The member reports onset of symptoms last night after eating fish. She reports ability to eat and drink with some soreness but is able to swallow without difficulty. **Diagnosis:** Foreign body in pharynx.

[redacted]. **KAISER PERMANENTE. [redacted] MD. Progress Note. (Final Premed-[redacted] - Page 190-191). Subjective:** The member was eating fish day before yesterday. Concerned fish bone may be stuck in throat since throat hurts. **Diagnosis:** Throat pain. No evidence of foreign body in throat.

[redacted]. **KAISER PERMANENTE. [redacted], MD. X-ray Neck Soft Tissue. (Final Premed-[redacted] - Page 187-188). Impression:** No significant abnormality noted.

[redacted]. **KAISER PERMANENTE. [redacted], MD. X-rays of the Chest. (Final Premed-[redacted] - Page 189-189). Impression:** No significant abnormality noted.

[redacted]. **KAISER PERMANENTE. [redacted], MD. Progress Note. (Final Premed-[redacted] - Page 200-201). Subjective:** The member complains of dysuria since this AM. She has noticed an increased UTIs over the past year after having sex. **Diagnosis:** Urinary tract infection.

[redacted] **KAISER PERMANENTE. [redacted], PA. Progress Note. (Final Premed-[redacted] - Page 207-207). Subjective:** The member complains of increased upper abdominal pain and nausea. **Diagnosis:** Dyspepsia.

[redacted]. **KAISER PERMANENTE. [redacted], MD. Progress Note. (Final Premed-[redacted] - Page 209-210). Subjective:** The member is seen for a follow-up of abdominal pain, completely resolved with famotidine and GI cocktail. She wanted to recheck. **Diagnosis:** Health checkup, adult (primary encounter diagnosis).

[redacted], [redacted]
[redacted]

[redacted]. **KAISER PERMANENTE. [redacted], DO. Progress Note. (Final Premed-[redacted] - Page 211-212). Subjective:** The member complains of increased URI symptoms, headaches, sore throat, plugged ears and fatigue. She felt hot last night. **Diagnoses:** 1) URI (primary encounter diagnosis). 2) Never smoked.

[redacted]. **KAISER PERMANENTE. [redacted], PA. Progress Note. (Final Premed-[redacted] - Page 216-217). Subjective:** The member is with 6-day history of congestion, nonproductive cough, and achiness. **Diagnoses:** 1) URI (primary encounter diagnosis). 2) Never smoked.

[redacted]. **KAISER PERMANENTE. [redacted], MD. Progress Note. (Final Premed-[redacted] - Page 222-225). Subjective:** The member presents for a routine pelvic exam. **Diagnoses:** 1) Laboratory examination (primary encounter diagnosis). 2) Never smoked. 3) Pelvic examination, periodic. 4) Screening for CA, breast. 5) STD screening.

[redacted]. **KAISER PERMANENTE. [redacted], MD. PAP Test Report. (Final Premed-[redacted] - Page 226-227). Comments:** Negative for intraepithelial lesion or malignancy.

[redacted]. **KAISER PERMANENTE. T[redacted], DO. Progress Note. (Final Premed-[redacted] - Page 238-239). Subjective:** The member reports her right ear started hurting yesterday, feels itchy, history of ear infections. **Diagnoses:** 1) Influenza (primary encounter diagnosis). 2) Otitis media.

[redacted]. **KAISER PERMANENTE. [redacted], DO. Progress Note. (Final Premed-[redacted] - Page 245-246). Subjective:** The member complains of skin tags on the neck and acne, a few on the back and face. **Diagnoses:** 1) Acne (primary encounter diagnosis). 2) Never smoked. 3) Skin tag.

[redacted]. **KAISER PERMANENTE. [redacted], MD. Progress Note. (Final Premed-[redacted] - Page 248-252). Subjective:** The member presents for routine pelvic exam. History of HPV but last PAP clearance feels well. **Diagnoses:** 1) Laboratory examination. 2) Pelvic examination, periodic. 3) Medication refill. 4) Prophylactic vaccine.

[redacted]. **KAISER PERMANENTE. [redacted], MD. PAP Test Report. (Final Premed-[redacted] - Page 252-253). Comments:** Negative for intraepithelial lesion or malignancy.

[redacted]. **KAISER PERMANENTE. [redacted], RN. Nurse Note. (Final Premed-[redacted] - Page 269-269). Comments:** The member reports she has a yeast infection. She complains of vaginal itching and burning. She has a history of HSV.

[redacted]. **KAISER PERMANENTE. [redacted], DO. Progress Note. (Final Premed-[redacted] - Page 271-272). Subjective:** The member presents with urinary tract infection symptoms, dysuria, and frequency. **Diagnosis:** 1) Urinary tract infection (primary encounter diagnosis).

[redacted], [redacted]
[redacted]

[redacted]. **KAISER PERMANENTE. [redacted], NP. Progress Note. (Final Premed-[redacted] - Page 274-275). Subjective:** The member presents for a gyn exam, birth control pill refill, annual exam, and STD check. **Assessment:** Physical exam is notable for a normal GYN exam.

[redacted]. **KAISER PERMANENTE. [redacted] NP. PAP Test Report. (Final Premed-[redacted] - Page 276-277). Comments:** Positive for human papilloma virus high/intermediate risk group.

[redacted] **KAISER PERMANENTE. [redacted] PA. Progress Note. (Final Premed-[redacted] - Page 289-292). Subjective:** The member reports back injury – playing ball on Sunday. **Diagnoses:** 1) Dorsalgia (primary encounter diagnosis). 2) Hematuria, microscopic.

[redacted]. **KAISER PERMANENTE. [redacted], DO. Progress Note. (Final Premed-[redacted] - Page 302-303). Subjective:** The member complains of left lower back pain after landing on it during soccer. She does have neck and mid upper back pain from her sitting at work. **Diagnosis:** Strain of back (primary encounter diagnosis).

[redacted] **KAISER PERMANENTE. [redacted] MD. Ultrasound of Kidney. (Final Premed-[redacted] - Page 296-298, 1734-1735). Reason:** Micro hematuria after injury 6 days ago. **Impression:** Renal ultrasound within normal limits.

[redacted]. **KAISER PERMANENTE. [redacted] PA. Progress Note. (Final Premed-[redacted] - Page 308-309). Subjective:** The member presents with urinary tract infection symptoms and right lower leg pain. She complains of pain in right calf. **Diagnoses:** 1) Strain/tear, gastrocnemius (primary encounter diagnosis). 2) Never smoked. 3) Urinary tract infection.

[redacted]. **KAISER PERMANENTE. [redacted] PA. Progress Note. (Final Premed-[redacted] - Page 316-318). Subjective:** The member complains of burning dysuria associated with urinary frequency since this morning. **Diagnosis:** Urinary tract infection (primary encounter diagnosis).

[redacted]. **KAISER PERMANENTE. [redacted], NP. Progress Note. (Final Premed-[redacted] - Page 325-326). Subjective:** The member presents for gyn exam and birth control pill refill. Requests STD screening. **Assessment:** Physical exam is notable for a normal GYN exam, STD screening, and contraceptive management.

[redacted]. **KAISER PERMANENTE. [redacted], NP. PAP Test Report. (Final Premed-[redacted] - Page 331-332). Comments:** Negative for human papilloma virus high/intermediate risk group.

[redacted]. **KAISER PERMANENTE. [redacted], MD. Progress Note. (Final Premed-[redacted] - Page 338-339). Subjective:** The member presents with a right knee injury. She injured her right knee while changing directions during soccer. **Diagnoses:** 1) Vaccine refused by The member (primary encounter diagnosis). 2) Sprain of the knee.

[redacted], [redacted]
[redacted]

[redacted]. **KAISER PERMANENTE. [redacted], MD. X-rays of the Right Knee. (Final Premed- [redacted] - Page 339-341). Clinical History:** Injury, rule out fracture. **Comparison:** No previous study available. **Impression:** No acute fracture is identified. The alignment is normal. No significant joint disease is noted. No significant soft tissue abnormality is identified.

[redacted]. **KAISER PERMANENTE. [redacted], MD. Progress Note. (Final Premed- [redacted] - Page 345-346). Subjective:** The member complains of pain in the right knee. **Diagnoses:** 1) Sprain of knee (primary encounter diagnosis). 2) Vaccine refused by The member.

[redacted]. **KAISER PERMANENTE. [redacted] MD. Progress Note. (Final Premed- [redacted] - Page 351-352). Subjective:** The member presents with right knee injury. **Diagnosis:** Tear, anterior cruciate ligament, acute (primary encounter diagnosis).

[redacted]. **KAISER PERMANENTE. [redacted], MD. Progress Note. (Final Premed- [redacted] - Page 357-359). Subjective:** The member with a history of right knee pain for 6 weeks. She did hear or feel a pop; immediate swelling was present. **Diagnosis:** Right knee anterior cruciate ligament tear, lacks full extension, cannot rule out bucket handle meniscus tear.

[redacted]. **KAISER PERMANENTE. [redacted], MD. MRI of the Right Knee with No Contrast. (Final Premed- [redacted] - Page 356-357, 360-363, 1738-1739). Clinical History:** Rule out locked bucket-handle meniscus tear. **Comparison:** Radiographic series of the right knee dated [redacted]. **Impression:** Vertical longitudinal tear involving the posterior horn and body of
the medial meniscus. There is no bucket-handle component. Complete or near-complete tear of the proximal portion of the anterior cruciate ligament. Contusion at the lateral femoral condyle.

[redacted]. **KAISER PERMANENTE. Physical Therapy Notes. (Final Premed- [redacted] – Page 364-366, 372-372). Total Sessions**: 2. **Diagnosis:** ACL tear right knee.

[redacted]. **KAISER PERMANENTE. [redacted], MD. Progress Note. (Final Premed- [redacted] - Page 368-369). Subjective:** The member presents with MRI results and a knee problem. **Diagnosis:** Right knee anterior cruciate ligament tear and medial meniscus tear, lacks full extension.

[redacted]. **KAISER PERMANENTE. [redacted], MD. Progress Note. (Final Premed- [redacted] - Page 375-376). Subjective:** The member presents with back spasm for 10 days and hair loss was noticed one week ago. She also noted her hair getting thin and asked for a blood test for thyroid. **Diagnoses:** 1) Prophylactic vaccine for tetanus, diphtheria, acellular pertussis (primary encounter diagnosis). 2) Strain of the back. 3) Alopecia. 4) Contraceptive management.

[redacted]. **KAISER PERMANENTE. [redacted]. Telephone Encounter. (Final Premed- [redacted] - Page 387-388). Comments:** Form for off work. The member states that she will need to have authorization from Dr. Csintalan to be on medical leave for her knee surgery from [redacted].

[redacted], [redacted]
[redacted]

[redacted] **KAISER PERMANENTE. [redacted], MD. Progress Note. (Final Premed-[redacted] - Page 393-394). Subjective:** The member presents with urinary tract infection symptoms. **Diagnosis:** Urinary tract infection (primary encounter diagnosis) – early.

[redacted]. KAISER PERMANENTE. Physical Therapy Notes. (Final Premed-[redacted] – Page 398-398, 453-456, 458-464, 468-475, 478-479, 480-481, 485-486, 488-489, 490-496, 499-505, 508-516, 526-529). Total Sessions: 24. **Diagnosis**: Status Postoperative right Anterior Cruciate Ligament Reconstruction hamstring autograft and medial meniscus repair.

[redacted]. KAISER PERMANENTE. [redacted], PA. History and Physical Note. (Final Premed-[redacted] - Page 403-406). Subjective: The member injured her right knee playing soccer. She was seen by Dr. [redacted] and noted to have an anterior cruciate ligament tear and has opted to proceed with right knee arthroscopy, anterior cruciate ligament reconstruction with hamstring autograft and possible meniscal surgery. **Diagnosis:** Right knee anterior cruciate ligament tear.

[redacted]. KAISER PERMANENTE. [redacted], MD. Operative Report. (Final Premed-[redacted] - Page 415-417). Operation: Right knee examination under anaesthesia, arthroscopic anterior cruciate ligament reconstruction using hamstring autograft and medial meniscus repair. **Pre-op Diagnosis:** Right knee anterior cruciate ligament tear with medial meniscus tear. **Post-op Diagnosis:** Same as pre-op diagnosis.

[redacted]. KAISER PERMANENTE. [redacted], PA. Telephone Encounter. (Final Premed-[redacted] - Page 423-424). Comments: The member is doing well postoperatively. Pain is not well controlled on PO pain medications. Having itching with Percocet.

[redacted]. KAISER PERMANENTE. [redacted] PA. Progress Note. (Final Premed-[redacted] - Page 465-467). Subjective: The member has no complaints. Pain is controlled with 2 tabs of Vicodin. **Diagnosis:** Status post right ACL reconstruction with hamstring autograft and medial meniscus tear.

[redacted]. KAISER PERMANENTE. [redacted], MD. X-rays of the Right Knee. (Final Premed-[redacted] - Page 483-484). Clinical History: AP and lateral 6-week post-op. **Comparison:** [redacted]. **Impressions:** 1) Postsurgical changes of anterior cruciate repair. 2) Small amount of joint fluid.

[redacted]. KAISER PERMANENTE. T[redacted], NP. Telephone Encounter Note. (Final Premed-[redacted] - Page 496-497). Subjective: The member complains of a urinary tract infection. **Diagnosis:** Urinary tract infection (primary).

[redacted]. KAISER PERMANENTE. [redacted] MD. Progress Note. (Final Premed-[redacted] - Page 507-507). Subjective: The member presents with knee pain. She had left knee ACL with hamstring and medial meniscus repair on [redacted]. **Diagnosis:** Post left ACL reconstruction - Healing well.

[redacted]. KAISER PERMANENTE. [redacted], NP. Progress Note. (Final Premed-[redacted] - Page 517-520). Subjective: The member reports throat pain on the right side of the head for 4 days. She started with sneezing runny nose. She felt warm. **Diagnoses:** 1) Eustachian

[redacted], [redacted]
[redacted]

tube dysfunction (primary encounter diagnosis). 2) Screening for ca, breast. 3) Vaccine refused by patient, influenza. 4) Pharyngitis.

[redacted]. **KAISER PERMANENTE. [redacted], NP. Telephone Encounter. (Final Premed-** [redacted] **- Page 524-525). Subjective:** The member complains of a urinary tract infection. **Diagnosis:** Urinary tract infection (primary).

[redacted]. **KAISER PERMANENTE. [redacted], PA. Progress Note. (Final Premed-** [redacted] **- Page 536-537). Subjective:** The member is status post left knee ACL reconstruction. She is doing well. She reports difficulty with running but has not kept up on strength work. **Diagnosis:** Post Left knee arthroscopy, anterior cruciate ligament reconstruction with hamstring autograft, medial meniscus repair.

[redacted]. **KAISER PERMANENTE. [redacted], MD. Progress Note. (Final Premed-** [redacted] **- Page 539-540). Subjective:** The member presents for a routine Gynecologic exam. She requests STD screening. **Diagnosis:** Normal gyn exam.

[redacted]. **KAISER PERMANENTE. [redacted], MD. PAP Test. (Final Premed-** [redacted] **- Page 540-542). Comments:** Negative for intraepithelial lesion or malignancy. Negative for human papilloma virus high/intermediate risk group.

[redacted]. **KAISER PERMANENTE. [redacted], PA. Progress Note. (Final Premed-** [redacted] **- Page 554-556). Subjective:** The member complains of dysuria, urgency, and increased frequency of urination for 1 day. **Diagnosis:** Urinary tract infection (primary).

[redacted]. **KAISER PERMANENTE. [redacted], DO. Progress Note. (Final Premed-** [redacted] **- Page 560-563). Subjective:** The member complains of a bladder infection. She reports pain and a burning sensation in the urethra. **Diagnosis:** Urinary tract infection (primary).

[redacted]. **WATKINS SPINE. Private Patient Orthopaedic Follow-Up Examination. (Final Premed-** [redacted] **- Page 1965-1967).** (This report belongs to a different patient named [redacted]. This report is reviewed but not summarized).

[redacted]. **KAISER PERMANENTE. [redacted] PA. Progress Note. (Final Premed-** [redacted] **- Page 567-569). Subjective:** The member complains of a non-productive cough, nasal congestion/runny nose with clear discharge, sore throat, and fever. **Diagnosis:** Nasopharyngitis (primary encounter diagnosis).

[redacted]. **KAISER PERMANENTE. [redacted], NP. Telephone Encounter. (Final Premed-** [redacted] **- Page 570-570). Diagnosis:** Urinary tract infection (primary).

[redacted] **KAISER PERMANENTE. [redacted] NP. Telephone Encounter. (Final Premed-** [redacted] **- Page 574-575). Diagnosis:** Urinary tract infection (primary).

[redacted]. **KAISER PERMANENTE. [redacted], MD. Progress Note. (Final Premed-** [redacted] **- Page 578-579). Subjective:** The member complains of a bladder infection. She

[redacted], [redacted]
[redacted]

reports lower abdominal discomfort with ciprofloxacin. She reports dysuria, frequency, and urgency. She urinated after sex. **Diagnoses:** 1) Urinary tract infection (primary). 2) Never smoked.

[redacted]. **KAISER PERMANENTE. [redacted], DO. Progress Note. (Final Premed-[redacted] - Page 587-593). Subjective:** The member complains of cough, nasal congestion, post-nasal drip, right ear pain, dizziness, sore throat, and flu. She reports worsening of sinus pressure/pain. **Diagnoses:** 1) Sinusitis (primary encounter diagnosis). 2) Cough. 3) Declines influenza vaccination.

[redacted]. **KAISER PERMANENTE. [redacted], NP. Telephone Encounter. (Final Premed-[redacted] - Page 596-597). Subjective:** The member complains of UTI.

[redacted]. **KAISER PERMANENTE. [redacted], PA-C. Telephone Encounter. (Final Premed-[redacted] - Page 600-601). Comments:** The examiner has reviewed the urinary tract screening tool, prescribed Macrobid and ordered a urine culture.

[redacted]. **KAISER PERMANENTE. [redacted], NP. Telephone Encounter. (Final Premed-[redacted] - Page 604-605). Comments:** The examiner has reviewed the UTI screening tool and prescribed nitrofurantoin monohydrate and ordered urine culture.

[redacted]. **KAISER PERMANENTE. [redacted] PA-C. Telephone Encounter. (Final Premed-[redacted] - Page 610-611). Comments:** The examiner has reviewed the UTI screening tool and prescribed Macrobid and ordered a urine culture.

[redacted]. **KAISER PERMANENTE. [redacted], NP. Telephone Encounter. (Final Premed-[redacted] - Page 610-611). Comments:** The examiner has reviewed the UTI screening tool, prescribed cephalexin and ordered a urine culture.

[redacted]. **KAISER PERMANENTE. [redacted], MD. Progress Note. (Final Premed-[redacted] - Page 621-622). Subjective:** The member complains of URI and UTI symptoms. **Diagnosis:** Urinary tract infection (primary).

[redacted]. **KAISER PERMANENTE. [redacted] NP. Progress Note. (Final Premed-[redacted] - Page 629-631). Subjective:** The member complains of a nodular rash on legs, arms, abdomen, back for 3 weeks. **Diagnoses:** 1) Rash. 2) Scabies handout.

[redacted]. **KAISER PERMANENTE. [redacted] MD. Progress Note. (Final Premed-[redacted] - Page 636-638). Subjective:** The member complains of scabies and a sore throat. **Diagnosis:** Scabies.

[redacted]. **KAISER PERMANENTE. [redacted], MD. Progress Note. (Final Premed-[redacted] - Page 645-646). Subjective:** The member is a social worker, so they may have been in contact with scabies. She was treated with permethrin but still complains of itching. **Diagnoses:** 1) Rash. 2) Melanocytic nevus. 3) Hand dermatitis.

[redacted]. **KAISER PERMANENTE. [redacted], DO. Progress Note. (Final Premed-[redacted] - Page 656-659). Subjective:** The member presents for physical exam. **Diagnoses:**

[redacted], [redacted]
[redacted]

1) Routine adult health check-up exam. 2) Screening mammogram for breast cancer. 3) Vaccination for influenza. 4) Screening for STD. 5) Contraceptive counselling.

[redacted]. KAISER PERMANENTE. [redacted] MD. Bilateral Screening Mammogram. (Final Premed- [redacted] - Page 672-674). **Clinical History:** Follow sequential breast imaging orders policy and procedures. Baseline digital screening mammogram. No complaints. **Comparison:** None. **Impression:** Benign. There is no mammographic evidence of malignancy. A routine screening mammogram is recommended within 2 years. BI-RADS: 2 benign.

[redacted]. KAISER PERMANENTE. [redacted], MD. Progress Note. (Final Premed- [redacted] - Page 695-697). **Subjective:** The member presents with abdominal pain and heavy periods. **The member reports being intense at work and stressed out. She has to carry heavy loads of documents when doing visits**. She complains of neck pain and strain from carrying all day. She reports pelvic cramps. The member is requesting modified duty. **Diagnoses:** 1) Menorrhagia. 2) Dysmenorrhea. 3) Neck pain. 4) **Emotional stress reaction**. **Plan: The member declined medication for stress. Discussed stress management.**

[redacted]. KAISER PERMANENTE. [redacted], MD/Brittany Hollonghurst. Ultrasound of the Abdomen and Pelvis. (Final Premed- [redacted] - Page 705-708). **Reason:** Menorrhagia and dysmenorrhea. **Impressions:** 1) Uterine masses which may reflect fibroids. 2) Cervical nabothian cyst(s).

[redacted]. KAISER PERMANENTE. [redacted] MD. GYN Cytology. (Final Premed- [redacted] - Page 723-724). **Diagnosis:** Cervix, liquid-based PAP test: Negative for intraepithelial lesion or malignancy (normal pap result).

[redacted]. KAISER PERMANENTE. [redacted] MD. Progress Note. (Final Premed- [redacted] - Page 720-722). **Subjective:** The member's last menstrual period was on [redacted]. She is on OCP for birth control. **Diagnosis:** Menorrhagia.

[redacted]. KAISER PERMANENTE. [redacted], MD. Progress Note. (Final Premed- [redacted] - Page 736-739). **Subjective:** The member presents for consultation for fibroids and hysteroscopy. She reports worsening of bleeding, cramping, and passing clots. **Diagnosis:** Enlarged fibroid uterus, symptomatic with menorrhagia.

[redacted]. KAISER PERMANENTE. [redacted], MD. History & Physical Note. (Final Premed- [redacted] - Page 748-752). **Subjective:** The member presents for pre-op evaluation with complains of heavy and painful bleeding with known fibroid uterus. **Diagnoses:** 1) Symptomatic fibroid uterus, desires definitive intervention. 2) Agreeable to salpingectomy for potential reduction of ovarian cancer risk, desires to preserve ovaries.

[redacted]. KAISER PERMANENTE. [redacted] MD. Operative Note. (Final Premed- [redacted] - Page 1756-1758). **Operation(s):** 1) Hysterectomy total laparoscopic. 2) Salpingectomy complete, bilateral. **Pre-op Diagnoses:** 1) Uterine fibroids. 2) Menorrhagia. **Post-op Diagnoses:** Same as pre-op diagnosis.

[redacted], [redacted]
[redacted]

[redacted]. **KAISER PERMANENTE. [redacted], MD. Surgical Pathology Report. (Final Premed- [redacted] - Page 1760-1761). Diagnosis:** Uterus, cervix and bilateral fallopian tubes, total hysterectomy, and bilateral salpingectomy: Multiple submucosal, intramural, and subserosal leiomyomata. Adenomyosis. Unremarkable fallopian tubes.

[redacted] **KAISER PERMANENTE. [redacted], MD. Discharge Summary. (Final Premed- [redacted] - Page 1752-7153). Date of Admission:** 05/27/16. **Hospital Course:** The member was admitted on the day of surgery for hysterectomy total laparoscopic salpingectomy complete, bilateral. She underwent an uncomplicated procedure and had an unremarkable recovery and was discharged in good condition from the PACU. **Discharge Diagnoses:** 1) Hysterectomy. 2) Menorrhagia.

[redacted] **KAISER PERMANENTE. [redacted], MD. Telephone Encounter. (Final Premed- [redacted] - Page 761-761). Comments:** The member is feeling well and is using ibuprofen, and she is short of Norco. A prescription is placed for Norco.

[redacted]. **KAISER PERMANENTE. [redacted], MD. Progress Notes. (Final Premed- [redacted] - Page 766-767). Subjective:** The member is seen for post op eval status post total laparoscopic hysterectomy and bilateral salpingectomy on [redacted]. She has been doing well and has had only mild pain post operatively, using narcotics for only a few days post op. **Assessment**: 3 weeks post-op from total laparoscopic hysterectomy and bilateral salpingectomy, doing well. Possible candidal infection.

[redacted]. **KAISER PERMANENTE. [redacted], MD. Progress Notes. (Final Premed- [redacted] - Page 770-772). Subjective:** The member presents for status post total laparoscopic hysterectomy and bilateral salpingectomy on [redacted]. She has been doing well. **Assessment**: 6 weeks post-op from total laparoscopic hysterectomy and bilateral salpingectomy, doing well. Small granulation tissue treated uneventfully.

[redacted] **KAISER PERMANENTE. [redacted] DO. Progress Notes. (Final Premed- [redacted] - Page 777-778). Subjective:** The member noticed very painful urination and urinary frequency. She has had UTI in the past and this feels like another UTI. **Diagnosis**: UTI (Urinary Tract Infection).

[redacted] **KAISER PERMANENTE. [redacted] DO. Telephone Encounter. (Final Premed- [redacted] - Page 784-784). Subjective:** The member is notified that the recent urine test shows a urine infection.

[redacted] **KAISER PERMANENTE. [redacted], MD. Progress Notes. (Final Premed- [redacted] - Page 787-789). Subjective:** The member presents with breast lump and itching. **Diagnoses**: 1) Dermatitis - Right areola. 2) Screening for alcohol use disorder. 3) Declines influenza vaccination.

[redacted] **KAISER PERMANENTE. [redacted] DO. Progress Notes. (Final Premed- [redacted] - Page 794-797). Subjective:** The member presents with rash on the chest & back. **Diagnoses**: 1) Rash. 2) Declines influenza vaccination.

[redacted], [redacted]
[redacted]

[redacted]. **KAISER PERMANENTE. [redacted], MD. Progress Notes. (Final Premed-[redacted] - Page 809-811). Subjective:** The member reports a rash on the upper back and abdominal area. She is coughing for 4 days. **Diagnoses**: 1) URI (upper respiratory infection). 2) Dermatitis.

[redacted]. **KAISER PERMANENTE. [redacted], DO. ECG Report. (Final Premed-[redacted] - Page 830-831). Impression**: Normal sinus rhythm. Normal ECG. No previous ECGs available.

[redacted] **KAISER PERMANENTE. [redacted], DO. Progress Notes. (Final Premed-[redacted] - Page 812-816). Subjective:** The member reports hot flashes and stress. **She has been under a lot of stress at work and has some questions about it. She has been stressed due to an employee at work. She was promoted to [redacted] for the state, but the job was more stressful. She has gone to HR, but when she deals with the employee, she feels anxious, gets palpitations at times**. Sometimes she feels hot throughout her body, last about 5 minutes then self-resolve. **Diagnoses**: 1**) Acute stress disorder**. 2) History of total hysterectomy, no vaginal pap smear required. 3) Screening. **Plan**: **Discussed different options for management, including Behavioral Therapy, medications or Psychiatry referral. The member does not wish to be on any medications at this time.**

[redacted]. **KAISER PERMANENTE. [redacted], DO. Progress Notes. (Final Premed-[redacted] - Page 835-836). Subjective:** The member presents for follow-up for lab test. **Diagnoses**: 1) Prediabetes. 2) Mixed hyperlipidemia.

[redacted]. **KAISER PERMANENTE. [redacted], DO. Telephone Appointment Visit (TAV). (Final Premed- [redacted] - Page 837-838). Subjective:** The member reports LUTS with frequency and dysuria. **Diagnosis**: Acute UTI.

[redacted] **KAISER PERMANENTE. [redacted], MD. Doctor's First Report of Occupational Injury or Illness. (Final Premed- [redacted] - Page 840-846). Subjective:** The member she was slipped on water in restroom that was on the floor causing right knee pain. **Diagnosis**: Right knee sprain.

[redacted]. **KAISER PERMANENTE. [redacted], MD. Progress Notes. (Final Premed-[redacted] - Page 850-851). Subjective:** The member presents with urinary tract infection, burning and hematuria. **Diagnosis**: UTI.

[redacted]. **KAISER PERMANENTE. [redacted] MD. Physician's Progress Notes. (Final Premed- [redacted] - Page 860-864). Subjective:** The member reports that since the last visit her right knee pain is reduced. **Diagnosis**: Right knee sprain, subsequent encounter.

[redacted]. **KAISER PERMANENTE. [redacted], MD. Physician's Progress Notes. (Final Premed- [redacted] - Page 866-870). Subjective:** Since last visit right knee pain is further reduced, completed 6/6 physical therapy, with home exercise program given. **Diagnosis**: Right knee sprain, subsequent encounter.

[redacted], [redacted]
[redacted]

[redacted]. KAISER PERMANENTE. [redacted], NP. Progress Notes. (Final Premed-[redacted] - Page 874-878). **Subjective:** The member presents with urinary symptoms and upper respiratory infection symptoms cough, congestion. **Diagnoses**: 1) UTI. 2) URI.

[redacted]. KAISER PERMANENTE. [redacted], PA. Progress Notes. (Final Premed-[redacted] - Page 893-895). **Subjective: The member presents with anxiety, palpitations and shortness of breath. The symptoms started months ago. They are intermittent, daily. The pain is triggered by work at stress or anxious thoughts and alleviated by deep breathing and relaxation techniques. Diagnoses**: 1) **Anxiety**. 2) Palpitations. **Plan: Prescribed Xanax.**

[redacted] KAISER PERMANENTE. [redacted] MD/Kajal Kotadiya, LVN. ECG Report. (Final Premed-[redacted] - Page 895-896). **Impression**: Normal sinus rhythm. Normal ECG.

[redacted]. KAISER PERMANENTE. [redacted], MD. Telephone Appointment Visit. (Final Premed-[redacted] - Page 901-903). **Subjective: The member complains of moderately severe anxiety, which started a month ago. Associated Symptoms: anxious mood, difficulty controlling worry, disturbed sleep, fatigue, heart palpitations, muscle tension and panic attacks. Triggered by work related stress or problems. Diagnosis**: **Anxiety disorder**. **Plan**: **Advised to use medications as directed**.

[redacted]. KAISER PERMANENTE. [redacted] MD. Mammo Bilat Screening Sequential W Or Wo Computer Aided Detection Analysis. (Final Premed-[redacted] - Page 922-925). **Comparison:** [redacted]. **Impression**: Negative. There is no mammographic evidence of malignancy. BI-RADS: 1 negative.

[redacted]. KAISER PERMANENTE. [redacted], MD. Progress Notes. (Final Premed-[redacted] - Page 906-908). **Subjective:** The member is seen for a physical examination. **She is seeing a psychiatrist for her anxiety. She was recommended Prozac but The member said she wants to wait and see first**. The member is requesting mammogram since her mom had breast cancer. **Diagnoses**: 1) Routine adult health checkup exam. 2) Declines influenza vaccination. 3) Obesity, BMI 30-30.9, adult. 4) Screening mammogram for breast cancer. 5) **Anxiety**.

[redacted]. KAISER PERMANENTE. [redacted], PA. Doctor's First Report of Occupational Injury or Illness. (Final Premed-[redacted] - Page 945-946, 2069-2073). **DOI:** [redacted] **Subjective**: The member complains of neck and low back pain. She was packing at work and felt a sharp pain. **Diagnoses**: 1) Back pain. 2) Neck pain.

[redacted]. PACIFIC MEDICAL CLINIC. [redacted] MD. Doctor's First Report of Occupational Injury or Illness. (Final Premed-[redacted] - Page 2074-2083). **DOI:** [redacted] **Subjective:** The member is complaining of pain in her lower back, both shoulders, right hand and wrist and right hip. She states the pain began when she was reassigned to a new desk at work due to construction in her building. **She said she was assigned a new task at work, became stressed, then began to feel muscle tightness in her right lower back. She says she is extremely stressed with work and is now losing sleep**. She complains of headaches. She also reports that [redacted] years ago, she sustained severe right-hand/wrist/shoulder strains secondary to repetitive motions at work as a [redacted], causing her to have a 20% decrease in dexterity in her right hand. **Diagnoses**: 1)

[redacted], [redacted]
[redacted]

Strain of the muscle, fascia and tendon of the lower back. 2) Strain of the muscle, fascia and tendon at the neck level. 3) **Anxiety disorder unspecified**. 4) Strain of unspecified muscle fascia and tendon wrist and hand. **Plan: Requested consultation with a psychiatrist.**

[redacted]. **PACIFIC MEDICAL CLINIC.** [redacted], **MD. Primary Treating Physician's Progress Report (PR-2). (Final Premed-** [redacted] **- Page 2084-2091). DOI:** [redacted] **Subjective:** The member is seen for her lower back, shoulders and right upper extremity. **Diagnoses**: Remain unchanged as of the [redacted] report.

[redacted]. **PACIFIC MEDICAL CLINIC.** [redacted], **MD. Primary Treating Physician's Progress Report (PR-2). (Final Premed-** [redacted] **- Page 2093-2101). DOI:** [redacted] **Subjective:** Currently, The member complains of numbness/paresthesias in her lower legs while sitting. She said the symptoms resolve with standing and walking. **Diagnoses**: Remain unchanged as of the [redacted] report.

[redacted]. **PACIFIC MEDICAL CLINIC.** [redacted], **MD. Primary Treating Physician's Progress Report (PR-2). (Final Premed-** [redacted] **- Page 2102-2109). DOI:** [redacted] **Subjective: The member reports that she was assigned a new task at work, became stressed**, then began to feel muscle tightness in her right lower back. Currently, she is feeling a little better because she had her first chiropractic treatment today. **Diagnoses**: Remain unchanged as of the [redacted] report.

[redacted]. **PACIFIC MEDICAL CLINIC. Therapy Note. (Final Premed-** [redacted] **– Page 2110-2112). Total Sessions**: 1. **Modalities:** Therapeutic exercise, infrared, EMS and CTM.

[redacted] **PACIFIC MEDICAL CLINIC.** [redacted], **MD. Primary Treating Physician's Progress Report (PR-2). (Final Premed-** [redacted] **- Page 2113-2121). DOI:** [redacted] **Subjective:** The member feels the same with no pain at rest but up to 4/10 pain with activity. She has muscle tightness in her neck, upper back and her right lower back. **Diagnoses**: Remain unchanged as of the [redacted] report.

[redacted]. **PACIFIC MEDICAL CLINIC.** [redacted], **MD. Primary Treating Physician's Progress Report (PR-2). (Final Premed-** [redacted] **- Page 2122-2130). DOI:** [redacted] **Subjective:** The member feels ok. She reports upper back pain and no lower back pain or discomfort. **Diagnoses**: Remain unchanged as of the [redacted] report.

[redacted]. **PACIFIC MEDICAL CLINIC. Acupuncture Therapy Notes. (Final Premed-** [redacted] **– Page 2131-2131, 2144-2144, 2157-2157, 2166-2166, 2170-2170, 2179-2179). Total Sessions:** 6. **Modalities**: Continue acupuncture and relax. **Body Parts**: Back, neck, shoulder, and Right arm/finger.

[redacted]. **PACIFIC MEDICAL CLINIC.** [redacted], **MD. Primary Treating Physician's Progress Report (PR-2). (Final Premed-** [redacted] **- Page 2132-2143). DOI:** [redacted] **Subjective:** The member reports that acupuncture is helping significantly. **Diagnoses**: Remain unchanged as of the [redacted] report.

[redacted], [redacted]
[redacted]

[redacted] **PACIFIC MEDICAL CLINIC. [redacted], MD. Primary Treating Physician's Progress Report (PR-2). (Final Premed-[redacted] - Page 2147-2156). DOI: [redacted] Subjective:** The member's complaints are remained unchanged. **Diagnoses**: Remain unchanged as of the [redacted] report.

[redacted]. **PACIFIC MEDICAL CLINIC. [redacted], MD. Primary Treating Physician's Progress Report (PR-2). (Final Premed-[redacted] - Page 2159-2165). DOI: [redacted] Subjective:** The member reports that she is still experiencing **stress at work and is having difficulty sleeping**. **Diagnoses**: Remain unchanged as of the [redacted] report.

[redacted]. **PACIFIC MEDICAL CLINIC. [redacted] MD. Primary Treating Physician's Progress Report (PR-2). (Final Premed-[redacted] - Page 2171-2178). DOI: [redacted] Subjective:** The member reports that **she is still experiencing stress at work and is having difficulty sleeping**. **Diagnoses**: Remain unchanged as of the [redacted] report.

[redacted]. **PACIFIC MEDICAL CLINIC. [redacted], MD. Primary Treating Physician's Progress Report (PR-2). (Final Premed-[redacted] - Page 2184-2191). DOI: [redacted] Subjective:** The member states the acupuncture helped but she still has pain and wants to have physical therapy. **Diagnoses**: Remain unchanged as of the [redacted] report.

[redacted]. **PACIFIC MEDICAL CLINIC. [redacted], MD. Primary Treating Physician's Progress Report (PR-2). (Final Premed-[redacted] - Page 2192-2198). DOI: [redacted] Subjective:** The member states the acupuncture helped and she requested additional acupuncture therapy. **Diagnoses**: Remain unchanged as of the [redacted] report.

[redacted] **PACIFIC MEDICAL CLINIC. [redacted], MD. Primary Treating Physician's Progress Report (PR-2). (Final Premed-[redacted] - Page 2200-2211). DOI: [redacted] Subjective:** The member states the acupuncture helped and she requested additional acupuncture therapy. **Diagnoses**: Remain unchanged as of the [redacted] report.

[redacted] **PACIFIC MEDICAL CLINIC. [redacted], MD. Primary Treating Physician's Progress Report (PR-2). (Final Premed-[redacted] - Page 2212-2219). DOI: [redacted] Subjective: The member became so stressed with all the responsibilities she was covering, 4 full units not just 1**. She developed chest pain and felt lightheaded because there was no one to help. **Diagnoses**: Remain unchanged as of the [redacted] report.

[redacted]. **KAISER PERMANENTE. [redacted], PA. Progress Note. (Final Premed-[redacted] - Page 964-965). Subjective:** The member complains of chest tightness and chest pain while at work. **She attributes it to stress at work. She had a stressful situation at work. Diagnosis:** Costochondritis.

[redacted], [redacted], **PT. Physical Therapy Notes. (Final Premed-[redacted] – Page 2220-2221, 2239-2239, 2276-2276, 2284-2284, 2293-2293, 2305-2305, 2307-2307, 2312-2312, 2325-2325, 2327-2327). Total Sessions**: 10. **Diagnosis**: Lower back, neck, and right hand.

[redacted], [redacted]
[redacted]

[redacted] **PACIFIC MEDICAL CLINIC. [redacted], MD. Primary Treating Physician's Progress Report (PR-2). (Final Premed- [redacted] - Page 2222 -2229). DOI: [redacted]** **Subjective:** The member states that she went to the Kaiser MD after leaving the clinic and was informed after her evaluation that she has costochondritis of the chest wall and it is not cardiac related. She has gastric discomfort with the prescribed ibuprofen. **Diagnoses**: Remain unchanged as of the [redacted] report.

[redacted]. **PACIFIC MEDICAL CLINIC. [redacted], MD. Primary Treating Physician's Progress Report (PR-2). (Final Premed- [redacted] - Page 2232-2238). DOI: [redacted]** **Diagnoses**: Remain unchanged as of the [redacted] report.

[redacted]. [redacted] **MD. Orthopedic AOE/COE Evaluation and Report. (Final Premed- [redacted] - Page 2240-2269). DOI: [redacted]** **History of Injury:** The member reports that during the course of her employment with the County of Orange, she was performing her usual and customary job duties when she sustained injuries to her neck, bilateral shoulders, right forearm and lower back with right hip pain, mid back pain and **psychological complaints of stress, dizziness and anxiety due to her workload. On [redacted] she reports that her office was located on a floor that was under construction and she was given 1 day to pack up her entire office and move downstairs. There was staff that had been hired to help with moving but they were unhelpful, and she had to repetitively re-pack boxes, which caused increased stress and anxiety. The member was already stressed due to the move and being understaffed. Present Complaints:** The member complains of pain in the cervical spine, bilateral shoulders/arms, and lumbar spine. **She also complains of constant stress and anxiety. Prior Industrial Injuries:** Approximately [redacted]+ years ago, while employed by [redacted], The member was involved in a work-related injury and sustained injuries to her bilateral wrists/hands and was diagnosed with overuse syndrome. As a result, medical attention was received and she was treated with medication, therapy and, lidocaine injection and **psychological treatment for 1-1/2 years**. On [redacted] and [redacted], while employed by the [redacted], **she was involved in stress-related work-related injuries. Diagnoses:** 1) Cervical strain/sprain. 2) Cervical radiculopathy. 3) Right upper extremity pain. 4) Lumbar strain/sprain. 5) Lumbar radiculopathy. 6) Bilateral shoulder pain. **Causation:** Industrial.

[redacted] **PACIFIC MEDICAL CLINIC. [redacted], MD. Primary Treating Physician's Progress Report (PR-2). (Final Premed- [redacted] - Page 2275). DOI: [redacted]** **Subjective:** The member continues to experience right lower back pain when sitting for any length of time, worsened with repetitive bending and reaching for documents when working. **Diagnoses**: Remain unchanged as of the [redacted] report.

[redacted]. **PACIFIC MEDICAL CLINIC. [redacted], MD. Primary Treating Physician's Progress Report (PR-2). (Final Premed- [redacted] - Page 2277-2283). DOI: [redacted]** **Subjective:** The member said that the issues at work are preventing her from improving and it was due to the fact that she was being sued by other employees who may be terminated because they have not been doing their assigned work. **Diagnoses**: Remain unchanged as of the [redacted] report.

[redacted]. **PACIFIC MEDICAL CLINIC. [redacted], MD. Primary Treating Physician's Progress Report (PR-2). (Final Premed- [redacted] - Page 2285-2292). DOI: [redacted]** **Subjective:** The member is feeling better due to working 3 days this week and the work

computer freezes up, leading to less use of her right hand and right wrist. She continues to experience pain on the right side of her face behind her right eye and right parietal, and it is achy. She said she is being written up. She admits to headache and nausea. **Diagnoses**: Remain unchanged as of the [redacted] report.

[redacted] **PACIFIC MEDICAL CLINIC. [redacted] MD. Primary Treating Physician's Progress Report (PR-2). (Final Premed- [redacted] - Page 2294-2299). DOI:** [redacted] **Subjective:** The member said she will be off work for the next two weeks on vacation and will be staying home. She said she is being written up. **Diagnoses**: Remain unchanged as of the [redacted] report.

[redacted] **PACIFIC MEDICAL CLINIC. [redacted], MD. Primary Treating Physician's Progress Report (PR-2). (Final Premed- [redacted] - Page 2300-2304). DOI:** [redacted] **Subjective:** The member is feeling better due to having two weeks off recently, but she still has pain in her right hand when she is using her computer for a long period of time. **Diagnoses**: Remain unchanged as of the [redacted] report.

[redacted]**. PACIFIC MEDICAL CLINIC. [redacted] MD. Primary Treating Physician's Progress Report (PR-2). (Final Premed- [redacted] - Page 2308-2311). DOI:** [redacted] **Subjective:** The member has not yet received approval for transfer of care to orthopedic specialist. **Diagnoses**: Remain unchanged as of the [redacted] report.

[redacted]**. PACIFIC MEDICAL CLINIC. [redacted] MD. Primary Treating Physician's Progress Report (PR-2). (Final Premed- [redacted] - Page 2315-2319). DOI:** [redacted] **Subjective: The member complains of multiple issues with supervisors, managers and staff and states the workload is constantly increasing, causing her to feel very anxious at work**. **Diagnoses**: Remain unchanged as of the [redacted] report.

[redacted]**. PACIFIC MEDICAL CLINIC. [redacted], MD. Primary Treating Physician's Progress Report (PR-2).**
(, 9 Final Premed- [redacted] - Page 2320-2324). DOI: [redacted] **Subjective:** Currently, The member is not feeling better due to having the additional responsibility of monitoring new additions to her department. She still has pain in her right hand when she is using her computer for a long period of time. She said her workload continues to increase and she complains of more pain in her right neck, left upper back, and left lower back. **Diagnoses**: Remain unchanged as of the [redacted] report.

[redacted] **PACIFIC MEDICAL CLINIC. [redacted], MD. Primary Treating Physician's Progress Report (PR-2). (Final Premed- [redacted] - Page 2328-2331). DOI:** [redacted] **Subjective:** Currently, The member states she is not feeling better due to having the additional responsibility of monitoring new additions to her department. **Diagnoses**: Remain unchanged as of the [redacted] report.

[redacted] **PACIFIC MEDICAL CLINIC. [redacted] MD. Primary Treating Physician's Progress Report (PR-2). (Final Premed- [redacted] - Page 2332-2338). DOI:** [redacted] **Subjective:** The member complains of pain in the neck, mid-back, and lower back. **Diagnoses**: Remain unchanged as of the [redacted] report.

[redacted], [redacted]
[redacted]

[redacted] **PACIFIC MEDICAL CLINIC.** [redacted], **MD. Primary Treating Physician's Progress Report (PR-2). (Final Premed-** [redacted] **- Page 2340-2343). DOI:** [redacted] **Subjective:** Overall, The member states that there has been no improvement in her discomfort and states it is most painful at the base of her neck and her right lower back. **Diagnoses**: Remain unchanged as of the [redacted] report.

[redacted]**. PACIFIC MEDICAL CLINIC.** [redacted] **MD. Primary Treating Physician's Progress Report (PR-2). (Final Premed-** [redacted] **- Page 2344-2348). DOI:** [redacted] **Subjective:** The member states that she has the approval to see the orthopedic surgeon but has not called to schedule an appointment yet because she has been too busy moving her office to a new office over the weekend. **Diagnoses**: Remain unchanged as of the [redacted] report.

[redacted]**, DC/LAc. Therapy Notes. (Final Premed-** [redacted] **– Page 2349-2351, 2358-2359, 2372-2372, 2388-2389, 2391-2392, 2398-2401). Total Sessions**: 12. **Diagnoses**: 1) Lower back pain. 2) Pain in the left shoulder. **Modalities:** CMT.

[redacted] **BACK BAY IMAGING, INC.** [redacted]**, MD. MRI of the Cervical Spine without Contrast. (Final Premed-** [redacted] **- Page 2352-2352). Indication:** Work related injury 01/2019 with neck pain. **Comparison:** None available. **Impressions:** 1) There are disc bulges measuring up to 2 mm seen from C4-5 to C6-7. 2) Straightening of the cervical spine.

[redacted]**. PACIFIC MEDICAL CLINIC.** [redacted]**, MD. Primary Treating Physician's Progress Report (PR-2). (Final Premed-** [redacted] **– Page 2353-2357). DOI**: [redacted] **Subjective:** The member reports the pain became worse when she spent Friday moving her office. **Diagnoses**: Remain unchanged as of the [redacted] report.

[redacted] **MD, INC.** [redacted]**. Progress Notes. (Final Premed-** [redacted] **- Page 2360-2363). DOI**: [redacted] **Subjective**: The member complains of lower back pain with bilateral leg pain, neck pain with right arm pain, bilateral shoulder pain, and numbness. **Diagnoses**: 1) Neck pain. 2) Lumbar stenosis with neurogenic claudication. 3) Lumbar radiculopathy. 4) Shoulder pain, unspecified chronicity, unspecified laterality.

[redacted] **PACIFIC MEDICAL CLINIC.** [redacted] **MD. Primary Treating Physician's Progress Report (PR-2). (Final Premed-** [redacted] **- Page 2364-2367). DOI**: [redacted] **Subjective:** The member reports pain in the neck, mid-back, and lower back. **Diagnoses**: Remain unchanged as of the [redacted] report.

[redacted] **PACIFIC MEDICAL CLINIC.** [redacted] **MD. Progress Note. (Final Premed-** [redacted] **- Page 2368-2371). DOI**: [redacted]. **Subjective:** The member was complaining of moderate pain and stiffness of her left neck, left upper back, left shoulder, and left lower back. **Diagnoses**: 1) Strain of muscle, fascia and tendon at neck level, initial encounter. 2) Strain of the muscle, fascia and tendon of the lower back, initial encounter. 3) Strain of the muscle and tendon of the back wall of the thorax, initial encounter. 4) Strain of muscle(s) and tendon(s) of the rotator cuff of the left shoulder, initial encounter.

[redacted], [redacted]
[redacted]

[redacted] **PACIFIC MEDICAL CLINIC. [redacted] [redacted] MD. Primary Treating Physician's Permanent and Stationary Report (PR-4). (Final Premed- [redacted] - Page 2373-2383). DOI:** [redacted] **Subjective:** The member reports she was able to obtain a transfer to another department and is very happy but continues to have pain. **Diagnoses**: Remain unchanged as of the [redacted] report. **Functional Capacity Assessment**: The member can climb, balance, crawl occasionally. She can stoop, kneel, crouch, twist, reach, handle, fingering, feel, see, hearing, speak frequently.

[redacted] **RESTORE ORTHOPEDICS AND SPINE CENTER. [redacted], MD. Initial Consult Note. (Final Premed- [redacted] - Page 2384-2387, 2390-2390). DOI:** [redacted] **Subjective:** The member is seen for initial spine surgical consultation and evaluation of a work-related condition. She reports that her symptoms are mildly improved. She also had a workstation ergonomic evaluation. **Diagnoses**: 1) Cervical radiculitis, aggravation of cervical spondylosis. 2) Lumbar radiculitis, right; aggravation of lumbar degenerative disk disease.

[redacted]. **KAISER PERMANENTE. [redacted], MD. Progress Note. (Final Premed-** [redacted] **- Page 977-987). Subjective**: The member complains of generalized body pains, dizziness, and URI symptoms. **Diagnoses**: 1) URI. 2) Vertigo. 3) Screening.

[redacted]. **RESTORE ORTHOPEDICS AND SPINE CENTER. [redacted], MD. Progress Note. (Final Premed-** [redacted] **- Page 2393-2396). DOI:** [redacted] **Subjective:** The member reports pain that radiates from her lower back into both legs. She gets pain in the sciatic distribution. She experiences relief with the current chiropractic treatment but notes that small things can aggravate and reaggravate the pain in her legs. **Diagnoses**: 1) Aggravation of cervical spondylosis. 2) Aggravation of lumbar stenosis L3-L4, L4-L5.

[redacted] **KAISER PERMANENTE. [redacted], MD. Progress Note. (Final Premed-** [redacted] **– Page 1018-1022). Subjective**: The member is seen for a physical exam and lab results. **Diagnoses**: 1) Routine adult health checkup exam. 2) Vaccination for influenza.

[redacted] **KAISER PERMANENTE. [redacted], MD. Mammogram Screening Bilateral Sequential with or without Computer Aided Detection Analysis. (Final Premed-** [redacted] **– Page 1023-1027). Comparison:** [redacted] and [redacted]. **Impression:** BI-RADS 1: Negative. There is no mammographic evidence of malignancy.

[redacted]. **RESTORE ORTHOPEDICS AND SPINE CENTER. [redacted], MD. Progress Note. (Final Premed-** [redacted] **- Page 2402-2404). DOI:** [redacted] **Subjective:** The member describes lower back pain aggravated by certain movements. **Diagnosis**: Aggravation of lumbar facet arthropathy, stenosis L3-L4, L4-L5.

[redacted]. **RESTORE ORTHOPEDICS AND SPINE CENTER. [redacted] MD/[redacted]a [redacted] PA-C. Progress Note. (Final Premed-** [redacted] **- Page 2406-2409). DOI:** [redacted] **Subjective:** The member is requesting rhizotomy ablations aimed at L3-L4 and L4-L5 segments and a transfer of care to Dr. [redacted]. **Diagnosis**: Aggravation of lumbar facet arthropathy, stenosis L3-L4, L4-L5.

[redacted], [redacted]
[redacted]

[redacted] **KAISER PERMANENTE.** [redacted] **NP. Telephone Encounter. (Final Premed-** [redacted] **– Page 1053-1054). Diagnosis**: UTI.

[redacted] **KAISER PERMANENTE.** [redacted] **, MD. Internal Medicine Supplemental Report. (Final Premed-** [redacted] **– Page 1062-1065, 2410-2414). DOI**: [redacted] **Subjective:** The member complains of upper back pain on the right side. She also complains of feeling dizzy in the past few days, feels like the room is spinning. **Diagnoses**: 1) Right trapezius strain, initial encounter. 2) Radiculopathy. 3) Bilateral benign paroxysmal positional vertigo. 4) Mixed HLD.

[redacted] **RESTORE ORTHOPEDICS AND SPINE CENTER.** [redacted] **, DO. Progress Note. (Final Premed-** [redacted] **- Page 2415-2418). DOI**: [redacted] **Subjective:** The member continues to complain of axial low back pain, worse with back extension or forward bending. **Diagnosis**: Facet arthropathy, lumbosacral.

[redacted] **. KAISER PERMANENTE.** [redacted] **, PA. Telephone Appointment Visit. (Final Premed-** [redacted] **– Page 1079-1080). Subjective:** She complains of URI symptoms. Her coworker tested + for COVID-19. She wants to get tested. **Diagnosis**: URI.

[redacted] **KAISER PERMANENTE.** [redacted] **MD. Telephone Appointment Visit. (Final Premed-** [redacted] **– Page 1090-1091). Subjective:** The member with a recent sore throat and cough would like COVID-19 testing. **Diagnosis**: Coronavirus COVID-19 disease, person under investigation.

[redacted] **KAISER PERMANENTE.** [redacted] **PA. Progress Note. (Final Premed-** [redacted] **– Page 1109-1111). Subjective:** She presents with URI, moderate nasal congestion, and persistent cough, which started 7 days ago. The member also reports dysuria/frequency x 3 days. **Diagnoses**: 1) Cough. 2) Postnasal drip. 3) Dysuria.

[redacted] **KAISER PERMANENTE.** [redacted] **PA. Progress Note. (Final Premed-** [redacted] **– Page 1124-1124). Subjective:** The member has continued cough for the past week. Chest pain was noted with coughing and shortness of breath. **Diagnoses**: 1) Cough. 2) History of UTI.

[redacted] **KAISER PERMANENTE.** [redacted] **MD. X-rays of the Chest. (Final Premed-** [redacted] **– Page 1132-1135). Clinical History:** Cough. **Comparison:** None. **Findings/Impression**: The lungs are clear. No pleural effusions are seen. The cardiomediastinal silhouette is normal.

[redacted] **KAISER PERMANENTE.** [redacted] **NP. Telephone Appointment Visit. (Final Premed-** [redacted] **– Page 1143-1144). Subjective:** The member feels like something is strangling her throat and she feels lightheaded. **Diagnosis**: Cough.

[redacted] **KAISER PERMANENTE.** [redacted] **NP. Telephone Appointment Visit. (Final Premed-** [redacted] **– Page 1153-1153). Subjective:** The member is feeling better on the antibiotics. She is to go on a trip tomorrow.

[redacted], [redacted]
[redacted]

[redacted] **KAISER PERMANENTE. [redacted], MD. Progress Note. (Final Premed-[redacted] – Page 1161-1163). Subjective:** The member complains of a cough. She has a history of allergic rhinitis. **Diagnoses**: 1) Allergic rhinitis. 2) Cough.

[redacted] **KAISER PERMANENTE. [redacted] PA. Progress Note. (Final Premed-[redacted] – Page 1169-1172). Subjective:** The member presents with URI, moderate nasal congestion, and persistent cough. **Diagnoses**: 1) Bilateral otitis media. 2) Postnasal drip. 3) Cough.

[redacted] **KAISER PERMANENTE. [redacted] MD. X-rays of the Chest. (Final Premed-[redacted] – Page 1175-1177). Clinical History:** Cough, rule out pneumonia. **Comparison:** None. **Impression**: The lungs are clear. No pleural effusions are seen. The cardio mediastinal silhouette is normal.

[redacted] **KAISER PERMANENTE. [redacted] MD. Progress Note. (Final Premed-[redacted] – Page 1183-1187). Subjective:** The member said she went to UCC because of an ongoing cough. Diagnosed with bilateral otitis media and taking medication prescribed. She would like to know the etiology of the ongoing cough for 6 weeks. **Diagnoses**: 1) Chronic cough. 2) Allergic rhinitis. 3) Reactive airway disease, unspecified.

[redacted]**. KAISER PERMANENTE. [redacted] NP. Progress Note. (Final Premed-[redacted] – Page 1195-1200). Subjective:** The member complains of fatigue, SOB, and cough. **Diagnosis**: Dyspnea.

[redacted] **KAISER PERMANENTE. [redacted], MD. CTA of Pulmonary with Contrast. (Final Premed-[redacted] – Page 1215-1220). Clinical History:** Rule out pulmonary embolism. **Comparison:** None. **Impression**: Study limited due to respiratory motion artifact. No evidence of pulmonary embolism.

[redacted] **KAISER PERMANENTE. [redacted], MD. Telephone Appointment Visit. (Final Premed-[redacted] – Page 1231-1233). Subjective:** The member reports her cough has improved with prednisone. But feels like having some anxiety symptoms, which gives her SOB and a more cough. She is interested in having anti-anxiety medication to be used on a need-to basis. **Diagnoses**: 1) Medication refill. 2) **Anxiety disorder**. 3) SOB. 4) Cough. **Plan**: **Prescribed lorazepam. Advised to consider evaluation by a mental health professional if symptoms do not improve.**

[redacted]**. [redacted] DC. Chiropractic Therapy Notes. (Final Premed-[redacted] - Page 2419-2434). Total Sessions**: 7. **Modalities:** Manual therapy. **Diagnoses**: 1) Other cervical disc disorders, unspecified cervical region. 2) Postural kyphosis, thoracic region. 3) Other intervertebral disc displacement, lumbar region. 4) Rotator cuff strain, right shoulder.

[redacted] **KAISER PERMANENTE. [redacted] FNP/[redacted] NP. Telephone Encounter. (Final Premed-[redacted] – Page 1250-1251). Subjective:** The member is eligible to have medication ordered without a visit. **Diagnosis**: UTI (Urinary Tract Infection).

[redacted], [redacted]
[redacted]

[redacted] **KAISER PERMANENTE. [redacted] MD. Spirometry Pre/Post Bronchodilator with Lung Volumes Plethysmography. (Final Premed- [redacted] – Page 1263-1275). PFT Interpretation**: Pulmonary function testing is within normal limits. Not consistent with COPD.

[redacted] **KAISER PERMANENTE. [redacted], RT. Respiratory Therapy Note. (Final Premed- [redacted] – Page 1262-1262). Total Sessions**: 1.

[redacted] **KAISER PERMANENTE. [redacted] MD. Progress Note. (Final Premed- [redacted] – Page 1282-1284). Subjective:** The member is requesting a COVID-19 screening. Symptoms are diarrhea and congestion. **Diagnosis**: Coronavirus COVID-19 disease, person under investigation.

[redacted] **KAISER PERMANENTE. [redacted] DO. ED Provider Note. (Final Premed- [redacted] – Page 1847-1854). Subjective:** The member presents with a complaint of chest pain. She relates that she started having discomfort last evening around 8:00 pm. She also states she suffers at times with a condition called costochondritis. **She lost her father 7 weeks ago to COVID-19. She has been dealing with organizing his burial. Her mother is having a mental health crisis presently as she is dealing with this issue. She herself suffers from anxiety and utilizes Ativan. Due to everything going on in her life, she wanted to make sure this was not her heart. Diagnoses**: 1) Atypical chest pain. 2) **Stress related disorder**. **Plan: Prescribed Ativan. The member was seen by Behavioral Health, and the member is scheduled to have a follow-up appointment on Monday. In the meantime the member will receive a very small course of Ativan.**

[redacted]. **KAISER PERMANENTE. [redacted], PA. Telephone Appointment Visit. (Final Premed- [redacted] – Page 1310-1311). Subjective:** The member complained of pain and swelling in the right ring fingertip. **Diagnosis**: Right finger paronychia.

[redacted] **KAISER PERMANENTE. [redacted] DO. Progress Note. (Final Premed- [redacted] – Page 1316-1320). Subjective:** The member presents with a finger problem. **She also wants a refill of Ativan**. **Diagnoses**: 1) Right finger paronychia (primary encounter diagnosis). 2) **Anxiety**. **Plan: Refilled Atarax**.

[redacted] **KAISER PERMANENTE. [redacted], MD. Telephone Appointment Visit. (Final Premed- [redacted] – Page 1326-1328). Subjective: The member wants to follow-up on anxiety. Symptoms improved with Ativan. Run out of Ativan prescribed in ER, requested more refill. She is seeing a psychiatric therapist regularly and feels it is helping. Using Ativan as needed only.** Requested screening labs before physical. **Diagnoses**: 1) Screening. 2) **Anxiety disorder**. **Plan**: **Continue Ativan**.

[redacted] **KAISER PERMANENTE. [redacted] MD. TAV Note. (Final Premed- [redacted] – Page 1360-1361). Subjective**: The member is complaining of gross blood in urine with a blood clot that started this morning. She also has dysuria and urinary frequency. She is requesting urine testing for culture. **Diagnoses**: 1) UTI. 2) Hematuria.

[redacted], [redacted]
[redacted]

[redacted] **KAISER PERMANENTE. [redacted] RN. Nurse Note. (Final Premed-[redacted] – Page 1370-1370). Subjective:** The member reports she had a bump in the vaginal area for several months. In the past week, she has had several bumps and vaginal discharge.

[redacted] **KAISER PERMANENTE. [redacted], NP. Progress Note. (Final Premed-[redacted] – Page 1373-1376). Subjective**: The member noticed 2 bumps on the left vulva 2.5. She is also requesting a breast exam. **Diagnoses**: 1) Epidural inclusion cyst (primary encounter diagnosis). 2) Screening for domestic violence. 3) Screening exam for breast cancer. 4) Vaginal discharge.

[redacted] **KAISER PERMANENTE. [redacted] MD. Telephone Appointment Visit. (Final Premed-[redacted] – Page 1383-1384). Subjective**: The member had food poisoning a week ago, ate a Subway tuna sandwich that was left out for a couple of hours in the heat and then Pollo Loco. She had nausea, loose stools, and cramping. She states symptoms improved, but now has cramping, feels a knot in her stomach. **Diagnosis**: Gastroenteritis.

[redacted] **KAISER PERMANENTE. [redacted], NP. Progress Note. (Final Premed-[redacted] – Page 1391-1396). Subjective**: The member presents with a history of low back pain and sciatica. She had a workplace injury about 2 years ago. She was receiving treatment around that time and had improved. She recently returned to work, which requires sitting for longer periods of time. **She is requesting a refill of Ativan. She does have a history of anxiety disorder. Diagnoses**: 1) Sciatica, right side. 2) Medication refill. 3) **Anxiety disorder**. **Plan: Refilled Atarax**.

[redacted] **KAISER PERMANENTE. [redacted] NP. Progress Note. (Final Premed-[redacted] – Page 1418-1422). Subjective:** The member complains of pain in the right leg. **Diagnosis**: Lumbar radiculopathy.

[redacted]**. KAISER PERMANENTE . Physical Therapy Notes. (Final Premed-[redacted] – Page 1422-1427, 1440-1444). Number of Sessions**: 2.

[redacted] **KAISER PERMANENTE. [redacted] NP. Progress Note. (Final Premed-[redacted] – Page 1438-1440). Subjective**: The member states no change in symptoms. Currently, pain is in the buttocks and posterior thigh. **Diagnosis**: Lumbar radiculopathy.

[redacted] **KAISER PERMANENTE. [redacted] NP. Progress Note. (Final Premed-[redacted] – Page 1454-1455). Subjective**: The member is eligible to have a medication order without a visit. **Diagnosis**: UTI.

[redacted] **MD. Orthopedic AOE/COE Re-Evaluation Report. (Final Premed-[redacted] – Page 2436-2452). DOI**: [redacted] [redacted]. **Subjective:** The member remains symptomatic with neck, bilateral shoulder, right forearm, and mid and lower back pain. **Diagnoses**: 1) Right greater than left shoulder pain. 2) Low back pain with radiculopathy. 3) L4-5 disc herniation. 4) Neck pain. **Disability Status:** The member has reached MMI with regards to cervical spine and bilateral shoulders and is a permanent and stationary. **Impairment Rating:** The member is assigned to cervical spine and bilateral shoulders DRE category 1 with 0% WPI.

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[redacted]

[redacted] **KAISER PERMANENTE. [redacted] DO. Progress Note. (Final Premed-[redacted] – Page 1466-1470). Subjective**: The member complains of headache, nausea, sound sensitivity, and associated neck pain, as she has had before. **She admits having a lot of stress at work**. She is also concerned that she has lost weight. **Diagnoses**: 1) Headache (primary encounter diagnosis). 2) Change in bowel habit. 3) Dizziness. 4) Unintentional weight loss.

[redacted] **KAISER PERMANENTE. [redacted] MD. Telephone Encounter. (Final Premed-[redacted] – Page 1489-1491). Subjective**: The member complains of aching pain in the right shoulder. **Diagnoses**: 1) Bilateral rotator cuff syndrome (primary encounter diagnosis). 2) Never smoked.

[redacted] **MD. Letter Note. (Final Premed-[redacted] – Page 2453-2453).** This report belongs to a different patient named [redacted]. This is reviewed but not summarized.

[redacted]**. KAISER PERMANENTE. [redacted], DO. TAV Note. (Final Premed-[redacted] – Page 1511-1512). Subjective**: The member reports congestion, sore throat, and ear pain. **Diagnoses**: 1) Sinus pain (primary encounter diagnosis). 2) Coronavirus Covid-19 disease, person under investigation.

[redacted] **KAISER PERMANENTE. [redacted] PA-C. Telephone Encounter. (Final Premed-[redacted] – Page 1525-1526). Subjective**: Received and reviewed the SCAL Urinary tract screening tool completely. **Diagnosis**: UTI.

[redacted] **KAISER PERMANENTE. [redacted] MD. Telephone Encounter. (Final Premed-[redacted] – Page 1536-1537). Comments: The member is requesting a refill of Lorazepam, but the pharmacy said she needs an appointment. The medication is needed for her anxiety related to work. The examiner states to schedule a TAV for medication refill**.

[redacted] **KAISER PERMANENTE. [redacted], MD. Progress Note. (Final Premed-[redacted] – Page 1539-1545). Subjective**: The member complains of fatigue, **anxiety,** and hoarseness. She reports a lot of work. **Diagnoses**: 1) Hoarseness-chronic. 2) Medication refill. 3) **Anxiety disorder**. 4) Screening for colon cancer. 5) Screening for breast cancer.

[redacted] **MD. Operative Report. (Final Premed-[redacted] – Page 2455-2455).** This report belongs to a different patient named [redacted]; DOB: [redacted]. This is reviewed but not summarized.

[redacted] **KAISER PERMANENTE. [redacted], MD. Mammogram Report. (Final Premed-[redacted] – Page 1546-1549). Comparison:** [redacted], [redacted] and [redacted]. **Impression**: BI-RADS: 2 Benign. There is no mammographic evidence of malignancy.

[redacted] **KAISER PERMANENTE. [redacted], MD. Progress Note. (Final Premed-[redacted] – Page 1561-1564). Subjective**: The member presents with consultation, hoarseness on and off. She has throat discomfort, frequent throat clearing and globus sensation. **Diagnosis**: Acute laryngitis.

[redacted], [redacted]
[redacted]

[redacted] KAISER PERMANENTE. [redacted], DO. Telephone Encounter. (Final Premed- [redacted] – Page 1591-1591). Comments: The examiner states The member's sodium level was slightly out of range.

[redacted] KAISER PERMANENTE. [redacted], MD. Doctor's First Report of Occupational Injury or Illness. (Final Premed- [redacted] – Page 2457-2468, 2539-2549). DOI: [redacted] Mechanism of Injury: The member was tossing her computer bag and rolling backpack into the trunk of her car and felt a right upper back and shoulder pull that worsened over the next 2 hours. Diagnoses: 1) Right shoulder muscle, strain, initial. 2) Thoracic spine strain, initial. 3) Muscle spasm of the thoracic back.

[redacted] KAISER PERMANENTE. [redacted] MD. Office Visit. (Final Premed- [redacted] – Page 1595-1597). Subjective: The member complains of right shoulder pain and neck pain. Diagnosis: 1) Right shoulder joint pain.

[redacted] KAISER PERMANENTE. [redacted], MD. X-rays of the Right Shoulder. (Final Premed- [redacted] – Page 1597-1600). Clinical History: Right shoulder pain. Comparison: None. Impression: No acute fracture is identified. The alignment is normal. Mild degenerative changes are noted involving the right AC joint. No significant soft tissue abnormality is identified.

[redacted] KAISER PERMANENTE. [redacted] MD. ED Provider Note. (Final Premed- [redacted] – Page 1934-1939, 2469-2474). Subjective: The member presents with right upper back pain that radiates to the right shoulder. ED Course: The member was given Ativan. Diagnosis: Back pain (primary encounter diagnosis).

[redacted], KAISER PERMANENTE. [redacted] MD. Progress Note. (Final Premed- [redacted] – Page 1613-1614, 2498-2503, 2505-2511). DOI: [redacted] Subjective: The member presents with right shoulder and scapular area pain. Diagnosis: Right shoulder joint pain.

[redacted] KAISER PERMANENTE. [redacted] MD. Telephone Appointment Visit. (Final Premed- [redacted] - Page 1628-1630). Subjective: The member requested modified duty work, not an extension for right shoulder pain. Diagnosis: Right shoulder joint pain.

[redacted] KAISER PERMANENTE. [redacted], MD. Doctor's First Report of Occupational Injury or Illness. (Final Premed- [redacted] - Page 1639-1646, 2515-2526). DOI: [redacted] Subjective: The member is a [redacted] and with working virtually and from office, she was tossing her computer bag and rolling backpack into the trunk of her car and felt a right upper back and shoulder pull that worsened over the next 2 hours. The member presents with complaints of right neck, thoracic and shoulder girdle pain that she relates to an incident at work. Diagnoses: 1) Right shoulder muscle strain, initial encounter. 2) Thoracic spine sprain, initial encounter. 3) Muscle spasm of the thoracic back.

[redacted] ALL WELLNESS NOW. [redacted], LAc. Acupuncture Therapy Notes. (Final Premed- [redacted] - Page 2560-2560, 2562-2562, 2750-2750). Total Sessions: Multiple. Modalities: Electrical acupuncture and herb patch. Diagnoses: 1) Back pain. 2) Right shoulder pain.

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[redacted]

[redacted] **HEALTHSOURCE OF ANAHEIM. [redacted] DC. Chiropractic Therapy Notes. (Final Premed- [redacted] - Page 2565-2567, 2570-2572, 2576-2576, 2578-2578, 2589-2589, 2612-2613, 2624-2624, 2677-2677, 2680-2686, 2711-2711, 3030-3032). Total Sessions**: Multiple. **Modalities**: CMT, electrical stimulation, cryotherapy/ thermal therapy, EMS, heat, traction, cold laser therapy, massage therapy, therapeutic exercise. **Diagnoses**: 1) Strain of an unspecified muscle, fascia, or tendon at the shoulder and upper arm level on the right arm, with the encounter being the initial encounter. 2) Sprain of the ligaments of the thoracic spine during an initial encounter. 3) Muscle spasm of the back. 4) Segmental and somatic dysfunction of the cervical region. 5) Segmental and somatic dysfunction of the thoracic region.

[redacted] **MD. Letter Note. (Final Premed- [redacted] - Page 2574-2574).** This report belonged to a different patient named [redacted] This is reviewed but not summarized.

[redacted] **KAISER PERMANENTE. [redacted], MD. Primary Treating Physician's Progress Note (PR-2). (Final Premed- [redacted] - Page 1660-1664, 2579-2587, 2590-2597). DOI**: [redacted] **Subjective:** Since the last visit, The member has started acupuncture but has had increased symptoms with the treatment. She did have some improvement in symptoms with chiropractic therapy. **Diagnosis**: 1) Right shoulder muscle strain, subsequent encounter. 2) Thoracic spine sprain, subsequent encounter. 3) Muscle spasm of the thoracic back.

[redacted] **KAISER PERMANENTE. [redacted], PA. Progress Note. (Final Premed- [redacted] - Page 1675-1676, 2614-2616, 2645-2646). DOI**: [redacted] **Subjective:** The member has a history of chronic right shoulder pain. She is requesting Toradol. **Diagnosis**: Right shoulder muscle strain, subsequent encounter. **Procedure**: Administered Ketorolac Injection 60 mg (Toradol).

[redacted] **KAISER PERMANENTE. [redacted] MD. Primary Treating Physician's Progress Note (PR-2). (Final Premed- [redacted] - Page 1688-1693, 2628-2628, 2631-2637, 2664-2671). DOI**: [redacted] **Subjective**: Since the last visit, The member is getting transient relief with acupuncture and chiropractic, but only up to 24 hours, then symptoms recur. **Diagnoses**: 1) Cervical radiculopathy. 2) Muscle spasm of the thoracic back. 3) Right shoulder muscle strain, subsequent encounter.

[redacted] **KAISER PERMANENTE. [redacted], MD. X-rays of the Cervical Spine. (Final Premed- [redacted] - Page 1694-1696, 1960-1961). Clinical History**: Right shoulder girdle and neck pain. **Comparison:** None. **Impression**: Cervical vertebral bodies are normal in height. The alignment is normal. No fracture is identified. No significant degenerative changes noted. The heights of the disc spaces are well preserved. No significant soft tissue abnormality.

[redacted] **KAISER PERMANENTE. A [redacted], PA. Telephone Encounter Note. (Final Premed- [redacted] - Page 1711-1712). Diagnosis**: UTI.

[redacted] **KAISER PERMANENTE. [redacted], MD. Primary Treating Physician's Progress Note (PR-2). (Final Premed- [redacted] - Page 1722-1727, 2692-2701, 2705-2710). DOI**: [redacted] **Subjective**: The member complains of pain in the right upper back/trap and right shoulder/arm. **Diagnoses**: 1) Cervical radiculopathy. 2) Muscle spasm of the thoracic back.

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[redacted]

[redacted] **CORONA ADVANCED IMAGING. [redacted], MD. MRI of the Cervical Spine Without Contrast. (Final Premed-[redacted] - Page 2687-2688, 2690-2691).** **History:** Neck and bilateral shoulder and arm pain. **Comparison:** None available. **Impressions**: **C3-4**: There is a 1 to 2 mm in AP diameter broad-based posterior disc bulge. The pedicles are congenitally shortened with mild spinal stenosis with no neural foraminal narrowing. **C4-5**: There is a 1 to 2 mm in AP diameter broad-based posterior disc bulge. The pedicles are congenitally short. There is mild spinal stenosis with no neural foraminal narrowing. **C5-6**: There is mild disc desiccation. There is a 2 mm in AP diameter broad-based posterior disc bulge and a small focus of annular fissure. There is mild spinal stenosis. There is no neural foraminal narrowing.

[redacted] **KAISER PERMANENTE. [redacted], MD. Primary Treating Physician's Progress Note (PR-2). (Final Premed-[redacted] - Page 2765-2770, 3035-3049). DOI: [redacted] Subjective**: Since the last visit, The member has been getting some benefit from chiropractic treatment as well as acupuncture. **Diagnoses**: 1) Neck muscle strain, subsequent encounter. 2) Thoracic spine sprain, subsequent encounter. 3) Right shoulder muscle strain, subsequent encounter.

[redacted] **KAISER PERMANENTE. [redacted], PA. Progress Notes. (Final Premed-[redacted] - Page 2778-2780, 3051-3066). Subjective**: The member complains of right shoulder pain. She is requesting Toradol injection. **Diagnoses**: 1) Right shoulder joint pain. 2) Right shoulder muscle strain, initial. 3) Thoracic spine sprain, initial. 4) Muscle spasm of the thoracic back. 5) Medication refill. 6) **Anxiety disorder**. **Plan: Prescribed Atarax. Procedure:** Administered Toradol and Solu-Medrol PF injection.

[redacted] **KAISER PERMANENTE. [redacted] MD. Primary Treating Physician's Progress Report (PR-2). (Final Premed-[redacted] – Page 2797-2803, 3090-3110).** **Subjective**: The member reports that symptoms are triggered with data entry, but also has symptoms provoked with use of her arms at or above chest level when adjusting the computer monitor height at her desk at work to adjust between sitting and standing for comfort (her desk at home is a powered desk for adjustment). **Diagnoses**: 1) Neck muscle strain, subsequent. 2) Thoracic spine sprain, subsequent. 3) Chronic neck pain.

[redacted] **KAISER PERMANENTE. [redacted], MD. Progress Notes. (Final Premed-[redacted] – Page 2828-2832). Chief Complaint**: Physical examination. **Diagnosis**: Screening.

[redacted], **MD #KAISER PERMANENTE. Telephone Encounter. (Final Premed-[redacted] – Page 2907-2908). Comments: The member has been taking Zoloft since Friday night. She has stopped it. She has experienced increased anxiety, could not focus and her jaw is clenching and feeling Shaky.**

[redacted] **KAISER PERMANENTE. [redacted] MD. Telephone Encounter. (Final Premed-[redacted] – Page 2932-2933). Reason for VR**: VMC adult primary care queue. **Phone Visit Documentation**: The member complains of headache, lower back pain, and **stress**. She refused presumptive treatment. She requested an FTF visit. . **Assessment**: Referral of the member without exam or treatment.

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[redacted]

[redacted] **KAISER PERMANENTE. [redacted] DO. Internal Medicine Progress Notes. (Final Premed- [redacted] – Page 2936-2939). Subjective**: The member presents with a complaint of headache and a prescription refill is requested. **She reports stress at work and lightheadedness. She is willing to try a new medication for stress. Diagnoses**: 1) **Unspecified anxiety disorder.** 2) Muscle spasm of the thoracic back. 3) Reactive airway disease, unspecified. 4) Headache. 5) Chest wall pain. **Plan: Prescribed Duloxetine. Follow-up with behavioral health.**

[redacted] **KAISER PERMANENTE. [redacted] MD. Adult Primary Care Office Visit Progress Note. (Final Premed- [redacted] – Page 2952-2956). Subjective**: The member presents for immunization care and URI symptoms for 3 days. She complains of cold symptoms. **She reports increased stress. Diagnosis**: Influenza.

[redacted] **KAISER PERMANENTE. [redacted], DO. Telephone Appointment Visit. (Final Premed- [redacted] – Page 2982-2983). Subjective**: The member complains of cough and back pain. **She is afraid to start Cymbalta due to bad reactions with Zoloft and Xanax. Diagnoses**: 1) Cough, unspecified. 2) Reactive airway disease, unspecified. 3) Back pain. 4) Mixed hyperlipidemia. 5) **Unspecified anxiety disorder**.

[redacted] **KAISER PERMANENTE. [redacted], MD. ED Provider Note. (Final Premed- [redacted] – Page 2991-2998). Subjective**: The member with a history of anxiety presents to the ED for evaluation of chest pain. **She describes a lot of stress related to her job recently**. Her chest pain improved when she told her boss that she would be taking the day off to go to the ER. Her chest pain is improving in severity. **Diagnosis**: Chest pain.

[redacted] **KAISER PERMANENTE. [redacted] MD. X-rays of the Chest. (Final Premed- [redacted] – Page 3019-3019). Clinical History:** Chest pain, cough portable. **Comparison:** [redacted]. **Impression**: The lungs are clear. No pleural effusions are seen. The cardiomediastinal silhouette is normal.

[redacted] **MD. EMG/NCV Study of the Upper Extremity. (Final Premed- [redacted] – Page 3260-3262). Impression**: The above electrodiagnostic study reveals evidence of a mild right carpal tunnel syndrome (median nerve entrapment at wrist) affecting sensory components. The above electrodiagnostic study reveals no evidence of cervical radiculopathy. Delayed conduction across the right elbow may reflect an ulnar nerve entrapment. Note that conventional EMG and nerve conduction studies cannot test small sensory fibers which, when relatively irritated, may underlie pain and paresthesias arising from within "named" peripheral nerves, soft tissues and bony structures, and sensory roots. Clinical correlation is recommended.

[redacted] **BEVERLY TOWER WILSHIRE. [redacted] MD. X-rays of the Right Shoulder. (Final Premed- [redacted] – Page 3244-3244, 3254-3254). History:** Pain. **Comparison:** None. **Impression**: Unremarkable examination.

[redacted] **BEVERLY TOWER WILSHIRE. [redacted] MD. X-rays of the Right Wrist. (Final Premed- [redacted] – Page 3240-3240, 3242-3242). History:** Pain. **Comparison:** None. **Impression**: Unremarkable wrist series.

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[redacted]

[redacted] **BEVERLY TOWER WILSHIRE. [redacted], MD. X-rays of the Right Elbow. (Final Premed- [redacted] – Page 3241-3241, 3255-3256). History:** Epicondylitis. **Comparison:** None. **Impression**: Unremarkable examination.

[redacted] **BEVERLY TOWER WILSHIRE. [redacted] MD. X-rays of the Cervical Spine. (Final Premed- [redacted] – Page 3243-3243, 3246-3246, 3258-3259). History:** Cervical Degenerative disc disease. **Comparison:** None. **Impression**: Rudimentary left cervical rib.

[redacted], **MD. Agreed Medical Examiner's Report, (Final Premed- [redacted] – Page 3290-3311). DOI**: CT [redacted] **History of Injury**: The member has been employed as a [redacted] with the [redacted] for [redacted]. She was injured on a continual trauma basis. She noted pain in her right arm, shoulder, neck and back about one year after working from home. She reports that one day, she lifted the laptop bag from the trunk of her car, she noted an increase in pain in her right shoulder, neck and back and the pain persisted for days and she notified her employer. It appears this injury date was on [redacted] **She stated she filed a stress claim on [redacted]. She is currently receiving psychiatric treatment on an industrial basis due to stress, depression and anxiety. She is receiving biofeedback treatment at Kaiser Occupational on an industrial basis. Present Complaints**: The member complains of pain in the right hand and digits, right wrist, right forearm, right shoulder and neck. **She has anxiety, depression and stress and is currently taking Zanaflex. Diagnoses**: 1) Carpal tunnel syndrome, mild, right, but no indication of any type of neuropathy on the left. 2) History of rotator cuff tendinosis, quiescent, right. 3) History of myofascial neck pain, quiescent at present. **Work Restrictions**: No very repetitive, forceful gripping, grasping, or pinching with her dominant right hand/wrist area, which is a 16% loss. Workstation to be modified to the appropriate levels, both at work and home, as well as in the office. **Disability State**: There does not appear to be any temporary total disability that would have been indicated for the CT period. She is permanent and stationary. **Causation**: Not indicated. **Apportionment**: Deferred at this time pending review of medical records. **Impairment Rating**: The member has 4% right upper extremity impairment rating and 0% WPI to the left upper extremity. Her neck has given 4% WPI.

[redacted] **MD. Supplemental Agreed Medical Examiner's Report. (Final Premed- [redacted] – Page 3317-3348). DOI**: CT [redacted] **Discussion:** Previously made opinions remained the same.

[redacted], **MD. Primary Treating Physician's Progress Report (PR-2). (Final Premed- [redacted] – Page 3614-3617). DOI**: [redacted] **Subjective**: The member complains of pain in the neck, right upper extremity and other body parts. **Diagnoses**: 1) Cervicalgia. 2) Pain in the right arm.

[redacted] **MD. Primary Treating Physician's Progress Report (PR-2). (Final Premed- [redacted] - Page 3653-3657). DOI**: [redacted] **Chief Complaint**: The member reports no changes since the last visit. She is experiencing achiness and shooting pain in digits 2-4. She is also having a major headache. **Diagnoses**: 1) Cervicalgia. 2) Pain in the right arm.

[redacted] **HEALTHPOINTE MED GROUP GARDEN GROVE. [redacted] MD. X-rays of the Cervical Spine. (Final Premed- [redacted] - Page 3658-3658). Impression**: X-ray of the cervical spine shows no definitive bony abnormality.

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[redacted]

[redacted] **MD. Orthopedic AOE/COE Re-Evaluation and Report. (Final Premed-[redacted] - Page 3133-3170). DOE: [redacted] DOI: [redacted]; CT [redacted] - [redacted] Subjective:** The member complains of pain in the lumbar spine. **Diagnoses**: 1) Low back pain with radiculopathy. 2) L3-L4 and L4-L5 discogenic disease, facet arthropathy with mild to moderate bilateral foraminal narrowing. 3) L4-5 disc herniation. **Work Status**: The member is given permanent restrictions of no pushing, pulling, lifting more than 15 pounds, no working greater than 5 hours, with no repetitive lifting and bending. **Disability Status**: At this time, she has reached MMI with regard to her lumbar spine and is at permanent stationary status. **Causation**: Industrial. **Apportionment**: It is the examiner's opinion that 80% of the degenerative changes noted on her lumbar spine MRI are related to the industrial accidents on [redacted] and cumulative trauma from [redacted] and 20% are related to nonindustrial causes with reasonable medical probability. **AMA Rating**: Lumbar: 13% WPI. As her pain level is above what is indicated in the DRE lumbar III category, 3% pain-related impairment is also appropriate in her case. **Vocational Rehab**: The member is considered a qualified injured worker if the employer cannot accommodate her restrictions.

[redacted] **MD. Primary Treating Physician's Progress Report (PR-2). (Final Premed-[redacted] - Page 3738-3742). DOI: [redacted] Subjective:** The member complains of constant pain in the neck, trapezius, right shoulder, and right wrist. She reports pain in all body parts. She reports that she is still struggling at work. She needs more specific work restrictions. **Diagnoses:** 1) Cervical spine pain, strain. 2) Right shoulder pain. 3) Cervicalgia. 4) Pain in the right arm.

[redacted] **MD. Primary Treating Physician's Progress Report (PR-2). (Final Premed-[redacted] - Page 3743-3747). DOI: [redacted] Subjective:** The member would like to increase in a lot of hours at work. Currently, she is feeling tightness and pain in her neck, going down to her right upper extremity. **Diagnoses**: 1) Cervicalgia. 2) Pain in the right arm.

[redacted] **DO. Primary Treating Physician's Progress Report (PR-2). (Final Premed-[redacted] - Page 3753-3758). DOI: [redacted] Subjective**: The member continues with pain throughout the day with no changes after being seen by the doctor. **Diagnoses**: 1) Radial styloid tenosynovitis. 2) Lateral epicondylitis, right elbow. 3) Other cervical disc degeneration.

[redacted] **HEALTHPOINTE, [redacted], DC. Chiropractic Therapy Notes. (Final Premed-[redacted] - Page 3775-3780, 3814-3815, 3806-3807, 3833-3836, 3854-3856, 3867-3868, 3882-3887, 3917-3918). Total Sessions**: 11. **Modalities**: CMT, EMS, IR, soft tissue mob, therapeutic exercise, kinetic activity, NMR, traction . **Diagnoses**: 1) Pain in the right arm. 2) Other cervical disc degeneration. 3) Cervicalgia.

[redacted] **, DO. Primary Treating Physician's Progress Report (PR-2). (Final Premed-[redacted] - Page 3781-3786). DOI: [redacted] Subjective**: The member reports her neck and wrist pain continues to remain the same. **Diagnoses**: 1) Radial styloid tenosynovitis. 2) Lateral epicondylitis, right elbow. 3) Other cervical disc degeneration.

[redacted] **MD. Primary Treating Physician's Progress Report (PR-2). (Final Premed-[redacted] - Page 3808-3809).** This report belongs to a different patient named [redacted]. This was reviewed but not summarized.

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[redacted]

[redacted] **DO. Primary Treating Physician's Progress Report (PR-2). (Final Premed-** [redacted] **- Page 3818-3824). DOI:** [redacted] **Subjective**: The member reports her pain around the neck has been slight discomfort due to working using her neck the most. Her right shoulder is still tender but has improved slightly. **Diagnoses**: 1) Radiculopathy, Cervical region. 2) Radial styloid tenosynovitis. 3) Lateral epicondylitis, right elbow. 4) Other cervical disc degeneration.

[redacted], **DO. Primary Treating Physician's Progress Report (PR-2). (Final Premed-** [redacted] **- Page 3837-3851). DOI:** [redacted] **Subjective**: The member reports trouble receiving medications due to not receiving a pharmacy card. She complains of pain in the cervical spine and radiates around the shoulders down to the right arm and spine. **Diagnoses**: 1) Radiculopathy, cervical region. 2) Radial styloid tenosynovitis. 3) Lateral epicondylitis, right elbow. 4) Other cervical disc degeneration.

[redacted] **DO. Primary Treating Physician's Progress Report (PR-2). (Final Premed-** [redacted] **- Page 3857-3864, 3877-3878). DOI:** [redacted] **Subjective**: The member noticed more flare-ups at work and tightness around the shoulders and arms. **Diagnoses**: 1) Radiculopathy, cervical region. 2) Radial styloid tenosynovitis. 3) Lateral epicondylitis, right elbow. 4) Other cervical disc degeneration.

[redacted] **DO. Primary Treating Physician's Progress Report (PR-2). (Final Premed-** [redacted] **- Page 3869-3876). DOI:** [redacted] **Subjective**: The member reports that the right wrist has continued to improve slowly since the previous visit. **She is taking Zanaflex and able to receive the Lyrica, but had higher levels of anxiety from the medication**, unsure if it was from the medication. **Diagnoses**: 1) Radiculopathy, cervical region. 2) Radial styloid tenosynovitis. 3) Lateral epicondylitis, right elbow. 4) Other cervical disc degeneration.

[redacted] **DO. Primary Treating Physician's Progress Report (PR-2). (Final Premed-** [redacted] **- Page 3897-3916). DOI:** [redacted] **Subjective**: The member reports that headaches have gotten worse. She is experiencing pain that comes and goes, R>L. The right wrist remains the same. The member reports that her worst pain is in the neck and the right wrist and forearm with neuropathic pain. **Diagnoses**: 1) Radiculopathy, cervical region. 2) Radial styloid tenosynovitis. 3) Lateral epicondylitis, right elbow. 4) Other cervical disc degeneration.

[redacted], **DC. Doctor's First Report of Occupational Injury or Illness. (Final Premed-** [redacted] **- Page 3940-3942).** (Handwritten report, partially illegible). **DOI:** [redacted] **Subjective**: The member complains of daily neck and shoulder pain. She also reports pain in her right arm and hand/fingers. **Diagnoses**: 1) Radiculopathy cervical spine. 2) Other cervical disc degeneration, unspecified, cervical region. 3) Radial styloid tenosynovitis.

[redacted] **Unknown Provider. Therapy Note. (Final Premed-** [redacted] **- Page 3943-3945). Total Sessions**: 1. **Body Parts:** 1) Neck. 2) Right shoulder/arm. **Modalities:** Massage.

[redacted] **DO. Primary Treating Physician's Progress Report (PR-2). (Final Premed-** [redacted] **- Page 3948-3956). DOI:** [redacted] **Subjective**: The member continues to report that her worst pain is in the neck and the right wrist and the forearm with neuropathic pain.

[redacted], [redacted]
[redacted]

Diagnoses: 1) Radiculopathy, cervical region. 2) Radial styloid tenosynovitis. 3) Lateral epicondylitis, right elbow. 4) Other cervical disc degeneration.

[redacted] **MD,. Supplemental Agreed Medical Examiner's Report. (Final Premed-** [redacted] **- Page 3962-3976). DOI:** Continual trauma. **Discussion**: The member had diffuse complaints with some inconsistencies between her complaints and her objective findings when seen in the examiner's office on [redacted]. If The member's function has deteriorated, the examiner feels conservative treatment would be appropriate. If The member continues to be symptomatic, a follow-up visit and a reassessment of the situation would be prudent, at which time the situation could be reevaluated. In the interim, the examiner does hope her workstation ergonomics have been modified since that is the usual cause of cervicalgia, myofascial neck pain, and tendinitis conditions in the workplace.

[redacted] **DO. Primary Treating Physician's Progress Report (PR-2). (Final Premed-** [redacted] **- Page 3988-4005). DOI:** [redacted] **Subjective**: The member reports that pain has improved overall. She still experiences pain radiating from the neck, right shoulder, and wrist. Headaches have improved as well. **Diagnoses**: 1) Radiculopathy, cervical region. 2) Radial styloid tenosynovitis. 3) Lateral epicondylitis, right elbow. 4) Other cervical disc degeneration.

[redacted] **MD. Primary Treating Physician's Progress Report (PR-2). (Final Premed-** [redacted] **- Page 4009-4013). DOI**: [redacted] **Subjective**: The member reports no changes since last visit. She is asking to fill out paperwork. **Diagnoses**: 1) Cervicalgia. 2) Pain in the right arm.

[redacted] **MD. EMG/NCV Study of the Upper Extremity. (Final Premed-** [redacted] **- Page 4015-4017). Impression**: The above electrodiagnostic study reveals evidence of a mild right carpal tunnel syndrome (median nerve entrapment at wrist) affecting sensory components. The above electrodiagnostic study reveals no evidence of cervical radiculopathy. Clinical correlation is recommended.

[redacted] **MD. Physician's Return-to-Work & Voucher Report. (Final Premed-** [redacted] **- Page 4072-4072). Job Title**: [redacted]. **Comment**: The member can work with the following restrictions: keyboarding, bilateral hands grasping, bilateral pushing/pulling up to 4-6 hrs, may not lift/carry at a height of 4 feet more than 10 lbs for more than 5 hours per day. No job analysis available to review.

[redacted] **DO. Primary Treating Physician's Progress Report (PR-2). (Final Premed-** [redacted] **- Page 4018-4027). DOI:** [redacted] **Subjective**: The member has completed massage therapy with benefit. Pain has improved overall, but still experiences radiating from the neck, right shoulder, and wrist. Headaches have improved as well. **Diagnoses**: 1) Radiculopathy, cervical region. 2) Radial styloid tenosynovitis. 3) Lateral epicondylitis, right elbow. 4) Other cervical disc degeneration.

[redacted] **OCERS.** [redacted] **DO. Physician's Statement of Disability. (Final Premed-** [redacted] **– Page 1-3).** (Handwritten report, partially illegible). **DOI**: [redacted] **Subjective Symptoms**: Massage therapy [redacted] done with benefit. Helped with pain and ROM. Still experiences pain radiating from the neck, right shoulder, and wrist. **Diagnoses:** 1) Cervical radiculopathy. 2)

[redacted], [redacted]
[redacted]

Radial styloid tenosynovitis [de Quervain). 3) Lateral epicondylitis, right elbow. 4) Other cervical disc degeneration, unspecified cervical region. **Limitations**: Some Limitations-push/pull/twist, grasping/handling, repetitive movement of hands/fingers/feet. operate electric equipment. Carrying/Lifting Ability: Never: 0-15 lbs. **Work Restrictions**: No keyboarding or use of the mouse for more than 10 minutes of each hour and no lifting, pushing, pulling, turning, or twisting greater than 15 lbs.

[redacted] **MD, FACS. Agreed Medical Examiner's Report. (Final Premed-** [redacted] **- Page 4030-4068, 4070-4070). DOI**: Continual trauma. **DOE**: [redacted]. **Subjective**: The member complains of pain in both hands and digits, both wrists, right forearm and elbow, both shoulders and neck. She continues to be treated with Dr. [redacted] and **she also sees a psychiatrist and psychologist**. She states she has not worked since [redacted] and she continues to have problems related to both upper extremities. **Diagnoses**: 1) Carpal tunnel syndrome, minimal. 2) Myofascial neck pain, quiescent with no indication of such at the present time. 3) History of shoulder strain, resolved, right. 4) No indication in this case of a brachial plexopathy, thoracic outlet or any type of a peripheral nerve entrapment problem at any level other than perhaps a minimal carpal tunnel syndrome on the right. **Discussion**: **The member appears to be incapable, based upon primarily on psychological reasons, and the examiner would defer to the QME or AME in psychology** to return to work for the [redacted] unless her job could be modified. **Disability Status**: The examiner would consider her to be temporarily partially disabled. **Permanent and Stationary Status**: The member is permanent and stationary. **Work Restrictions**: The examiner gave her restrictions on a prophylactic basis, since the examiner did feel she could work, but perhaps slightly more stringent restrictions would be indicated such as no very repetitive work at or above shoulder level, no very heavy lifting and carrying, no very repetitive pushing and pulling, but no repetitive, forceful gripping, grasping, pinching, holding, twisting, torquing or flexion-extension. **Causation**: The causation of the disability in this case is due to continual trauma, but **there is a considerable psychological overlay, and that needs to be quantified by a different evaluator**. **Apportionment**: Apportionment is not applicable for the 7% whole person impairment. **Impairment Rating**: Overall whole person impairment of her upper extremity is 7%.

[redacted] **OCERS. Employee's Statement of Disability. (Final Premed-** [redacted] **- Page 20-23). Job Title**: [redacted] **Statement of Disability**: Limited use of upper extremities; unable to prolong sitting or standing; **acute anxiety and depression**. Right carpal tunnel syndrome – severe pain in upper extremities but primarily on the right with repetitive typing, writing, computer mouse, holding items; and overall weakness in hands and numbness. Severe headaches, sharp/stabbing pain on both sides of neck and upper/mid back; back aches and spasms; and legs go numb when sitting more than 20 minutes. Fibromyalgia and Myofascial pain syndrome – experience painful/tenderness areas in arms/legs/buttocks/calves and tops of feet, fatigue, and headaches with flare ups. Experience closing of throat when stressed. I've seen an ENT through Kaiser Permanente in Corona and had an endoscopy and it was determined to be stress related. **Acute anxiety/panic attacks and Depression**. Costochondritis – experience severe chest pains, tightening and painful tenderness in rib cage and in the clavicle areas on both sides. Sciatica pain – sharp shooting pain in buttocks and numbness down legs with prolonged sitting; burning and pain along the thighs. **Permanent Restrictions**: No pushing, pulling, lifting more than 15 lbs, no working greater than 5 hours with no repetitive lifting and bending. Approximately [redacted]. Repetitive typing, data entry, computer mouse use, writing, conducting home visits, conducting research and creating processing guides, documenting by taking hand written notes especially during home visits that can last anywhere from

[redacted]

20 min and up to an hour; lifting and carrying laptop bag and equipment including ergo equipment, office supplies, client case information and resources, having to hold a clip board when assessing clients during a home visit and conducting a walk-through of the home and documenting statements and observations to ensure their safety.

[redacted] **OCERS. SupervisorStatement. (Final Premed-** [redacted] **- Page 32-32). Job Title**: [redacted] **Job Duties**: Desk job-using laptop to research and review documents, completing forms, attending meetings, creating, and revising policy and processing guides. On Field-conducting home visits. **Work Restrictions**: No keyboarding, using the mouse for more than 10 minutes per hour. No lifting, pushing, pulling, turning, or twisting greater than 15 lbs. **Comments**: Per the application statement,The member did not feel that the equipment and the software provided as an accommodation aided her in performing the essential functions of her job duties. She was on intermittent leave periodically and participated in the transitional work assignment program as a [redacted] for approximately 6 months. She took intermittent leave due to flare-ups. She was not assigned to any outside job or extracurricular activities.

[redacted] **OCERS. Employer's Statement of Disability. (Final Premed-** [redacted] **- Page 4-19). JobTitle**: [redacted] (7020SM). **Example of Duties**: **First level SupervisorAssignment**: 1) Plans, organizes, assigns, and reviews the workload over either a unit of [redacted] and other supporting staff providing basic [redacted] services or a unit of [redacted] providing childcare/counselling services at [redacted] 2) Evaluates the performance of subordinates and recommends disciplinary action when appropriate. 3) Reviews and confers with staff on case plans, case records, and other documents necessary to determine or deliver client services. 4) Maintains up-to-date knowledge of Federal and State laws, regulations, policies, and procedures which govern program operations and explains to subordinate staff. **Second level** [redacted] **ignment**: 1) [redacted], through subordinate [redacted], several units of e[redacted] in determining [redacted] benefits; reviews and analyzes the work of assigned units to ensure quality of performance and compliance with standards; guide difficult case situations and suggest appropriate actions. 2)ssists subordinate [redacted] in counselling employees and handling disciplinary problems. 3)dvises subordinate regarding program interpretation and application of regulations/directives; explains Federal, State and County policies and procedures to staff. 4)ssists in the development of county policies, procedures, and standards. **Administrati Assignments**: 1) Prepares and presents the [redacted] case at state hearings; provides testimony and answers questions of counsel, complainant, and State Hearing Officer; examines witnesses; summarizes the [redacted] position, as appropriate; stipulates to binding agreements during the hearing process on behalf of the [redacted] cts as [redacted] ng [redacted] at [redacted] hearings for such programs as [redacted] Completes investigations involving discrimination complaints. 2) Develops, coordinates, and conducts training for agency staff on Federal, State, and County policies, procedures, relations, laws, and various supervisory topics. [redacted] staff during intensive in-service training. 3) Plans, evaluates and makes recommendations to management regarding automated system changes or enhancements that will assist users in meeting agency program goals. 4) Represents agency users andTechnology Services in local and [redacted]. 5) Coordinates proposed automation activities with impacted user groups and technical support staff and uses their recommendations in the preparation and implementation of testing plans and in the development of appropriate policies. 6) Researches and interprets new and changed Federal, State, and County laws; answers program questions as assigned. 7)cts as liaison with community members, community

organizations, state policy staff, and other agencies from within and outside the [redacted] 8) Assists in the development of program policies and procedures. Assists in the coordination of special projects and audits. **Comment**: The agency cannot accommodate the permanent medical restrictions of no pushing, pulling, lifting more than 15 pounds, no working greater than 5 hours, with no repetitive and bending.

Undated. KAISER PERMANENTE. Prenatal Record-Part 1 Report. (Final Premed- [redacted] - Page 33-34). (Handwritten report, partially illegible)

Undated. Unknown Provider. Primary Treating Physician's Progress Report (PR-2). (Final Premed- [redacted] - Page 4098-4098). (Incomplete Report). **DOI**: [redacted] **Subjective**: The member is seen for unresolved neck, mid back with the pain mainly focused on the right-hand side of her body. **Diagnoses**: 1) Strain of unspecified muscle, fascia and tendon at the shoulder and upper arm level, right arm, initial encounter. 2) Sprain of the ligaments of the thoracic spine, initial encounter. 3) Muscle spasm of the back. 4) Segmental and somatic dysfunction of the cervical region. 5) Segmental and somatic dysfunction of the thoracic region.

Undated. PACIFIC MEDICAL CLINIC. Injury Care Report. (Final Premed- [redacted] - Page 4099-4099). (Handwritten report, partially illegible). **DOI**: [redacted] **Diagnoses**: 1) Cervical strain. 2) Lumbar spine strain. 3) Headaches. **Work Status**: The member returns to modified work, with a restriction to limit the use of the computer to 1 hour. No pulling, pushing and lifting over 20 lbs.

Undated. PACIFIC MEDICAL CLINIC. Injury Care Report. (Final Premed- [redacted] - Page 4100-4100). (Handwritten report, partially illegible). **Diagnoses**: 1) Left shoulder strain. 2) Lumbar spine strain. **Work Status**: The member returns to regular work, with a restriction to limit the use of the computer to 1 hour. No lifting over 20 lbs. No pushing or pulling.

Undated. PACIFIC MEDICAL CLINIC. Injury Care Report. (Final Premed- [redacted] - Page 4101-4101). (Handwritten report, partially illegible). **DOI**: [redacted] **Diagnoses:** 1) Left shoulder strain. 2) Right hand wrist strain. **Work Status:** The member returns to modified work, with a restriction limiting the use of the keyboard to 4 hours/day. No lifting over 25 lbs.

Undated. PACIFIC MEDICAL CLINIC. Injury Care Report. (Final Premed- [redacted] - Page 4102-4102). (Handwritten report, partially illegible). **DOI**: [redacted] **Diagnoses**: 1) Cervical strain. 2) Thoracic strain. 3) Lumbar spine strain. **Work Status**: The member returns to modified work, with a restriction limiting the use of the keyboard to 4 hours/day. No lifting over 25 lbs.

MISCELLANEOUS RECORDS:

List of doctors; perinatal record section; laboratory reports; multidisciplinary plan of care; doctor's orders; newborn admission and discharge record; pre-anesthetic assessment; intraoperative record; multidisciplinary patient education plan; postpartum patient care flow record; flow sheets; labor & delivery patient care record; graphic trending record; intake and output flow record; pain management 24 hour record; peri-operative flow record; perinatal discipline-specific initial assessment; multidisciplinary post-partum discharge instructions; admission and discharge record; hospital conditions of admission; consent to operation, admission of anesthetics and rendering of other medical

services; care plans; informed consent; anesthesia intraoperative & procedure record; declaration of custodian of medical records; confidential patient information; contracted facilities patient referral form; utilization review recommendations certified; affidavit of custodian of records; request for authorization fax cover sheet; employees disability questionnaire; itemized statement; physician declaration of record review; QME appointment notification form; consent for release of confidential information to primary care physician; notice of privacy practices; mental health disclosure; consumer notice of rights and respect; appeals and grievances; authorization for release of protected health information for mental health/chemical dependency; communication consent form; financial policy; right of access form for family/friend; telehealth general; controlled substance utilization review & evaluation system; additional doctor's list; comprehensive patient information questionnaire; patient registration and health history are reviewed but not summarized.

Thank you for the opportunity to evaluate the disability claim of [redacted] [redacted]. Please let me know if you have any questions.

Alexander Sones, MD

Alexander Sones, M.D.	**Date**
	1/4/2026

Alexander C. Sones, M.D.
Qualified Medical Examiner
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2223 E Wellington Ave #100
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DISABILITY INDEPENDENT MEDICAL EVALUATION

Member Name: [redacted] (DOB: [redacted])
Soc. Sec. No.: xxx-xx-[redacted]
Employer: [redacted]
Occupation: [redacted]
Evaluation Date: [redacted]

IDENTIFICATION:
The member is a [redacted]-year-old female employed by the [redacted] as a [redacted]. The member last worked on [redacted]. Per Employee's Statement of Disability dated [redacted], the member claimed inability to perform duties of her position due to chronic stress of being a [redacted] for over [redacted]. She suffered a series of progressively worsening illnesses/injuries, particularly following investigations of [redacted], which resulted in compression of the spine and leaving her with spinal stenosis, spondylolisthesis, retrolisthesis, anterolisthesis, decreased mobility and chronic pain.

The applicant was evaluated through HIPAA-compliant videoconference. The applicant consented to be examined through videoconference. A physical examination was not necessary to perform this evaluation.

At the start of the examination the applicant was informed that the evaluation was in connection with her [redacted] disability claim and that no treatment relationship existed. It was explained to her that she had the right to terminate the examination at any time no matter what the reason. The applicant was also made aware that any communication would not be confidential. She was notified that any information provided, as well as the results of psychological testing and my conclusions regarding the evaluation, would be included in the report and that this report would be read by others involved in her claim. She was informed that she was permitted to ask questions at any time during the evaluation. The applicant indicated that she understood the aforementioned and agreed to proceed with the evaluation. If the applicant wishes to review this report, I would prefer that she review it under the supervision of a physician or mental health professional since this report could be easily misinterpreted.

The applicant resides in an apartment in [redacted] She has been residing at this location for the past one month prior to my evaluation. She moved to save costs during her retirement.

[redacted], [redacted] [redacted]

ABSTRACT:

1. **Is the member currently incapacitated? Yes**
2. **Is the member continuously incapacitated? Yes**
3. **If so, date continuous incapacity commenced?** [redacted]
4. **Is the member permanently incapacitated? Yes**
5. **If so, which claimed injury (injuries) do you find as permanently incapacitating? Major Depressive Disorder and Posttraumatic Stress Disorder**
6. **If so, is the incapacity service connected? Yes**
7. **Can the member return to work with treatment? No**

RECOMMENDATION:

Based on my review of the records/documents and my examination of [redacted] [redacted], I recommend that a service-connected disability retirement be granted based on the applicant's psychiatric injuries of Major Depressive Disorder and Posttraumatic Stress Disorder.

HISTORY OF INDUSTRIAL INJURY:

The applicant began working for the [redacted] in [redacted]. She worked full-time from 40 to 70 hours per week with an average of 60 hours per week. When she started working at the [redacted], she earned approximately $50,000 per year. When she last worked, she earned approximately $100,000 per year. She has had no concurrent employment or schooling while working for the [redacted].

The applicant was stopped working due to injury on [redacted]. She formally retired on [redacted].

The applicant was hired by the [redacted] as a [redacted]. Her initial assignment was in the [redacted] division. Her duties included investigating allegations of [redacted], coordinating with [redacted] and the [redacted] Department, interviewing children, reviewing child pornography media, investigating domestic violence allegations, preparing reports, testifying in court, filing protective custody warrants, and placing children into protective custody. She worked in the [redacted] division from [redacted].

In [redacted], she was transferred to the [redacted] Hotline. Her duties in that role included receiving allegations of suspected child abuse, preparing reports, and submitting reports for investigation. Throughout her employment, the applicant did not receive formal reprimands, suspensions, or disciplinary actions.

During the initial phase of her employment, the applicant "loved" her job. She did not initially experience any work-related difficulties that adversely affected her psychological condition. From a psychological standpoint, she felt "good." She was neither depressed nor anxious. She remained calm, relaxed, and content most of the time. She got along well with coworkers and supervisors.

The applicant reports that her psychological condition began to change around [redacted] although she did not recognize this at the time. She reports that her first assigned case involved a child fatality. She was

required to view and document a deceased [redacted]-month-old infant while she was newly hired and on probation. In [redacted], she was assigned to interview the mother of a [redacted] child who had attempted suicide by hanging himself on a backyard swing. The child was in a coma and remained in a coma for approximately one year. The mother expressed significant hope that the child would survive. The applicant also recalls a case involving a [redacted] child who was decapitated in a motor vehicle accident caused by an intoxicated father. She interviewed the child's siblings, who were also involved in the accident. She reports a vivid sensory memory of the smell of a surviving child's mouth, which was filled with blood and medical equipment.

The applicant reports that work became "all-consuming." She states that she would go home and sleep throughout the weekend. She reports having no social life or friendships during this period. A coworker encouraged her to seek medical care, where she was diagnosed with adrenal insufficiency attributed to chronic fatigue.

The applicant reports that she did not initially recognize the extent to which her work was affecting her health. Following each hospitalization, she reports telling herself that she would recover within a few weeks and then return to work functioning better. She continued to persevere and remain at work despite progressively worsening pain and stress. In approximately [redacted], the applicant reports she first met with a psychiatrist. She is unaware of the specific psychiatric condition that she was diagnosed with, but reports she went due to anxiety and increased alcohol use.

In [redacted], after completing several particularly difficult cases, the applicant reports that she became unable to function at work. She reported debilitating pain and significant emotional dysregulation. She described anger, poor concentration, irritability, frequent crying spells, and sleep disturbance. She sought treatment from a therapist and multiple medical providers. She took approximately two weeks off work using sick leave.

During this period, she reports that her supervisor contacted her daily by phone and text, requesting that she return to work and accusing her of lacking pre-approval for her absence. She obtained medical documentation recommending work accommodations, including ten-day response time for assignments, removal from immediate response duties, and assignment to a daytime shift. In response, she was transferred to the [redacted] Hotline. She reports that she did not want this transfer because she valued fieldwork and directly helping children, despite the significant stress associated with those duties.

Also in [redacted], the applicant began meeting with a psychotherapist. She saw this therapist twice weekly for approximately two years prior to transferring to a psychotherapist assigned through her Workers' Compensation case. She was diagnosed with Posttraumatic Stress Disorder, Major Depressive Disorder, and Anxiety.

Since [redacted] the applicant has met with a therapist once weekly and a psychiatrist approximately every six weeks. She has trialed multiple psychotropic medications, including Wellbutrin, amitriptyline, Trintellix, Buspar, Latuda, Haldol, Cymbalta, Lexapro, Zoloft, and Prozac. She discontinued these medications due to side effects, including worsening depressive symptoms. She reports that she is unwilling to take additional antidepressants.

She participated in a residential treatment program, [redacted] for approximately two weeks in [redacted]. She used sick leave during this period and did not work. She reports that the

program primarily focused on substance use treatment and she felt as if it was not a good fit for her needs. She reports that shortly after her arrival, a significant portion of the staff left the program, and during the second week her assigned therapist became ill. She elected to leave the program, believing she could receive more effective treatment at home while working.

After transferring to the hotline position, she reports that her physical pain continued to worsen. She describes spending her workdays listening to repeated reports of abuse. She reports worsening symptoms, which she states she minimized at the time because she wanted to continue working and maintain income. She reports persistently low mood, minimal social interaction, frequent uncontrollable crying, emotional detachment, and anger. She reports difficulty falling asleep due to ruminative thoughts. She reports nightly awakenings with panic and sweating, without recall of specific dreams. She reports becoming emotionally dysregulated in response to minor stressors. She reports frequent flashbacks and involuntary re-experiencing of traumatic events.
She reported testifying in court on a case approximately one week prior to relocating. The case involved parents who attempted to raise a [redacted] infant on a vegan diet, resulting in starvation. She reports that this case reminded her of the [redacted] child who attempted hanging, particularly due to the appearance of the child's head.

The applicant stopped working on [redacted]. She was hospitalized for sepsis for approximately six days and underwent emergency removal of left breast tissue due to infection. She reports that she wished to return to work but experienced severe spinal symptoms, which she described as her spine "locking up." She underwent spinal surgery on [redacted]. She reports persistent cervical spine pain following surgery.

The applicant reports that she has consistently maintained a goal of returning to work. She described uncertainty regarding her functional limitations and frustration regarding her inability to return to employment despite a desire to do so.

The applicant has not applied for any positions since ceasing employment with the [redacted].

CURRENT ACTIVITIES:

The applicant last worked on [redacted]. She was performing her full duties as a [redacted] for the [redacted]. She reported that she had been performing her job well. In her last performance evaluation in approximately [redacted], she reports she was rated as "exceeding expectations." In response to direct questioning, the applicant stated that while at work she was able to ask simple questions and respond appropriately to criticism from supervisors. She had not been distracting those who worked near her, nor had she been excessively distracted by them. She had not been provoking altercations. She did not require special supervision. She could carry out detailed instructions. She was able to maintain her attention and concentration for her assigned tasks. She could make simple work-related decisions. She was completing her work on schedule. She did not have problems with attendance or punctuality. She was completing a normal workday and workweek without interruptions from psychologically based symptoms. She had been remembering her work procedures. She was able to understand and remember short, simple instructions as well as detailed instructions. She was interacting appropriately with supervisors and co-workers. She was able to respond appropriately to changes in the work setting. She was aware of normal hazards and could take appropriate precautions.

The applicant reports spending approximately two hours per day using a smartphone, tablet, or computer for email and text correspondence, playing games, web browsing, making phone calls, using social media, and taking photographs. She reports spending approximately two hours per day watching movies and television. She does not spend time reading books or magazines.

The applicant spends approximately four hours per week attending the gym. She does not attend church. She spends approximately three hours per week meditating. She does not spend any time dining at restaurants, going to parks, or volunteering.

At home, the applicant reports performing routine household chores for approximately one hour per day. These include washing dishes, preparing meals, sweeping, mopping, dusting, laundry, taking out the trash, gardening, caring for pet cats, cleaning the kitchen, performing minor household repairs, and maintaining her vehicles. She spends approximately two hours per week running routine errands, including trips to the market, car parts store, gas station, bank, pet store, home improvement store, warehouse store, and department store.

The applicant spends approximately one hour per week traveling to and attending medical appointments. She does not spend time going to casinos, concerts, or bars.

The applicant describes a typical day as including exercise, meditation, physical therapy exercises, meal preparation and consumption, and grocery shopping. She reports that on some days, due to significant pain, she spends most of the day sleeping.

The applicant reports independence in all activities of daily living, including bathing, dressing, toileting, transferring, continence, feeding, standing, sitting, vision, hearing, sensation, sexual arousal, and sleep.

The applicant reports independence in all instrumental activities of daily living, including telephone use, food preparation, laundry, travel by bus or car, medication management, writing and typing, Internet use, shopping, housekeeping, and household financial management.

The applicant has not attended school and has not engaged in recreational travel since her last employment with the [redacted]. In [redacted], she relocated from Tustin, California to Franklin, Tennessee to pursue a lower cost of living. She stated that, due to pain, it took approximately one year to pack and relocate her apartment.

PAST PSYCHIATRIC HISTORY

The applicant first participated in mental health treatment at age [redacted] following the divorce of her parents. She attended approximately 10 sessions of family psychotherapy with her mother and siblings. She reported the treatment was helpful but has limited recollection of the sessions.

In [redacted], the applicant initiated psychotherapy with [redacted] [redacted], PsyD. She attended approximately 100 sessions [redacted] Diagnoses included Post-Traumatic Stress Disorder (PTSD), Depression, and Anxiety. She found the treatment helpful but discontinued because she sought a provider who accepted her insurance.

In [redacted], while concurrently seeing Dr. [redacted], the applicant attended approximately 15 psychotherapy sessions with [redacted] [redacted], PhD. She utilized his services because he accepted

insurance. She discontinued treatment with Dr. [redacted] because she found Dr. [redacted] more effective.
The applicant began psychotherapy with [redacted], LMFT, in [redacted]. She attends sessions once to twice weekly. Diagnoses include PTSD, Depression, and Anxiety. She finds the treatment helpful.

The applicant saw psychiatrist [redacted], MD, for a single session in [redacted]. She does not recall the diagnosis. She was prescribed Trintellix but discontinued the medication and treatment because the medication exacerbated her depressive symptoms.

From [redacted], the applicant saw [redacted], MD, for approximately 20 psychiatric sessions. She is unaware of the specific diagnosis. Prescribed medications included Cymbalta, Lexapro, Prozac, Zoloft, Latuda, Haldol, and Buspar. She discontinued treatment to transition to a psychiatrist provided through her workers' compensation claim.

In [redacted], the applicant began psychiatric treatment with [redacted], MD. She has participated in approximately 20 sessions. Diagnoses include PTSD, Depression, and Anxiety. Prescribed medications include Xanax and Klonopin. She reported that psychiatric medications are not helpful due to side effects.

The applicant entered a residential treatment program, [redacted] for two weeks in [redacted]. She reported the program focused primarily on substance use, which was not useful to her. She noted significant staffing turnover during her first week and the illness of her therapist during the second week. She left the program early, believing she could receive better treatment at home while working.

In [redacted] following the completion of several difficult cases, the applicant reported an inability to function at work. She experienced debilitating pain and significant emotional dysregulation, including anger, irritability, impaired concentration, frequent crying spells, and sleep disturbance. Consequently, she utilized two weeks of sick leave during that month. She took an additional two weeks of leave for residential treatment in [redacted].

The applicant first experienced suicidal ideation in [redacted]. She reported passive thoughts, such as believing it would be easier to die, but denied intent or plan. These thoughts occurred daily until [redacted]. Currently, these thoughts occur approximately once per month when physical pain is heightened.

The applicant has no recollection of contact with any other specialists in psychiatry or mental health professionals except as stated. She has never been psychiatrically hospitalized. She has never used psychotropic medications except as mentioned. She has never received treatment for problems regarding the use of drugs or alcohol, including at a sober living or a drug and alcohol treatment center. She has never attempted suicide or harmed herself.

PAST MEDICAL HISTORY

The applicant describes a medical history significant for adrenal insufficiency, migraines, fibromyalgia, restless leg syndrome, spinal stenosis, neck pain, hypothyroidism, and Horner's syndrome. She states that all of these conditions began after [redacted].

[redacted], [redacted] [redacted]

The applicant has been hospitalized a total of [redacted] times. She experienced two episodes of sepsis following steroid epidural injections administered for neck and back pain. These hospitalizations occurred in [redacted] and [redacted]. She was hospitalized for four nights in [redacted] and six nights in [redacted]. She was also hospitalized on three occasions following cervical disc replacement surgeries, with one night of hospitalization each in [redacted], [redacted], and [redacted].

The applicant's surgical history includes a tonsillectomy in [redacted], septoplasty in [redacted] breast reductions in [redacted] and [redacted], cervical disc replacements in [redacted], [redacted], and [redacted], a cholecystectomy in [redacted], a left mastectomy in [redacted] related to sepsis, and a right mastectomy in [redacted].

The applicant is currently prescribed alprazolam 0.5 mg as needed, which she takes approximately once per month for anxiety; clonazepam 0.5 mg as needed, which she uses for insomnia approximately three to five times per month; tizanidine 2 mg as needed, which she takes approximately three times per month; and methocarbamol 500 mg, which she takes approximately five times per month. She also uses multiple vitamins and supplements, including SAMe 400 mg daily, vitamin D, vitamin C, vitamin K, trimethylglycine, Perfect Amino tablets, a daily probiotic, DHEA, pregnanolone, vitamin B complex, magnesium 500 mg twice daily, a trace minerals supplement, tyrosine, and L-tryptophan.

The applicant estimates that she has presented to the emergency room approximately [redacted] times in her life and to urgent care clinics approximately [redacted] times. Emergency room visits were for sepsis, gallbladder surgery, and other reasons she cannot recall. Urgent care visits were for symptoms including difficulty breathing, elevated blood pressure, and neck pain.

The applicant reports no prior industrial injuries other than those stated. She denies any history of serious head injury or loss of consciousness.

CURRENT PHYSICAL COMPLAINTS

The applicant currently complains of pain "all over" her body, "starting from my spine and radiating from head to toe," rated a 7 out of 10 with 10 being the worst pain imaginable. The pain occurs for approximately 12 hours per day on seven days per week. The pain is aggravated by standing without moving and alleviated by exercising, breathing, and movement.

REVIEW OF CURRENT PSYCHIATRIC SYMPTOMATOLOGY

I reviewed the applicant's psychiatric symptomatology through direct questioning. The applicant described her current mood as: "blah."

1. Anxiety. The applicant states that she feels anxious on a daily basis for approximately 12 hours per day. On a scale from 0-10 with 0 being the absence of anxiety and 10 being the worst level of anxiety she can possibly imagine, the applicant rates her level of anxiety during these episodes as an 8. She worries about her physical symptoms and ability to work again. Her anxiety is worsened by isolating from others and is relieved by exercising and breathing exercises. She has not been experiencing obsessions, rituals, chills, derealization, or depersonalization.
2. Mood. The applicant states that her mood is low on a daily basis for approximately 12 hours per day. On a scale from 0-10 with 0 being the absence of depression and 10 being the worst level of depression she can possibly imagine, the applicant rates her level of depression during these episodes as 4. Her mood is worsened by isolating and is improved when she is exercising and meditating. She complains of disordered sleep, feelings of guilt and hopelessness, low energy, difficulty concentrating, appetite

problems, and lack of enjoyment of activities she previously found enjoyable. She has experienced suicidal thoughts. She has not attempted suicide. She has not experienced homicidal thoughts. She does not report episodes of persistently elevated mood.

3. Psychosis. The applicant does not report any delusions or hallucinations. She does not believe that her thoughts can be heard by others. She does not believe that her mind can be controlled by others.
4. Trauma- and Stressor-Related. The applicant describes exposure to serious injury, threatened death, or sexual violence. She experiences recurrent and intrusive memories of the traumatic events. She does not recall specific nightmares but reports waking nightly in a panic with sweating. She experiences flashbacks. She demonstrates avoidance behaviors, including avoiding touching or interacting with children. She does not report an inability to recall important aspects of the traumatic events. She endorses persistent negative beliefs about herself and the world. She reports distorted cognitions regarding the cause and consequences of the trauma, including guilt and self-blame, and feels she should be able to work. She reports a marked loss of interest in activities and difficulty experiencing positive emotions. She describes irritability with episodes of crying and periods of intense emotional upset accompanied by impulsive behavior. She reports reckless behaviors, including excessive alcohol use and increased sexual interest. She endorses hypervigilance. She reports difficulty with concentration and sleep.
5. Appetite. The applicant does report disturbances in her appetite such that she eats significantly less than usual. Since the onset of her low mood, the applicant has lost approximately 20 pounds. She currently weighs [redacted] pounds and is [redacted] feet [redacted] inches tall.
6. Sleep. The applicant falls asleep at approximately 9:30 PM and wakes up at approximately 6 AM. The applicant reports that her sleep has not been restorative. She has difficulty falling asleep due to ruminations and wakes up throughout the night approximately five times per night.
7. Sexual Functioning. The applicant does report a change in her sexual functioning or desire such that she has no sexual desire.
8. Social Functioning. The applicant reports significant problems in social functioning. Prior to feeling unwell, she socialized with friends or family every weekend and engaged in activities such as attending parties, going to restaurants, and going to the beach. She reports that she currently does not socialize at all. She states that she is unable to initiate social contact, explaining that socializing would require her to leave her apartment, which she does not want to do. She denies provoking altercations. She reports no current hobbies or recreational activities and states, “it was all work, and now it’s all healing.” She reports that she was raised [redacted] but currently identifies as spiritual rather than religious and does not participate in organized religious activities. She reports a clear decline in social functioning with marked social withdrawal and disengagement from previously enjoyed activities.
9. Alcohol. The applicant first consumed alcohol at age [redacted]. She reports her heaviest alcohol use occurred in approximately [redacted] when she was drinking approximately four beers per night. She reports a history of one [redacted] at age [redacted]. At that time, she was drinking approximately two to three beers with friends and, during that period, typically drank on weekends in social settings. Over the past month, she reports no alcohol use due to lack of interest.
10. Tobacco. The applicant reports she smoked cigarettes when she was [redacted]; she smoked approximately half a pack per month.
11. Recreational Substance Use. The applicant began using marijuana at age [redacted]. At peak use, at approximately age [redacted] she reports vaping approximately three grams of marijuana per month. Over the past month, she reports daily cannabis use, with an estimated total use of approximately two grams per month. She denies any past or current use of cocaine, methamphetamine, PCP, hallucinogens, ketamine, narcotics, sedatives, or other recreational substances.

FAMILY PSYCHIATRIC HISTORY

The applicant has a maternal grandfather who suffers from Alcohol Use Disorder and committed suicide prior to the applicant's birth. She is not aware of any other history of psychiatric illness within her family.

SOCIAL HISTORY

The applicant was born in [redacted]. She was healthy at birth. The emotional climate of her home was stable, and there were no unusual circumstances surrounding her birth. She is not aware of the ages at which she achieved her developmental milestones but does not believe there were any developmental delays. During childhood, she had no significant problems with bedwetting, temper tantrums, stuttering, nightmares, head bumping, rocking, or phobias.

She describes her childhood as "typical." Her parents divorced when she was [redacted] years old. They lived approximately two miles apart, and she frequently traveled between their homes. Her family was heavily involved in the [redacted] community. She attended church school, public school, boarding school, college, and later moved to California. She participated in church activities and sports, including gymnastics, volleyball, and softball. Her father served as a coach, and her mother acted as a sports coordinator. She also participated in [redacted] and [redacted]. She reports that her parents were highly involved and supportive. She did not perceive significant parental conflict during childhood and reports no incidents rising to the level of law enforcement involvement.

She attended boarding school beginning at approximately age [redacted] and relocated there full time at age [redacted] This was customary within the [redacted] community and was not related to behavioral problems. She reports that the decision was voluntary, academically motivated, and enjoyable. She returned home on weekends.

She began to distance herself from organized religion during middle school, expressing a desire for more personal time rather than spending weekends at church. Her parents were accepting of this decision. In adulthood, she does not attend church and describes herself as spiritual rather than religious.

The applicant was raised by both parents and did not live with other individuals for a significant period during childhood. She reports that both parents treated her well. She denies any history of physical, emotional, sexual, or verbal abuse, violence, neglect, substance use problems in the household, significant mental health problems in the household, incarceration of family members during childhood, or gang involvement.

She reports that her maternal grandfather died by [redacted] when the applicant's mother was [redacted] years old. The applicant did not know him.

The applicant's father is deceased. He died when the applicant was approximately [redacted] old at age [redacted] due to kidney failure and diabetes. She reports being very close to her father and describes his death as significantly impactful. She was particularly distressed by concerns regarding the care of her disabled brother immediately following her father's death. She reports that she was able to continue functioning, socializing with friends, and returned to work within two days. Her father was a [redacted] [redacted] and owned a [redacted].

[redacted], [redacted] [redacted]

The applicant's mother is [redacted] years old and lives in [redacted] She is retired and previously worked as a [redacted] in a hospital operating room. The applicant reports her mother is in good health and describes their relationship as good.

The applicant has three half-siblings and one full brother. She has a paternal half-brother, age [redacted], who lives in [redacted] and is disabled, with diagnoses of epilepsy, intellectual disability, blindness, and cerebral palsy secondary to in utero rubella exposure. He is unable to engage in meaningful conversation. She has another paternal half-brother, age [redacted], who lives in [redacted] and has a history of traumatic brain injury following a possible fall. She has minimal contact with him. She has a maternal half-sister, age [redacted] who lives in [redacted] is retired, and previously worked as a [redacted] The applicant describes their relationship as good. She also has a full brother, age [redacted] who lives in [redacted] and works as an [redacted] She reports a good relationship with him. She grew up with her full brother and maternal half-sister. Her paternal half-brothers were raised by their maternal family.

The applicant has never been married and has no children. She reports no committed romantic relationship lasting longer than three years. She states that she has not met a mutually compatible partner. She reports interest in having a romantic partner but describes limited dating during much of her adult life due to occupational demands, stating that for nearly 10 years her life was largely consumed by work, with diminished libido, limited desire for relationships, and reduced social engagement.

The applicant did not experience difficulties starting school and denies any history of school phobias. She graduated from [redacted] in [redacted] She completed a Bachelor's degree from [redacted], California and a Master's degree in [redacted] She did not repeat any grades and reports strong academic performance, earning mostly A grades. She formed friendships with peers, had no significant difficulties with teachers, and participated in extracurricular activities including sports, [redacted] church groups, and band. She denies any behavioral problems, suspensions, disciplinary actions, or learning disabilities and did not receive special education services.

Following completion of her master's degree, she worked as an intern from [redacted] and obtained licensure in [redacted] She began working at age [redacted] [redacted] She worked as a [redacted] from approximately age [redacted] as a [redacted] from approximately age [redacted] and as a [redacted] during summers from approximately age [redacted] She worked for [redacted] from approximately age [redacted] in roles including [redacted] She then worked for [redacted] from approximately age [redacted] as a [redacted] and [redacted]. She subsequently began employment with the [redacted] at approximately age [redacted] as a [redacted].

She reports that she generally enjoyed her work and performed well in her positions prior to her employment with the [redacted]. She reports one termination from [redacted], which she attributes to advocacy on behalf of children and an administrative dispute related to incomplete documentation on a day she was not scheduled to work. She reports leaving other positions to pursue improved compensation or scheduling.

The applicant reports a current monthly income of $3,200 from a pension related to her employment with [redacted]. She began receiving this income in [redacted].

The applicant reports one prior arrest at age [redacted] for driving under the influence. She spent one night in jail and was convicted, fined, and required to attend mandatory group classes. She reports that this matter is no longer on her record.

The applicant does not identify any recent non-industrial stressors except as mentioned. In response to direct questioning, the applicant states that she has never served in the military, never faced any legal problems, never been involved in a civil lawsuit apart from employment related matters, never been exposed to physical, mental, emotional, or sexual abuse apart from her employment, and never faced the death of a close friend or family member except as mentioned. She has never faced a foreclosure of her home or experienced homelessness. Neither she nor anyone close to her has had any problems with government agencies. There have been no burglaries, robberies, or similar crises. No one close to her has attempted suicide. No one close to her has been involved in any situations of domestic violence or child abuse. No one close to her has been incarcerated. She has never been the victim of stalking and has never experienced a miscarriage.

MENTAL STATUS EXAMINATION

The applicant presented on time for the appointment. She states she had no difficulty finding the location or navigating the check-in process. She was casually dressed, well groomed, and neatly attired. She appeared her stated age. She maintained appropriate eye contact. There were no unusual facial expressions or gestures.

The applicant maintained a pleasant and cooperative attitude. She was neither evasive nor guarded. She was a fair informant although had difficulty remembering specific details of historical events. She was able to express her feelings freely. Her subjective report of her psychological condition was consistent with the objective findings.

The applicant moved frequently due to pain during the examination. There was no evidence of tics, tremors, pacing, grimacing, nail biting, wringing of the hands, tapping of the foot, chewing movements, or any other abnormal psychomotor activity.

There was no evidence of any significant disturbance in her speech. Her speech was fluent without aphasia.

The applicant's affect and mood were depressed. She demonstrated a limited range of affect that was appropriate to the content of the interview; her affect was neither blunted nor elevated. She frequently became tearful when discussing her work-related psychological difficulties. She smiled occasionally.

The applicant's thought processes were logical, coherent, goal-directed, and productive. There was no paucity of ideas, over-abundance of ideas, loosening of associations, flight of ideas, circumstantiality, tangentiality, thought blocking, derailment, nor neologisms.

The applicant's thought content was without any suicidal nor homicidal ideation. There were no ideas of reference, thought broadcasting, thought insertion, bizarre ideas, delusions, nor excessive suspiciousness.

The applicant did not report any disturbances in her sensory perception. She did not appear to be responding to internal stimuli. There was no evidence of depersonalization or derealization.

The applicant remained attentive and alert throughout the examination. There were no fluctuations in her level of consciousness. Her fund of knowledge was commensurate with her level of education. Her intelligence was estimated to be in the average range. She was alert and oriented in all spheres. Concentration was intact. Her memory for distant events was poor, but there were no significant disturbances in recent or immediate memory. Her judgment and insight were fair.

PSYCHOLOGICAL TESTING

Psychological testing has been administered and interpreted as an aid in the diagnosis and therapeutic planning and for evaluation of intellectual strength, psychopathology, psychodynamics, mental health risk, insight, motivation and other factors influencing treatment and prognosis.

The purpose of this examination is to determine the presence or signs of a mental illness for which psychological testing is indicated as an aid in the diagnosis, disability, and therapeutic planning. These tests are not being utilized solely as a screening procedure. Each test that has been performed is medically necessary. These tests are not being performed solely for Medical Legal purposes.

The interpretation of psychological testing which has been administered has been integrated with the information obtained from other sources and incorporated in the conclusions of the psychiatric report giving further meaning to the psychological testing and results.

It must be pointed out that psychological testing is only one aspect of a comprehensive psychiatric examination. Psychodiagnostic testing, in and of itself, can never provide a conclusive diagnostic picture and this is regardless of the number of tests administered. Test findings must be integrated with various other forms of data including mental status examination and history. The various aspects of the testing may suggest a clinical diagnosis, whereas the final determination is that the diagnosis is either different than that suggested by the testing or there is no clinical condition. Some tests are highly subjective and their value is for the examiner to gain a picture of the individual's perceived condition and symptomatology. Sometimes this is highly discrepant with their actual state. Psychological testing is also vulnerable to various forms of bias, and these must also be considered in terms of the final clinical determination.

The following psychological tests were performed:

1. Minnesota Multiphasic Personality Inventory-3 (MMPI-3)
2. Millon Clinical Multiaxial Inventory-IV (MCMI-IV)
3. Brief Symptom Inventory (BSI)
4. Beck Depression Inventory, Second Edition (BDI-II)
5. Beck Anxiety Inventory, Second Edition (BAI)

1. The **Minnesota Multiphasic Personality Inventory-3 (MMPI-3)** was scored using a computer application provided by Pearson. This MMPI interpretation can serve as a useful source of hypothesis about clients. This report is based on objectively derived scale indexes and scale interpretations that have been developed in diverse groups of patients. The personality descriptions, inferences and recommendations contained herein need to be verified by other sources of clinical information since individual clients may not fully match the prototype. The following is a summary of the applicant's clinical profile interpretation:

Scores on the MMPI-3 Validity Scales raise concerns about the possible impact of over-reporting (specifically, of general psychological dysfunction and of somatic symptoms) on the validity of this protocol. With that caution noted, scores on the Substantive Scales indicate somatic and cognitive complaints, and emotional and thought dysfunction. Somatic complaints include preoccupation with poor health and malaise. Cognitive

complaints include difficulties in memory and concentration. Emotional-internalizing findings include suicidal ideation, demoralization, perceived inefficacy, negative emotionality, stress, worry, anxiety, and compulsivity. Dysfunctional thinking relates to aberrant perceptions and thoughts.

The test taker produced scorable responses to all the MMPI-3 items. She also responded relevantly to the items on the basis of their content.

The test taker generated a larger than average number of infrequent responses to the MMPI-3 items. This level of infrequent responding may occur in individuals with genuine, substantial psychological difficulties who report credible symptoms. However, for individuals with no history or current corroborating evidence of substantial dysfunction it likely indicates over-reporting.

She also reported a much larger than average number of somatic symptoms rarely reported by individuals with genuine medical conditions. This level and type of infrequent responding may occur in individuals with substantial medical problems who report credible symptoms, but it could also reflect exaggeration. In individuals with no history or other corroborating evidence of physical health problems this likely indicates non-credible reporting of somatic symptoms. Scores on the Somatic Complaints (RC1), Malaise (MLS), and Neurological Complaints (NUC) scales should be interpreted in light of this caution.

There are no indications of under-reporting in this protocol.

The test taker reports multiple somatic complaints including gastrointestinal symptoms. She likely is prone to developing physical symptoms in response to stress and perceives her physical problems as life-interfering. She also reports experiencing poor health and feeling weak or tired. Indeed she is likely preoccupied with poor health and complains of sleep disturbance, fatigue, low energy, and sexual dysfunction.

She reports a diffuse pattern of cognitive difficulties including memory problems, difficulties with attention and concentration, and possible confusion. Indeed she very likely complains about memory problems, has low tolerance for frustration, does not cope well with stress, and experiences difficulties in attention and/or concentration.

The test taker reports a history of suicidal/death ideation and/or past suicide attempts. She likely is at risk for self-harm, is preoccupied with suicide and death, and is at risk for current suicidal ideation and attempts.

MMPI-3 T SCORES (BY DOMAIN)

PROTOCOL VALIDITY

Content Non-Responsiveness	0 CNS	66 CRIN	68 VRIN	67 T TRIN				
Over-Reporting	**75 F**	58 Fp		**86 Fs**	67 FBS	72 RBS		
Under-Reporting	40 L	38 K						

SUBSTANTIVE SCALES

Somatic/Cognitive Dysfunction		**72 RC1**	**68 MLS**	60 NUC	65 EAT	**76 COG**			
Emotional Dysfunction	**66 EID**	**67 RCd**	**65 SUI**	51 HLP	59 SFD	**66 NFC**			
		47 RC2	50 INTR						
		82 RC7	**76 STR**	**72 WRY**	**76 CMP**	**77 ARX**	62 ANP	63 BRF	**72 NEGE**
Thought Dysfunction	58 THD	50 RC6							
		67 RC8							
		59 PSYC							
Behavioral Dysfunction	54 BXD	58 RC4	59 FML	56 JCP	54 SUB				
		46 RC9	52 IMP	46 ACT	55 AGG	42 CYN			
		57 DISC							
Interpersonal Functioning		49 SFI	49 DOM	53 AGGR	52 DSF	48 SAV	55 SHY		

Her responses indicate significant emotional distress. More specifically, she reports various negative emotional experiences and very likely is self-critical and guilt-prone. In particular, she reports multiple anxiety-related experiences, including generalized anxiety and reexperiencing and/or panic. She indeed likely experiences significant anxiety and anxiety-related problems, PTSD features including intrusive ideation, nightmares, and dissociative experiences, and panic. She also reports multiple problems involving stress and feeling nervous. She very likely complains about stress and feels incapable of controlling her anxiety level. In addition, she reports excessive worry, including worries about misfortune and finances, as well as preoccupation with disappointments. She indeed likely worries excessively and ruminates. She reports engaging in compulsive behavior, including repetitive checking and counting, and making sure things are in place. She indeed very likely engages in compulsive behavior such as repeated checking, experiences obsessions, and is rigid and perfectionistic.

The test taker reports feeling sad and unhappy and being dissatisfied with her current life circumstances. She likely complains of feeling depressed and experiences sadness and despair. More specifically, she reports being indecisive and inefficacious. She likely experiences subjective incompetence and shame and lacks perseverance and self-reliance.

The test taker reports unusual thought processes46. She likely experiences thought disorganization, engages in unrealistic thinking, and believes she has unusual sensory-perceptual abilities. Her aberrant experiences may include somatic delusions.

There are no indications of maladaptive externalizing behavior in this protocol.

These scales provide no further evidence of dysfunction.

DIAGNOSTIC CONSIDERATIONS

This section provides recommendations for psychodiagnostic assessment based on the test taker's MMPI-3 results if her score reaches or exceeds the recommended cutoff in the MMPI-3 Manual for Administration, Scoring, and Interpretation. It is recommended that she be evaluated for the following, bearing in mind possible threats to protocol validity noted earlier in this report:

Somatic/Cognitive Disorders
- Somatic symptom disorder, if physical origin for malaise has been ruled out
- Disorders related to attention difficulties

Emotional-Internalizing Disorders
- Features of personality disorders involving negative emotionality such as Dependent and Obsessive-Compulsive
- Anxiety-related disorders including generalized anxiety disorder, PTSD, and panic disorder
- Disorders involving excessive worry
- Obsessive-compulsive disorder
- Depression-related disorder

Thought Disorders
- Disorders manifesting psychotic symptoms
- Features of personality disorders manifesting unusual thoughts and perceptions such as schizotypal personality disorder

TREATMENT CONSIDERATIONS

This section provides inferential treatment-related recommendations based on the test taker's MMPI-3 scores. The following recommendations need to be considered in light of cautions noted earlier about possible threats to protocol validity.

Areas for Further Evaluation
- Risk for suicide should be assessed immediately.
- Need for anxiolytic medication.
- Extent to which genuine physical health problems contribute to the score on the Somatic Complaints (RC1) scale.
- Origin of malaise complaints.
- Origin of cognitive complaints. May require a neuropsychological evaluation.

Psychotherapy Process Issues
- Likely to reject psychological interpretations of somatic complaints.
- Malaise may impede her willingness or ability to engage in treatment.
- Serious emotional difficulties may motivate her for treatment
- Indecisiveness may interfere with establishing treatment goals and progress in treatment.
- Impaired thinking may disrupt treatment.

Possible Targets for Treatment
- Serious dysfunctional negative emotions
- Anxiety
- Developing stress management skills
- Excessive worry and rumination
- Obsessive-compulsive thoughts and behaviors
- Demoralization as an initial target

Comment: This profile is of questionable validity due to the applicant's tendency to respond to the test items in an exaggerated fashion. While this response pattern is frequently seen in malingering, during the examination I was not left with the impression that the applicant was being intentionally deceptive. The test results confirm my impression that the applicant is experiencing significant psychological symptomatology.

2. The **Millon Clinical Multiaxial Inventory-IV (MCMI-IV)** was scored using a computer application provided by Pearson. The MCMI- IV reports are normed on patients who were in the early phases of assessment or psychotherapy for emotional discomfort or social difficulties. Respondents who do not fit this normative population or have inappropriately taken the MCMI-IV for nonclinical purposes may have distorted reports. The MCMI-IV report cannot be considered definitive. It should

be evaluated in conjunction with additional clinical data. The following is a summary of the applicant's MCMI-IV clinical profile interpretation:

> *Scores for scales 2B (Melancholic), 8B (Masochistic), and C (Borderline) have been adjusted to compensate for the potential over reporting of symptoms based on the elevated scores from scales A (Generalized Anxiety) and CC (Major Depression). Additional score adjustments have also been made on scores for scales 2A (Avoidant) and S (Schizotypal).*
>
> *The following paragraphs refer to those enduring and pervasive personality traits that underlie this woman's emotional, cognitive, and interpersonal difficulties. Rather than focus on the largely transitory symptoms that make up clinical syndromes, this section concentrates on her more habitual and maladaptive methods of relating, behaving, thinking, and feeling.*
>
> *The MCMI-IV profile of this woman suggests that she is unpredictable, characterized by depressive moods, edgy irritability, and the feeling of being cheated, misunderstood, and unappreciated. Her need for dependency and for autonomy conflict, contributing to her impulsive emotionality. Possibly critical and bitter, she may feel like a victim, overburdened and mistreated. She may use guilt to undermine the criticism of others, claiming that she has been misunderstood and unfairly accused. A pattern of self-pity, negativism, sullen pouting, faultfinding, and pessimism may be present, possibly punctuated by occasional angry outbursts, followed by expressions of guilt and contrition.*
>
> *It is possible that this woman permits herself to be exploited by engaging in self-sacrificing behaviors. She may then anticipate being disillusioned; for this reason, she behaves obstructively, thereby confusing others and producing the expected disappointment. Personal relationships are likely to be tenuous and turbulent. They may be fraught with wrangles and antagonism that are occasionally provoked by her characteristic complaining and passive-aggressive attitude. She may seek out marginal or acting-out types with whom she will suffer and complain as a martyr. Her likely struggle between feelings of resentment, depression, and guilt may result in a rapid succession of moods. At times unstable and erratic, she may be easily offended and dejected by trifles. A low tolerance for frustration may be notable as is a vacillation between being distraught and despondent and being petty and contentious. Due to her self-sabotaging and self-debasing, she may be stereotyped as a person who dampens spirits: a depressive malcontent who demoralizes and obstructs the pleasures of others.*
>
> *There may be a struggle in her life between acting out and curtailing resentments. Vacillating between feeling cared for by others and then feeling discarded by them, her occasional sulking, unpredictable, and erratic behavior induces others to react in a similarly inconsistent manner. As a consequence, she may feel misunderstood and unappreciated, and she may tend to be disconsolate, sensitive, and defensive.*
>
> *By examining the elevated Grossman Facet Scale scores for the Clinical Personality Patterns and Severe Personality Pathology scales, it is possible to identify a patient's most troublesome or clinically-significant functional and structural domains (e.g., self-*

MILLON CLINICAL MULTIAXIAL INVENTORY-IV

PROFILE SUMMARY

HIGH-POINT CODE = 8A 2B 2A
BR ADJUSTMENTS = A/CC

INVALIDITY (V) = 0
INCONSISTENCY (W) = 9

VALIDITY		Score Raw	Score BR	Profile of BR Scores 0 35 75 100
Modifying Indices				Low Average High
Disclosure	X	47	69	
Desirability	Y	10	50	
Debasement	Z	14	70	

PERSONALITY		Score Raw	Score PR	Score BR	Profile of BR Scores 0 60 75 85 115
Clinical Personality Patterns					Style Type Disorder
AASchd	1	10	64	66	
SRAvoid	2A	10	60	72	
DFMelan	2B	15	67	74	
DADepn	3	9	69	72	
SPHistr	4A	9	37	49	
EETurbu	4B	9	42	54	
CENarc	5	2	19	24	
ADAntis	6A	3	43	60	
ADSadis	6B	9	77	69	
RCComp	7	16	58	65	
DRNegat	8A	14	82	77	
AAMasoc	8B	11	70	70	
Severe Personality Pathology					
ESSchizoph	S	16	85	72	
UBCycloph	C	13	72	72	
MPParaph	P	5	54	62	

PSYCHOPATHOLOGY		Score Raw	Score PR	Score BR	Profile of BR Scores 0 60 75 85 115
Clinical Syndromes					Present Prominent
GENanx	A	13	90	97	
SOMsym	H	11	83	78	
BIPspe	N	8	66	69	
PERdep	D	17	73	74	
ALCuse	B	2	70	68	
DRGuse	T	1	36	60	
P-Tstr	R	15	93	95	
Severe Clinical Syndromes					
SCHspe	SS	12	77	66	
MAJdep	CC	10	65	77	
DELdis	PP	1	45	60	

image, interpersonal conduct). A careful analysis of this individual's facet scale scores suggests the following characteristics are among her most prominent personality features.

Most notable is her tendency to be invariably pessimistic and to give the gloomiest interpretation of events. She may try to fight back depressive feelings and thoughts by consciously diverting her ideas and preoccupations away from her characteristically depressive mood. For the most part, however, these ruminations are replaced by more troublesome ones. Moreover, she tends to reactivate and then brood over minor incidents from the past. She is likely to believe that her current state is irreversible and that any attitude other than pessimism or gloom is merely illusory.

Also salient is her tendency to be petulant, obstinate, and resentful. She is easily annoyed and aggravated by others, and prone to withdrawing into sulky and grumpy moods. She is frequently offended by trifles, and often provoked into sullenness and contrariness. She has a low tolerance for frustration, and she may be chronically impatient, irritable, and fidgety unless things go her way. There are periods when she vacillates between being distraught and despondent one moment and petty and contentious the next. At other times she may be enthusiastic and cheerful, but these moods are usually rare and short-lived.

Also worthy of attention are her ruminative and circumstantial thinking, ideas of reference and metaphorical asides, and speech characterized by self-absorption and personal irrelevancies. When motivated or prompted to relate to others, she is frequently unable to orient her thoughts logically, and becomes lost in personal irrelevancies and tangential asides that are not pertinent to the topic at hand. She seems to be out of touch with others and is unable to order her ideas in terms that are appropriate to reciprocal social communication.

Also noteworthy is her habit of judging herself as a valueless, insignificant, and inconsequential person. A pervasive sadness characterizes her psychic make-up, and minor failures can plunge her into more severe states of dejection. Events such as these only reinforce her belief that she is unworthy and of little value to others. Similarly, innocuous critical remarks may set into motion obsessive worrying and brooding, further intensifying her sense of worthlessness. Even when things are going well, she is likely to retain a deep sense of personal inadequacy.

Early treatment efforts are likely to produce optimal results if they are oriented toward modifying these personality features.

The following diagnostic assignments should be considered judgments of personality and clinical prototypes that correspond conceptually to formal diagnostic categories. The diagnostic criteria and items used in the MCMI-IV differ somewhat from those in the DSM-5, but there are sufficient parallels in the MCMI-IV items to recommend consideration of the following assignments. It should be noted that several DSM-5 clinical syndromes are not assessed in the MCMI-IV. Definitive diagnoses must draw on biographical, observational, and interview data in addition to self-report inventories such as the MCMI-IV.

Before each disorder name, ICD-9-CM codes are provided, followed by ICD-10-CM codes in parentheses.

Clinical Syndromes
The major complaints and behaviors of the patient parallel the following clinical syndrome diagnoses, listed in order of their clinical significance and salience.
296.33 (F33.2) Major Depression (recurrent, severe)
300.02 (F41.1) Generalized Anxiety Disorder
309.81 (F43.10) Posttraumatic Stress Disorder

Course: The clinical syndromes described previously tend to be relatively transient, waxing and waning in their prominence and intensity depending on the presence of environmental stress.

Personality Disorders
Deeply ingrained and pervasive patterns of maladaptive functioning underlie clinical syndromal pictures. The following personality prototypes correspond to the most probable DSM-5 diagnoses that characterize this patient.

Personality configuration composed of the following:
Unspecified Personality Disorder (Negativistic) Type
Unspecified Personality Disorder (Melancholic) Style
and Schizotypal Personality Style

Course: The major personality features described previously reflect long-term or chronic traits that are likely to have persisted for several years prior to the present assessment.

Comment: This profile is valid. The test results confirm my impression that the applicant is experiencing significant psychological symptomatology and that she is experiencing Major Depressive Disorder and Posttraumatic Stress Disorder. During the examination there was insufficient historical or corroborative data to substantiate the diagnosis of Generalized Anxiety Disorder or a Personality Disorder within reasonable medical probability.

3. The **Brief Symptom Inventory (BSI)** was scored using a computer application provided by Pearson. This test is a 53 item symptom inventory designed to reflect psychological symptoms patterns. Each item of the BSI is rated on a five point scale of distress (0 to 4) ranging from “not at all” (0) at one pole to “extremely” (4) at the other. The BSI is scored and profiled in terms of nine primary symptom dimensions and three global indices of distress. The following is a summary of the applicant’s BSI clinical profile interpretation:

The respondent's BSI symptom profile reveals a pattern and magnitude to be considered in the clinical range, and qualifies her as a positive clinical case.

Her symptomatic distress levels are clearly defined as being in the clinical range, which suggests that a more intensive and detailed evaluation of mental status is called for.

Overall intensity of distress is clinical in nature and she has endorsed a marked number of symptoms.

The respondent's somatization level is unquestionably in the clinical range, and suggests a focus for more intensive future review.

Extremely high levels of obsessive-compulsive symptoms are in evidence in this test record. These levels may reflect the existence of a true obsessive-compulsive disorder, or may be associated with a primary disorder of a different nature.



The respondent reveals evidence of self-deprecation, feelings of inferiority, and a sense of inadequacy and self-doubt that is clinical in nature, and should be evaluated in greater detail.

The respondent's level of depression is manifestly elevated and clinical in nature. There is evidence suggesting a true depressive disorder may be present.

A moderate level of anxiety is evident in the respondent's current BSI protocol. These symptoms may simply represent the normal functional anxiety level for this individual; however they may also be indicative of an emerging anxiety disorder.

The respondent reports levels of conscious anger and manifest hostility that appear to be clinical in nature. She seems to be struggling with substantial levels of unresolved conflict and frustration at the moment.

The client's levels of phobic anxiety are elevated and approaching the clinical range. There may be some evidence of phobic and avoidant behaviors present.

Levels of paranoid ideation are somewhat elevated in the respondent's record, and while they are not quite in the clinical range, they may suggest a less than optimal adjustment posture.

The respondent's psychoticism score is in the clinical range. However, it is more likely that this reflects an intense experience with social alienation, rather than a thought disorder.

Comment: The results of this test confirm my impression the applicant is experiencing significant psychological symptomatology.

4. The **Beck Depression Inventory, Second Edition (BDI-II)** was scored using a computer application provided by Pearson. This is a 21 item inventory for measuring the severity of depression. The BDI-II was developed as an indicator of the presence and degree of depressive symptoms consistent with the DSM-IV, not as an instrument for specifying a clinical diagnosis. The BDI-II should be used cautiously as the sole diagnostic measure because depression may accompany a variety of primary diagnostic disorders. The BDI-II is scored by summing the ratings for the 21 items. Each item is rated on a four point scale range from 0 to 3. The maximum total score is 63. Total scores from 0 to 13 points are considered to reflect a minimal level of depressive symptoms; scores from 14 to 19 indicate mild depressive symptoms; scores of 20 to 28 reflect moderate depressive symptoms; and scores of 29 to 63 indicate severe depressive symptoms.

Comment: The applicant scored 37 on this test, placing her at the 99.4th percentile, indicating a severe level of depression. The results of this test confirm my impression the applicant is experiencing significant depressive symptomatology.

5. The **Beck Anxiety Inventory (BAI)** was scored using a computer application provided by Pearson. This is a 21 item scale that measures the severity of anxiety. The scale consists of 21 descriptive statements of anxiety symptoms which are rated on a four point scale from 0 (“Not at all”) to 3 (“I could barely stand it”). The BAI total score is the sum of the ratings for the 21 symptoms. The maximum total score is 63. Total scores from 0 to 7 points are considered to reflect a minimal level of anxiety; scores from 8 to 15 indicate mild anxiety; scores of 16 to 25 reflect moderate anxiety; and scores of 26 to 63 indicate severe anxiety.

Comment: The applicant scored 16 on this test, placing her at the 95th percentile, indicating a moderate level of anxiety. The results of this test confirm my impression the applicant is experiencing significant anxious symptomatology.

[redacted], [redacted] [redacted]

Psychiatric Diagnosis
The *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision* (*DSM-5-TR*) diagnosis that is most consistent with the applicant's presentation is:

F33.9, Major Depressive Disorder, Recurrent, Unspecified
F43.10, Posttraumatic Stress Disorder

IMPRESSION AND RECOMMENDATIONS:
The member is a [redacted]-year-old female employed by the [redacted] as a [redacted]. The member last worked on [redacted].

The applicant's psychiatric diagnoses include Posttraumatic Stress Disorder, Major Depressive Disorder, and clinically significant anxiety. The historical narrative reflects a prolonged course of occupational overextension, medical complications, and cumulative psychological stressors. Over many years, the applicant devoted the majority of her time and energy to work, with progressive erosion of social, emotional, and personal functioning. This pattern coincided with the onset and worsening of multiple serious medical conditions, repeated hospitalizations, invasive procedures, episodes of sepsis, and significant physical decline. These experiences were accompanied by repeated exposures to perceived threat, loss of bodily integrity, and fear of serious injury or death, which form the basis of her posttraumatic stress symptomatology.

Psychiatrically, the applicant describes persistent trauma-related symptoms including intrusive memories, flashbacks, physiological panic on awakening, avoidance behaviors, negative beliefs about herself and the world, guilt, emotional numbing, irritability, impulsive behaviors, hypervigilance, impaired concentration, and chronic sleep disturbance. In parallel, she developed prominent depressive symptoms, including loss of interest, diminished capacity to experience pleasure, low mood, low energy, social withdrawal, and feelings of hopelessness regarding her ability to function and work. Anxiety has remained pervasive and closely tied to concerns about health, safety, and future functioning.

RESPONSES TO QUESTIONS:
The answer to each question must deal ONLY within your field of expertise and strictly answer ONLY the question at hand. Any opinion given outside of your field will be refused by OCERS. Please corroborate your opinions with references to specific records, as well as your objective findings.

1. Is the applicant incapacitated from performing his or her usual job duties? Please explain your opinion.
Yes, the applicant is psychiatrically incapacitated from performing her usual job duties. During the evaluation, she demonstrated prominent symptoms of Posttraumatic Stress Disorder and Major Depressive Disorder, including marked emotional dysregulation, tearfulness, irritability, impaired concentration, and pronounced anxiety when discussing work-related topics. She was unable to sustain discussion of her occupational duties without repeatedly pausing to regain emotional control, which is inconsistent with the cognitive, emotional, and interpersonal demands of her usual employment.

This opinion is supported by objective clinical findings on mental status examination and psychodiagnostics testing, which revealed dysphoric mood, impaired distress tolerance, and reduced capacity for sustained focus. Her symptom presentation includes guilt, hopelessness, sleep disturbance,

intrusive trauma-related symptoms, and avoidance behaviors, all of which interfere with reliable attendance, effective communication, judgment, and emotional regulation in a work setting. These findings are consistent with the history documented in the records reviewed and with the symptom severity reported during the evaluation, and they support the conclusion that she is psychiatrically unable to perform her usual job duties at this time.

2. Is the applicant capable of performing each of the duties described in the class specification for the applicant's occupation? Describe which duties the applicant can and cannot perform. Please explain your opinion.

No, the applicant is not capable of performing the core duties described in the class specification. The position requires repeated exposure to emotionally distressing material, including child abuse, neglect, family dysfunction, and threats to client safety, as well as sustained concentration, emotional regulation, judgment under stress, and complex interpersonal communication. The applicant's Posttraumatic Stress Disorder is characterized by intrusive trauma-related symptoms, avoidance, impaired concentration, emotional dysregulation, hyperarousal, and markedly reduced distress tolerance. During the psychiatric evaluation, discussion of work-related material resulted in visible emotional decompensation, tearfulness, difficulty sustaining attention, and the need to pause repeatedly to regain composure. These objective findings are incompatible with duties involving assessment of abuse, interviewing vulnerable populations, formulating and defending complex case plans, making safety-critical decisions, and preparing legally sound reports under time constraints.

Specifically, the applicant is unable to perform duties involving identification and assessment of child abuse, dependency, guardianship, and family dysfunction; gathering data through interviews and home calls; determining the extent and causes of social dysfunction; formulating and revising complex case plans; providing and monitoring treatment services; preparing detailed court reports; informing legal professionals regarding child welfare codes; and taking children into custody. These tasks would predictably expose her to trauma reminders that exacerbate PTSD symptoms, leading to impaired focus, emotional instability, and compromised judgment.

Additionally, her depressive symptoms, including low energy, impaired concentration, guilt, hopelessness, and sleep disturbance, further interfere with sustained cognitive performance, documentation accuracy, decision-making, and timely completion of complex administrative and legal tasks.

3. Is the applicant's incapacity permanent? (Refer to the Legal Standards, above, for the meaning of "permanent.") Please explain your opinion.

Yes, the applicant's psychiatric incapacity is permanent as defined by the applicable legal standard. Based on my psychiatric evaluation, review of the medical and mental health records, and objective findings on examination, further material improvement in her psychiatric condition is not medically probable with or without additional treatment. The applicant has participated in extensive and appropriate psychiatric treatment, including numerous psychotropic medication trials, prolonged courses of psychotherapy with multiple psychotherapy providers, and treatment at a residential level of care. These modalities have not resulted in meaningful or sustained improvement in her psychiatric functioning.

The applicant has actively participated in reasonable and appropriate psychiatric treatment. Current treatment appears to maintain her symptoms at a relatively stable baseline but has not resulted in restoration of functional capacity sufficient to perform her occupational duties. Given the chronicity of symptoms, treatment refractoriness, and lack of sustained improvement despite comprehensive interventions, further change in her psychiatric condition is not medically probable.

4. Has the applicant received appropriate treatment for the stated injury/disease?
Yes. The applicant has received appropriate psychiatric treatment for her conditions. Treatment has included multiple trials of psychotropic medications, extensive outpatient psychotherapy with multiple licensed psychotherapy providers over a prolonged period, and treatment at a residential level of care. She has actively participated in these interventions.

5. In your opinion does the applicant require additional medical treatment? If so, describe the treatment, the timeframe, and the anticipated results.
In my opinion, the applicant does require additional medical treatment. From a psychiatric standpoint, continued outpatient psychotherapy on a weekly basis is medically indicated. The anticipated timeframe is ongoing. The expected result of continued treatment is maintenance of her current level of functioning and prevention of further psychiatric decompensation, with the possibility of only modest and gradual improvement over an extended period of time.

6. Was the applicant <u>continuously incapacitated</u> from the date that they last worked to the date that the disability retirement application was filed? If, in your opinion, the applicant became incapacitated after they last worked, please state when the incapacity began. Please explain how the medical records support your conclusion.

Yes. The applicant was continuously psychiatrically incapacitated from the date she last worked on [redacted]. Medical records document persistent and severe psychiatric symptoms during this entire interval, including Posttraumatic Stress Disorder and Depressive Disorder, with no sustained period of functional recovery.

The medical records document persistent and severe psychiatric symptoms beyond [redacted].

Treating psychiatric providers [redacted], MD, and [redacted], NP consistently documented ongoing symptoms of Posttraumatic Stress Disorder and Depressive Disorder during multiple evaluations in [redacted], [redacted], [redacted], and [redacted] During each of these visits, the applicant was assessed as temporarily totally disabled and unable to return to work due to psychiatric impairment. Clinical notes described severe anxiety, depressive symptoms, emotional lability, cognitive disruption under stress, and functional shutdown. No clearance to return to work was provided at any time.

An agreed medical re-examination performed by [redacted], MD on [redacted] documented that the applicant had been placed off work on [redacted] and remained temporarily totally disabled at the time of that evaluation. This assessment confirms that the applicant's incapacity persisted continuously from the date she last worked.

A panel-qualified medical re-evaluation in psychiatry performed by [redacted], MD and [redacted], PhD in [redacted] determined that the applicant was permanent and stationary due to

Posttraumatic Stress Disorder and Major Depressive Disorder with a Global Assessment of Functioning rating of 54, indicating moderate symptoms and impairment in functioning.

The applicant's disability retirement application, filed on [redacted], described ongoing debilitating psychiatric symptoms with significant functional limitations. Treating psychiatric records shortly after the filing date continued to document the applicant as temporarily totally disabled.

7. Based on your evaluation and medical history, please state what permanent work restrictions, if any, you would recommend for the applicant. Please specify what injury/body part requires the work restrictions. Please explain your opinion. Please provide the applicant's weight limitations in pounds/ounces and time limits in terms of consecutive hours/minutes, as well as total hours/minutes in a defined workday. Also, please include the length of any required breaks.

The applicant has permanent psychiatric work restrictions due to psychological injury involving the brain and mental health functioning, specifically Posttraumatic Stress Disorder and Major Depressive Disorder.

The applicant is not capable of performing competitive employment on a sustained basis. Her psychiatric symptoms are severe and chronic. These symptoms include markedly impaired concentration, poor attention, impaired memory under stress, emotional dysregulation, intrusive trauma-related symptoms, hyperarousal, low motivation, anhedonia, and extremely poor distress tolerance. These impairments significantly interfere with her ability to maintain pace, persistence, reliability, and appropriate interpersonal functioning in a work setting.

The applicant's Posttraumatic Stress Disorder results in heightened physiological reactivity, anxiety, and emotional shutdown when exposed to stressors. Even routine workplace demands would reasonably be expected to precipitate symptom exacerbation. Her Major Depressive Disorder contributes to low energy, impaired initiation, poor motivation, and reduced cognitive efficiency. In combination, these conditions prevent her from sustaining attention, tolerating ordinary work stress, or reliably completing tasks.

As a result of these psychiatric limitations, no safe or feasible permanent work capacity can be identified. She is unable to work for any number of consecutive hours or minutes and is unable to tolerate a defined workday of any duration.

8. Is the applicant able to perform other job duties within the restrictions you have indicated? Identify which duties the applicant is still able to perform.

No. The applicant is not able to perform other job duties within the restrictions previously identified. Due to the severity and persistence of her psychiatric impairments, the applicant is unable to reliably perform any identified job duties on a sustained basis.

9. Is the applicant's incapacity service-connected – i.e., did employment contribute substantially to the applicant's incapacity? Identify and explain in detail the "real and measurable connection" between

the employment and applicant's incapacity.

Yes. The applicant's incapacity is service-connected. Her [redacted] employment contributed substantially to her incapacity and bears a real and measurable connection to the development of her disabling psychiatric conditions.

The applicant developed Posttraumatic Stress Disorder and Major Depressive Disorder in the context of her work in denial. Her job duties required repeated and sustained exposure to psychologically distressing material and emotionally demanding circumstances. This exposure was inherent to her position and occurred as a regular and expected part of her employment.

The medical history demonstrates a temporal and causal relationship between the applicant's employment and the onset and progression of her psychiatric symptoms. Her symptoms emerged and worsened while she was performing her [redacted] duties. Over time, the cumulative psychological stress associated with this work exceeded her ability to cope and resulted in clinically significant trauma-related and depressive symptoms that ultimately rendered her incapacitated.

10. If it is your opinion that the applicant is permanently incapacitated for nonservice- connected reasons, please identify and explain all factors that caused or contributed to the applicant's incapacity.

The applicant's permanent psychiatric incapacity is not attributable to nonservice-connected causes.

Her incapacity is best explained by psychiatric injury arising out of and in the course of her employment. The chronic psychological stress associated with repeated exposure to traumatic material and events in the course of her job duties was a substantial contributing factor to the development of her Posttraumatic Stress Disorder and Major Depressive Disorder. These conditions directly account for her functional decline and inability to work.

11. Is applicant's incapacity the result of a permanent aggravation or acceleration of a pre-existing or nonindustrial medical condition? If so, did employment contribute substantially to this permanent aggravation or acceleration? Please explain your opinion.

No, the applicant's incapacity is not the result of a permanent aggravation or acceleration of a pre-existing or nonindustrial medical condition. Her Posttraumatic Stress Disorder and Major Depressive Disorder developed in response to work-related psychological stressors inherent to her job duties.

The evidence supports that the applicant's psychiatric conditions represent a primary industrial injury, not the worsening of a prior nonindustrial condition. Accordingly, the applicant's incapacity is not due to a permanent aggravation or acceleration of a pre-existing or nonindustrial medical condition.

12. Even if you do not find applicant to be permanently incapacitated, please provide your opinion regarding the cause of applicant's alleged injuries or illnesses. Are those injuries/illnesses service-connected – i.e., did employment contribute substantially to those injuries/illnesses? Please explain.

The applicant's alleged psychiatric injuries are service-connected.

The applicant developed Posttraumatic Stress Disorder and Major Depressive Disorder as a result of her work-related duties. Her position required repeated exposure to psychologically distressing and traumatic material as a routine part of her employment. This exposure was chronic, cumulative, and inherent to the job.

The medical history supports a temporal and causal relationship between the applicant's employment and the onset of her psychiatric conditions. Her symptoms developed and progressed while she was actively performing her [redacted] duties. Over time, the cumulative emotional burden of this work exceeded her psychological coping capacity, resulting in clinically significant trauma-related symptoms, mood disturbance, impaired concentration, emotional dysregulation, and functional decline. Employment contributed substantially to the development of these psychiatric injuries. There is a real and measurable connection between the applicant's job duties and her Posttraumatic Stress Disorder and Major Depressive Disorder. Accordingly, the applicant's alleged psychiatric injuries are service-connected.

DSM-V Question set:

1. *Answer the following if the individual has a mental disorder(s), as defined in DSM-V-Text Revision. Identify the disorder and list elements of the disorder(s) utilizing DSM-State facts that support your findings of the elements of DSM- disorder(s). Discuss when this disorder first came into existence. Discuss the cause(s) of the disorder.*

The applicant has mental disorders as defined in the DSM-5-Text Revision. She meets diagnostic criteria for Posttraumatic Stress Disorder and Major Depressive Disorder.

With respect to Posttraumatic Stress Disorder, the applicant was exposed to repeated and cumulative psychologically traumatic material in the course of her employment. This exposure constitutes traumatic stress through repeated confrontation with distressing details inherent to her job duties. She developed persistent intrusive symptoms related to these work experiences, including recurrent distressing recollections and psychological distress when exposed to reminders. She demonstrated avoidance of stimuli associated with the traumatic material. She developed negative alterations in mood and cognition, including persistent negative emotional states, diminished interest in activities, emotional numbing, and impaired concentration. She also exhibited marked alterations in arousal and reactivity, including heightened anxiety, irritability, sleep disturbance, hypervigilance, and poor distress tolerance. These symptoms persisted for well over one month, caused clinically significant distress and functional impairment, and were not attributable to substances or another medical condition.

The applicant also meets criteria for Major Depressive Disorder. She experienced a persistent depressed mood, markedly diminished interest and pleasure in activities, low energy, impaired concentration, psychomotor slowing under stress, and feelings of hopelessness. These symptoms were present for extended periods, represented a change from prior functioning, caused significant impairment in occupational functioning, and were not better explained by another psychiatric or medical condition.

The applicant's psychiatric conditions first began to develop around [redacted], when she sought psychiatric care in the context of accumulating occupational stress. At that time, her symptoms were present but relatively contained, and she was able to continue working. Her conditions remained intermittently

symptomatic but largely quiescent for several years. In approximately [redacted], following several particularly difficult and emotionally taxing work-related cases, her symptoms worsened substantially. From that point forward, both her Posttraumatic Stress Disorder and Major Depressive Disorder progressed in severity and chronicity, ultimately resulting in significant functional impairment.

The cause of both disorders is cumulative psychological stress arising out of and occurring in the course of her employment. Her work required sustained emotional engagement with distressing material over many years. This chronic exposure exceeded her psychological coping capacity and directly resulted in the development and progression of her Posttraumatic Stress Disorder and Major Depressive Disorder.

2. State present recommended treatment, including type of treatment, anticipated results and time frame.

The applicant requires ongoing psychiatric treatment for her work-related mental disorders.
It is recommended that she continue individual psychotherapy on a weekly basis for a period of one year. The focus of treatment should be on symptom stabilization, emotional regulation, and management of trauma-related and depressive symptoms. Given the chronicity and severity of her condition, psychotherapy is expected to help prevent further psychiatric decompensation rather than result in full symptom remission.

It is also recommended that she continue psychiatric medication management with a psychiatrist every two to three months for the next year. The goal of psychiatric treatment is maintenance of relative stability, monitoring of symptoms, and adjustment of medications as clinically indicated.

The anticipated result of this treatment is stabilization of the applicant's psychiatric condition and reduction in the risk of further deterioration. Significant improvement or return to baseline functioning is not expected within the anticipated treatment timeframe.

3. *If you found a mental disorder at Question 1, and the mental disorder(s) affects ability to work, discuss the following:*

a. Describe any psychiatric limitations of applicant's ability to work. Describe specific tasks that cannot be performed, if any, due to the mental disorder.

The applicant has severe psychiatric limitations that prevent her from working. Due to Posttraumatic Stress Disorder and Major Depressive Disorder, she is unable to sustain concentration, attention, or memory under stress. She cannot reliably initiate tasks, maintain pace or persistence, follow complex instructions, or complete assignments. She is unable to tolerate routine work stress, deadlines, productivity demands, or changes in routine. Emotional dysregulation and intrusive trauma-related symptoms prevent consistent and appropriate interpersonal interactions with supervisors, coworkers, or the public. She is unable to maintain regular attendance or function for any defined workday duration.

b. *If you identified any limitations above, state facts and reasons that support your opinion.*

The applicant's Posttraumatic Stress Disorder results in heightened physiological reactivity, anxiety, hyperarousal, and emotional shutdown when exposed to stressors, including routine workplace demands. Her Major Depressive Disorder contributes to low energy, impaired initiation, poor motivation, anhedonia, and reduced cognitive efficiency. In combination, these conditions impair her

ability to sustain attention, tolerate ordinary work stress, regulate emotions, and perform tasks reliably. These limitations are supported by the applicant's chronic and severe psychiatric symptomatology documented throughout the medical record. The persistence and severity of these symptoms prevent safe or feasible participation in competitive employment on a sustained basis.

c. *State the expected duration of any limitation(s) described above with and without treatment discussed above.*

The psychiatric limitations described above are expected to be permanent.

With ongoing treatment, including weekly psychotherapy and periodic psychiatric medication management, the applicant's symptoms may be maintained at a relatively stable level and the risk of further decompensation may be reduced. However, treatment is not expected to result in significant functional recovery or restoration of work capacity.

Without treatment, the applicant's psychiatric condition would be expected to deteriorate further, with increased symptom severity, emotional instability, and functional impairment.

4. *If you stated any limitations at Question 3 above, answer the following:*
a. *What is the natural course of the mental disorder stated in Question 1 above?*

The natural course of the applicant's mental disorders is lifelong.

Posttraumatic Stress Disorder and Major Depressive Disorder are chronic conditions that may fluctuate in severity over time. The applicant may experience periods of slightly improved functioning as well as periods of symptom exacerbation, particularly when exposed to stressors or trauma-related triggers.

However, based on the longitudinal medical history and current level of impairment, her present level of functioning represents a new baseline. Sustained remission or return to prior levels of occupational functioning is not expected.

b. *What has been the course of the individual's life up to the time at which his work activities became subject to limitations?*

Prior to the onset of work-related limitations, the applicant's life course was marked by adequate overall functioning and the ability to meet personal, social, and occupational demands. She was able to maintain employment, manage daily responsibilities, and function independently. She participated in routine activities of daily living and demonstrated sufficient emotional and cognitive capacity to sustain work performance.

Although she experienced occupational stress over time, she continued working and remained functional without significant restrictions for many years. There is no indication that she required work limitations or was unable to meet job expectations prior to the escalation of her psychiatric symptoms. A comprehensive description of her life course is written above in the *Social History* section.

REVIEW OF MEDICAL RECORDS: Total Pages: 1,181

[redacted] **KAISER PERMANENTE. PT Note. (Final premed part 1 -** [redacted] **- Page 20-23). Total Session**: 1. **Modalities**: Therapeutic exercise and E-stim (unattended). **Diagnosis**: Chronic neck myofascial pain.

[redacted]**. KAISER PERMANENTE.** [redacted]**, DO. Progress Report. (Final premed part 1 -** [redacted] **- Page 24-27). Subjective:** The member presented with neck pain. **Diagnosis**: Cervicalgia (primary). **Procedure**: Kenalog and Marcaine/lidocaine were administered into the bilateral trapezius.

[redacted]**. KAISER PERMANENTE.** [redacted]**, DO. Progress Report. (Final premed part 1 -** [redacted] **- Page 29-31). Subjective:** The member was going to Seattle during the holidays. **Diagnoses**: 1) Health check-up, adult. 2) Cervicalgia. **Plan**: The examiner ordered labs. Recommended stress management. Continue neck exercises. **Procedure**: Trigger point injection in the bilateral trapezius.

[redacted]**. KAISER PERMANENTE.** [redacted]**, DO. Progress Report. (Final premed part 1 -** [redacted] **- Page 53-55). Subjective:** The member presented for a follow-up of chronic neck pain and was requesting a trigger point injection. She reported she lost several lbs. since going on a natural diet. She also complained of right foot pain and inhibited exercise due to pain. **Plan**: Recommended increase in exercise and ROM exercises. **Procedure**: Trigger point injection in the bilateral trapezius.

[redacted]**. KAISER PERMANENTE.** [redacted]**, DO. Clinic Note. (Final premed part 1 -** [redacted] **- Page 59-59). Comments**: The member was referred to a podiatrist.

[redacted]**. KAISER PERMANENTE.** [redacted]**, DPM. Progress Report. (Final premed part 1 -** [redacted] **- Page 62-63). Subjective:** The member complained of right foot pain and ankle pain. **Diagnoses**: 1) Metatarsalgia (primary encounter diagnosis). 2) Foot pain. **Plan**: The examiner ordered x-rays of the right and left ankle. Recommended shoes.

[redacted]**. KAISER PERMANENTE.** [redacted]**, MD. X-rays of the Right Foot. (Final premed part 1 -** [redacted] **- Page 56-57). Findings**: There was sclerosis of the proximal ph[redacted]x of the fifth digit. This might represent an old, healed fracture. No acute disease was seen.

[redacted]**. KAISER PERMANENTE.** [redacted]**, DO. Progress Report. (Final premed part 1 -** [redacted] **- Page 72-75). Subjective:** The member complained of chronic myofascial neck pain, worst on the right. She reported stress was okay but working about 20 hours more every 2 weeks. **Diagnosis**: Myofascial pain syndrome (primary). **Plan**: Recommended stress management and ROM exercises as directed. **Procedure**: Trigger point injection in the left trapezius, left scapula and right trapezius.

[redacted]**. KAISER PERMANENTE.** [redacted]**, DO. Progress Report. (Final premed part 1 -** [redacted] **- Page 76-78). Subjective:** The member complained of myofascial neck and back pain. **Diagnosis**: Myofascial pain syndrome (primary). **Procedure**: Trigger point injection in the bilateral trapezius.

[redacted]. KAISER PERMANENTE. [redacted], DO. Progress Report. (Final premed part 1 - [redacted] [redacted] - Page 78-80). Subjective: The member presented for neck injections. **Diagnosis**: Myofascial pain syndrome (primary). **Procedure**: Trigger point injection in the bilateral trapezius.

[redacted]. KAISER PERMANENTE. [redacted] DO. Progress Report. (Final premed part 1 - [redacted] [redacted] - Page 86-89). Subjective: The member continued to have neck pain. **Diagnoses**: Myofascial pain syndrome. 2) Prophylactic vaccine for influenza (primary). **Plan**: Prescribed gabapentin. Continue the TENS unit. **Procedure**: Trigger point injection in the bilateral trapezius.

[redacted]. KAISER PERMANENTE. RT Note. (Final premed part 1 - [redacted] [redacted] - Page 92-95). Total Session: 1. **Diagnosis**: Sleep apnea, evaluation for (primary).

[redacted]. KAISER PERMANENTE. [redacted], DO. Sleep Study Report. (Final premed part 1 - [redacted] [redacted] - Page 100-100). Impression: There was no evidence of sleep-disordered breathing.

[redacted]. KAISER PERMANENTE. [redacted], DO. Progress Report. (Final premed part 1 - [redacted] [redacted] - Page 105-107). Subjective: The member presented for neck injections. **Diagnosis**: Myofascial pain syndrome (primary). **Procedure**: Trigger point injections in the bilateral trapezius.

[redacted]. KAISER PERMANENTE. [redacted], DO. Progress Report. (Final premed part 1 - [redacted] [redacted] - Page 110-112). Subjective: The member complained of severe, tearful neck pain. She had no change in stress. She had sleep difficulty due to pain. **Diagnosis**: Myofascial pain syndrome (primary). **Plan**: Prescribed prednisone and methylprednisolone acetate injection. **Procedure**: Trigger point injection in the bilateral trapezius.

[redacted]. KAISER PERMANENTE. [redacted] DO. Progress Report. (Final premed part 1 - [redacted] [redacted] - Page 116-118). Subjective: The member presented for neck injections. She was feeling much better since the last injection. **Diagnosis**: Myofascial pain syndrome (primary). **Plan**: The examiner ordered labs. **Procedure**: Trigger point injection in the bilateral trapezius.

[redacted] KAISER PERMANENTE. [redacted], DO. Progress Report. (Final premed part 1 - [redacted] [redacted] - Page 121-123). Subjective: The member is seen for neck pain. **Diagnosis**: Myofascial pain syndrome (primary). **Procedure**: Trigger point injection.

[redacted]. KAISER PERMANENTE. [redacted], DO. Progress Report. (Final premed part 1 - [redacted] [redacted] - Page 125-128). Subjective: The member complained of chronic neck pain. **Diagnosis**: Myofascial pain syndrome (primary). **Plan**: The examiner ordered labs. **Procedure**: Trigger point injection.

[redacted]. KAISER PERMANENTE. [redacted], DO. Progress Report. (Final premed part 1 - [redacted] [redacted] - Page 131-133). Subjective: The member presented for a follow-up of neck myofascial pain. **Diagnosis**: Myofascial pain syndrome (primary). **Procedure**: Trigger point injection in the bilateral trapezius.

[redacted]. KAISER PERMANENTE. [redacted], DO. Progress Report. **(Final premed part 1 - [redacted] - Page 133-135). Subjective:** The member presented for neck injections. **Diagnosis**: Myofascial pain syndrome (primary). **Procedure**: Trigger point injection in the bilateral trapezius.

[redacted]. KAISER PERMANENTE. [redacted] DO. Progress Report. **(Final premed part 1 - [redacted] - Page 133-138). Subjective:** The member presented for neck injections and PAP smear testing. **Diagnoses**: 1) Myofascial pain syndrome. 2) Screening for CA, cervix (primary). 3) Prophylactic vaccine for influenza. **Plan**: The examiner ordered labs. **Procedure**: Trigger point injection in the bilateral trapezius.

[redacted]. KAISER PERMANENTE. [redacted] DO. Progress Report. **(Final premed part 1 - [redacted] - Page 145-147). Subjective:** The member presented for a follow-up of neck pain. **Diagnosis**: Myofascial pain syndrome (primary). **Plan**: Continue ROM exercises. **Procedure**: Trigger point injection in the bilateral trapezius.

[redacted]. KAISER PERMANENTE. [redacted] DO. Progress Report. **(Final premed part 1 - [redacted] - Page 147-149). Subjective:** The member reported neck pain and right TMJ pain. **Diagnoses**: 1) Myofascial pain syndrome (primary). 2) TMJ disorder. **Plan**: Prescribed lidocaine HCL 5% topical ointment. The examiner ordered labs. **Procedure**: Trigger point injection in the bilateral trapezius.

[redacted]. KAISER PERMANENTE. [redacted] DO. Progress Report. **(Final premed part 1 - [redacted] - Page 154-157). Subjective:** The member presented for a follow-up of neck pain and labs. **Diagnoses**: 1) Myofascial pain syndrome. 2) Hyperlipidemia. **Plan**: Recommended diet and exercise. **Procedure**: Trigger point injection in the bilateral trapezius.

[redacted]. KAISER PERMANENTE. [redacted] DO. Progress Report. **(Final premed part 1 - [redacted] - Page 176-179). Subjective:** The member complained of myofascial pain syndrome. **Diagnosis**: Myofascial pain syndrome (primary). **Plan**: Continue ROM exercise as tolerated. **Procedure**: Trigger point injection in the bilateral trapezius.

[redacted]. KAISER PERMANENTE. [redacted] DO. Progress Report. **(Final premed part 1 - [redacted] - Page 183-185). Subjective:** The member complained of bilateral trapezius/neck pain and was requesting an injection. **Diagnoses**: 1) Myofascial pain syndrome (primary). 2) Overweight adult (BMI 25-29.9). **Plan**: Prescribed phentermine. Continue ROM exercise as tolerated. **Procedure**: Trigger point injection in the bilateral trapezius.

[redacted]. KAISER PERMANENTE. [redacted] DO. Progress Report. **(Final premed part 1 - [redacted] - Page 186-188). Subjective:** The member complained of myofascial pain syndrome. **Diagnosis**: Myofascial pain syndrome (primary). **Procedure**: Trigger point injection in the bilateral trapezius.

[redacted]. KAISER PERMANENTE. [redacted] DO. Progress Report. **(Final premed part 1 - [redacted] - Page 190-193). Subjective:** The member presented with right shoulder pain. She had muscle issues and gets an injection every 6 weeks. **Diagnosis**:

Myofascial pain syndrome (primary). **Plan**: Recommended diet and exercise. **Procedure**: Trigger point injection in the bilateral trapezius.

[redacted] KAISER PERMANENTE. [redacted] DO. Progress Report. (Final premed part 1 - [redacted] - Page 196-185). Subjective: The member complained of bilateral trapezius/neck pain and was requesting an injection. **Diagnoses**: 1) Myofascial pain syndrome. 2) Prophylactic vaccine for influenza (primary). **Procedure**: Trigger point injection in the bilateral trapezius.

[redacted] KAISER PERMANENTE. [redacted] DO. Progress Report. (Final premed part 1 - [redacted] - Page 196-202). Subjective: The member complained of bilateral trapezius/neck pain and was requesting an injection. **Diagnoses**: 1) Myofascial pain syndrome (primary). 2) Tendonitis of the shoulder. **Procedure**: Trigger point injection in the bilateral trapezius. Right shoulder joint injection.

[redacted] KAISER PERMANENTE. [redacted], MD. X-rays of the Right Shoulder. (Final premed part 1 - [redacted] - Page 202-203). Findings: Mild degenerative changes were suggested in the acromioclavicular joint. The glenohumeral joint shows a normal appearance.

[redacted] KAISER PERMANENTE. [redacted] DO. Progress Report. (Final premed part 1 - [redacted] - Page 205-207). Subjective: The member complained of bilateral trapezius/neck pain and was requesting an injection. **Diagnosis**: Myofascial pain syndrome (primary). **Procedure**: Trigger point injection in the bilateral trapezius.

[redacted]. KAISER PERMANENTE. Dr. [redacted] / [redacted], RN. Message Note. (Final premed part 1 - [redacted] - Page 215-215). Comments: Labs were ordered.

[redacted]. KAISER PERMANENTE. [redacted] DO. Progress Report. (Final premed part 1 - [redacted] - Page 218-221). Subjective: The member complained of bilateral trapezius/neck pain and was requesting an injection. **Diagnoses**: 1) Myofascial pain syndrome (primary). 2) Overweight. **Plan**: Trial of Taurine and Ginseng was given. The examiner ordered labs. Recommended physical therapy, diet and exercise as tolerated. **Procedure**: Bilateral trapezius trigger point injection. Right subacromial joint injection.

[redacted]. KAISER PERMANENTE. [redacted] DO. Progress Report. (Final premed part 1 - [redacted] - Page 240-243). Subjective: The member had chronic neck, shoulder and back pain. **Diagnoses**: 1) Myofascial pain syndrome. 2) Overweight (primary). **Plan**: Prescribed chromium, Cortef, vitamin C, Pantothenic acid and Licorice extract. The examiner ordered labs. Consider Armour thyroid instead of bioidentical hormones. Monitor weight. Recommended sleep hygiene and stress management. **Procedure**: Trigger point injection in the bilateral trapezius.

[redacted] [redacted] MD. Office Visit. (Final premed part 1 - [redacted] - Page 471-471). Subjective: The member would like to lose weight. She reports fatigue and insomnia. She also complains of itching all over after pellet insertion. **Diagnoses**: 1) Fatigue. 2) Insomnia, chronic. 3) Weight gain. **Plan:** Prescribed Qi Gong, Adapten, Glucophage and Myocalm PM. **Procedure**: B12/lipo injection.

[redacted], [redacted] [redacted]

[redacted]. KAISER PERMANENTE. [redacted] DO. Progress Report. (Final premed part 1 - [redacted] - Page 264-267). Subjective: The member presented for injection. Diagnosis: Myofascial pain syndrome (primary). Plan: The examiner ordered labs. Continue bioidentical hormones. Procedure: Bilateral trapezius trigger point injection.

[redacted]. KAISER PERMANENTE. [redacted] DO. Progress Report. (Final premed part 1 - [redacted] - Page 272-275). Subjective: The member presented for trigger point injection. Diagnoses: 1) Myofascial pain syndrome. 2) Prophylactic vaccine for tetanus, diphtheria, acellular pertussis (primary). Plan: The examiner ordered labs. Procedure: Trigger point injection in the bilateral trapezius.

[redacted]. KAISER PERMANENTE. [redacted] DO. Progress Report. (Final premed part 1 - [redacted] - Page 307-310). Subjective: The member presented for injection. She complained of neck pain and lost about 40 lbs. She was feeling great. Diagnoses: 1) Myofascial pain syndrome (primary). 2) Endocrine disorder. Procedure: Trigger point injection in the bilateral trapezius.

[redacted]. KAISER PERMANENTE. [redacted] DO. Progress Report. (Final premed part 1 - [redacted] - Page 323-326). Subjective: The member presented for injection. She complained of chest cold and cold sore. She reported chest congestion improving slowly. Diagnoses: 1) Myofascial pain syndrome. 2) Prophylactic vaccine for influenza (primary). 3) Skin lesion. 4) Nasopharyngitis. Plan: Prescribed Oralone 0.1% and Cheratussin AC. The examiner ordered labs. Procedure: Bilateral trapezius trigger point injection.

[redacted]. KAISER PERMANENTE. [redacted] DO. Progress Report. (Final premed part 1 - [redacted] - Page 348-351). Subjective: The member presented for trigger point injection. Diagnoses: 1) Myofascial pain syndrome (primary). 2) Endocrine disorder. Plan: Prescribed Armour Thyroid. The examiner ordered labs. Procedure: Bilateral trapezius trigger point injection.

[redacted]. KAISER PERMANENTE. [redacted], DO. Progress Report. (Final premed part 1 - [redacted] - Page 370-373). Subjective: The member presented for PAP test. Diagnoses: 1) Screening for human papillomavirus. 2) Well-woman exam. 3) Screening for CA, cervix. 4) Screening for CA, breast. Plan: The examiner ordered labs. Recommend monthly SBE.

[redacted] MD. Office Visit. (Final premed part 1 - [redacted] - Page 491-491). Subjective: The member is seen for allergy testing. Diagnoses: 1) Constipation. 2) Fibromyalgia. 3) Weight gain. Plan: Prescribed AdrenFuel+T and InflamCore.

[redacted] MD. Office Visit. (Final premed part 1 - [redacted] - Page 494-494). Subjective: The member is seen for pellet insertion. She noticed symptoms of mental fog, energy, bloating and irregularity. Diagnoses: 1) Constipation. 2) PMS. Plan: Prescribed Biotic, Diflucan and Natural Calm. Procedure: Pellet implant.

[redacted]. KAISER PERMANENTE. [redacted] DO. Progress Report. (Final premed part 1 - [redacted] - Page 389-392). Subjective: The member presented with neck

pain and was requesting an injection. She was doing well and had testosterone increased. **Diagnoses**: 1) Myofascial pain syndrome (primary). 2) Endocrine disorder. 3) Overweight. **Plan**: The examiner ordered labs. **Procedure**: Bilateral trapezius and mid paraspinal trigger point injection.

[redacted]. KAISER PERMANENTE. [redacted] DO. Telephone Encounter Note. (Final premed part 1 - [redacted] - Page 433-434). Comments: The examiner recommended a refill of Armour thyroid.

[redacted]. KAISER PERMANENTE. [redacted] DO. Progress Report. (Final premed part 1 - [redacted] - Page 435-437). Subjective: The member presented for lab results. **Diagnoses**: 1) Myofascial pain syndrome (primary). 2) Endocrine disorder. **Plan**: Prescribed Armour thyroid, Glucophage, Diflucan, erythromycin with ethanol 2% topical gel and Penecort 2.5% topical cream. The examiner ordered labs. Recommended diet modification and exercise as tolerated.

[redacted]. KAISER PERMANENTE. [redacted] DO. Message Note. (Final premed part 1 - [redacted] - Page 459-460). Comments: The member was informed that blood tests looked great. Her testosterone was higher than before, and her cholesterol was normal.

[redacted]. KAISER PERMANENTE. [redacted] DO. Letter Note. (Final premed part 1 - [redacted] - Page 461-461). Comments: The member had a history of ankylosing spondylitis with +HLA-B27 testing (reported in [redacted]) and thoracic and lumbar spine x-rays dated [redacted] and [redacted] revealed minimal arthritic changes. She reported treatment including anti-inflammatories, exercise program and proper body mechanics. In [redacted], the member required multiple trapezius trigger point injections to treat her myofascial pain syndrome. She progressed well with weight loss, physical therapy, massage therapy, chiropractic care and medication.

[redacted] [redacted] MD. Weight Loss Program Notes. (Final premed part 1 - [redacted] - Page 497-501, 506-508, 511-516, 522-522, 525-526). Total Visits: Multiple. **Diagnosis:** Weight gain. **Procedure:** B12/lipo.

[redacted] [redacted] MD. Bio-Identical Testosterone Pellet Therapy. (Final premed part 1 - [redacted] - Page 504-505, 518-519, 523-524, 537-538). Total Visits: 4.

[redacted]. [redacted] MD. Office Visit. (Final premed part 1 - [redacted] - Page 506-506). Subjective: The member is very motivated for weight loss. She desires to lose 15 lbs. **Diagnosis:** Weight gain. **Procedure:** B12/lipo.

[redacted]. ST JOSEPH HERITAGE HEALTHCARE. [redacted] MD. Bilateral Breast Digital Screening Mammogram. (Final premed part 1 - [redacted] - Page 520-521). Impression: BI-RADS category 2 – benign findings.

[redacted]. [redacted] MD. Office Visit. (Final premed part 1 - [redacted] - Page 534-535). Plan: Prescribed Chill Pill+, Aldactone and testosterone pellet.

[redacted]. ADVANTAGE MRI. [redacted] MD. MRI of the Cervical Spine. (Final premed part 1 - [redacted] [redacted] - Page 601-602). Impressions: 1) There are no significant marrow signal abnormalities. No compression fracture is noted. 2) **C2-C3 Level:** There is slight loss of disc height and disc signal. There is a 1-2 mm disc osteophyte complex, not causing any central or nerve root canal stenosis. Facet joint arthrosis is noted. 3) **C3-C4 Level:** There is a 2-3 mm diffuse disc bulge, which effaces the ventral subarachnoid space, contributes to central spinal canal stenosis (AP diameter is 10 mm) and right greater than left foraminal exit zone compromise. Uncovertebral joint hypertrophy is noted. 4) **C4-C5 Level:** There is loss of disc height and disc signal and retrolisthesis of C4 over C5. A 3 mm disc osteophyte complex is noted with left foraminal focality. This contributes to central spinal stenosis (AP diameter is 10 mm) and moderate to severe left and moderate right foraminal exit zone compromise. Please correlate clinically for symptoms of left C5 radiculopathy. 5) **C5-C6 Level:** Disc desiccation is noted. There is a 2 mm disc osteophyte complex, not contributing to significant central spinal canal stenosis. There is bilateral foraminal exit zone compromise secondary to the uncovertebral joint hypertrophy, right worse than left. 6) **C6-C7 Level:** The disc height is maintained. There is a 2-3 mm diffuse disc bulge, which effaces the ventral CSF without causing central or foraminal stenosis. There is no significant facet joint hypertrophy.

[redacted]. UCI HEALTH. [redacted] MD. Outpatient Consultation. (Final premed part 1 - [redacted] [redacted] - Page 545-547, 570-572, 590-592). Subjective: The member complains of neck and left shoulder pain. **Diagnosis:** Cervical spondylosis myelopathy. **Plan:** The member will continue observation.

[redacted] [redacted] MD. Bio-Identical Testosterone Pellet Therapy. (Final premed part 1 - [redacted] [redacted] - Page 603-603, 607-608). Total Visits: 2.

[redacted]. UCI HEALTH. [redacted] MD. Progress Note. (Final premed part 1 - [redacted] [redacted] - Page 619-620, 635-636). Subjective: The member complains of pain in the neck and left shoulder. **Diagnosis:** Cervical spondylosis myelopathy. **Plan:** Recommended C4-C5 and C5-C6 disc arthroplasty.

[redacted]. UCI HEALTH. [redacted] MD. X-rays of the Cervical Spine. (Final premed part 1 - [redacted] [redacted] - Page 670-671). Impression: Moderate degenerative changes of the cervical spine, most pronounced at C4-C5 and C5-C6, with grade 1 retrolisthesis of C4 and C5, which remains stable with movement.

[redacted]. UCI HEALTH. [redacted] MD. Pre-Operative History and Physical Note. (Final premed part 1 - [redacted] [redacted] - Page 683-684, 698-699). Subjective: The member is seen for pre-operative evaluation before her C4-C5 cervical disc arthroplasty. **Diagnosis:** Neck pain. **Plan:** The member is okay to proceed with surgery.

[redacted]. [redacted] MD. Operative Note. (Final premed part 1 - [redacted] [redacted] - Page 720-721). Operation: Cervical C4-C5, C5-C6 disc arthroplasty. **Pre-op Diagnosis:** Cervical spondylotic myelopathy. **Post-op Diagnosis:** Same as pre-op diagnosis.

[redacted]. UCI HEALTH. [redacted] MD. Intraoperative Neurophysiological Monitoring Report. (Final premed part 1 - [redacted] [redacted] - Page 889-897). Procedure: Anterior cervical C4-C5, C5-C6 decompression, fusion, instrumentation, disc arthroplasty.

[redacted]. UCI HEALTH. [redacted] MD/[redacted] MD. Orthopedic Surgery Progress Note. (Final premed part 1 -[redacted] [redacted] - Page 742-744). Subjective: No acute events overnight. Pain controlled. **Assessment/Plan:** Status post C4-C6 cervical disc arthroplasty. WBAT x4 in soft collar for comfort. Keep dressing c/d/i -VSS, Hgb stable -Abx: X 24 hrs. DVT prophylaxis: Ambulate, scds. Pain controlled. PT/OT. Diet: Regular. Disposition: Discharge home pending pain control, therapy and DME.

[redacted]. UCI HEALTH. [redacted] MD/[redacted] MD. X-rays of the Cervical Spine. (Final premed part 1 -[redacted] [redacted] - Page 758-759). Impression: Interval intervertebral disc arthroplasty of C4-C5 and C5-C6. Significant prevertebral soft tissue swelling, likely related to recent surgery.

[redacted]. UCI HEALTH. [redacted] PT. Physical Therapy Note. (Final premed part 1 -[redacted] [redacted] - Page 734-738). Total Session: 1. **Diagnosis:** Status post C4-C5, C5-C6 disc arthroplasty.

[redacted]. UCI HEALTH. [redacted] MD. Discharge Summary. (Final premed part 1 -[redacted] [redacted] - Page 730-733). Admission Date: 12/07/17. **Hospital Course:** The member tolerated surgery well. **Plan:** Start Augmentin, Roxicodone and Senokot. Continue Xanax, Armour Thyroid, clonazepam, Claritin and testosterone pellet. She was discharged home in stable condition.

[redacted]. UCI HEALTH. [redacted] MD. Spine Surgery Postoperative Visit. (Final premed part 1 -[redacted] [redacted] - Page 966-966). Subjective: The member is doing well and has no complaints. **Plan:** Discussed postoperative instructions.

[redacted]. UCI HEALTH. [redacted] MD/[redacted] MD. X-rays of the Cervical Spine. (Final premed part 1 -[redacted] [redacted] - Page 963-964). Impression: Status post C4-C5 and C5-C6 discectomy and prosthetic disc placement. Prevertebral soft tissue swelling has slightly increased in the interim. This may be related to postsurgical change or an infectious process.

[redacted]. UCI HEALTH. [redacted] MD. Spine Surgery Postoperative Visit. (Final premed part 1 -[redacted] [redacted] - Page 986-986). Subjective: The member is doing well and has no complaints. **Plan:** Discussed postoperative instructions.

[redacted]. UCI HEALTH. [redacted] MD/[redacted] MD. X-rays of the Cervical Spine. (Final premed part 1 -[redacted] [redacted] - Page 987-988). Impression: Improved, but persistent prevertebral soft tissue swelling. Otherwise, no significant interval change.

[redacted]. UCI HEALTH. [redacted] MD. Spine Surgery Postoperative Visit. (Final premed part 1 -[redacted] [redacted] - Page 1033-1034). Subjective: The member is doing well and has no complaints. **Plan:** Discussed postoperative instructions.

[redacted]. UCI HEALTH. [redacted] MD. X-rays of the Cervical Spine. (Final premed part 1 -[redacted] [redacted] - Page 1057-1058). Impression: No significant interval change.

[redacted]. **UCI HEALTH.** [redacted] **MD. X-rays of the Thoracic Spine.** **(Final premed part 1 -** [redacted] **- Page 1059-1060). Impression:** Mild degenerative changes of the thoracic spine.

[redacted] **MD. Bio-Identical Testosterone Pellet Therapy.** **(Final premed part 1 -** [redacted] **- Page 1068-1071, 1106-1108, 1590-1596). Total Visits:** 3.

[redacted]. **UCI HEALTH.** [redacted] **MD. Spine Surgery Postoperative Visit.** **(Final premed part 1 -** [redacted] **- Page 1076-1076). Subjective:** The member is doing well but has pain at the top of her neck. **Plan:** Referred to Pain Management for facet injections at C2-C3, C3-C4. Discussed postoperative instructions.

[redacted]. **UCI HEALTH.** [redacted] **MD. X-rays of the Cervical Spine.** **(Final premed part 1 -** [redacted] **- Page 1072-1072). Impression:** No significant interval change.

[redacted]. **HOAG CLINIC.** [redacted] **FNP. Progress Note.** **(Final premed part 1 -** [redacted] **- Page 1102-1104). Subjective:** The member complains of pain in the left ankle. **Diagnosis:** Left ankle pain. **Plan:** Ordered x-rays of the left ankle. The member declines office treatment and crutches.

[redacted]. **UCI HEALTH.** [redacted] **MD. Digital Screening Mammogram with Computer Aided Detection.** **(Final premed part 2** [redacted] **- Page 2840-2842). Impression:** BI-RADS Category 2 - Benign Finding.

[redacted]. **UCI HEALTH.** [redacted] **MD. Orthopedic Spine Surgery Note.** **(Final premed part 1 -** [redacted] **- Page 1117-1160). Subjective:** The member complains of neck and bilateral arm pain. She reports numbness in the small fingers and her hands will fall asleep when she drives. She has loss of hand dexterity. She had a C4-C5 and C5-C6 levels cervical spine disc displacement and has been doing well but a few months ago, she started developing increasing pain in the upper left side of the neck and numbness in the hands. **Diagnosis**: Other spondylosis with myelopathy, cervical spine region (primary encounter diagnosis). **Plan**: MRI of the cervical spine is ordered.

[redacted]. **UCI HEALTH.** [redacted] **MD. X-rays of the Cervical Spine.** **(Final premed part 1 -** [redacted] **- Page 1162-1162, 1166-1166). Impression**: No significant interval change.

[redacted]. **UCI HEALTH.** [redacted] **MD. Orthopedic Spine Surgery Note.** **(Final premed part 1 -** [redacted] **- Page 1186-1220). Subjective**: The member is seen for follow-up. **Diagnosis**: Other spondylosis with myelopathy, cervical spine region (primary encounter diagnosis). **Plan**: MRI of the cervical spine is ordered.

[redacted]. **UCI HEALTH.** [redacted] **MD/**[redacted] **PA. Office Visit.** **(Final premed part 1 -** [redacted] **- Page 1230-1232, 1597-1598). Subjective**: The member is seen for pellet insertion. She reports palpitations, night sweats and brain fog. **Diagnoses**: 1) Menopause,

symptomatic. 2) Fatigue. 3) Weight gain, abnormal. 4) Premenstrual tension syndrome. 5) Testosterone deficiency-female. 6) Fibromyalgia. 7) Hypothyroidism. 8) Insomnia, chronic. 9) Mixed hyperlipidemia. 10) Headaches. **Plan**: Cytomel, Armour Thyroid, Vivelle-Dot, Adronfuel, pregnenolone, DHEA, Diflucan, Glucophage, albuterol and cipro are prescribed. **Procedure**: Pellet implant fixation is performed.

[redacted]. UCI HEALTH. [redacted] DO/[redacted] MD. Initial Consultation Note. (Final premed part 1 - [redacted] - Page 1236-1266). Subjective: The member complains of neck pain localized on the left side. She has been dealing with the pain since she had a wisdom tooth removal. She reports 70% pain in her neck and 30% in her shoulder. **Diagnoses**: 1) Cervical spine spondylosis. 2) Cervical spine radiculopathy. 3) Cervical spine myofascial pain. 4) Osteoarthritis of the cervical spine, unspecified spinal osteoarthritis complication status. **Plan**: Continue Flexeril. The examiner ordered cervical spine MBB on the left at the C3-C5 level.

[redacted]. HOAG CLINIC. [redacted] NP. Urgent Care Note. (Final premed part 1 - [redacted] - Page 1271-1273). Subjective: The member presents to urgent care with sinus congestion and cough. **Diagnosis**: Acute sinusitis. **Plan**: Augmentin, prednisone and promethazine-codeine are prescribed. Continue Mucinex-D and Tylenol. The examiner recommended trying sinus irrigation or saline spray. Recommended humidifier or steamy showers. Recommended to increase fluids and get adequate rest.

[redacted]. UCI HEALTH. [redacted] Telephone Encounter Note. (Final premed part 1 - [redacted] - Page 1276-1276). Comments: The member reports she has tried multiple conservative treatments and goes for weekly PT. She needs a cervical spine injection as she likely has a component of cervical radiculopathy given her previous radicular symptoms down her arm.

[redacted]. UCI HEALTH. [redacted] MD/[redacted] MD. Procedure Note. (Final premed part 1 - [redacted] - Page 1285-1288, 1290-1294, 1309-1316). Procedure(s): 1) C4, C5 and C6 levels cervical spine medial branch block. 2) Intraoperative fluoroscopy. **Pre-Procedure Diagnosis**: Cervical spine spondylosis. **Post-Procedure Diagnosis**: Same as the pre-procedure diagnosis.

[redacted]. UCI HEALTH. [redacted] DO. Rheumatology Initial Consultation Note. (Final premed part 1 - [redacted] - Page 1322-1327, 1335-1339). Subjective: The member reported that at the age of 22, following an episode of the right-sided TMJ, she started having severe pain and stiffness in the cervical and thoracic spine. A few years later, the pain spread to involve her lumbar spine and SI joints. Eventually, her PCP obtained an HLA-B27 that was positive, so told that she might have ankylosing spondylitis at the age of [redacted]. At the age of [redacted], the member started to get numbness in her arms. At the age of [redacted], she was seen by a rheumatologist who did not feel she had AS. At [redacted], the member started gaining weight. At [redacted], she was seen by a hormone specialist who figured out she had hormone deficiency, hypothyroidism and adrenal fatigue. In [redacted], she started to have recurrence of her arm numbness. The member is not having any more AM stiffness or pain, other than some milder pain and stiffness throughout the rest of her spine. She is still having pain intermittently in the neck region that radiates down to her shoulder blades. She felt a lot of pain in her muscles as well. **Diagnoses**: 1) Ankylosing spondylitis. 2) Chronic neck pain. 3) History of the herniated discs

and cervical spine radiculopathy. 4) Possible secondary fibromyalgia. **Plan**: Humira is prescribed. The examiner recommended repeat imaging.

[redacted]. UCI HEALTH. [redacted] MD/[redacted] MD. Procedure Note. (Final premed part 1 - [redacted] - Page 1368-1371, 1378-1382, 1392-1399). Procedure(s): 1) Left C4, C5, C6 and C7 levels cervical spine medial branch block. 2) Intraoperative fluoroscopy. **Pre-Procedure Diagnosis**: Cervical spine spondylosis. **Post-Procedure Diagnosis**: Same as the pre-procedure diagnosis.

[redacted]. UCI HEALTH. [redacted] MD. Initial Consultation Note. (Final premed part 1 - [redacted] - Page 1409-1415, 1419-1432). Subjective: The member reports pain in the left side of the neck. The pain radiates into the left arm and left shoulder. **Diagnoses**: 1) Cervical spine spondylosis. 2) Cervical spine radiculopathy. 3) Cervical spine myofascial pain. **Plan**: Continue Flexeril. The authorization request is placed for C3, C4, C5 and C6 levels of the left cervical spine medial branch nerves.

[redacted]. UCI HEALTH. [redacted] MD. Procedure Note. (Final premed part 1 - [redacted] - Page 1440-1444, 1453-1462, 1466-1469). Procedure(s): 1) Radiofrequency ablation of the left C4 level medial branch nerve. 2) Intraoperative fluoroscopy. **Pre-Procedure Diagnosis**: Cervical spine spondylosis. **Post-Procedure Diagnosis**: Same as the pre-procedure diagnosis.

[redacted]. UCI HEALTH. [redacted] MD/[redacted] PA. Office Visit. (Final premed part 1 - [redacted] - Page 1482-1484, 1599-1601). Subjective: The member is seen for pellet insertion. She reports irritability. **Diagnoses**: 1) Menopause, symptomatic. 2) Fatigue. 3) Weight gain, abnormal. 4) Hypothyroidism. 5) Insomnia, chronic. **Plan**: Cytomel, Glucophage, Adrenfuel+T, DHEA, pregnenolone, vitamin D and Nature-Throid are prescribed. **Procedure**: Pellet implant.

[redacted]. UCI HEALTH. [redacted] MD. Procedure Note. (Final premed part 1 - [redacted] - Page 1490-1514). Procedure(s): 1) Radiofrequency ablation of the left C5, C6 and C7 medial branch nerves. 2) Intraoperative fluoroscopy. **Pre-Procedure Diagnosis**: Cervical spine spondylosis. **Post-Procedure Diagnosis**: Same as the pre-procedure diagnosis.

[redacted]. UCI HEALTH. [redacted] DO. Rheumatology Follow-Up Note. (Final premed part 1 - [redacted] - Page 1523-1526). Subjective: The member had RFA on her cervical spine without benefit. She reports constant pain. She is going for follow-up to have trigger point injections. **Diagnoses**: 1) Ankylosing spondylitis. 2) Chronic neck pain with history of herniated discs and cervical spine radiculopathy. 3) Possible secondary fibromyalgia. 4) HTN. **Plan**: Humira is prescribed. The examiner will obtain infectious screening.

[redacted]. UCI HEALTH. [redacted] MD. Procedure Note. (Final premed part 1 - [redacted] - Page 1533-1536, 1550-1552). Procedure: Trigger point injection. **Pre-Procedure Diagnosis**: Myalgia/myositis. **Post-Procedure Diagnosis**: Same as the pre-procedure diagnosis.

[redacted]. UCI HEALTH. [redacted] MD. Cardiac Electrophysiology Clinic Note. (Final premed part 1 - [redacted] - Page 1555-1557, 1565-1570, 1572-1574).

Subjective: The member reports high blood pressure. Her blood pressure is associated with headaches sometimes. She had workup for sleep apnea 10 years ago, which was negative. **Diagnoses**: 1) Ankylosing spondylitis. 2) Elevated BP without diagnosis of hypertension. Possible masked hypertension. **Plan**: Discontinue Armour Thyroid and testosterone. The examiner recommended 24-hour ambulatory BP. The examiner requests to provide records from the Washington ER visit be forwarded for review.

[redacted]. UCI HEALTH. [redacted] MD. ECG Report. (Final premed part 1 - [redacted] - Page 1571-1571, 1575-1576). Impressions: Sinus rhythm with sinus arrhythmia with short PR interval. Borderline ECG.

[redacted]. UCI HEALTH. [redacted] MD/[redacted] MD. Procedure Note. (Final premed part 1 - [redacted] - Page 1604-1607, 1622-1625). Procedure: Trigger point injection. **Pre-Procedure Diagnosis**: Myalgia/myositis. **Post-Procedure Diagnosis**: Same as the pre-procedure diagnosis.

[redacted] UCI HEALTH. [redacted] MD/[redacted] MD. Procedure Note. (Final premed part 1 - [redacted] - Page 1631-1633, 1635-1638). Procedure: Trigger point injection. **Pre-Procedure Diagnosis**: Myalgia/myositis. **Post-Procedure Diagnosis**: Same as the pre-procedure diagnosis.

[redacted]. HOAG CLINIC. [redacted] NP. Progress Note. (Final premed part 1 - [redacted] - Page 1652-1655). Subjective: The member complains of shortness of breathing and wheezing. She has history of autoimmune reactive airway disease. She reports cracking and irritation in her right nostril. She also has cold sores that come and go. She reports soreness on the bottom lip. **Diagnoses**: 1) Cough. 2) Shortness of breath. 3) Sore in the nose. 4) History of cold sores. 5) Cold sore. **Plan**: Valacyclovir HCL is prescribed. Continue mupirocin ointment. X-rays of the chest is ordered. Follow-up with the PCP and rheumatologist. **Procedure**: Medrol injection is administered.

[redacted]. UCI HEALTH. [redacted] DO. Rheumatology Follow-Up Note. (Final premed part 1 - [redacted] - Page 1660-1664, 1671-1678, 1684-1688). Subjective: The member is having trouble breathing. She had bronchial hyper-responsiveness and was seen by an immunologist. The symptoms have been triggered by some exposures she has had from recent ceiling repairs. She reports headaches. She is seeing a psychiatrist for OCD, triggered by ovulation. She reports it helped with Klonopin when she ruminates and takes Xanax. **Diagnoses**: 1) Ankylosing spondylitis. 2) Chronic neck pain with history of herniated discs and cervical spine radiculopathy. 3) Possible secondary fibromyalgia. 4) HTN possibly 2/2 anxiety. 5) Episodic airway hyperreactivity of unclear etiology. **Plan**: Continue Humira. The examiner recommended referral to the Samueli Center and the Immunology/Allergy Department. The member is recommended to establish care with PCP.

[redacted]. UCI HEALTH. Ambulatory BP Monitoring Report. (Final premed part 1 - [redacted] - Page 1709-1715). Interpretation: **Systolic Synopsis**: For all measurements, 34.5% of systolic BP readings exceeded the set limit of 140 mmHg. While the member was awake, 44.0% of systolic readings exceeded the set limit of 135 mmHg. While the member was asleep, 87.5% of systolic readings exceeded the set limit of 120 mmHg. **Diastolic Synopsis**: For all measurements, 37.9% of diastolic BP readings exceeded the set limit of 90

mmHg. While the member was awake, 74.0% of diastolic readings exceeded the set limit of 85 mmHg. While the member was asleep, 100% of diastolic readings exceeded the set limit of 70 mmHg.

[redacted]. HOAG CLINIC. [redacted] DO. Progress Note. (Final premed part 1 - [redacted] - Page 1739-1742). Subjective: The member complained of neck pain. The member had a history of ankylosing spondylitis and started on Humira. She had been taking Flexeril. **Diagnosis**: Neck pain. **Plan**: Prescribed prednisone and Solu-medrol. Ordered x-rays of the cervical spine and thoracic spines. Follow-up with an ortho.

[redacted] HOAG CLINIC. [redacted] PA. Progress Note. (Final premed part 1 - [redacted] - Page 1745-1749). Subjective: The member presented with right foot pain after accidentally kicking the door. She admitted swelling and pain when walking. She was able to bear weight but was limping. **Diagnosis**: Foot pain. **Plan**: Recommended rest, weightbearing and activity as tolerated. Prescribed Tylenol or ibuprofen. Recommended to apply ice for 20 minutes. Follow-up with PCP.

[redacted]. UCI HEALTH. [redacted] MD. Orthopedic Spine Surgery. (Final premed part 1 - [redacted] - Page 1750-1771). Subjective: The member complained of neck and bilateral arm pain. She had a C4-C5, C5-C6 disc replacement. She had been doing well but a few months ago developed increasing pain in her neck on the upper left side. She had tried physical therapy. **Diagnosis**: Other spondylosis with myelopathy, cervical region. **Plan**: Recommended C3-C4 disc replacement.

[redacted]. UCI HEALTH. [redacted] MD. X-rays of the Cervical Spine. (Final premed part 1 - [redacted] - Page 1788-1788, 1792-1792). Impression: Stable degenerative and postsurgical changes of the cervical spine.

[redacted]. UCI HEALTH. [redacted] MD. Consultation Report. (Final premed part 1 - [redacted] - Page 1808-1844). Subjective: The member was scheduled for C3-C4 disc replacement. **Diagnoses:** 1) Ankylosing spondylosis; no known or suspected associated aortic disease. 2) Hypothyroidism: clinically euthyroid. 3) Reactive airway disease. 4) Insulin resistance. 5) HTN; anxiety-induced. 6) Intermittent steroid use for AS, reactive airway disease; 3 times over the last years, duration < 2 weeks each; at low risk for adrenal insufficiency. **Plan**: Labs were ordered. Hold Metformin. Continue Humira after the surgery. Prescribed benzodiazepines for anxiety. Scheduled for surgery. Advised no NSAIDs for 3 days after surgery. Hold all vitamins and supplements on the day of surgery.

[redacted]. UCI HEALTH. [redacted] MD. Progress Report. (Final premed part 1 - [redacted] - Page 1858-1860, 1867-1867, 1874-1877, 1889-1892). Subjective: The member is seen for preoperative clearance. **Diagnosis**: Preoperative clearance. **Plan**: Recommended C3-C4 disc replacement.

[redacted]. UCI HEALTH. [redacted] MD. ECG Report. (Final premed part 1 - [redacted] - Page 1863-1868, 1886-1886, 2201-2201, 2217-2217). Impression: Sinus rhythm, normal ECG.

[redacted]. UCI HEALTH. [redacted] MD. Progress Note. (Final premed part 1 - [redacted] [redacted] - Page 1916-1918, 1922-1924, 1935-1937). Subjective: The member was seen for an upcoming cervical discectomy. The current symptoms include pain and numbness in her hand, requiring splinting at night. The member endorses significant postnasal drainage. She was interested in seeing a subspecialist to improve her symptoms. Her nasal obstruction impairs her ability to practice jiu-jitsu. **Social History:** The member quit smoking in [redacted] and consumes alcohol socially. **Assessment/Plan**: The member was recommended with an anterior approach to the cervical spine to facilitate C3-C4 discectomy for [redacted] Referral placed to UCI rhinology. **Procedure:** Flexible laryngoscopy.

[redacted]. [redacted] MD. Office Visit. (Final premed part 1 - [redacted] [redacted] - Page 1966-1968). Subjective: The member presented for a physical exam. **Plan**: Prescribed Aldactone, Glucophage, liposomal glutathione, liposomal vitamin C, Naturethroid, pregnenolone, DHEA, nystatin and Adrenfuel.

[redacted]. UCI HEALTH. [redacted] MD. Operative Report. (Final premed part 1 - [redacted] [redacted] - Page 1979-1980, 2000-2002, 2221-2221, 2233-2235). Operation(s): 1) Cervical spine C3-4-disc replacement; wound class 1 (clean). Incision closure: Deep and superficial layers. 2) Revision anterior approach to the cervical spine for C3-C4 fusion; wound class 1 (clean). Incision closure: No layers. **Pre-operative Diagnoses:** 1) Cervical stenosis. 2) Cervical spondylosis. **Post-operative Diagnoses**: Same as the pre-operative diagnosis.

[redacted]. UCI HEALTH. [redacted] MD. Intraoperative Neuromonitoring Report. (Final premed part 1 - [redacted] [redacted] - Page 1995-1995, 2167-2173, 2231-2231). Impression: No definite intraoperative impairment was observed.

. [redacted] MD/[redacted] MD. Orthopedic Surgery Progress Note. [redacted]. (Final premed part 1 - [redacted] [redacted] - Page 1988-1990, 2228-2230). Subjective: No acute events overnight. Pain controlled. No acute complaints. **Assessment**: Status post C3-C4 disc arthroplasty with revision anterior approach to the neck on [redacted]. **Plan**: Requested weightbearing as tolerated. Recommended soft C-collar for comfort. Requested splint and dressing. Prescribed Ancef and oxycodone. Referred PT and OT. Advised regular diet. The member was discharged home with pending pain control, therapy and DME.

[redacted]. UCI HEALTH. [redacted] MD/[redacted] MD. Daily Progress Note. (Final premed part 1 - [redacted] [redacted] - Page 1996-1998). Subjective: The throat was slightly sore; otherwise, she was doing well. The member was tolerating PO, ambulating and voiding. The pain was controlled. **Assessment**: Status post C3-C4 disc replacement via anterior approach. She was doing well postoperatively and cranial nerves were intact. **Plan**: Referred neck incision, which appears C/D/I. Recommended drain management and global care by a primary team.

[redacted]. UCI HEALTH. OT Note. (Final premed part 1 - [redacted] [redacted] - Page 1990-1991). Total Session: 1.

[redacted]. UCI HEALTH. [redacted] MD/[redacted] MD. Discharge Summary. (Final premed part 1 - [redacted] [redacted] - Page 1981-1985, 2222-2226). Date of Admission: [redacted]. **Hospital Course:** The member tolerated the procedure well. She was admitted for

monitoring of vitals, pain control and physical and occupational therapy. She began working with therapy on POD #1. **Diagnosis**: Other spondylosis with myelopathy, cervical region. **Plan**: The member's condition was stable and discharged. Follow-up in ortho clinic as scheduled.

[redacted]. **UCI HEALTH. [redacted] MD. Postoperative Follow-Up Report. (Final premed part 1 -[redacted] [redacted] - Page 1985-1986). Subjective:** The member was status post cervical C3-C4 disc replacement revision, anterior approach to the cervical spine for the C3-C4 fusion. She tolerated the procedure well. The pain was controlled. **Assessment/Plan**: Requested weight bearing as tolerated. Recommended soft C-collar. Prescribed Ancef. Advised to keep dressing. Monitor drain output. Referred PT and OT.

[redacted]. **[redacted] MD. Operative Note. (Final premed part 1 -[redacted] [redacted] - Page 1999-2000, 2232-2232). Operation:** Revision anterior approach to the cervical spine for C3-C4 fusion. **Pre-operative Diagnosis:** Other spondylosis with myelopathy, cervical region. **Post-operative Diagnosis**: Same as the preoperative diagnosis.

[redacted]. **UCI HEALTH. [redacted] DO. Rheumatology Follow-Up Note. (Final premed part 1 -[redacted] [redacted] - Page 2291-2304). Subjective:** The member had another disc replacement in early [redacted], before which she held Humira 3 weeks prior to this on [redacted]. **Diagnoses:** 1) Ankylosing spondylitis-HLA-B27 positive with inflammatory axial pain since 20's, family history of HLA-B27 positivity and also back pain. 2) Possible Secondary fibromyalgia. 3) HTN possibly 2/2 anxiety. 4) Episodes of airway hyperactivity of unclear etiology, no clear triggers identified; had been seen by an outside specialist. **Plan**: Restart Humira. **Work Status**: Work modification to include being off rotation, work from home and not conduct face to face contacts to lessen her risk of exposure to the COVID-19 virus until [redacted] or until the State of Emergency/Quarantine is concluded.

[redacted]. **UCI HEALTH. [redacted] MD. Cardiac Electrophysiology Clinic Note. (Final premed part 1 -[redacted] [redacted] - Page 2308-2317). Subjective:** The member reported that after starting amlodipine, headaches disappeared and BP ranged mostly 120-140/70-90. **Diagnoses:** 1) Ankylosing spondylitis. 2) Hypertension. **Plan**: Continue spironolactone. Labs are ordered.

[redacted]. **UCI HEALTH. [redacted] MD. Letter Note. (Final premed part 1 -[redacted] [redacted] - Page 1869-1870, 1887-1887, 2281-2281, 2286-2286). Comments**: The member is immunocompromised, and due to the current state of emergency, she has been provided a work modification that includes being off rotation. The member should work from home and avoid any face-to-face contact to minimize her exposure to the COVID-19 virus until the state of emergency/quarantine is concluded.

[redacted]. **HOAG CLINIC. [redacted] DO. Progress Note. (Final premed part 1 -[redacted] [redacted] - Page 2318-2321). Subjective:** The member complained of hives. **Diagnoses:** 1) Allergic reaction. 2) Hives of unknown origin. 3) Medication refill. **Plan**: Prescribed prednisone and valacyclovir HCL.

[redacted]. **UCI HEALTH. [redacted] MD. Spine Surgery Postoperative Visit. (Final permed part 1-[redacted] [redacted] – Page 2327-2375). Subjective:** The member was approximately 3 weeks following C3-C4 disc arthroplasty. She was doing well. **Impression:**

The member was doing well. **Plan**: Wound care instruction was provided. Discussed postoperative instructions.

[redacted]. UCI HEALTH. [redacted] MD/[redacted] MD. X-rays of the Cervical Spine.
(Final permed part 1-[redacted] [redacted] – Page 2377-2382). Impression: Interval C3-C4 arthroplasty with interbody disc prosthesis with appropriate alignment and no evidence of hardware fracture. Stable appearing the C4-C5 and C5-C6 interbody disc prosthesis.

[redacted]. UCI HEALTH. [redacted] MD. Spine Surgery Postoperative Visit. (Final premed part 1 -[redacted] [redacted] - Page 2398-2411). Subjective: The member was 6 weeks status post C3-C4 disc arthroplasty. She was doing well. **Assessment/Plan:** Wound care instruction was provided. Discussed postoperative instructions.

[redacted]. UCI HEALTH. [redacted] MD/[redacted] DO. X-rays of the Cervical Spine. (Final premed part 1 -[redacted] [redacted] - Page 2413-2413, 2417-2417). Impression: Stable examination since [redacted].

[redacted]. UCI HEALTH. [redacted] ND. Progress Note. (Final premed part 1 - [redacted] [redacted] - Page 2423-2438). Subjective: The member is seen for BHRT, lung issues and constipation. **Diagnoses**: 1) SOB. 2) Constipation, unspecified constipation type. 3) Vaginal yeast infection. 4) History of smoking. 5) Hypothyroidism, unspecified type. **Plan**: Consider MRT, Genova test.

[redacted]. UCI HEALTH. [redacted] MD. ED Observation Note. (Final premed part 1 - [redacted] [redacted] - Page 2446-2453, 2573-2577). Subjective: The member reported worsening SOB despite using her inhaler, 11 lbs. weight loss, chills, chest pain, abdominal pain when she takes a deep breath and chronic constipation. **Diagnoses:** 1) SOB (shortness of breath). 2) History of ankylosing spondylitis. 3) Autoimmune disorder (CMS-HCC). 4) Reactive airway disease without complication, unspecified asthma severity, unspecified whether persistent. 5) Atelectasis of the right lung. **Plan:** Ordered labs and x-rays of the chest.

[redacted]. UCI HEALTH. ECG Report. (Final premed part 1 -[redacted] [redacted] - Page 2465-2466, 2471-2471, 2523-2523, 2589-2590, 2594-2594). Impression: Normal sinus rhythm. Normal ECG.

[redacted]. UCI HEALTH. [redacted] MD. ECG Interpretation Note. (Final premed part 1 -[redacted] [redacted] - Page 2444-2445). Impression: Normal sinus rhythm.

[redacted]. UCI HEALTH. [redacted] MD. X-rays of the Chest. (Final premed part 1 - [redacted] [redacted] - Page 2463-2464, 2587-2587). Findings/Impression: Cardiomediastinal silhouette was within normal limits. Nodular density adjacent to the AP window was likely vascular; attention on follow-up study or reevaluate with oblique imaging. There was elevation of the right hemidiaphragm and right basilar atelectasis; however, underlying infection cannot be excluded. Mild peribronchial thickening. No acute osseous abnormality.

[redacted]. UCI HEALTH. [redacted] MD. 2D Echocardiogram Report. (Final premed part 1 -[redacted] [redacted] - Page 2466-2468, 2591-2592). Impressions: 1) Normal left ventricular

systolic function. The left ventricular ejection fraction is 64% by Biplane. 2) Normal diastolic LV function.

[redacted]. UCI HEALTH. [redacted] MD. Progress Note. (Final premed part 1 - [redacted] [redacted] - Page 2609-2614, 2630-2635). Subjective: The member had asthma for 4 years; she was on albuterol and required steroid courses about 4 times. She had dyspnea on exertion with some cough. **Assessment**: Asthma, poorly controlled, possibly related to past smoking. **Plan**: Prescribed albuterol, Symbicort and montelukast. Recommended a new nebulizer. Ordered PFT.

[redacted]. INTEGRATIVE WELLNESS CENTER. [redacted] MD. Office Visit Summary. (Final premed part 1 - [redacted] [redacted] - Page 2657-2659). Comments: The member is seen for physical exam.

[redacted]. UCI HEALTH. [redacted] MD. Spine Surgery Postoperative Visit. (Final premed part 1 - [redacted] [redacted] - Page 2683-2683, 2688-2688, 2702-2702). Subjective: The member is 3 months following C3-C4 disc arthroplasty. She was doing well. **Plan**: Wound care instruction was provided. Discussed postoperative instructions.

[redacted]. UCI HEALTH. [redacted] MD. Letter Note. (Final premed part 1 - [redacted] [redacted] - Page 2695-2696, 2706-2707). Comments: The member is treated for her autoimmune diseases. As part of ongoing care, she is prescribed medication to help manage her chronic, inflammatory and degenerative medical condition. A side effect of one of the medications is known to cause drowsiness and may alter her state of awareness. She was advised not to operate a motor vehicle while under the influence of this medication, as it could be unsafe. The member is scheduled to take medication at 07:00 pm to receive the most benefit. As such, it is recommended that she be provided a work modification to include not being assigned any new investigations past 06:00 pm, to help ensure her availability to safely take the medication at the scheduled time. The member's condition is degenerative and not going to improve, so she is going to be maintained on medication and likely undergo additional procedures in the future to slow the progression of the disease and improve her quality of life.

[redacted]. UCI HEALTH. [redacted] MD/[redacted] MD. X-rays of the Cervical Spine. (Final premed part 1 - [redacted] [redacted] - Page 2710-2716). Impression: Stable examination compared to radiographs from 05/08/20.

[redacted]. UCI HEALTH. [redacted] MD. Pulmonary Function Test. (Final premed part 1 - [redacted] [redacted] - Page 2602-2603, 2724-2725). Impression: Spirometry was normal. Flow volume loops were normal. Lung volumes were normal. DLCO was normal.

[redacted]. UCI HEALTH. [redacted] MD. Cardiac Electrophysiology Clinic Note. (Final premed part 1 - [redacted] [redacted] - Page 2755-2759, 2780-2783). Subjective: The member had no return of headache symptoms. Not measuring BP regularly. She was still on spironolactone and amlodipine. **Diagnoses:** 1) Ankylosing spondylitis. 2) Hypertension. **Plan**: Labs were ordered. Spironolactone dosage is reduced.

[redacted]. UCI HEALTH. [redacted] MD. ECG Report. (Final premed part 1 - [redacted] - Page 2761-2761, 2773-2773). Impression: Normal sinus rhythm. Normal ECG.

[redacted]. INTEGRATIVE WELLNESS CENTER. [redacted] MD. Office Visit Summary. (Final premed part 1 - [redacted] - Page 2789-2790). Plan: The member is prescribed Armour thyroid, estradiol pellet, testosterone pellet, AdrenFuel +T and progesterone BLA tablets.

[redacted]. UCI HEALTH. [redacted] MD. Spine Surgery Postoperative Visit. (Final premed part 1 - [redacted] - Page 2812-2816). Subjective: The member is status post C3-C4 disc arthroplasty. She was doing well. **Plan**: Wound care instruction was provided. Discussed postoperative instructions.

[redacted]. UCI HEALTH. [redacted] MD. X-rays of the Cervical Spine. (Final premed part 1 - [redacted] - Page 2841-2842, 2847-2848). Impression: No significant interval change.

[redacted]. UCI HEALTH. [redacted] MD. X-rays of the Thoracic Spine. (Final premed part 1 - [redacted] - Page 2843-2843, 2849-2849). Findings/Impression: There was no acute fracture. There were multilevel mild degenerative changes of the thoracic spine with marginal osteophyte formation. Vertebral heights and disc spaces were relatively maintained. There was minimal S-shaped curvature of the upper thorax spine.

[redacted]. INTEGRATIVE WELLNESS CENTER. [redacted] MD. Clinical Summary. (Final premed part 1 - [redacted] - Page 2859-2861). Subjective: The member was seen for follow-up. She still had a high titer to aspergillosis but improved from before. The apartment was cleaned up for mold under a lot of stress. She was not sleeping well. Klonopin had helped in the past. She felt very fatigued. **Plan**: Clonazepam and supplements were prescribed.

[redacted]. INTEGRATIVE WELLNESS CENTER. [redacted] MD/[redacted] NP. Clinical Summary. (Final premed part 1 - [redacted] - Page 2862-2865). Subjective: The member was seen for pellet insertion. She had menopause. The member noticed associated symptoms like fatigue, irritability, stress, crying and night sweats. **Plan:** Prescribed progesterone BLA tablets and supplements. **Procedure**: Estradiol pellet and testosterone pellet were inserted into the left glute region.

[redacted]. UCI HEALTH. [redacted] LVN. Clinic Note. (Final premed part 1 - [redacted] - Page 2874-2874). Comments: The member was requesting a prescription for prednisone. The message was routed to Dr. [redacted].

[redacted]. ADVANTAGE MRI. [redacted] MD. MRI of the Thoracic Spine Without Contrast. (Final premed part 2 [redacted] – Page 142-143). Impression: Disc bulge or protrusion at multiple disc levels, without significant central canal or neural foraminal narrowing. The largest of these was at level T9-10, measuring 2 mm.

[redacted]. UCI HEALTH. [redacted] MD. Spine Surgery Postoperative Visit Note. (Final premed part 2 [redacted] - Page 20-20). Subjective: The member was 1 year status

post following C3-C4 level disc arthroplasty. She had a recent episode where she became very tight and her muscles locked up. She was being overworked. She had been on prednisone and was improved. **Plan:** The member was noted to be doing well. Wound care instructions were provided.

[redacted]. UCI HEALTH. [redacted] MD. X-rays of the Cervical Spine. (Final premed part 2 [redacted] [redacted] - Page 22-23, 25-27). Impression: Mild bony bridging at the C3-C4 through C5-C6 level, otherwise, no significant interval change.

[redacted]. THE CENTER FOR COMPREHENSIVE PAIN MANAGEMENT UNIVERSITY OF CALIFORNIA, IRVINE/UCI. [redacted] MD/[redacted] MD. Follow-Up Visit. (Final premed part 2 [redacted] [redacted] - Page 28-36, 40-49, 56-65). Subjective: The member was status post cervical disc revision at the C3-C4 level on [redacted]. She was limited in her ability to follow-up with her rheumatologist and orthopedic surgeon due to COVID-19 lockdown restrictions. Her cervical symptoms had been stable. She developed mid-thoracic pain, with areas of pain most significant between the lower margins of the scapula close to the midline. The pain was associated with difficulty with deep inspiration. She had been undergoing therapy for presumed asthma without significant improvement. She continued to stay active with physical therapy and jujitsu regularly. She recently had a flare-up of her ankylosing spondylitis and her pain had improved significantly with the prednisone. **Diagnoses**: 1) Degenerative disc disease, thoracic spine region. 2) Chronic myofascial pain. 3) Osteoarthritis of the spine with radiculopathy, cervical spine region. 4) Cervical spondylosis with myelopathy. 5) History of fusion of the cervical spine. 6) Cervical radiculopathy. **Plan**: The member was scheduled to see the rheumatologist. Discontinue Flexeril, Valium, ibuprofen and naproxen. Start tizanidine, Tylenol and meloxicam. Discussed non-opioid modalities. Continue physical therapy. Follow-up with Pain Management. Restart Humira. Follow-up in 2 weeks with Dr. [redacted].

[redacted]. UCI. [redacted] DO. Rheumatology Follow-Up Note. (Final premed part 2 [redacted] [redacted] - Page 69-74, 84-102). Subjective: The member reported chronic neck pain and had another disc replacement in early [redacted], with success for her neck pain. She continued to have her chronic thoracic back pain, where she had known scoliosis and herniated discs that tend to worsen in the afternoon and evenings but tend to exacerbate with inactivity. She had lots of muscle tension throughout her back and knots from her physical therapist. She started on Meloxicam instead of Advil. Of note, muscle relaxants tend to be over-sedating. Her thoracic pain was associated at times with decreased mobility of her rib cage and rib cage tightness. She reported problems with breathing. She had significant stress and burnout. She started having a typical but rare flare, causing severe pain from her neck down to her lower back. She had more widespread pains throughout her body as well as fatigue. She started on Prednisone with benefits. **Family History**: HLA-B27. **Diagnoses**: 1) Ankylosing Spondylitis. 2) Episodic restricted breathing of unclear etiology. 3) Chronic neck pain with a history of herniated discs and cervical radiculopathy improved. 4) Possible Fibromyalgia. 5) HTN possibly due to anxiety. 6) Episodic Airway hyperreactivity of unclear etiology. **Plan**: Restart Humira. Continue meloxicam. Pending MRI of the thoracic spine review. Labs were ordered. Referral to Pain Management.

[redacted]. [redacted] [redacted]. Psychotherapy Notes. (Final premed part 2 [redacted] [redacted] - Page 103-103, 135-136, 173-173, 174-175, 182-182). Total Sessions: 4. **Diagnoses**: 1) Posttraumatic stress disorder, unspecified. 2) Adjustment disorder with mixed anxiety and depressed mood.

[redacted]. **UCI HEALTH. Pharmacy Notes. (Final premed part 2 [redacted] - Page 107-109, 131-133, 186-187, 318-319, 366-367, 440-441, 521-522). Total Sessions**: 7.

[redacted]. **THE CENTER FOR COMPREHENSIVE PAIN MANAGEMENT UNIVERSITY OF CALIFORNIA, IRVINE/UCI. [redacted] MD/[redacted] PA. Follow-Up Visit. (Final premed part 2 [redacted] - Page 147-155, 160-167). Subjective**: The member reported good pain relief with meloxicam but tizanidine was making her feel foggy. She noticed more pain and spasm in the neck area if she sits behind a computer for a long period of time. She reported pain from her tailbone to her neck. The pain was associated with numbness, tingling and spasms with occasional electric sensations. **Diagnoses**: 1) Cervical spine radiculopathy. 2) Degenerative disc disease, thoracic spine. 3) Osteoarthritis of the spine with radiculopathy, cervical spine region. 4) Cervical spine spondylosis with myelopathy. 5) Chronic myofascial pain. 6) History of fusion of the cervical spine. **Plan:** Restart Humaria. Referred to a rheumatologist. Discontinue Flexeril, Valium, ibuprofen and naproxen. Continue tizanidine. Doses of meloxicam were increased. Continue Tylenol. Discussed non-opioid modalities. Continue physical therapy. Follow-up in 2 weeks with Dr. [redacted].

[redacted]. **UCI HEALTH. [redacted] MD. Cardiac Electrophysiology Clinic Note. (Final premed part 2 [redacted] - Page 204-208, 219-223, 225-233). Diagnoses**: 1) Ankylosing spondylitis. 2) Hypertension. 3) Hyperkalemia. **Discussion/Plan**: Hypertension was well controlled. No evidence of cardiac involvement or sequelae of ankylosing spondylitis. Hyperkalemia noted on labs from one month ago might be related to spironolactone. Stop spironolactone. Labs were ordered. Follow-up in 6 months with an echo.

[redacted]. **UCI HEALTH. [redacted] MD. ECG Report. (Final premed part 2 [redacted] - Page 212-213, 224-224). Study Date**: [redacted]. **Impression:** Sinus rhythm. Short PR interval.

[redacted]. **UCI HEALTH. [redacted] MD. ED Provider Note. (Final premed part 2 [redacted] - Page 247-251, 260-271, 277-288, 301-303). Subjective**: The member presented with a history of autoimmune (ankylosing spondylitis) and was on Humira. The member was diagnosed with COVID-19. The member reported nasal congestion and body aches. **Diagnoses**: 1) Lab test positive for detection of the COVID-19 virus. 2) Rhinitis, unspecified type. 3) Ankylosing spondylitis, unspecified site of spine (CMS-HCC). **Plan**: The member will be discharged.

[redacted]. **THE CENTER FOR COMPREHENSIVE PAIN MANAGEMENT UNIVERSITY OF CALIFORNIA, IRVINE/UCI HEALTH. [redacted] MD/[redacted] PA. Follow-Up Visit. (Final premed part 2 [redacted] - Page 335-343, 346-353). Subjective**: The member continued to complain of pain from her tailbone all the way up to the neck area and would wrap around the chest into the arms and fingers. The member reported ongoing pain. She was on meloxicam and tizanidine. She was requesting refills on her medications. **Diagnoses**: 1) Degenerative disc disease, thoracic spine. 2) Osteoarthritis of the spine with radiculopathy, cervical spine region. 3) Cervical spine spondylosis with myelopathy. **Plan**: Discontinue Flexeril, Valium, ibuprofen and naproxen. Scheduled to meet with the rheumatologist. Restart Humira. Continue meloxicam, tizanidine and Tylenol. Discussed non-

opioid modalities. Continue physical therapy. Recommended multi-modal pain therapy. Follow-up in 3 months with Dr. [redacted].

[redacted] **UCI HEALTH. [redacted] MD. Spine Surgery Postoperative Visit. (Final premed part 2 [redacted] [redacted] - Page 372-373, 382-383, 391-391). Subjective**: The member returned approximately 1 year following C3-C4 level disc arthroplasty. She had a recent episode where she became very tight and her muscles locked up. She was being overworked. She had been on prednisone and was improved. **Assessment**: The member was doing well. **Plan**: Discussed postoperative instructions. Wound care instructions had been provided. Referred to a foot and ankle specialist.

[redacted]. **UCI HEALTH. [redacted] MD/[redacted] MD. X-rays of the Left Foot. (Final premed part 2 [redacted] [redacted] - Page 393-394, 397-398). Findings**: Mildly displaced acute to subacute fracture of the second proximal ph[redacted]x shaft. There was soft tissue swelling and edema throughout the visualized foot. No evidence of joint dislocation. Mildly displaced acute to subacute fracture of the second proximal ph[redacted]x shaft.

[redacted]. **UCI HEALTH. [redacted] MD. Initial H&P Office Visit. (Final premed part 2 [redacted] [redacted] - Page 409-414, 425-429). Subjective**: The member was seen for orthopedic evaluation of the left 2nd toe pain. Approximately 3 weeks ago, she kicked a couch by accident and subsequently developed pain in the left 2nd toe. The pain was localized to the proximal ph[redacted]x. She had been taking NSAIDs for pain relief and buddy taping. The member enjoyed mixed martial arts. **Diagnosis**: Mildly displaced P1 fracture, left 2nd toe; DOI [redacted] **Plan**: Recommend avoiding physical activity. Advised to continue to practice MMA and buddy tape to the 3rd toe, especially if she is going to be doing jiujitsu or other explosive activities. Follow-up in 4 weeks with x-rays of the left 2nd toe.

[redacted]. **UCI HEALTH. [redacted] MD/[redacted] MD. X-rays of the Cervical Spine. (Final premed part 2 [redacted] [redacted] - Page 400-401, 404-405). Impression**: No significant interval change in cervical vertebral body arthroplasties from C3 to C6 level.

[redacted]. **Integrative Wellness Center. [redacted] MD. Clinical Summary. (Final premed part 2 [redacted] [redacted] - Page 434-436). Subjective**: The member was seen for pellet insertion. The member noticed her symptoms were localized in the back, including low energy and difficulty falling asleep. **Plan**: Prescribed clonazepam, pregnenolone/DHEA, Armour Thyroid, metformin, minocycline and supplements. **Procedure**: Estradiol pellet and testosterone pellet were inserted into the right glute region.

[redacted]. **UCI HEALTH. Estefany Bretado. Clinic Note. (Final premed part 2 [redacted] [redacted] - Page 466-466). Comments**: The member reported symptoms on Humira and wanted to stop. The member reported pain from the neck down to the pelvis and from the base of the skull. She had low energy and depression.

[redacted]. **UCI HEALTH. [redacted] MD. Spine Surgery Postoperative Visit. (Final premed part 2 [redacted] [redacted] - Page 477-477, 480-481, 488-489). Subjective**: The member had a recent episode where she became very tight and her muscles locked up. She had been on prednisone and was improved. **Assessment**: The member was doing well. **Plan**:

Discussed postoperative instructions. Wound care instructions had been provided. Referred to a foot and ankle specialist.

[redacted]. UCI HEALTH. [redacted] MD. X-rays of the Cervical Spine. (Final premed part 2 [redacted] - Page 493-494, 497-498). Impression: No significant interval change in cervical vertebral body arthroplasties from C3 to C6 level.

[redacted]. [redacted] MD. Office Visit Summary. (Final premed part 2 [redacted] - Page 518-518). Plan: Recommended colon hydrotherapy, enema at home daily. Doses of Armour thyroid were increased. Prescribed Testosterone Pellet and supplements.

[redacted]. [redacted] MD. Doctor's First Report of Occupational Injury or Illness. (Final premed part 2 [redacted] - Page 524-526). DOI: [redacted] **Subjective**: The member reported drinking primarily until she blacked out. She had several times per week with increased frequency lately. She had been taking Benzodiazepines, Xanax and Ativan for her PTSD, anxiety and insomnia but reported that she had not taken either for about one month. She was recently seen by a psychiatrist who prescribed Propranolol. She had a history of hypertension, adrenal insufficiency, hypothyroidism, recurrent yeast infections and was on medications for those disorders as well. She presented with agitation. She experienced constipation, fatigue, mood swings, anxiety, irritability, variable concentration, headaches, muscle pain and cramps, weakness and restlessness. She felt that she was depressed, distracted, had difficulty focusing, a feeling of hopelessness and lack of coping skills/impulse control. The member became manipulative, restless and shameful and had social anxiety. The member had been working for [redacted] for the past 15 years and related that it was killing her. She had a history of PTSD, anxiety and alcohol use disorder. Her alcohol use had escalated recently due to ongoing stress at work with CPS. The member needed help to attain sobriety, as she has been binge drinking. She is currently looking to learn how to stop drinking and to deal with her PTSD. **Diagnoses:** 1) Alcohol use disorder – severe. 2) Posttraumatic stress disorder. 3) History of disorder of the adrenal gland. 4) History of hypothyroidism. 5) Obsessive-compulsive disorder. 6) HTN. 7) History of yeast infections. 8) History of ankylosing spondylitis. **Work Status**: Off work.

[redacted]. THE CENTER FOR COMPREHENSIVE PAIN MANAGEMENT UNIVERSITY OF CALIFORNIA, IRVINE/UCI HEALTH. [redacted] MD/[redacted] MD. Telemedicine Follow-Up Visit. (Final premed part 2 [redacted] - Page 540-549, 556-565). Subjective: The member reported chronic neck and thoracic pain. The pain was relatively unchanged. The pain radiated diffusely. The member was actively participating in jiu jitsu, boot camp and MMA. The member was on meloxicam and tizanidine. Overall, the member reported satisfaction with her pain regimen. **Diagnoses**: 1) Degenerative disc disease, thoracic spine. 2) Osteoarthritis of the spine with radiculopathy, cervical spine region. 3) Chronic myofascial pain. 4) History of fusion of the cervical spine. **Plan**: Continue meloxicam and tizanidine. Discussed non-opioid modalities. Follow-up with Pain Management. Continue physical therapy. Follow-up with Dr. [redacted] in 6 months.

[redacted] UCI HEALTH. [redacted] MD. Complete 2D ECHO with Image. (Final premed part 2 [redacted] - Page 603-605). Impressions: 1) Normal left ventricular systolic function. The left ventricular ejection fraction was 60% by Biplane. 2) Spectral Doppler showed a pseudonormal pattern of LV diastolic filling. 3) The aortic valve was not well visualized.

Trivial aortic valve regurgitation was seen. 4) The saline contrast bubble study was indeterminate for evidence of right-to-left intracardiac shunt.

[redacted]. UCI HEALTH. [redacted] MD/[redacted] MD. Cardiac Electrophysiology Clinic Note. (Final premed part 2 [redacted] - Page 620-623, 629-632). Subjective: The member reported no symptoms. Her hyperkalemia had resolved, BP well controlled, echo with pseudonormal LV filling; however, overall normal. The member bought the Kardia device and was able to practice strenuous Brazilian jiu-jitsu without cardiac symptoms. **Diagnoses**: 1) Ankylosing spondylitis. 2) Hypertension - well controlled. 3) Hyperkalemia. **Plan**: Continue current medications. Repeat ECG in 6 months. Continue to follow with serial ECGs and Echo.

[redacted]. UCI HEALTH. [redacted] MD/Abrar Khan, DO. MRI of the Lumbar Spine without Contrast. (Final premed part 2 [redacted] - Page 637-640, 649-652). Impression: Degenerative changes at the L4-L5 level, with resultant moderate central canal stenosis.

[redacted]. UCI HEALTH. [redacted] MD. Orthopedic Spine Surgery Note. (Final premed part 2 [redacted] - Page 661-664, 672-674). Subjective: The member complained of back and bilateral hip pain. The pain was rated at [redacted]. The pain was described as constant and aching. The member had difficulty walking. The pain was made worse by sitting. She sat for over 40 hours a week at work. **Diagnoses**: 1) Other spondylosis with myelopathy, cervical spine region. 2) Other spondylosis with myelopathy, lumbar spine region. **Plan**: Recommended epidural steroid injections.

[redacted]. UCI HEALTH. [redacted] MD. X-rays of the Cervical Spine. (Final premed part 2 [redacted] - Page 676-677, 680-681). Impression: No significant interval change in cervical vertebral body arthroplasties from C3 to C6 level.

[redacted]. THE CENTER FOR COMPREHENSIVE PAIN MANAGEMENT UNIVERSITY OF CALIFORNIA, IRVINE/UCI HEALTH. [redacted] DO/[redacted] MD. Telemedicine Follow-Up Visit. (Final premed part 2 [redacted] - Page 685-694, 698-707). Subjective: The member presented for telemedicine follow-up. She had been referred by her orthopedic surgeon after obtaining a lumbar MRI with positive findings. The pain in the lower back radiated primarily into the right hip. Rarely radiated into the thigh but it did not cross the knee. **Diagnoses**: 1) Degenerative disc disease, thoracic spine. 2) Osteoarthritis of the spine with radiculopathy, cervical spine region. 3) Chronic myofascial pain. 4) History of fusion of the cervical spine. 5) Cervical spondylosis with myelopathy. 6) Cervical radiculopathy. **Plan**: The examiner offered LESI versus caudal ESI with Dr. [redacted] in 2 weeks. Continue with tizanidine and meloxicam. Continue physical therapy. Counseled to avoid using other NSAID agents. Discussed non-opioid modalities.

[redacted]. THE CENTER FOR COMPREHENSIVE PAIN MANAGEMENT UNIVERSITY OF CALIFORNIA, IRVINE/UCI HEALTH. [redacted] DO/[redacted] MD. Procedure Report. (Final premed part 2 [redacted] - Page 711-719, 730-735, 751-756). Procedure(s): 1) Caudal epidural steroid injection. 2) Intraoperative fluoroscopy. **Pre-Procedure Diagnosis**: Lumbosacral radiculopathy. **Post-Procedure Diagnosis:** Same as the pre-procedure diagnosis.

[redacted]. UCI HEALTH. [redacted] Clinic Note. (Final premed part 2 [redacted] - Page 755-755). Comments: The member denied being diabetic but diabetes medication was on her current medication list. She was insulin-resistant-BS 81. She denied taking blood thinner. She was taking minocycline for a skin rash.

[redacted] UCI HEALTH. [redacted] MD. ED Provider Note. (Final premed part 2 - [redacted] - Page 768-770, 776-779). Subjective: The member presents with abdominal pain. She reports a small amount of blood when wiping. **Diagnoses:** 1) Epigastric pain. 2) Biliary colic. **Plan:** Ordered labs. Administered GI cocktail.

[redacted]. UCI HEALTH. [redacted] MD. ECG Report. (Final premed part 2 - [redacted] - Page 788-789, 821-821). Impression: Sinus rhythm with sinus arrhythmia. Normal ECG.

[redacted]. UCI HEALTH. [redacted] MD. Telemedicine Follow-Up Visit. (Final premed part 2 [redacted] - Page 892-902, 909-919). Subjective: The member presents with neck, midback and lower back pain. She continues with abdominal pain and vomiting that has worsened her pain, especially in the lower back. **Diagnoses:** 1) Sacroiliac joint dysfunction of the right side. 2) Degenerative disc disease, thoracic. 3) Osteoarthritis of the spine with radiculopathy, cervical region. 4) Chronic myofascial pain. 5) History of fusion of the cervical spine. **Plan:** Continue tizanidine and meloxicam. Prescribed Lyrica. Recommended Right sacroiliac joint steroid injection. Behavioral therapies: Pain psychology (biofeedback, CBT and counseling). Rehab, massage and aqua therapies.

[redacted]. SEDGWICK. Notice of Denial of Claim for Workers' Compensation Benefits. (Final premed part 2 [redacted] - Page 2308-2310). DOI: [redacted]. Comments: After careful consideration of all available information, the liability for the member's claim of injury and compensation benefits is denied because the claims examiner has concluded that the member's alleged injury to stress is not compensable.

[redacted]. UCI HEALTH. [redacted] NP. Progress Note. (Final premed part 2 [redacted] - Page 924-926, 966-967). Subjective: The member complains of UTI symptoms. **Diagnoses:** 1) Nausea and vomiting, intractability of vomiting not specified, unspecified vomiting type. 2) Acute cystitis with hematuria. **Plan:** Discontinued Zofran injection. Prescribed Macrobid.

[redacted]. UCI HEALTH. [redacted] MD/[redacted] MD. Telemedicine Follow-Up Visit. (Final premed part 2 [redacted] - Page 976-988, 1007-1018). Subjective: The member presents for follow-up and evaluation of possible SIJ injection. She continues to have pain in the lower back. **Diagnoses:** 1) Sacroiliac joint dysfunction of the right side. 2) Degenerative disc disease, thoracic. 3) Chronic myofascial pain. 4) History of fusion of the cervical spine. 5) Spinal stenosis of the lumbar region, unspecified whether neurogenic claudication is present. **Plan:** Continue tizanidine and meloxicam. Prescribed Naltrexone. Referred to PT. Continue follow-up with surgery for gallstones.

[redacted]. UCI HEALTH. [redacted] MD. Progress Note. (Final premed part 2 [redacted] - Page 1026-1031). Subjective: The member is seen for vaginal

discharge. Her urinary symptoms have improved. **Diagnosis:** Vaginal discharge. **Plan:** Prescribed fluconazole. Ordered labs.

[redacted]. [redacted], PsyD. **Individual Psychotherapy Notes. (Final premed part 2 [redacted] - Page 1052-1052, 1102-1102, 1490-1490, 1528-1530, 1540-1541, 1622-1623, 1636-1636, 1688-1691, 1745-1745, 1838-1838, 2247-2247, 2330-2330, 2349-2350, 2500-2501, 2798-2800, 2921-2921). Total Sessions:** Multiple. **Diagnosis:** Posttraumatic stress disorder, unspecified.

[redacted] **UCI HEALTH. [redacted] MD. Outpatient Consult Note. (Final premed part 2 [redacted] - Page 1053-1056). Subjective:** The member is seen for recurrent biliary colic with a recent ED visit where the presence of gallstones was confirmed.

[redacted]. **UCI HEALTH. [redacted] MD. Interval Note. (Final premed part 2 [redacted] - Page 1124-1127). Subjective:** The member presents with pain and is here for a planned procedure. **Plan:** Proceed with the planned procedure.

[redacted]. **UCI HEALTH. [redacted] MD/[redacted] MD. Procedure Note. (Final premed part 2 [redacted] - Page 903-904, 1127-1128). Procedures:** 1) Right sacroiliac joint injection. 2) Intraoperative fluoroscopy. **Pre-procedure Diagnosis:** Sacroiliac dysfunction. **Post-procedure Diagnosis:** Same as pre-procedure diagnosis.

[redacted]. [redacted], PsyD. **Individual Psychotherapy Notes. (Final premed part 2 [redacted] - Page 1120-1120). Comments:** Clinician cancelled due to a personal injury.

[redacted]. **UCI HEALTH. [redacted] MD. Operative Report. (Final premed part 2 [redacted] - Page 1153-1155). Operation:** Robotic cholecystectomy with ICG cholangiogram. **Pre-op Diagnosis:** Biliary colic. **Post-procedure Diagnosis:** Same as pre-op diagnosis.

[redacted]. **UCI HEALTH. [redacted] MD. Pathology – Tissue Exam Report. (Final premed part 2 [redacted] - Page 1157-1158). Diagnosis:** Gallbladder and contents, cholecystectomy: Chronic cholecystitis with cholesterolosis.

[redacted] **UCI HEALTH. [redacted] MD. Follow-Up Visit. (Final premed part 2 [redacted] - Page 1367-1379). Subjective:** The member reports that she has noticed significant improvement in her lower back. **Diagnoses:** 1) Sacroiliac joint dysfunction of the right side. 2) Degenerative disc disease, thoracic. 3) Chronic myofascial pain. 4) Osteoarthritis of the spine with radiculopathy, cervical region. 5) History of fusion of the cervical spine. **Plan:** Continue medications. Resume Lyrica.

[redacted]. **UCI HEALTH. [redacted] MD. Spine Surgery Postoperative Visit. (Final premed part 2 [redacted] - Page 1426-1426). Subjective:** The member returns approximately 1.5 years following C3-4 disc arthroplasty. **Assessment/Plan:** Doing well. Discussed postoperative instructions.

[redacted] **UCI HEALTH. [redacted] MD. X-rays of the Cervical Spine. (Final premed part 2 [redacted] [redacted] - Page 1432-1432). Findings:** 2 upright views of the cervical spine are obtained. There have been prior intervertebral disc arthroplasty placements at C3-C4, C4-C5, C5-C6, which are intact and appropriately positioned. There is hypolordosis of the cervical spine. There is progressive moderate C6-C7 and slightly progressed C2-C3 degenerative disc disease. The vertebral body heights are preserved, and there is no evidence of an acute fracture.

[redacted]. **UCI HEALTH. [redacted] MD. Progress Note. (Final premed part 2 [redacted] [redacted] - Page 1437-1443, 1478-1484). Subjective:** The member presents for internal hemorrhoids with prolapse. **Diagnosis:** Hemorrhoids. **Plan:** Recommended steroid cream/suppository, fiber and sitz baths.

[redacted]. **UCI HEALTH. [redacted] MD. Work Status. (Final premed part 2 [redacted] [redacted] - Page 1489-1489). Comments:** The member may return to work on [redacted].

[redacted] **UCI HEALTH. [redacted] MD. Progress Note. (Final premed part 2 [redacted] [redacted] - Page 1501-1504). Subjective:** The member returns for follow-up after a laparoscopic procedure with robot-assisted cholecystectomy. She is feeling better.

[redacted]. **UCI HEALTH. [redacted] MD. History and Physical Note. (Final premed part 2 [redacted] [redacted] - Page 1551-1553). Subjective:** The member presents for a pain procedure. **Plan:** Proceed with the planned procedure.

[redacted] **UCI HEALTH. [redacted] MD. Procedure Note. (Final premed part 2 [redacted] [redacted] - Page 1554-1555). Procedure:** Trigger point injection. **Pre-Procedure diagnosis:** Myalgia/myositis. **Post-Procedure Diagnosis:** Same as pre-procedure diagnosis.

[redacted]. **UCI HEALTH. [redacted] MD. Cardiac Electrophysiology Clinic Note. (Final premed part 2 [redacted] [redacted] - Page 1568-1571). Subjective:** Since the last visit, the member had her gallbladder out. She continues with a vigorous workout. No other cardiac symptoms, including chest pain. **Diagnoses:** 1) Ankylosis spondylitis. 2) Trivial aortic regurgitation. 3) Hypertension – well controlled. 4) Hyperkalemia. **Plan:** Continue current medications. RTC in 6 months with echo.

[redacted]. **UCI HEALTH. [redacted] MD. ECG Report. (Final premed part 2 [redacted] [redacted] - Page 1572-1573). Impression:** Sinus rhythm. Normal ECG.

[redacted]. **UCI HEALTH. [redacted] MD/[redacted] PA-C. Telemedicine Follow-Up Visit. (Final premed part 2 [redacted] [redacted] - Page 1593-1604). Subjective:** The member has pain from the neck to the tailbone. She underwent trigger point injections, which provided some relief. **Plan:** Prescribed gabapentin. Stop Naltrexone, Lyrica. Continue tizanidine and meloxicam.

[redacted] **CORPORATE PARK WELLNESS CENTER, INC. Physical Therapy Note. (Final premed part 2 [redacted] [redacted] - Page 3360-3360).** (Handwritten report, partially illegible). **Total Session:** 1.

[redacted] **UCI HEALTH. Toch Onyekwuluje, MD. Progress Note. (Final premed part 2 [redacted] [redacted] - Page 1624-1629). Subjective:** The member presents with right foot and toe pain. **Diagnoses:** 1) Right foot pain. 2) Closed nondisplaced fracture of the distal ph[redacted]x of the right great toe, initial encounter. **Plan:** Ordered x-rays of the right foot. Referred to Podiatry.

[redacted] **UCI HEALTH. [redacted] MD#. X-rays of the Right Foot. (Final premed part 2 [redacted] [redacted] - Page 4456-4456). Impression:** Nondisplaced extra-articular fracture involving the 1st distal ph[redacted]x.

[redacted]**. CORPORATE PARK WELLNESS CENTER, INC. Therapy Note. (Final premed part 2 [redacted] [redacted] - Page 3361-3370).** (Handwritten report, partially illegible). **Total Sessions:** Multiple. **Modalities:** Therapeutic activities, manual therapy and NMR.

[redacted] **UCI HEALTH. [redacted] MD. History and Physical Note. (Final premed part 2 [redacted] [redacted] - Page 1637-1639). Subjective:** The member presents for pain procedure. **Plan:** Proceed with the planned procedure.

[redacted]**. UCI HEALTH. [redacted] MD. Procedure Note. (Final premed part 2 [redacted] [redacted] - Page 1639-1641). Procedure:** Right sacroiliac joint radiofrequency ablation. **Pre-procedure Diagnosis:** Right sacroiliitis. **Post-procedure Diagnosis:** Same as pre-procedure diagnosis.

[redacted]**. UCI HEALTH. [redacted] MD. Telemedicine Follow-Up Visit. (Final premed part 2 [redacted] [redacted] - Page 1692-1703). Subjective:** The member reports 90% improvement in her right hip pain. However, she states that her back pain has significantly worsened, and she believes that the increased stress at work. In trial prep- doing a lot of prep as the main witness. Significant stress. **Diagnoses:** 1) Sacroiliitis. 2) Degenerative disc disease, thoracic. 3) Chronic myofascial pain. 4) Osteoarthritis of the spine with radiculopathy, cervical region. **Plan:** Refilled gabapentin, tizanidine and meloxicam. Recommend duloxetine if she tries an SNRI.

[redacted] **UCI HEALTH. [redacted] MD. Bone Density Report. (Final premed part 2 [redacted] [redacted] - Page 1752-1753). Impression:** The member's bone mineral density measurements are in the expected range.

[redacted]**. STATE-OF-THE-ART PHYSICAL THERAPY. Physical Therapy Notes. (Final premed part 2 [redacted] [redacted] - Page 1869-1871, 3327-3332, 3334-3358). Total Sessions:** Multiple. **Diagnoses:** 1) Ankylosing spondylitis of multiple sites in the spine. 2) Sacrococcygeal disorders, not elsewhere classified. 3) Other intervertebral disc degeneration, thoracic region. 4) Myalgia, other site. 5) Other chronic pain. **Modalities:** Therapeutic exercises and manual therapy.

[redacted]**. UCI HEALTH. [redacted] MD. Interval Note. (Final premed part 2 [redacted] [redacted] - Page 1798-1800). Subjective:** The member presents with pain and is here for a planned procedure. **Plan:** Proceed with the planned procedure.

[redacted]. UCI HEALTH. [redacted] MD. Procedure Note. (Final premed part 2 [redacted] [redacted] - Page 1801-1802). Procedure: 1) C7-T1 cervical epidural steroid injection. 2) Intraoperative fluoroscopy. **Pre-procedure Diagnosis:** Cervical radiculopathy. **Post-procedure Diagnosis:** Same as pre-procedure diagnosis.

[redacted]. UCI HEALTH. [redacted] MD. Telemedicine Follow-Up Visit. (Final premed part 2 [redacted] [redacted] - Page 1842-1853). Subjective: The member would like to have x-rays done on her neck due to the pain she is having from her ankylosing spondylitis. **Diagnoses:** 1) Cervical radiculopathy. 2) Sacroiliitis. 2) Thoracic radiculopathy. **Plan:** Refilled gabapentin, tizanidine and meloxicam. Recommend duloxetine if she tries an SNRI. SIJ RFA repeat when indicated.

[redacted]. [redacted] MD. Certification of Health Care Provider. (Final premed part 2 [redacted] [redacted] - Page 2376-2377). (Handwritten report, partially illegible). **Date Medical Condition or Need for Treatment Commenced: [redacted]. Probable Duration of Medical Condition or Need for Treatment:** Undetermined. **Comments:** The member's condition qualifies as a serious health condition. The member is unable to perform any kind of work or essential functions.

[redacted]. UCI HEALTH. [redacted] DO. ED Provider Note. (Final premed part 2 [redacted] [redacted] - Page 1910-1914). Subjective: The member presents with headaches. She went to work out and started having headache and fever. She took all scheduled medication but her symptoms did not improve. She is worried about her left breast lump getting bigger, and this has never happened before. **Diagnoses:** 1) Sepsis, due to unspecified organism, unspecified whether acute organ dysfunction is present. 2) Breast implant rupture, initial encounter. 3) Breast pain, left. **Plan:** The member's condition requires IVAB, IVF, plastic consult, medicine consult and admission and multiple visits to the bedside, multiple interpretations of vital signs and integration of complex laboratory, imaging, clinical examination and historical elements.

[redacted] UCI HEALTH. [redacted] DO. Admission History and Physical – Hospital Medicine. (Final premed part 2 [redacted] [redacted] - Page 1915-1921). Subjective: The member presents with an acute onset of left breast pain. [redacted] was admitted for sepsis due to tissue infection. **Diagnoses:** 1) Sepsis, suspect 2/2 left breast implant partial rupture and infection. 2) Complex regional pain syndrome. 3) Cervical radiculopathy. 4) Sacroiliitis. 5) Thoracic radiculopathy. 6) Hypothyroidism. 7) Hypertension. **Plan:** Admit to medicine. Vancomycin/cefepime for treatment of extensive cellulitis/deep infection. Follow-up plastic surgeon recommendations, right upper quadrant ultrasound, daily labs, and cardiac diet. Continue tizanidine and meloxicam, home propranolol, amlodipine and Armour. Restart gabapentin. Prescribed Xanax for anxiety.

[redacted]. UCI HEALTH. [redacted] MD. CT of the Head and Cervical Spine without Contrast. (Final premed part 2 [redacted] [redacted] - Page 1963-1967). Impressions: 1) No acute intracranial abnormality. 2) No evidence of cervical spine fracture.

[redacted]. UCI HEALTH. [redacted] MD. CTA Pulmonary Embolus. (Final premed part 2 [redacted] [redacted] - Page 1969-1970). Impressions: 1) No CT evidence of pulmonary embolism. 2) Abnormal contour along the margins of the left breast implant with

infiltration of the left breast parenchyma with small volume of fluid surrounding the left breast implant. This constellation of findings can be seen with dehiscence/partial rupture of the left breast implant with or without peri-implant infection. Clinical correlation is recommended. 3) Prominent bilateral, left greater than right, axillary lymph nodes, which are not enlarged by size criteria and are most likely reactive.

[redacted]. UCI HEALTH. [redacted], MD/[redacted], MD. X-rays of the Abdomen KUB. (Final premed part 2 [redacted] - Page 1971-1972). Impression: No acute process identified.

[redacted]. UCI HEALTH. [redacted], MD. X-rays of the Chest. (Final premed part 2 [redacted] - Page 1973-1974). Impression: The lungs are clear. The cardiomediastinal silhouette and osseous structures are unremarkable, aside from an orthopedic fixation device in the lower cervical spine. Deformities in the contours of the breast may be related to the member's history of prior breast surgeries.

[redacted]. UCI HEALTH. [redacted] MD. Plastic Surgery Consultation Visit. (Final premed part 2 [redacted] - Page 1891-1896). Subjective: The member is seen for left breast swelling with subjective fever and pain. **Assessment:** Left breast swelling, erythema and subjective fevers. Concern for left breast implant infection vs rupture. **Plan:** Recommended broad-spectrum IV antibiotics, daily labs, and regular diet. Continue to monitor left breast swelling and erythema. Pain control per medicine. Admitted to medicine, plastic surgery to follow.

[redacted]. UCI HEALTH. [redacted] MD. Plastic Surgery Daily Progress Note. (Final premed part 2 [redacted] - Page 1926-1927). Subjective: The member remains afebrile. Pain is well controlled. Endorses foul, discolored urine. Lower back pain. **Diagnoses:** 1) Mild peri-prosthetic infection without threatened exposure. 2) Possible L breast implant rupture. **Plan:** Ordered urinalysis and reflux UCx. Agree with IV antibiotics, can discharge on PO antibiotics. Follow-up with the breast surgeon to discuss implant removal electively.

[redacted]. UCI HEALTH. Alexander Paradyse, RPH. Pharmacokinetics Note – Vancomycin Initial. (Final premed part 2 [redacted] - Page 1921-1922). Total Visits: 1.

[redacted]. UCI HEALTH. [redacted] MD. ECG Report. (Final premed part 2 [redacted] - Page 1981-1982). Impression: Sinus tachycardia with short PR interval. Right axis deviation. ST deviation and moderate T-wave abnormality, consider anterolateral ischemia. ST deviation and moderate T-wave abnormality, consider inferior ischemia. Abnormal ECG.

[redacted]. UCI HEALTH. [redacted] MD/[redacted] MD. Plastic Surgery Daily Progress Note. (Final premed part 2 [redacted] - Page 1927-1928). Subjective: The member endorses improvement in left breast pain and erythema. She reports tenderness below the left breast. **Diagnoses:** 1) Mild peri-prosthetic infection without threatened exposure. 2) Possible L breast implant rupture. **Plan:** Prescribed antibiotics. Follow-up with the plastic surgeon.

[redacted]. UCI HEALTH. [redacted] MD. X-rays of the Chest. (Final premed part 2 [redacted] - Page 1980-1980). Impression: There is haziness projecting over the left lung base, which may at least partly be explained by an overlying breast implant. There is hardware projecting over the cervical spine. No significant size effusion or pneumothorax is identified. No focal consolidation and no edema. Normal cardiomediastinal silhouette. No apparent acute displaced fractures.

[redacted]. UCI HEALTH. [redacted] RN#. Case Management Assessment. (Final premed part 2 [redacted] - Page 1922-1923). Total Visits: 1.

[redacted]. UCI HEALTH. [redacted] DO/[redacted] DO. Discharge Summary. (Final premed part 2 [redacted] - Page 1897-1906). Admission Date: [redacted]. **Reason for Admission:** The member presents with left breast pain. Approximately 1 year ago, there was concern that the left breast implant had undergone encapsulation. So repeat procedure was done to remove that implant and replace it. During the procedure, it was noted that the member's breast was not encapsulated but underwent replacement. In the ED workup, was notable for left breast implant was notable for partial rupture and infection. Plastic surgery was consulted in the ED. **Diagnoses:** 1) Sepsis secondary to mild peri-prosthetic infection/non-purulent cellulitis. 2) Possible left breast implant rupture. 3) Complex regional pain syndrome. 4) Cervical radiculopathy. 5) Sacroiliitis. 6) Thoracic radiculopathy. 7) Hypothyroidism. 8) Hypertension. **Plan:** Continue Augmentin, Vibramycin, Xanax, Klonopin, Neurontin, Mobic, Inderal LA, Zanaflex, home medications. Prescribed propranolol and thyroid. Follow-up with Plastic Surgeon, Pain Management and PCP. Discharge condition: Stable.

[redacted]. UCI HEALTH. [redacted] MD. Follow-Up Visit Note. (Final premed part 2 [redacted] - Page 2283-2291). Subjective: The member is seen for hospital follow-up. She is doing better. She is still having headaches. She reports pain in the left breast area has subsided. **Diagnoses:** 1) Hospital discharge follow-up. 2) Leakage of breast implant, subsequent encounter. 3) Breast infection in females. **Plan:** Continue Augmentin, doxycycline. Ordered labs, additional testing/abdominal ultrasound. Breast MRI scheduled on [redacted] and follow-up with plastic surgeon after MRI. Certification of health care provider completed from [redacted] to allow the member to complete antibiotics, MRI and follow-up with plastic surgeon.

[redacted]. [redacted] MD. Certification of Health Care Provider. (Final premed part 2 [redacted] - Page 2296-2297). (Handwritten report, partially illegible). **Date Medical Condition or Need for Treatment Commenced:** [redacted]. **Probable Duration of Medical Condition or Need for Treatment:** [redacted]. **Comments:** The member's condition qualifies as a serious health condition. The member is unable to perform any kind of work or essential functions.

[redacted]. HOAG. [redacted] MRI of the Bilateral Breast without Contrast. (Final premed part 2 [redacted] - Page 2470-2471, 4434-4434). Impression: No MR evidence of implant rupture. Reported left breast cellulitis with recent antibiotic treatment. Other than minimal trace left per-implant fluid and prominent left axillary lymph nodes, there are no significant findings on this limited MRI of the breasts.

[redacted]. UCI HEALTH. [redacted] MD. MRI of the Thoracic Spine without Contrast. (Final premed part 2 [redacted] - Page 2334-2335). Findings: There is multilevel

degenerative change of the thoracic spine, with disc desiccation and marginal osteophyte formation. There are Modic type II degenerative changes of the T10-11 level. There is a small high T2 signal intensity focus at the posterior inferior corner of T8 on the T1 sagittal sequences, which appears to be fat-saturated and is not well-seen on the T1 and T2 images, which may represent a small focus of focal fatty infiltration. There is an approximate 3 mm maximum left subarticular/foraminal broad-based posterior disc protrusion at the T4-5 level, with associated flattening/distortion of the left side of the cord at this level. There is an approximately 1 mm-sized asymmetric posterior disc bulge at the T5-6 level, greater on the left, with minimal associated flattening of the anterior profile of the cord at this level. There is an approximately 1 mm-sized posterior disc bulge at the T6-7 and T7-8 levels. There are approximate one-2 mm sized posterior disc bulges at the T8-9, T9-10, and T10-11 levels. There are scattered Schmorl's nodes of the thoracic spine. **Impressions:** 1) No significant appearing acute abnormality detected within the thoracic spine. 2) Multilevel degenerative change of the thoracic spine as noted above.

[redacted] **UCI HEALTH. [redacted] MD. Orthopedic Spine Surgery Office Visit. (Final premed part 2 [redacted] [redacted] - Page 2354-2357). Subjective:** The member complains of neck and bilateral arm pain. **Diagnosis:** Other spondylosis with myelopathy, cervical region. **Plan:** Recommended C6-7 disc replacement.

[redacted]. **UCI HEALTH. [redacted] MD. X-rays of the Cervical Spine. (Final premed part 2 [redacted] [redacted] - Page 2394-2394). Impression:** Degenerative and postsurgical changes of the cervical spine.

[redacted]. **UCI HEALTH. [redacted] MD. Progress Note. (Final premed part 2 [redacted] [redacted] - Page 2412-2417). DOE: [redacted]. Subjective:** The member presents for CPE and PAP. **Diagnoses:** 1) Breast screening. 2) Preventive health care. 3) Screening for malignant neoplasms of the cervix. 4) Hemorrhoids. **Plan:** Ordered mammogram, ultrasound of the breast, labs and cytology GYN.

[redacted]. **UCI HEALTH. [redacted] MD. Gynecologic Cytology Report. (Final premed part 2 [redacted] [redacted] - Page 2418-2420). Impression:** Negative for intraepithelial lesion or malignancy.

[redacted]. **UCI HEALTH. [redacted] MD. MRI of the Cervical Spine without Contrast. (Final premed part 2 [redacted] [redacted] - Page 2480-2481). Impression:** Postsurgical changes from anterior instrumentation at C3-6. Multilevel spondylosis of the cervical spine nosebleed up to mild to moderate spinal canal stenosis at C3-4. Up to severe bilateral neural foraminal narrowing at C3-6.

[redacted]. **UCI HEALTH. [redacted] (Speech Therapist). Speech Language Pathology Swallow Evaluation – Video Swallow Study. (Final premed part 2 [redacted] [redacted] - Page 2520-2524). Total Session:** 1.

[redacted]. **UCI HEALTH. [redacted], MD. X-ray Swallowing Function Cine/Video. (Final premed part 2 [redacted] [redacted] - Page 2525-2526). Impressions:** 1) Shallow, transient laryngeal penetration with thin liquids. 2) No evidence of tracheal aspiration. 3) A full report will be forthcoming from speech pathology.

[redacted] UCI HEALTH. [redacted] DO. Rheumatology Follow-Up Note. (Final premed part 2 [redacted] [redacted] - Page 2564-2568). Subjective: The member presents with chronic back pain. She is very stressed at work, and she has poor sleep. **Diagnoses:** 1) Ankylosis spondylitis. 2) Episodic restricted breathing of unclear etiology. 3) Chronic neck pain with history of herniated discs and cervical radiculopathy – improved. 4) Possible fibromyalgia. 5) Hypertension, possibly 2/2 anxiety. 6) Episodic airway hyperactivity of unclear etiology. **Plan:** Continue meloxicam. Obtain SI and lumbar spine x-rays. Ordered labs. Recommended another disc replacement [redacted].

[redacted]. UCI HEALTH. [redacted] MD. Progress Note. (Final premed part 2 [redacted] [redacted] - Page 2598-2600). Subjective: The member requires re-revision of the anterior cervical discectomy and fusion of C6-7. She reports no significant changes to her health apart from recent hospitalization for sepsis. **Plan:** Planned for [redacted] with orthopaedic surgery. **Procedure:** Flexible laryngoscopy.

[redacted]. UCI HEALTH. [redacted] MD/[redacted] DO. X-rays of the Pelvis. (Final premed part 2 [redacted] [redacted] - Page 2572-2573). Findings: Bilateral hips and SI joints are preserved. No erosion or asymmetric sclerotic changes of the SI joints. No fusion of the SI joints. Small calcification adjacent to the left greater trochanter, likely due to calcified subgluteal bursitis, unchanged. Also tiny accessory os acetabuli on the left side. Small radiopaque densities projecting over the left pelvis likely retained contrast within diverticula. Redemonstrated ovoid-shaped peripheral calcification in the left lower quadrant may represent fat necrosis with calcification, unchanged from prior. **Impression:** No radiographic evidence of sacroiliitis. Other chronic findings noted as above.

[redacted] UCI HEALTH. [redacted] MD. Outpatient Preoperative Evaluation. (Final premed part 2 [redacted] [redacted] - Page 2629-2635). Subjective: The member with ankylosing spondylitis with 2 prior anterior cervical discectomies in [redacted] and [redacted], hypothyroidism and hypertension seen for pre-operative evaluation. She is scheduled for a cervical C6-7 anterior disc replacement. **Assessment/Plan:** The member is optimized for surgery. Recommended incentive spirometry perioperatively. Hold NSAIDs 10 days before surgery, all vitamins, supplements and herbal medications. Recommended VTE prophylaxis.

[redacted]. UCI HEALTH. [redacted] MD. ECG Report. (Final premed part 2 [redacted] [redacted] - Page 2638-2640). Impression: Sinus rhythm. Normal ECG.

[redacted]. UCI HEALTH. [redacted] MD. Progress Note. (Final premed part 2 [redacted] [redacted] - Page 2723-2723). Subjective: The member had PT on her cervical spine while she was having therapy on her lumbar spine over the past 2 months.

[redacted]. UCI HEALTH. [redacted] MD. Work Status Letter Note. (Final premed part 2 [redacted] [redacted] - Page 2826-2826). Comments: The member is diagnosed with a medical condition that qualifies as a disability. Being stationary for extended periods of time exacerbates the condition and worsens the disability; therefore, being assigned to a full-time desk job at the [redacted], whether sitting or standing or a combination of both, is contraindicated, and therefore, this work assignment has become a work restriction in and of itself. A transfer to a more suitable position with accommodations to meet the member's disability and medical needs is recommended and requested.

[redacted]. **UCI HEALTH. [redacted] MD. Ultrasound of the Breast. (Final premed part 2 [redacted] [redacted] - Page 2828-2828, 2836-2837). Impression:** ACR BI-RADS Category 3 - Probably Benign Finding.

[redacted]. **UCI HEALTH. [redacted] MD. Progress Note. (Final premed part 2 [redacted] - Page 2847-2850). Subjective:** The member complains of neck and bilateral arm pain. **Diagnosis:** Other spondylosis with myelopathy, cervical region. **Plan:** Ordered EMG/NCV study.

[redacted] **UCI HEALTH. [redacted] MD. Work Status Letter Note. (Final premed part 2 [redacted] [redacted] - Page 2862-2863). Comments:** The member has a condition that qualifies as a disability. She has slipped and fallen twice in the past 2 months in the bathtub/shower. The examiner recommended that management put in safety rails in her shower to prevent another fall. She would also benefit from having a washer/dryer hook-up installed in her unit to prevent falling down the stairs when she is carrying her laundry.

[redacted]. **UCI HEALTH. [redacted] MD. Complete 2D Echocardiogram Report. (Final premed part 2 [redacted] [redacted] - Page 2913-2915). Impressions:** 1) Poor acoustic windows. 2) Normal left ventricular size and wall thicknesses, with normal systolic and diastolic function. 3) The left ventricular ejection fraction is 57.5% by Biplane. 4) The aortic valve was not well visualized.

[redacted]. **UCI HEALTH. [redacted] MD. Cardiac Electrophysiology Clinic Note. (Final premed part 2 [redacted] [redacted] - Page 2924-2927). Subjective:** Since the last visit, the member had some lightheadedness, some elevated BP episodes with headache, and occasional foot and ankle swelling. **Diagnoses:** 1) Ankylosis spondylitis. 2) Trivial aortic regurgitation. 3) Hypertension – well controlled. 4) Hyperkalemia. **Plan:** Decreased dose of amlodipine. RTC in 12 months.

[redacted]. **UCI HEALTH. [redacted] MD. In-Person Follow-Up Visit. (Final premed part 2 [redacted] [redacted] - Page 2949-2961). Subjective:** The member complains of pain in the cervical spine. She has been taking meloxicam and tizanidine but has experienced abdominal pain with meloxicam doses recently. She is interested in repeat lumbar epidural steroid injection when able. She is taking Klonopin and Xanax. **Diagnoses:** 1) Sacroiliitis. 2) Cervical radiculopathy. 3) Osteoarthritis of the spine with radiculopathy, cervical region. 4) Sacroiliac joint dysfunction of the right side. 5) Degenerative disc disease, thoracic. 6) Chronic myofascial pain. 7) History of fusion of the cervical spine. 8) Discogenic pain. **Plan:** Continue tizanidine, decrease meloxicam. Follow-up in 4 weeks for LESI.

[redacted]. **FORENSIC PSYCH GROUP. [redacted], MD/[redacted], PhD. Panel Qualified Medical Evaluation in Psychiatry. (Final premed part 2 [redacted] [redacted] - Page 3002-3058). DOI:** CT 01/17/06 – 02/28/22. 02/11/21. **History of Injury:** The member reports that she was doing well emotionally when she accepted the job, and she was excited about her position. Before working for the [redacted], she had been in Seattle, where she was born and raised, working as a [redacted] and [redacted] in a group home. She states that she was excited to move back to [redacted], where she had lived before, to "start a new path." She started experiencing mid-back pain at the age of [redacted] and was diagnosed with myalgia and

myositis. The member reports that she receives yearly performance evaluations, and she states that she has always been found to exceed expectations. In regard to personnel actions, she reports that she had a write-up sometime in [redacted] and [redacted]. She reports that the write-up involved a complaint against her in a case where there was a videotaped police interview. She notes that [redacted] is to avoid participating in videotaped meetings, so she declined to do so. Consequently, somebody complained about this, and she states that there was a brand new supervisor who wrote her up. The member states, "I told her that I followed policy. She wrote me up saying I did follow the policy, so it really didn't make any sense." Then, in approximately [redacted], her last year in the [redacted], the member missed a call-out for an emergency response. Her supervisor fought for her at the time, but the manager insisted on a write-up. This was particularly annoying as she always took her calls and, for over 15 years, was considered stellar at on-call work and rated higher than everyone else. However, she states that in the scheme of things, the write-up was not a major stressor. She notes that the two write-ups were minor and did not have lasting impacts on her career or her emotional state. In [redacted], the member's new supervisor was [redacted], with whom she worked until [redacted]. The member states that working with Ms. [redacted] was one of the worst experiences with a supervisor. She found Ms. [redacted] behavior towards her very stressful. At the time, the member's [redacted] (and Ms. [redacted] supervisor) was [redacted]. The member wrote Mr. [redacted] a letter equating her relationship with Ms. [redacted] to domestic violence. The member states, "I told him that I never knew when she might go off on me. Just when things started to get better, she would find something and start yelling, telling me I wasn't a good worker. I went from being cherry-picked for difficult cases, considered an exceptional worker, to being questioned, but there had been no change in my work performance. I told him in the letter that I didn't like coming to work anymore, that I was waiting for the next explosion. I had tried to make our working relationship better by talking to her, asking what I could do and how to improve, but nothing helped. I couldn't effect a change, and my coworkers were overhearing how she was talking to me." The member reports that a meeting was set up with Ms. [redacted], Mr. [redacted], and herself to try to address the issues. During that time, the member states that she told Mr. [redacted] that she was not willing to continue working under Ms. [redacted] requested a transfer to a different supervisor. She switched supervisors and came under the supervision of [redacted] between [redacted] and [redacted]. She described Ms. [redacted] as one of the best supervisors she had worked for the [redacted]. Despite her good working relationship with Ms. [redacted], it was a particularly stressful time in terms of her caseload. The [redacted] was having a budget crisis, and the [redacted] were expected to furlough hours, yet keep the same caseload. The member states that even under normal circumstances, she had a particularly high caseload. Ms. [redacted] was the member's supervisor from [redacted] through [redacted]. The member states, "She made it known she didn't like me from day one." The member and her group were going to be moved to a new area, and she states that none of them wanted to go. She notes that there was a meeting with the [redacted] at the time, who listened to their concerns and moved them anyway. The member states, [redacted] wanted to move when no one else did. Word got back to [redacted] that we were disgruntled. She took the member into the office, had a talk with me, and heard that I was saying things about the transfer. I told her I hadn't said anything that the other units hadn't said as well, that I was part of a larger conversation where everyone was talking about it. She heard that it was only me, and from day one, we got off on the wrong foot." The member states that the policy was changed to allow for a [redacted] to have two days off after a child fatality case in order to process all the paperwork and get caught up on other cases. During that period, she had too much to deal with, managing a complicated on-call case and dealing with all of her regular casework. She experienced similar situations over time, where she was juggling complex cases that

combined both her regular caseload and on-call cases, resulting in very long hours. She had to work harder and longer than some of the other workers. The member also notes that the very nature of the cases she dealt with was extremely emotionally draining. She states that she oversaw at least [redacted] cases, numerous suicides (sometimes by parents), and all manner of what she described as heartbreaking situations with children. The content of these cases stayed with her over time and was highly traumatic for her. The member reports that by this time, she was experiencing emotional difficulties secondary to stress on the job. She felt overwhelmed, anxious and had difficulty relaxing. She experienced sleep disturbance and intrusive thoughts of the difficult cases that she had worked on. She sought treatment with Dr. [redacted], a psychiatrist, whom she saw "once or twice." Dr. [redacted] prescribed several different SSRI medications, but the member did not have a positive reaction to them. Dr. [redacted] eventually prescribed Klonopin and Xanax, which the member found helpful. The member also notes that she had several meetings with the program manager, [redacted], about overtime. The member states that beginning in [redacted], her new supervisor was [redacted]. She began having difficulty turning her cases in on time because Ms. [redacted] took so long to sign off on them. The member states that by that time, she was overwhelmed by difficulties at work, although she reports that while she was on the job, she continued to perform effectively and efficiently and kept her emotions in check. However, she states that when she was not working, she was overwhelmed, anxious and felt traumatized by the cases and the lack of backup she felt she was receiving. She went to see a psychiatrist in [redacted], Dr. [redacted] [redacted], who prescribed Klonopin and Xanax to take during the day as needed. The member states, "I just kept medicating myself so I could deal with the job. She also notes that at some point after she began working for the [redacted], she developed neck pain. Her cervical spine pain worsened over time, and by [redacted], she underwent the first of two surgeries (C4-5, C5-6 cervical arthroplasty). The surgery was effective for a period of time, but her pain worsened once again, and she underwent a second surgery (C3-4 cervical arthroplasty) in [redacted]. She reports that at some point she also started developing lumbar spine pain, which increased in severity when work was particularly stressful. The member states that she also had difficulty getting overtime hours under [redacted] The member also notes that work became even more stressful secondary to COVID-19. Although she always felt overworked, it was worse after the pandemic hit. During the first two months of COVID-19, the [redacted] offered people money to leave as there were too many workers because the cases had dropped off. However, when referrals increased again, there were not enough workers to cover the cases, requiring people to work more cases and incorporate more on-call time. The member states that she told [redacted] that she was feeling overwhelmed by the number of referrals she was receiving. She further told her that she was exhausted, and that if she was struggling, she could not imagine how the other workers were feeling. The member ended up having some horrible on-call cases, and her regular cases were particularly difficult and would blow up into very complicated situations. Her orthopedic situation had worsened with the amount of stress she was experiencing. Her cervical spine and her lumbar spine were hurting her regularly, further complicating her difficulties at work. By early [redacted], the member felt overwhelmed by work. She states, "I knew something was wrong, that something was off." She recalls hiking with a friend and feeling "almost manic" the whole time. The member states, "It wasn't until mile five that I was able to feel a little calmer. My friend was just exhausted by me." She was experiencing emotional lability. Because of the pace at work, she felt that she had no time to process what was going on with her very difficult and traumatic cases, and they kept coming in one after the other. She frequently experienced sleep disturbance, particularly insomnia. The member states that she felt like she was having a breakdown, as she was experiencing significant emotional symptoms by this point. She could not stop crying. Consequently, she took two weeks off work as sick time in

[redacted]. She finally called in sick because she was so overwhelmed. The whole of her two weeks off was spent trying to attend to both her physical and emotional needs. She attended physical therapy, and she saw several doctors (an orthopedic surgeon, pain management specialist, and internist). She also contacted her company's EAP for psychotherapy. She was told that she would be allocated three sessions. The member felt that she needed more than three sessions, so she began psychotherapy (EMDR) on a private basis with [redacted], Psy.D. She continued in treatment with psychiatrist, Dr. [redacted], whom she first saw in [redacted]. While the member was off work, her supervisor, Ms. [redacted], reportedly called her frequently asking her when she was coming back and where her doctor's note was. The member told Ms. [redacted] that she would bring the doctor's note in when she returned, and Ms. [redacted] allegedly responded, "That's if you have a job to come back to." The member returned to work after two weeks, although she states that she did not feel ready. She had a doctor's note when she returned from her orthopedist, Dr. [redacted]. The note reportedly came with the restriction of taking the member off immediate response calls, so that she would only be working 10-day cases. In [redacted], two months after she returned to work, the member was transferred to the [redacted] ([redacted]). She states, "They just told me what my start date was and my hours, and I got no say in it [the transfer)." The member states that [redacted] was even more stressful than the [redacted], because she was listening to these horrible trauma stories all day long, one after the other, and she could not intervene in any way. She was given particularly difficult hours. They put her on weekend shifts, which took away her whole support system. The member states that the new position was also more difficult for her physically. She was much less active in her new position, and she states that this was (and continues to be) very hard on her orthopedic condition. In fact, she has since then been scheduled for a third cervical spine surgery at the C6-7 level. In [redacted], the member was hospitalized for three days with sepsis and placed off work for two months. She has been back at work for a month. Ms. [redacted] has been the member's supervisor since she returned from leave. She has not been under Ms. [redacted] supervision long but notes, "She is new to the position and tends to micro-manage." Since returning to work, the member's neck and lower back have been increasingly painful, and her hands have become numb and fall asleep at night. In addition, she has been experiencing radicular pain in her lower back, right worse than left. The member remains emotionally symptomatic, although she feels that her symptoms have changed somewhat. She is less angry and anxious and states that she is more depressed about everything that has happened. She is apathetic, and she spends much of her downtime in bed. She feels a greater sense of resignation about work. After fighting for what she described as her rights, including overtime pay, and fighting her transfer to [redacted], she states she feels resigned at this point, because she feels that advocating for her rights has generally been ineffective. She states that all the people she has mentored and trained over the years have been promoted while she has remained stagnant. She was on the list for promotion for about 10 years. She currently undergoes EMDR sessions with [redacted], PsyD, two to four times a week. In addition, she is prescribed Xanax and Klonopin by Dr. [redacted]. **Present Complaints: Physical Complaints:** The member complains of pain in the neck, lower back, and shoulders. Due to her orthopedic issues, she has some difficulty with basic tasks. She experiences numbness in her hands. Her hand issues have worsened since she was transferred to the [redacted] department, which requires significant computer work and typing. **Emotional Complaints:** The member reports that secondary to stressors in the workplace, she developed emotional symptoms. Specifically, her work was overwhelming at times, and she would experience intrusive thoughts of particularly difficult cases. She reports being "triggered" in certain situations. She would also have distressing dreams at night, typically involving work cases. She reports that she developed emotional lability as well. She states that she would "cry at the drop of a hat," and there were

times when she would "cry hysterically." At times, she would become overly reactive to minor incidents. For instance, she would become easily angered and take it out on people. She found it very difficult to control her emotional state. She would think about work all the time, and she reports that she wore her friends down with her constant talk about what was going on at work. She had a difficult time maintaining her relationships. She states that over time, she lost most of her friends due to the constant stressors of work. She began drinking more frequently than she had in the past, particularly at night when she was alone. She reports that she was always professional during work hours and spent a good deal of mental energy avoiding thoughts, feelings and memories. She has found mental health treatment helpful; she continues to experience significant psychiatric symptoms. Her emotional symptoms profile has changed in the past few months, per her report. Instead of emotional lability, the member reports that she is quite depressed and shut down. She has fought hard to make changes at work and to improve her circumstances, but she feels resigned at this point to the difficulties at work. She is depressed and apathetic, with reduced energy levels. She is socially avoidant and has little interest in social contact. She continues to experience anxiety as well as intrusive thoughts and memories of difficult cases she has managed. Sometimes the anxiety wakes her up at night and causes stomachaches. She experiences fleeting, passive, suicidal ideation, but she denies any plan or intention of acting on these thoughts. **Surgical History:** Deviated septum surgery ([redacted] and [redacted]); tonsillectomy ([redacted]); abdominoplasty and breast reduction ([redacted]); abdominoplasty scar revision and inner thigh lift ([redacted]); uterine ablation for suspected endometriosis ([redacted]; lower body lift/skin reduction ([redacted]); scar revision around the middle and thigh lift ([redacted]); C4-5, C5-6 cervical arthroplasty ([redacted]); C3-4 cervical arthroplasty [redacted]); second breast reduction [redacted]); cholecystectomy ([redacted]). **Social History:** Social drinker as an adult, she had never been a solo drinker until several years ago, when she began drinking at night to deal with her emotional difficulties. Her alcohol use increased over time, and she presently drinks about four shots of vodka a night to facilitate sleep and to dampen her feelings. **Mental Health History:** The member underwent family therapy for her parents' divorce when she was young. She reports no other history of psychotherapy or mental health intervention as a child. She first sought mental health treatment as an adult after she began working for [redacted]. She states that her "OCD tendencies" had not caused any significant problems before working for [redacted]. She started engaging in certain behaviors to reduce anxiety, such as counting things. A friend recommended a psychiatrist, Dr. [redacted], whom the member saw sometime before [redacted]. Dr. [redacted] prescribed Klonopin and Xanax, which she continues to take at present. **Personal and Family History:** The member reports that her parents separated when she was five years old. Her oldest half-brother has been disabled from birth and is blind, has palsy, is epileptic, and severely mentally retarded. Her sister accused her father of sexually abusing her, but the member states that although her father had poor boundaries at times, she has no recollection of him being sexually inappropriate with her or her sister. The member was arrested for [redacted] in [redacted] while she was in college. **Occupational History:** After graduating from college, the member began working at [redacted], a [redacted] for neglected/abused children who had been removed from their homes. She started in [redacted] as a [redacted]. She then became [redacted], then [redacted], then [redacted]. She concurrently taught undergraduate psychology courses as [redacted] until [redacted]. She was terminated from [redacted] in [redacted]. From late [redacted] until [redacted], she worked as a [redacted] at [redacted], a [redacted] in Washington, where children had been removed from their homes due to abuse. She worked there until she got a job with [redacted] in [redacted] **Diagnoses:** 1) Posttraumatic stress disorder, chronic. 2) Major depressive disorder. 3) Alcohol use disorder. **Plan:** Recommended ongoing psychotherapy, with

a frequency of at least once a week, given the severity of her emotional symptoms. Recommended psychiatric consultation to assess her current psychotropic medication regimen and to make adjustments if necessary. Six months of monthly medication follow-up sessions are recommended as well. **Disability Status:** The member's psychiatric condition has not yet reached permanent and stationary status for rating purposes. **Causation:** The predominant cause of the member's psychiatric injury is the result of industrial factors. **Apportionment:** Issues of apportionment are deferred until her condition reaches MMI.

[redacted]. UCI HEALTH. [redacted] MD. EMG/NCV Study of the Upper Extremity. (Final premed part 2 [redacted] - Page 3184-3187). Impression: Normal study. There is no electrophysiologic evidence for a neuropathy or cervical radiculopathy in either upper extremity at this time.

[redacted] UCI HEALTH. [redacted] MD. Progress Note. (Final premed part 2 [redacted] - Page 3207-3212). Subjective: The member presents for an autoimmune disorder, ankylosing spondylitis and dry eye evaluation. **Diagnoses:** 1) Dry eye syndrome of both eyes due to meibomian gland dysfunction. 2) History of laser-assisted in situ keratomileusis. 3) Nuclear sclerosis of both eyes. 4) Blurred vision. 5) Other spondylosis with myelopathy, cervical region.

[redacted]. UCI HEALTH. [redacted] MD. OCT Retina – OU – Both Eyes. (Final premed part 2 [redacted] - Page 3213-3213). Impression: Right/left eye: RPE irregularity.

[redacted]. UCI HEALTH. Araina Nelson, MD. Procedure Note. (Final premed part 2 [redacted] - Page 3236-3237). Procedure: 1) L5-S1 lumbar epidural steroid injection (interlaminar). 2) Intraoperative fluoroscopy. **Pre-procedure Diagnosis:** Radiculopathy. **Post-procedure Diagnosis:** Same as pre-procedure diagnosis.

[redacted]. UCI HEALTH. [redacted] MD. Progress Note. (Final premed part 2 [redacted] - Page 3277-3281). Subjective: The member presents with neck and bilateral arm pain. She also has a grade 1 spondylolisthesis in her lumbar spine. **Diagnoses:** 1) Other spondylosis with myelopathy, cervical region. 2) Other spondylosis with myelopathy, lumbar region. **Plan:** Consider surgery.

[redacted]. UCI HEALTH. [redacted] MD. X-rays of the Lumbosacral Spine. (Final premed part 2 [redacted] - Page 3373-3374). Impression: 2 views of the lumbar spine were obtained. There is no acute fracture. There is mild levoscoliosis of the lumbar spine. There are mild degenerative changes of the lumbar spine with tiny marginal osteophyte formation and facet arthropathy. There is a grade 1 3 mm retrolisthesis of L2 on L3 and a 3 mm anterolisthesis of L4 on L5. Bone mineralization is normal.

[redacted] UCI HEALTH. [redacted] MD. X-rays of the Cervical Spine. (Final premed part 2 [redacted] - Page 3378-3379). Impression: 2 views of the cervical spine were obtained. Redemonstrated is disc arthroplasty of C3-4, C4-5 and C5-6 with unchanged alignment and hardware. No acute displaced fracture or spinal dislocation is seen. There is severe narrowing of the C6-7 disc space with endplate sclerosis and osteophyte formation. There is also mild degenerative disc disease of C2-3. There is no prevertebral soft tissue swelling. The atlantodens interval is normal.

[redacted], [redacted] [redacted]

[redacted]. **UCI HEALTH. [redacted] DO. Rheumatology Follow-Up Note. (Final premed part 2 [redacted] - Page 3385-3389). Subjective:** The member is still having chronic mechanical pain throughout her cervical, thoracic and lumbar spine and status post another disc replacement as of [redacted]. She has also had an RFA in this region. These pains worsen throughout the day and are not worse in the middle of the night or in the AM. **Diagnoses:** 1) History of ankylosing spondylitis. 2) Episodic restricted breathing of unclear etiology. 3) Chronic neck pain with history of herniated discs and cervical radiculopathy – improved. 4) Possible fibromyalgia – anxiety/high stress. 5) Hypertension possibly 2/2 anxiety. 6) Episodic airway hyperreactivity of unclear etiology. **Plan:** Continue follow-up with Orthopedics and Pain Management.

[redacted], MD. **Agreed Medical Examination Complex Medical Legal Orthopedic Evaluation. (Final premed part 2 [redacted] - Page 3412-3480). DOI:** CT [redacted]. **History of Injury:** The member reports that over the course of her employment, she developed the gradual onset of pain in her neck and lower back. She feels that her symptoms were attributed to the constant and repetitive nature of her work, as well as related to "adrenal fatigue," which she felt was related to the constant demands of her job. She was treating her neck symptoms on a private basis at UCI, and her treatment was ongoing through her employment at the [redacted]. She received treatment in the form of trigger point injections to her neck and shoulders, massage therapy, acupuncture and acupressure since her symptoms would increase due to stress. She ultimately underwent cervical disc replacement surgery at C4 and C6 in or around [redacted]. She states that this surgery was performed under her private insurance, since she did not want to gain/file for workers' compensation at that time. She states that a second disc replacement surgery took place in [redacted]. She took two weeks off sometime in or around [redacted] Over those two weeks, she sought medical care with Dr. [redacted] She received treatment in the form of adrenal insufficiency and her orthopedic surgeon, Dr. [redacted] at UCI, with respect to her neck and back pain. She started to receive physical therapy at Corporate Park Wellness Group and also received psychotherapy with Dr. [redacted]. She states that when she returned to work in or around the end of [redacted] or beginning of [redacted] her supervisor would call her to return to work. She states that when she returned to work, she provided a doctor's note requesting her to be removed from the immediate response team. She states that her manager assigned her to work as a floater and required her to work in other departments, and in or around [redacted], she was assigned to work in the [redacted]. She states that she worked at the office from [redacted], and then she was sent home to work remotely full-time. She relates that immediately after she started working in the [redacted], she started to notice increased pain in her neck and lower back. She feels that her symptoms were attributed to the constant sitting performed at work. She states that she did not report her symptoms to her employer and continued working regular duties without missing time off work. She states that she initially treated her symptoms conservatively by massaging her areas of pain with rollers; however, she eventually sought treatment at UCI and underwent an MRI scan of her lower back. She has seen an orthopedic surgeon, who diagnosed her with spinal stenosis and recommended that she might need a lumbar fusion. On [redacted], she underwent a radiofrequency ablation of her SI joint performed by Dr. [redacted] at UCI. She had an epidural injection in her lower back sometime in [redacted]. **Current Orthopedic Complaints:** The member complains of pain in the cervical spine, thoracic spine and lumbar spine. **Job Description:** The member started working for the [redacted] as a [redacted] on or around [redacted]. She describes this position as entailing investigating allegations of child abuse and neglect. She was required to make unannounced home visits, work alongside law

enforcement, pick up children from homes, schools, police stations and accident emergency sites. She describes this position as entailing about 50% clerical work and 50% field work. She is required to perform typing, filing and other clerical duties as well as driving, lifting and carrying. The heaviest lifting required was of children's bags/luggage or babies/toddlers on carriers. She was required to sit, stand, walk and drive throughout her shift. She was required to work a 4/10 schedule, with regular overtime, since once an investigation/case is started, she cannot leave until it's finished. She explains that in or around [redacted], she was assigned to work as a [redacted] at the hotline unit. She describes this position as entailing working at a desk, screen hotline calls involving reports of child abuse and neglect, making quick assessments and making decisions on whether the claim is valid and needs to be investigated. She is required to constantly type on a computer to enter data and change between five applications and constantly keep her body in a seated and straight position. She continues to work a 4/10 schedule. **Diagnoses:** 1) Cervical sprain, with cervical spondylosis, status post artificial disc replacement with evidence of degenerative disc disease at C6-7 and C2-3. 2) Thoracic sprain, with chronic degenerative disc disease. 3) Lumbar sprain, with degenerative disc disease, with evidence of retrolisthesis. and anterolisthesis. **Plan:** Ordered x-rays of the cervical, lumbar and thoracic spine. Recommended evaluation by AME in the field of psychiatry and internal medicine. **Disability Status:** The member has not yet reached MMI. She is currently working and may continue to do so in her current capacity. **Causation:** Industrial.

[redacted]. UCI HEALTH. [redacted] MD. Progress Note. (Final premed part 2 [redacted] - Page 3491-3495). Subjective: The member presents for left ankle injury. She reports twisting her left ankle with immediate onset of pain in the left lateral ankle. **Diagnosis:** Pain of joint of the left ankle and foot. **Plan:** Ordered x-rays of the left ankle.

[redacted] UCI HEALTH. [redacted] MD. X-rays of the Left Ankle. (Final premed part 2 [redacted] - Page 3550-3551). Impression: Essentially nondisplaced acute intra-articular fracture of the caudal tip of the lateral malleolus with overlying soft tissue swelling/edema.

[redacted] UCI HEALTH. [redacted] MD. X-rays of the Left Ankle. (Final premed part 2 [redacted] - Page 3555-3556). Impression: Essentially nondisplaced acute fracture of the caudal tip of the lateral malleolus, which appears to subtly extend into the caudal aspect of the lateral clear space of the mortise joint.

[redacted] UCI HEALTH. [redacted]. Clinic Note. (Final premed part 2 [redacted] - Page 3561-3561). Comments: The member was requesting a call back for medical advice as she had tested positive for COVID last week and her blood pressure had been very high, even when taking amlodipine. The member sometimes felt very faint and short of breath.

[redacted] HOAG HOSPITAL IRVINE. [redacted]. Care Ambulance ePCR Report. (Final premed part 2 [redacted] - Page 4370-4377). Narrative: 6399 responded code 2 with OCFA engine 37 to an apartment complex for a dispatched complaint of a sick person. AOS to FIJD, the member was sitting upright on her couch with a complaint of head pain and back pain. The member was negative for trauma-related pain. The member was positive for chronic back pain. No interventions performed before arrival. The pain was rated 10/10. The member was A&O x 4 with a GCS 15. The member was transported for further treatment and evaluation. The member was ambulatory on scene with assistance.

[redacted], [redacted] [redacted]

Reassessment enroute found the member stable and unchanged. The member walked herself safely to the gurney and sat down semi-Fowler's. The member was transported code 2 BLS to Hoag Irvine. No interventions performed enroute. The member scooted herself safely off the gurney and onto the hospital bed and was placed semi-Fowler's. The member care was transferred to the RN.

[redacted] **HOAG HOSPITAL IRVINE. [redacted] MD. ED Provider Note. (Final premed part 2 [redacted] - Page 3793-3853). Subjective**: The member presented with fevers, neck pain, headaches and breast pain associated with body aches. The member complained of left breast pain, abdominal pain and worsening chronic back pain. Of note, the member had URI symptoms and was COVID positive at home on 12/30 but tested negative on [redacted] The member had metal hardware in her neck from a previous surgery. **Diagnoses**: 1) Sepsis, due to unspecified organism, unspecified whether acute organ dysfunction present (HCC) Acute. 2) Acute non-intractable headache, unspecified headache type. 3) Chronic midline posterior neck pain, acute. 4) Cellulitis of the left breast, acute. **Plan**: Ordered CT chest. Recommended to consult a plastic surgeon. The member was admitted to telemetry. **Procedure**: Lumbar puncture.

[redacted]. **HOAG HOSPITAL IRVINE. [redacted] MD. Hospitalist History and Physical Note. (Final premed part 2 [redacted] - Page 3853-3862). Subjective**: The member presented with an acute headache with associated neck pain, associated with a high fever. There were some diffuse muscle and body aches. Her left breast had been feeling more tender and swollen. She has had prior cervical arthroplasty done and there was hardware. She was noted to be febrile with mild tachycardia and mildly elevated blood pressure. Labs pending. She was started on the sepsis pathway. **Diagnoses**: 1) Sepsis due to skin infection. 2) Cellulitis of the left breast. 3) HTN. 4) Acute tension-type headache. 5) Acute neck pain. 6) Anxiety, stable, no acute issues. 7) Insulin resistance; A1c. 8) Primary hypothyroidism, stable, no acute issues. 9) Chronic back pain. **Plan:** Continue home regimen as indicated. Follow-up with MRI of the cervical spine, CT of the chest and CSF studies. Continue to closely monitor. Continue broad-spectrum antibiotics and IV fluid hydration. Adjust and de-escalate as indicated. Continue to monitor labs. Follow-up microbiology cultures. Continue pain control and supportive care as indicated.

[redacted]. **HOAG HOSPITAL IRVINE. [redacted] MD/[redacted] MD. CT of the Chest with Contrast. (Final premed part 2 [redacted] - Page 4001-4003). Impressions**: 1) Findings suspicious for an acute infected left breast implant with abnormal soft tissue infiltration and surrounding fluid density suspicious for abscess. Assessment was somewhat limited as the lateral aspect of the left breast was not completely imaged. Recommended further assessment with a dedicated ultrasound and possible image-guided intervention at a dedicated breast imaging center. 2) Otherwise, unremarkable chest CT. 3) There was no significant change between the preliminary and final reports.

[redacted]. **HOAG HOSPITAL IRVINE. [redacted] ECG Report. (Final premed part 2 [redacted] - Page 4008-4009, 4378-4378). Impression**: Sinus tachycardia. No previous ECG available for comparison. Otherwise, normal ECG.

[redacted]. **HOAG HOSPITAL IRVINE. [redacted] MD/[redacted] MD. MRI of the Cervical Spine without Contrast. (Final premed part 2 [redacted] - Page 4006-**

[redacted], [redacted] [redacted]

4007). Impressions: 1) Status post C3-C6 level anterior spinal fusion. Evaluation of the spinal canal, spinal cord and neural foramen at these levels was limited by susceptibility artifact from fusion hardware. 2) Degenerative changes superimposed on a congenitally narrowed spinal canal resulted in mild to moderate spinal stenosis at the C6-C7 level and multilevel neural foraminal narrowing. No evidence of severe spinal stenosis or cord compression.

[redacted]. **HOAG HOSPITAL IRVINE. [redacted] MD. X-rays of the Chest. (Final premed part 2 [redacted] [redacted] - Page 4000-4001). Impression**: No acute chest abnormality.

[redacted]. **HOAG HOSPITAL IRVINE. [redacted] MD. Hospitalist Progress Note. (Final premed part 2 [redacted] [redacted] - Page 3896-3905). Subjective**: The member reported no acute events overnight. Afebrile. Clinical status stable. Symptoms improved. Pain controlled. Tolerating PO. **Diagnoses**: 1) Sepsis due to skin infection. 2) Cellulitis of the left breast; white count remains elevated with procalcitonin trending up. 3) HTN. 4) Acute tension-type headaches. 5) Acute neck pain. 6) Anxiety. 7) Insulin resistance; A1c 5.3. 8) Primary hypothyroidism. 9) Chronic back pain. **Plan**: Continue pain control and home regimen as indicated. Follow-up with CSF studies. Continue to closely monitor. Resume home antihypertensive regimen withhold parameters specified. Continue hydralazine as needed. Hold diuretics. Follow-up microbiology cultures. Continue supportive care as indicated. Continue broad-spectrum antibiotics and IV fluid hydration. Adjust and de-escalate as indicated. Anticipated discharge in 1-2 days.

[redacted]. **HOAG HOSPITAL IRVINE. [redacted] MD. Infectious Disease Consult Note. (Final premed part 2 [redacted] [redacted] - Page 3871-3878). Subjective**: The member reported a recent onset of respiratory symptoms around [redacted], with eventual testing positive for COVID-19 on [redacted]. She developed fatigue, headaches, worsening neck pain, and fever at home. She had increasing tenderness and fullness in her left breast over the last couple of days. Her white count was markedly elevated to 38 and procalcitonin was 0.51. The member continued to remain positive with antigen testing negative. She has currently been started on cefazolin. **Diagnoses**: 1) Fever/leukocytosis with source likely left breast cellulitis +/- abscess. 2) Recent COVID-19 infection (symptom onset 12/26/22). 3) History of bilateral breast implantation, reduction. 4) History of ankylosing spondylitis, not on treatment. 5) History of neck/back pain. Status post C3-C7 level fusion. 6) Hypothyroidism. **Plan**: Continue cefazolin with the addition of vancomycin. Awaiting surgery evaluation. Ultrasound of the chest was ordered. Follow-up with blood cultures.

[redacted]. **HOAG HOSPITAL IRVINE. Physical Therapy Note. (Final premed part 2 [redacted] [redacted] - Page 3884-3889). Total Sessions**: 1. **Diagnoses**: 1) Acute non-intractable headaches, unspecified headache type. 2) Chronic midline posterior neck pain. 3) Cellulitis of the left breast.

[redacted]. **HOAG HOSPITAL IRVINE. [redacted] MD. Procedure Note. (Final premed part 2 [redacted] [redacted] - Page 3869-3871). Procedure**: Removal of left breast implant. **Pre-Procedure Diagnosis**: Left breast cellulitis. **Post-Procedure Diagnosis**: Same as the pre-procedure diagnosis.

[redacted]. **HOAG HOSPITAL IRVINE. [redacted] MD. History and Physical Note. (Final premed part 2 [redacted] [redacted] - Page 3862-3863). Subjective**: The member

reported headaches, associated with myalgias and rash. **Diagnosis**: Left breast cellulitis. **Plan**: Removal of the left breast implant was recommended.

[redacted]. HOAG HOSPITAL IRVINE. [redacted] MD. History and Physical Update Note. (Final premed part 2 [redacted] [redacted] - Page 3879-3879). Subjective: The member reported no change in her condition.

[redacted]. HOAG HOSPITAL IRVINE. [redacted] MD. Hospitalist Progress Note. (Final premed part 2 [redacted] [redacted] - Page 3905-3911). Subjective: The member reported no acute events overnight. Afebrile. Clinical status stable. Symptoms improved. Pain controlled. Tolerating PO. **Diagnoses**: 1) Sepsis due to skin infection. 2) Cellulitis of the left breast; white count remains elevated, with procalcitonin improving. 3) HTN. 4) Acute tension-type headaches. 5) Acute neck pain. 6) Anxiety, stable, no acute issues. 7) Insulin resistance; A1c 5.3. 8) Primary hypothyroidism; stable, no acute issues. 9) Chronic back pain. **Plan**: Continue pain control and home regimen as indicated. Continue to closely monitor. Continue Hydralazine as needed. Hold diuretics. Follow-up microbiology cultures. Continue supportive care as indicated. Continue broad-spectrum antibiotics and IV fluid hydration. Recommended removal of the left breast implant. Follow-up with intraoperative cultures. Advised Bio K for C. difficile prevention. Resume home antihypertensive regimen withhold parameters specified. Anticipated discharge in 1-2 days.

[redacted]. HOAG HOSPITAL IRVINE. [redacted] MD. Infectious Disease Progress Note. (Final premed part 2 [redacted] [redacted] - Page 3911-3918). Subjective: The member was seen post-OR in the morning with the removal of the left breast implant. Operative findings included infected fluid collected and sent for cultures. WBC with ongoing improvement. **Diagnoses**: 1) Fever/leukocytosis with source likely left breast cellulitis +/- abscess. 2) Recent COVID-19 infection (symptom onset [redacted]). 3) History of bilateral breast implantation, reduction. 4) History of ankylosing spondylitis, not on treatment. 5) History of neck/back pain. Status post C3-C7 level fusion. 6) Hypothyroidism. **Plan**: Continue cefazolin with the addition of vancomycin. Recommended oral therapy. Follow-up with blood cultures.

[redacted] HOAG HOSPITAL IRVINE. Social Worker Notes. (Final premed part 2 [redacted] [redacted] - Page 3891-3892, 3894-3895). Total Sessions: 2.

[redacted]. HOAG HOSPITAL IRVINE. [redacted] MD. Operative Report. (Final premed part 2 [redacted] [redacted] - Page 3879-3881). Operative: Removal of left breast implant and incision and drainage of the left breast abscess. **Preoperative Diagnosis**: Left breast infection. **Postoperative Diagnosis**: Same as the preoperative diagnosis.

[redacted] HOAG HOSPITAL IRVINE. [redacted] MD. Surgical Pathology Report. (Final premed part 2 [redacted] [redacted] - Page 3985-3989, 4390-4391). Final Diagnosis: **Breast Implant, Left**: Explanted intact silastic silicone breast implant (gross only).

[redacted]. HOAG HOSPITAL IRVINE. [redacted] MD. Hospitalist Progress Note. (Final premed part 2 [redacted] [redacted] - Page 3878-3879, 3925-3931). Subjective: The member reported no acute events overnight. Afebrile. Clinical status stable. Symptoms improved. Pain controlled. Tolerating PO. Mildly anxious. **Diagnoses**: 1) Sepsis due to skin infection. 2) Cellulitis of the left breast; WBC and inflammatory markers were improving. 3) HTN. 4) Acute

tension-type headaches. 5) Acute neck pain. 6) Anxiety, stable, no acute issues. 7) Insulin resistance; A1c 5.3. 8) Primary hypothyroidism; stable, no acute issues. 9) Chronic back pain. **Plan**: Continue pain control and home regimen as indicated. Continue to closely monitor. Continue Hydralazine as needed. Hold diuretics. Continue supportive care as indicated. Continue broad-spectrum antibiotics. Follow-up with intraoperative cultures. Advised Bio K for C. difficile prevention. Resume home antihypertensive regimen withhold parameters specified. Anticipated discharge in 1-2 days.

[redacted]. HOAG HOSPITAL IRVINE. [redacted] MD. Infectious Disease Progress Note. (Final premed part 2 [redacted] [redacted] - Page 3918-3925). Subjective: The member was afebrile. Her WBC was improving. She was asking about being discharged today. Surgical drain in place with purulent fluid noted. **Diagnoses**: 1) Left breast cellulitis and abscess; status post I&D and removal of implant (01/10/22). 2) Recent COVID-19 infection (symptom onset 12/26/22). 3) History of bilateral breast implantation, reduction. 4) History of ankylosing spondylitis, not on treatment. 5) History of neck/back pain, status post C3-C7 level fusion. 6) Hypothyroidism. **Plan**: Adjusted to ceftriaxone with GNR isolated from surgical cultures. Continue vancomycin. Follow-up with final surgical cultures. Awaiting final ID/sensitivities prior to consideration of discharge home.

[redacted]. HOAG HOSPITAL IRVINE. [redacted] ECG Report. (Final premed part 2 [redacted] [redacted] - Page 4009-4011, 4388-4389). Impression: Sinus rhythm. Borderline short PR interval. Borderline low voltage, extremity leads. When compared with the ECG of [redacted] [redacted], significant rate decrease. Otherwise, normal ECG.

[redacted]. HOAG HOSPITAL IRVINE. [redacted] MD. Hospitalist Progress Note. (Final premed part 2 [redacted] [redacted] - Page 3938-3944). Subjective: The member reported no acute events overnight. Afebrile. Clinical status stable. Symptoms improved. Pain controlled. Tolerating PO. **Diagnoses**: 1) Sepsis due to skin infection. 2) Cellulitis of the left breast; WBC and inflammatory markers were improving. 3) HTN. 4) Acute tension-type headaches. 5) Acute neck pain. 6) Anxiety, stable, no acute issues. 7) Insulin resistance; A1c 5.3. 8) Primary hypothyroidism; stable, no acute issues. 9) Chronic back pain. **Plan**: Continue pain control and home regimen as indicated. Continue to closely monitor. Continue Hydralazine as needed. Hold diuretics. Await sensitivities. Antibiotics adjusted. Continue supportive care as indicated. Advised Bio K for C. difficile prevention. Resume home antihypertensive regimen withhold parameters specified. The member will be discharged with a drain and follow-up as an outpatient.

[redacted]. HOAG HOSPITAL IRVINE. [redacted] MD. Infectious Disease Progress Note. (Final premed part 2 [redacted] [redacted] - Page 3931-3938). Subjective: The member was doing okay with the current antibiotics. Discussed the possible need for IV therapy based on return sensitivities. She had a prior Pseudomonas and E. coli infection in her left leg. Ultras returned with Pseudomonas. **Diagnoses**: 1) Left breast cellulitis and abscess; status post I&D and removal of implant ([redacted]). 2) Recent COVID-19 infection (symptom onset [redacted]). 3) History of bilateral breast implantation, reduction. 4) History of ankylosing spondylitis, not on treatment. 5) History of neck/back pain, status post C3-C7 level fusion. 6) Hypothyroidism. 7) Left ankle fracture. 8) Oral HSV. **Plan**: Adjusted antibiotics further to cefepime with isolation of Pseudomonas from surgical cultures. Continue vancomycin. Pending final culture results. Follow-up with final surgical cultures. Continue valacyclovir. Awaiting final sensitivities prior to discharge home.

[redacted], [redacted] [redacted]

[redacted]. **HOAG HOSPITAL IRVINE. [redacted] MD. Infectious Disease Progress Note. (Final premed part 2 [redacted] [redacted] - Page 3944-3952). Subjective**: The member was doing well overall. Tolerating abx without issues. Discussed the antibiotic plan as well as side effects related to levofloxacin. The member had some discomfort on the right side, but no erythema or fluctuance was noted. **Diagnoses**: 1) Left breast cellulitis and abscess; status post I&D and removal of implant ([redacted]). Cx with Pseudomonas aeruginosa. 2) Recent COVID-19 infection (symptom onset [redacted]. 3) History of bilateral breast implantation, reduction. 4) History of ankylosing spondylitis, not on treatment. 5) History of neck/back pain, status post C3-C7 level fusion. 6) Hypothyroidism. 7) Left ankle fracture. 8) Oral HSV. **Plan**: Continue cefepime with isolation of Pseudomonas from surgical cultures. Stop vancomycin. The member was okay to be discharged home. Recommended 12 weeks of therapy with levofloxacin. Scheduled for follow-up with surgery on [redacted].

[redacted] **HOAG HOSPITAL IRVINE. [redacted] MD. Hospitalist Discharge Summary. (Final premed part 2 [redacted] [redacted] - Page 3864-3869). Date of Admission**: [redacted]. **Reason for Admission:** The member was admitted with Sepsis due to a skin infection (HCC). **Diagnoses**: 1) Sepsis due to skin infection. 2) Cellulitis of the left breast; WBC and inflammatory markers were improving. 3) HTN. 4) Acute tension-type headaches. 5) Acute neck pain. 6) Anxiety, stable, no acute issues. 7) Insulin resistance; A1c 5.3. 8) Primary hypothyroidism; stable, no acute issues. 9) Chronic back pain. **Plan**: Transitioned to oral antibiotics regimen per Infectious Diseases. Resume home antihypertensive regimen withhold parameters specified. Continue pain control and home regimen as indicated. Advised Bio K for C. difficile prevention. The member remained clinically and hemodynamically stable through the remainder of the hospital course. The member was deemed stable from a medical standpoint for discharge and follow-up as an outpatient. Prescribed levofloxacin and Lactobacillus DR capsule. Follow-up with [redacted] MD and [redacted] MD. Scheduled for orthopedic surgery follow-up with [redacted], DO.

[redacted]. **HOAG HOSPITAL IRVINE. [redacted] MA. Clinic Note. (Final premed part 2 [redacted] [redacted] - Page 3582-3583). Comments**: The member was noted to have sepsis form abscess. She was scheduled for an appointment with Dr. [redacted] on [redacted].

[redacted]. **UCI HEALTH. [redacted] MD. Hospital Follow-Up. (Final premed part 2 [redacted] [redacted] - Page 3588-3591, 3599-3610). Subjective**: The member presented for post-hospital evaluation. The member was recently admitted for sepsis secondary to SSTI at the site of left breast implant rupture. She was confirmed positive for Pseudomonas growth from cultures and removal of the left breast implant. She continued to take PO antibiotics with Pseudomonas coverage as prescribed. She reported feeling overall significantly improved. The member endorsed back pain. She reported improving left ankle pain. She continued to wear a left ankle brace while the left foot was elevated in bed and a CAM boot while ambulating (both during recent hospitalization and at home). **Diagnoses**: 1) Hospital discharge follow-up. 2) Leukocytosis, unspecified type. 3) Sepsis due to Pseudomonas species, unspecified whether acute organ dysfunction present (CMS-HCC), resolved. 4) Closed fracture of the malleolus of the left ankle with routine healing, subsequent encounter. **Plan**: Labs were ordered. Follow-up with ID and Plastics as scheduled. Advised CAM boot and left ankle orthosis. X-rays of the left ankle were ordered.

[redacted]. UCI HEALTH. [redacted] MD. X-rays of the Left Ankle. (Final premed part 2 [redacted] [redacted] - Page 3617-3618). Impression: Unchanged appearance and alignment of nondisplaced Weber type A lateral malleolus tip fracture.

[redacted]. THE CENTER FOR COMPREHENSIVE PAIN MANAGEMENT UNIVERSITY OF CALIFORNIA, IRVINE/UCI HEALTH. [redacted] MD/[redacted] PA. Telemedicine Follow-Up Visit. (Final premed part 2 [redacted] [redacted] – Page 3624-3636, 3642-3653). Subjective: The member was status post L5-S1 level interlaminar epidural steroid injection on [redacted], with benefit. The member developed sepsis due to an infected breast implant. The culture revealed Pseudomonas. The member was hospitalized with IV antibiotics. The member had a COVID infection, broke her ankle, and was in her boots. She reported more pain and significant fatigue. The pain was rated at 7/10. Awaiting authorization for an artificial disc replacement with Dr. [redacted]. She was taking tizanidine and meloxicam with benefit. **Diagnoses**: 1) Degenerative disc disease, thoracic spine. 2) Chronic myofascial pain. 3) Osteoarthritis of the spine with radiculopathy, cervical region. 4) History of fusion of the cervical spine. **Plan**: Stopped low-dose compounded naltrexone. Continue tizanidine. Start Robaxin. Doses of meloxicam were decreased. Counseled to avoid using other NSAID agents. Discussed non-opioid modalities. Follow-up in 3 months with Dr. [redacted].

[redacted]. UCI HEALTH. [redacted] MD. Orthopedic Spine Surgery Note. (Final premed part 2 [redacted] [redacted] - Page 3657-3660, 3666-3682). Subjective: The member complained of neck and bilateral arm pain. The pain was described as constant and aching, rated at 6/10. She had a loss of hand dexterity. The pain was made worse by activity. She tried physical therapy and epidural steroid injections. She reported no changes in bowel and bladder function. **Diagnosis**: Cervical spine spondylosis. **Discussion**: The member was noted to have worsening hand numbness. **Plan**: Recommended disc replacement at the C6-C7 level.

[redacted]. ORANGE COUNTY FIRE AUTHORITY. [redacted] OCFA Patient Care Report v6 (with Attachments). (Final premed part 2 [redacted] [redacted] - Page 3761-3771). Narrative: The member was experiencing anxiety and hyperventilating. The member has stable vitals and no other complaints. The 12-lead showed sinus tachycardia. The member calmed and was reassured with improvement. The member was transported BLS to HOAG Irvine via Care #6699.

[redacted]. HOAG HOSPITAL IRVINE. [redacted] MD. ED Provider Note. (Final premed part 2 [redacted] [redacted] - Page 3692-3716, 3751-3758, 3777-3784). Subjective: The member arrived by ambulance. She presented with worsening left LUQ pain, radiating into her left chest. She had nausea. She had a scheduled appointment with her cardiologist and was advised to come to the ED. She was taking pain medication for symptom relief. Her breast implant was removed, and she had a JP drain placed at discharge. **Diagnosis**: Abdominal pain, unspecified abdominal location, acute. **Plan**: The examiner sent blood for culture. Recommend close follow-up with her PCP. The member was discharged home in improved condition. Schedule an appointment with [redacted], DO and [redacted], MD. Recommended consultation with the cardiologist.

[redacted]. HOAG HOSPITAL IRVINE. [redacted], MD. CT of the Chest/Abdomen/Pelvis with Contrast. (Final premed part 2 [redacted] [redacted] - Page 3726-3728). Impressions: 1) No acute findings in the chest, abdomen or pelvis. 2) Interval

[redacted], [redacted] [redacted]

removal of the left breast implants without evidence of fluid collection in the left chest wall. 3) Colonic diverticula without evidence of diverticulitis.

[redacted]. **HOAG HOSPITAL IRVINE. [redacted] MD. X-rays of the Chest. (Final premed part 2 [redacted] - Page 3725-3726). Impression**: No acute chest abnormality.

[redacted]. **UCI HEALTH. [redacted] MD[redacted], MD. MRI of the Cervical Spine without Contrast. (Final premed part 2 [redacted] - Page 4479-4482). Impressions**: 1) Stable postsurgical changes from disc arthroplasties at the C3-C4 to C5-C6 levels. 2) Mild multilevel spinal canal stenosis was seen, not significantly changed from [redacted] Intact cord signal, allowing for susceptibility artifact. 3) Multilevel neuroforaminal stenosis of varying degrees, again most prominent at the right C5-C6 level.

[redacted]. **PROVIDENCE REZOLUT IRVINE IMAGING CENTER. [redacted] MD. X-rays of the Cervical Spine. (Final premed part 2 [redacted] - Page 4488-4489, 4492-4492, 4497-4497). Impression**: Intact intervertebral arthroplasty involving C3-C4, C4-C5 and C5-C6 levels.

[redacted]. **PROVIDENCE REZOLUT IRVINE IMAGING CENTER. [redacted] MD. X-rays of the Lumbar Spine. (Final premed part 2 [redacted] - Page 4491-4491, 4494-4494, 4496-4496). Impression**: Mild multilevel degenerative lumbar spondylosis. Grade 1 anterolisthesis of the L4 on the L5 level accentuated in flexion.

[redacted]. **PROVIDENCE REZOLUT IRVINE IMAGING CENTER. [redacted] MD. X-rays of the Thoracic Spine. (Final premed part 2 [redacted] - Page 4490-4490, 4493-4493, 4495-4495). Impressions**: 1) No acute fracture or thoracic malalignment. 2) Moderate degenerative thoracic spondylosis.

[redacted]. **UCI HEALTH. [redacted], RN. Clinic Note. (Final premed part 2 [redacted] - Page 4500-4500). Comments**: The member confirmed the cardiac stress test appointment.

[redacted]. **UCI HEALTH. [redacted] MD. Exercise Echo with US Enhancement Agent. (Final premed part 2 [redacted] - Page 4504-4506). Impressions**: 1) Negative stress echo for ischemia. 2) Normal left ventricular systolic function. 3) Calculated ejection fraction at rest was 60%. 4) Contrast agent used for left ventricular opacification. 5) Test terminated due to shortness of breath. 6) Stress images examined: apical 4 chamber: 2/3, apical 2 chamber: 1/3, apical 3 chamber: 3/3.

[redacted]. **UCI HEALTH. [redacted] MD[redacted] MD. Outpatient Psychiatry Initial Evaluation Note. (Final premed part 2 [redacted] - Page 4515-4521, 4525-4542). Subjective**: The member was seen for initial psychiatric evaluation and establishment of care. She indicated that her psychiatrist initially stated that he was going to retire but then found a new office and decided not to retire. The member figured that she should find a new psychiatrist so that she would have one for when her psychiatrist retires. She was on clonazepam and Xanax, which she started after her hospitalization in [redacted] at Hoag when she was admitted for sepsis; however, she had been prescribed these medications since [redacted] She had probably tried all the

SSRIs. She worked as an [redacted], so she knew all about the medications. During the evaluation, the examiner advised the member that, as she might have learned about in her studies, SSRIs were approved treatment for MDD, GAD, panic disorder and PTSD; in response to this, the member stood up and walked quickly toward the interviewer, raised her voice, stating it was not her study but her work. She was compliant and began crying. She reported she had tried so many medications and nothing worked, so she was considering trying EMS. The member was referring to TMS as she was not manic depressive. She had stressors at work, particularly her manager never paid her correctly, even though she did all the important work. She endorsed depressed mood, constant anxiety and difficulty with her memory, which she attributed to her recent hospitalization and the sepsis was concerning her. On evaluation, the member displayed mood lability, with moments of agitation and moments of tearfulness. **Diagnoses**: Unspecified mood disorder - chronic, with exacerbation. **Plan**: Continue medications as prescribed by the outside psychiatrist.

[redacted]. UCI HEALTH. [redacted], MA. Telephone Encounter Note. (Final premed part 2 [redacted] [redacted] - Page 4563-4563). Comments: The member was scheduled to have spine surgery with Dr. [redacted] on [redacted] at UCI. Medical clearance was requested.

[redacted]. UCI HEALTH. [redacted] MD. Orthopedic Spine Surgery Note. (Final premed part 2 [redacted] [redacted] - Page 4573-4576, 4586-4597). Subjective: The member complained of neck and bilateral arm pain. The member had a loss of hand dexterity. **Diagnosis**: Cervical spondylosis. **Plan**: Recommended anterior cervical discectomy and fusion at the C6-C7 level.

[redacted]. UCI HEALTH. [redacted] MD. Brief Visit. (Final premed part 2 [redacted] [redacted] - Page 4604-4608, 4616-4629). Subjective: The member reported intermittent abdominal pain. The pain was localized just beneath her sternum, slightly to the left, and was accompanied by a knot-like/hardening sensation. It tends to occur with increased intra-abdominal pressure or position change. She noted concurrent nausea and difficulty eating for the past few months. **Diagnosis**: Abdominal pain, unspecified abdominal location. **Plan**: Ultrasound of the abdomen was ordered. Labs were ordered. Follow-up with GI as scheduled.

[redacted]. UCI HEALTH. [redacted] MD. Outpatient Preoperative Evaluation. (Final premed part 2 [redacted] [redacted] - Page 4649-4657, 4667-4682). Subjective: The member presented for preoperative evaluation. She was scheduled for C6-C7 anterior discectomy with Ortho-Spine on [redacted]. She had undergone multiple comparable surgical interventions in the past for the management of ankylosing spondylitis. She had been managed with steroid injection and PT without significant improvement but with adverse events of recurrent sepsis secondary to SSTI. She was experiencing recurrent headaches in the setting of elevated blood pressure and underwent stress testing. She reported good exercise tolerance and was participating in jiu-jitsu training 5 times/week. **Assessment**: The member with a history of ankylosing spondylitis, C3-C6 spinal surgery (followed by Ortho Spine, Dr. [redacted]), CRPS and hormone replacement therapy was being evaluated for preoperative evaluation and optimization. **Plan:** Recommend VTE prophylaxis. Continue medications. Recommended incentive spirometry. Advised to hold all vitamins, supplements and herbal medications.

[redacted], [redacted] [redacted]

[redacted]. UCI HEALTH. [redacted] MD. ECG Report. (Final premed part 2 [redacted] - Page 4659-4660, 4683-4683). Study Date: [redacted]. **Impression**: Sinus rhythm with short PR interval. Borderline ECG.

[redacted] UCI HEALTH. [redacted] MD. Cardiac Electrophysiology Clinic Note. (Final premed part 2 [redacted] - Page 4733-4736, 4741-4747, 4749-4755). Subjective: Since the last visit, the member reported some chest pains and had a normal stress test. BP returned to normal, and doses of amlodipine were decreased. Currently, the member reported no chest pain or other cardiac symptoms. **Diagnoses:** 1) Ankylosing spondylitis. 2) Trivial aortic regurgitation, not present on most recent echo. 3) Hypertension - well controlled. 4) Hyperkalemia. **Discussion/Plan**: There was no cardiac contraindication to surgery. Exercise stress was normal and showed good functional capacity. She was at low risk for surgery. Continue propranolol. If the member's SBP was less than 110, she should hold amlodipine on the morning of surgery.

[redacted]. UCI HEALTH. [redacted], MD. ECG Report. (Final premed part 2 [redacted] - Page 4737-4739, 4748-4748). Study Date: [redacted]. **Impression**: Sinus rhythm with sinus arrhythmia. Normal ECG.

[redacted]. UCI HEALTH. [redacted] MD. Progress Note. (Final premed part 2 [redacted] - Page 4764-4767, 4773-4786). Subjective: The member presented for re-revision of the anterior cervical discectomy approach. Otolaryngology-assisted with the revision approach in [redacted] (left-sided) was uncomplicated and without scarring of the esophagus/trachea to the surrounding musculature. Otolaryngology will assist with the approach. She had new symptomatology and imaging concerning C6-C7 stenosis, requiring C6-C7 cervical disc replacement. She reported no significant changes to her health apart from recent hospitalization for sepsis, which immediately followed her spinal injections. She was told that it was due to breast implant rupture. MRI of the breast was negative. She reported new and occasional oral blisters x3 months, which were minimally tender. Since the last visit, she was scheduled for surgery but it was denied by insurance. However, she has appealed to have it improved. **Assessment/Plan**: The member with a medical history of ankylosing spondylitis, who had two prior cervical surgeries in [redacted] and [redacted], required re-revision anterior cervical discectomy and fusion of the C6-C7 level. The surgery was planned for [redacted] with Dr. [redacted] of orthopedic surgery.

[redacted]. UCI HEALTH. Gerald Lee, MD. Ultrasound of the Upper Abdomen Limited. (Final premed part 2 [redacted] - Page 4801-4802). Impressions: 1) Mildly echogenic liver that might represent fatty infiltration. Small liver cyst. 2) Status post cholecystectomy.

[redacted] UCI HEALTH. Gerald Lee, MD. Ultrasound of the Hernia Abdomen. (Final premed part 2 [redacted] - Page 4796-4797). Impression: No hernia visualized.

[redacted]. THE CENTER FOR COMPREHENSIVE PAIN MANAGEMENT UNIVERSITY OF CALIFORNIA, IRVINE/UCI HEALTH. [redacted] MD/[redacted] PA. Procedure Note. (Final premed part 2 [redacted] - Page 4828-4833, 4843-4860). Procedure: Trigger point injection. **Pre-Procedure Diagnosis**: Myalgia/Myositis. **Post-Procedure Diagnosis**: Same as the pre-procedure diagnosis.

[redacted]. UCI HEALTH. [redacted] MD. Spine Surgery Postoperative Visit Note. (Final premed part 2 [redacted] [redacted] - Page 4866-4867, 4872-4898). Subjective: The member was 2 weeks status post C6-C7 level disc replacement. She was wearing the brace and tolerating it well. **Assessment**: The member was doing well. **Plan**: Discussed postoperative instructions. Follow-up in 4 weeks.

[redacted]. UCI HEALTH. [redacted] MD. X-rays of the Cervical Spine. (Final premed part 2 [redacted] [redacted] - Page 4906-4907). Findings/Impression: Upright frontal and lateral views of the cervical spine were acquired for review.

[redacted]. THE CENTER FOR COMPREHENSIVE PAIN MANAGEMENT UNIVERSITY OF CALIFORNIA, IRVINE/UCI HEALTH. Brent Yeung, MD/[redacted] PA. Procedure Note. (Final premed part 2 [redacted] [redacted] - Page 4921-4926, 4936-4951). Procedure: Trigger point injection. **Pre-Procedure Diagnosis**: Myalgia/Myositis. **Post-Procedure Diagnosis**: Same as the pre-procedure diagnoses.

[redacted]. THE CENTER FOR COMPREHENSIVE PAIN MANAGEMENT UNIVERSITY OF CALIFORNIA, IRVINE/UCI HEALTH. Brent Yeung, MD/Tristan Loesberg, MD. Procedure Note. (Final premed part 2 [redacted] [redacted] - Page 4957-4962, 4972-4979, 4982-4989). Procedure: Trigger point injection. **Pre-Procedure Diagnosis**: Myalgia/Myositis. **Post-Procedure Diagnosis**: Same as the pre-procedure diagnoses.

[redacted]. THE CENTER FOR COMPREHENSIVE PAIN MANAGEMENT UNIVERSITY OF CALIFORNIA, IRVINE/UCI HEALTH. Nathaniel Dusto, MD/[redacted] MD. Telemedicine Follow-Up Visit Note. (Final premed part 2 [redacted] [redacted] - Page 4993-5007, 5014-5031). Subjective: The member was status post multiple rounds of trigger point injections. She developed Horner's syndrome. She reported her neck pain had improved. She was looking to have another surgery with Dr. [redacted] for an L5 fusion. Her insurance denied the surgery. She is currently going to physical therapy outside of UCI. She was engaged in regular exercise programs. The member was not a candidate for a repeat epidural. **Diagnoses**: 1) Discogenic pain. 2) Chronic myofascial pain. 3) Degenerative disc disease, thoracic spine. 4) Osteoarthritis of the spine with radiculopathy, cervical spine region. 5) History of fusion of the cervical spine. **Plan**: Continue tizanidine, Robaxin and meloxicam. Counseled to avoid using other NSAID agents. Discontinued LDN and Lyrica. Await outside perioperative window for repeat ESI. Discussed non-opioid modalities. Follow-up in 3 months with Dr. [redacted].

[redacted]. UCI HEALTH. [redacted] MD. Progress Note. (Final premed part 2 [redacted] [redacted] - Page 5035-5039, 5046-5061). Subjective: The member complained of back and bilateral hip pain. The pain level was 7/10. She had difficulty walking. The member had worsening leg numbness and weakness despite doing physical therapy for the past 6 months. **Diagnoses**: 1) Other spondylosis with myelopathy, cervical spine region. 2) Other spondylosis with myelopathy, lumbar spine region. **Plan**: MRI of the lumbar spine was ordered.

[redacted]. UCI HEALTH. [redacted] MD. X-rays of the Cervical Spine/Lumbosacral Spine. (Final premed part 2 [redacted] [redacted] - Page 5064-5065, 5069-5070). Findings/Impression: **2 views of the cervical spine are obtained**. Prior intervertebral disc arthroplasties at the C3-C7 level with intact implants. There was no acute

fracture. Cervical spine alignment was normal. Moderate C2-C3 degenerative disc disease. **2 views of the lumbar spine were obtained**. Grade 1 anterolisthesis of L4 on L5 and mild levorotatory curvature of the lumbar spine. The vertebral body heights were normal. No fractures. Mild multilevel lumbar spine degenerative disc disease. Lower lumbar spine facet joint osteoarthritis.

[redacted]. **UCI HEALTH. [redacted], MD. Gastroenterology Consult Note. (Final premed part 2 [redacted] - Page 5081-5093, 5107-5128). Subjective**: The member has a history of low vitamin B12 and chronic intermittent upper epigastric and LUQ abdominal pain. Workup included an abdominal ultrasound, showing, besides a mildly echogenic liver, a 1.6 cm septated cyst in the right lobe. **Diagnoses**: 1) Epigastric pain. 2) Liver cyst. 3) Chronic constipation. 4) Fatty liver disease, nonalcoholic. 5) Low vitamin B12 level. 6) Liver lesion. **Plan**: MRI of the abdomen with/without contrast was performed. Labs were ordered. GI endoscopy procedure service was requested.

[redacted] **UCI HEALTH. [redacted] MD. MRI of the Lumbar Spine without Contrast. (Final premed part 2 [redacted] - Page 3225-3227). Impression**: Lumbar spondylosis was most prominent at the L4-L5 level, where there was severe spinal stenosis.

[redacted]. **UCI HEALTH. [redacted], MD#. MRI of the Abdomen with/without Contrast. (Final premed part 2 [redacted] - Page 5135-5136). Impression**: Benign 1.8 cm simple cyst in the inferior right hepatic lobe. No suspicious hepatic lesion.

[redacted], [redacted] **MD. Medical Evaluation Preliminary Report. (Final premed part 2 [redacted] - Page 5172-5172). DOI**: [redacted]; CT [redacted]. **DOE**: [redacted] **Comments**: The member's condition was related to HTN (claimed injury). Her condition was permanent and stationary. The member required treatment.

[redacted] [redacted] **MD. Agreed Medical Examination. (Final premed part 2 [redacted] - Page 5173-5186). DOI**: [redacted] CT [redacted]. **DOE**: [redacted]. **Subjective**: The member was off work due to hospitalization from [redacted] to [redacted] for sepsis with left breast surgery for pseudomonas infection. She had persistent spinal pain involving both the cervical and lumbar areas. The examiner will defer further comment on the orthopedic complaints to the appropriate specialist. The member had been treated for PTSD. She reported stress from her job duties. The member noted that from the Joint Interrogatory of [redacted], her PTSD claim was accepted. At work, she would handle cases basically one after the other for 15 years, which she believed led to a constant state of arousal and strain on her internal systems. The member is currently under care for PTSD. She was on amlodipine and propranolol. Her BP was high in [redacted]. She suffered from adrenal insufficiency. She was under the care of Dr. [redacted] at the [redacted] or hormone replacement. The member reported malaise, fatigue, anxiety, depression, periods of loss of appetite, social withdrawal, difficulty concentrating and sleep problems. She was on clonazepam, methocarbamol, tizanidine, meloxicam, Tylenol and Xanax. **Surgical History**: Septoplasty ([redacted]). Gallbladder removal [redacted] Cervical spine surgeries ([redacted]). **Family History**: The member's father died of kidney failure at age [redacted] Her father had diabetes and a tumor in the pancreas. Her mother had cardiomyopathy with low blood pressure. **Occupational History:** The member began working for the [redacted] more than 17 years ago. She worked as an [redacted]

[redacted], [redacted] [redacted]

[redacted] [redacted] for [redacted] for over 15 years, doing both field work and computer work. The member initially worked as a therapist between [redacted] and [redacted] for the [redacted] and then was a [redacted] at [redacted]. The member also worked at the [redacted] between [redacted] and [redacted]. In [redacted], she began working for the [redacted]. The member was a part of the [redacted], which specialized in the severe cases of abuse and neglect. She was the [redacted] with the [redacted] as well as their [redacted] The task force investigated child pornography. She worked as an [redacted] and responded to emergencies. **Diagnoses:** 1) Hypertension. 2) Request records from the office of Dr. [redacted]. 3) Request an echocardiogram. **Plan**: Ordered an updated echocardiogram. The examiner requested medical records for review. **Work/Disability Status**: The member was considered MMI and apparently did not require TTD due to hypertension. **Causation**: Industrial.

[redacted]. [redacted] [redacted], MD. **Supplemental Report by an Agreed Medical Examiner. (Final premed part 2 [redacted] [redacted] - Page 5190-5192). DOI**: CT [redacted] **Discussion:** The examiner reviewed the additional medical records and the report dated [redacted]. It was noted that the member was not yet permanent and stationary. The examiner felt that the member should be afforded a course of treatment on an industrial basis and should return for a final AME re-evaluation once her treatment has been completed. The member would be a candidate for surgery at the C6-C7 level. During the examination, the member was working regular duties from home. The member was referred to psychiatry and internal medicine. No further medical records have been sent to the examiner about any treatment she had received since the examiner's initial report, so it was unclear as to whether or not she had reached MMI without further documentation.

[redacted]. **CARDIOLOGY SPECIALISTS OF ORANGE COUNTY. [redacted], MD. Echocardiography Report. (Final premed part 2 [redacted] [redacted] - Page 5194-5200). Impressions**: 1) LV size, wall thickness and systolic function were normal, with an EF of 55-60 % at rest. 2) The right ventricular systolic pressure, as measured by Doppler, was 4 mmHg + CVP.

[redacted]. [redacted] [redacted], MD. **Initial Treating Physician's Evaluation and Request for Authorization to Treat. (Final premed part 2 [redacted] [redacted] - Page 5193-5193, 5202-5205). DOI**: [redacted]. **Discussion**: The member appeared severely emotionally labile and brittle. The member was only minimally able to cooperate with the interview process. The member was increasingly tearful and tangential to the point where it was difficult to find logic or purpose in her lengthy barrage of thoughts, experiences and concerns. She was emotionally unstable. She had difficulty answering the simplest questions. She was receiving eye movement desensitization reprocessing treatments over the course of the last two years, provided by Dr. [redacted] [redacted]. The member urgently pressed a request, before any discussion had taken place about her condition, focused on conflict with her Workers' Compensation carrier. Most of the conversation consisted of her complaints about the difficulties she has in pursuing treatment, disability, and her return to work. The member indicated that she was on vacation and that Workers' Compensation had refused to provide her the vacation time that she had accrued. She had been receiving services that she was highly satisfied with through private insurance. She intended to continue treatment with her team of private providers, Dr. [redacted], Dr. [redacted] and Dr. [redacted], a psychiatrist, who is providing her transcranial magnetic stimulation and ketamine treatments. It was determined shortly thereafter that the member was seeking assistance from the

examiner in a severely tangential manner, as she believed that, as a member of the insurance network, she would be able to collect temporary disability benefits if an off-work letter was provided by the examiner. The member intended to continue treatment with her team of mental health professionals, though belatedly added that she no longer had medical benefits through her private insurance, again a matter of contention between herself and her Workers' Compensation carrier. It became clear that the member had anticipated that she would be able to continue treatment with her current providers. It was not communicated in an insulting or derogatory manner but appeared to be a genuine expression of her confidence and fear of coming under the care of our treatment team. The member became increasingly upset and tearful, and the conversation lacked coherence and appeared illogical. The examiner believed that the member was doing her very best to answer questions, though her responses were difficult to understand, with severe perseveration describing details about her circumstance irrelevant to my questions. Her monologue could not be interrupted. It became very clear to the examiner that continuing to press the member for details required to write a coherent description of her current condition was not possible. The member appeared to be making the best effort possible and was cooperative to the extent that she was able, though severely perseverated on her immediate needs and requests for a response as to when she could expect to receive disability benefits and continue her visits with Dr. [redacted], Dr. [redacted] and Dr. [redacted]. The examiner will provide further help after reviewing additional medical records. The member seemed taken aback but was reassured on multiple occasions and appeared to agree. The examiner was unable to formulate a coherent medical history, mental status examination or current diagnosis. The examiner reviewed the qualified medical evaluation report of Dr. [redacted], which was clearly helpful in moving toward a direction for the member, though she clearly was not in sufficient mental health to provide clarity on her current condition. The examiner was very concerned about the member. She did not appear to be an imminent danger to herself or others and verbally contracted for safety, though it was clear that she was emotionally fragile. The member was informed to continue treatment under her current providers. She was not sufficiently stable at present to transfer care to a new provider. In addition, it was clear that the member needed intensive mental health services at present.

[redacted]. [redacted], MD/[redacted], NP. Primary Treating Physician's Progress Report (PR-2). (Final premed part 2 [redacted] - Page 5208-5209).
Subjective: The member indicated that her mood and overall well-being had been good. She had no complaints of depression and her sleep duration was 7-10 hours/night. She was experiencing anxiety occasionally; she asserts she manages it using CBT techniques. She worked as a therapist herself and was aware of her triggers and employed strategies to combat them. She was on Spravato nasal spray, Vraylar, alprazolam and clonazepam. The member is currently under the care of Dr. [redacted] and wishes to continue with her current team of mental health providers, intending to use workers' compensation for the services. **Diagnoses:** 1) PTSD. 2) Depressive disorder, not otherwise specified. **Plan:** Continue psychotherapy, Spravato nasal spray, cariprazine, alprazolam and clonazepam. **Work Status**: TTD.

[redacted]. [redacted], MD/[redacted], NP. Primary Treating Physician's Progress Report (PR-2). (Final premed part 2 [redacted] - Page 5210-5211). DOI: [redacted]. **Subjective**: The member reports the trial of Vraylar ended on the 7th day due to severe headaches and brain fog. Her most recent Spravato treatment was administered last week. Multiple medication options were suggested but the member reported negative reactions to each one. The member expressed reluctance to try SSRI/SNRI medications, citing concerns about their

ineffectiveness and side effects. She is adamantly requesting to stay on benzodiazepines, as she reports it is the only treatment that will work. She liked to discontinue the Xanax and have the Klonopin and would find a better sleeping aid or keep the Xanax and find another sleeping aid. When non-SSRI/SNRI options were proposed, the member reported trying Mucinex but confused it with guaifenesin, resulting in difficulty recalling side effects. The member became emotionally overwhelmed during the discussion of scheduled anxiolytic medications, leading to uncontrollable crying. **Diagnoses**: 1) Posttraumatic stress disorder, acute. 2) Depressive disorder, not otherwise specified. **Plan**: The examiner recommended psychotherapy. **Work Status**: TTD.

[redacted] [redacted] [redacted], MD/[redacted] [redacted], NP. **Primary Treating Physician's Progress Report (PR-2). (Final premed part 2 [redacted] [redacted] - Page 5246-5247). DOI**: [redacted]. **Subjective**: The member reports persistent anxiety. She is using benzodiazepines sparingly, approximately 1-2 times a week. The member demonstrated heightened stress/anxiety, resulting in a complete shutdown and stuttering. **Diagnoses**: 1) Posttraumatic stress disorder, acute. 2) Depressive disorder, not otherwise specified. **Plan**: Buspirone is prescribed. Continue psychotherapy. **Work Status**: TTD.

[redacted]. [redacted] [redacted], **MD, A MEDICAL CORPORATION. Psychotherapy Notes. (Final premed part 2 [redacted] [redacted] - Page 5229-5229, 5248-5248, 5291-5291, 5300-5300, 5527-5527, 5530-5531, 5533-5533, 5541-5541). Total Sessions**: 8.

[redacted]. [redacted] **MD. Agreed Medical Supplemental Report. (Final premed part 2 [redacted] [redacted] - Page 5221-5228, 5230-5245). DOI**: [redacted]; CT [redacted]. **DOE**: [redacted] **Comments**: In the report of [redacted], the examiner indicated that the member developed hypertension but the examiner would need the updated records from Dr. [redacted] office, as well as an echocardiogram, before coming to any conclusions. The medical records indicated that, indeed, in [redacted], the member was found to have elevated blood pressure, leading to treatment. With treatment, the blood pressure did come under good control. The examiner believed the member developed hypertension, most likely related to PTSD, and also had a lot of pain, though the examiner noted from the records reviewed previously that of great interest was that the blood pressure was not associated with the pain surrounding the surgeries. The member did indicate in her deposition that she was having cardiac ultrasounds done every 6 months, and the examiner saw that the reason that was done was that Dr. [redacted] wanted to find out if there was any cardiac involvement secondary to the ankylosing spondylitis. The echocardiograms, however, were normal, and the examiner must point out that the echocardiogram that the examiner ordered on [redacted] was normal as well. The member was MMI as per page 13 of the examiner's [redacted] report. The member is at 5% WPI, given hypertension with no end-organ damage, with very well-controlled blood pressure on a small amount of medication. Regarding apportionment, 100% of the impairment is industrial related to the CT claim ending [redacted]. Regarding treatment, doctor's visits two to three times a year will be needed with annual testing as recommended by the treating physician.

[redacted], [redacted] [redacted], MD/[redacted] [redacted], NP. **Primary Treating Physician's Progress Report (PR-2). (Final premed part 2 [redacted] [redacted] - Page 5249-5250). DOI**: [redacted] **Subjective**: The member reports initiating buspirone, experiencing headaches but they subsequently resolved. She continues to have tension headaches, and it is uncertain whether it is a chronic issue or a side effect of Buspar. She is committed to continuing Buspar to observe its

effect on her anxiety. She attends therapy weekly, finding it beneficial but emotionally draining, often resulting in tears. She acknowledges lacking emotional support at home and was encouraged to reach out to loved ones or friends for support. She reports ongoing financial stressors impact her sleep, and she is using clonazepam. **Diagnoses**: 1) Posttraumatic stress disorder, acute. 2) Depressive disorder, not otherwise specified. **Plan**: Continue psychotherapy. **Work Status**: TTD.

[redacted]. [redacted], MD/[redacted], NP. Primary Treating Physician's Progress Report (PR-2). (Final premed part 2 [redacted] - Page 5292-5293). DOI: [redacted]. **Subjective**: The member is observed crying during the session. She reports ongoing issues with anxiety and depression. She expressed a desire to restart Spravato treatment, which she claimed had been beneficial. **Diagnoses**: 1) Posttraumatic stress disorder, acute. 2) Depressive disorder, not otherwise specified. **Pan**: The examiner recommended increasing the dosage of buspirone. The examiner requests that the psychiatrist's records be forwarded for review. Continue psychotherapy. **Work Status**: TTD.

[redacted]. [redacted], MD. Agreed Medical Re-Examination Complex Medical Legal Orthopedic Evaluation Report. (Final premed part 2 [redacted] - Page 5263-5284, 5289-5289). DOI: CT [redacted]. **Subjective**: **Cervical Spine**: The member reports pain at the posterior aspect as well as the right side. The pain radiates down the right arm to all fingers. **Thoracic Spine**: The member reports pain in the middle of the upper back. **Lumbar Spine**: The member reports pain radiating into the right leg down to the level of the right ankle. **Surgical History**: Left breast implant removal (01/10/23) and C6-C7 level arthroplasty by [redacted] MD ([redacted]). **Social History**: **Alcohol**: The member consumes 1-2 drinks about 1-2 times a month. **Current Work Status**: The member is TTD. She was placed off work on [redacted], when she was diagnosed with sepsis. **Prior Injuries**: The member twisted her right ankle at home ([redacted]). **Diagnoses**: 1) Cervical spine sprain, with cervical spine spondylosis, status post cervical spine fusion C3-C7 level. 2) Thoracic spine sprain, with chronic degenerative disc disease. 3) Lumbar spine sprain, with degenerative disc disease, with evidence of retrolisthesis and anterolisthesis. 4) Anxiety, PTSD. **Future Medical Care**: The future medical care includes further orthopedic evaluations and future imaging studies. The member has been attending Pain Reprocessing PT at UC Irvine's Integrative Medicine Clinic and reports it has been extremely helpful. Provisions should be made available for her to continue with the treatment on an industrial basis. In addition, she may benefit from physical therapy treatment, acupuncture treatment, and chiropractic treatment (3 times a week for 2 weeks for 2 sessions/year). She should have access to non-steroidal anti-inflammatory medication and analgesic medication, if needed. Psychiatric evaluation and treatment should also be provided on an industrial basis. **Disability Status**: The member has reached MMI and is considered permanent and stationary. **Causation**: Industrial. **Apportionment**: The examiner opined that 90% of the permanent disability is the direct result of the subject's cumulative trauma injury beginning [redacted], ending [redacted], and 10% is the result of other factors, including chronic degenerative changes occurring due to the natural aging process. **Impairment Rating**: Based on the AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition, she has the following permanent impairment: **Cervical Spine**: 28% WPI. **Thoracic Spine:** 5% WPI. LUMBAR SPINE: 6% WPI. In addition, she is given 3% WPI for pain in the cervical spine with activities of daily living. **Total WPI**: 38%.

[redacted] [redacted], MD/[redacted] [redacted], NP. Primary Treating Physician's Progress Report (PR-2). (Final premed part 2 [redacted] [redacted] - Page 5301-5302). DOI: [redacted]. **Subjective**: The member reports starting Spravato from Dr. [redacted] and tried the increased buspirone. She experienced dissociative symptoms with the higher dose of buspirone and decided to return to her original dose. She reports improvement in anxiety and depression since starting Spravato but inquired about starting ketamine due to ocular muscular issues from the nasal route. She has been attending weekly therapy sessions to address her issues with depression and anxiety. **Diagnoses**: 1) Posttraumatic stress disorder, acute. 2) Depressive disorder not otherwise specified. **Plan**: The examiner recommended decreasing the dosage of buspirone. Continue Spravato treatment and consultation with Dr. [redacted]. Continue psychotherapy. **Work Status**: TTD.

[redacted]. SUNRISE MULTISPECIALTY MEDICAL GROUP. [redacted], DO. Initial Orthopedic Consultation Report. (Final premed part 2 [redacted] [redacted] - Page 5303-5308). DOI: [redacted]. **Subjective**: The member sustained an injury in her neck while performing her regular job duties. Her job is stressful, and her neck has started to bulge. The member reports discomfort and pain in the neck. She has numbness and tingling in both arms. **Current Work Status**: The member is not working. **Diagnoses**: 1) Degenerative disc disease, cervical spine. 2) Cervicalgia. 3) Cervical spine radiculopathy. **Discussion**: The member is noted to have significant narrowing based on the radiographs that the examiner evaluated at the C3-C4 and C4-C5 levels. She needs to get the workers' compensation issues addressed through the workers' compensation general doctor. She has already had multiple levels of spine surgery, and the examiner would not recommend disc replacements; she may need to have revision, complete decompression and fusion. The examiner is discharging the member from care. **Work Status**: The member is discharged from care.

[redacted]. [redacted] [redacted], MD/[redacted] [redacted], NP. Primary Treating Physician's Progress Report (PR-2). (Final premed part 2 [redacted] [redacted] - Page 5528-5529). DOI: [redacted]. **Subjective**: The member has stopped her Spravato treatment. However, she has been feeling much better. She reports going out with a friend for coffee, and her dissociative symptoms have resolved since decreasing buspirone. Despite the improvement in mood, the member has been experiencing intense anxiety and uncertainty regarding the continuation of her Spravato treatment with workers' compensation. She reports more difficulty sleeping but rarely takes her clonazepam. She continues to attend therapy, which she finds helpful. **Diagnoses**: 1) Posttraumatic stress disorder, acute. 2) Depressive disorder not otherwise specified. **Plan**: Continue psychotherapy. **Work Status**: TTD.

[redacted]. FORENSIC PSYCH GROUP. [redacted], MD/[redacted], PhD. Panel Qualified Medical Re-Evaluation in Psychiatry. (Final premed part 2 [redacted] [redacted] - Page 5329-5392, 5395-5458, 5461-5524). DOI: CT [redacted] [redacted]. **Subjective**: The member reports neck pain localized in the lower end. Her mobility increases after treatments. When she experiences a heightened emotional response, her neck locks up. She continues to experience lower back pain. Her lower back pain radiates into her hips and buttocks and down her legs. She experiences mid-back pain. She reports her orthopedic symptoms worsen with stress and tension. She continues to experience difficulty with activities of daily living. She continues to experience numbness in her hands as well as reduced grip strength. She is still experiencing intrusive thoughts of the difficult cases she managed but she is better able to manage them. She is still triggered by certain situations but she is better at coping with the triggers and visualizing a

safe space. She finds both the intrusive thoughts and the triggers are exhausting at times, and sometimes she has to lie down on her couch afterwards. She continues to have bad dreams but they are neither as frequent nor as intense. She has a distressing dream about 1-2 times a week but she has also begun to have positive dreams as well. She still cries easily and intensely. However, she is less reactive to minor incidents. Although she continues to think about work daily, she does so less frequently. She has been trying to re-engage with friends with the help of therapy, and she avoids talking to friends about her work-related issues. She is less depressed, although she still does feel hopeless and helpless at times, particularly regarding her future. She continues to experience intermittent suicidal ideation. However, she denies any plan or intention of acting on these thoughts. She continues to experience significant symptoms of anxiety. About once a month, she becomes extremely agitated and stressed and she vomits throughout the day and is exhausted the following day. She is still highly triggered regarding the difficulties she experienced in the workplace. When she is triggered, she becomes highly anxious and overwhelmed. A few times a week, she does not leave her apartment at all. When she is in a heightened state of anxiety, she becomes overwhelmed and sweats profusely. She has difficulty breathing and experiences a rapid heartbeat. She recalls only 3-4 panic attacks when her anxiety was so acute that she felt like she was going to die. **Diagnoses**: 1) Posttraumatic stress disorder, chronic, improved. 2) Major depressive disorder, moderate, improved. **Plan**: Continue current treatment regimen. She has been under the care of Dr. [redacted] and has been recommended to continue treatment for the next year on an industrial basis. **Work Status**: TTD. **Disability Status**: The member has reached permanent and stationary. Her GAF rating is 54, consistent with moderate symptoms and impairment in functioning. **Causation**: The predominant cause (60%) of the member's psychiatric injury is the result of industrial factors. 20% of her psychiatric injury was caused by personnel actions. The remaining 20% of the member's psychiatric injury was caused by her orthopedic condition. **Apportionment**: 50% of the member's permanent psychiatric disability is apportioned to the traumatic events she experienced during her employment. 40% of the member's permanent psychiatric disability is apportioned to her orthopedic condition, primarily her cervical and lumbar spine symptoms. 5% of the member's permanent psychiatric disability is apportioned to the loss of her left breast, and 5% is apportioned to financial stress.

[redacted]. [redacted] MD. [redacted] Physician's Statement of Disability. (Final premed part 1 - [redacted] - Page 1-3). History: The member's first symptoms appeared on [redacted]. **Present Condition**: The member was noted to have neck, lower back pain and right leg pain. The member was noted to be ambulatory. **Diagnoses**: The member was diagnosed with cervical spondylosis and lumbar spondylosis. **Limitations**: **No limitations**: The member was not allowed to have exposure to dust/gases/fumes, chemicals/solvents, temperature extremes, allergenic agents and drafts/damp areas. The member was not allowed to drive passengers. **Some Limitations**: The member was allowed to have some exposure to noise levels. The member was allowed to stand, sit, reach forward/overhead, push/pull/twist, grasp/handle and b[redacted]ce. The member was asked to completely avoid cramped/unusual positions, repetitive movement of hands/fingers/feet, stairs or ladders, bend/stoop/squat, operate truck/car/dolly and operate heavy and electric equipment. The member was allowed to lift and carry 0-15 lbs. and was not allowed to lift and carry 16-100 lbs. **Disability Evaluation**: The member was permanently disabled from performing the duties of her occupation. If accommodation was necessary for the member, then the member was allowed to do part-time work (2 hours a day).

[redacted], [redacted] [redacted]

[redacted]. [redacted] **Employee's Statement of Disability. (Final premed part 1 - [redacted] - Page 16-18). Member Information**: The member was employed by the [redacted] as a [redacted]. **Statement of Disability**: The member indicated that due to chronic stress of being a [redacted] for over 17 years, she suffered a series of progressively worsening illnesses/injuries, particularly following investigations of child fatalities, which resulted in compression of the spine and leaving her with spinal stenosis, spondylolisthesis, retrolisthesis, anterolisthesis, decreased mobility and chronic pain. The position of an [redacted] in [redacted] was a high-stress job and entails a lot of sedentary work, such as driving, interviewing, computer and meetings. The member's injuries/symptoms/pain were triggered especially by stress, exacerbated by periods of inactivity, and were unpredictable, often lasting days, making it challenging to maintain a work schedule. In [redacted], right after investigating a child fatality, the member lost function in her left hand. An MRI found cervical disc herniations. The member subsequently experienced several muscular/skeletal injuries, underwent 3 spinal surgeries and had 2 episodes of sepsis following extremely traumatic investigations or a series of stressful events, a pattern that was recently discovered. On [redacted], the member was hospitalized for 2nd time with sepsis. 3 months later, the member underwent her 3rd spinal surgery and developed nerve damage in her left eye (Horner's Syndrome). With the PTSD, the anxiety and HTN became debilitating, and her cognitive and physical functioning steadily declined. These injuries were deemed industrial by WC. An [redacted] job was stressful, and stress triggers symptoms. Also, the member had trouble sitting/standing/typing for extended periods of time, the length of which depended on the day. The member was unable to keep a fixed schedule due to the unpredictability of her symptoms. Ignoring the triggers and/or going past her physical limits could lead to increased pain or further injury. **Employment History**: The member stopped working on [redacted]; her pay period ended on [redacted] **Work Restrictions**: The member was provided work restrictions of 2-4 hours standing/walking/sitting/forward bending/twisting, 2-4 hours of computer work, and not lifting more than 15 lbs for more than 4 hours a day. **Medical History**: The member was noted to be treated by Dr. [redacted] for three separate spinal surgeries with pre and postoperative visits, Dr. [redacted] AME for Workers' Compensation neck and back injuries case, Dr. [redacted] for autoimmune disorder, UCI Pain Management Clinic (Dr. [redacted] for neck and back including medications, injections and surgical procedures and Hoag Emergency Hospital for 6 day hospitalization and emergency surgery for pseudomonas sepsis secondary to steroid.

[redacted]. [redacted] [redacted], MD/[redacted] [redacted], NP. **Primary Treating Physician's Progress Report (PR-2). (Final premed part 2 [redacted] [redacted] - Page 5535-5536). DOI**: [redacted]. **Subjective**: The member continues to struggle with anxiety and depression but has noticed small improvements in her anxiety. She has made more effort to go out and socialize. She feels the Buspar has helped with anxiety, although she noted a higher dosage would be intolerable. **Diagnoses**: 1) Posttraumatic stress disorder, acute. 2) Depressive disorder, not otherwise specified. **Plan**: Continue psychotherapy. The examiner requests to provide records from Dr. [redacted] be forwarded for review. **Work Status**: TTD.

[redacted]. [redacted]. **OCERS Supervisor Statement. (Final premed part 1 - [redacted] [redacted] - Page 19-19). Member Information**: The supervisor indicated that the member was employed as a [redacted] for the [redacted]. **Supervisor Statement**: The supervisor indicated that the member was supervised in the month of [redacted]. The member's job duties included child abuse and adult protective services hotline calls, documenting and evaluating all reports for appropriate response. The supervisor opined that the

member performed her usual job duties before the last day of work. The supervisor had not made any observation regarding the member's injury/illness and her inability to perform her job duties. The supervisor was not aware of any work restrictions that the member had. The supervisor indicated that the member was able to substantially perform her usual and customary job duties with accommodations. The member stopped coming to work due to the discontinuity of work. The supervisor was aware of the other details. The supervisor opined of not know about the member's extracurricular activities, such as outside jobs or activities that were physically demanding.

[redacted]. [redacted]. [redacted] **Employer's Statement of Disability. (Final premed part 1 - [redacted] - Page 4-15). Member Information**: The member was employed by [redacted] as a [redacted]. **Information about Last Position Held**: The member's job duties included: Identification, assessment and treatment of a variety of complex social problems associated with such areas as child abuse, dependency, adoptions, guardianship to the mentally disabled, individual protective services and individual and/or family social dysfunctioning. Incumbents analyze, evaluate and treat individual and family groups in which a variety of social and economic problems are typically involved. Assessing complex [redacted] of applicants and recipients with a variety of social and economic problems by gathering relevant data from interviews, home calls, professional staff and various other informational sources; determine the type and extent of client social dysfunction; identify underlying social psychological causes of dysfunction. Formulating complex case plans and alternative plans of action designed to develop and/or restore individual and/or family social functioning that might be reviewed by the courts or regulatory agencies; making decisions which impact the potential safety and well-being of clients; preparing social histories, counseling schedules and summaries of major social and psychological causes of dysfunctioning. Providing treatment services for a variety of complex client social service needs; monitoring progress of case plan implementation by evaluating client behavior change and by consultation with other professionals regarding client progress; redefining and altering case plans as necessary to meet changing social service needs of clients; terminating services or referring clients to other agencies when appropriate. Rejecting inappropriate social services referrals and referring the case to other staff or agencies when client problems were not within the position's functional assignment area. Monitoring placement facilities to ensure compliance with contracts; advising providers of deficiencies in services; recommending cancellation of contract or non-placement if deficiencies were not corrected; consulting with placement workers to determine the type of care facilities needed; advising placement workers on care available at facilities. Providing information to individuals and public and private agencies on Agency programs, policies, rules and regulations. Informing private attorneys, public defenders and County Counsel regarding child welfare codes and regulations and explaining recommendations. Developing, using and coordinating Agency and community resources to meet social service needs of clients. Innovation was sometimes required to locate or create suitable referrals. Preparing complex case records, detailed and legally sound court reports and related Agency and program reports within designated time frames. Taking into custody neglected, abandoned, abused or drug-exposed children for placement. Complying with statistical data concerning child abuse, contacts and disposition of cases, complying with and implementing specific court orders related to the presentation and disposition of cases, which might include detailed research, notification of missing parents and transporting minors out of state. Entering data accurately online into one or more computer systems; utilizing and understanding various computer software programs. Body mobility to climb stairs, stand, walk, run, bend, twist and/or kneel in the course of making visits to client homes, transporting children and their possessions.

Ability to sit for up to two hours with little movement while driving or performing paperwork. Hearing and smelling sufficiently to detect sounds and odors within a home. Vision sufficient to read lengthy documents, identify and distinguish between colors of a bruise or wound and visually appraise the living conditions of a home. Ability to speak and hear well enough to communicate clearly in person or on the telephone. Manual dexterity sufficient to operate office equipment, such as a computer keyboard or to take field notes. **Information About Work-Related Injuries and Illnesses**: [redacted] – Present Occupational Leave of Absence (Continuous LOA). **Information About Non-Work-Related Injuries and Illnesses**: [redacted] Non-Occupational Leave of Absence (Continuous LOA). [redacted] Non-Occupational Leave of Absence (Continuous LOA). [redacted] Non-Occupational Leave of Absence (Continuous LOA). [redacted] Non-Occupational Leave of Absence (Continuous LOA). [redacted] Non-Occupational Leave of Absence (Continuous LOA). [redacted] Non-Occupational Leave of Absence (Continuous LOA). **Interactive Process/Work Restrictions/Accommodations** [redacted] **– Non-work-related condition**: Employee Health Services. Limit lifting or carrying to: 10 lbs. Limit pulling or pushing to: 10 lbs. Reduce caseload by 50%. **Employee Status**: The member's last day of work was [redacted]. The member was noted to be an active employee. **Payment Status**: The member was paid workers' compensation.

Undated. [redacted] MD. Office Visit. (Final premed part 1 - [redacted] [redacted] - Page 482-483, 502-503). Plan: Continue Glucosamine Plus and Adapten-all. Recommended relaxation exercise at night. Prescribed Probiotics, Diflucan and testosterone pellet.

Undated. [redacted] MD. Office Visit. (Final premed part 1 - [redacted] [redacted] - Page 509-510). Plan: Prescribed Testosterone pellet and AdrenFuel+T. Recommended colon hydrotherapy and enema at home. Up armour thyroid to 1.5 tablets and Immudrip.

Undated. [redacted] MD. Office Visit. (Final premed part 1 - [redacted] [redacted] - Page 1650-1651). Plan: In-clinic, bio-identical testosterone pellet therapy was given. Testosterone pellet is prescribed.

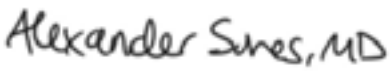
MISCELLANEOUS RECORDS:

Consent to Operation; Administration of Anesthetics, the Rendering of Other Medical Services and Informed Consent for Surgical/Invasive Procedure and/or Transfusion; Declaration of Custodian of Medical Records; Laboratory Reports; Ambulatory Intake Note – OP Orthopedics; Flowsheets; Comprehensive Spine Program New Patient Form; Preoperative Anesthesia Screening; Blood Transfusion: Options/Refusal & Consent; Consent for Operation/Procedures or Rendering of Other Medical Services; Pre/Post Anesthesia Reports; COVID-19 Vaccination Record; Notice of Obligation with Regard to PHI; Subpoena Duces Tecum; Member Eligibility Details; Cardiac Rhythm Strips; Proof of Service Affidavit; Service List; MRI Safety Questionnaire; Conditions of Treatment; Health Information Exchange Authorization; Acknowledgement of Receipt of Notice of Privacy Practices; Driver License; QME Appointment Notification Form; Cover Letters; Notice of Qualified Medical Evaluation; Declaration of Defendant in Compliance with CCR 9793(n); Signature Certificate and Provider Dispute Resolution Request; Notice of Approval; Nondiscrimination Notice and Access to Communication Services; Multi-language Interpreter Services; Terms and Conditions of Service Emergency Department Visit; Orthopaedic Patient History Questionnaire; Bills; Standard Intake

Questionnaire Template; Physician Statement of Informed Risks and Complications; Outpatient Psychiatry Billing Policy; Open Payments Disclosure; Consent for Psychiatric Treatment with Resident/Fellow Physicians; Informed Consent for Anesthesia; Consent for Surgery or Procedure; Hardcopy Scans; Order Details; Anesthesia Flowsheets; Pre-Anesthesia Evaluation; Post-Anesthesia Evaluation; Anesthesia Handoff Note; ED E-Handoff; Sepsis Note; Authorization for Administration of Intravenous Contrast Agent; Conditions of Admission; Anesthesia Post Note; Anesthesia Post-Op Handoff; Anesthesia Post-Procedure Evaluation; Anesthesia Procedure Notes; Rhythm Strip and Request for Authorization for Diagnostic Testing; Orders; Labs; Patient Instructions; Visit Information; Notice Informing Individual about Nondiscrimination and Accessibility Requirements; Notice of the Availability of Language Assistance Service; Acknowledgement of Notice of Privacy Practices; UCI Health Terms and Conditions of Service Admission, Medical Service and Financial Agreement; UC Irvine Health Terms and Conditions of Service; Fax Form; UC Irvine Health System; Health Failure Booklet and DVD; Consent for Operation Procedures or Rendering of Other Medical Services; Physician Statement of Informed Risk and Complications; Pre-Operative Anesthesia Screening; Perioperative Surgical Home Pathway Cervical Fusion; and Declaration of Custodian of Record; Consent for Operation/Procedures Rendering of Other Medical Service; Letters from Hanna, Brophy, MacLean & Jensen, LLP; Proof of Service by Mail; Letter from [redacted] Missed Appointment Notice; Pain Diagram; Questions Concerning Activities of Daily Living (ADL); Physician's Return-to-Work and Voucher Report for Injuries Occurring On or After [redacted]; AME or QME Declaration of Service of Medical – Legal Report (Lab. Code Section 4062.3(i)); Declaration of Service; Email and Vaccine/Medication Consent Form are reviewed but not summarized.

I thank you for allowing me the opportunity to evaluate this applicant. I reserve the right to change my opinion should additional information be received in the future. Should you have any questions regarding him or this report, please feel free to contact me at your earliest convenience.

Very truly yours,



Alexander C. Sones, M.D.
Diplomate, American Board of Psychiatry and Neurology
Diplomate, American Board of Psychiatry and Neurology, Forensic Psychiatry
Voluntary Clinical Professor of Psychiatry
David Geffen School of Medicine at UCLA
Department of Psychiatry & Biobehavioral Sciences

I personally examined the applicant, reviewed the history and the past medical records directly with the applicant, interpreted tests, developed the opinions and conclusions contained in the report, and prepared, dictated, edited, and reviewed the final report. I reviewed the applicant's medical records. All psychological tests, if enclosed, were scored by Pearson Testing. I have not discriminated against any party to this action or the injured worker in the evaluation process or in the content of this report. I declare under penalty of perjury that I have not violated the provisions of California Labor Code section 139.3 with regard to the evaluation of this applicant or the preparation of this report.

I personally performed the evaluation of the applicant on the date noted on Page 1 of this report (D.O.E.) in Los Angeles, California. Except as otherwise stated herein, the evaluation and the time spent performing the evaluation (as noted on the bill and/or report) complied with the guidelines, if any, established by the Division of Workers' Compensation or the administrative director pursuant to paragraph (5) of subdivision (j) of Section 139.2 or Section 5307.6 of the California Labor Code.

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 certify under penalty of perjury that the foregoing is true and correct.

Alexander Sues, MD 1/14/2026

Signature Date

Signed in the County of Los Angeles, California

April 15, 2026

TO: Each Trustee
Board of Retirement

FROM: Tamara Caldwell, Division Manager
Disability Retirement Services Division

Patty Silva, DRS Interim Supervisor
Disability Retirement Services Division

FOR: May 6, 2026, Disability Board of Retirement Meeting

SUBJECT: RECOMMENDATION TO APPROVE NICOLE K. WARD D.O. (RHEUMATOLOGY/INTERNAL MEDICINE) TO THE LACERA PANEL OF PHYSICIANS

RECOMMENDATION

To support timely, high-quality medical-legal evaluations and maintain a geographically accessible and appropriately credentialed panel of examining physicians, staff recommends that the Board of Retirement approve the application of Nicole Ward, D.O., for appointment to LACERA's Panel of Examining Physicians.

DISCUSSION

Certifications & Licensure

Dr. Nicole K. Ward is board certified in Rheumatology and Internal Medicine in the State of California. She holds an active California medical license and is authorized to practice Rheumatology and Internal medicine.

Education & Training

Dr. Ward completed a fellowship in Rheumatology at the University of Southern California and residency training in Internal Medicine at Westchester Medical Center / New York Medical College. She earned her Doctor of Osteopathic Medicine degree from Touro College of Osteopathic Medicine and a Master of Public Health from the University of California, Los Angeles. She received her undergraduate degree from the University of California, Santa Cruz (B.A., English Literature with Honors in the Humanities).

Professional Experience

Dr. Ward currently practices as an Attending Physician with the Arthritis and Osteoporosis Medical Center (Monterey Park, CA) and as an Attending Physician

at Cedars-Sinai Medical Center. These roles reflect ongoing clinical work evaluating and treating patients within her specialty areas.

Academic & Professional Contributions

Dr. Nicole K. Ward is board certified in Rheumatology and Internal Medicine. She is a Division of Workers' Compensation (DWC) Qualified Medical Evaluator (QME). Her American Board of Internal Medicine (ABIM) certificate reflects certification as a Diplomate in Internal Medicine. Dr. Ward has contributed to the field through scholarly writing and professional service. Her curriculum vitae reflects multiple peer-reviewed publications, book chapter contributions, and presentations at national meetings, including the American College of Rheumatology. She is a member of the American College of Rheumatology and the American College of Physicians and has participated in teaching and mentorship activities in clinical settings.

Panel Onboarding & Compliance

If approved, Disability Retirement Services (DRS) will provide an orientation for Dr. Ward and her practice team covering LACERA's Panel Physician Guidelines, evaluation standards under applicable disability retirement law, report requirements and timelines, fee and billing procedures, and ongoing quality-control processes. DRS will also confirm continuing compliance with licensing, board certification, and insurance requirements.

Medical Advisor Review

On April 1, 2026, Board Medical Advisor Glenn Ehresmann, M.D., reviewed Dr. Ward's application and credentials and concurred with forwarding the application to the Board of Retirement for consideration.

TLC:PS/mc

Attachments

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 02/17/2026
Physician Name: Nicole Ward	Group Name: Dr. Nicole K. Ward, A Professional Corporation
Primary Address: 2628 Foothill Blvd #305 La Crescenta, Ca 91214	
Primary Contact: 818-806-8830	Title: Medical Director
Telephone:	Email: workerscomp@rheumwork.com
Secondary Address:	
Telephone:	Email:

PHYSICIAN BACKGROUND	
Field of Specialty: Internal Medicine Board Certification ☑ Yes ☐ No	Subspecialty: Rheumatology Board Certification ☑ Yes ☐ No
License # 20A18553 Expiration Date: 09/30/2026	
Has your license been suspended in the last 3 years? ☐ Yes ☑ No Has there been any disciplinary actions filed against you in the last 3 year? ☐ Yes ☑ No	

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

Type	Number of Years	Current Practice	Time Spent (%)
AME	4 years	Treatment	70%
IME	4 years	Evaluations	20%
QME	4 years	Research	5%
Workers' Compensation Evaluations	4 years	Teaching	5%
Disability Evaluations	4 years		100 %
Med-Legal Reports	4 years		

Performing Medical Evaluations for Public Organizations ☑ Yes ☐ No Performing Medical Evaluations for Private Organizations ☑ Yes ☐ No Please Names of Organizations: QME for California Division of Workers Compensation, City of LA ADR AME, CalPERS, Riverside County.	
Estimated Time from Appointment to Examination: ○ 2 weeks ◉ 3-4 Weeks ○ Over a month	Able to Submit a Final Report and Invoice in 30 days: ☑ Yes ☐ No

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

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

What is you Cancellation Policy? (Attach policy, if applicable).

Cancellation Policy:
A minimum of six (6) business days' notice is required for any cancellations of appointments, depositions, or trial appearances.
A $1,000 fee will apply to cancellations or no-shows for appointments with less than the required notice.

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

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

Name of person completing this form:

Print Name:	Title:
Mia Nelle German	Billing Admin
Physician Signature: 	Date 02/18/2025

You may attach additional pages if necessary.

Revised: 12/8/21

Dr. Nicole Ward DO, MPH, QME

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Board Certified - Rheumatology

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Attending Physician, Cedars Sinai Medical Center

BIOGRAPHICAL INFORMATION

Education and Certifications

11/2022 – present	Division of Workers Compensation (DWC)	Qualified Medical Evaluator (QME)
07/2020 – 06/2022	University of Southern California	Fellowship in Rheumatology
07/2017 – 06/2020	Westchester Medical Center at New York Medical College	Residency in Internal Medicine
07/2013 – 06/2017	Touro College of Osteopathic Medicine	D.O.
08/2010 – 06/2012	University of California, Los Angeles	MPH
08/2004 – 06/2009	University of California, Santa Cruz- English Literature with Honors in the Humanities	B.A., Hn.

Employment

03/2023 – present	Attending Physician, Arthritis and Osteoporosis Medical Center, Monterey Park, CA

07/2022 – present	Attending Physician, Cedars Sinai Medical Center (CSMC), Beverly Hills, California
07/2012 – 06/2013	Health Science Specialist, Veterans Health Administration, Veteran Emergency Management and Evaluation Center (VEMEC)
06/2011 – 06/2012	Transcranial Magnetic Stimulation Technician, Brain Stimulation Center
07/2010 – 07/2011	Behavioral Therapist, Autism Behavioral Consultants
06/2009 – 07/2010	Healthcare Aid and Instructional Assistant, BALANCE4Kids State Certified Non-Public Agency

Academic and Professional Honors

2023	Board Certified in Rheumatology
2021	Board Certified in Internal Medicine
2012	Bixby Research Fellow. Health Services Research and Development, Department of Veterans Affairs, University of California, Los Angeles
2009	Deans Honors List. University of California, Santa Cruz
2009	Honors in Humanities. University of California, Santa Cruz

RESEARCH ACTIVITIES

Peer Reviewed Journal Articles

1) Ward N.K., Panush, R.S., Environmental and Occupational Contributors to Autoimmune, Inflammatory, and Musculoskeletal Rheumatic Disease: A Review of Emerging Evidence and Clinical Implications. Current Opinion in Rheumatology. Epub ahead of print, October 24, 2025. doi: 10.1097/BOR.0000000000001130. PMID: 41133473.

2) Kobashigawa L., Ward N.K., Ruddy K., Stohl W., Taylor-Albert E., Rheumatic Immune-Related Adverse Events Immune Checkpoint Inhibitor Therapy and Ramifications for Health Disparities. Cureus. 2025 Aug 20;17(8):e90585. doi: 10.7759/cureus.90585. PMID: 40979015; PMCID: PMC12448134.

3) Ward N.K., Pal, S. Savvas, S. Attitudes And Beliefs Towards COVID-19 and COVID-19 Vaccination Among Rheumatology Patients in a Los Angeles County Safety Net Clinic. BMC Rheumatology. 2023, June 1; 13 (2023). doi: 10.1186/s41927-023-00338-7. PMID: 37259135.

4) Zagelbaum Ward N.K., Jun JA, Vecerek N, Donaldson M, Quismorio FP Jr. Dissecting Cellulitis Of The Scalp Associated With Peripheral And Axial Spondyloarthritis: Report Of A Case And Review Of The Literature. Clinical Rheumatology. 2022 Aug;41; (8):2553-2560. doi: 10.1007/s10067-022-06128-9. PMID: 35460009.

5) Solomon D.H., Pincus T., Shadick N.A., Stratton J., Ellrodt J., Santacroce L., Katz J.N., Smolen JS... Zagelbaum Ward N.K., Kaine J. Implementing A Treat-To-Target Approach For Rheumatoid Arthritis During The Covid-19 Pandemic: Results Of A Virtual Learning Collaborative Program. Arthritis Care Res. 2021 Dec 7. doi: 10.1002/acr.24830. PMID: 35119779.

6) Seto R., Mathias K., Zagelbaum Ward N.K., Panush R.S., Challenges Of Caring For Homeless Patients With Rheumatic And Musculoskeletal Disorders In Los Angeles. Clinical Rheumatology. 2021 January; 40(1):413-420. doi: 10.1007/s10067-020-05505-6.

7) Zagelbaum Ward N.K., Linares-Koloffon C., Posligua A., Gandrabur L., Wasserman A., Ash J., Cardiac Manifestations of Systemic Lupus Erythematosus. Cardiology in Review. 2020 September; doi: 10.1097/CRD.0000000000000358.

8) Zagelbaum N.K., Bhinder J., Aranow W., Frishman W., Peripartum Cardiomyopathy. Incidence, Risk Factors, Diagnostic Criteria, Pathophysiology And Treatment Options. Cardiology in Review. 2020 January; 2(28): 148–155. doi: 10.1097/CRD.0000000000000249.

9) Zagelbaum N.K., Yandrapalli S., Nabors C., Frishman W., Bempedoic Acid (ETC-1002) ATP Citrate Lyase Inhibitor. Cardiology in Review. 2018 December; 1(27): 49-56. doi: 10.1097/CRD.000000000000021.

10) Zagelbaum N.K., AlBadri A., Shufelt C., Wei J., Bairey Merz N.C. Lesser Severity Of Recurrent Takotsubo Cardiomyopathy While Taking Angiotensin II Receptor Blocker And Beta Blocker. Journal of Medical Cases. 2018 May; 9(7): 201-203. doi: https://doi.org/10.14740/jmc3079w.

11) Zagelbaum N.K., Yandrapalli S., Frishman W. Ranolazine-Associated Delirium In The Elderly. American Journal of Therapeutics. 2018 Jan; 27(6): 700-701. doi: 10.1097/MJT.0000000000000711.

12) Zagelbaum N.K. Perspective. Special Issue of Journal of Medical Humanities: Pre-Health Humanities. 2017 May; 38(4): 503-504. doi: 10.1007/s10912-017-9458-0.

13) Spano C., Ward M.F., Zagelbaum N.K. Spinal Epidural Abscess Complicated By Meningitis, Sepsis, And Thrombocytopenia In A Patient Lacking Traditional Risk Factors: A Case Report. Clinical Practice and Cases in Emergency Medicine. 2017 May; 1(2): 115–117. doi: 10.5811/cpcem.2016.12.33001.

14) Zagelbaum N.K., Gilani A., El Zarif S., Krishna K. D'Agati V.D., Obligado S. Granulomatous With Polyangiitis (GPA): Case Report Outlining The Importance Of Urinalysis In Patients Presenting With Pulmonary Cavitating Lesions. Pulmonary and Critical Care Medicine. 2016 Nov 24; 1(3): 4-4. doi: 10.15761/PCCM.1000119.

15) Zagelbaum N.K., Ward M.F., Okby N., Karpoff H. Invasive Ductal Carcinoma With Osteoclast Like Giant Cells And Clear Cell Features: Novel Finding And Review Of The Literature. World J Surg Oncol. 2016 Aug 26; 14(1): 227. doi: 10.1186/s12957-016-0982-6.

16) Zagelbaum N.K., Heslin K.C., Stein J.A., Ruzek J., Smith R.E., Nyugen T., Dobalian A. Factors Influencing Readiness To Deploy In Disaster Response: Findings From A Cross-Sectional Survey Of The Department Of Veterans Affairs Disaster Emergency Medical Personnel System. BMC Emerg Med. 2014 Jul 19; 19;14:16. doi: 10.1186/1471-227X-14-16.

Book Chapters

1) Ward, N.K. (2025). Work, Trauma and Rheumatic Disease: A Guide to Understanding.

2) Zagelbaum Ward, N.K., Zagelbaum, G. (2023). COVID-19 and Health: A Guide to Understanding.

3) Zagelbaum N.K., Obligado S. (2019) "Acid Base" in Critical Care Examination and Board Review. ISBN-13: 9781259834356. Mcgraw Hill Professional Publishing.

Presentations

1) Kobashigawa, L., Ward N.K., Stohl, W., Rheumatic Immune-Related Adverse Events Following Immune Checkpoint Inhibitor Therapy and Subsequent Referrals to Rheumatologists at a Private vs Public Medical Center in Los Angeles: Ramifications for Health Disparities. American College of Rheumatology Annual Meeting; Presentation; 2023 November 13.

2) Solomon D.H., Pincus T., Shadick N.A., Stratton J., Ellrodt J., Santacroce L., Katz J.N., Smolen J.S... Zagelbaum Ward N.K., Kaine J. Implementing Treat to Target (TTT) for Rheumatoid Arthritis (RA) 2) Through a Virtual Learning Collaborative (LC) Program During COVID. American College of Rheumatology Annual Meeting; Virtual Presentation; 2021 November 5-9.

3) Zagelbaum Ward N.K., Amarnani, A., Panush R.S. How Might We Care for Rheumatoid Arthritis Patients Unable to See a Rheumatologist And/or Use Certain of Our Medications? Proposed Preliminary Recommendations for RA Patients Who Don't Meet Our Established Guidelines. American College of Rheumatology Annual Meeting; Virtual Presentation; 2021 November 5-9.

4) Rai B., Zagelbaum Ward N.K., Amarnani, A., Panush R.S. Challenges of Caring for Patients with Inflammatory Arthritis Experiencing Homelessness: Preliminary (12- Month) Follow-up Observations and Identification of Certain Barriers to Care. American College of Rheumatology Annual Meeting; Virtual Presentation; 2021 November 5-9.

5) Akbar S., Bhinder J., Zagelbaum N.K., Zaid S., Dutta T. Epicardial Adipose Tissue Predicts The Presence of Aortic Valve Stenosis. American College of Cardiology National Conference; Virtual Presentation; 2020 March 29.

6) Pal S., Zagelbaum N.K., Gennarelli, M., Newman, R., Nabors C. Determinants Of Primary Healthcare Utilization Among LGBT Individuals In Westchester County, New York. Society of General Internal Medicine National Conference; Oral Presentation; 2019 May 11; Washington D.C.

7) Zagelbaum N.K., Ward M.F., Brooks H. Establishing A High-Risk Breast Cancer Cohort In A Rural Health Setting. Osteopathic Medical Education Conference National Conference; Oral Presentation; 2016 September 17-20; Anaheim, CA.

8) Zagelbaum N.K., Ward M.F., Brooks H. Factors Influencing Follow Up Amongst High-Risk Breast Cancer Patients: A Retrospective Case-Control Analysis. Orange Regional Medical Center Annual Poster Competition; 2016 April 20; Middletown, NY.

9) Zagelbaum N.K., Ward M.F. Utilizing An Evidenced Based Mental Health Training Program Among Medical Students. New York Osteopathic Medical Society Regional Osteopathic Convention; 2015 April 17; Rhode Island, NY.

10) Zagelbaum N.K., Heslin K.C., Stein J.A., Ruzek J, Smith R.E., Nyugen T., Dobalian A. Factors Influencing Readiness To Deploy In Disaster Response: Findings From A Cross-Sectional Survey Of The

Department Of Veterans Affairs Disaster Emergency Medical Personnel System, AcademyHealth Gender and Health Interest Group National Meeting; June 22, 2013. Baltimore.

Vignettes

1) Zagelbaum Ward N.K., Zagelbaum G., Long COVID and Work: An Update. Workers Compensation Quarterly. Workers Compensation Section of the California Lawyers Association. Vol 37, No. 1, 2024.

2) Rai, B., Amarnani, A., Zagelbaum Ward N.K., Panush, R. When Rheumatic Disease May Have Effected the Course of Western Civilization. The Rheumatologist. 2022 November; https://www.the-rheumatologist.org/article/when-rheumatic-disease-may-have-affected-the-course-of-western-civilization/

3) Amarnani, A., Zagelbaum Ward N.K., Stohl, W. 2 Cases of SLE-Associated Diffuse Alveolar Hemorrhage. The Rheumatologist. 2021 August; https://www.the-rheumatologist.org/article/2-cases-of-sle-associated-diffuse-alveolar-hemorrhage/

4) Zagelbaum Ward N.K., Panush R.S. Reflections On Starting A Rheumatology Fellowship During The Pandemic. The Rheumatologist. 2020 October; https://www.the-rheumatologist.org/article/reflections-on-starting-a-rheumatology-fellowship-during-the-pandemic/

5) Kim W., Sen A., Zagelbaum N.K., Cho R. Kikuchi-Fujimoto's Disease And SLE. Abstract published at Hospital Medicine 2020, Virtual Competition. Abstract 628. Journal of Hospital Medicine. 2021 May 1; https://shmabstracts.org/abstract/kikuchi-fujimotos-disease-and-sle/

6) Zagelbaum N.K., Kabra N., Horblitt A., Dutta T., Jain D. A Case Of Takotsubo Cardiomyopathy In The Setting Of Obstructive Coronary Artery Disease. American College of Cardiology National Conference; Oral Presentation; 2019 March 18; New Orleans, LA.

7) Zagelbaum N.K, Bairy-Merz, N. Lesser Severity Of Recurrent Takotsubo Cardiomyopathy With The Use Of Beta Blockers And Angiotensin II Receptor Blockers. Western Regional Medical Conference; Oral Presentation; 2018 January 25; Monterey, CA.

8) Zagelbaum N.K., Vernatter, J. First Case Of Brucella Ovis In Human. American College of Physicians, New York Chapter Regional Conference; Oral Presentation; 2017 June 3; Rochester, NY.

PROFESSIONAL ACTIVITIES

Professional Memberships

06/2019 – present	Member, American College of Rheumatology
03/2016 – present	Member, American College of Physicians
07/2012 – 07/2013	Member, VA Women's Health Research Consortium
06/2012 – present	Member, Delta Omega Honorary Society, IOTA Chapter, University of California, Los Angeles

Community Service

07/2013 – 07/2015	Research Coordinator/Mentor, Medachieve Scholars After-School Science Enrichment Program
08/2010 – 08/2012	Student Health Educator, Sex and Cookies Reproductive and Sexual Health Education Program, University of California, Los Angeles
01/2007 – 06/2009	Writing Tutor for inmates at Santa Cruz County Jail, University of California, Santa Cruz

Teaching Positions

10/2022 – present	Preceptor, Cedars-Sinai Medical Center
10/2018 – 06/2020	Preceptor, Foundations of Clinical Medicine Course, New York Medical College
07/2014 – 07/2015	Teachers Assistant, Department of Biochemistry, Touro College of Osteopathic Medicine
06/2007 – 06/2009	HIV Test Counselor, Student Health and Outreach Promotions, University of California, Santa Cruz

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CHAIR, RHEUMATOLOGY APPROVAL COMMITTEE – INITIAL CERTIFICATION & TRADITIONAL, 10-YEAR MOC EXAM

ABIM# **420016**

YEAR ISSUED: **2023**

Nicole Zagelbaum Ward, DO, MPH
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Diplomate, American Board of Internal Medicine - Rheumatology
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[redacted]

PANEL QUALIFIED MEDICAL EVALUATOR'S RHEUMATOLOGY MEDICAL LEGAL RE-EVALUATION REPORT

RE: [redacted]
DOB: [redacted]
DOI: [redacted]
EMPLOYER: [redacted] Distributing Company, Inc.
WCAB NO.: [redacted]
CLAIM NO.: [redacted]
DATE OF EXAM: [redacted]
DATE OF PREVIOUS EVALUATION: [redacted]

To whom it may concern:

This medical-legal evaluation qualifies for an ML201.

Pursuant to Labor Code Sections 4620, 4621 and 4622, the evaluation and report is based on *AMA Guides to the Evaluation of Permanent Impairment.* The medical-legal billing codes used are effective as of [redacted]

Based on California Code of Regulations 9793 through 9795 this report is billed under the appropriate medical legal fee schedule codes for evaluations performed by an Agreed

Medical Evaluation or PQME. The physician shall be reimbursed per sections 9793 (h), 9794 (a) and 9795 "Reasonable Level of Fees for Medical Legal Expenses, Follow-up, Supplemental and Comprehensive Medical Legal Evaluations and Medical Legal Testimony."

_____ Missed Appointment

_____ Initial Comprehensive Medical Legal Evaluation (200 pages of records included)

____X_____ Follow-up Medical Legal Evaluation – **Less than 18 months** from last evaluation
(200 pages of records included in reimbursement)
I verify under penalty of perjury, I reviewed 1, 000 pages of records plus videos as part of the medical-legal evaluation and preparation of the report.

_____ Follow-up Medical Legal Evaluation - **More than 18 month** from last evaluation
(200 pages of records included in reimbursement)

_____ Supplemental Report
(50 pages of records included in reimbursement)

_____ Medical Legal Testimony/Deposition ($455.00 X 2 hours = $910.00)

_____ Sub-Rosa Recording Review $325 per hour at _____ hours

_____ Interpreter

DIAGNOSTIC TESTING:
Spirometry, EKG, Pulse Ox

LIST OF DIAGNOSTIC TESTS AND TIME SPENT ADMINISTERING EACH TEST:
Spirometry – 15 Mins
EKG – 15 Mins
Pulse Ox – 2 Mins

Per your request, I had the opportunity to reexamine Ms. [redacted] on [redacted] at my office located at [redacted]

Per the initial cover letter dated [redacted] from Ms. [redacted] I was asked to address two separate claims against two separate employers. The first is a specific injury to the thumbs, neck, back, chest, head, teeth, elbows, fibromyalgia and jaw on [redacted]

[redacted] while working as an auto part salesperson at [redacted] The second is a continuous trauma claim to the neck, back, arms, shoulders, chest, psyche, head, teeth, elbows, thumbs and jaw from [redacted], while working as an auto part salesperson at [redacted] Distributing. I was asked to assess if the applicant sustained an industrial injury as a result of a specific trauma, continuous trauma, or both. I was tasked to address whether the subjective findings were consistent with objective complaints. I was also asked to address issues of disability, determine if the applicant has met maximum medical improvement, and apply disability using the *AMA guides, 5th edition* as applicable. I was to determine if the applicant could return to her former occupation, state if aspects of the medical treatment provided were reasonable, and discuss the need for future medical care. I am also to address issues of apportionment and causation.

On [redacted] I received a letter from [redacted] requesting a reevaluation. I was informed that since my initial assessment, the applicant has sought additional treatment and/or further discovery has been conducted. Copies of relevant medical records were provided for my review. I was asked to conduct a comprehensive reevaluation and provide a detailed report addressing the issues and medical questions outlined in the cover letter.

CHIEF COMPLAINT:

Pain throughout her body including the back, gluteal region, neck, bilateral legs, knees, hips, arms, and feet.

OCCUPATIONAL HISTORY AND JOB DESCRIPTION:

Ms. [redacted] was employed as an auto parts salesperson at [redacted] from approximately [redacted] Her job responsibilities included various administrative tasks, answering phones, assisting customers, and handling sales. Her duties required computer work, wrist extension, typing and reaching. Breaks included one 30-minute lunch break. The physical activities included: standing, bending, stooping, kneeling, squatting, twisting, turning, pushing, lifting, carrying, reaching at and above shoulder level, walking, pulling, reaching at waist level and below, moving their head up and down, bending her neck at uncomfortable angles, gripping, fine hand and finger manipulation, and keyboarding/computer usage.

Ms. [redacted] further describes her employment at [redacted], where she was involved in both resale and wholesale activities. The applicant would lift objects weighing up to 40 pounds. She was also required to climb shelves approximately 8 feet in height and navigate stairs. Breaks included one 30-minute lunch break. The physical activities included: standing, bending, stooping, kneeling, squatting, twisting, turning, pushing, lifting, carrying, reaching at and above shoulder level, walking, pulling,

reaching at waist level and below, moving their head up and down, gripping, fine hand and finger manipulation, and keyboarding/computer usage.

The applicant has not worked since [redacted]. She is receiving Social Security Disability benefits.

HISTORY OF PRESENT ILLNESS:

Ms. [redacted] again confirms that her symptoms began in [redacted] while employed at [redacted] she noted daily and progressive pain and stiffness in both thumbs. She reported her symptoms to her supervisor, [redacted]. She sought care from her primary care physician, Dr. [redacted], who subsequently referred her to a hand specialist. Her treatment included bilateral corticosteroid injections in both thumbs for the diagnosis of trigger finger as well as oral medications, including Advil and Norco. She also underwent physical therapy and occupational therapy. Despite her symptoms, she was able to continue working without any modifications to her job duties. In [redacted] Ms. [redacted] reports that her workplace warehouse was relocated, requiring her to participate in the moving process. This move significantly increased her physical workload, as she was required to lift heavy mechanical equipment, pack, and box items. As a result, she experienced worsening symptoms in both thumbs. Furthermore, the relocation increased her daily commute by approximately 20 miles, adding an additional hour of travel time each day. Due to the increased commute, she ultimately left the company. Ms. [redacted] denies experiencing any acute trauma, such as slamming her thumbs or sustaining an acute strain or injury. Additionally, she denies any history of acute illness, infections, rashes, Raynaud's phenomenon, sicca symptoms.

Ms. [redacted] began her employment at [redacted] She reports that her manager at the time, created a stressful work environment throughout her employment and was eventually terminated due to his interpersonal conduct. She also mentions another manager, [redacted] did not accommodate her work restrictions, including limitations on lifting. Ms. [redacted] asserts that upon starting this job, she disclosed her prior injuries and work restrictions, which included a lifting limit of no more than 10 pounds and restrictions on repetitive thumb movements. She was assured that these accommodations would be provided. However, she states that within her first year at [redacted] her thumb pain progressively worsened, ultimately requiring surgical intervention. She underwent surgeries on both thumbs in [redacted] followed by subsequent revision procedures. Ms. [redacted] identifies her surgeon as Dr. [redacted] and reports experiencing multiple post-surgical complications, including nerve damage. Additionally, she states that she felt pressured to return to work before receiving medical clearance from her healthcare providers. In the weeks following her surgeries, Ms. [redacted] developed pain in her arms, chest, shoulders, and neck, prompting her to seek medical evaluation. Her treatments at the time included Advil, Motrin, Cymbalta, muscle relaxants, Soma, Gabapentin, Lyrica, ganglion nerve blocks, trigger point

injections, and Botox injections. She was managed by a pain management specialist, who diagnosed her with thoracic outlet syndrome. Additionally, she received care from neurology and psychiatry, with Dr. [redacted] overseeing her treatment for depression. Ms. [redacted] reports that the workplace bathrooms were not adequately cleaned throughout the day. She was frequently asked to clean the restroom. She states that after requesting improved facility maintenance, she was reassigned to work in the warehouse and placed on phone duties, which she perceived as a form of punishment. She reports that this situation caused her significant stress. She subsequently left her position and has not been employed since [redacted] due to ongoing diffuse body pain. In [redacted] she was declared temporarily totally disabled (TTD) by her pain management specialist, Dr. [redacted] Ms. [redacted] denies experiencing heartburn, reflux symptoms, or an acid taste in her mouth. She reports a history of snoring and seasonal allergies but has not undergone a sleep study. She does not experience nighttime awakenings due to shortness of breath and denies a history of elevated blood pressure.

Since her previous medical evaluation, Ms. [redacted] reports the onset of new symptoms, including back pain that radiates around the ribs. Around the same time, she experienced persistent neck and lower back pain. She was evaluated by a workers' compensation physician, Dr. [redacted] who diagnosed her with neuritis. She continues to receive care from Dr. [redacted] a pain specialist and neurologist, on a regular basis. She denies experiencing any associated rashes and has not been diagnosed with shingles. Ms. [redacted] has undergone imaging studies, including MRI and X-rays of the neck and back, which revealed cervical disc herniation. Her treatment has included bilateral rib nerve blocks, which provided symptom relief. She also reports that her workers' compensation physician recommended epidural injections for arthritis of the back and neck; however, she has not yet undergone this procedure. She has been prescribed oxycodone and morphine and states that oxymorphone has been effective in relieving her symptoms, though she has encountered difficulty obtaining refills. She reports an increasing need for pain medication due to the progression of her symptoms.

Her current medications include Fentanyl patches (100 mcg every two days), Xtampza (18 mg, two pills twice daily), Oxycodone (20 mg, three pills daily), Ambien (10 mg, two pills daily), Trokendi (200 mg, one pill daily), Pregabalin (150 mg, three pills daily), Flector patch (once daily), and Lidocaine patches (5 mg, once daily). She has previously been prescribed muscle relaxants but is not currently taking any, as they did not provide symptom relief. Ms. [redacted] denies receiving any psychiatric, rheumatologic, or pain management care through workers' compensation at this time. She has not undergone trigger point injections in many years and has not participated in aquatic therapy. She reports experiencing jaw pain, jaw clicking, brain fog, non-restorative sleep, sleep disturbances, depression, anxiety, and occasional headaches. She denies a history of rashes, stomachaches, diarrhea, constipation, bloody stools, Raynaud's phenomenon, sicca symptoms, focal alopecia, oral or nasal ulcers, blood clots, or miscarriages. Ms. [redacted] also reports a history of two seizures, which she attributes to complications

from her medication. She has been on anti-seizure medication since [redacted] and plans to gradually taper off the medication.

ADDITIONAL WORK HISTORY:

The applicant previously worked for [redacted] in [redacted], [redacted] also in [redacted], and [redacted].

NON-WORK RELATED INJURY

Denies.

PRIOR AUTOMOBILE ACCIDENTS

The applicant was involved in a motorcycle accident in [redacted] during which she was struck by another driver. As a result of the accident, she sustained six fractured ribs and a pneumothorax. She was hospitalized at [redacted] Hospital and [redacted] for her injuries. The applicant reports that, after receiving medical treatment, she eventually recovered from the injuries.

PRIOR FRACTURES

The applicant reports six fractured ribs from a motorcycle accident in [redacted] and R foot fracture twice as a teenager from gymnastics and playing frisbee.

SUBSEQUENT INDUSTRIAL AND NON-INDUSTRIAL INJURIES:

Following her industrial injury, Ms. [redacted] was prescribed various medications over the ensuing years, including narcotics, Ativan, and fentanyl patches. In [redacted] she experienced a seizure, which she attributes to a complication related to the use of benzodiazepines. Ms. [redacted] reports that, as a result of the seizure, she collapsed, sustaining bruising and experiencing significant pain. She indicates that she continues to suffer from residual pain as a result of this incident.

PAST MEDICAL HISTORY:

The applicant reports a past medical history of anxiety, depression, history of seizures, menopause, fibromyalgia, and high cholesterol.

PAST SURGICAL HISTORY:

The applicant underwent gallbladder surgery in [redacted] and myomectomy in [redacted]

SOCIAL HISTORY:

Tobacco: Never smoked.

Alcohol: Never or rarely per week.

Drugs: Medicinal marijuana PRN (to be used only if opioids are ineffective).

Caffeine: 1 cup of coffee a day.

FAMILY HISTORY:

Sister – Cancer.
Mother – Osteoarthritis.
Father – Coronary Artery Disease/Heart Attack and Diabetes Mellitus.
No history autoimmune diseases, including lupus, rheumatoid arthritis, scleroderma, Sjogren's disease, inflammatory bowel disease.

CURRENT MEDICATIONS:

Fentanyl patches 100 mc, every two days
Xtampza Oxycodone ER 18mg 2 pills, BID
Oxycodone 20 mg, 3 pills QD
Ambien 10 mg, 2 pill QD
Lyrica 150mg TID
Wellbutrin 150mg, 3 pills QD
Topirimate 200 mg, 1 pill QD
Pregabalin 150 mg, 3 pills QD
Flector patch, QD
Lidocaine patch 5 mg, QD

DRUG ALLERGIES:

NKDA

REVIEW OF SYSTEMS:

The applicant had the following symptoms over the past couple of weeks:

Constitutional: No fevers, no night sweats.

Endocrine: No cold/heat intolerance.

Heart: Chest pain.

Lungs: Shortness of breath.

Gastrointestinal: No stomach discomfort at present.

Orthopedic: Pain in arms, legs, or back.

Psychiatric: No sleep problems.

FIBROMYALGIA DIAGNOSTIC CRITERIA:

The applicant completed the new clinical fibromyalgia diagnostic criteria with the following findings:
She reports that she has had pain in the following areas over the past week: left shoulder girdle, right shoulder girdle, left upper arm, right upper arm, left lower arm, right lower arm, left hip (buttock), right hip (buttock), left upper leg, right upper leg, chest, abdomen, neck, upper back, lower back.
The widespread pain index score is 15.
In her symptom severity score part IIA, she notes that she has had the following symptoms: moderate fatigue, moderate waking unrefreshed, and slight cognitive symptoms.
The score for part IIA is 5.
In the symptom severity score part IIB, she reports that she has had the following symptoms over the past week: muscle pain, fatigue/tiredness, thinking or remembering problems, pain/cramps in the abdomen, insomnia, depression, pain in the upper abdomen, and chest pain, dry mouth.
The total score of IIB is 1.
The total score for parts IIA and IIB is 6.
Based on these findings, she does meet the criteria for diagnosis of fibromyalgia if there is no other explanation for her clinical symptoms.

PAIN DRAWING:

The applicant supplied me with a pain drawing with the following findings:
On a scale of 1–10, the patient rated her overall pain as 8.5, with 10 being the worst pain.
She noted aching in the following areas: forehead, neck, bilateral shoulders, bilateral breasts, bilateral knees, bilateral legs, upper back, and lower back.
She noted numbness in the following areas: bilateral shoulders, bilateral arms, bilateral wrists, bilateral upper thighs, bilateral gluteal region, and lower back.
She denied pins and needles sensations.
She denied burning sensations.

She noted stabbing in the following areas: bilateral feet, upper back, and anterior and posterior cervical region.

ACTIVITIES OF DAILY LIVING:

The applicant filled out an Activities of Daily Living report with the following findings:
She is able to perform the following activities without difficulty: dress herself including shoes, comb her hair, get on and off the toilet, brush her teeth, cut her food, lift a full cup/glass to her mouth, see a television screen, use a telephone, speak clearly, feel what she touches, taste the food she eats, open previously opened jars, and turn faucets on and off.
She is able to perform the following activities with some difficulty: wash and dry herself, take a bath, open a new milk carton, make a meal, write a note, type a message on a computer, work outdoors on flat ground, stand for over ½ hour, sit, recline, rise from a chair, run errands, do light housework, smell the food she eats, shop, and get in and out of a car.
She is able to perform the following activities with much difficulty: climb up 1 flight of 10 steps, sleep, and engage in sexual activity.
She reports that she is unable to perform the following activities: denies.

EPWORTH SLEEPINESS SCALE:

The applicant filled out an Epworth Sleepiness Scale form with the following findings:
The following activities would induce a high chance of dozing: denies.
The following activity would induce a moderate chance of dozing: lying down to rest in the afternoon when circumstances permit.
The following activity would induce a slight chance of dozing: watching television.
The following activities would induce no chance of dozing: sitting and reading, sitting inactive in a public place, riding as a passenger in a car for an hour without a break, sitting and talking to someone, sitting quietly after lunch without alcohol, and sitting in a car while stopped for a few minutes in traffic.
Total: 3

A score of 10 or more is considered sleepy. A score of 18 or more is very sleepy. If the applicant scores 10 or more on this test, it is recommended to consider whether adequate sleep is being obtained to improve sleep hygiene and/or whether there is a need to see a sleep specialist. These issues should be discussed with the applicant's personal physician.

PHYSICAL EXAM:

Visit Vitals
Blood Pressure: 131/38 mmHg
Heart rate: 81 bpm

Respiratory rate: 20 breaths/min
Pulse Ox: 96%
Temperature: 97.4°F
Height: [redacted]
Weight: [redacted]
BMI: [redacted]

Head: Increased lordosis of the cervical spine, increased kyphosis of the thoracic spine, diffused alopecia.

Eyes: Pupils are round and reactive normally to light in combination.

Mouth: Dry mucous membrane.

Chest: Symmetrical expansion, no adventitious breath sounds.

Heart: No heaves, thrills, or murmurs.

Abdomen: No guarding, normal bowel sounds.

Neuro: Intact.

Skin: Excoriating rash to distal fingertips 2-4, bilateral rash bottom heel.

Gait: Antalgic gait.

Articular Exam:

	R tender	R swollen	Comment	L tender	L swollen	Comment
CMC			Not swollen or tender			Not swollen or tender
MCP			Not swollen or tender			Not swollen or tender
PIP	X	X	5th PIP	X	X	5th PIP
DIP		X	2-4 rash on fingertips		X	2-4 rash on fingertips
Wrist			Not swollen or tender			Not swollen or tender
Elbow			Not swollen or tender			Not swollen or tender

Shoulder			Not swollen or tender			Not swollen or tender
Hip			Not swollen or tender			Not swollen or tender
Knee			Not swollen or tender			Not swollen or tender
Ankle		X	Mild fullness (R>L)			Not swollen or tender
Foot			MTP squeeze			MTP squeeze

Notes: Positive SLR (R>L)

Tender Points:

	Rt	Comment	Lt	Comment
Sub Occipital		Not tender to palpation		Not tender to palpation
Sternocleidomastoid	X	Tender to palpation		Not tender to palpation
Trapezius	X	Tender to palpation		Not tender to palpation
Supraspinatus Insertion		Not tender to palpation	X	Tender to palpation
Gluteal Bursa	X	R>L	X	R>L
Trochanteric Bursa	X	Tender to palpation	X	Tender to palpation
Medial Fat Pad Knee	X	Tender to palpation	X	Tender to palpation
Costochondral Junction		Not tender to palpation		Not tender to palpation
Lat. Epicondyle		Not tender to palpation	X	Tender to palpation

Spine Exam:

	Comments
Cervical ROM	Limited

Range of Motion:

RANGE OF MOTION			
HANDS			
THUMBS	**NORMAL**	**RIGHT**	**LEFT**
Interphalangeal Joints			

Flexion	0-80°	80°	80°
Extension	0-30°	30°	30°
Metacarpophalangeal Joints			
Flexion	0-60°	60°	60°
Extension	0-40°	40°	40°
Carpometacarpal Joints			
Abduction	0-50°	50°	50°
Adduction	0cm	0cm	0cm
INDEX FINGERS			
Distal Interphalangeal Joints			
Flexion	0-70°	70°	70°
Extension	+30°	+30°	+30°
Proximal Interphalangeal Joints			
Flexion	0-100°	100°	100°
Extension	+30°	+30°	+30°
Metacarpophalangeal Joints			
Flexion	0-90°	90°	90°
Extension	+20°	+20°	+20°
MIDDLE FINGERS			
Distal Interphalangeal Joints			
Flexion	0-70°	70°	70°
Extension	+30°	+30°	+30°
Proximal Interphalangeal Joints			
Flexion	0-100°	100°	100°
Extension	+30°	+30°	+30°
Metacarpophalangeal Joints			
Flexion	0-90°	90°	90°
Extension	+20°	+20°	+20°
RING FINGERS			
Distal Interphalangeal Joints			
Flexion	0-70°	70°	70°
Extension	+30°	+30°	+30°
Proximal Interphalangeal Joints			

Flexion	0-100°	100°	100°
Extension	+30°	+30°	+30°
Metacarpophalangeal Joints			
Flexion	0-90°	90°	90°
Extension	+20°	+20°	+20°
SMALL FINGERS			
Distal Interphalangeal Joints			
Flexion	0-70°	70°	70°
Extension	+30°	+30°	+30°
Proximal Interphalangeal Joints			
Flexion	0-100°	100°	100°
Extension	+30°	+30°	+30°
Metacarpophalangeal Joints			
Flexion	0-90°	90°	90°
Extension	+20°	+20°	+20°
SHOULDERS			
Flexion	150°	150°	150°
Abduction	180°	180°	180°
External Rotation	90°	90°	90°
Internal Rotation	80°	80°	80°
ELBOWS			
Extension	0°	0°	0°
Flexion	140°	140°	140°
WRISTS			
Extension (Dorsiflexion)	60°	60°	60°
Flexion (Palmar Flexion)	60°	60°	60°
HIPS			
Flexion	100°	100°	100°
Internal Rotation	40°	40°	40°
External Rotation	50°	50°	50°
KNEES			
Extension	0°	0°	0°
Flexion	150°	150°	150°
ANKLES/FEET			

Extension (Dorsiflexion)	20°	20°	20°
Flexion (Plantar Flexion)	40°	40°	40°
CERVICAL SPINE			
Extension	60°	50°	
Flexion	50°	50°	
Lateral Rotation	80°	70°	60°
Lateral Bending	45°	15°	35°
LUMBAR SPINE			
Extension	25°	15°	
Forward Flexion	60°	60°	

DIAGNOSTICS:

LABS:

BIOCHEMICAL PROFILE: Processed on [redacted] Tests performed by [redacted] Diagnostics.

Cholesterol, Total	**233 (H)**	mg/dL	Glucose	**101 (H)**	mg/dL
HDL Cholesterol	**39 (L)**	mg/dL	Urea Nitrogen (BUN)	15	mg/dL
Triglycerides	**245 (H)**	mg/dL	Creatinine	0.78	mg/dL
LDL-Cholesterol	**152 (H)**	mg/dL	Sodium	140	mmol/L
Chol/HDLC Ratio	**6.0 (H)**		Potassium	3.9	mmol/L
Non-HDL Cholesterol	**194 (H)**	mg/dL	Chloride	105	mmol/L
Albumin	4.6	g/dL	Carbon Dioxide	26	mmol/L
Globulin	2.8	g/dL	Calcium	9.9	mg/dL
Albumin/Globulin Ratio	1.6		Protein, Total	7.4	g/dL
Bilirubin, Total	0.3	mg/dL	eGFR	86	mL/min/ 1.73m^2
AST (SGOT)	24	U/L	Alkaline Phosphatase	114	U/L
ALT (SGPT)	27	U/L			

COMPLETE BLOOD COUNT W/DIFF: Processed on [redacted] Tests performed by [redacted] Diagnostics.

White Blood Cell Count	6.7	Thous/uL	Absolute Neutro	4389	cells/uL
Red Blood Cell Count	4.54	Mill/uL	Absolute Lymph	1642	cells/uL
Hemoglobin	13.2	g/dL	Absolute Mono	576	cells/uL
Hematocrit	39.9	%	Absolute Eosin	67	cells/uL

MCV	87.9	fL	Absolute Baso	27	cells/uL
MCH	29.1	Pg	Neutrophils	65.5	%
MCHC	33.1	g/dL	Lymphocytes	24.5	%
RDW	13.4	%	Monocytes	8.6	%
Platelet Count	349	Thous/uL	Eosinophils	1.0	%
MPV	10.6	fL	Basophils	0.4	%

URINALYSIS W/MICRO: Processed on [redacted]. Tests performed by [redacted] Diagnostics.

Color	Yellow	Protein	Negative
Appearance	Clear	Nitrite	Negative
Specific Gravity	1.004	Leukocyte Esterase	Negative
PH	7.5	WBC	None Seen
Glucose	Negative	RBC	None Seen
Bilirubin	Negative	Squamous Epithelial Cells	None Seen
Ketones	Negative	Bacteria	None Seen
Occult Blood	Negative	Hyaline Cast	None Seen

IRON AND TOTAL IRON BINDING CAPACITY: Processed on [redacted] Tests performed by [redacted] Diagnostics.

Test	Result	Reference Range
Iron, Total	54	45-160 mcg/dL
Iron Binding Capacity	315	250-450 mcg/dL (calc)
% Saturation	17	16-45 % (calc)
Ferritin	45	16-288 ng/mL

IMMUNOLOGY: Processed on [redacted]. Tests performed by [redacted] Diagnostics.

Test	Result	Reference Range
DNA (DS) Antibody	<1	IU/mL < or = 4 Negative 5-9 Indeterminate > or = 10 Positive
SCL-70 Antibody	<1.0 Neg	<1.0 Neg
SM and SM/RNP Antibodies		
SM Antibody	<1.0 Neg	<1.0 Neg Al
SM/RNP Antibody	<1.0 Neg	<1.0 Neg Al
Sjogren's Antibodies (SS-A, SS-B)		
Sjogren's Antibodies (SS-A)	<1.0 Neg	<1.0 Neg Al
Sjogren's Antibodies (SS-B)	<1.0 Neg	<1.0 Neg Al

ANA SCREEN, IFA, W/REFL TITER, AND PATTERN: Processed on [redacted] Tests performed by [redacted] Diagnostics.

Test	Result	Reference Range
ANA Screen, IFA	**Positive**	Negative
Antinuclear Antibodies Titer and Pattern		
ANA Titer	**1:40 (H)**	titer
ANA Pattern	**Nuclear, Speckled**	

COMPLEMENT COMP C3 + C4: Processed on [redacted]. Tests performed by [redacted] Diagnostics.

Test	Result	Reference Range
Complement Component C3C	170	83-193 mg/dL
Complement Component C4C	23	15-57 mg/dL

CARDIOLIPIN AB (IGA, IGG, IGM): Processed on [redacted]. Tests performed by [redacted] Diagnostics.

Test	Result	Reference Range
Cardiolipin AB (IGA)	5.9	APL-U/mL
Cardiolipin AB (IGG)	<2.0	GPL-U/mL
Cardiolipin AB (IGM)	9.3	MPL-U/mL

LUPUS ANTICOAGULANT EVALUATION WITH REFLEX: Processed on [redacted]. Tests performed by [redacted] Diagnostics.

Test	Result	Reference Range
Lupus Anticoagulant Evaluation with Reflex	Not detected	Not detected
PTT-LA Screen	32	< or = 40 seconds
DRVVT Screen	37	< or = 45 seconds

PROTEIN, TOTAL W/ CREAT, RANDOM URINE: Processed on [redacted] Tests performed by [redacted] Diagnostics.

Test	Result	Reference Range
Creatinine, Random Urine	**17 (L)**	20-275 mg/dL
Protein, Total, Random UR	**<4 (L)**	5-24 mg/dL

HEMOGLOBIN A1c: Processed on [redacted] Tests performed by [redacted] Diagnostics.

5.8 (H) (reference range: ≥ 6.5% consistent with diabetes)

PARATHYROID HORMONE, INTACT: Processed on [redacted]. Tests performed by Quest Diagnostics.

23 (reference range: 16-77 pg/mL)

MAGNESIUM: Processed on [redacted] Tests performed by [redacted] Diagnostics.

2.4 (reference range: 1.5-2.5 ng/dL)

PHOSPHATE (AS PHOSPHORUS): Processed on [redacted] Tests performed by [redacted] Diagnostics.

4.0 (reference range: 2.5-4.5 mg/dL)

URIC ACID: Processed on [redacted] Tests performed by [redacted] Diagnostics.

4.9 (reference range: 2.5 - 7.0 mg/dL)

IMMUNOGLOBULIN E: Processed on [redacted] Tests performed by [redacted] Diagnostics.

8 (reference range: < or = 114 kU/L)

CREATINE KINASE, TOTAL: Processed on [redacted] Tests performed by [redacted] Diagnostics.

47 (reference range: 20-243 U/L)

TSH: Processed on [redacted]. Tests performed by [redacted] Diagnostics.

2.59 (reference range: 0.40-4.50 mIU/L)

SED RATE BY MODIFIED WESTEGREN: Processed on [redacted] Tests performed by [redacted] Diagnostics.

58 (H) (reference range: < OR= 30 mm/h)

VITAMIN B12: Processed on [redacted] Tests performed by [redacted] Diagnostics.

691 (reference range: 200-1100 pg/mL)

RHEUMATOID FACTOR: Processed on [redacted] Tests performed by [redacted] Diagnostics.

<10 (reference range: <14 IU/mL)

C-REACTIVE PROTEIN: Processed on [redacted] Tests performed by [redacted] Diagnostics.

9.9 (H) (reference range: <8.0 mg/L)

ANGIOTENSIN-1-CONVERTING ENZYME: Processed on [redacted] Tests performed by [redacted] Diagnostics.

25 (reference range: 9-67 U/L)

VITAMIN D, 25-OH, TOTAL, IA: Processed on [redacted] Tests performed by [redacted] Diagnostics.

37 (reference range: 30-100 ng/mL)

CYCLIC CITRULLINATED PEPTIDE (CCP) AB (IGG): Processed on [redacted] Tests performed by [redacted] Diagnostics.

<16 units

LACTATE DEHYDROGENASE (LD): Processed on [redacted] Tests performed by [redacted] Diagnostics.

132 (reference range: 120-250 U/L)

BETA 2 MIGROGLOBULIN, SERUM: Processed on [redacted]. Tests performed by [redacted] Diagnostics.

2.79 (H) (reference range: < or = 2.51 mg/L)

DIRECT ANTIGLOBULIN W/ REFL ANTI C3, ANTI IGG: Processed on [redacted]. Tests performed by [redacted] Diagnostics.

Negative (reference range: negative)

THYROGLOBULIN ANTIBODIES: Processed on [redacted] Tests performed by [redacted] Diagnostics.

<1 (reference range: < or = 1 IU/mL)

THYROID PEROXIDASE ANTIBODIES: Processed on [redacted] Tests performed by [redacted] Diagnostics.

10 (H) (reference range: <9 IU/mL)

HELICOBACTER PYLORI UREA BREATH TEST:

Pending test results.

STUDIES:

MRI OF THE RIGHT HAND: Performed on [redacted] and interpreted by Dr. [redacted]

IMPRESSION:
1. No bony lesion is noted.
2. Small amount of fluid is seen surrounding the flexor pollicis longus tendon that may be tenosynovitis.
3. Small amount of carpal joint effusion.

MRI OF THE RIGHT THUMB: Performed on [redacted] and interpreted by Dr. [redacted]

IMPRESSION: Thickening and hyperintensity with surrounding fluid that might be tenosynovitis of the flexor pollicis longus tendon, possibly post-surgical changes.

MRI OF THE CERVICAL SPINE: Performed on [redacted] and interpreted by Dr. [redacted]

IMPRESSION:
1. Slight spondylosis and straightening of the cervical spine.
2. C3-4 left uncovertebral and lateral spur-disc complex of 2 to 3 mm and left facet joint hypertrophy with left neural foraminal narrowing.
3. C4-5, 1 to 2 mm central disc bulging with flattening of the thecal sac.

EMG & NERVE CONDUCTION STUDY REPORT: Performed on [redacted] and interpreted by Dr. [redacted]

IMPRESSION: This is a normal EMG and nerve conduction study of the bilateral upper extremities. There is no evidence of media, ulnar, and radial neuropathy. Brachial plexopathy, or significant radiculopathy. The patient has intermittent severe pain in the left thumb. She has tenderness to palpation in the left radial wrist. Consider tenosynovitis as the cause of her pain.

BILATERAL CARPAL TUNNEL VIEWS: Performed on [redacted] and interpreted by Dr. [redacted]

IMPRESSION: Normal examination.

BILATERAL HANDS AND WRIST: Performed on [redacted] and interpreted by Dr. [redacted]

IMPRESSION: Normal examination.

BONE WHOLE BODY SCAN: Performed on [redacted] and interpreted by Dr. [redacted]

IMPRESSION:
1. No abnormal tracer uptake defect within the right and left upper extremities.
2. Findings suggestive of osteoarthritis on the left side of the cervical spine and thoracic spine. Correlation with an x-ray of the cervical spine and thoracic spine is recommended.

MRI OF THE LEFT WRIST: Performed on [redacted] and interpreted by Dr. [redacted]

IMPRESSION:
1. Minimal negative ulnar variance.
2. No abnormality is seen in the triangular fibrocartilage complex. No lesion is seen in the carpal tunnel.

MRI OF THE LEFT HAND: Performed on [redacted] and interpreted by Dr. [redacted]

IMPRESSION: No abnormality is seen.

MRI OF THE THORACIC SPINE: Performed on [redacted] and interpreted by Dr. [redacted]

IMPRESSION: Small disc is seen at T7-T8 at the right uncovertebral with slight indentation of the right lateral recess. No neuroforaminal narrowing is seen.

MRI OF THE RIGHT BRACHIAL PLEXUS: Performed on [redacted] and interpreted by Dr. [redacted]

IMPRESSION:

1. The morphology and signal intensity of the supra, mid and infraclavicular plexus appears normal.

2. Prominent supraclavicular vein extending between the upper and middle trunks. This vein is larger on the left when compared to the right side. There is no evidence of mass effect by this vein and this finding is of uncertain significance.

3. The left anterior and middle scalene musculature appears unremarkable.

ELECTRODIAGNOSTIC CONSULTATION: Performed on [redacted] and interpreted by Dr. [redacted]

IMPRESSION: Normal electrodiagnostic study of both upper limbs. There is no electrodiagnostic evidence of nerve entrapment or cervical radiculopathy.

EMG REPORT: Performed on [redacted] and interpreted by Dr. [redacted]

IMPRESSION: Findings consistent chronic denervation a brachial plexus distribution, however, the abnormalities in the brachioradialis and pronator teres suggests the possibility of a cervical radiculopathy. These results should be correlated with findings from MRI imaging. The rapidly firing units in the proximal shoulder and neck muscles is consistent with active spasm and dystonia that had been previously noted by EMG exam in this patient.

MRI OF THE CERVICAL SPINE: Performed [redacted] and interpreted by Dr. [redacted]

IMPRESSION:

1. There is moderate to severe left C4 facet joint arthropathy contributing to moderate to severe left C3-4 foraminal encroachment. There is potential for impingement on the exiting left C4 nerve.

2. There is moderate left and moderate right C4-5 facet joint arthropathy with a mild approximately 2.5 anterolisthesis of

C4 on C5. Mild left C4-5 foraminal encroachment is identified.

3. There is mild disc degeneration at C5-6 with a 2 mm central and right posterior disc bulge in conjunction with mild facet joint arthropathy results in mild right C5-6 foraminal encroachment.

MRI OF THE LUMBOSACRAL SPINE: Performed on [redacted] and interpreted by Dr. [redacted]

IMPRESSION: Abnormal MRI scan of the lumbar spine demonstrating a disc herniation, more so on the left side than on the right side at the L5-Sl levels.

XR CHEST PORTABLE: Performed on [redacted] and interpreted by Dr. [redacted]

IMPRESSION: Chronic changes with old rib fractures. No acute abnormality.

CT BRAIN WO CONTRAST: Performed on [redacted] and interpreted by Dr. [redacted]

IMPRESSION:
1. No CT evidence for acute intracranial abnormality.
2. Findings were discussed with PA Gilboy shortly following completion of the study.

MRI BRAIN W/WO CONTRAST: Performed on [redacted] and interpreted by Dr. [redacted]

CONCLUSION**:** Normal MRI of the brain.

EEG REPORT: Performed [redacted] and interpreted by Dr. [redacted]

IMPRESSION: This EEG was not significant for epileptic discharges. There was diffuse slowing of the posterior dominant rhythm throughout the recording.

MRI LUMBAR SPINE HIGH RESOLUTION WITH 3D REFORMATIONS: Performed on [redacted] and interpreted by Dr. [redacted]

IMPRESSION: Abnormal MRI scan of the lumbar spine demonstrating multiplannular tears in the lumbar spine.

ABDOMINAL ULTRASOUND: Performed on [redacted] and interpreted by Dr. [redacted]

CONCLUSION:
1. Cholelithiasis with dilatation of the common bile duct up to 1 centimeter and wall thickening raises the suspicion for acute cholecystitis.
2. Mild hepatic steatosis and hepatomegaly

MRI OF THE ABDOMEN WITH MRCP WITHOUT IV CONTRAST: Performed on [redacted] and interpreted by Dr. [redacted]

CONCLUSION:
1. Choledocholithiasis with dilatation of the common bile duct up to 1 centimeter.
2. No evidence for acute cholecystitis.

MRI OF CERVICAL SPINE: Performed on [redacted] and interpreted by Dr. [redacted]

IMPRESSION:
1. Subtle focus of increased signal within the spinal cord at level of C6 which may reflect myelopathy in a proper clinical setting.
2. Grade 1 anterolisthesis of C3 on C4. Also seen is Grade 1 posteriorlisthesis of c5 on C6.
3. Mild reversal of the cervical lordosis. Concomitant mild dextroscoliosis of the cervical spine is seen.
4. Modic type II endplate degenerative changes seen at C4 down through C6.
5. Schmorl's node at C5 down through C7.
6. Mild loss of vertebral body height of C5 and C6.
7. Mild edema of the endplates of C4 down through C7 likely related to degenerative changes.
8. Moderate to severe disc desiccation involving C2-C3 down through C7-T1. Mild to moderate loss of disc height seen at C5-C6 and C6-C7.

9. Right perineural cyst is identified at T2-T3.

10. C2-C3. A disc protrusion is identified. Disc deformity measures 2.3 mm

11. C3-C4. Anterolisthesis of C3 on C4 with associated uncovering of the disc and a disc protrusion is identified. Concurrent bilateral uncovertebral joint hypertrophy is seen. Also noted is bilateral facet joint arthrosis. There is moderate bilateral neural foraminal narrowing. Associated indentation of bilateral exiting nerve root is seen. Disc deformity measures 2.4 mm.

12. C4-C5. A disc protrusion is identified. Disc material causes mild spinal canal narrowing. There is no abnormal signal within the spinal cord at this level. Concurrent bilateral uncovertebral joint hypertrophy is seen. Also noted is left facet joint arthrosis. There is moderate left neural foraminal narrowing. Associated indentation of left exiting nerve root is seen. Disc deformity measures 2.5 mm.

13. C5-C6. A disc protrusion is identified. Disc material abuts the anterior aspect of the spinal cord and causes mild spinal canal narrowing. There is no abnormal signal within the spinal cord at this level. Concurrent bilateral uncovertebral joint hypertrophy is seen. Also noted is bilateral facet joint arthrosis. There is moderate bilateral neural foraminal narrowing. Associated indentation of bilateral exiting nerve root is seen. Annular fissure is identified. Disc deformity measures 2.6 mm

14. C6-C7. A disc protrusion is identified. Disc material abuts the anterior aspect of the spinal cord and causes mild spinal canal narrowing. There is subtle increased signal within the spinal cord at this level which may reflect myelopathy in a proper clinical setting. Concurrent bilateral uncovertebral joint hypertrophy is seen. Also noted is bilateral facet joint arthrosis. There is mild to moderate bilateral neural foraminal narrowing. Associated abutment on bilateral exiting nerve root is seen. Annular fissure is identified. Disc deformity measures 3.3 mm.

MRI OF LUMBAR SPINE: Performed on [redacted] and interpreted by Dr. [redacted].

IMPRESSION:

1. Modic type II endplate degenerative changes seen at S1.

2. Moderate disc desiccation involving T12-L1 down through L5-S1. Mild loss of disc height is seen at L3-L4.

3. Subcutaneous tissue edema of the lower back at L1 down through sacral level.

4. L1-L2. A disc protrusion is identified with prominent right central component. Disc material causes mild spinal canal narrowing. There is associated mild right neural foraminal narrowing. There is an abutment on right exiting nerve root. Annular fissure is identified. Disc deformity measures 2.4 mm.

5. L2-L3. A disc protrusion is identified. Disc material causes mild spinal canal narrowing. Hypertrophy of the bilateral facet is seen. There is associated mild bilateral neural foraminal narrowing. Concurrent mild bilateral lateral recess stenosis is seen. Disc deformity measures 2.7 mm.

6. L3-L4. A disc protrusion is identified. Disc material causes mild spinal canal narrowing. Hypertrophy of the bilateral facet is seen. There is associated mild to moderate bilateral neural foraminal narrowing. Concurrent moderate bilateral lateral recess stenosis is seen. There is abutment on bilateral exiting nerve root. Associated abutment on bilateral transiting nerve root is noted. Annular fissure is identified. Disc deformity measures 3.2 mm.

7. L4-L5. A disc protrusion is identified. Disc material causes mild spinal canal narrowing. Hypertrophy of the bilateral facet is seen. There is associated mild to moderate bilateral left greater than the right neural foraminal narrowing. Concurrent mild to moderate bilateral left greater than the right lateral recess stenosis is seen. There is abutment on left exiting nerve root. Associated abutment on left transiting nerve root is noted. Annular fissure is identified. Disc deformity measures 2.3 mm.

8. L5-S1. A disc protrusion is identified. Disc material causes mild spinal canal narrowing. Hypertrophy of the bilateral facet is seen. There is associated mild bilateral neural foraminal narrowing. Concurrent mild bilateral lateral recess stenosis is seen. Disc deformity measures 2.6 mm.

SPIROMETRIC LUNG FUNCTION TESTING: Performed on [redacted] and interpreted by Dr. [redacted]

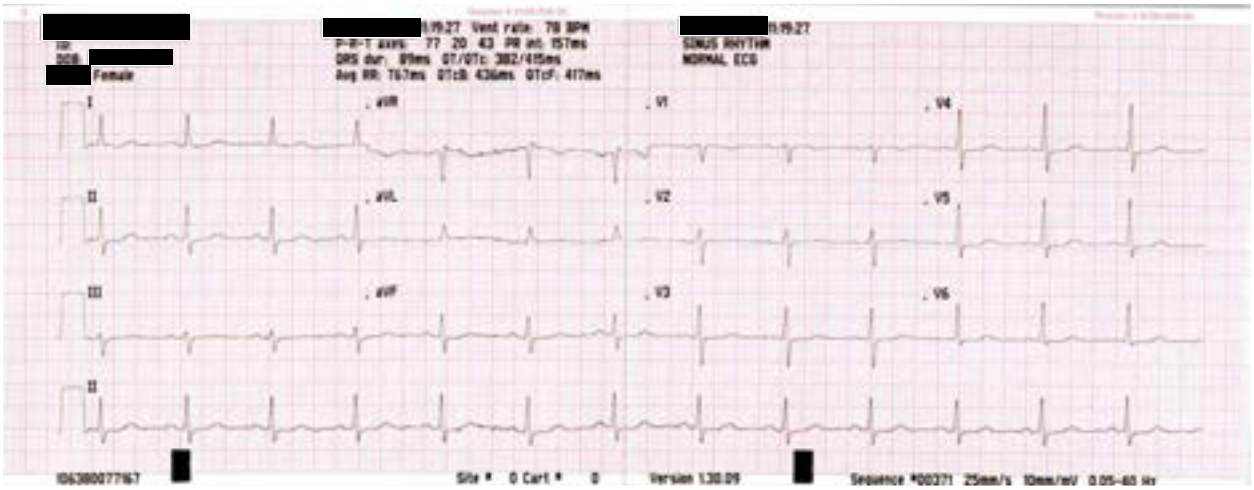
Parameter	Best	Pred	LLN	% Pred	Best 1 10:04:47	Best 2 10:04:31	Best 3 10:05:00
FVC (L)	2.79	3.19	2.40	87	2.76	2.73	2.79
FEV1 (L)	2.29	2.50	1.87	92	2.27	2.29	2.34
FEV1 Ratio	0.82	0.79	0.67	104	0.82	0.84	0.84
PEF (L/s)	4.50	6.33	4.57	71	3.57	3.96	4.50
FEF25-75 (L/s)	2.53	2.21	1.11	114	2.53	2.68	2.76

Values at BTPS

Note: Differences of up to ±20% between predicted and measured values are generally considered to be within normal limits.

CONCLUSION: Normal expiratory flow rates.

ELECTROCARDIOGRAM: Performed on [redacted] and interpreted by Dr. [redacted]



IMPRESSION: 1. Normal sinus rhythm with a ventricular rate of 78/min.

2. No acute ischemic changes.

REVIEW OF RECORDS:

Medical records totaling 1,000 pages plus videos were received, and all of these materials were thoroughly reviewed to ensure that no relevant information was overlooked.

[redacted] - SDT Records - [redacted] Orthopedic Medical Group - Workers' Compensation Claim Form (DWC1). Page 48
Date of Injury: Started [redacted] **Describe the injury and part of the body affected:** Both thumbs & palms.

[redacted] - SDT Records - [redacted] Orthopedic Medical Group - Dr. [redacted] Orthopedic Surgery. [redacted] Orthopedic Medical Group, Inc. Primary Treating Physician's Supplemental Report. Pages 33-41, 69-77
Review of Medical Records: [redacted] Chest X-ray: Conclusion: No active cardiopulmonary disease. [redacted] MRI Scan of Right Hand: Impression: Small amount of fluid seen surrounding the flexor pollicis longus tendon that might be tenosynovitis and some amount of carpal joint effusion. [redacted] MRI Scan of the Cervical Spine: Impression: 1) Slight spondylosis and straining of the cervical spine. 2) C3-4 uncovertebral and lateral spur/disc complex of 2-3 mm and left facet joint hypertrophy with left neuroforaminal narrowing. 3) C4-5 1-2 mm central disc bulge with flattening of the thecal sac. [redacted] Bone Scan of Whole Body: Impression: 1) No abnormal tracer uptake defect within the right and left upper extremities. 2) The cervical spine shows a focal area of increased tracer uptake on the left side at the C3 and C5 levels. 3) The thoracic spine demonstrates a focal area of increased tracer uptake on the left side at the T9 level at the costovertebral junction. [redacted] MRI Scan of the Left Hand: Impression: No abnormality is seen. [redacted] MRI Scan of the Thoracic Spine: Impression: There is a small disc in the right uncovertebral with slight indentation of the thecal sac at the T7-8 level. No neuroforaminal narrowing is seen. [redacted] EMG and Nerve Conduction Studies of the Bilateral Upper Extremities: Impression: There is a normal EMG and nerve conduction velocity studies of the bilateral upper extremities. There is no evidence of median, ulnar and radial neuropathy, brachial plexopathy or significant radiculopathy. The patient has intermittent severe pain in the left thumb. She has tenderness to palpation in the left radial wrist and tenosynovitis is considered as the cause of her pain. **Summary and Discussion:** In review of the provided medical records, it appears that Ms. [redacted] sustained a work-related cumulative trauma involving her bilateral wrists and hands while she was an auto part clerk for [redacted] Subsequent to the above injury, the patient underwent bilateral thumb trigger release performed by Dr. [redacted] with subsequent left thumb flexor tenolysis performed by Dr. [redacted] In review of Dr. [redacted] Orthopedic Consultation Report dated [redacted] he stated that it is quite possible that the patient may have a systemic neurological problem which is presenting as pain in her right and left hands, wrists, upper extremities, shoulders and even chest. Dr. [redacted] recommended that the patient undergo a bone scan and a neurological consultation. The bone scan was eventually obtained on [redacted] and revealed a focal area of increased tracer uptake on the left side at the C4-5 and C5 levels, as well as the left side at the T9 level. In review of the Neurological Consultation Report dated [redacted] from Dr. [redacted] he stated that there is no indication by the nature of the subjective complaints or the examination or testing of any neurological pathology. He further stated that there is no indication by the

nature of the patient's complaints or examination of a thoracic outlet syndrome or complex regional pain syndrome (reflex sympathetic dystrophy). Nonetheless, Dr. [redacted] recommended an MRI scan of the thoracic spine. Eventually, this was obtained on [redacted] and revealed a small disc in the right uncovertebral with slight indentation of the thecal sac at the T7-8 level, but no neuroforaminal narrowing. Lastly, in review of Dr. [redacted] Pain Management Consultation Report dated [redacted] he stated that the patient may have a component of complex regional pain syndrome (CRPS) which is known as reflex sympathetic dystrophy (RSD) and he discussed a trial of a sympathetic nerve block for diagnostic and potentially therapeutic purposes. As I indicated earlier, Ms. [redacted] is scheduled to be seen in this office on [redacted] and the above provided medical records will be taken into consideration at that time. It took 1 hour and 35 minutes to review the provided medical records and to prepare this report. Hopefully this will suffice to explain the billing codes utilized.

[redacted] - SDT Records - [redacted] Orthopedic Medical Group - Dr. [redacted] Orthopedic Surgery. [redacted] Orthopedic Medical Group, Inc. Primary Treating Physician's Progress Report. Complex Initial Orthopedic Evaluation. Pages 4-17, 19-30, 81-94, 99-112

Chief Complaints: Bilateral wrist, hand and thumb pain and weakness, left side worse than right, with occasional hypersensitivity in the left forearm, wrist and hand. **History of Injury:** The patient began employment as an [redacted] with [redacted] in approximately [redacted] Her usual and customary job duties required repetitive use of her hands and arms for typing, writing, and computer keyboarding while taking orders and selling various auto parts. The patient relates that in early [redacted] her employer purchased a new computer system, and her new monitor took up most of the counter space. As a result, the keyboard was at the edge of the counter which required her to hyperextend her wrists. The patient reports that by [redacted] she began to experience bilateral thumb pain associated with triggering. Over the next two to three months, she also noted the gradual onset of bilateral wrist and hand pain. In [redacted] the patient sought medical treatment through her primary care physician, who prescribed her ibuprofen 800 mg. The patient was then referred to Dr. [redacted] an orthopedic surgeon, who provided her with a short course of occupational therapy, which provided minimal benefit. Ms. [redacted] was also provided with cortisone injections to her thumbs, which provided pain relief for a few weeks. As the patient continued to experience ongoing bilateral wrist and thumb pain, she finally reported her symptoms to her employer and filed a Workers' Compensation claim on [redacted] Shortly after, the patient was referred to the industrial medical clinic and later she was referred to Dr. [redacted], a hand specialist. Following evaluation, the patient underwent a short course of occupational therapy, providing minimal benefit. Due to the persistent bilateral thumb triggering, Dr. [redacted] eventually recommended bilateral thumb trigger release. On [redacted] the patient subsequently underwent left thumb trigger release followed by right thumb trigger release on [redacted] both performed by Dr. [redacted] The patient relates that following these surgeries the triggering had resolved; however, she continued to experience stiffness in her left thumb. Later on, the patient changed primary

treating physicians to Dr. [redacted] and she subsequently underwent left thumb flexor tenolysis on [redacted] The patient states that after the surgery she began to experience her wrist, hand and thumb pain shooting up to her upper extremities into the upper arms and shoulders. The patient states that she mentioned these complaints to Dr. [redacted] however, no further medical treatment was provided. Later on, the patient changed primary treating physicians to Dr. [redacted] Following evaluation, she was referred for a short course of occupational therapy which provided no benefit. Dr. [redacted] then obtained various diagnostic studies, including MRI scans of the bilateral wrists and hands and cervical spine, as well as a bone scan, and she was told that these studies revealed minimal degenerative changes in her neck. The patient was then referred for a neurological consultation and does not recall the name of the doctor; however, she was recommended for an MRI scan of the thoracic spine. Eventually, the thoracic spine MRI study was obtained in [redacted] and the patient was told that this study revealed normal findings. Later on, the patient was referred to Dr. [redacted] a pain management specialist, who diagnosed her with possible early reflex sympathetic dystrophy condition and she was recommended for a trial of a sympathetic nerve block. In [redacted] the patient underwent the first sympathetic nerve block for her left upper extremity and she reports temporary minimal benefit. The patient is scheduled to follow up with Dr. [redacted] on [redacted] On this date, the patient presents to this office for further evaluation and treatment after having requested a change in treating physicians. It should be noted that the patient is currently working for a different employer, [redacted] as an [redacted] She relates that she had been working with [redacted] in late [redacted] with restrictions of no lifting over five pounds and no repetitive gripping, grasping, pushing and pulling, and she denies increasing symptoms to her bilateral wrists, hands and thumbs. **Occupational History:** The patient was employed as an [redacted] with [redacted] for approximately [redacted] years. Her work duties mainly involved taking orders and selling various auto parts using a computer. She worked eight hours a day, five days a week, during which time she would sit for most of the time, requiring repetitive use of her hands and arms for typing, writing, computer keyboarding, gripping and grasping. Occasional lifting various pounds was also required. objects weighing up to five Her job duties also required intermittent bending and twisting of her neck and back and occasional pushing, pulling, squatting, stooping and climbing. **General Examination:** Wt. [redacted] BP 139/80 **Diagnosis:** 1) Status post left thumb trigger release on [redacted] performed by Dr. [redacted] with subsequent left thumb flexor tenolysis on [redacted] performed by Dr. [redacted] with possible early reflex sympathetic dystrophy. 2) Status post right thumb trigger release on [redacted] performed by Dr. [redacted] 3) Bilateral forearm and wrist overuse flexor and extensor tenosynovitis with bilateral thumb carpometacarpal joint osteoarthritis. **Summary and Discussion:** Ms. [redacted] was examined in this office on [redacted] with presenting complaints involving her bilateral wrists, hands and thumbs, resulting from a work- related continuous trauma while she was employed as an auto parts clerk with [redacted] The patient attributed her symptoms to performing her usual and customary work duties which involved repetitive use of her hands and arms for typing, writing, computer keyboarding while taking orders and selling various auto parts. Subsequent to the above injury, the

patient underwent bilateral thumb trigger release, both performed by [redacted] followed by left thumb flexor tenolysis in [redacted] performed by Dr. [redacted] The patient related that following these surgeries she began to experience shooting pain into her upper arms and into the shoulders. Furthermore, the patient reports occasional hypersensitivity in her left forearm and wrist. In early [redacted] the patient was seen by a pain management specialist, Dr. [redacted], who diagnosed her with a possible reflex sympathetic dystrophy condition and recommended a trial of a sympathetic nerve block. Eventually, in the end of [redacted] the patient underwent the first sympathetic block for her left upper extremity and she reports temporary minimal benefit. The patient is scheduled to follow up with Dr. [redacted] Following my examination, it is felt that the patient's presenting complaints are consistent with the above diagnosis. Given my examination findings and the patient's presenting complaints, especially involving her left wrist, hand and thumb, it is my opinion that she may have early reflex sympathetic dystrophy following the thumb surgeries. For this condition, she has recently undergone the first sympathetic nerve block, reporting temporary minimal benefit. Therefore, I recommended that the patient continue to follow up with Dr. [redacted] for possible further sympathetic nerve blocks. With regard to the patient's chronic bilateral forearm, wrist and hand, as well as right thumb conditions, it is my opinion that she would benefit from a short course of acupuncture treatment for pain management and control. **Causation:** Based on the provided history and findings on examination, the patient's presenting complaints are believed to be 100% caused by the work-related continuous trauma extending through [redacted] while she was employed as an [redacted] with [redacted] in relationship to performing her usual and customary work duties which involved repetitive use of her hands and arms for typing, writing and computer keyboarding. **Disability Status:** Temporarily partially disabled. The patient is currently working for a different employer with restrictions of no lifting over five pounds and no repetitive or forceful gripping, grasping, pushing or pulling. **Estimated Time of Disability:** 6 to 8 weeks. **Permanent Residual Disability:** At this time, the patient's condition has not reached maximum medical improvement, and additional treatment is required. At this time, we cannot determine whether the patient will have permanent impairment or whether the patient will be able to resume/continue full previous work duties.

[redacted] - SDT Records - [redacted] Orthopedic Medical Group - Dr. [redacted] Orthopedic Surgery. [redacted] Orthopedic Medical Group, Inc. Doctor's First Report of Occupational Injury or Illness. Pages 43-44

Describe How the Accident or Exposure Happened: Due to repetitive typing, writing, and computer keyboarding, the patient injured her bilateral wrists, hands and thumbs. **Subjective Complaints:** The patient complains of bilateral wrist, hand and thumb pain and weakness, left side greater than right, with occasional hypersensitive left wrist and hand. **Objective Findings:** A. Physical Examination: There are healed scars over the bilateral thumbs. There is a slightly increased sensation over the left wrist and hand. Tenderness to palpation is present over the flexor and extensor musculature and thumb carpometacarpal joints, the left side greater than the right. Grind test is positive over the bilateral thumb

carpometacarpal joints. There is decreased grip strength in the bilateral upper extremities. There is a slightly decreased left wrist range of motion. B. X-ray and laboratory results. **Work Status:** Is residual permanent disability anticipated? Yes. Will the patient eventually be able to engage in the occupation being performed at the time of injury? Unable to determine at this time. Modified Work: [redacted] Restrictions: No lifting greater than 5 lbs. No repetitive or forceful gripping/grasping, pushing and pulling. **Diagnosis:** 1) Status post left thumb trigger release performed on [redacted] followed by flexor tenolysis performed on [redacted] with resultant possible early reflex sympathetic dystrophy. 2) Status post right thumb trigger release performed on [redacted] 3) Bilateral forearm/wrist flexor and extensor tendonitis and bilateral carpometacarpal joint osteoarthritis. **Treatment:** Type: Acupuncture Frequency: 3 weeks; if improvement with functional gains, then continue 2x3. **Consult/Surgery:** Continue to follow up with Dr. [redacted] a pain management specialist. **Other:** Ketorub-B. Duration: 6-8 weeks.

[redacted]- SDT Records - [redacted] Orthopedic Medical Group - Unknown Provider. Progress Note. Page 49

BP: 139/80, Wt. [redacted] **Present Complaint**: B wrist/hands. Thumb. The remainder of the report is handwritten and illegible

[redacted]- SDT Records - [redacted] MD - Dr. [redacted] Psychiatry. [redacted] Medical Group. Psychiatric Evaluation Report. Pages 132-136

Chief Complaint/History of Present Illness: depression and pain. The claimant states that she has chronic regional pain syndrome and also thoracic outlet syndrome and this causes a lot of impairments in her life. **Mental Status Exam:** Mood: The claimant described/her mood as "This pain is very debilitating to my life." Concentration: She correctly spelled the word "world" forward and backward. **Diagnosis By DSM IV: Axis I: Adjustment Disorder with Depressed Mood. Axis II: Deferred. Axis III: Chronic regional pain syndrome, brachial plexus neuropathy, suprascapular neuropathy, and hypertension. Axis IV: Stressor is economies. Axis V: 75. Functional Assessment:** Although the claimant reports symptoms of depression, she was able to do relatively well in her psychiatric interview. Much of her depression is related to the fact that she has a lot of physical pain that prevents her to do what she was able to do previously. Claimant's ability to understand and carry out simple instructions is normal. Claimant's ability to understand and carry out complex or detailed instructions is normal. Claimant's ability to maintain focus and concentration required to do work related activities is normal. Claimant's ability to relate to and interact with co-workers, colleagues, and supervisors is normal. Claimant's ability to cope with workplace stress is normal. Claimant's ability to deal with changes in a routine work setting is normal. Claimant's activities of daily living are normal. **Prognosis:** From a psychiatric standpoint, the claimant's prognosis is fair. **Financial Capabilities:** Based on this presentation, the claimant does appear able to appropriately handle funds at this time.

[redacted] - SDT Records - [redacted] MD - Dr. [redacted] Neurology. Primary Treating Physician's Progress Report (PR-2). Page 150
Subjective Complaints: Neck and shoulder pain. **Objective Findings**: Limited shoulder ROM. **Diagnoses**: 1) Brachial plexopathy. 2) CRPS. The remaining notes are handwritten and illegible.

[redacted] - SDT Records - [redacted] MD – [redacted] Claims Representative. Health Consultant Utilization Review Assessment. Pages 611-614
Treatment Request, Prospective: 1) Left brachial plexus block and supra scapular block. **Decision: DENY:** Left Brachial Plexus block and suprascapular block. **Analysis:** Left Brachial Plexus block and suprascapular block should be denied based on the following: There is limited information in the submitted medical report and insufficient information to support the medical necessity of a Left Brachial Plexus block and suprascapular block.

[redacted] - SDT Records - [redacted] MD - Dr. [redacted] Family Practice. [redacted] Physician Review Recommendation. Pages 644-645
Reason for Referral:1) Request: **A) Bupropion sustained -relief (SR) 150 mg #60 [redacted] - CERTIFIED.** B) Omeprazole 20mg #30 [redacted] - NON-CERTIFIED. **Clinical Summary:** This [redacted] year-old female was injured over [redacted] years ago, on [redacted] by a mechanism that was not provided. She had acceptable body parts of bilateral upper extremity (BUE) and hands. Her diagnoses were bilateral shoulder pain, frozen shoulders, cervical spondylosis, chronic pain syndrome, brachial plexopathy, and subsequent depression. The patient, in the past, had been authorized for OxyContin, Percocet, and Ativan. She also needed sleeping pills as well. The patient was most recently seen on [redacted] Her prior medications, Norco, four times a day, and OxyContin, three times a day, were noted. She also had been taking Omeprazole and Zolpidem. The note on the medication list said minimal pain relief with no side effects. The office assistant clarified the handwritten note, which appeared to say that Botox had been used in the past with no relief. There was no relief from facet blocks. She had no relief from stellate ganglion blocks and continued to have left shoulder and neck pain. There was minimal examination noted and the evaluation gave the diagnoses that were deciphered by Ann. The patient did have chronic pain and required reasonably high doses of medication. She had been on bupropion twice a day in the past and had automatic refills. Her recent refills had run out.

[redacted] - SDT Records - [redacted] MD - Dr. [redacted] Neurology. Primary Treating Physician's Progress Report (PR-2). Page 143
Subjective Complaints: Constant neck pain. **Objective Findings**: Limited and painful neck ROM. **Diagnoses**: 1) CRPS. 2) Frozen shoulder. 3) Cervical spondylosis. 4) Brachial plexopathy. 5) Facet arthritis. **Treatment Plan**: Suprascapular block/plexus block. Physical Therapy. **Work Status**: Off work until [redacted] The remaining notes are handwritten and illegible.

[redacted]

[redacted] **Records -** [redacted] **MD - Dr.** [redacted] **Neurology. Neurological Associates** [redacted] **Review of Systems. Page 307**

Review of Systems: Constitutional: sleepiness, insomnia Musculoskeletal: muscle pain, weakness, joint pain, stiffness, posture Neurological: headache Chest/breasts: pain Genitourinary: hesitancy Gastrointestinal: heartburn, nausea, constipation Psychiatric: mood, thoughts, anxiety, enjoyment, motivation, control, focus Skin: discoloration.

[redacted] **- SDT Records -** [redacted] **MD - Dr.** [redacted] **Surgery.** [redacted] **Physician Review Recommendation. Pages 626-627**

Reason for Referral: 1) Request: Lorazepam 0.5mg #60. **Recommendation:** **NON-CERTIFIED.**

[redacted] **SDT Records -** [redacted] **MD -** [redacted] **PT. Physical Therapy.** [redacted] **Physical Therapy. Shoulder Progress Summary. Page 324**

Diagnosis: Frozen shoulder, c Spondylosis, CRPS. **Order:** PT eval and treat; seen 8 times. **Current Status:** Ms. [redacted] has made some improvements. **Treatment:** Treatment provided.

[redacted] **- SDT Records -** [redacted] **MD - Dr.** [redacted] **Neurology. Primary Treating Physician's Progress Report (PR-2). Page 128-129**

Subjective Complaints: Constant neck, shoulder and arm pain. **Objective Findings**: Tight/tender neck, shoulder muscle, decreased ROM. Depression. **Diagnoses**: 1) Brachial plexus neuropathy. 2) CRPS. 3) Suprascapular neuropathy, frozen shoulder. **Treatment Plan**: Rx Flector, Lidoderm and Wellbutrin XL, Ambien, Norco, OxyContin. Brachial plexus, suprascapular block. Refer to psyche for cognitive therapy. **Work Status**: Off work until [redacted]

[redacted] **- SDT Records -** [redacted] **MD - Dr.** [redacted] **Neurology. Neurological Associates** [redacted] **Review of Systems. Page 316**

Review of Systems: Constitutional: fatigue, sleepiness, insomnia Musculoskeletal: muscle pain, weakness, joint pain, stiffness, posture Neurological: headache Chest/breasts: pain ENT: swallowing problem Genitourinary: urgency, hesitancy Psychiatric: mood, thoughts, anxiety, enjoyment, motivation, control, focus Skin: sweating.

[redacted] **- SDT Records - Sheldon Jordan MD -** [redacted] **PT. Physical Therapy.** [redacted] **Physical Therapy. Shoulder Progress Summary. Page 287**

Diagnosis: Frozen shoulder, C Spondylosis, CRPS. **Order:** PT eval and treat; seen 8 times. **Current Status:** Ms. [redacted] has made some improvements. **Treatment:** Treatment provided.

[redacted] SDT Records - [redacted] MD - Dr. [redacted] Family Practice. [redacted] Physician Review Recommendation. Pages 341-342
Reason for Referral: Determine the medical necessity for Bupropion XL 150 mg #90, 2 refills. **Recommendation**: **MODIFIED – Bupropion XL 150 mg, #90, no refills.** **Rationale for Recommendation:** 1) Modified - Bupropion XL 150 mg,#90, no refills.

[redacted] SDT Records - [redacted] MD - Dr. [redacted] Neurology. Primary Treating Physician's Progress Report (PR-2). Pages 86-87
Subjective Complaints: Left shoulder pain improved after brachial plexus and suprascapular injections. **Objective Findings**: Limited shoulder range of motion. **Diagnoses**: 1) CRPS. 2) Frozen shoulder. **Treatment Plan**: Omeprazole, Lyrica, Lorazepam, Zolpidem, Norco, Lidoderm patch, OxyContin, and Flector patch. **Work Status**: PNS. The remaining notes are handwritten and illegible.

[redacted] SDT Records - [redacted] MD - [redacted] PT. Physical Therapy. [redacted] Physical Therapy. Shoulder Progress Summary. Page 286, 323
Diagnosis: Frozen shoulder, c Spondylosis, CRPS. **Orders:** PT Eval and treat; seen 12 times. **Current Status:** Current status: Ms. [redacted] has made some improvements. Symptoms have decreased, with improved alignment, soft tissue & joint mobility, ROM, control, and functional mobility. **Treatment:** Treatment provided.

[redacted] SDT Records - [redacted] MD - Dr. [redacted] Neurology. Primary Treating Physician's Progress Report (PR-2). Pages 112-113
Subjective Complaints: Pain in neck, arm and leg, generalized pain; depressed secondary to pain. **Objective Findings**: Tight/tender neck muscle. **Diagnoses**: 1) CRPS. 2) Depression due to # 1. **Treatment Plan**: Rx OxyContin, Wellbutrin. TENS unit. **Work Status**: Off work until [redacted].

[redacted] - SDT Records - [redacted] MD - Dr. [redacted] Neurology. Neurological Associates [redacted] Review of Systems. Page 298
Review of Systems: Constitutional: sleepiness, insomnia Musculoskeletal: muscle pain, atrophy, weakness, joint pain, stiffness, posture change Neurological: memory loss, headache Chest/breasts: pain ENT: hearing loss Genitourinary: hesitancy Psychiatric: mood, thoughts, anxiety, enjoyment, motivation, control, focus Skin: itch.

[redacted] - SDT Records - [redacted] MD - Dr. [redacted] Occupational Medicine. [redacted] Inc. Health Consultant Utilization Review Assessment. Pages 544-548
Treatment Request: Lidocaine-Prilocaine 2.5%-2.5% #30. **Decision:** I recommend to **DENY Lidocaine-Prilocaine 2.5%-2.5% #30**.

[redacted] - SDT Records - [redacted] MD - Dr. [redacted] Occupational Medicine. [redacted] Inc. Health Consultant Utilization Review Assessment. Pages 585-593

Treatment Request, Prospective: 1) Cognitive Therapy (frequency not provided) with Dr. Stampler. 2) Increase Wellbutrin (Bupropion) dosage and quantity unknown. 3) Emla Cream 30g #10. 4) Oxycontin (strength and quantity unknown) 5) Revia 21 mcg/ml. **Decision: 1) MODIFY Cognitive Therapy with Dr. [redacted] to Cognitive Therapy with Dr. [redacted] for 6 sessions over 6 weeks.** 2) DENY Increase Wellbutrin (Bupropion) dosage and quantity unknown (not actually requested) 3) DENY EMLA 2.5% lidocaine/2.5% prilocaine Cream, 30 gm **4) MODIFY Oxycontin 20mg, #120 to Oxycontin 20mg, #90** 5) DENY Revia 25 mcg/ml.

[redacted] - SDT Records - [redacted] MD - Dr. [redacted] Neurology. Primary Treating Physician's Progress Report (PR-2). Pages 125-126

Subjective Complaint: Neck and arm pain; depressed due to pain. Lidoderm helped her. **Objective Findings**: Tight/tender neck muscle. Swollen left hand. Tinel's sign over the brachial plexus. **Diagnoses**: 1) Brachial plexus neuropathy. 2) CRPS. 3) Depression. **Treatment Plan**: Cognitive therapy, TENS unit. Rx Wellbutrin, OxyContin, Lidoderm patch, Norco, Ativan, OxyContin. **Work Status**: Off work until [redacted] The remaining notes are handwritten and illegible.

[redacted] SDT Records - [redacted] MD - Dr. [redacted] Neurology. Neurological Associates [redacted] Review of Systems. Page 289

Review of Systems: Constitutional: fatigue, chills, sleepiness, insomnia Musculoskeletal: muscle pain, weakness, joint pain, stiffness, posture change Neurological: headache Chest/breasts: pain ENT: swallowing problem Genitourinary: incomplete empty Gastrointestinal: heartburn Psychiatric: mood, thoughts, anxiety, enjoyment, motivation, control, focus Respiratory: pain Skin: itch, rash, discoloration, sweating, burns.

[redacted] - SDT Records - [redacted] MD - Dr. [redacted] Neurology. Neurological Associates of [redacted] Neurology Report. Page 114

This patient of mine has brachial plexus neuritis and CRPS. We have a request for a "legible copy" of the [redacted] note. We will again send the same copy, which is entirely legible. The TEN's unit should be purchased since they are so cheap nowadays, it does not make sense to rent them. The application will be obviously for pain management in someone with the above diagnosis who has failed to respond well enough to medications, PT and various interventions.

[redacted] MD -Dr. [redacted] Family Practice. [redacted]. Physician Review Recommendation. Pages 597-598

Reason for Referral: Determine the medical necessity for Request #[redacted] – **Zolpidem 10mg #60 [redacted]**) and Request #[redacted] – **transcutaneous electrical neurostimulation (TENS) unit: BOTH NON-CERTIFIED.**

[redacted] - SDT Records - [redacted] MD - Dr. [redacted] Family Practice. [redacted] Physician Review Recommendation. Pages 577-578
Reason for Referral: Determine the medical necessity for Request # [redacted] – TENS unit: **MODIFIED to TENS unit, 1-month rental.**

[redacted] - SDT Records - [redacted] MD - Dr. [redacted] Occupational Medicine. [redacted] Inc. Health Consultant Utilization Review Assessment. Pages 570-573
Treatment Request: Prospective request, source of document: Email from ESI on [redacted] with the date of service of [redacted] prescriber [redacted] MD for **Lidoderm 5% (700mg) #90**. **Decision:** I recommend **DENY for Lidoderm 5% (700 mg), #90 at this time.**

[redacted] - SDT Records - [redacted] MD - Dr. [redacted] Neurology. Primary Treating Physician's Progress Report (PR-2). Pages 110-111
Subjective Complaints: Constant upper and LE pain. The patient states that the TENS unit helped. **Objective Findings**: Mottled color in bilateral arms and left leg. **Diagnoses**: 1) CRPS. 2) Depression. **Treatment Plan**: Rx OxyContin, Lyrica, Norco, Wellbutrin and Ambien. Brachial plexus and suprascapular nerve block. TENS unit. The remaining notes are handwritten and illegible.

[redacted] - SDT Records - [redacted] MD - Dr. [redacted] Neurology. Neurological [redacted] Review of Systems. Page 276
Review of Systems: Constitutional: sleepiness, insomnia Musculoskeletal: muscle pain, atrophy, weakness, joint pain, stiffness, posture change Neurological: headache Chest/breasts: pain ENT: swallowing problem Genitourinary: incomplete empty Gastrointestinal: heartburn Psychiatric: mood, thoughts, anxiety, enjoyment, motivation, control, focus Respiratory: hoarseness Skin: discoloration, sweating.

[redacted] - SDT Records - [redacted] MD - Dr. [redacted] Occupational/General Medicine. [redacted] Inc. Health Consultant Utilization Review Assessment. Pages 534-539, 552-557
Treatment Request: Prospective: 1) Oxycontin, 40mg #60 bid. 2) TENS unit. 3) Brachial plexus nerve block. 4) Suprascapular nerve block. 5) Norco 10/325 mg #120 6) Lyrica 50 mg #60 **Decision: 1) AUTHORIZE Oxycontin, 40mg #60** 2) DENY TENS unit. **3) MODIFIED authorization is recommended for a left brachial plexus nerve block. 4) MODIFIED authorization is recommended for a left suprascapular nerve block. 5) AUTHORIZE Norco 10/325 mg, #120. 6) AUTHORIZE Lyrica 50 mg #60.**

[redacted] - SDT Records - [redacted] MD - Dr. [redacted] Neurology. The [redacted] Surgical Treatment. Operative Report. Pages 17-18

Clinical Diagnosis: 1) Suprascapular neuropathy 1. Frozen shoulder 2) Rotator cuff syndrome 3) Brachial plexus neuropathy 4) Complex regional pain syndrome. **Postoperative Diagnosis:** 1) Suprascapular neuropathy 2) Frozen shoulder 3) Rotator cuff syndrome 4) Brachial plexus neuropathy 5) Complex regional pain syndrome **Procedures Performed:** 1) Left brachial plexus block. 2) Unlisted procedure, pulsed radiofrequency procedure left brachial plexus. 3) Suprascapular nerve block. 4) Unlisted procedure, pulsed radiofrequency procedure of left suprascapular nerve. 5) Fluoroscopic guidance. 6) Intraoperative ultrasound.

[redacted] - SDT Records - [redacted] MD - [redacted] Neurology. Primary Treating Physician's Progress Report (PR-2). Pages 86-87, 94-95

Subjective Complaints: Left shoulder pain improved after plexus and suprascapular injection. **Objective Findings**: Limited shoulder ROM. **Diagnoses**: 1) CRPS. 2) Frozen shoulder. 3) Suprascapular neuropathy. **Treatment Plan**: Rx Omeprazole, Lyrica, Lorazepam, Norco, Zolpidem, OxyContin. **Work Status**: PNS. The remaining notes are handwritten and illegible.

[redacted] - SDT Records - [redacted] Neurology. Neurological Associates of WLA. Review of Systems. Page 259

Review of Systems: Constitutional: fatigue, sleepiness, insomnia Musculoskeletal: muscle pain, atrophy, weakness, joint pain, stiffness, posture change Neurological: memory loss Chest/breasts: pain ENT: swallowing problem Genitourinary: hesitancy, incomplete empty Gastrointestinal: heartburn Psychiatric: mood, thoughts, anxiety, enjoyment, motivation, control, focus Skin: discoloration.

[redacted] Neurology. Primary Treating Physician's Progress Report (PR-2). Pages 88-89

Subjective Complaints: Increased spasm, Botox used in past; frozen left shoulder. **Objective Findings**: Spasm with shoulder elevation secondary to tenderness in trapezial/scalene. **Diagnoses**: 1) CRPS. 2) Frozen shoulder. 3) Depression secondary to muscle spasm. **Treatment Plan**: Due to cortisone injection L shoulder. Due to repeat Botox neck/shoulder. Rx Flexeril, Omeprazole, Lyrica, Lorazepam, Norco, Zolpidem, OxyContin, Lidocaine and Flector patch. The remaining notes are handwritten and illegible.

[redacted] Neurology. Neurological Associates of WLA. Review of Systems. Pages 235

Review of Systems: Constitutional: sleepiness, insomnia Musculoskeletal: muscle pain, weakness, joint pain, posture change Neurological: memory loss, incoordination Chest/breasts: pain ENT: swallowing problem Genitourinary: incomplete empty

Gastrointestinal: heartburn Psychiatric: mood, thoughts, anxiety, enjoyment, motivation, control, focus Skin: discoloration.

[redacted] Occupational Medicine. [redacted] Inc. Health Consultant Utilization Review Assessment. Pages 516-523

Treatment Request: Prospective: 1) Cortisone injection left shoulder 2) Injection - Botox injection neck/shoulders. 3) Flexeril 4) Lyrica 5) Norco 6) Oxycontin 7) Intradermal Cream **Decision: 1) Cortisone injection left shoulder, AUTHORIZE** 2) Injection - Botox injection neck/shoulder. DENY. 3) Flexeril. DENY. 4) Lyrica. DENY. 5) Norco. DENY. 6) Oxycontin. DENY. 7) Intradermal Cream. DENY.

[redacted] Neurology. [redacted] Operative Report. Pages 13-14, 15-16

Clinical Diagnosis: 1) Shoulder rotator cuff syndrome 2) Frozen shoulder 3) Shoulder bursitis 4) Shoulder tendinitis 5) Arthritis of the phalangeal metacarpal joint of the thumbs bilaterally **Postoperative Diagnosis:** 1) Shoulder rotator cuff syndrome 2) Frozen shoulder 3) Shoulder bursitis 4) Shoulder tendinitis 5) Arthritis of the phalangeal metacarpal joint of the thumbs bilaterally **Procedures Performed:** 1) Injection of the left shoulder 2) Injection of the thumb joints bilaterally at metacarpophalangeal joint 3. Intraoperative ultrasound.

[redacted] Neurology. Neurological Associates [redacted] Review of Systems. Pages 227

Review of Systems: Constitutional: fatigue, sleepiness, insomnia Musculoskeletal: muscle pain, atrophy, weakness, joint pain, stiffness, posture change Neurological: memory loss, language problem, headache, incoordination, gait Chest/breasts: pain, lung ENT: swallowing problem Eyes: blurring Genitourinary: hesitancy, incomplete empty Psychiatric: mood, thoughts, anxiety, enjoyment, motivation, control, focus Respiratory: shortness of breath Skin: itch, sweating.

[redacted] Neurology. Primary Treating Physician's Progress Report (PR-2). Pages 77-78

Subjective Complaints: Constant neck and arm pain. **Objective Findings**: Spasm of neck. **Diagnoses**: 1) CRPS. 2) Frozen shoulder. 3) Thumb tendinitis. **Treatment Plan**: Rx OxyContin 40 mg, Zolpidem 10 mg, Lyrica 50 mg, Lorazepam 0.5 mg, Norco. Trigger point injection to the left neck. **Disability Status**: P & S. The remaining notes are handwritten and illegible.

[redacted] Review of Systems. Page 218

Review of Systems: Constitutional: fatigue, sleepiness, insomnia Musculoskeletal: muscle pain, atrophy, weakness, joint pain, stiffness, posture change Neurological: memory loss, incoordination Chest/breasts: pain ENT: swallowing problem Eyes: blurring Genitourinary:

hesitancy, incomplete empty Psychiatric: mood, thoughts, anxiety, enjoyment, motivation, control, focus Skin: sweating.

[redacted] **Family Practice. Physician Review Recommendation. Pages 484-485**
Reason for Referral: Determine the medical necessity for Request # [redacted] – Carisoprodol 350mg #120: **MODIFIED to Carisoprodol (Soma) 350mg, #60, no refills, with DOS** [redacted]

[redacted] **Occupational Medicine.** [redacted] **Health Consultant Utilization Review Assessment. Pages 496-501**
Treatment Request: Prospective: 1) Norco 2) Lyrica 3) Lorazepam **Decision: 1) Norco. DENIED. 2) Lyrica. DENIED. 3) Lorazepam. DENIED.**

[redacted] **Neurology. Primary Treating Physician's Progress Report (PR-2). Pages 59-60, 72-73**
Subjective Complaints: Constant neck/shoulder pain. Sleep disturbance due to pain. HA secondary to depression. **Objective Findings**: Dystrophy due to spasm. **Diagnoses**: 1) CRPS. 2) Depression due to pain. 3) Dystonia secondary to muscle spasm. 4) Myofascial pain. 5) Thumb tendinitis. **Treatment Plan**: Rx Oxycodone 5-10 mg, OxyContin 40 mg, Ambien CR 6.25 mg and Doxepin 25 mg. Trigger point injection for muscle pain. **Work Status**: Off work until [redacted] The remaining notes are handwritten and illegible.

[redacted] **Neurology. Neurological Associates** [redacted] **Progress Notes. Page 74-75**
Review of System: Constitutional: weight gain, fatigue, sleepiness, insomnia. Musculoskeletal: muscle pain, atrophy, weakness, joint pain, stiffness, posture change. Neurological: memory loss, headache, incoordination. Chest/breast: pain. ENT: swallowing problem. Eyes: blurring. Genitourinary: hesitancy, incomplete empty, incontinence. Gastrointestinal: constipation. Psychiatric: mood, thoughts, anxiety, enjoyment, motivation, control, focus. Respiratory: shortness of breath. Skin: discoloration.

[redacted] **Physical Medicine and Rehabilitation. CompPartners. Physician Review Recommendation. Pages 481-483**
Reason for Referral: Determine the medical necessity for the following medications: Ambien CR – NON-CERTIFIED, an unknown drug (illegible) "added for mood and sleep" – NON-CERTIFIED, **Oxycontin 40mg #90 – CERTIFIED,** and Oxycodone 5–10mg #120 – NON-CERTIFIED.

[redacted] **Neurology.**
Primary Treating Physician's Progress Report (PR-2). Pages 67-68
Subjective Complaints: Total body pain including knees as CRPS has spread over body. **Objective Findings**: Spasm/dysfunction. **Diagnoses**: 1) CRPS. 2) Depression due to pain. 3) Myofascial pain. **Treatment Plan**: Rx Lyrica 50 mg, Oxycodone 5 mg, OxyContin 40 mg, Ambien CR 6.25 mg, Ambien CR 12.5 mg and Doxepin 25 mg. **Work Status**: Off work unti[redacted] The remaining notes are handwritten and illegible.

[redacted] **Neurology.**
Neurological Associates [redacted] Review of Systems. Pages 198
Review of Systems: Constitutional: weight gain, sleepiness, insomnia Musculoskeletal: muscle pain, atrophy, weakness, joint pain, stiffness, posture change Neurological: memory loss, incoordination Chest/breasts: pain ENT: swallowing problem Genitourinary: urgency, hesitancy, incomplete empty Gastrointestinal: heartburn Psychiatric: mood, thoughts, anxiety, enjoyment, motivation, control, focus Respiratory: hoarseness (has cold) Skin: discoloration, sweating.

[redacted]
Anesthesiology/Pain Medicine. [redacted] Physician Review Recommendation. Pages 461-462
Reason for Referral: Determine the medical necessity for Request #[redacted] – Pennsaid 1.5% Topical: NON-CERTIFIED.

[redacted] **Occupational Medicine. Pain Management. [redacted] Inc. Health Consultant Utilization Review Assessment. Pages 455-460**
Treatment Request: 1) Lyrica 50 mg 4/day 2) Oxycontin 40 mg 3/day 3) Doxepin/Sinequan. **Decision:** I recommend 1) **DENY** Lyrica 50mg 4/day, 2) **DENY** Oxycontin 40 mg 3/day 3) **DENY** Doxepin/Sinequan.

[redacted] **Neurology.**
Primary Treating Physician's Progress Report (PR-2). Pages 45-46, 51-52
Subjective: Meds are reducing pain and improving function in ADLs. Botox will be required every 6 months for spasm and dystonia of neck/shoulder. **Objective Findings**: Spasm/dystonia. **Diagnoses**: 1) CRPS. 2) Depression due to pain. 3) Myofascial pain. **Treatment Plan**: Rx: Lyrica 50 mg, Oxycodone 5 mg, Lidoderm patch, Wellbutrin XL 150 mg, OxyContin 40 mg, Voltaren 200 mg, Lyrica 50 mg, Oxycodone 50 mg, Ambien CR 6.25 mg and Doxepin 25 mg. **Disability Status**: P & S. The remaining notes are handwritten and illegible.

[redacted] **Neurology. Neurological Associates [redacted] Review of Systems. Page 188**
Review of Systems: Constitutional: weight gain, fatigue, sleepiness, insomnia Musculoskeletal: muscle pain, weakness, joint pain, stiffness, posture change Neurological: memory loss, headache, incoordination. Chest/breast: pain ENT: swallowing problem Genitourinary: hesitancy, incomplete empty Gastrointestinal: heartburn Psychiatric: mood, thought, anxiety, enjoyment, motivation, control, focus Respiratory: pain Skin: discoloration.

[redacted] **Anesthesiology and Pain Management. [redacted] Notice of Utilization Review Decision to the Provider. Pages 432-444**
Treatment Requested: 1) Lyrica 50 mg 4/day 2) Oxycodone 5mg 8/day 3) Oxycontin 40mg 3/day 4) Ambien CR 6.25mg 5) Doxepin 25mg qhs 6) Lidoderm patch 3/day 7) Wellbutrin 150 xl 3/day #90 8) Trigger point injection left neck **Recommendations: 1) Lyrica 50mg 4/day #120: CERTIFIED 2) Oxycodone 5mg 8/day #240: CERTIFIED only for one month 3) Oxycontin 40mg 3/day #90: CERTIFIED only for one month. 4) Ambien CR 6.25mg #30: CERTIFIED only for one month to allow for weaning off. 5) Doxepin 25mg q h s: CERTIFIED** 6) Lidoderm patch 3/day: NON-CERTIFIED **7) Wellbutrin 150XL 3/day #90: CERTIFIED for one month to allow for evidence to be provided that there has been an adequate trial of the tricyclic and SNRI antidepressants.** 8) Trigger point injection left neck: NON-CERTIFIED.

[redacted] **Occupational Medicine. Health Consultant Utilization Review Assessment. Pages 425-430**
Treatment Request: 1) Zolpidem Tartrate 12.5 #30 w/ 1 refill. Accepted Body Parts: neck, arms, shoulders, and hands. **Decision**: **DENY Zolpidem Tartrate 12.5mg #30 w/ 1 refill.**

[redacted] **Neurology. Primary Treating Physician's Progress Report (PR-2). Pages 47-48, 53-54**
Chief Complaint: Constant neck, back and leg pain. **Objective Findings**: Limited back ROM. **Diagnoses**: 1) CRPS. 2) Piriformis syndrome. **Treatment Plan**: Rx OxyContin Oxycodone. **Disability Status**: P & S. The remaining notes are handwritten and illegible.

[redacted] **Neurology. Neurological Associates [redacted] Review of Systems. Pages 181**
Review of Systems: Constitutional: weight gain, sleepiness, insomnia. Musculoskeletal: muscle pain, atrophy, weakness, joint pain, stiffness, posture change. Neurological: memory loss, incoordination. Chest/breasts: pain. ENT: swallowing problem. Genitourinary: urgency, hesitancy, incomplete empty. Psychiatric: mood, thoughts, anxiety, enjoyment, motivation, control, focus.

[redacted] **Neurology.**
Primary Treating Physician's Progress Report (PR-2). Pages 32-33, 38-39
Subjective Complaints: Constant shoulder, neck and leg pain due to Botox every 6 months; spasm and dystonia to neck/shoulder. **Objective Findings**: Spasm/dystonia. **Diagnoses**: 1) CRPS. 2) Depression. 3) Dystonia. **Treatment Plan**: Repeat Botox injection to neck/shoulder. Rx: Clonidine, Lyrica 50 mg, Oxycodone 50 mg, OxyContin 40 mg, Ambien CR 6.25 mg, Lorazepam 0.5 mg, Doxepin 25 mg, Lidoderm patch, Wellbutrin XL 150 mg. **Disability Status**: P & S. The remaining notes are handwritten and illegible.

[redacted] **Neurology.**
Neurological Associates [redacted] Review of Systems. Page 170
Review of Systems: Constitutional: weight gain, fatigue, chills, sleepiness, insomnia. Musculoskeletal: muscle pain, atrophy, weakness, joint pain, stiffness, posture change. Neurological: memory loss. Chest/breasts: pain. Genitourinary: urine frequency, incomplete empty. Psychiatric: mood, thoughts, anxiety, enjoyment, motivation, control, focus. Respiratory: shortness of breath. Skin: itch, rash, discoloration.

[redacted] **Administrative Law Judge. Decision. Social Security Administration. Office of Disability Adjudication and Review. Pages 374-382**
Jurisdiction and Procedural History: On [redacted] the claimant filed a Title II application for a period of disability and Disability Insurance Benefits, alleging disability beginning [redacted] claim was denied initially on [redacted]
The claimant, through her representative, argues that the consultative neurologist, Dr. [redacted] did not spend enough time with her and that his assessment should therefore be rejected (Exhibits 8E and 10E). Decision: Based on the application for a period of disability and Disability Insurance Benefits filed on [redacted] the claimant is not disabled under sections 216 (i) and 223 (d) of the Social Security Act.

[redacted] **Neurology.**
Neurological Associates of [redacted] Interventional Neurology and Pain Management Report. Pages 26-31
This letter is in response to denial of botulinum chemodenervation. This patient has a recognized injury to the shoulder and upper extremity with diagnostic labels that include dystonia 33389. Industrial and occupational dystonia is a commonly recognized complication of injury to the shoulder and arm and is the subject of the appended references. I am recommending botulinum injections for treatment of dystonia in this case. She had five months of relief with prior injection with less pain, improved dystonia and improved function in terms of activities of daily living.

[redacted] **Occupational Medicine. Health Consultant Utilization Review Assessment. Pages 402-411**
Prospective Treatment Request: Date of service: [redacted] Received: [redacted] 1) Botox injection Shoulder 2) Clonidine Patch 3) Lyrica 50mg 4. Oxycodone 5mg 5) Oxycontin 40mg 6. Ambien CR 6.25mg 7) Doxepin 25mg 8) Lidoderm 9) Wellbutrin 10) Repeat illegible treatment 11. Illegible treatment. Accepted body parts: Hands.
Decision: AUTHORIZE: 1) Clonidine Patch 2) Lyrica 50mg 3) Doxepin 25 mg. DENY: 4) Botox injection shoulder 5) Oxycodone 50 mg 6) Oxycontin 40 mg 7) Ambien CR 6.25 mg 8) Lidoderm 9) Wellbutrin 10) Repeat illegible treatment 11) Illegible treatment.

[redacted] **Neurology. Primary Treating Physician's Progress Report (PR-2). Pages 20-21**
Subjective: OxyContin was refused by Insurance. **Objective**: Spasm/dystonia. **Diagnoses**: 1) CRPS. 2) Depression. 3) Dystonia. **Treatment Plan**: Due for Botox. Rx Doxepin 25 mg, Lyrica 50 mg, MS Contin 30, Wellbutrin, HCTZ 25 mg, Soma 350 mg, Lidocaine, Lidoderm patch, Bupropion SR150 mg and Ambien 10 mg. **Disability Status**: P & S. The remaining notes are handwritten and illegible.

[redacted] **Neurology. Neurological Associates of West Los Angeles. Review of Systems. Page 161, 412**
Review of Systems: Constitutional: weight gain, fatigue, chills, sleepiness, insomnia. Musculoskeletal: muscle pain, atrophy, weakness, joint pain, stiffness, posture change. Neurological: memory loss, language problems, incoordination, gait. Chest/breasts: pain. ENT: swallowing problem. Genitourinary: hesitancy, incomplete, empty Psychiatric: mood, thoughts, anxiety, enjoyment, motivation, control, focus. Respiratory: pain. Skin: discoloration, sweating.

[redacted] **Anesthesiology and Pain Management. [redacted] Notice of Utilization Review Decision to the Provider. Pages 356-364**
Workers' compensation insurance carrier/employer requested utilization review. **Items requested:** 1) Appeal for repeat Botox injection to the neck. Qty: 1.00. 2) Appeal for repeat Botox injection to the shoulder. Qty: 1.00. 3) Ultrasonic guidance, intraoperative. Qty: 1.00. 4) Needle electromyography for guidance in conjunction with chemodenervation. Qty: 1.00. 5) Botox. Qty: 1.00. **Determination: NON-CERTIFIED.**

[redacted] **Neurology. Neurological Associates of [redacted] Interventional Neurology and Pain Medicine Report. Pages 24**
This report is filed in lieu of PR2 for today's date and is in response to denial for botulinum chemodenervation for this patient as authored by Dr. [redacted] and [redacted] Dr. [redacted] comments about the lack of documentation and the lack of need for botulinum are nonsense and only serves to delay required treatment.

[redacted] Neurology. Neurological Associates of [redacted] Review of Systems. Page 152

Review of Systems: Constitutional: weight gain, fatigue, sleepiness, insomnia. Musculoskeletal: muscle pain, atrophy, weakness, joint pain, stiffness, posture change. Neurological: memory loss, headache, incoordination. Chest/Breasts: pain. ENT: swallowing problem. Genitourinary: urine frequency, hesitancy, incomplete empty. Gastrointestinal: heartburn. Psychiatric: mood, thoughts, anxiety, enjoyment, motivation, control, focus. Skin: discoloration, rash, burns. Allergy/Immunology: rash

[redacted] Automobile Insurance Co – State Farm Letter to Ms. [redacted]. Page 10-11

An investigation into the motor vehicle accident involving [redacted] C. [redacted], which occurred on [redacted] concluded that the driver of her vehicle was at least 51% at fault due to traveling at an unsafe distance.

[redacted] – State Farm Letter to Ms. [redacted]. Page 8-9

On [redacted] Ms. [redacted] C. [redacted] was involved in a motor vehicle accident. Following an investigation, it was determined that the driver of her vehicle was at least 51% at fault for the accident, which occurred due to traveling at an unsafe distance.

[redacted] - Laboratory Report. Page 2

Labs: Opiates: Opiates Class - Screen: reactive, Codeine – Confirmation: negative, Morphine - Confirmation: negative, Hydrocodone - Confirmation: negative, Norhydrocodone - Confirmation: negative, Hydromorphone - Confirmation: negative, Oxycodone - Screen: reactive, **Oxycodone - Confirmation: positive, Noroxycodone - Confirmation: positive, Oxymorphone - Confirmation: positive, Fentanyl - Confirmation: positive, Fentanyl Metabolite - Confirmation: positive,** Methadone - Screen: negative Benzodiazepines: Benzodiazepines Class: negative Illicits: Cocaine Metabolite (BE) - Screen: negative, Cocaine Metabolite (BE) - Confirmation: negative, Heroin Metabolite - Confirmation: negative, Phencyclidine (PCP) - Screen: negative, Phencyclidine (PCP) - Confirmation: negative, cTHC - Screen: negative, cTHC - Confirmation: negative, MDMA - Confirmation: negative, MDA - Confirmation: negative, MDEA - Confirmation: negative, Methamphetamine - Confirmation: negative. Other: Amphetamines/MDMA - Screen: negative, Amphetamine - Confirmation: negative, Barbiturates - Screen: negative, **Zolpidem Metabolite - Confirmation: positive,** Ethyl Sulfate - Confirmation: negative, Ethyl Glucuronide - Confirmation: negative Specimen Validity: Creatinine 77.39

[redacted] **Neurology.** [redacted]

Neurology Report. Page 1

This is just a summary to help focus her treatment plan and approvals. She is a very straightforward case. She has chronic pain due to facet arthritis in the neck and back where she had temporary improvement with test injection. She is an excellent candidate for facet joint RF which should allow her to have better pain control and allow tapering of her opioids.

[redacted] **Orthopedic Surgery.** [redacted] **Orthopedic Associates. Doctor's First Report of Occupational Injury or Illness (PR-1) & Request for Authorization. Pages 62-68**

Subjective Complaints/Interim History: The patient is a [redacted] year-old female who presents with a complaint of cervical and lumbar spine pain. The patient works in [redacted] She has been TTD since [redacted] and is currently on Social Security Disability Insurance. The patient has severe lumbar spine pain that radiates down both legs and severe cervical spine pain that radiates down the left arm, sustained from lifting heavy objects after bilateral thumb surgery. **Vitals:** Wt. [redacted] **Diagnosis & Treatment Plan: 1) Other intervertebral disc degeneration, lumbar region.** XR Lumbar spine, 4 views, routine. Impression: Severe facet arthropathy at L4-S2. Left convex 20 degree scoliosis at L2-L5. How to access health information online using patient portal and 3rd party apps. **2) Other cervical disc degeneration, high cervical region.** XR cervical spine, 4 views, routine. Impression: Severe degenerative disc disease at C5-C6 and spondylolisthesis at C4-C5. Poor sagittal balance. **3) Other cervical disc displacement, mid-cervical region, unspecified level 4) Other intervertebral disc displacement, lumbar region 5) Other spondylosis with radiculopathy, cervical region 6) Other spondylosis with radiculopathy, lumbar region 7) Spinal stenosis, lumbar region without neurogenic claudication 8) Stenosis of cervical spine region 9) Facet arthropathy, lumbar 10) Facet arthropathy, cervical 11) Other secondary scoliosis, lumbar region Impression:** Disc degeneration of the cervical and lumbar spine; herniated nucleus pulposus; cervical and lumbar radiculopathy, facet arthropathy, stenosis, spondylolisthesis at C4-C5, spondylosis, scoliosis. **Plan:** The patient has severe degenerative disc disease at C5-C6 with acute exacerbation of radicular pain along the C6 nerve root. The patient reports that a prior cervical injection performed outside of this facility helped to improve her cervical spine pain. The patient needs an MRI of the cervical spine for a definitive diagnosis. The patient has failed conservative treatment including physical therapy, NSAIDS, pain medications, rest, and modified activities. I recommend a cervical epidural steroid injection at C6-C7 to calm the pain followed by six sessions of post-injection physical therapy for cervical traction. The patient has severe facet arthropathy at L4-S1 with acute exacerbation of radicular pain along the S1 nerve root. I recommend a lumbar epidural steroid injection at L5-S1 to calm the pain followed by six sessions of physical therapy for trunk stabilization. Please accept this report as my formal request for authorization for: 1) an MRI of the cervical spine for a definitive diagnosis. 2) a cervical epidural steroid injection at C6-C7 to calm the pain followed by six sessions of post-injection physical therapy for cervical

traction. 3) an MRI of the lumbar spine for a definitive diagnosis. 4) a lumbar epidural steroid injection at L5-S1 to calm the pain followed by six sessions of physical therapy for trunk stabilization. 5) a Far-Infrared Heating Pad to increase the flexibility of collagen tissue, reduce inflammation, decrease joint stiffness, relieve muscle spasms, reduce pain, increase range of motion, and promote healing in the affected area. **Work Status:** The patient is TTD from [redacted]

[redacted] **Orthopedic Surgery. [redacted] Orthopedic Associates. Primary Treating Physician's Progress Report (PR-2). Pages 53-57**

Subjective Complaints/Interim History: The patient is a [redacted]-year-old female who presents for a follow-up for cervical and lumbar spine pain. The patient has severe lumbar spine pain that radiates down both legs and severe cervical spine pain that radiates across both shoulders. **Vitals:** [redacted] lbs. **Diagnosis & Treatment Plan: 1) Other cervical disc degeneration, high cervical region.** PR-2 Report (WC002), routine. How to Access Health Information Online Using Patient Portal and 3rd Party Apps. **2) Other intervertebral disc degeneration, lumbar region 3) Other cervical disc displacement, mid-cervical region, unspecified level 4) Other intervertebral disc displacement, lumbar region 5) Other spondylosis with radiculopathy, cervical region 6) Other spondylosis with radiculopathy, lumbar region 7) Stenosis of cervical spine region 8) Spinal stenosis, lumbar region without neurogenic claudication 9) Facet arthropathy, lumbar 10) Facet arthropathy, cervical 11) Other secondary scoliosis, lumbar region 12) Spondylolisthesis of cervical region. Impressions:** Disc degeneration of the cervical and lumbar spine; herniated nucleus pulposus, cervical and lumbar radiculopathy, facet arthropathy, stenosis, spondylolisthesis at C4-C5, spondylosis. **Plan:** The patient has severe degenerative disc disease at C5-C6 with radicular pain along the bilateral C6 nerve root. Her cervical epidural steroid injection and MRI of the cervical spine are pending. The patient has 5 degree scoliosis and radicular pain along the SI nerve root. Her lumbar epidural steroid injection and MRI of the lumbar spine are pending. The patient will schedule her injections once approved. The patient may continue with their current regimen of medication as needed for pain management. I will see the patient back for a follow-up visit when the results of the MRI are available. **Work Status:** The patient is TTD from [redacted] to [redacted]

[redacted] **Orthopedic Surgery. [redacted] Orthopedic Associates. Primary Treating Physician's Progress Report (PR-2). Pages 47-52**

Subjective Complaints/Interim History: The patient is a [redacted]-year-old female who presents for a follow-up for cervical and lumbar spine pain. **Procedures:** 1) Injection of trigger finger [redacted] Injection of trigger finger. [redacted] **Diagnosis and Treatment Plan: 1) Other cervical disc degeneration, high cervical region.** PR-2 Report (WC002) routine. How to Access Health Information Online using Patient Portal and 3rd Party Apps. **2) Facet arthropathy, cervical 3) Facet arthropathy, lumbar 4) Other**

spondylosis with radiculopathy, cervical region 5) Other spondylosis with radiculopathy, lumbar region 6) Other cervical disc displacement, mid-cervical region, unspecified level 7) Spinal stenosis, lumbar region without neurogenic claudication 8) Stenosis of cervical spine region 9) Trigger thumb, left thumb. Injection, cortisone, routine. Injection of lidocaine 1%. Syringe with needle, sterile 5 cc or greater, each, routine. Injection of trigger finger, routine. Procedure: the left thumb flexor tendon sheath was injected with 10 mg of Kenalog mixed with a local anesthetic. **10) Trigger thumb, right thumb.** Injection, cortisone, routine. Injection of lidocaine 1%. Syringe with needle, sterile 5 cc or greater, each, routine. Injection of trigger finger, routine. Procedure: the left thumb flexor tendon sheath was injected with 10 mg of Kenalog mixed with a local anesthetic. **11) Overweight for height.** Lifestyle education regarding diet. **Impression:** Disc degeneration of the cervical and lumbar spine, herniated nucleus pulposus; cervical and lumbar radiculopathy, facet arthropathy, stenosis, spondylosis; bilateral thumb trigger finger. **Plan:** The patient has severe degenerative disc disease at C5-C6 with complete collapse of disc height. She has an acute exacerbation of radicular pain along the bilateral C6 nerve root distribution. She needs an updated MRI of the cervical spine for a definitive diagnosis due to worsening symptoms. Her last MRI was in [redacted] I recommend a cervical epidural steroid injection at C6-C7 to calm the pain followed by six sessions of post-injection physical therapy for cervical traction. Additionally, she has degenerative disc disease at L5-S1 and severe facet arthropathy at L4-S1. I recommend a lumbar epidural steroid injection at L5-S1 to calm the pain followed by six sessions of physical therapy for trunk stabilization. Furthermore, she has bilateral thumb trigger fingers. I recommend a local injection into both thumb flexor tendon sheaths. **Work Status:** The patient is TTD from [redacted]

[redacted] **Orthopedic Surgery. [redacted] Orthopedic Associates. Progress Notes. Pages 41-46**

History of Present Illness: The patient is a [redacted]-year-old female who presents for a follow-up for cervical and lumbar spine pain. **Assessment/Plan: 1) Other Intervertebral disc degeneration, lumbar region.** PR-2 Report (WC002); Routine. How to Access Health Information Online using Patient Portal and 3rd Party Apps. **2) Other spondylosis with radiculopathy, lumbar region. 3) Spinal stenosis, lumbar region without neurogenic claudication. 4) Facet arthropathy, lumbar. 5) De Quervain's tenosynovitis, right.** Injection, trigger point muscle, 1 or more muscles; routine. Methylprednisolone acetate, 40 mg; routine. Lidocaine injection; routine. **6) Overweight for height. Lifestyle education regarding diet; routine. Impression:** Disc degeneration of the lumbar spine; lumbar radiculopathy; facet arthropathy; stenosis; spondylosis. **Plan:** The patient's lumbar spine pain is quite severe. She needs an updated MRI of the lumbar spine for a definitive diagnosis. The MRI for the lumbar spine is pending authorization. She needs a lumbar epidural steroid injection. The injection is pending authorization. She will schedule the injection accordingly once it has been approved. The patient has cervical degenerative disc disease at C5-C6 with kyphosis. She needs an MRI of the cervical spine for a definitive diagnosis. The MRI for the cervical spine is pending authorization. She needs a cervical epidural steroid injection. The injection is pending authorization. She will schedule the

injection accordingly once it has been approved. The patient is to progress with ambulation as tolerated. She received a local injection today and tolerated it well. I will see the patient back for a follow-up visit when the results of the MRI are available. **Procedure:** Performed trigger point injection under sterile conditions, 1 cc of Depo-Medrol 40mg, 1 cc of Lidocaine 1% was injected into the right De Quervain's. The patient tolerated it well. **Work Status:** The patient is TTD from [redacted]

[redacted] **- Laboratory Report. Pages 1-8**

Labs: Lipid Panel with Reflex to Direct LDL: **Cholesterol, total: 229 (H), HDL Cholesterol 49 (L), Triglycerides 259 (H), LDL Cholesterol 140 (H),** Chol/HDLC Ratio 4.7, **Non HDL Cholesterol 180 (H)** Comprehensive Metabolic Panel: Glucose 87, Urea Nitrogen (BUN) 19, Creatinine 0.85, EGFR 78, Sodium 141, Potassium 3.9, Chloride 103, Carbon Dioxide 28, Calcium 9.9, Protein Total 7.5, Albumin 4.5, Globulin 3.0, Albumin/Globulin Ratio 1.5, Bilirubin Total 0.3, Alkaline Phosphatase 134, AST 27, ALT 28. Hemoglobin A1C: **Hemoglobin A1C 6.2 (H)** PTH, Intact: Parathyroid Hormone, Intact: 32, Calcium 9.9, Vitamin D, 25-OH, Total, IA 33, Magnesium 2.2, Phosphate (AS Phosphorus) 4.3, Uric Acid 6.2, Immunoglobulin E 8, LD 178, TSH 2.80, T4 Free 1.0, T3 Total 85 Sed Rate by Modified Westergren: **Sed Rate by Modified Westergren 38 (H).** CBC: WBC 10.7, RBC 4.51, Hemoglobin 13.3, Hematocrit 39.0, MCV 86.5, MCH 29.5, MCHC 34.1, RDW 13.2, Platelet Count 295, MPV 10.3 Urinalysis: Color: yellow, Appearance: clear, Sp. Gravity: 1.008, PH: 8.0, Glucose: negative, Bilirubin: negative, Ketones: negative, Occult blood: negative, Protein: negative, Nitrite: negative, Leukocyte Esterase: negative, WBC: none seen, RBC: none seen, Squamous epithelial Cells: none seen, Bacteria: none seen, **Amorphous Sediment: many,** Hyaline cast: none seen Iron and Total Iron Binding Capacity: Iron Total 74, Iron Binding Capacity 364, % Saturation 20, Ferritin 54, Vitamin B12 613 ANA Screen, IFA, W/ REFL Titer and Pattern: **ANA Screen, IFA: Positive, ANA Titer 1:40 (H),** Ana Pattern: Nuclear, speckled. Rheumatoid Factor: Rheumatoid Factor: <14. C-Reactive Protein: **C-Reactive Protein 12.9 (H)** Cyclic Citrullinated Peptide (CCP) AB (IGG): Cyclic Citrullinated Peptide (CCP) AB (IGG) <16

[redacted] **Orthopedic Surgery. [redacted] Orthopedic Associates. Progress Notes. Pages 27-32**

History of Present Illness: The patient is a [redacted]-year-old female who presents for a follow-up for cervical and lumbar spine pain. She states that she has continuing severe cervical and lumbar spine pain. **Diagnostic Studies:** MRI, Lumbar Spine [redacted] Degenerative disc disease at L3–L5. MRI, Cervical Spine [redacted]: Severe degenerative disc disease and kyphosis at C5–C6. Pathology Report [redacted]: Interpreted by Dr. [redacted]: Chronic gastritis. No Helicobacter pylori organisms, intestinal metaplasia, dysplasia, or malignancy identified. Benign squamous epithelium with no significant lesion. No evidence of eosinophilic esophagitis, dysplasia, or malignancy identified. **Assessment/Plan: 1) Other intervertebral disc degeneration, lumbar region.** PR-2 Report (WC002); routine. How to Access Health Information Online using Patient Portal and 3rd Party Apps. **2) Other intervertebral disc displacement, lumbar region. 3) Facet arthropathy, cervical. 4)**

Spinal stenosis, lumbar region without neurologic claudication. 5) Other spondylosis with radiculopathy, lumbar region. 6) Spondylolisthesis of cervical region. 7) Overweight for height. Impression: Disc degeneration of the cervical and lumbar spine; cervical and lumbar radiculopathy; facet arthropathy; stenosis; spondylolisthesis at C4-CS; spondylosis. **Plan:** The patient has cervical kyphosis at C4-C6. I recommend a cervical epidural steroid injection at C5-C7 to calm the pain followed by six sessions of post-injection physical therapy for cervical traction. She needs an MRI of the cervical spine for a definitive diagnosis. She has degenerative disc disease at L2-L4. I recommend a lumbar epidural steroid injection at L4-L5 to calm the pain followed by six sessions of postinjection physical therapy for trunk stabilization. She needs an MRI of the lumbar spine for a definitive diagnosis. Please accept this report as my formal request for authorization for: 1) A cervical epidural steroid injection at C6-C7 to calm the pain followed by six sessions of post-injection physical therapy for cervical traction. 2) An MRI of the cervical spine for a definitive diagnosis. 3) A lumbar epidural steroid injection at L4-L5 to calm the pain followed by six sessions of postinjection physical therapy for trunk stabilization. 4) An MRI of the lumbar spine for a definitive diagnosis. **Work Status:** Retired.

[redacted] **MRI of Cervical Spine. Pages 3-4**

Impression: 1) Subtle focus of increased signal within the spinal cord at level of C6 which may reflect myelopathy in a proper clinical setting. 2) Grade I anterior listhesis of C3 on C4. Also seen is Grade I posterior listhesis of C5 on C6. 3) Mild reversal of the cervical lordosis. Concomitant mild dextroscoliosis of the cervical spine is seen. 4) Modic type II endplate degenerative changes seen at C4 down through C6. 5) Schmorl's node at C5 down through C7. 6) Mild loss of vertebral body height of C5 and C6. 7) Mild edema of the endplates of C4 down through C7 likely related to degenerative changes. 8) Moderate to severe disc desiccation involving C2-C3 down through C7-T1. Mild to moderate loss of disc height seen at C5-C6 and C6-C7. 9) Right perineural cyst is identified at T2-T3. 10) C2-C3. A disc protrusion is identified. Disc deformity measures 2.3 mm. 11) C3-C4. Anterolisthesis of C3 on C4 with associated uncovering of the disc and a disc protrusion is identified. Concurrent bilateral uncovertebral joint hypertrophy is seen. Also noted is bilateral facet joint arthrosis. There is moderate bilateral neural foraminal narrowing. Associated indentation of bilateral exiting nerve root is seen. Disc deformity measures 2.4 mm. 12) C4-C5. A disc protrusion is identified. Disc material causes mild spinal canal narrowing. There is no abnormal signal within the spinal cord at this level. Concurrent bilateral uncovertebral joint hypertrophy is seen. Also noted is left facet joint arthrosis. There is moderate left neural foraminal narrowing. Associated indentation of left exiting nerve root is seen. Disc deformity measures 2.5 mm. 13) C5-C6. A disc protrusion is identified. Disc material abuts the anterior aspect of the spinal cord and causes mild spinal canal narrowing. There is no abnormal signal within the spinal cord at this level. Concurrent bilateral uncovertebral joint hypertrophy is seen. Also noted is bilateral facet joint arthrosis. There is moderate bilateral neural foraminal narrowing. Associated indentation of bilateral exiting nerve root is seen. Annular fissure is identified. Disc deformity measures 2.6 mm. 14) C6-C7. A disc protrusion is identified. Disc material abuts the anterior aspect of the

spinal cord and causes mild spinal canal narrowing. There is subtle increased signal within the spinal cord at this level which may reflect myelopathy in a proper clinical setting. Concurrent bilateral uncovertebral joint hypertrophy is seen. Also noted is bilateral facet joint arthrosis. There is mild to moderate bilateral neural foraminal narrowing. Associated abutment on bilateral exiting nerve root is seen. Annular fissure is identified. Disc deformity measures 3.3 mm.

[redacted] MRI of Lumbar Spine. Pages 12-13

[redacted] MRI of Lumbar Spine. Pages 1-2

Impression: 1) Modic type II endplate degenerative changes seen at S1. 2) Moderate disc desiccation involving T12-L1 down through L5-S1. Mild loss of disc height is seen at L3-L4. 3) Subcutaneous tissue edema of the lower back at L1 down through sacral level. 4) L1-L2. A disc protrusion is identified with prominent right central component. Disc material causes mild spinal canal narrowing. There is associated mild right neural foraminal narrowing. There is an abutment on right exiting nerve root. Annular fissure is identified. Disc deformity measures 2.4 mm. 5) L2-L3. A disc protrusion is identified. Disc material causes mild spinal canal narrowing. Hypertrophy of the bilateral facet is seen. There is associated mild bilateral neural foraminal narrowing. Concurrent mild bilateral lateral recess stenosis is seen. Disc deformity measures 2.7 mm. 6) L3-L4. A disc protrusion is identified. Disc material causes mild spinal canal narrowing. Hypertrophy of the bilateral facet is seen. There is associated mild to moderate bilateral neural foraminal narrowing. Concurrent moderate bilateral lateral recess stenosis is seen. There is abutment on bilateral exiting nerve root. Associated abutment on bilateral transiting nerve root is noted. Annular fissure is identified. Disc deformity measures 3.2 mm. 7) L4-L5. A disc protrusion is identified. Disc material causes mild spinal canal narrowing. Hypertrophy of the bilateral facet is seen. There is associated mild to moderate bilateral left greater than the right neural foraminal narrowing. Concurrent mild to moderate bilateral left greater than the right lateral recess stenosis is seen. There is abutment on left exiting nerve root. Associated abutment on left transiting nerve root is noted. Annular fissure is identified. Disc deformity measures 2.3 mm. 8) L5-S1. A disc protrusion is identified. Disc material causes mild spinal canal narrowing. Hypertrophy of the bilateral facet is seen. There is associated mild bilateral neural foraminal narrowing. Concurrent mild bilateral lateral recess stenosis is seen. Disc deformity measures 2.6 mm.

[redacted] Orthopedic Surgery. [redacted] Orthopedic Associates. Progress Notes. Pages 21-26, 35-40

History of Present Illness: The patient is a [redacted]year-old female who presents for a follow-up for cervical and lumbar spine pain. She states that she has continuing cervical and lumbar spine pain. Her lower back pain is worse than her cervical spine pain. She reports having pain across her lumbar spine radiating to both of her hips. She has pain across her shoulders. The patient has severe degenerative disc disease with neuroforaminal stenosis at CS-C6 and

loss of cervical lordosis. Her activities of daily life are becoming more difficult. Her lumbar pain and neurogenic claudication are only worsening. All of her activities of daily life are difficult and limited. We had a long 45-minute discussion about the MRI images, diagnosis, and treatment options. The patient rates their overall level of pain to be 8/10. There are no changes in medical history, surgical history, medication, allergies, and review of systems since the last visit. **Vitals:** Wt. [redacted] lbs. **Assessment/Plan: 1) Other cervical disc degeneration, high cervical region.** PR-2 Report (WC002); Routine. How to Access Health Information Online using Patient Portal and 3rd Party Apps. **2) Other intervertebral disc degeneration, lumbar region. 3) Other cervical disc displacement, mid-cervical region, unspecified level 4) Other intervertebral disc displacement, lumbar region. 5) Other spondylosis with radiculopathy, lumbar region. 6) Other spondylosis with radiculopathy, cervical region. 7) Stenosis of cervical spine region . 8) Spinal stenosis, lumbar region without neurogenic claudication. 9) Facet arthropathy, cervical 10) Facet arthropathy, lumbar. 11) Overweight for height.** Lifestyle education regarding diet. **Impressions:** Disc degeneration of the cervical and lumbar spine; cervical and lumbar radiculopathy; facet arthropathy; stenosis; spondylosis. **Plan**: The patient has severe degenerative disc disease at C5-C6 and moderate degenerative disc disease at C4-C5/C6-C7. I recommend a cervical epidural steroid injection at C6-C7 to calm the pain followed by six sessions of post-injection physical therapy for cervical traction. She has lumbar degenerative disc disease and facet arthropathy. The lumbar epidural steroid injection continues to be denied. She needs a pulse radiofrequency unit for the lumbar spine. I will see the patient back in 4-6 weeks for a follow-up visit. Please accept this report as my formal request for authorization for: 1) A cervical epidural steroid injection at C6-C7 to calm the pain followed by six sessions of post-injection physical therapy for cervical traction. 2) A pulsed radiofrequency unit for the lumbar spine. **Work Status:** The patient is on Social Security Disability Insurance.

[redacted] Depo Transcripts of Dr. [redacted] Deposition Transcript of [redacted] Pages 1-31

Pages 7-9 - Dr. [redacted] whose specialty is neurology and interventional pain medicine, confirmed under oath that he has been treating [redacted] since approximately [redacted]. He stated that Ms. [redacted] was referred to him by another neurologist, Dr. [redacted] from the [redacted] Clinic. Dr. [redacted] clarified that he operates on a cash-only basis, does not take insurance, and is not a workers' compensation provider, so he assumes that Ms. [redacted] has been paying out of pocket. He also indicated that his office staff likely sent medical reports to the State Compensation Insurance Fund, though he personally does not handle that aspect of care. He noted that he has eight volumes of medical records on Ms. [redacted], underscoring the length and complexity of her treatment history.

Pages 9-12: Dr. [redacted] testified that Ms. [redacted] was referred by Dr. [redacted] due to complaints involving her neck, shoulder, and left upper extremity, primarily affecting her left arm. Dr. [redacted] explained that Ms. [redacted] has experienced

chronic neck and back pain, along with pain radiating down her left leg. While he was unsure whether her symptoms were symmetrical, his records suggested one side was more affected than the other. Although initially there was discussion regarding bilateral thumb complaints, Dr. [redacted] clarified that his treatment focused more on upper extremity issues, particularly those associated with thoracic outlet syndrome, as Dr. [redacted] had intended. He noted that Ms. [redacted] presented with widespread pain from the start and that her current predominant issues are disc and facet-related neck and back pain with some radicular features.

Pages 12-15: Dr. [redacted] testified that he could not determine whether the conditions he currently treats [redacted] for are related to any of her claimed industrial injuries, due to the length of time that has passed and the complexity of her case. He noted that she is of advanced age, suffers from chronic pain and disability, and he did not review all eight volumes of her records prior to the deposition. Dr. [redacted] stated that her current treatment is primarily limited to medications due to financial constraints. He expressed concern over her use of multiple opiates and painkillers and indicated that she has had issues with her pain regimen, including recent gastritis possibly caused by NSAIDs. Dr. [redacted] described Ms. [redacted] as grossly overweight and significantly disabled, noting she is now on Ozempic. He recommended facet radiofrequency as a more direct and effective treatment for her chronic facet pain and noted she previously experienced some relief from facet test injections. He emphasized the need to transition her off opiates and considered radiofrequency a viable option, though costly if paid out of pocket. He offered to refer her to programs that could potentially provide the treatment at a lower cost.

Pages 15-17: Dr. [redacted] confirmed that [redacted] continues to be a cash-paying patient. He acknowledged that another medical evaluator suggested an inpatient drug treatment program in [redacted] which he agreed could be worth trying, especially since outpatient efforts to taper her off opiates have not been successful. However, he expressed skepticism about its effectiveness due to her ongoing issues with multiple disc levels and facet joints, indicating that without targeted intervention for these physical conditions, the success of drug treatment alone would be limited. He emphasized the need for definitive treatment and noted that while financial support could make such a program possible, it may not address the root of her pain. Dr. [redacted] stated that he does not believe Ms. [redacted] is capable of working, citing her severe physical limitations, dependence on opiates, difficulty concentrating, inability to sit or function for extended periods, and trouble driving. From a medical standpoint, he described her as profoundly disabled. He was not certain about the extent of her current in-home support services from the [redacted] but expressed doubt about her ability to perform household tasks. Dr. [redacted] was unsure whether he had filled out paperwork to certify her for such support, stating that he only reviewed his recent notes and not all eight volumes of her records before the deposition.

Pages 17-19: Dr. [redacted] confirmed that his current medical treatment of [redacted] primarily involves prescribing a range of medications, including opiates. Her regimen

includes muscle relaxers, pain modifiers such as Lyrica and Trokendi, Lidoderm patches, sleeping agents like Seroquel, and opioids. He stated she is on three opioid formulations: a fentanyl patch, oxymorphone, and Xtampza. Attempts to transition her to buprenorphine failed, and Levorphanol was not tolerated. Dr. [redacted] described her as very compliant, with straightforward drug tests and no signs of addictive behavior. He emphasized she is not an addict, but someone functioning marginally on pain medications. He acknowledged that fentanyl can affect a patient's physical and mental capabilities but noted they adjust dosages to balance pain control with maintaining function. While her current treatment is not ideal, he supports exploring inpatient treatment if financially possible, recognizing it may not be successful but is still worth trying.

Pages 20-21: Dr. [redacted] testified that he is not offering any opinions regarding causation related to her condition, particularly in connection to her history of numerous motor vehicle accidents. He stated he has not reviewed outside records such as prior workers' compensation claims or accident reports and does not intend to, as his role is strictly that of a treating physician. He acknowledged that Ms. [redacted] had been in several motor vehicle accidents, including a major one in [redacted] and others dated [redacted]; [redacted] However, his current chart begins in [redacted], and he did not review the earlier volumes for this deposition. While he does not recall any specific conversations with Ms. [redacted] about these accidents and cannot confirm whether they were disclosed to other physicians, he conceded that, based on her extensive history of trauma, it would be reasonable to assume that these incidents contributed to her current condition. He described his position as "suboptimal," having been asked to continue treating her without serving in an expert capacity. Dr. [redacted] added that from a practical standpoint, the accumulation of trauma could plausibly play a role in her medical state.

Pages 22-25: Dr. [redacted] testified regarding the IHSS (In-Home Supportive Services) documentation and process related to his patient, [redacted]. He explained that whether the certification is sent to IHSS directly or to attorneys depends on the patient's request. Although he could not recall exactly when he began certifying Ms. [redacted] for IHSS, he stated that her condition is chronic and has remained largely unchanged for over [redacted] years, suggesting it is a long-term issue dating back as far as [redacted] He does not necessarily document the IHSS certification in his reports but maintains copies of forms in the chart and provides them to the patient. He reviewed a [redacted] notice from IHSS indicating she requires assistance with transportation to medical appointments and speculated this was due to difficulty getting to the office, as she lives far away and often struggles with mobility. He noted that she is seen monthly due to her use of controlled substances. Dr. [redacted] stated he could not imagine she is able to drive, and confirmed she has significant limitations in lifting, carrying, bending, and twisting, and that transportation and vehicle access are likely very difficult for her. He would not recommend she lift more than 10 pounds and observed that she always arrives carrying only light items like a small purse or backpack. Regarding ambulation, he noted she does not require someone to walk with her, but moves very slowly and, due to her inactivity, has gained significant weight.

Pages 25-26: Dr. [redacted] confirmed that his patient, [redacted], is currently on a weight reduction program using Ozempic, which may assist her mobility. He estimated that her walking capacity is likely limited to a short distance—perhaps a few blocks. She completes paperwork on her own but does so slowly. Dr. [redacted] explained that her need for assistance with meal preparation includes difficulties with tasks such as washing dishes, cutting, cooking, and using utensils due to limitations in bending, leaning, reaching, grasping, and lifting. He stated that general housekeeping would also be problematic, including vacuuming, cleaning, making beds, or opening windows. Taking out the trash would also likely be difficult, especially if it exceeds 10 pounds. He noted that she could perhaps handle lightweight items, such as rolling a small trash bin or dropping a light bag into a dumpster.

Pages 26-27: Dr. [redacted] acknowledged that [redacted] had a history of taking various medications, including rare use of Vicodin in [redacted] Ambien, and Ultram following a thumb surgery in [redacted] and later additional Vicodin prescribed by Dr. [redacted] A [redacted] report also noted the suspected presence of opiate-induced hyperalgesia. Dr. [redacted] testified that he believed the treatment, including prolonged use of these medications, may have contributed to a worsening of her condition. He expressed a strong desire to wean her off the medications, acknowledging that multiple attempts and substitutions had been unsuccessful. He supported the idea of a six-to-eight-week detox rehabilitation program, stating that while he was not highly optimistic about its success without definitive treatment, he would still support it if resources were available.

[redacted] **Orthopedic Surgery. [redacted] Orthopedic Associates. Progress Notes. Pages 1-6**

History of Present Illness: The patient is a [redacted]-year-old female who presents for a follow-up for cervical and lumbar spine pain. **Diagnostic Studies:** Pathology Report [redacted] Interpreted by Dr. Bishop: Chronic gastritis. No helicobacter pylori organisms, intestinal metaplasia, dysplasia, or malignancy identified. Benign squamous epithelium with no significant lesion. No evidence of eosinophilic esophagitis, dysplasia, or malignancy identified. **Assessment and Plan: 1) Other intervertebral disc degeneration, lumbar region.** PR-2 report (WC002); routine. How to Access Health Information Online using Patient Portal and 3rd Party Apps. **2) Other cervical disc degeneration, high cervical region. 3) Other spondylosis with radiculopathy, cervical region. 4) Other spondylosis with radiculopathy, lumbar region. 5) Facet arthropathy, lumbar. 6) Facet arthropathy, cervical. 7) Overweight for height.** Lifestyle education regarding diet; routine. **Impressions:** Disc degeneration of the cervical and lumbar spine; cervical and lumbar radiculopathy; facet arthropathy; stenosis. **Plan:** The patient has degenerative disc disease at C5-C7. She would benefit from a cervical epidural steroid injection. The patient has lumbar facet disease. I recommend a lumbar facet block to calm the pain followed by six sessions of postinjection physical therapy for trunk stabilization. She is taking medications per her pain management specialist. She needs a radiofrequency ablation to be

done with her pain management specialist. The patient is to progress with ambulation as tolerated. I will see the patient back in 4-6 weeks for a follow-up visit. Please accept this report as my formal request for authorization for: 1) A lumbar facet block to calm the pain followed by six sessions of postinjection physical therapy for trunk stabilization. 2) A radiofrequency ablation to be done with her pain management specialist. **Work Status:** Retired.

[redacted] **Health. Worker's Compensation Orthopedic Progress Report (PR-2). Pages 15-20**

History of Present Illness: [redacted] is a [redacted] year-old female who presents today for a follow-up for cervical and lumbar spine pain. **Assessment/Plan: 1) Other intervertebral disc degeneration, lumbar region with discogenic back pain only.** Case request operating room. **2) Lumbar facet arthropathy. 3) Facet arthropathy, cervical. Impressions:** Disc degeneration of the lumbar spine: herniated nucleus pulposus; lumbar radiculopathy; facet arthropathy; stenos; spondylosis. **Plan:** The patient has degenerative disc disease at L4-S1 with acute exacerbation of radicular pain along the right L5 nerve root distribution. The patient has failed six weeks of conservative treatment including physical therapy, NSAIDS, pain medications, rest, and modified activities. A six week physical therapy program for trunk stabilization exercises, extremity postural and strengthening exercises, and aerobic conditioning were unable to treat intractable pain. The patient is losing functionality and is having difficulty with activities of daily life secondary to the pain. The patient satisfies all MTUS guidelines for injection. I recommend a lumbar epidural steroid injection at L4-L5 to calm the pain followed by six sessions of postinjection physical therapy for trunk stabilization. She has had no prior injection. I will see the patient back in 4-6 weeks for a follow-up visit. Please accept this report as my formal request for authorization for: 1) A lumbar epidural steroid injection at L4-L5 to calm the pain followed by six sessions of postinjection physical therapy for trunk stabilization. **Work Status:** Retired.

[redacted] **Orthopedic Surgery.** [redacted] **Worker's Compensation Orthopedic Progress Report (PR-2). Pages 8-11**

History of Present Illness: [redacted] is a [redacted] year-old female who presents today for a follow-up for cervical spine and lumbar spine pain. **Plan:** The patient has spondylolisthesis at C4-C5 and degenerative disc disease at C5-C7. The cervical epidural steroid injection was authorized. However, she needs authorization for use of Congress Medical Surgery Center. If her pain persists, she will need a total disc replacement at C4-C5 with an anterior cervical discectomy and fusion at C5-C7. Additionally, she has central and foraminal stenosis at L3-S1. There is bilateral lower extremity radicular pain, left worse than right. There is clear sensory and motor loss with nerve tension, consistent with acute radiculopathy. The patient has failed six weeks of conservative treatment including physical therapy, NSAIDS, pain medications, rest, and modified activities. A six week physical

therapy program for trunk stabilization exercises, extremity postural and strengthening exercises, and aerobic conditioning were unable to treat intractable pain. The patient is losing functionality and is having difficulty with activities of daily life secondary to the pain. The patient satisfies all MTUS guidelines for injection. I recommend a lumbar epidural steroid injection at L4-L5 to calm the pain followed by six sessions of postinjection physical therapy for trunk stabilization. I will see the patient back in 4-6 weeks for a follow-up visit. Please accept this report as my formal request for authorization for: 1) Use of Congress Medical Surgery Center. 2) A lumbar epidural steroid injection at L4-L5 to calm the pain followed by six sessions of postinjection physical therapy for trunk stabilization.
Work Status: Retired.

SURVEILLANCE VIDEOS:

[redacted], [redacted]. [redacted] **Surveillance Video**
[redacted]
Ms. [redacted] is spotted waiting in line at a counter.

[redacted], [redacted]. [redacted] **Surveillance Video**

[redacted]
Ms. [redacted] can be seen approaching a gray vehicle and getting into the driver's seat.

[redacted]
After exiting her vehicle and stopping to check something in her bag, Ms. [redacted] is seen making her way to the bank. She was seen exiting the bank a short while later, walking to her car, and getting into the driver's seat.

[redacted]
Ms. [redacted] is seen carrying a few papers as she makes her way to the post office entrance; she needs to pick up some papers that are falling before she can enter.

[redacted]
Ms. [redacted] is seen getting out of the driver's seat of a gray sedan while holding a few objects. A few minutes later, she can be seen crossing the street with a few items before returning.

[redacted], [redacted] **Surveillance Video**

[redacted]

Ms. [redacted] has been observed carrying some flagpoles as she walks around.

Video Timestamp: 1:28-2:12
Date & Time: [redacted]2:50 PM-2:51 PM
Ms. [redacted] is observed outside her residence, pulling a large residential trash bin.

[redacted]

Ms. [redacted] is seen carrying a metal container and a bottle of water across the street. She then bends over and places something on the ground. After that, she crosses the street again and makes her way home.

[redacted], [redacted], [redacted] **Surveillance Video**

[redacted]

It shows Ms. [redacted] picking up something off the ground quite slowly. She seems to have trouble bending, which makes her rub her back. No assistive device is visible, and the action is completed independently.

[redacted], [redacted] **Surveillance Video**

[redacted]

Ms. [redacted] is seen collecting something from her front yard before slowly making her way back into her home.

[redacted], [redacted], [redacted] **Surveillance Video**

[redacted]

Ms. [redacted] is seen making her way to her car and waiting for a few minutes before driving.

[redacted]

Ms. [redacted] is observed exiting her vehicle and independently walking across the street toward [redacted] Medical Associates. She is unaccompanied and does not utilize any assistive devices.

[redacted]
Ms. [redacted] is observed crossing the street and walking unassisted toward her parked vehicle. She then enters the driver's seat with deliberate movements. After sitting inside the car for several minutes, she drives away.

[redacted]
Ms. [redacted] is observed exiting her vehicle and walking at a slow, steady pace toward her residence.

[redacted] **Surveillance Video**

[redacted]
Ms. [redacted] is seen talking to someone inside a black vehicle for approximately eight minutes before turning to gaze at something in her front yard. After that, a man she spoke with follows her as she walks normally back to her house.

[redacted]
Ms. [redacted] is seen standing outside the driver's seat a few minutes later, speaking briefly with someone inside the vehicle before making her way back to her home.

[redacted] **Surveillance Video**

[redacted]
Ms. [redacted] is observed simply walking around.

[redacted] **Surveillance Video**

[redacted]
Ms. [redacted] is observed walking along the side of the road toward what appears to be a residential property. She is holding a phone. She walks independently without the use of assistive devices. There appears to be mild irregularity in her gait.

[redacted] **Surveillance Video**

[redacted]

[redacted]

Ms. [redacted] is seen sitting in the front seat of a white car appearing comfortable and relaxed.

[redacted]

Ms. [redacted] is seen returning to the white car and sitting in the front seat with the front seat door open, holding some papers. Her movements appear fluid and unrestricted.

[redacted]

Ms. [redacted] is seen walking forward after exiting a white car.

[redacted]

Ms. [redacted] is shown standing on a shelf, browsing a number of vinyl records before choosing one. She demonstrates the ability to stand and inspect items without visible discomfort or limitation.

[redacted]

Ms. [redacted] and a man are spotted leaving a store together and making their way to a white vehicle. Her walking pattern continues to appear steady and unrestricted.

[redacted]

Inside a white sedan, Ms. [redacted] is seen sitting in the front seat and conversing with the man who's driving.

[redacted]

Ms. [redacted] can be seen standing and looking at some framed artwork. Then, she went to a nearby shelf while talking to someone. She may also be seen inspecting a few toys before going to the store's clothes section and finally to the checkout counter.

[redacted]

[redacted]

Ms. [redacted] is seen walking unrestricted outside the store.

[redacted]

[redacted]

[redacted]

Ms. [redacted] is seen leaving a white automobile with her companion and making their way to a fast-food restaurant. Moreover, she is spotted conversing with her companion while eating in comfort. Ms. [redacted] is observed moving freely after eating and departing the fast-food establishment.

[redacted]

Ms. [redacted] can be seen leaving a white sedan with a few items while speaking to her companion as she makes her way to her home.

BLOOD PRESSURE EXTRACTED FROM RECORDS:	
Date	Blood Pressure (mmHg)
[redacted]	139/80

WEIGHT SUMMARY EXTRACTED FROM RECORDS:		
Date	Weight (lbs.)	-/+
[redacted]	[redacted]	0
[redacted]	[redacted]	+25
[redacted]	[redacted]	+2
[redacted]	[redacted]	0
[redacted]	[redacted]	0
[redacted]	[redacted]	0
[redacted]	[redacted]	0
[redacted]	[redacted]	0

FINAL DIAGNOSIS:

1. Fibromyalgia Syndrome (FMS)

2. Multiple orthopedic diagnoses: Cervical spine facet degenerative arthritis, disc herniation, and radiculopathy, Lumbar spine degenerative arthritis, disc herniation and radiculopathy, Thoracic spine degenerative disc disease, left shoulder adhesive capsulitis,

concern for thoracic outlet syndrome, right hand tendinitis and carpal joint effusion, bilateral trigger thumb, osteoarthritis bilateral feet

3. Hypertensive Cardiovascular Disease

4. Major depressive disorder and anxiety disorder

5. Generalized seizures

SUMMARY:

In preparation for this report medical records totaling 1000 pages were reviewed which I will now summarize with an emphasis on the medical legal issues at hand. On [redacted] medical records were reviewed by Dr. [redacted] in the field of orthopedic surgery and diagnoses included bilateral trigger thumb, concern for thoracic outlet syndrome, concern for complex regional pain syndrome, thoracic spine arthritis and others. On [redacted] Ms. [redacted] was seen in the field of orthopedic surgery and recommendations were given for concern for complex regional pain syndrome including acupuncture and follow-up with pain management. On [redacted] the applicant was seen in the field of psychiatry and diagnosis included adjustment disorder, regional pain syndrome, hypertension and others. On [redacted] the request for a left plexus block was denied. On [redacted] a review was done and medications included bupropion and omeprazole. In [redacted] the applicant underwent physical therapy for the shoulder and cervical spine. In [redacted] the applicant experienced a motor vehicle accident for which the details are not clear. On [redacted] the applicant was seen in the field of orthopedic surgery. On [redacted] the applicant had follow-up in the field of orthopedic surgery. On [redacted] the applicant had follow-up in the field of orthopedic surgery where she reported ongoing pain. On [redacted] Ms. [redacted] underwent blood work which demonstrated elevated inflammatory markers. On [redacted] MRI of the cervical spine demonstrated degenerative changes, disc desiccation, neural foraminal narrowing and other abnormalities. On [redacted] MRI of the lumbar spine demonstrated degenerative changes, disc protrusions, spinal canal narrowing and other abnormalities. [redacted] her neurologist was deposed. The doctor confirmed her diagnosis and medications including opiates. He did not believe the applicant to be capable of working. The doctor noted several motor vehicle accidents including the years [redacted] In [redacted] the applicant had follow-up with her orthopedic surgeon. I was supplied several videos showing the applicant ambulating and of note she has difficulty when bending and taking upwards steps.

In summary, Ms. [redacted] has a history of a motor vehicle accident in [redacted] with resultant rib fractures, pneumothorax and requiring hospitalization, who worked auto parts salesperson in [redacted] when she experienced pain in the bilateral thumbs. She was subsequently diagnosed with trigger thumbs and required medications, injections and

surgery. The applicant had continual pain and symptoms in the bilateral hand which over the next several years progressed to include the bilateral wrists, elbows, arms, and neck. The pain eventually progressed to include the mid back and lower back. She subsequently also developed symptoms of mood disorder, sleep disturbances, cognitive symptoms, jaw pain, and paresthesias. At the time of my reevaluation the applicant noted ongoing pain including the neck, back, legs, knees, hips, arm and feet as well as fatigue, sleep disturbances, cognitive symptoms, brain fog, abdominal pain and mood disorder. Ms. [redacted] has undergone evaluations in the fields of neurology, orthopedic surgery, psychiatry, psychology, rheumatology, dentistry, and others. Diagnoses has included cervical spine degenerative arthritis and radiculopathy, lumbar spine degenerative arthritis and radiculopathy, left shoulder adhesive capsulitis, concern for thoracic outlet syndrome, concern for complex regional pain syndrome, bilateral trigger thumb, shoulder bursitis and tendinitis, fibromyalgia syndrome (initially documented in [redacted] and diagnosed in [redacted], major depressive disorder, neuropathy and others. Medications have included Ambien, Lorazepam, Seroquel, Doxepin, Paxil, bupropion, Lidoderm, Zanaflex, Vicodin, Percocet, Norco, OxyContin, oxymorphone, morphine, Fentanyl patches, Flexeril, topiramate, mirtazapine, Lyrica, gabapentin, Soma, Ultram, ibuprofen, clonidine, hydrochlorothiazide, trokendi, lidocaine patches, Flector patches, omeprazole, and reported ozempic. Therapies have included multiple sessions of physical therapy, occupational Therapy, TENS sessions and others. Interventions have included bilateral trigger thumb release, Botox injections, brachial plexus blocks, facet nerve blocks, shoulder injections, hand injections, epidurals, trigger point injections, ganglion block, left piriformis nerve block, and others.

As previously outlined in this case I have been asked to assess the applicant as a qualified medical evaluator in the field of rheumatology for 2 injuries. The first is a specific injury which occurred on [redacted] while working as an auto parts salesperson to the bilateral thumbs, neck, back, chest, Psyche, head, teeth, elbows, fibromyalgia and jaw. The second is a continuous trauma from [redacted] through [redacted] while working as an auto parts salesperson with injury to the neck, back, arms, shoulders, chest, Psyche, head, teeth, elbows, thumbs and jaw. I will now outline my final diagnoses and recommendations.

COMMENTS AND CONCLUSIONS:

1. Fibromyalgia Syndrome (FMS)

In this case I was asked to conduct a medical legal rheumatologic evaluation and assess for multiple diagnoses including but not limited to inflammatory arthritis, systemic lupus erythematosus, rheumatoid arthritis, fibromyalgia syndrome and others. A thorough rheumatologic evaluation requires a combination of obtaining a detailed patient history, lab work including inflammatory markers as well as serologic markers which can help support the clinical question at hand, imaging including x-rays, MRI studies and others.

As outlined previously, Ms. [redacted] has a history of diffuse pain as well as a previous diagnosis of fibromyalgia (FMS) diagnosed by her qualified medical evaluator in the field of rheumatology. The applicant has been on multiple medications over the years including muscle relaxants, gabapentin, and Cymbalta and is currently on pregabalin, trazodone, and receiving trigger point injections. Based on my review of medical records as well as clinical exam of the applicant the symptoms of FMS are not under control. Her current complaints are heavily focused on her back pain, hand pain, shoulder pain, neck pain, sleep disturbances, issues with concentration, and cognitive impairment issues. Therefore, at the time of this writing, assuming Ms. [redacted] had no complaints of generalized pain, sleep disturbances, and cognitive disturbances prior to her industrial accidents I believe the applicant's FMS symptoms have worsened since her industrial injuries.

As I previously noted, FMS is a chronic, noninflammatory, nonautoimmune central processing disorder that leads to pain. Typical symptoms of FMS include diffuse pain, fatigue, stiffness, sleep disturbances, cognitive difficulties, and mood disorder. FMS in this case has manifested itself with complaints of widespread pain not otherwise explained by her orthopedic injuries, as well as nonrestorative sleep, chronic fatigue, headaches, temporomandibular joint dysfunction, depression, anxiety, symptoms consistent with cognitive dysfunction, and hypersensitivity to environmental stimuli. It is a disease with no objective findings and a disease of exclusion of other diseases to explain symptoms. It is a subjective disease, as physical exam findings and laboratory investigation reveal no evidence of inflammation or degeneration to explain the symptoms. FMS has several variables that can contribute to its onset and progression, including biologic predisposition, environmental triggers such as infections, acute and chronic orthopedic trauma, as well as psychological triggers including psychological distress.

This case is complex and multiple considerations must be taken into account. FMS can be precipitated by traumatic events such as motor vehicle accidents which Ms. [redacted] had prior to her industrial accident. I continue to note that she was in a motorcycle accident in [redacted] and experienced extensive injuries including fractured ribs, pneumothorax and requiring hospitalization. I also note in the medical records provided to me for other motor vehicle accidents dated in the years [redacted] However I was not provided details surrounding the accidents as well as subsequent symptoms and treatments. Therefore, if possible I continue to request being provided with copies of the medical treatment notes and hospital records surrounding these accidents which may give insight into the onset and progression of her FMS.

There are number of other diagnoses that are of concern that should be addressed and are likely contributing to her symptoms. This includes her diagnoses of Cervical spine facet degenerative arthritis, disc herniation, and radiculopathy, Lumbar spine degenerative arthritis, disc herniation and radiculopathy, Thoracic spine degenerative disc disease, left shoulder adhesive capsulitis, concern for thoracic outlet syndrome, right hand tendinitis and carpal joint effusion, left hand osteoarthritis bilateral feet. I note that this patient sustained repetitive strain injuries, and overuse syndrome on a cumulative traumatic work-related basis resulting in strains of the cervical, thoracic, and lumbar spines, bilateral shoulders, bilateral upper extremities. This continuous trauma has likely led to pain to her neck, back, shoulders, elbows, and thumbs. I defer to the medical legal evaluators in the field of orthopedics in regard to these injuries.

There are other internal medicine diagnosis which are likely to be contributing to symptoms including vitamin D deficiency which can contribute to symptoms of fatigue and weakness. I recommend treatment by their primary care providers and monitoring of symptoms. I continue have concern for sleep apnea including sleep disturbances, headaches and elevated blood pressure which can contribute to cognitive disturbances, as well as sleep disturbances. I previously recommended a sleep study which has not been performed to date. I note a history of psychiatric diagnosis including depression for which she is currently on treatment. I defer to her treating providers regarding these diagnoses.

Based on my medical evaluation as well as my review of the medical records Ms. [redacted] does not meet criteria for any underlying autoimmune inflammatory rheumatologic diagnosis including systemic lupus erythematosus, rheumatoid arthritis, or vasculitis. Based on my review of records and clinical evaluation, I do not see evidence of chronic regional pain syndrome. The applicant does have an elevated ANA (1:40) however, all other serologies are negative including SSA, SSB, Smith, and RNP. The complement levels including C3, C4 were normal. In addition, the inflammatory markers are minimally elevated which can be seen in the setting of obesity. I note the diagnosis of autoimmune thyroiditis, however the thyroid function was normal. The applicant has no skin or internal organ abnormalities including renal disease or abnormal blood counts, which are involved in patients with active systemic lupus erythematosus. On my exam I noted no swelling of the small joints including of the bilateral hands, wrists, feet or others which I would expect to see in a case of active inflammatory arthritis.

Based on the information provided to me I continue to tentatively conclude that there has been an aggravation or permanent worsening of FMS due to injuries at both of places of employment, the first injury involving her hands and upper extremities while working as an [redacted] at [redacted] and the second cumulative injury while her symptoms progressed to include to shoulders, neck, back with progression of systemic symptoms while working as an autoparts salesperson at Hanson Distributing. FMS in this case has manifested itself with complaints of widespread pain not otherwise

explained by her orthopedic injuries, as well as nonrestorative sleep, chronic fatigue, headaches, temporomandibular joint dysfunction, depression, anxiety, symptoms consistent with cognitive dysfunction, and hypersensitivity to environmental stimuli. However, coexisting comorbidities are likely contributing to these symptoms including her orthopedic complaints as outlined above, vitamin d deficiency, polypharmacy and long-term dependence on both opioids and benzodiazepines, temporomandibular jaw dysfunction, depression, and anxiety. For these diagnoses I defer to her medical legal evaluators in the fields of orthopedics, psychiatry, psychology, and dentistry.

I recommend the following. If possible, I continue to request being provided with copies of the medical treatment notes and hospital records surrounding her motor vehicle accidents including in [redacted] which may give insight into the onset and progression of her FMS. I also request a sleep study due to symptoms of sleep apnea including sleep disturbances, elevated blood pressure and daytime fatigue. Once I am provided with more information, I will issue a supplemental report with my updated findings on the case in regard to the rheumatologic medical legal issues at hand.

In terms of whole person impairment utilizing the *AMA guides fifth edition* I continue to point out that FMS is not specifically rated in the *AMA guides* although it is discussed in chapter 18. In order to determine a whole person impairment rating regarding fibromyalgia I will apply the Almaraz/Guzman principle by considering the major symptoms that interfere with activities of daily living.

In this case, the applicant has a sleep and arousal disorder that is partially due to FMS. This is addressed in chapter 13 of the *AMA guides*, table 13-4 page 317. Based upon the available medical information, Epworth Sleepiness Scale, and fatigue severity scale she qualifies for class I representing 1% to 9% impairment of the whole person. This is characterized by reduced daytime alertness interfering with ability to perform some activities of daily living which Ms. [redacted] reports. I assign 5% impairment of the whole person regarding sleep and arousal disorder. However, there is other contributing factors which warrant evaluation. One is her daily use of medications including opioids and topiramate which have the side effect of sleepiness and fatigue. The second which warrants further evaluation is the diagnosis of obstructive sleep apnea and for this I continue to request a polysomnography study which is pending to date.

In this case, the applicant has a cognitive impairment issues that are partially due to FMS. This is addressed in chapter 13 of the *American Medical Association Guides to the Evaluation of Permanent Impairment fifth edition*, table 13-3 page 312. Based upon the available medical information, activities of daily living assessment, and clinical exam they qualify for class II representing 15% to 39% impairment of the whole person. This is characterized by the severity of symptoms interfering with ability to perform some activities of daily living. I assign 20% impairment of the whole person. However, there are other contributing factors in this case. One is the daily use of medications including

opioids and topiramate which have the side effect of cognitive dysfunction. The second which warrants further evaluation is the diagnosis of obstructive sleep apnea which can contribute to cognitive disturbances and for this I request a polysomnography study.

This applicant has been noted to have an emotional behavioral disorder associated with her chronic pain syndrome. In regard to this I defer to her specialist and psychiatry and psychology. Ms. [redacted] also has the diagnosis of temporomandibular joint dysfunction which has been addressed by her medical legal evaluators in the field of dentistry.

As extensively outlined above this applicant has the complaint of diffuse and uncontrolled pain that is not otherwise explained by her multiple orthopedic injuries. This is addressed in chapter 18 of the *AMA guides fifth edition*. This chapter allows additional impairment of 3% to be given to individual if individual has a pain-related impairment that increases the burden of illness. In my opinion, Ms. [redacted] would qualify for 3% add on which should be added on top of any whole person impairment determined by her medical legal evaluators in the field of orthopedics.

2. Multiple orthopedic diagnoses: Cervical spine facet degenerative arthritis, disc herniation, and radiculopathy, Lumbar spine degenerative arthritis, disc herniation and radiculopathy, Thoracic spine degenerative disc disease, left shoulder adhesive capsulitis, concern for thoracic outlet syndrome, right hand tendinitis and carpal joint effusion, bilateral trigger thumb, osteoarthritis bilateral feet

As previously outlined, Ms. [redacted] has multiple orthopedic diagnoses as outlined above and has undergone extensive procedures including bilateral trigger thumb release, Botox injections, brachial plexus blocks, facet nerve blocks, shoulder injections, hand injections, epidurals, trigger point injections, ganglion block, left piriformis nerve block, and others. Treatment have included multiple sessions of physical therapy, occupational therapy, and TENS sessions. She has been evaluated by medical legal specialist in the field of orthopedics and for issues regarding disability, causation, and whole person impairment and for these diagnoses I defer to her specialists. However, of note these diagnoses are likely contributing to her diffuse and chronic pain concomitantly with her diagnosis of FMS.

3. Hypertensive Cardiovascular Disease

As previously noted, Ms. [redacted] has a history of hypertension with multiple blood pressure readings with systolic blood pressure >140 mmHg and diastolic blood pressure readings >90 mmHg dating back to [redacted]. Her blood pressure was noted to be elevated at the time of my evaluation. She has been on medications in the past but was not at the time of my evaluation. Of note, other internal medical diagnoses in the case include pre-diabetes, obesity (BMI >30) and high cholesterol. The records outline a history of gastro-esophageal reflux disease however she denied symptoms at the time of my evaluation.

She also has a history of gallstone pancreatitis and is status post laparoscopic cholecystectomy and did not report residual symptoms. She should be monitored by her treating internists for these conditions.

4. Major depressive disorder and anxiety disorder

Ms. [redacted] has a diagnosis of depression and anxiety and has been evaluated by a psychiatry medical evaluator. This has been assigned to be partially a result of her industrial injury and I defer to her treating psychiatrists and psychologists for further recommendations in regard to treatment.

5. Generalized seizures

Ms. [redacted] has a history of seizures and has undergone evaluation in the field of neurology, and I defer to her specialists regarding this diagnosis as well as issues of impairment, causation and apportionment.

PERMANENT AND STATIONARY STATUS

Due to the fact that Ms. [redacted] has failed treatments for fibromyalgia including physical therapy, gabapentinoids, muscle relaxants, duloxetine, and trigger point injections I would determine her to be maximum medical improvement and assign permanent and stationary status.

APPORTIONMENT AND CAUSATION:

Based on the information provided to me I continue to conclude that there has been an aggravation or permanent worsening of FMS due to injuries at both of places of employment, the first injury involving her hands and upper extremities while working as an auto parts salesperson at [redacted] and the second cumulative injury while her symptoms progressed to include to shoulders, neck, back with progression of systemic symptoms while working as an autoparts salesperson at [redacted] Distributing. The applicants' current complaints are heavily focused on back pain, shoulder pain, neck pain, sleep disturbances, issues with concentration, and cognitive impairment issues. Therefore, at the time of this writing, assuming Ms. [redacted] had no complaints of generalized pain, sleep disturbances, and cognitive disturbances prior to the industrial accidents I believe the applicant's FMS symptoms have worsened since the industrial injuries.

Regarding apportionment of disability with regard to the diagnosis of FMS, I believe there are multiple factors contributing to current impairment and disability. Specifically, the applicant has a number of non-industrial factors, including vitamin D deficiency, and the possible diagnosis of obstructive sleep apnea. I also have concern for polypharmacy

and medication side effects as contributing to symptoms. I have the following requests. If possible, I continue to request being provided with copies of the medical treatment notes and hospital records surrounding her motor vehicle accidents including in [redacted] which may give insight into the onset and progression of her FMS. I also request a sleep study due to symptoms of sleep apnea including sleep disturbances, elevated blood pressure and daytime fatigue. Once I am provided with more information, I will issue a supplemental report with my updated findings regarding apportionment.

DISABILITY AND WORK RESTRICTIONS:

I was asked to address issues regarding disability and work restrictions in regard to her rheumatologic diagnosis of FMS. In terms of disability and work restrictions, the applicant has been determined to be disabled. I defer to the work restrictions as outlined by her orthopedic medical evaluators, regarding the lumbar spine, shoulders, and hands.

FUTURE MEDICAL CARE:

I will now outline my recommendations for future medical care. My opinions regarding treatment of industrially related FMS include both nonpharmacologic and pharmacologic approaches. In terms of nonpharmacologic approaches, I continue to recommend aquatic therapy acupuncture. In terms of cognitive behavioral therapy, I defer to the treating psychologist and psychiatrist in this case. In regard to the pharmacologic approaches to treating FMS I agree with her current treatment of pregabalin. Other medications which have not been trialed which can be used in FMS include amitriptyline and milnacipran however this would require close monitoring for side effects with her current medications. The patient should be considered for care with a treating orthopedist, pain management and rheumatologist as well as in the areas of internal medicine and psychiatry. She should be tapered off of her opioids as possible as her polypharmacy may be contributing to symptoms of fatigue and cognitive impairment.

In regard to her orthopedic diagnoses, Ms. [redacted] should continue to follow with her treating orthopedists and pain doctors. For the diagnosis of hypertension, high cholesterol, vitamin d deficiency, autoimmune thyroiditis she should follow with her treating internists. For the diagnosis of Major depressive disorder and anxiety disorder Ms. [redacted] should follow with her psychologists. For history of seizures, she should follow with her treating neurologist.

Medical records were placed in chronological order and preliminarily reviewed and transcribed by [redacted]. Final review of records by Dr. Nicole Zagelbaum Ward. Questionnaire forms filled out by the patient at the time of the evaluation may be included as an addendum at the end of the report.

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 the information 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 to be true.

I further declare under penalty of perjury that I have not violated Labor Code Section 139.3 of the California Labor Code, and the contents of the bill are true and correct to the best of my knowledge, in 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 referenced examination or evaluation.

Sincerely,

_____

Nicole Zagelbaum Ward, DO
Internal Medicine & Rheumatology
Cedars-Sinai Medical Center

Nicole Zagelbaum Ward, DO, MPH
A PROFESSIONAL CORPORATION
Diplomate, American Board of Internal Medicine - Internal Medicine
Diplomate, American Board of Internal Medicine - Rheumatology
Qualified Medical Evaluator – Independent Medical Evaluator
Telephone: ***818-806-8830*** *•* *Facsimile* ***818-536-7695***

[redacted]

RHEUMATOLOGY MEDICAL LEGAL CONSULTATION SUPPLEMENTAL REPORT

RE: [redacted]

To whom it may concern:

This medical-legal evaluation qualifies for an ML203.

Pursuant to Labor Code Sections 4620, 4621 and 4622, the evaluation and report is based on *AMA Guides to the Evaluation of Permanent Impairment.* The medical-legal billing codes used are effective as of [redacted]

Based on California Code of Regulations 9793 through 9795 this report is billed under the appropriate medical legal fee schedule codes for evaluations performed by an Agreed

Medical Evaluation or PQME. The physician shall be reimbursed per sections 9793 (h), 9794 (a) and 9795 "Reasonable Level of Fees for Medical Legal Expenses, Follow-up, Supplemental and Comprehensive Medical Legal Evaluations and Medical Legal Testimony."

_____ Missed Appointment

_____ Initial Comprehensive Medical Legal Evaluation (200 pages of records included)

_____ Follow-up Medical Legal Evaluation – **Less than 18 months** from last evaluation
(200 pages of records included in reimbursement)

_____ Follow-up Medical Legal Evaluation - **More than 18 month** from last evaluation
(200 pages of records included in reimbursement)

____X_____ Supplemental Report
(50 pages of records included in reimbursement)
Medical Records total 536 pages were received, and all of these materials were thoroughly reviewed to ensure no relevant information was overlooked.

_____ Medical Legal Testimony/Deposition ($455.00 X 2 hours = $910.00)

_____ Sub-Rosa Recording Review $325 per hour at _____ hours

Per your request I had the opportunity to examine [redacted] on [redacted] over letter dated [redacted] I was asked to address conduct a rheumatologic evaluation, and assess manifestations of long COVID-19. I issued a report based on my findings. I have now received an additional cover letter. Per the cover letter addressed to me on [redacted] I was provided additional treatment records from his treating rheumatologist, pulmonologist, cardiologist, neurologist and internist. I was asked to review the records and issue a supplemental report addressing injury, diagnosis, causation, maximum medical improvement and or permanent and stationary status, impairment, apportionment, work restrictions and recommendations for future medical treatment. I am now issuing a supplemental report based on this request.

HISTORY OF PRESENT ILLNESS:

In my initial evaluation Mr. [redacted] reports that during the COVID-19 pandemic, he was working fulltime in [redacted]. Mr. [redacted] interacted with multiple

colleagues and patients who were unmasked and came to work with symptoms including coughing, sneezing.

On [redacted] Mr. [redacted] woke up with a fever of 101, body aches, feeling unwell. Mr. [redacted] called off sick from work and quarantined after. Mr. [redacted] reported he stayed at home and his symptoms and in the next few weeks developed symptoms of cough, headaches, recurrent fevers that were escalating (tmax 105), brain fog, muscle pains, joint pain, brain fog, shortness of breath. Mr. [redacted] walks with a cane due to his symptoms of muscle fatigue and weakness. Mr. [redacted] returned to work on a trial basis with modified duties in [redacted] for 90 days but was told he would no longer be accommodated with his work restrictions. Mr. [redacted] was also assigned to concentra during his course of evaluation and treatment in [redacted] and at the end of [redacted] was placed on disability.

Mr. [redacted] reports ongoing symptoms of diffuse muscle pain, joint pain, shortness of breath, dyspnea on exertion, brain fog, chest pain, fatigue. Medications include duloxetine 60mg daily with minimal benefit. Mr. [redacted] denies other exposures to COVID including travel, concerts, conferences, family sick contacts.

PRIOR AUTOMOBILE ACCIDENTS

Rear ended [redacted], went to ER, no residual symptoms

PAST MEDICAL HISTORY:

1. Acute COVID
2. Long COVID

CURRENT MEDICATIONS:

Albuterol, trelegy, duloxetine

FIBROMYALGIA DIAGNOSTIC CRITERIA:

The applicant filled out the new clinical fibromyalgia diagnostic criteria with the following findings. He reports that he has had pain in the following areas over the past week: left upper arm, right upper arm, left lower arm, right lower arm, left hip, right hip, left lower leg, right lower left, and chest.
The widespread pain index score is 9.
In his symptom severity score part IIA, he notes that he has had the following symptoms: Severe Fatigue, Severe waking unrefreshed, and Severe cognitive symptoms.
The score for part IIA is 9.

In the symptom severity score part IIB, he reports that he has had the following symptoms over the past week: muscle pain, fatigue/tiredness, thinking or remembering problems, muscle weakness, headache, numbness/tingling, dizziness, insomnia, nausea, nervousness, chest pain, wheezing, loss/change in taste, shortness of breath, and hearing difficulties.
The total score IIB is 2.
The total score for parts IIA and IIB is 11.
Based on these findings, he does meet the criteria for diagnosis of fibromyalgia if there is no other explanation for his clinical symptoms.

PAIN DRAWING:

The applicant supplied me with a pain drawing with the following findings.
He noted aching in the following areas: both hands.
He noted numbness in the following areas: both arms and forearms.
He noted pins and needles in the following areas: both thighs, both legs, both ankles, both arms, and both forearms.
He noted burning in the following areas: both hands and left feet.
He noted stabbing in the following areas: both shoulders, both elbows, both hips, both knees, both ankles, and both hands.

ACTIVITIES OF DAILY LIVING:

The applicant filled out an Activities of Daily Living report with the following findings.
The following activities are able to be done without difficulty: see a television screen, use a telephone, feel what he touches, and turn faucets on and off.
He is able to do the following activities with some difficulty: lift a full cup/glass to his mouth, open a new milk carton, write a note, speak clearly, recline, taste the food he eats, and sleep. He is able to do the following activities with much difficulty: dressing, including shoes, combing his hair, washing and drying himself, taking a bath, getting on and off the toilet, brushing his teeth, making a meal, typing a message on a computer, work outdoors on flat ground, climb up 1 flight of 10 steps, stand, sit, rise from a chair, run errands, light housework, shop, get in and out of a car, and engage in sexual activity.
He reports that he is unable to do the following activities: lift a full cup/glass to his mouth, smell the food he eats, and open previously opened jars.

EPWORTH SLEEPINESS SCALE:

The applicant filled out an Epworth Sleepiness Scale form with the following findings.
The following activities would induce a high chance of dozing: sitting and reading, watching television, sitting inactive in a public place (e.g., a theater or meeting), as a passenger in a car for an hour without a break, lying down to rest in the afternoon when

circumstances permit, sitting and talking to someone, sitting quietly after a lunch without alcohol, in a car, and while stopped for a few minutes in traffic.

DIAGNOSTICS:

LABS:

BIOCHEMICAL PROFILE: Processed on [redacted]. Tests performed by [redacted] Diagnostics.

Cholesterol, Total	**208 (H)**	mg/dL	Glucose	**272 (H)**	mg/dL
HDL Cholesterol	**34 (L)**	mg/dL	Urea Nitrogen (BUN)	14	mg/dL
Triglycerides	**239 (H)**	mg/dL	Creatinine	1.00	mg/dL
LDL-Cholesterol	**135 (H)**	mg/dL	Uric Acid	5.7	mg/dL
Chol/HDLC Ratio	**6.1 (H)**		Sodium	140	mmol/L
Non-HDL Cholesterol	**174 (H)**	mg/dL	Potassium	4.0	mmol/L
Albumin	4.7	g/dL	Chloride	102	mmol/L
Globulin	3.1	g/dL	Carbon Dioxide	26	mmol/L
Albumin/Globulin Ratio	1.5		Calcium	9.9	mg/dL
Bilirubin, Total	0.8	mg/dL	Protein, Total	7.8	g/dL
Alkaline Phosphatase	69	U/L	eGFR	96	mL/min/ 1.73m^2
AST (SGOT)	**56 (H)**	U/L	ALT (SGPT)	**87 (H)**	U/L

COMPLETE BLOOD COUNT W/DIFF: Processed on [redacted]. Tests performed by [redacted] Diagnostics.

White Blood Cell Count	6.1	Thous/uL	Absolute Neutro	3148	cells/uL
Red Blood Cell Count	5.25	Mill/uL	Absolute Lymph	2288	cells/uL
Hemoglobin	16.3	g/dL	Absolute Mono	482	cells/uL
Hematocrit	47.7	%	Absolute Eosin	122	cells/uL
MCV	90.9	fL	Absolute Baso	61	cells/uL
MCH	31.0	Pg	Neutrophils	51.6	%
MCHC	34.2	g/dL	Lymphocytes	37.5	%
RDW	14.4	%	Monocytes	7.9	%
Platelet Count	180	Thous/uL	Eosinophils	2.0	%
MPV	11.6	fL	Basophils	1.0	%

IRON PANEL: Processed on [redacted] Tests performed by [redacted] Diagnostics.

Test	Result	Reference Range
Iron, Total	129	50-180 mcg/dL
Iron Binding Capacity	332	250-425 mcg/dL
% Saturation	39	20-48 % (calc)
Ferritin	370	38-380 ng/mL

SACCHAROMYCES CEREVISIAE ANTIBODIES (ASCA) (IGG, IGA): Processed on [redacted]. Tests performed by [redacted] Diagnostics.

Test	Result	Reference Range
Saccharomyces Cerevisiae AB (ASCA) (IGG)	<20	<=20: Negative 20.1-29.9: Equivocal >=30: Positive
Saccharomyces Cerevisiae AB (ASCA) (IGA)	<20	<=20 Negative 20.1-29.9 Equivocal >=30 Positive

ANTIPHOSPHOLIPID SYNDROME DIAGNOSTIC PANEL: Processed on [redacted] Tests performed by [redacted] Diagnostics.

Test	Result	Reference Range
Cardiolipin AB (IGG)	2.8	<20.0: Antibody not detected > or = 20.0: Antibody detected
Cardiolipin AB (IGM)	2.3	<20.0: Antibody not detected > or = 20.0: Antibody detected
Cardiolipin AB (IGA)	2.0	<20.0: Antibody not detected > or = 20.0: Antibody detected
B2 Glycoprotein I (IGG) AB	2.0	<20.0: Antibody not detected > or = 20.0: Antibody detected
B2 Glycoprotein I (IGA) AB	2.0	<20.0: Antibody not detected > or = 20.0: Antibody detected
B2 Glycoprotein I (IGM) AB	2.0	<20.0: Antibody not detected > or = 20.0: Antibody detected

IMMUNOLOGY: Processed on [redacted] Tests performed by [redacted] Diagnostics.

Test	Result	Reference Range
Lupus Panel 2 W/ANA, IFA W Refl Titer Pattern		
DNA (DS) Antibody	1	< or = 4: Negative 5-9: Indeterminate > or = 10: Positive
SCL-70 Antibody	<1.0 Neg	<1.0 Neg Al

SM And RM/RNP Antibodies		
SM Antibody	<1.0 Neg	<1.0 Neg Al
SM/RNP Antibody	SM Antibody	<1.0 Neg Al
Sjogren's Antibodies (SS-A, SS-B)		
Sjogren's Antibodies (SS-A)	<1.0 Neg	<1.0 Neg Al
Sjogren's Antibodies (SS-B)	<1.0 Neg	<1.0 Neg Al
ANA Screen, IFA, W/ Refl Titer Pattern		
Ana Screen, IFA	**Positive (A)**	Negative
Antinuclear Antibodies Titer and Pattern		
ANA Titer	**1:40 (H)**	<1:40: Negative 1:40-1:80: Low Antibody Level >1:80: Elevated Antibody Level
ANA Pattern	**Nuclear, Speckled**	
DNA (DS) Antibody	1	< or = 4: Negative 5-9: Indeterminate > or 10: Positive
SCL-70 Antibody	<1.0 Neg	<1.0 Neg Al
SM And SM/RNP Antibodies		
SM Antibody	<1.0 Neg	<1.0 Neg Al
SM/RNP Antibody	<1.0 Neg	<1.0 Neg Al
Sjogren's Antibodies (SS-A, SS-B)		
Sjogren's Antibodies (SS-A)	<1.0 Neg	<1.0 Neg Al
Sjogren's Antibodies (SS-B)	<1.0 Neg	<1.0 Neg Al

URINALYSIS W/MICRO: Processed on [redacted] Tests performed by [redacted] Diagnostics.

Color	Yellow	Protein	Negative
Appearance	Clear	Nitrite	Negative
Specific Gravity	1.031	Leukocyte Esterase	Negative
PH	6.5	WBC	None Seen
Glucose	**3+ (A)**	RBC	None Seen
Bilirubin	Negative	Squamous Epithelial Cells	None Seen
Ketones	Negative	Bacteria	None Seen
Occult Blood	Negative	Hyaline Cast	None Seen

HEMOGLOBIN A1c: Processed on [redacted] Tests performed by [redacted] Diagnostics.

7.4 (H) (reference range: ≥ 6.5% consistent with diabetes)

IMMUNOGLOBULIN E: Processed on [redacted] Tests performed by [redacted]

70 (normal: ≤114 kU/L)

CREATINE KINASE: Processed [redacted] Tests performed by [redacted] Diagnostics.

136 (reference range: 44-196 U/L)

TSH W/ REFLEX TO FT4: Processed on [redacted] Tests performed by [redacted] Diagnostics.

1.83 (reference range: 0.40-4.50 mIU/L)

VITAMIN B12: Processed on [redacted] Tests performed by [redacted] Diagnostics.

668 (reference range: 200-1100 pg/mL)

RHEUMATOID FACTOR: Processed on [redacted] Tests performed by [redacted] Diagnostics.

<10 (reference range: <14 IU/mL)

C-REACTIVE PROTEIN: Processed on [redacted]. Tests performed by [redacted] Diagnostics.

<3.0 (reference range: <8.0 mg/L)

HELICOBACTER PYLORI, UREA BREATH TEST: Processed on [redacted]. Tests performed by [redacted] Diagnostics.

Not detected (reference range: not detected)

ANGIOTENSIN-1-CONVERTING ENZYME: Processed on [redacted]. Tests performed by [redacted] Diagnostics.

45 (reference range: 9-67 U/L)

VITAMIN D,25-OH, TOTAL, IA: Processed on [redacted] Tests performed by [redacted] Diagnostics.

22 (L) (reference: 30-100 ng/mL)

CYCLIC CITRULLINATED PEPTIDE (CCP) AB (IGG): Processed on [redacted] Tests performed by [redacted] Diagnostics.

<16 units

STUDIES:

XR CHEST, 2 VIEWS: Performed on [redacted] and interpreted by [redacted]

IMPRESSION: Normal study.

XR CHEST, 2 VIEWS: Performed on [redacted] and interpreted by [redacted]

IMPRESSION: No interval change.

XR CHEST, 1 VIEW: Performed on [redacted] and interpreted by [redacted]

IMPRESSION: Normal study.

US ABDOMEN: Performed on [redacted] interpreted by [redacted]

IMPRESSION:

1. Minimal sludge or gravel in the gallbladder neck. The wall thickness is normal. There is no ductal obstruction. However, the patient demonstrates what appears to be a positive Murphy's sign.
2. Diffuse fatty liver.
3. Splenomegaly at 13.2 cm.

XR CHEST, 2 VIEWS: Performed on [redacted] and interpreted by [redacted]

IMPRESSION: No interval change.

XR LEFT ELBOW, 3 TO 4 VIEWS: Performed on [redacted] and interpreted by [redacted]

IMPRESSION: Soft tissue swelling.

HOME SLEEP TEST W TYPE 3 PORTABLE MONITOR, UNATTENDED, MINIMUM 4 CHANNELS: Performed on [redacted] and interpreted by [redacted]

IMPRESSION: The patient demonstrates severe obstructive sleep apnea (OSA) with an apnea-hypopnea index (AHI) of 76.3 events/hour. Oxygen saturation by pulse oximetry fell to as low as 66.0 during the study.

AUTO CPAP: Performed on [redacted] and interpreted by [redacted]

IMPRESSION:
1. History of severe obstructive sleep apnea.
2. Successful APAP titration.

XR CHEST, 1 VIEW: Performed on [redacted] and interpreted by [redacted]

IMPRESSION: Left lower lobe subsegmental atelectasis.

XR CHEST, 2 VIEWS: Performed on [redacted] and interpreted by [redacted]

IMPRESSION: No significant abnormality.

CT CHEST, STANDARD, NO CONTRAST: Performed on [redacted] and interpreted by [redacted]

IMPRESSION:
1. Minimal lingular scar versus atelectasis; otherwise, no pulmonary abnormality identified.
2. Splenomegaly.
3. Fatty liver.

CTA PULMONARY W CONTRAST: Performed on [redacted] and interpreted by [redacted]

IMPRESSION: No evidence of pulmonary embolism. Unchanged small linear lingular scarring. Otherwise, clear lungs.

SPIROMETRY, PRE/POST BRONCHODILATOR, DLCO, LUNG VOLUMES PLETHYSMOGRAPHY: Performed on [redacted] and interpreted by [redacted]

IMPRESSION: Pulmonary function testing is within normal limits. Test performed includes spirometry with and without bronchodilator, measurement of lung volume, and diffusing capacity. Quality of data is acceptable and reproducible. Spirometry is within

normal limits. Flow-Volume loops are normal. Plethysmographic lung volumes are within normal limits. Diffusing capacity of the lung is normal.

TRASTHORACIC ECHO REAL TIME W 2D IMAGE, SPECTRAL AND COLOR FLOW DOPPLER COMPLETE: Performed on [redacted] and interpreted by [redacted]

SUMMARY: Normal left ventricular wall motion and systolic function with estimated EF 60-65%. Normal left ventricular size. Normal left ventricular wall thickness. Normal diastolic function. Grossly normal right ventricular size and systolic function. No overt septal flattening to suggest RV pressure or volume overload. Normal left atrial size. Normal right atrial size. Mild tricuspid regurgitation. Trace MR, no mitral stenosis. Trileaflet aortic valve with mild aortic annular calcification more prominent at the RCC. Mild aortic regurgitation (PHT 518 ms). No significant aortic stenosis. Normal aortic root diameter. DDx of likely focal calcification on the right coronary cusp of the aortic valve includes vegetation; this echo density appears more likely to be calcium, is dependently mobile with the valve leaflet, and is on the aortic side of the valve. Correlate clinically. PCP messaged with plan and recommendations.

PULMONARY FUNCTION TEST: Performed on [redacted] and interpreted by [redacted]

IMPRESSION: Essentially normal pulmonary function test.

6 MINUTE WALK TEST: Performed on [redacted] and interpreted by [redacted]

IMPRESSION: Oxygen walk study without desaturation.

MRI BRAIN AND BRAIN STEM WO/W CONTRAST: Performed on [redacted] and interpreted by [redacted]

IMPRESSION: There are numerous nonspecific punctate T2 hyperintense lesions in the bilateral subcortical and deep white matter, which may represent demyelinating disease versus vasculitis versus migraine headache versus early chronic microvascular ischemic changes.

XR CHEST, 2 VIEWS: Performed on [redacted] and interpreted by [redacted]

IMPRESSION: No significant abnormality.

NM PULMONARY VENTILATION PERFUSION IMAGING PARTICULATE W REBREATHING AND WASHOUT W OR WO 1 BREATH: Performed on [redacted] and interpreted by [redacted]

IMPRESSION: Normal perfusion scan. No evidence for acute or chronic PE.

CT ANGIO, PULMONARY (FOR PULMONARY EMBOLISM): Performed on [redacted] and interpreted by [redacted]

IMPRESSION: There is no CT angiographic evidence of pulmonary embolism.

US DUPLEX SCAN BILAT EXTRACRANIAL CAROTID ARTS COMPLETE: Performed on [redacted] and interpreted by [redacted]

IMPRESSION: Carotid Duplex Procedure: A carotid ultrasound scan was performed using 2D-color flow imaging and pulsed Doppler in the longitudinal scan plane. The common carotid at proximal and distal sites; the internal carotid at proximal, mid and distal sites; one external carotid and one vertebral sites were evaluated with Doppler spectral analysis. Peak systolic and diastolic velocities were measured at these locations with the following results: Right: Duplex displays an entirely normal cervical carotid system. No evidence of atherosclerosis, aneurysm, or any other vascular pathology. Antegrade flow in the vertebral artery. Left: Duplex displays an entirely normal cervical carotid system. No evidence of atherosclerosis, aneurysm, or any other vascular pathology. Antegrade flow in the vertebral artery.

MRI BRAIN AND BRAIN STEM NO CONTRAST: Performed on [redacted] at and interpreted by [redacted]

IMPRESSION: Multiple T2 hyperintensities located in the subcortical region of both frontal lobes measuring 5 mm or smaller. They appear stable when compared with prior study performed on [redacted]

XR HAND LEFT 3 + VW: Performed on [redacted] and interpreted by [redacted] MD.

IMPRESSION: No acute osseous abnormality.

XR HAND RIGHT 3 + VW: Performed on [redacted] and interpreted by [redacted]

IMPRESSION: No acute osseous abnormality.

XR KNEE LEFT 3 VW: Performed on [redacted] and interpreted by [redacted],
[redacted]

IMPRESSION: No acute osseous abnormality.

XR KNEE RIGHT 3 VW: Performed on [redacted] and interpreted by [redacted]
[redacted]

IMPRESSION: No acute osseous abnormality.

XR FOOT LEFT 3 + VW: Performed on [redacted] and interpreted by [redacted],
[redacted]

IMPRESSION: Calcific densities consistent with chronic sequela of plantar fasciitis. Posterior and plantar calcaneal spurs. Otherwise, no acute osseous abnormality.

XR FOOT RIGHT 3 + VW: Performed on [redacted] and interpreted by [redacted]
[redacted]

IMPRESSION: Posterior and plantar calcaneal spurs. No acute osseous abnormality.

REVIEW OF RECORDS:

Medical records totaling 536 pages were received and all of these materials were thoroughly reviewed to ensure that no relevant information was overlooked.

[redacted] - [redacted] [redacted]. **Records.** [redacted] **Family Medicine.** [redacted] **Visit Notes. Pages 294-295.**
CC: Upper Respiratory Infection (Cough; Right Ear Pain; Chest Congestion). **Visit Diagnoses**: 1) Rhinitis, Non-Allergic. 2) Otitis Media. **Vitals**: **BP**: 118/67. **Weight**: [redacted] **Subjective**: Patient complains of postnasal drip, dry cough and headache for 2 days. **Assessment**: Viral upper respiratory illness, sinusitis and asthma. **Plan**: Symptomatic therapy suggested: push fluids, rest and return office visit prn if symptoms persist or worsen. Call or return to clinic prn if these symptoms worsen or fail to improve as anticipated. **Medications**: 1) Amoxicillin 500 mg. 2) Amitex PSE 120 MG-600 MG 12 HR. 3) Codeine-Guaifenesin 10 mg-100 mg/5 ml. 4) Nasarel 29 mcg Nasal Spray Aerosol.

[redacted] - [redacted] [redacted]. **Records.** [redacted] – [redacted] **MD. Family Medicine.** [redacted] **Progress Notes. Pages 296-297.**
CC: Cough. **Visit Diagnoses**: URI. **Vitals**: **BP**: 123/61. **Weight**: [redacted] **Procedures**: **XR Chest, 2 Views. Impression**: Normal Study. **Subjective**: Patient seen for cough and put on Abx but did not finish Tx. Return and took Keflex. Patient still with postnasal drip and

coughing happening. **Assessment**: URI (primary encounter diagnosis) **Plan**: Increase fluids, rest, return as needed. **Orders Placed This Encounter**: 1) XR Chest, 2 Views. 2) Amitex PSE 120 mg-600 mg 12 HR. 3) Benzonatate 100 mg.

[redacted] **Permanente. XR Chest, 2 Views. Page 297.**
Impression: Normal study.

[redacted] **Records.** [redacted] **. Family Practice.** [redacted] **Progress Notes. Page 300.**
CC: Chest Discomfort. **Visit Diagnoses**: 1) URI. 2) Chest Pain, Pleuritic. **Vitals**: **BP**: 130/74. **Weight** [redacted] **Subjective**: Presents with congestion and nonproductive cough for 6 days. **Associated symptoms**: chest discomfort. Patient not related to exertion but w/ deep breathing. Patient was seen last week and given Pen.

[redacted] **. XR chest, 2 views. Page 299.**
Impression: No interval change.

[redacted] **Records.** [redacted] **MD. Emergency Medicine.** [redacted] **ED Notes. Pages 245.**
CC: Rib Pain. **Visit Diagnoses**: 1) Biliary Colic. 2) Gallstones. **Medications Administrations**: 1) Ibuprofen Tab 800 mg. 2) VICODIN 5-500 mg. **HPI**: Patient with RUQ Abd. pain/lower right side chest wall pain that started about midnight. Pain colicky in nature. **Vitals**: **BP**: 151/80. **Weight** [redacted] lbs. **Physical Examination**: **Abdominal**: TTP to RUQ - mild murphy sign. **Assessment/Plan**: **1) RUQ pain** - Eval for gallbladder disease. **2) Pain control** - Motrin (patient preference). 3) Sign-out to [redacted]

[redacted] **MD. Emergency Medicine.** [redacted] **Emergency Department Note. Page 246-247.**
Patient endorsed from Dr. [redacted] 6 a.m. for follow-up labs and UTZ. **Assessment**: Abd pain, likely biliary colic. Gallbladder sludge vs gravel. **Plan**: Abd pain and gallstone precautions given. Appy precautions given. OTC NSAIDs. Vicodin RX. PMD 2 d. G surg referral. **Reevaluation at 11:01am**: States feels much better and ready for discharge.

[redacted] **M.D.** [redacted] **XR Chest, 1 View. Page 248.**
Findings: The lungs are normal. The heart and mediastinum are normal. **Impression**: Normal study.

[redacted] **M.D.** [redacted] **US Abdomen. Page 248-249.**
Impression: 1) Minimal sludge or gravel in the gallbladder neck. The wall thickness is normal. There is no ductal obstruction. However, the patient demonstrates what appears to be a positive Murphy's sign. 2) Diffuse fatty liver. 3) Splenomegaly at 13.2 cm.

[redacted] **- [redacted] Records. [redacted] – Laboratory Report. Pages 249-258.**
CBC No Diff: WBC 8.4, RBC 4.77, HGB 14.7, HCT 43.1, MCV 90.3, MCH 30.7, MCHC 34.0, RDW 13.9, Platelets 207, MPV 9.0. Electrolytes, Serum: Sodium 138, Potassium 3.9, Chloride 103, CO2 25. Creatinine, Serum: Creatinine 1.0, Glomerular Filtration Rate >89. Glucose, Random: 113. Amylase, Serum: 43. **ALT, Serum: 51 (H).** AST: 28. Bilirubin, Total and Direct (At PC, WL, WH, LA, FN - Order Total & Direct Separately): Bilirubin Total 0.8, Bilirubin Direct 0.1.

[redacted] **- [redacted] Records. [redacted] MD. Family Practice. [redacted] Progress Notes. Pages 302-303.**
CC: Gallstones (f/u). **Visit Diagnoses**: Cholelithiasis. **Vitals**: **BP**: 114/73. **Weight**: [redacted] **Subjective**: Patient presents with gallstones - f/u. F/u Abd. pain. Was seen in ER with u/s showing sludge vs gravel. Patient has not had pain since. Patient was seen by surgery but was told urgent surgery is not necessary. **Assessment**: Cholelithiasis. **Plan**: Hydrocodone-Acetaminophen 5 mg-500 mg. Take Vicodin as needed for severe pain.

[redacted] **Records. [redacted] MD. General Surgery. [redacted] Progress Notes. Page 301.**
Assessment: Cholecystitis. **Plan**: Patient is getting married [redacted] and will be on his honeymoon for 1 month. Patient is entirely asymptomatic and if he avoids junk food he should do well. Discussed laparoscopic versus open cholecystectomy. He will think it over and let me know if and when he wants surgery. All questions answered.

[redacted] **Records. [redacted] Family Practice. [redacted] Progress Notes. Pages 305-306.**
CC: Cough. **Visit Diagnoses**: Influenza. **Vitals**: **BP**: 133/78. **Weight**: [redacted] **Subjective**: Patient complains of congestion, sore throat, swollen glands and myalgias for 5 days. **Assessment**: Influenza. **Plan**: Risks, benefits, alternatives, potential outcomes, and side effects of treatments were discussed with the patient. Signs and Symptoms to report. RTC PRN. **Orders Placed This Encounter**: Phenyleph-Promethazine-COD 5-6.25-10 mg/5 ml.

[redacted] **- [redacted] Records. [redacted] Head & Neck Surgery. [redacted] Progress Notes. Pages 307.**
Assessment: Rhinitis with ETD improved. Hearing normal. **Plan**: Continue with Nasarel spray bid as directed and reviewed at length the proper administration and timing of spray, nasal saline as directed. RTC if any change in hearing or congestion worsens.

[redacted] - [redacted]. Records. [redacted] MD. Family Practice. [redacted] Progress Notes. Pages 309-310.

CC: 1) URI Symptoms (and sore throat for 5 days). 2) Sinus Problems (for 5 days). **Visit Diagnoses**: Acute Bronchitis. **Vitals**: **BP**: 128/81. **Weight**: [redacted] **History**: St cough for 5 days. **Physical Exam**: HEENT: Throat injected. **Assessment**: Acute Bronchitis. **Plan:** Promethazine-Codeine 6.25-10 mg/5 ml. Amoxicillin 500 mg.

[redacted] [redacted]. Records. [redacted] MD. Family Practice. [redacted] Progress Notes. Pages 311-313.

CC: URI (f/u, not better, thick phlegm, cough). **Visit Diagnoses**: URI. **Vitals**: **BP**: 120/90. **Weight**: [redacted] **Subjective**: Patient complains of cough- productive, + fever 4 days ago. Worse in the evening. Patient is currently using Flonase. Completed 10-day course of Amoxicillin. No night sweats Has been a prob for 6 months. Never quite gets better. Currently takin Entex. **Assessment**: Viral upper respiratory illness. **Plan**: Symptomatic therapy suggested: push fluids, rest and return office visit prn if symptoms persist or worsen. Lack of antibiotic effectiveness discussed with him. Call or return to clinic prn if these symptoms worsen or fail to improve as anticipated. If not better in 1 wk. Patient will notify me. Trial of prednisone burst. Given DMI.

[redacted] - [redacted]. Records. [redacted] XR, Chest, 2 Views. Pages 311-312.

Impression: No interval change.

[redacted] - [redacted]. Records. [redacted] MD. Family Practice. [redacted] Progress Notes. Pages 317.

CC: Elbow Pain (right c/o "I had a fall a few weeks ago and my elbow hurts" x 2 weeks). **Visit Diagnoses**: 1) Weight Loss Counseling. 2) Left Elbow Joint Pain. **Vitals**: **BP**: 136/92. **Weight**: [redacted] **Subjective**: Patient sustained a left elbow injury 2 weeks ago. **Mechanism of injury:** fell off his bike. **Immediate symptoms**: immediate pain, immediate swelling, inability to use arm directly after injury. Symptoms have been constant since that time. **Prior history of related problems**: no prior problems with this area in the past. **Assessment**: 1) Weight Loss Counseling. 2) Left Elbow Joint Pain. **Plan**: Rest the injured area as much as practical, apply ice packs, elevate the injured limb, X-Ray ordered, prescription for NSAID given. **Orders Placed This Encounter**: 1) XR Left Elbow 3 to 4 Views. 2) Naproxen (Naprosyn) 500 mg Oral Tab. XR Left Elbow 3 to 4 Views Impression: Soft tissue swelling.

[redacted] [redacted] [redacted] XR Left Elbow 3 to 4 Views. Pages 316-317

Impression: Soft tissue swelling.

[redacted]

[redacted] - [redacted] [redacted]. **Records.** [redacted] **MD. Family Practice.** [redacted] **Progress Notes. Pages 320-321**

CC: 1) Sleep Problem (c/o "my wife thinks I have sleep apnea. She said she finds me not breathing at night"). 2) Prescription Refill Requested (Lamisil c/o "some nail problem on my feet" x 2 years). **Visit Diagnoses**: 1) Weight Loss Counseling. 2) Snoring. 3) Onychomycosis. 4) Dermatitis. **Vitals**: **BP**: 124/86. **Weight**: [redacted] **Subjective**: Patient presents with his wife for f/u: 1) Sleep problem - per wife she has to shake him awake because he stops breathing. Request sleep apnea test. 2) Request Lamisil for toenail fungus. Used it in the past. 3) R ear is pruritic. Using a q-tip to scratch. **Current Outpatient Prescriptions**: 1) Ibuprofen (Motrin) 800mg. 2) Virtussin AC 10-100mg/5ml. **Assessment/ Plan**: 1) Weight Loss Counseling. 2) Snoring: Sleep on stomach, Sleep clinic. 3) Onychomycosis: We discussed using Lamisil. 4) Dermatitis(ear): Fluocinolone 0.01 % Top Oil. **Orders Placed This Encounter**: 1) ALT (Result: within normal range). 2) Referral Sleep Clinic. 3) Terbinafine (Lamisil) 250 mg. 4) Fluocinolone (Derma-Smoothe/FS Body Oil) 0.01 % Top Oil.

[redacted] - [redacted] [redacted] **– Laboratory Report. Pages 321-322.**

ALT: 44.

[redacted] [redacted] [redacted]. **Records.** [redacted] **Home Sleep Test W Type 3 Portable Monitor, Unattended, Minimum 4 Channels. Pages 324-328**

Impression: The patient demonstrates severe obstructive sleep apnea (OSA) with an apnea-hypopnea index (AHI) of 76.3 events/hour. Oxygen saturation by pulse oximetry fell to as low as 66.0 during the study.

[redacted] [redacted] [redacted]. **Records.** [redacted] **Auto CPAP. Pages 330-333.**

Impression: 1) History of Severe obstructive sleep apnea. 2) Successful APAP titration.

[redacted] [redacted] [redacted]. **Records.** [redacted] **Sleep Apnea Clinic. Progress Notes. Pages 330-333.**

CC: Sleep apnea. Patient presents with obstructive sleep apnea. **Vitals:** Wt. [redacted] lbs. **Studies completed:** 1) Pre-AHI: 76.3. 2) Corrected AHI: 4.0. 3) **Epworth Sleepiness Scale**: 7/24. **Follow Up Visit**: 30-120 days for compliance use. **Follow up with referring/primary physician:** Dr. [redacted] **Orders Placed This Encounter**: 1) CPAP or BPAP Humidifier, Heated (DME). 2) CPAP, Self-Titrating (DME).

[redacted] [redacted] [redacted]. **Records.** [redacted] **Family Practice.** [redacted] **Progress Notes. Pages 339-341.**

Subjective: Patient presents with chest tightness. Chest discomfort. Started a few days ago. No fever/chills. Has runny nose at night. Dry cough also at night. No shortness of

breath. Discomfort along sternal region. Has not taken any over-the-counter medication. Denies recent travel. Works at KP pharmacy. Denies chest pain. Has epigastric discomfort with specific foods. **Physical Exam**: **Vitals**: **BP**: 137/79. **Weight** [redacted] **Assessment**: 1) Chest Tightness. 2) Severe Obesity Equivalent. 3) URI. **Plan**: **Orders Placed This Encounter**: 1) XR chest, 2 views. 2) Electrolyte panel (Na, K, Cl, CO2). 3) Creatinine. 4) CBC no differential. 5) ALT. 6) TSH. 7) LDL cholesterol, direct. 8) HDL cholesterol. 9) Cholesterol. 10) Hemoglobin A1C, screening or prediabetic monitoring. 11) Chlamydia + GC, urine, amplified probe. 12) Albuterol (Proair/Proventil/Ventolin) 90 mcg/actuation inhaler HFAA. **Plan**: Viral upper respiratory infection vs Gerd? Check chest x-ray. Advised anti-reflux measures including over the counter anti-acids at this time. Routine labs ordered. RTC prn if symptoms persist, become worse, increase in severity, or fail to improve.

[redacted] **– Laboratory Report. Pages 342-359.**
Electrolyte panel (Na, K, Cl, CO2): **Sodium 146 (H);** Potassium 3.9; Chloride 106. Creatinine: Creatinine 1.02, Glomerular Filtration Rate 93. CBC No Differential: RBC, auto 4.91; HGB 14.7; HCT, auto 46.1; MCV 93.9; MCH 29.9; **MCHC 31.9 (L);** RDW, Blood 14.3; Platelets, Automated Count 194. **ALT: 65 (H).** TSH: 1.56**. LD Cholesterol: 149 (H). HDL Cholesterol: 39 (L). HGBA1c: 5.7 (H).** Syphilis Antibody Screen, Immunoassay: Treponema Pallidum AB, EIA non-reactive.

[redacted] **Records.** [redacted] **MD. Family Practice.** [redacted] **Telephone Appointment Visit Notes. Pages 360.**
C/o ST, fever and body aches for past 2-3 days. Denies hx strep throat/asthma/smoker. No pain with swallowing. Fever 100.3 to 103, "taking Tylenol 24 hrs. a day". Denies N/V/SOB/wheezes. Wife dx with Influenza-type illness and given Tamiflu. Patient very concerned about COVID since works at pharmacy in [redacted] request testing. Creat 1.02 [redacted]. HgA1c 5.7 [redacted] **Assessment**: **1) Suspected Coronavirus COVID-19.** Comment: Patient advised on isolation measures and to contact us if symptoms persist/worsen. DMI given. **2) Influenza-like illness**. Comment: Patient advised to contact us or go to ER if symptoms worsen. **3) Acute pharyngitis.** Comment: Most likely viral syndrome. **4) Fever with chills.** Comment: Take Tylenol prn. Plan: per orders and patient instructions. **Orders Placed This Encounter**: COVID-19 (SARS-COV-2), RNA, PCR, Quest Lab. Oseltamivir (Tamiflu) 75 mg Oral Cap. Azithromycin (Zithromax) 250 mg Oral Tab.

[redacted] **Laboratory Report. Page 361.**
SARS-COV-2 (Covid-19), Qualitative, Naa Detected (A)

[redacted] **MD. Family Practice.** [redacted] **Telephone Appointment Visit Notes. Pages 365.**
Reason for TAV: Results review. F/u TAV on weekend, patient has had fevers and now with slight cough. Denies shortness of breath/ST. Last day of work was Friday [redacted].

Creat 1.02 [redacted] HgA1c 5.7 [redacted] **Assessment**: **1) Coronavirus COVID-19 disease.** Comment: Patient stable, not requiring hospitalization at this time. Contact [redacted] if symptoms worsen/persist. Patient advised to contact EHS since he is a [redacted] employee. **Plan**: per orders and patient instructions. No orders of the defined types were placed in this encounter.

[redacted] **– MD. [redacted] ED Notes. Pages 260-263.**

CC: 1) Cough. 2) Congestion. **HPI**: Patient c/o increasing cough and chest pain w/ inspiration. Patient tested positive for COVID. Works [redacted] outpatient. Patient with a known COVID positive test on [redacted] here with ongoing cough for the last 1 week. Says his coughing has increased in the last couple of days and especially worse when he takes a deep breath. Also has mild chest pain with inspiration but more concerned about the excess coughing with deep inspiration. Also says has been wheezing which is confirmed by a PA who examined him today. Patient denies any nausea or vomiting but has diarrhea of 3-4 episodes a day. **Past Medical History**: 1) Varicella. 2) Obesity (BMI 30-39.9). 3) Allergic Rhinitis. 4) Cholelithiasis. 5) Strain Of Thoracic Region. 6) Hydrocele Testis. 7) Vasectomy. 8) Anxiety. 9) Bereavement. 10) Screening for Obstructive Sleep Apnea Syndrome. 11) Obstructive Sleep Apnea. 12) Low Back Pain. **Outpatient Medications:** 1) Albuterol. 2) Inhaler, assist device, med mask (Aerochamber Plus Flow-Vu, M MSK) Misc Spacer. **Review of Systems**: **Constitutional**: Positive for fatigue and fever. **Respiratory**: Positive for cough and wheezing. **Vitals**: BP: 134/84. **Orders Placed This Encounter**: 1) XR Chest 1 View Albuterol (ProAir/Proventil/Ventolin) 90 mcg/actuation Inhaler HFA. 2) Inhaler, assist device, med mask (Aerochamber Plus Flow-Vu, M mask) Misc Spacer. **Assessment/ Plan**: **Coronavirus COVID-19 Lower Respiratory Infection**: 1) Albuterol P.R.N. for wheezing. 2) Monitor for now. 3) Continue Tylenol P.R.N. for feet. 4) Return precautions.

[redacted] **M.D. [redacted] XR Chest, 1 View. Pages 264-265.**

Impression: Left lower lobe subsegmental atelectasis.

[redacted] **MD. [redacted] Family Practice. Telephone Appointment Visit Notes. Pages 367.**

Reason for TAV: Follow-up care. F/u COVID-19 dx on [redacted] symptoms since [redacted] h [redacted] continues with dry cough, SOBOE, shortness of breath after showering. Fevers up to 105.5. Using inhaler twice a day without much difference. Called paramedics yesterday— "everything was Ok". "don't feel as weak as he did yesterday." Denies N/V - eating this morning. **Comment**: Examined yesterday, patient feeling as weak as he did yesterday. **Assessment**: **1) Coronavirus COVID-19 disease.** Comment: Patient NAD/comfortable on exam today. Will contact ID for advice on outpatient R. **2) Fever with chills. PLAN**: Per orders and patient instructions. **Orders Placed This Encounter:**

• Dr. Advice Infectious Disease. **Notes**: Spoke with patient at [redacted] Patient reports fevers are better after increased hydration/Gatorade. Denies pain and fevers at this time; however still with cough. After hearing the discussion at the Town Hall meeting with the ID/Pulm specialist today regarding the use of Plaquenil outpatient, I advised the patient against using the prescription unless he is monitored inpatient due to potential harmful effects, especially cardiac. The patient is advised to go to the ER if he feels his symptoms worsening. I have scheduled a follow-up telephone appointment (TAV) with the PCP within 2 days.

[redacted] – [redacted] MD. Family Practice. [redacted] Telephone Appointment Visit Notes. Pages 369-370.

Reason for TAV: Person Under Investigation. **Phone Visit Documentation**: Verified pt's id, allergies and medication list. He has tested positive for COVID 19. He was seen in ED. Yesterday was the first day that he had an appetite. He still has cough and intermittent shortness of breath. The fever has been intermittent. Use cold towel on his forehead to help. 2 weeks ago, today was the onset of his symptoms'. Family is doing ok. Needs work note work excuse. **Assessment**: Coronavirus Covid-19 Disease. **Plan**: No orders of defined types were placed in this encounter.

[redacted] COVID-19 Positive Test Telephone Follow Up. Page 371.

Phone Documentation: Received a call back from patient. Introduced self to patient. Patient is a [redacted] Patient tested positive on [redacted]. Followed by Employee Health. Patient was re-tested on [redacted]. Patient states he was already notified by Employee Health that he re-tested positive. Patient states that he is feeling a lot better than he was a week ago. Denies having any breathing difficulties, SOB, or fevers. Continues to have a very slight cough. States he still gets a little winded when walking around his Cul de sac at home. Reports that he is maintaining his home isolation.

[redacted] – Laboratory Report. Pages 372-373.

SARS-CoV-2 (COVID-19), Qualitative, NAA: Detected (A).

[redacted] – [redacted]. Records. [redacted] Permanente. COVID-19 Positive Test Telephone Follow Up. Page 374.

Phone Documentation: Patient reports that he is feeling well. Denies having any breathing difficulties, SOB, cough, or fevers. Continues to have diarrhea which really hasn't changed since his symptoms first started. He is keeping himself hydrated. He is able to walk around his house and take short walks without any symptoms but states he still gets a little "winded" when he takes long walks around the neighborhood.

[redacted] – Laboratory Report. Pages 375-376.

SARS-CoV-2 (COVID-19), Qualitative, NAA: Not Detected.

[redacted]
Permanente. COVID-19 Positive Test Telephone Follow Up. Page 377.
Phone Documentation: Patient states he continues to feel good for the most part. Reports that his stools are more formed today for the first time. Denies having any breathing difficulties, SOB, cough, or fevers.

[redacted] **Records.** [redacted] **– Lauren Torres, RN.** [redacted]
COVID-19 Positive Test Telephone Follow Up. Page 378-379.
Phone Documentation: Patient c/o SOB on exertion. Denies cough or fevers. States he is feeling better overall.

[redacted]
Family Practice. [redacted] **Visit Notes. Pages 386-387**
Subjective: Patient with a history of COVID, currently with two negative tests, who came in for evaluation of dyspnea on exertion; he had a chest x-ray yesterday and notes he can walk 1/2 to 1 block with dyspnea on exertion, doesn't feel well enough to return to work due to his dyspnea, becomes short of breath after speaking for a while, works in a pharmacy, discussed his emotional and physical response to COVID, is still having trouble sleeping, and hasn't tried his inhaler prior to activity. **Objective**: BP 129/80. **Chest X-ray**: No acute disease on my review. Pending radiology review. **Assessment**: 1) Dyspnea on exertion. 2) Hx of Covid-19 disease. 3) Medical excuse provided for absence from work. Notes: Stable vital signs. Dyspnea on exertion may be multifactorial-deconditioning. ? of scarring. **Plan**: Albuterol 30 minutes prior to exercise and as needed. F/u chest Xray. Off work for now **Orders Placed This Encounter**: CT Chest, Standard, No Contrast.

[redacted]
XR Chest 2 Views. Pages 381-383.
Impression: No significant abnormality.

[redacted] **MD.** [redacted]
CT Chest, Standard, No Contrast. Pages 265-266.
Impression: [redacted]) Minimal lingular scar versus atelectasis-otherwise no pulmonary abnormality identified. 2) Splenomegaly. 3) Fatty liver.

[redacted] **MD.**
Family Practice. [redacted] **Telephone Appointment Visit Notes. Pages 388-393.**
Patient with a history of COVID was cleared to work, went back to work yesterday, and felt very short of breath, feeling better when he took off his mask; he felt wiped out at the end of the day, is just getting off work now, and is feeling tired; the albuterol is used prior to exercise but he hasn't used it at work, still feels worn out, can take a deeper breath

now, and describes it as "feeling like I just ran a few miles," with sore legs from being on his feet all day (from waist down), and feels he breathes better without his mask. **Assessment**: 1) SOB. 2) Reactive Airway Disease, Unspecified. **Plan**: Will check with his boss for modified duty. F/u for PFT's. Likely has some deconditioning. Due for f/u labs. **Orders Placed this Encounter**: Referral Respiratory Therapy.

[redacted] **MD. [redacted] CTA Pulmonary W Contrast. Pages 268-269, 388-389.**
Impression: No evidence of pulmonary embolism. Unchanged small linear lingular scarring. Otherwise, clear lungs.

[redacted] **MD. [redacted] Spirometry, Pre/Post Bronchodilator, DLCO, Lung Volumes Plethysmography. Pages 272-273**
PFT Impression: Pulmonary function testing is within normal limits. **Test Performed**: Complete pulmonary function tests, including spirometry with and without bronchodilator, measurement of lung volume, and diffusing capacity **Quality of Data**: The patient's efforts are acceptable and reproducible. **Spirometry Interpretation**: Spirometry is within normal limits. **Flow Volume Loops**: Flow-Volume loops are normal. **Lung Volumes:** Plethysmographic lung volumes are within normal limits. **Diffusing Capacity**: Diffusing capacity of the lung is normal.

[redacted] **MD. [redacted] Occupational Health. Doctor's First Report of Occupational Injury or Illness. Pages 396-401.**
The patient's job responsibilities include light lifting, prolonged standing, squatting/kneeling, prolonged walking, upper extremity repetitive motion and repetitive bending/twisting at waist level. **Mechanism of Injury**: Mental stress. **Video Call Documentation**: DOI [redacted] with unknown exposure as a pharmacy assistant, felt tired and exhausted and had a fever initially; during the 2nd and 3rd weeks could not take a deep breath, with a constant fever as high as 105.5; tested positive on [redacted] had a telemedicine appointment and was prescribed Tamiflu and azithromycin and was isolated; went to the ER on [redacted] where Albuterol MDI was prescribed, but no nebulizer treatment was given and a CXR was done; positive for 39 days; scheduled to go back to work on [redacted] but struggled to breathe, with symptoms worsening while wearing a mask; used FMLA since [redacted] to be off work; went to PMD and was referred to a pulmonologist yesterday, had breathing tests but no repeat CXR, did have a chest CT scan a few weeks ago which was reported as clear; concerned that breathing has not returned to normal, with shortness of breath when walking down a few blocks and worsened with any activity. **History Of Injury**: Patient is a male pharmacist who is an employee of above employer. On above date of injury the patient claims having an exposure to COVID 19 virus at work. **Exposure Assessment**: **Exposure Time/Date**: [redacted] **Exposure Location**: Unknown. Exposure Length of

Time: Unknown minutes (Note: high risk > 15 minutes). **The location of exposure is a**: Specific covid designated treatment areas: Yes. Public area with high flow: Yes. **COVID-19 contact individual (source) was unknown:** Tested for COVID 19: unknown. Wearing masked at time of exposure: Unknown. Within 6 feet of the employee: Unknown. **PPE**: The employee wear mask at time of exposure: Yes. **The employee denies having known exposures to Covid-19 in location other than work (home, family, travel):** No. **Subjective Complaints**: **Treatment History for This Injury:** Patient states his symptoms started immediately. The patient was initially seen for the injury at a non-[redacted] Clinic. **Diagnostic tests:** CT scan. **Treatment History and Medications**: On Albuterol MDI as needed. **Work Status Before This Visit**: Total Temporary Disability (TTD). **Diagnoses:** 1) Hx of Coronavirus Covid-19 disease. 2) Reactive Airway Disease, Unspecified. **Causation Statement**: **Are your findings and diagnosis consistent with patient's account of injury or onset of Illness?** YES. Unless evidences could be demonstrated otherwise, more likely than not, this employee's claim meets criteria to qualify for temporary rebuttable presumption of AOE/COE issued by Governor Newsom [redacted] (Code sections 8567, 8571, and 8627). **A. Criteria for work relatedness**: 1) Within 14 days after exposure (from the day at work) the employee tested positive or was diagnosed with COVID 19. 2) The employee worked outside of home at direction of employer between [redacted] (effective within 60 days of the executive order): YES. 3) If not rejected within 30 days after the date the claim filed, the illness shall be presumed compensable, unless rebutted by evidence only discovered subsequent to the 30-day period. 4) Please note: Exposure/working on [redacted] could result in symptoms starting as late as [redacted] **Treatment Rendered**: Continue inhaler. **Treatment and Supplies**: Patient was given light duty with sit-down work with minimal exertion due to his symptoms. A Dr Advice Referral was sent to Pulmonology to review his case. Patient to follow-up in 1-2 weeks. **Addendum**: Case discussed with Dr. [redacted] after receipt of response from Dr. [redacted] Pulmonology. Not much history was provided on this DR advice, but review of the chart shows that the patient was COVID positive on [redacted] but since that time he has had 2 follow-up COVID negative tests. During the times he was COVID positive, his CXR was basically negative, so he did not have COVID pneumonia. CT of the chest on [redacted] per my review, is basically normal with no significant infiltrates. CTPA from May 7th showed no PE. PFTs were recently done and the result is pending, but per my review of the PFTs, there is no obstruction, restriction, or diffusion impairment. Thus, based on these findings, I do not believe the patient's SOB is from a pulmonary cause. May want to order an ECHO to see if there are any cardiac findings that can explain DOE. If this is negative, then would refer back to respiratory and order an exercise oximetry test, and if this is negative, then would have to consider his anxiety disorder as a possible cause. Dr. [redacted]. Patient called and message left. Made aware that he is clear from a pulmonology standpoint. Thus, his WC case will be closed and he will be released to full duty. It is highly encouraged that he returns to his PCP for a work-up of his dyspnea on exertion to rule out a cardiac cause. Work note amended. **Addendum** [redacted]: Received request from [redacted] Sedgwick [redacted] Facts do not support that his dyspnea

on exertion is related to his recent COVID-19 infection or any respiratory causes. This is also the opinion of the pulmonologist who reviewed this case, given normal chest x-ray, chest CT, and pulmonary testing. I am standing by my original recommendation that his dyspnea on exertion be worked up by his primary care physician, which would include vascular and cardiac pathologies. Once the work-up is performed and the cause is known, the case can be re-opened if there is a causal link. Another suggestion would be a QME for cardiology for evaluation of causation. **If Further Treatment Required, Specify Treatment Plan/Estimated Duration**: More than likely the patient's condition is expected to improve or reach maximum medical improvement or full recovery in 4-6 week(s). **If Hospitalized as Inpatient, Give Hospital Name, Location, And Date Admitted**: No. **Work Status**: This patient is discharged/released and return to regular work with no need for future medical care and no ratable impairment per AMA guides, 5th edition as of today.

[redacted] - [redacted] Records. [redacted] MD. [redacted] Transthoracic Echo Real Time W 2D Image, Spectral and Color Flow Doppler Complete. Pages 404-406.

Summary: Normal left ventricular wall motion and systolic function with estimated EF 60-65%. Normal left ventricular size. Normal left ventricular wall thickness. Normal diastolic function. Grossly normal right ventricular size and systolic function. No overt septal flattening to suggest RV pressure or volume overload. Normal left atrial size. Normal right atrial size. Mild tricuspid regurgitation. Trace MR, no mitral stenosis. Trileaflet aortic valve with mild aortic annular calcification more prominent at the RCC. Mild aortic regurgitation (PHT 518 ms). No significant aortic stenosis. Normal aortic root diameter. DDx of likely focal calcification on the right coronary cusp of the aortic valve includes vegetation; this echo density appears more likely to be calcium, is dependently mobile with the valve leaflet, and is on the aortic side of the valve. Correlate clinically. PCP messaged with plan and recommendations. **Findings**: Mitral Valve: Trace mitral annular calcification. Trace MR. No mitral stenosis. Aortic Valve: Trileaflet aortic valve with mild aortic annular calcification, more prominent at the RCC. Mild aortic regurgitation (PHT 518 ms). No significant aortic stenosis. Tricuspid Valve: Normal tricuspid valve structure and function. Mild tricuspid regurgitation. There is insufficient tricuspid regurgitation present to assess pulmonary artery pressure. Pulmonic Valve: Trace PR. Left Atrium: Normal left atrial size. Left Ventricle: Normal left ventricular size. Normal left ventricular wall thickness. Normal left ventricular wall motion and systolic function with estimated EF 60-65%. Normal diastolic function. Right Atrium: Normal right atrial size. IVC normal in size and respiratory variation suggests normal RA pressure. Right Ventricle: Grossly normal right ventricular size and systolic function. No overt septal flattening to suggest RV pressure or volume overload. Pericardial Effusion: No evidence of significant pericardial effusion. Aorta: Normal aortic root diameter.

[redacted] - [redacted] [redacted]. Records. [redacted] MD. Family Practice. [redacted] Telephone Appointment Visit Notes. Pages 407-409.

Patient with history of covid infection. He has residual symptoms related to infection with fatigue and dyspnea on exertion (pulmonary and cardiac evaluation ok -needs f/u echocardiogram in 2 months). He wanted to let me know what has been happening: **1) Excessive hair loss**: Able to see his scalp now; TSH 1.55 [redacted] WBC'S Auto 6.0 [redacted] HGB 14.6 [redacted] HGT Auto 45.5 [redacted] PL T'S Auto 185 [redacted] no results found for this base name: Iron, IBC, Fesat, Ferritin. **2) Body ache:** He has had the aches and pains 24/7; he feels like they are getting worse; "I have pain from head to toe all the time"; certain areas are worse - feet, Achilles/legs; feels that it is hard to stand upright after bending over. **3) Headaches more often than not:** He has felt lightheaded at times; headaches could last all day; he takes Tylenol intermittently, which isn't helping. **4) Dry cough has returned:** Coughing spells; has intermittent discomfort in the anterior and posterior chest wall; patient was ruled out for PE. **5) Fatigue.** Feeling lethargic; he has trouble staying awake even at work; "I feel like my eyelids are heavy." **6) Feels "foggy brain".** Sometimes difficulty concentrating. Speaking in complete sentences; diet is healthy. **Assessment**: 1) Alopecia. 2) Multiple Joint Pain. 3) Fatigue. 4) Cough. 5) HX of Coronavirus COVID-19 Disease. **Plan**: Patient with diagnosis of COVID-1[redacted]. And has sequalae from infection. Will r/u rheumatological problem as mentioned in up to date. F/u labs. Consider Rheumatology referral. Consider Cymbalta for pain - he will do some research and let me know if wants to try it. **Orders Placed This Encounter:** 1) CBC no diff. 2) Iron and total iron binding capacity. 3) Ferritin. 4) CBC w differential, auto. 5) Creatinine, serum. 6) Liver function panel (T bili, ALT, ALKP). 7) Erythrocyte sedimentation rate, automated. 8) Rheumatoid factor, serum. 9) Cardiac, high sensitivity. 10) Cyclic citrullinated peptide (CCP) IgG. 11) Hepatitis B virus surface antigen (HBsAg) w reflex to viral load. 12) HCV antibody w reflex to viral load and genotype.

[redacted] - [redacted] [redacted]. [redacted] – Laboratory Report. Pages 410-422

Iron and Total Iron Binding Capacity: Iron 86; Total Iron Binding Capacity: 352; Iron Saturation: 24%. **Ferritin: 338 (H).** CBC W/ Differential, Auto: WBC's Auto: 6.7; RBC, Auto: 5.13; HGB: 15.6; HCT, Auto: 48.0%; MCV: 93.6 fL; MCH: 30.4; MCHC: 32.5; RDW, Blood: 13.2%; Platelets, Automated Count: 184. Creatinine, Serum: Creatinine: 1.03; Glomerular Filtration Rate (GFR): 92. Liver Function Panel (T Bili, ALT, ALKP): ALT: 38; Alkaline Phosphatase: 44; Bilirubin, Total: 0.8. ESR: 4. C-Reactive Protein: 2.1. Rheumatoid Factor, Serum: Rheumatoid Factor <10. CCP IGG: <3.0.

[redacted] - [redacted] [redacted]. [redacted] MD. Family Practice. [redacted] Telephone Appointment Visit Notes. Pages 423-425.

Patient with a history of COVID with residual fatigue and joint pain; he has been on a trial of gabapentin for 2 weeks, taking 2 tablets daily, but reports that the pain feels more

like it is in the bones rather than the muscles, affecting his hands and legs, and he still experiences headaches, having missed work 3 days ago due to the pain; he had double vision with the headache, which lasted for about 30 minutes and was vertical, but this symptom has not recurred, and there were no associated nausea or vomiting or TIA symptoms with the headache, and his vision is now normal. **Medication**: 1) Gabapentin (Neurontin) 100 mg. 2) Albuterol (Ventolin HFA) 90 mcg/actuation Inhl HFAA. 3) Inhaler, assist devices (Aerochamber Z Stat Plus Flow Signal Inhaler Spacer) Misc Spacer. **Assessment:** 1) Pain. 2) Headache. 3) Multiple Joint Pain. 4) Diplopia. 5) HX of Coronavirus COVID-19 Disease. **Plan**: 1 episode of headache with diplopia. If returns check imaging. Given TIA precautions. Continue Neurontin. Referral Rheumatology.

[redacted] - [redacted] MD. Rheumatology. [redacted] Telephone Appointment Visit Notes in Rheumatology. Pages 428-429.

Referred for diffuse pain. He reports that he has diffuse pain which started when he developed the COVID-19 infection in March, with symptoms lasting for 39 days including cough, fevers, and shortness of breath, and he was bed bound for about two and one half weeks; he does not feel he has recovered, with muscles diffusely aching, headaches and fatigue persisting, and standing worsening the pain; he has not exercised outside of work, reports no joint swelling, works at [redacted] in the [redacted] was active prior to his illness with biking and hiking, and describes the pain as deep and not sensitive to touch, with no improvement from Neurontin; his overall health is good, he has a history of sleep apnea and uses his CPAP, and his active problem list includes low back pain, obesity (BMI 30-39.9), allergic rhinitis, cholelithiasis, strain of the thoracic region, hydrocele testis, vasectomy, anxiety, bereavement, screening for obstructive sleep apnea syndrome, obstructive sleep apnea, and splenomegaly. Persistent myalgias, arthralgias, and fatigue have been reported post-COVID infection in March, with no symptoms prior to COVID; additional tests have been requested, and according to UpToDate, fatigue and myalgia can be found post-COVID, with an estimated occurrence of 35 percent 14-21 days after the initial illness; pool exercise was discussed as a potential management strategy. **Patient Active Problem List**: 1) Low Back Pain. 2) Obesity (BMI 30-39.9). 3) Allergic Rhinitis. 4) Cholelithiasis. 5) Strain of Thoracic Region. 6) Hydrocele Testis. 7) Vasectomy. 8) Anxiety. 9) Bereavement. 10) Screening for Obstructive Sleep Apnea Syndrome. 10) Obstructive Sleep Apnea. 11) Splenomegaly. **Current Medication**: 1) Gabapentin (Neurontin) 100 mg. 2) Albuterol (Ventolin HFA) 90 mcg/actuation Inhl HFAA. 3) Inhaler, assist devices (Aerochamber Z Stat Plus Flow Signal Inhaler Spacer) Misc Spacer. **Assessment/Plan:** Persistent myalgias, arthralgias, fatigue post COVID infection in March. No symptoms prior to COVID. Have asked for additional tests. Through UpToDate, fatigue myalgia can be found post COVID (estimate was 35 percent 14-21 days after initial illness). Discussed pool exercise. Office visit within three weeks. Ok to add on. He finishes his day at 3:30. Ok to add him on at that time.

[redacted] **– Laboratory Report. Pages 430-438.**
C3 and C4 Complement: C3: 117; C4: 24. DSDNA Antibody: DNA DS AB: <12.3. SM AB+RNP AB, Serum: 3. Lupus Anticoagulant Panel: APTT Anticoagulant Absent; APTT Lupus Sensitive 35 sec, Dilute Russel Viper Venom Induced 35. Cardiolipin IGG, IGM: Cardiolipin IGG, EIA 1.7, Cardiolipin IGM, EIA 6.5. Creatinine Kinase: CK 128. Aldolase: 4.9.

[redacted] **MD. Pulmonology. Visit Notes. Pages 78-81.**
HPI: Patient sustained a work-related injury on [redacted] while performing his usual and customary job duties as a Pharmacy Assistant. The patient presents to this office today, for examination and treatment of injuries. **Current Work Status**: **Date last worked**: [redacted] due to COVID. Back to work [redacted] but was unable to accommodate and currently off work and was taken back off work on [redacted] **Vitals**: **Weight**: [redacted] **BP**: 139/89. **Active Medication**: 1) Ibuprofen 800 mg. 2) Tylenol Extra Str. 3) Ventolin HFA 108 (90 base) MCG/ACT inhalation aerosol solution. **Assessment**: **New Problems**: 1) Dx of Deep venous thrombophlebitis. Rule out Onset: [redacted] 2) Dx of Myocarditis. Rule out Onset: [redacted] 3) Dx of Aortic regurgitation, mild. Onset: [redacted] 4) Dx of Body aches. Onset: [redacted] 5) Dx of Memory loss. Onset: [redacted]. 6) Dx of Fatigue. Onset: [redacted]. 7) Dx of Shortness of breath. Onset: [redacted] **Pulmonary Function Testing:** Essentially normal pulmonary function test. **Oxygen Walk Study**: Without desaturation. **Echo**: With mild to moderate aortic regurgitation. **Venous US**: Negative for DVT. **Plan**: **New medications**: 1) Ibuprofen 800 mg. 2) Tylenol Extra Str. 3) Ventolin HFA 108 (90 base) MCG/ACT inhalation aerosol solution. **Additional Plan Comments**: Pulmonary function testing to assess lung function. Chest X-ray to assess for lingering parenchymal changes. Venous US and D-dimer with increased risk of clotting with COVID-related infections. Echocardiogram and CK level to assess for myocarditis and cardiac dysfunction. Oxygen walk study to assess for oxygen desaturation. Consider CT chest and stress testing if patient does not improve. Consider cardiac evaluation.

[redacted] **MD. Pulmonary Function Test. Pages 82-83.**
Impression: Essentially normal pulmonary function test.

[redacted] **MD. 6 Minute Walk Test. Pages 84.**
Impression: Oxygen walk study without desaturation.

[redacted] **MD. Pulmonology. Visit Notes. Pages 85-87.**

Vitals: **Weight**: [redacted] **BP**: 122/81. **Additional HPI**: Patient presents today for follow up. still notes fatigue. has started Vitamin D. still with reduced stamina but has doubled his activity. Walking 3 miles per day. having some joint pains. Notes occasional use of Ventolin. Has had difficulty standing 8 hours per day and was painful. **Active Medications (reviewed today)**: 1) Ibuprofen 800mg tab. 2) Tylenol Extra Strength tab. 3) Ventolin HFA 108 (90base) MCG/ACT Inhalation Aerosol Solution. **Review of Systems**: **Cardiovascular**: Dyspnea with increased activity and at rest. **Musculoskeletal**: joint pains and some tightness. **Neurologic**: difficulty concentrating saw neurology and plans to have brain MRI. **Assessment**: **Status of Existing Problems**: Assessed Body aches as comment only - [redacted] MD. Assessed Shortness of breath as comment only - [redacted] MD. Assessed COVID-19 coronavirus infection as comment only - [redacted] MD. **Plan**: 1) Continue same. 2) Return to work per Dr. Ford. 3) Plans to have MRI. 4) Increase activity as able. 5) Consider CT chest. 6) Proceed with stress echo with noted ongoing dyspnea with increased activity level.

[redacted] **MD. Rheumatology.** [redacted] **Progress Notes. Pages 441-444.**

History: Patient reports that he has diffuse pain which started when he developed the COVID-19 infection in [redacted] He reports symptoms of COVID for 39 days including cough, fevers, and shortness of breath. He was bed bound for fatigue. He finds standing makes the pain worse. He has done exercises. Headaches and no joint swelling. He works at [redacted] in the [redacted] He was active prior to his illness, biking, hiking. Pain feels deep, not sensitive to touch. No improvement with Neurontin. Overall health is good. History of sleep apnea, uses his CPAP. Today, Patient reports that he has persistent muscle aches, sensation of chest tightness, and fatigue. He had evaluation outside of [redacted] through workers' compensation. A neurologist prescribed Elavil at 10 mg, which seemed to help. He reports feeling about 60 percent better, but his muscles ache after activities. He feels his memory and concentration are reduced since his COVID infection. He does use his CPAP. He has not yet returned to work. **Current Medication**: (same from [redacted]). **Physical Exam**: **Vitals**: BP 138/79, Wt. [redacted] **Musculoskeletal**: 0/18 tender points. Strength in upper and lower extremities 5/5. 0/28 warm swollen joints. No loss of motion in hand closure, bilateral wrist, and elbow motion; shoulder flexion estimated at 140 degrees bilaterally; full knee extension bilaterally. **Labs reviewed** [redacted]: **Creat**:1.03, **GFR**:92, **ALT**:38, **ALKP**:44, **TBILI**:0.8, **ESR**:4, CRP:2.1, **RF**:<10, **CCP IGG**:<3.0, **HBSAG**: Nonreactive, **HEP C AB, SER QL**: Nonreactive, **IMMAT Granulocytes Auto**:0.01, **Lupus Anticoagulant**: Absent, **Lupus Anticoagulant Interpretation**: Lupus Anticoagulant not detected. However, where clinical suspicion for.. **APTT Lupus**:35, **RVV Induced**:35, **C3**:117, **C4**:24, **ENA SM+ RNP AB, SER**:3 **ENA AB EIA**:3, **Cardiolipin IGG EIA**:1.7, **Cardiolipin IGM EIA**:6.5, **DNA DS AB**:<12.3, **CK**:128, **Aldolase**:4.9. **Assessment/Plan**: Symptoms of fatigue, diffuse pain since the COVID infection. Today,

no evidence of RA, lupus, or fibromyalgia is seen. Labs requested. Encouraged daily exercise. RTC prn.

[redacted] – **Laboratory Report. Pages 444-446.**
Erythrocyte Sedimentation Rate, Automated: ESR 6. CRP: 1.1.

[redacted] **MD. Rheumatology.** [redacted] **Video Visit Progress Notes. Pages 449-453.**
Patient followed for a history of persistent muscle aches, fatigue, chest tightness since his COVID infection. Per last visit was feeling 60 percent improved [redacted] On Elavil. [redacted] nurse manager, is on the speaker phone through workers' compensation. Today: Has had worsening pain over the weekend. Elavil was given for one month outside [redacted] workers' compensation. Improvement noted while on this. Prior gabapentin, no improvement, tapered up to three tablets daily 100 mg. Currently not working. On light duty but the pharmacy cannot accommodate. Work status though [redacted] Sees Dr. [redacted] through workers' compensation. Walks about a mile for exercise. **Current Outpatient Medication**: (Same from [redacted]. **Labs Reviewed:** ESR 6 [redacted], ESR West 9[redacted], CRP 1.1 [redacted], WBC Auto 6.7 [redacted], HGB 15.6 [redacted] HCT Auto 48.0 ([redacted] PLT Auto 184 [redacted], Creat 1.03 [redacted]: Lupus Anticoagulant Absent, APTT Lupus 35, RV Induced 35, C3 117 (90 - 180 mg/dL), C4 24 (10 - 40 mg/dL), ENA SM+ RNP AB, SER 3 (<=19 unit(s)), ENA AB EIA 3 (<=19 unit(s)), Cardiolipin IGG EIA 1.7 (<=14.9 GPL Units), Cardiolipin IGM EIA 6.5 (<=12.4 MPL Units),DNA DS AB <12.3 (<=29.9 /U/mL), CK 128 (<=397 U/L), Aldolase 4.9 (< OR = 8.1 U/L).
Assessment/Plan: Able to fully close hands. No obvious swelling. Able to flex shoulders overhead Labs reviewed. Markers of inflammation are low. No evidence of lupus, myositis by labs. Have referred patient to acupuncture for chronic pain. Recommended reviewing with Dr [redacted] resuming Elavil. RTC prn.

[redacted] **MD. Pulmonology. Visit Notes. Pages 88-90.**
Vitals: **Weight**: [redacted] **BP**: 114/87. **Additional HPI**: Patient presents today for follow up. The patient recently had CT done and is here for results. He states his breathing has worsened and notes some chest tightness. He is using Ventolin with mild relief. Reviewed prior results and update of symptoms. **Active Medications (Reviewed Today)**: 1) Ibuprofen 800mg tab. 2) Tylenol Extra Strength tab. 3) Ventolin HFA 108 (90base) MCG/ACT Inhalation Aerosol Solution. **Review of Systems**: **Cardiovascular**: Dyspnea with increased activity and at rest. **Musculoskeletal**: joint pains and some tightness. **Neurologic**: Difficulty concentrating saw neurology and plans to have brain MRI. **Vaccines Administered/Entered**: **1) Vaccination Group**: COVID-19. **Vaccination**: Pfizer COVID-19 Vaccine Dose 1. **Administered Date**: [redacted] **2) Vaccination Group**: COVID-19. **Vaccination**: Pfizer COVID-19 Vaccine Dose 2. **Administered Date**: [redacted] **Assessment**: **Status of Existing Problems:** Assessed COVID-19

coronavirus infection as comment only - [redacted] Assessed Shortness of breath as comment only - [redacted] Assessed Chest pain as comment only - [redacted]. **New Problems:** Dx of Bronchospasm (ICD-519.11) possible Onset: [redacted] **Plan**: 1) CT Chest clear. 2) Return for methacholine challenge to assess for occult asthma. 3) Nitric oxide to assess for airway inflammation.

[redacted] **MD. Neurology.** [redacted] **Video Visit Notes in Neuro. Pages 457-458**

HPI: Patient referred by his PCP for new persistent headache since he acquired COVID [redacted] The patient reports having a near-daily headache, persistent after COVID. During COVID he was not hospitalized but states he suffered bad symptoms with 19 days of nonstop fever, as high as 105 at times. Had a lot of coughing, shortness of breath, body aches, and headaches. He returned to work about mid-[redacted], at least a couple of months later. He still suffered from fatigue, SOB, couldn't walk two houses down the block, body aches and pain, headaches, and fogginess in the brain, with poor memory. Not a coffee drinker. Triggers: Increased activity... Prior to COVID had no headaches, or at least sporadic and infrequent. Was prescribed Amitriptyline (Elavil) 10mg in [redacted] which he only took this low dose for a month (no more than 10mg). Recalls it gave him dry mouth, otherwise tolerated it. Outside [redacted] provider prescribed Nortriptyline which he titrated up to 30mg but only took it for 3 weeks. No side effects but didn't help. **Other issue**: Can't think clearly, forgets people's names but later comes to him after a few minutes. Mother and many other family members affected with Alzheimer's dementia. Mom passed [redacted] years ago in her [redacted] **Medications** [redacted] **Encounter**: 1) Cyanocobalamin, vitamin B-12. 2) Multivitamin/iron/folic acid (Centrum). 3) Albuterol (Ventolin HFA) 90 mcg/actuation lnhl HFM. **Assessment/Plan**: **1) Daily new persistent headache (primary encounter diagnosis):** Plan: Amitriptyline (Elavil) 25mg at bedtime for 2 weeks, then if needed increase to 50mg at bedtime. SE profile discussed. Lower dose or hold if intolerant and notify me. Continue with acupuncture. Consider future MRI brain if he fails prophylaxis. Schedule headache class. Follow up in 3 months or sooner if needed. **2) FHX of Alzheimer's disease:** Subjective memory loss, concentration deficits, and word finding since COVID. Had good focus and no language deficits during this encounter. He has risk of future Alzheimer's, given mother and multiple family members affected. Advised following the MIND diet, get daily exercise, and good sleep. **3) Myalgia. 4) Malaise and fatigue:** Since COVID. Normal CK. Evaluated by rheumatologist. Of note, the patient had someone on another phone line. He states it's a nurse case manager, [redacted] who I spoke with. States this was authorized, being treated under workers comp. He and she asked that this note be faxed to her. Just to clarify... this referral came in as a routine referral, as a [redacted] patient, that came from his PCP. It doesn't indicate anywhere on the referral that this is a worker's comp case.

[redacted] **MD. Neurology.** [redacted] **Progress Notes. Pages 462-464**

[redacted] **Routine follow-up on chronic headaches.** Accompanied by his case manager. States it's a worker's comp case. Case [redacted]. For clarification, the patient was referred to us as a normal, standard referral as a [redacted] member. In the interim, he never picked up Amitriptyline (Elavil). States a doctor through worker's comp recommended and prescribed Topamax. He took up to 50mg daily but only for 2.5 weeks or so. Didn't notice a difference. No SE but discontinued because he ran out, only given 30 pills. Also previously had tried Amitriptyline (Elavil) but only 10mg daily for a month. Same issue, ran out and never refilled. Still having headaches near-daily headaches, some days better than others. Not able to think clearly where he feels there is a stop in his thinking. Can't always see it clearly in his head. Has headaches 25 days out of the month with severe headaches 7 days a month. Usually last 4-6 hours. Location varies. Sometimes at the forehead, front of the head, other times at the back of the head. Feels like his whole head is throbbing. Can have nausea but most of the time not. Vomiting is rare, maybe once in 30 days. Sensitive to loud noise, and maybe to light. Finds himself squinting a lot to bright sunlight. Tries to look for a quiet place for relief. Used to take daily Tylenol and ibuprofen but not lately. It doesn't help. Suffers from anxiety, panic attacks. Has been feeling dizzy lately, attributed to panic attack but he's not sure. States he felt dizzy for a couple of days after having a panic attack. **Vitals**: BP 137/86, [redacted] lbs. **Assessment/Plan**: **Daily new persistent headache** (primary encounter diagnosis) since acquiring COVID [redacted] with occasional migraine features. Counseling on the role of pain prophylaxis. Discussed potential SEs of Amitriptyline (Elavil) and Topamax. Amitriptyline (Elavil) would be a better choice because he suffers from anxiety and panic attacks. Topamax is an option, but he complains of poor memory, and Topamax can add to word-finding difficulty. Can consider it if he doesn't do well on Amitriptyline (Elavil). Reschedule headache class (missed the class). MRI brain with and without contrast, due to persistent daily headaches. Amitriptyline (Elavil) 25mg qhs x 2 weeks, then 50mg qhs. Follow up in 2 months, HCA.

[redacted] **MD. Rheumatology.** [redacted] **Telephone Appointment Visit Notes in Rheumatology. Pages 466-467.**

Follow-up for diffuse pain, fatigue. **Per initial consultation** [redacted] Patient reports that he has diffuse pain which started when he developed the COVID-19 infection. Reports symptoms of COVID for 39 days including cough, fevers, and shortness of breath. He was bedridden for two and one-half weeks. He does not feel he has recovered. His muscles diffusely ache. Headaches persist. He finds standing makes the pain worse. He has not exercised outside of work. No joint swelling. He works at [redacted] in the pharmacy. He was active prior to his illness, biking and hiking. Pain feels deep, not sensitive to touch. No improvement with Neurontin. Overall health is good. History of sleep apnea, uses his CPAP. **Visit** [redacted]: Acupuncture referral sent. **Today**: Case manager was included: [redacted] Patient reports that acupuncture was helpful

(less severe pain when on acupuncture). Continues to have diffuse pain, body aches, and body pain. Sensation of burning of his skin intermittently. Will feel out of breath. Skin feels tight after exercise. Additional sessions requested through workers' compensation. Was placed on Elavil for headaches several days ago through Dr. [redacted] Neurology. Walks about two to three miles daily. Prior Gabapentin: no improvement when on 100 bid, so discontinued this medication. Chronic diffuse pain. Labs reviewed, no evidence to suggest RA, lupus, or myositis. Reviewed how Elavil can help both headaches and diffuse pain. I let patient know that I can authorize future acupuncture treatments. He reports that he would let me know if he wanted additional treatments through [redacted] RTC PRN.

[redacted] **MD. [redacted]**
MRI Brain and Brain Stem WO/W Contrast. Pages 282-283.
Impression: There are numerous nonspecific punctate T2 hyperintense lesions in the bilateral subcortical and deep white matter, which may represent demyelinating disease versus vasculitis versus migraine headache versus early chronic microvascular ischemic changes.

[redacted] **MD. Neurology. [redacted] Phone Visit Notes in Neuro. Pages 468-475.**
CC: Test Results, onset date [redacted] **Visit Diagnoses**:1) Chronic Daily Headache. 2) Abnormal Brain MRI (primary). **Phone Visit Documentation**: Please inform the patient that his brain MRI shows findings suggestive of chronic small vessel disease, which is a common finding on MRI. I will order a lipid panel and hemoglobin A1c. If the patient snores or has sleep apnea, recommend compliance with CPAP. Advise daily exercise, as the American Heart Association recommends walking 10,000 steps per day for the prevention of heart attacks and stroke. He can take a baby aspirin 81 mg daily for stroke prevention. Advised to follow the MIND diet. Inquire if he smokes, and if he does, advise him to quit. **Labs**: 1) **Lipid Panel**: Cholesterol: **186**, Triglyceride: **115**, HDL: **34(low)**, LDL Calculated: **129(High)**, Cholesterol/High Density Lipoprotein: **5.5(High)**, Cholesterol, Non-HDL: **152**. 2) **Hemoglobin A1c, Screening or Prediabetic Monitoring**: HGBA1C%: **5.5%**.

[redacted] **– Laboratory Report. Pages 471-475**
Lipid Panel: Cholesterol 186, Triglyceride 115, **HDL 34 (L). LDL Calculated 129 (H), Cholesterol/High Density Lipoprotein 5.5 (H),** Cholesterol Non-HDL 152.
Hemoglobin: 5.5.

[redacted] **– [redacted] MD. Family Practice. [redacted] Telephone Appointment Visit Notes. Pages 476-479.**
Verified pt's ID, allergies, and medication list. "I haven't been ok for a while". Patient had COVID [redacted]. Never went back to baseline. He has lingering

symptoms. He was recently seen in Neurology for persistent headaches. He has the following symptoms: Fatigue, shortness of breath, myalgia, headaches, joint pains, difficulty concentrating and memory issues, anxiety – PTSD, has trouble being around people and dizziness. Symptoms seem to worsen as he goes about his day. The more active he is, the worse his symptoms are. "I know that there are no answers." Neurology started him on ASA and TCA for migraine. Described an episode of dizziness after walking. Associated shortness of breath. His weight has been stable. "I can't physically push myself to the limit like I used to." Worried about his memory; he is concerned about translating. He has been mentally drained. Brain fog. He has reached out to Psychiatry. **Studies**: **MRI Brain and Brain Stem WO/W Contrast,** [redacted] **Impression**: There are numerous nonspecific punctate T2 hyperintense lesions in the bilateral subcortical and deep white matter, which may represent demyelinating disease versus vasculitis versus migraine headache versus early chronic microvascular ischemic changes. This report electronically signed by [redacted] **Assessment**: **HX of Coronavirus COVID-19 Disease**. Long haul COVID symptoms. Normal cardiac and pulmonary workup last year. Symptoms have remained stable. He is not back to baseline. **Plan**: Follow up with Neurology. Repeat echocardiogram for stability. No s/s of endocarditis when echocardiogram performed last year.

[redacted] **MD.**
Family Practice. [redacted] **Telephone Encounter. Page 482.**
Called Dr. Habib, who works at Cleveland Clinic, regarding his concerns. Question of chronic embolic HTN. He recommended: Echocardiogram/VQ scan and CT angiogram. Due to desaturation to 81 after 6-minute walk. **Orders Placed This Encounter**: CT Angio, Pulmonary (for pulmonary embolism). NM Pulm Ventilation Perfusion Imaging Particulate with Rebreathing and Washout with or without 1 breath. Creatinine. Referral Cardiology.

[redacted] **MD.** [redacted]
XR Chest 2 Views. Page 484.
Impression: No significant abnormality.

[redacted] **MD.** [redacted]
NM Pulmonary Ventilation Perfusion Imaging Particulate W Rebreathing and Washout W or WO 1 Breath. [redacted] **Pages 284-283, 480**
Impression: Normal perfusion scan. No evidence for acute or chronic PE.

[redacted] **MD.** [redacted]
CT Angio, Pulmonary (For Pulmonary Embolism). [redacted] **Pages 481-482**
Impression: There is no CT angiographic evidence of pulmonary embolism.

DOI:

MD. Cardiology. Progress Notes. Page 485

TTE (2D) complete with spectral and color flow doppler procedure completed during this visit.

LVN. Visit Notes Covid-19 Immunization Clinic. Pages 494-495.

CC: COVID-19 Vaccine, onset date **Visit Diagnoses**: Vaccination for SARS-COV-2. **Immunization**: **Vaccine COVID-19, MRNA, LNP-5, PF (Pfizer-Biontech), 30 mcg/0.3 ml.:** Done. **Immunization Records**: 1) Pfizer-BioNTech . 2) Pfizer-BioNTech . 3) Pfizer-BioNTech .

MD. Neurology. Phone Visit Notes in Neuro. Pages 497-499

TAV follow-up on chronic daily headaches. Tried Amitriptyline (Elavil), takes 50mg qhs but having side effects of bad nightmares, vivid dreams. When he was on a lower dose of 25mg, he was having side effects but they were less intense. He's still having headaches. Reports bad memory, word-finding difficulty. Still having trouble breathing. Still not back to work. Concerned about the report on MRI brain, states demyelinating disease. **Assessment**: Chronic daily headaches. Patient reports new persistent headaches, memory loss, difficulty breathing since COVID **Plan**: Wean off amitriptyline (Elavil) because of intolerant side effects. Take 25mg daily at bedtime for two weeks, then take 12.5mg at bedtime for two weeks, then off. Topamax 25mg twice a day for a week. Then if needed, increase to 50mg twice a day for a week, then if needed 75mg twice a day for a week, then if needed 100mg twice a day thereafter. SE profile may include: tingling in the hands and feet, weight loss, loss of appetite, loss of tastes to carbonated drinks, 1-2% chance of kidney store (drink 8 glasses of water a day). Memory loss at high doses. Follow up in headache clinic with NP. Reschedule missed headache class. Personally reviewed MRI brain. It's mild symmetric small vessel disease. Patient counseled on this common incidental finding. Advised to live healthy, exercise, eat healthy, and manage blood pressure, cholesterol, and blood sugars. It's a common finding also with aging. Migraines can cause small vessel disease, but it's often more asymmetric. Patient shared that he read that COVID can cause small vessel disease.

MD. Family Practice. Telephone Appointment Visit Notes. Page 501.

Echocardiogram show moderate to severe aortic stenosis. A referral has been sent for you to the Cardiology Department. **Note**: – Referral to Cardiology still not scheduled.

[redacted] **MD. Family Practice.** [redacted] **Video Visit Notes. Page 503-505**

Reason for VAV: Joint Pains. **History/ Review of Systems**: Patient with long COVID has had joint pain since contracting the virus. Over the last 2 weeks, he has experienced severe pain in his hands, with difficulty closing his right fist in the morning, though the pain improves as the day progresses. He reports paresthesia in both upper extremities randomly throughout the day, with movement alleviating the symptoms; the tingling is in different areas of his body but most pronounced in the right upper extremity. **Assessment**: **1) Paresthesia. 2) Weakness. 3) Joint Pain. 4) HX of Coronavirus COVID-19 Disease.** On permanent disability. Living with limitations. Work on meditation and journaling. **Plan**: **Orders Placed This Encounter**: 1) Erythrocyte Sedimentation Rate, Automated. 2) Creatine Kinase. 3) Lipid Panel. 4) ALT. 5) Creatinine. 6) Electrolyte Panel (NA, K, CL, CO2). 7) Referral Physical Medicine. He reports monitoring his Apple Watch and notes that his O2 levels drop below 90 during certain exercises, occurring maybe 3 times per month and staying in that range for about 1-2 minutes. His respiratory rate goes up to 34 when doing normal things around the house. He had pulmonary function tests (PFTs) in 2020 and plans to get a pulse oximeter to compare.

[redacted] **MD. Neurology. Workers' Compensation Neurologic Consultation. Pages 5-11.**

History of Present Injury: Date of injury was [redacted] The patient was at work at that day and got COVID infection. He was not hospitalized. One week later, he got worse and developed fever of 105.5 with increasing shortness of breath and he was taken to the hospital emergency room. The patient states that during this time, he had headaches and he still complains of headache, shortness of breath, and myalgias with activity. The patient was out of work from [redacted] and then was off again for two months until [redacted] He was placed on modified duty for 90 days last year but continued to experience work-related problems and was placed on disability in [redacted] During this period, he saw his primary doctor, Dr. [redacted] who referred him to cardiologist Dr. [redacted] and pulmonologist Dr. [redacted] in [redacted] He underwent x-rays and a stress test, but no medications were prescribed. Additionally, he consulted with Dr. [redacted] a psychologist, who placed him on disability, and a second psychologist who diagnosed him with PTSD, depression, and anxiety. He also had a one-time consultation with Dr. [redacted], an infectious disease specialist. The patient was referred to Dr. [redacted] a neurologist, for headaches and saw him once, followed by another neurologist, whom he visited twice starting in [redacted]. This second neurologist ordered an MRI of his brain to investigate his headaches and forgetfulness. Furthermore, he saw a rheumatologist twice, and the neurologist prescribed baby aspirin 81 mg. **Current Complaints**: He complains of headaches lasting hours daily lasting two to four hours at a time. The pain is diffuse, bioccipital and bifrontal throbbing pain. He complains of "brain fog" with slow thinking. He cannot get his worries out and has memory problems. Sometimes, he loses his balance to the left

side. Numbness in his hands certainly occurs at night and then he can shake it out. He has joint pain in his ankles, knees, elbows, shoulders, and wrists. **Past Medical History**: 1) Gallstone attack one time, no surgery, in 2007. 2) Obesity. He is now 270 pounds, 6 feet 2 inches tall. **Medications**: Albuterol and baby aspirin. **Physical Examination: Vitals:** BP: 160/100**. Lungs**: Decreased breath sounds bilaterally. **Neurologic Diagnoses:** 1) Previous history of sleep apnea. 2) Long COVID-19. 3) Cognitive disorder secondary to COVID-19 infection, with intermittent long COVID-19, including headaches. 4) Loss of smell and taste secondary to COVID-19. **Discussion**: I saw Mr. [redacted] in neurologic consultation on [redacted] He is a [redacted]-year-old right-handed man who was referred here for headaches. He denies headaches before his injury. He was hired as a hospital pharmacy assistant in [redacted]. He did have a previous history of sleep apnea and diagnosed in [redacted] The patient was diagnosed with COVID-19 infection in [redacted] He had a loss of smell and taste, myalgia, fever, some diarrhea and was basically quarantine. He developed headaches starting with COVID-19. The patient has seen multiple doctors. He was out of work from [redacted] and he gets a little confusing here. He then stopped working on [redacted] He was off duty for a couple of months, and then, on modified duty for 90 days last year. He was finally placed on permanent disability on [redacted] The patient saw at least two neurologists before me, including Dr. [redacted] once. He also saw a psychologist for depression, Dr. [redacted]; a cardiologist; and Dr. [redacted] a pulmonologist, in [redacted] He also saw at least one infectious disease expert, Dr. [redacted]. MRI scan of his brain was done. He saw a rheumatologist at least twice and is on aspirin. He did complain to me of headaches, which basically he did not have before COVID-19. The patient also complains of daily and constant depression and panic attacks, slow thinking, difficulty with word finding, and increased irritability. He wears bifocals for reading. He has dizzy spells, panic attacks, and numbness in his hands. He has multiple joint pains in his ankles, knees, elbows, shoulder, and wrists. Physical exam shows that he is very obese. His blood pressure is elevated at 160/100. After review of Mr. [redacted]'s information, he probably has long COVID-19 with pulmonary possibly cardiac and rheumatologic symptoms. Also, depression and anxiety, again all due to either directly to long COVID-19 or depression and anxiety mainly due to his COVID-19 infection. His headaches are migraine like. I think he needs a neuropsychological evaluation. I think he needs to be followed by his pulmonologist and rheumatologist. I will need to see his medical records, especially the MRI scan of his brain and also records to the other two neurologists should be sent for me. **Plan**: 1) Topamax 25 mg at h.s. 2) Continue pulmonary and rheumatologic treatment. 3) Send me the medical records. 4) Treat his blood pressure as soon as possible. 5) Temporary total disability. 6) Return in one month.

[redacted] **MD. Pulmonology. Visit Notes. Pages 91-93.**

Vitals: **Weight**: 286 lbs. **BP**: 148/90. **Additional HPI**: Patient presents today for follow-up. Notes that symptoms are not improving; last seen [redacted] Patient referred back for repeat workup and evaluation. Notes shortness of breath has been an issue and

not improving; oxygen will occasionally drop below 90% with minimal exertion, and will get dyspneic with a flight of stairs. He is only able to walk and unable to exert himself. Patient aware that he has valvular heart disease and had been seen by cardiology; no recent visit in 1 year. Overall care reviewed from prior visit. Medication management reviewed. Issues reviewed in detail with patient. Patient concerns addressed in detail. Review of medical concerns discussed in detail. Past medical history, family history, and social history reviewed and discussed with patient and updated. **Active Medications (Reviewed Today)**: 1) Ibuprofen 800mg tab. 2) Tylenol Extra Strength tab. 3) Ventolin HFA 108 (90base) MCG/ACT Inhalation Aerosol Solution. **Review of Systems**: **Cardiovascular**: Had seen cardiology, valvular heart disease. **Musculoskeletal**: joint pains and some tightness. **Assessment**: **Status of Existing Problems:** Assessed Myocarditis as comment only. Assessed Deep venous thrombophlebitis as comment only. Assessed Chest pain as comment only - [redacted] Assessed Shortness of breath as comment only. Assessed Memory loss as comment only. **Additional Assessment Comments: Work Status** - Not working currently. **Plan**: 1) Repeat pulmonary function testing and CXR. 2) Consider CTPA to further assess for pulmonary emboli and/or parenchymal changes. 3) Oxygen walk study. 4) Echo with noted valvular heart changes. 5) FENO to assess for asthma predisposition. 6) Consider cardiopulmonary exercise testing. 7) Cardiology follow up recommended.

[redacted] **MD. Neurology.**
Workers' Compensation Neurologic Follow-up. Pages 12-14.
Current Complaints: Mr. [redacted] is not working at this time and denies any new injuries or illnesses. He continues to experience shortness of breath and will see Dr. [redacted] his previous pulmonologist who treated him for sleep apnea. He still has dyspnea on exertion, which makes exercising difficult, and his condition remains unchanged since [redacted] He continues to suffer from daily headaches that last from 30 minutes to 10-12 hours, with a severity of 3-10/10, requiring him to lie down four to five times a week for two to three hours in a dark and quiet room. His medication has been denied. There is no nausea, vomiting, seizures, blackouts, or memory loss, and he denies any tremors, shakes, loss of smell or taste, diplopia, blurred vision, hearing loss, or tinnitus. He does experience dizzy spells described as lightheadedness and has trouble with his gait due to joint pain, making walking painful and resulting in total joint pain. **Neurologic Diagnoses:** 1) Previous history of sleep apnea. 2) Long COVID-19. 3) Cognitive disorder secondary to COVID-19 infection, with intermittent long COVID-19, including headaches. 4) Loss of smell and taste secondary to COVID-19. **Discussion**: I think the patient should get a rheumatology consult because of diffuse joint pain. I am also trying to get his Topamax again. He can exercise by walking 30-40 minutes a day, which should reduce his headaches, it may impair his shortness of breath. **Plan:** 1) Try to take Topamax 25 mg. 2) Exercise as above. 3) Rheumatological consult. 4) Return in six weeks.

[redacted] **Phone Visit Notes in Neuro. Pages 513**

Please let the patient know that I received a request to prescribe ASA. The patient has never had a stroke that I am aware of, but he is on it because his MRI brain shows mild chronic small vessel disease. Small vessel disease is a common finding on brain MRIs. Treatment involves good brain health practices, such as cardiovascular exercise, sleeping well, and following the MIND diet. ASA 81 mg lowers the risk of recurrent stroke in patients who have had a stroke; however, there is no data to show that its benefits outweigh the risk of bleeding in patients who have never had a stroke. I am ordering a carotid ultrasound to look for evidence of atherosclerosis (plaque formation in the arteries). If atherosclerosis is found, there would be more reason to continue ASA. If none is found, then I recommend discontinuing ASA and continuing with good brain health practices.

[redacted] **MD. [redacted]. US Duplex Scan Bilat Extracranial Carotid Arts Complete. Pages 511-512**

Impression: Carotid Duplex Procedure: A carotid ultrasound scan was performed using 2D-color flow imaging and pulsed Doppler in the longitudinal scan plane. The common carotid at proximal and distal sites; the internal carotid at proximal, mid and distal sites; one external carotid and one vertebral sites were evaluated with Doppler spectral analysis. Peak systolic and diastolic velocities were measured at these locations with the following results: **Right**: Duplex displays an entirely normal cervical carotid system. No evidence of atherosclerosis, aneurysm, or any other vascular pathology. Antegrade flow in the vertebral artery. **Left**: Duplex displays an entirely normal cervical carotid system. No evidence of atherosclerosis, aneurysm, or any other vascular pathology. Antegrade flow in the vertebral artery.

[redacted] **MD. Family Practice. [redacted] Progress Notes. Page 517-519**

Subjective: Patient presents for follow-up on blood pressure. **Current Outpatient Medications**: 1) Aspirin (Ecotrin Low Strength) 81mg. 2) Amoxicillin 500 mg 3) Acetaminophen (arthritis pain Take 1 tablet by mouth relief) 650mg. 4) Diclofenac Sodium (Voltaren) 1% % Top Gel. 5) Topiramate (Topamax) 25 mg. Oral Tab 6) Multivitamin/iron/folic acid (Centrum Oral). **Objective**: BP 135/86, Wt. 282 lbs. **Assessment**: **1) Vaccination for Diphtheria, Tetanus and Acellular Pertussis. 2) Late Sequelae of Covid-19. 3) BP Elevation. 4) Weight Loss Counseling. 5) Severe Obesity Equivalent (BMI 35-39.9 W Co-Morbidity). 6) Panic Disorder. 7) Reactive Airway Disease. 8) Screening**. Blood pressure elevated, lifestyle changes. Follow-up in 6 weeks. **Plan**: Repeat labs ordered prior to next appointment. Try meditation.

[redacted] **– Laboratory Report. Pages 520-537**

ALT: 81 (H). BUN: 16. CBC No Differential: WBC 7.1, RBC 4.90, HGB 14.9, HCT 44.6%, MCV 91.0, MCH 30.4, MCHC 33.4, RDW, Blood 13.9, Platelets Automated Count 197. Creatinine: 0.95, EGFR, Creatinine 104. Electrolyte Panel: Sodium 145, Potassium 3.6, Cl 104, CO2 28. **HGBA1c: 5.7 (H). Lipid Panel: Triglyceride 191 (H); HDL 31 (L); LDL Calculated 107 (H); Cholesterol/High Density Lipoprotein 5.5 (H);** Cholesterol, Non-Hdl 141. Creatinine Kinase: 214. ESR: 4.

[redacted] **MD. Neurology. [redacted] Telephone Encounter. Page 539.**

Please inform the patient that carotid ultrasound does not show stenosis of carotid arteries. I will repeat MRI brain no contrast, just to rule out any new lesions. Provide radiology contact to schedule. If stable he can come off ASA.

[redacted] **MD. Neurology. Workers' Compensation Neurologic Follow-up. Pages 15-17.**

Current Complaints: Mr. [redacted] is still not working because his employer will not accept his work restrictions. His headaches are daily, lasting 30 minutes to two hours, and range from 2 up to 9/10 in severity, with a throbbing pain. Additionally, he is experiencing progressive memory loss and difficulties with word finding. **Neurologic Diagnoses:** 1) Previous history of sleep apnea. 2) Long COVID-19. 3) Cognitive disorder secondary to COVID-19 infection, with intermittent long COVID-19, including headaches. 4) Loss of smell and taste secondary to COVID-19. 5) Depression and Anxiety. **Discussion**: The patient's depression and anxiety are likely affecting his mental status, potentially as a consequence of his COVID-19 infection; therefore, I recommend obtaining neuropsychological testing. The patient is currently not working because his employer will not lift his restrictions and has not obtained the neuropsychological testing. Additionally, his Topamax refill was denied. Regarding his headaches, I would like to prescribe Topamax, as literature suggests that COVID-19 can be associated with persistent headaches. The patient also wishes to see Dr. [redacted] for an ENT evaluation, particularly concerning his cough. He remains not permanent and stationary for rating purposes. **Plan:** 1) Send me the records form Dr. [redacted]. 2) Neuropsychological testing. 3) Continue Topamax 75 mg at h.s.

[redacted] **MRI Brain and Brain Stem No Contrast. Pages 289-290, 538.**

Impression: Multiple T2 hyperintensities located in the subcortical region of both frontal lobes measuring 5 mm or smaller. They appear stable when compared with prior study performed on [redacted]

[redacted] **MD. Neurology.**
Workers' Compensation Neurologic Follow-up. Pages 18-20.
Current Complaints: Mr. [redacted] is still not working due to shortness of breath and fatigue. His oxygen levels dip below 95% about 30 to 40 times each month, reaching as low as SpO2 88%. He previously saw Dr. [redacted] who wanted to perform tests that were not approved, and another doctor who prescribed albuterol. He also saw Dr. [redacted] an ENT specialist, who also recommended tests that were not approved. He was scheduled to see an internal medicine doctor for his obesity and hypertension. He continues to experience daily headaches lasting 20 minutes to two hours, with severity ranging from 2 to 10/10, described as explosive pain from the back of his head to the top. These headaches are accompanied by some nausea and vomiting, and my Topamax prescription was not approved. Additionally, he complains of bilateral hand pain and occasionally drops things. He denies seizures or blackouts, but his memory and concentration are impaired, and he has increased irritability. He sleeps 7 to 8 hours per night, has an Epworth scale score of 3, and walks for about 20 minutes at a time for exercise. **Neurological Examination**: **Mental Status**: He is depressed appearing. His mini-mental status exam is 25-27/30 testable subjects. **Neurologic Diagnoses:** 1) Previous history of sleep apnea, 2) Lung COVID-19 infection, 3) Cognitive disorder secondary to COVID-19 infection and/or depression, 4) Headache, probably migraine-like, due to COVID infection, 5) Loss of smell and taste secondary to COVID-19, and 6) Depression and anxiety. **Discussion**: It is hard for me to justify seeing this patient if medications for his headaches are denied. However, he has seen the consults that I recommended. I would also ask, therefore, appealing the denial of his Topamax. The literature does suggest that COVID-19 can cause different type of headaches including migraine-like headaches. **Plan:** 1) Topamax 25 mg at h.s. 2) Psychiatric consultation and/or neuropsychological testing. 3) Return in one month.

[redacted] **MD. Neurology.**
Workers' Compensation Telehealth Neurologic Follow-up. Pages 21-22.
Current Complaints: Mr. [redacted] is not working at this time and denies any new injuries or illnesses. He still has an impaired gait. The cane was not approved for his use. He complains of headaches. He has problems with thinking. **Neurologic Diagnoses:** 1) Previous history of sleep apnea. 2) COVID-19 infection. 3) Cognitive disorder secondary to COVID-19 infection and/or depression. 4) Headache, probably migraine like due to COVID infection. 5) Loss of smell and taste, secondary to COVID-19. 6) Depression and anxiety. **Discussion**: The patient does have migraine headaches. The literature which I did look out suggested a different kind of headache associated with COVID-19 which will be chronic and can be migraine like. Therefore, this is the reason why I want him to take Topamax 25 mg at night. As far as his body pain is concerned, he should see pain management. **Plan:** 1) Return in one month. 2) Topamax 25 mg

[redacted] **MD. Neurology. Workers' Compensation Neurologic Follow-up. Pages 23-24.**

Current Complaints: Mr. [redacted] is still not working at this time. He denies any new injuries or illnesses. He still has walking problem and he walks about 20 minutes and gets pain allover and shortness of breath. His headaches are daily, lasting 30 minutes to two hours, 3-5/10 in severity. Medications reduce his headaches by 50%. He did not get his Topamax yet. There are no seizures or blackouts. However, he has "problems with thinking" and is depressed. **Neurological Examination**: **Gait And Station**: He uses a cane to walk. **Neurologic Diagnoses:** 1) Previous history of sleep apnea. 2) COVID-19 infection. 3) Cognitive disorder secondary to COVID-19 infection and/or depression. 4) Headache probably migraine like headaches due to COVID infection. 5) Loss of smell and taste secondary to COVID-19 infection. 6) Depression and anxiety. **Discussion**: The patient unfortunately has not got his Topamax and I am requesting that he gets Topamax. He was not permanent stationary for rating purposes just yet. **Plan:** 1) Topamax 25 mg. 2) Return in one month's time.

[redacted] **MD. Neurology. Workers' Compensation Record Review. Pages 25-27.**

Review of Records pulmonology QME Dr[redacted]. Diagnostic Impression: 1) History of COVID-19 infection and pneumonia, with a chest x-ray showing left lower lobe subsegmental atelectasis; 2) Acute post-SARS COVID II syndrome characterized by a) cognitive impairment, b) hyposomnia and ageusia, c) restrictive lung disease, d) exacerbation of headaches, e) anxiety and depression, and f) arthralgias; 3) Obstructive sleep apnea, which has improved with CPAP; 4) History of migraine headaches, diagnosed in 2015; 5) History of moderate-to-severe aortic regurgitation; 6) Abnormal MRI of the brain, first diagnosed in [redacted] 7) Restrictive lung disease; 8) Moderate obesity with a BMI of 32.1; 9) Two neurology records were incomplete. **Assessment and Recommendations**: In his discussion, he goes over the patient's information and his testing. On the spirometry, he was given 10-25% impairment of the whole person. **Causation**: Causation is restrictive lung disease was 100% industrially related. There is rebuttable presumption that this almost was industrially related. **Permanent Impairment**: He was given 20% whole person impairment for his respiratory symptoms and 2% whole person impairment for pain. **Apportionment**: His respiratory impairment was 100% industrially related. Future medical care was offered. **Discussion:** I basically agree with Dr[redacted]s conclusions.

[redacted] **MD. Pulmonology. Visit Notes. Pages 94-97.**

Vitals: **Weight**[redacted] **BP**: 144/85. **Additional HPI**: Pt reports that he has persistent shortness of breath, intermittent wheezing, headaches, joint and body pains, and fatigue. Pt reports hypoxia with home monitoring. Notes diffuse joint pains as well. **Active Medications (Reviewed Today)**: 1) Ibuprofen 800mg tab. 2) Tylenol Extra Strength tab. 3) Ventolin HFA 108 (90base) MCG/ACT Inhalation Aerosol Solution. **Assessment**: **New**

Problems: 1) Dx of Wheezing. 2) Dx of Migraine headaches. 3) Dx of Chest tightness. **Additional Assessment Comments:** Echo overall negative. ECG with some desaturation but over 90%. CXR overall clear. Pulmonary function testing. **Plan**: **Prescriptions/Refills**: Trelegy Ellipta 200-62.5-25 mcg blister with device. **Additional Plan Comments**: Reviewed testing. Recommend Trial of Trelegy 200. CT chest with IV contrast. Pulmonary function testing overall very different from prior pulmonary function testing done in [redacted]. Need follow up spiro to assess for improvement.

[redacted] **MD. Neurology. Workers' Compensation Telehealth Evaluation. Pages 28-29.**

Current Complaints: Mr. [redacted] is still not working at this time mainly because of joint pain and shortness of breath. The patient took his Topamax, which he got on [redacted] However, unfortunately it caused a persistent cough and also caused visual and auditory hallucinations. Therefore, he stopped taking it. He still has headaches nearly daily, lasting 30 minutes to two hours, 3 to 8 or 9/10 in severity. He is still seeing Dr. [redacted] pulmonologist, who wants to do further tests on him. **Neurologic Diagnoses:** 1) Previous history of sleep apnea. 2) COVID-19 infection. 3) Cognitive disorder secondary to COVID-19 infection and/or depression. 4) Headache probably migraine like headaches due to COVID infection. 5) Loss of smell and taste secondary to COVID-19 infection. 6) Depression and anxiety. **Discussion:** The patient's headaches are throbbing, again suggesting migraine like type headache disorder, which can occur after infection of COVID-19. He supposed to also see his psychiatrist. It is unusual for Topamax to cause hallucinations in my experience over the years. Therefore, I will try him on Nurtec 75 mg every other day and he can return in one month's time. **Plan:** 1) Return in one month. 2) Nurtec 75 mg.

[redacted] **MD. Pulmonology. Visit Notes. Pages 98-100.**

Vitals: **Weight**: [redacted] lbs. **BP**: 140/78. **Additional HPI**: Patient presents today for follow-up and testing. The patient notes ongoing pulmonary symptoms despite Trelegy use. He reports that he is using the medication once daily, typically at night. His breathing has improved since his bout with COVID, but he denies significant improvement since starting the Trelegy. He wants to continue to use it for 1 more month to assess for improvement. The patient notes that his oxygen will occasionally drop below 95% at home, but he does not note specific numbers. The patient completed his CTPA and would like to review. **Active Medications (Reviewed Today)**: 1) Ibuprofen 800mg tab. 2) Tylenol Extra Strength tab. 3) Trelegy Ellipta 200-62.5-25 mcg blister with device. 4) Albuterol sulfate 90 mcg/actuation HFA aerosol inhaler. **Plan**: **Comments**: CTPA negative - lungs normal/ clear. Spirometry reviewed. Minimal improvement with Trelegy - patient wants to continue for 1 month. Will discontinue next month pending evaluation.

[redacted] **MD. Neurology. Workers' Compensation Neurologic Follow-up. Pages 30-31.**

Current Complaints: He has a lot of problem with joint pains. He also has shortness of breath and sees Dr. [redacted]. He has headaches. Nurtec was denied and apparently, he took eight tablets which failed to help his headaches. Dr. [redacted] relieved his headaches for the 24-36 hours with acupuncture. **Neurologic Diagnoses:** 1) Previous history of sleep apnea. 2) COVID-19 infection. 3) Cognitive disorder secondary to COVID-19 infection and/or depression. 4) Headache probably migraine like due to COVID infection. 5) Loss of smell and taste secondary to COVID-19. 6) Depression and anxiety. **Discussion:** I am going to try this patient on Aimovig for his headaches, but acupuncture helps his headaches. We can obtain acupuncture three times a week for two months. He can then return in one month's time. I also gave him three samples of Qulipta for his headache. He may also need a rheumatology consult. I am also going to try Namenda for his headaches. **Plan**: 1) Qulipta three samples one a day. 2) Rheumatology consult. 3) Namenda 5 mg at night. 4) Return in one month's time.

[redacted] **MD. Neurology. Workers' Compensation Telehealth Neurologic Follow-up. Pages 32-33.**

Current Complaints: Mr. [redacted] is not working at this time. He denies any new injuries or illnesses. He still has myalgias with shortness of breath. He is on memantine 5 mg which reduced his headaches by about 10%. His headaches are daily, last one to two hours. He can get to the point where he has to lie down. **Neurologic Diagnoses**: 1) Previous history of sleep apnea. 2) COVID-19 infection. 3) Cognitive disorder secondary to COVID-19 infection and/or depression. 4) Headache probably migraine like headache due to COVID infection. 5) Loss of smell and taste, secondary to COVID-19 infection. 6) Depression and anxiety. **Discussion**: I think he should get home health care four hours a day to start with. I am going to also increase his memantine to 5 mg twice a day. **Plan**: 1) Return in one month. 2) Memantine 5 mg. 3) Home health four hours a day, five days a week.

[redacted] **MD. Pulmonology. Visit Notes. Pages 101-103.**

Vitals: **Weight**: [redacted] lbs. **BP**: 131/82. **Additional HPI**: Patient presents today for follow-up. Notes some shortness of breath and is here with a cane. Will get dyspneic with ADLs and will easily get fatigued. He has been using Trelegy. Still pending rheum and cardiology visits. **Active Medications (Reviewed Today)**: 1) Ibuprofen 800mg tab. 2) Tylenol Extra Strength tab. 3) Memantine 5 mg tablet. 4) Trelegy Ellipta 200-62.5-25 mcg blister with device. 5) Albuterol sulfate 90 mcg/actuation HFA aerosol inhaler. **Plan**: Memantine 5 mg tablet. **Additional Plan Comments**: Ongoing Trelegy. Need Eosinophil and Ige level. Repeat spirometry and assess for improvement on Trelegy. Consider biologic use with significant obstructive lung disease and hyperinflation. Stress echo if able to assess reserve and limitations.

[redacted] **MD. Neurology. Workers' Compensation Medical Legal Supplemental Report in Neurology. Pages 36-64.**

Discussion: After review of his medical records, it is evident that he has a history of stress and headaches preceding his [redacted] injury. Notably, on [redacted], he reported severe, constant, frontal, and pulsating headaches. By [redacted] of a subsequent year, he had a lower back injury, which he initially did not attribute to work but later acknowledged as work-related. In [redacted] he complained of right knee pain and noted difficulty performing his usual work. In [redacted] he reported pain in his right index finger without any identifiable injury while working long hours and experiencing headaches. On [redacted] he expressed feeling overwhelmed, tearful, and sleep-deprived to Dr. [redacted], and by [redacted] his headaches were lasting two days. On [redacted] Mr. [redacted] reported increased stress and mood changes, and on [redacted] he requested a doctor's note for work due to stress. In the summer of [redacted] he experienced headaches with blurred vision, leading to a diagnosis of a corneal abrasion. On [redacted] he left a message about ongoing stress related to legal issues and requested lorazepam. By [redacted] he complained of shortness of breath and did not feel well enough to return to work, although he returned briefly on [redacted] only to feel short of breath again. A telehealth appointment on [redacted], with Dr. [redacted] marked the first report of occupational illness due to mental stress related to his [redacted] injury, compounded by a positive COVID test on [redacted] When he saw Dr. [redacted] neurologist, on [redacted] he reported an increase in headache frequency and severity since COVID, leading to a diagnosis of daily new persistent headache and the initiation of treatment with Elavil. An MRI on [redacted] revealed nonspecific lesions that could indicate several conditions, including demyelinating diseases or chronic microvascular ischemic changes. By [redacted] Mr. [redacted] was also experiencing forgetfulness and dizziness, attributing some symptoms to panic attacks. Despite trials with Topamax and Elavil, his symptoms persisted, and he was not working by [redacted] with diagnoses of chronic daily headaches. Discrepancies were noted in his reports, particularly regarding the frequency of his headaches before and after the COVID infection, and the impact of work-related and personal stressors on his condition. He was not formally treated for headaches at [redacted] before seeing Dr. [redacted], and further evaluation by a psychiatrist and cognitive therapy was recommended. The [redacted] report indicates that his headaches, exacerbated by COVID, remain uncontrolled despite new treatments with Nurtec and memantine, and his vocational rehabilitation status and disability rating will be deferred until he is permanently stationary. The plan includes home health support, considering his wife's significant issues, and potential neuropsychological evaluation. Apportionment will be considered when his condition is deemed permanent. **Plan**: 1) Neuropsychological evaluation. 2) Psychiatric evaluation for depression and anxiety. 3) Continue memantine 5 mg. 4) Home health four hours a day, five days a week.

[redacted] **MD., FACC. Internal Medicine-Cardiology. Comprehensive Medical-Legal Evaluation Corrected Report. Pages 111-152.**

History of Injury: Applicant reports coming home from work [redacted] more tired than usual. COVID-19 testing on [redacted] came back positive. He was evaluated at [redacted] but ultimately not admitted and was discharged home. CT scan of the chest performed [redacted] revealed minimal lingular scar versus atelectasis. Vascular and cardiac structures were normal. Applicant self-isolated for 39 days and went back to work [redacted] After returning to work, he noted physical and cognitive challenges. He worked for about two weeks before he had to stop working. Towards the end of [redacted] he attempted to return to modified duty and worked for about 90 days before he could no longer be accommodated. Applicant underwent cardiac workup to evaluate his dyspnea on exertion. Transthoracic echocardiogram performed [redacted] at [redacted] reported a tri-leaflet aortic valve with likely focal calcification of the right coronary cusp. Pressure half-time (PHT) was 518 msec, consistent with mild aortic regurgitation. He has had no history of previous echocardiogram studies prior to his COVID infection. He denies ever being told he had a heart murmur. A follow-up echocardiogram performed [redacted] by Dr. [redacted] revealed normal aortic valve structure with normal opening and mild to moderate aortic insufficiency. On [redacted] after reporting chest pain and tightness during a trip to [redacted] applicant underwent exercise stress echocardiogram testing with Dr. [redacted] He exercised 5:52 on a standard Bruce protocol, achieving 85 percent of maximum predicted heart rate, with no chest pain and normotensive BP response to exercise. No wall motion abnormalities were noted pre or post stress. 24-hour Holter monitor performed by cardiologist [redacted] MD, revealed no significant arrhythmias. A follow-up echocardiogram performed [redacted] by Dr [redacted] revealed moderate-severe aortic regurgitation with PHT 500 msec; aortic valve was noted to be mildly calcified with possible fusion of the left and right cusps. Echocardiogram performed [redacted] at [redacted] revealed possible bicuspid aortic valve with probable fusion of the left and right coronary cusps. Aortic valve PHT was 282 msec, consistent with severe aortic regurgitation. On [redacted] he had an echocardiogram which showed severe aortic regurgitation. Possible bicuspid aortic valve with mild to moderate calcification normal left ventricular ejection fraction trace mitral and tricuspid regurgitation and left atrial enlargement. Applicant reports his cardiologist is [redacted] MD in [redacted] Last visit with Dr. [redacted] was sometime before [redacted] He was told he had New York Heart Association class II dyspnea. Pulmonary rehabilitation was ordered but not approved by insurance. **Current Work Status:** The applicant was off work for two months after his initial test. He then resumed regular duties until [redacted] He returned to work at modified duty working four hours a day in [redacted] which was accommodated by his employer for three months only. He has remained off work. **Current Complaints**: Prior to his illness, he would bike 20-30 miles on the weekends near the [redacted] In [redacted] he went on a vacation to the Mexican coast where he did a lot of jet skiing and swimming. He has not had a

COVID infection since that one infection. The lowest weight he ever achieved was [redacted] pounds sometime in [redacted]. He denies baseline asthma. He is currently using the inhaler Trelegy daily and an albuterol inhaler which he uses 4-5 times per week, mostly in response to feeling wheeziness or tightness in his chest. He gets short of breath after 20 minutes. He does try to push himself physically but is forced to limit his activities. He develops body and joint pains while cooking food and stirring food. **Past Medical History:** 1) Covid-19 infection [redacted] 2) Sleep apnea, diagnosed [redacted] treating with CPAP. **Surgeries/Hospitalizations:** He had left testicle surgery about [redacted] years ago. **Current Medications:** 1) Trelegy inhaler. 2) Albuterol inhaler. 3) Memantine 5mg daily for headaches**Physical Examination**: **Weight**: [redacted] **BP**: 146/82. **Procedures Done**: **Exercise Treadmill Test Performed at** [redacted] Impression**:** Negative exercise treadmill test to heart rate achieved. Nondiagnostic test for ischemia secondary to inadequate heart rate achieved. **Transthoracic Echocardiogram Performed at** [redacted] **2**[redacted]**:** Conclusions: 1) Left ventricle cavity is normal in size. 2) Mild concentric hypertrophy of the left ventricle. 3) Normal global wall motion. Visual EF is 55-60%. 4) Doppler evidence of grade II (pseudo normal) diastolic dysfunction, normal LAP. **Impression:** 1) Aortic Regurgitation, Non-Industrial**,** Bicuspid Aortic Valve, Congenital. 2) Hypertension. **Discussion**: This [redacted] year-old man developed persistent symptoms after COVID-19 infection [redacted] His persistent symptoms include shortness of breath, pain, fatigue, and memory issues. In the course of work-up, he was noted to have aortic regurgitation that appeared progressively worse on serial echocardiograms. Echocardiogram reveals findings consistent with bicuspid aortic valve. The normal aortic valve has three almost equally sized leaflets. A bicuspid aortic valve is the result of abnormal aortic cusp formation during valvulogenesis. Although bicuspid aortic valves can function normally, the valve leaflets are subject to increased hemodynamic stress because of their shape and can therefore degenerate, calcify, and stenose or become incompetent. Bicuspid aortic valves also predispose the patient to endocarditis and are strongly associated with aneurysms and dissection of the aorta. Bicuspid aortic valves have been suggested to be associated with greater mortality and morbidity than all other congenital heart defects combined. Bicuspid aortic valve (BAV) occurs in 0.8-2% of European and North American populations and is the most common congenital reason for a predisposition to severe aortic regurgitation or stenosis in middle life, but patients are asymptomatic until late in the disease. Failure to present until clinical symptoms develop—usually in the fifth or sixth decade of life—either because the murmur is not detected or is lost to follow-up—can have important consequences. Early detection and continued surveillance are crucial to allow early intervention and preservation of cardiac function. Current guidelines place a heavy emphasis on the presence of symptoms to prompt surgical intervention in patients with severe aortic regurgitation. These guidelines were developed at a time when risks associated with valve replacement were much higher; there is a growing body of evidence to suggest that these current guidelines are too conservative, and prior to the development of left ventricular dilatation or left ventricular systolic dysfunction, there is ongoing and irreversible myocardial damage, which is associated with worse outcomes [Circulation: Cardiovascular Imaging 2022;

15(12): e015004]. Unlike his [redacted] exercise test, applicant was not able to achieve his target heart rate during today's exercise test. Applicant's aortic regurgitation became more severe with exercise and estimated pulmonary pressures post-exercise were severely elevated, suggesting some aortic contribution to his exertional shortness of breath. To date, COVID-19 research has not revealed evidence that COVID-19 infection accelerates the progression of disease in BAV patients, and the applicant is of the age where BAV patients are known to develop symptoms. There is growing appreciation of the association between COVID-19 infection and subsequent development and diagnosis of hypertension. New onset hypertension was observed in 12% of post-COVID-19 patients after 30 days, involving both systolic and diastolic pressure [Angiology 2022; 73(7):682-687]. In the LOCHINVAR study, patients at 12 weeks post-COVID-19 infection were seen to have greater than 8 mmHg higher pressures [Open Heart 2022; 9(1) ce002057]. The presence of left ventricular hypertrophy (LVH) is associated with increased cardiovascular risk, the severity of risk increasing with increased left ventricular wall thickness [NEJM 1990; 322:1561]. LVH is not typically observed in regurgitant type valvular conditions, including aortic regurgitation. **Causation**: **Hypertension**: It is within a reasonable degree of medical probability that the applicant's hypertension was caused and/or aggravated by the emotional stress and on-call responsibilities of his employment as a pharmacy assistant with [redacted] There is growing appreciation in the medical literature of the relationship between COVID-19 infection and the development of hypertension, both in patients with and without risk factors for hypertension. AOE/COE (Lab. Code, § 3600). The applicant's injury of hypertension arose out of employment and was caused by employment and is AOE/COE. **Permanent And Stationary: Hypertension***:* The applicant was at MMI as of my evaluation and he is P&S on [redacted] **Impairment**: Recent case law, Almaraz-Guzman II charges the rating physician with providing a Whole Person Impairment rating utilizing any chapter, table or method in the AMA Guides 5th Edition that most accurately reflects the injured claimant's impairment. The AMA Guides state, "impairment percentages or ratings developed by medical specialists are consensus derived, estimated to reflect the severity of the medical condition and the degree to which the impairment decreases an individual's ability to perform common Activities of Daily Living, excluding work". I opine that the Whole Person Impairment rating given in this report adequately addresses the legitimate objective medical factors in pathology and constitutes substantial medical evidence using the AMA Guides 5th Edition and taking into account Almaraz-Guzman II. **Hypertension**: Using the Guides to the Evaluation of Permanent Impairment Fifth Edition, AMA: **There are no periods of disability related to hypertension**. According to the above tables (Table 4-2 Criteria for Rating Permanent Impairment Due to Hypertensive Cardiovascular Disease; 5th Edition AMA Guides to the Evaluation of Permanent Impairment, page 66.) the applicant would fall into Class 3. He has stage 2 hypertension, which is currently untreated. He has left ventricular hypertrophy according to his left ventricular mass index, which is considered the most accurate method to calculate left ventricular hypertrophy and is the standard recommended by international guidelines [J Am Soc Echocardiogr 2015;28:1-39]. He is

definitely not Class 4 as he has no evidence of congestive heart failure or cerebro-vascular impairment. **I opine with reasonable medical probability that a whole person impairment rating of 30% is accurate and reflective of the applicant's condition.** **Apportionment**: **Hypertension**: From a medical perspective and in my apportionment determination, I have considered a number of conditions as they apply to the applicant including the non-industrial conditions: age, sex, pre-existing obesity, family history of hypertension, and obstructive sleep apnea; as well as the industrial conditions: COVID-19 infection. I have reviewed all of the available weights on the applicant. Prior to the applicant's presumed industrial injuries, he was already obese, based on his body mass index (34.7 in [redacted]. I opine that the applicant had pre-existing, non-industrial obesity. Clearly, the applicant had documented weight gain, but I am unable to determine with reasonable medical probability that this was other than for personal lifestyle choices. Nonetheless, obesity is associated with hypertension [JACC 2001; 38:1829]. The applicant was diagnosed with obstructive sleep apnea in [redacted] The relationship between obstructive sleep apnea and hypertension was best demonstrated in a prospective study published in 2000 [N Engl J Med 2000; 342:1378-1384]. This study demonstrated a dose-dependent association between sleep-disordered breathing at baseline and the presence of hypertension four years later that was independent of other known confounding factors. These findings suggest that sleep-disordered breathing is likely to be a risk factor for hypertension and consequent cardiovascular morbidity in the general population. In summary, the applicant has 5 known conditions that can contribute to hypertension and these include his age, sex, family history, pre-existing obesity, and non-industrial obstructive sleep apnea, and the industrial conditions of his history of COVID-19. **I apportion 20% of the applicant's hypertension impairment to the specific incident of COVID-19 infection while performing his duties as a [redacted] I apportion 80% of the hypertension disability to non-industrial conditions to include his sex, age, pre-existing obesity, family history, and the non-industrial component of his obstructive sleep apnea.** **Work Restrictions**: There are no restrictions in regard to his hypertension. **Future Medical Care**: The applicant should have a provision for his medications and medical management with periodic visits with his primary treating physician to treat his hypertension. He should be afforded follow-up of his congenital heart disease to include any diagnostic testing and therapeutic procedures/surgeries as determined by his treating cardiologist.

[redacted] **MD. Pulmonology. Visit Notes. Pages 104-107.**

Vitals: **Weight** [redacted] **BP**: 151/87. **Additional HPI**: Patient presents today for follow-up. The patient's condition is overall the same since his last visit. He continues to feel winded with activity and continues to use a cane for support. **Active Medications (Reviewed Today)**: 1) Ibuprofen 800mg tab. 2) Tylenol Extra Strength tab. 3) Memantine 5 mg tablet. 4) Trelegy Ellipta 200-62.5-25 mcg blister with device. 5) Ventolin HFA 90 meg/actuation HFA aerosol inhaler. **Plan**: **Additional Plan Comments**: Patient with spiro today - ongoing severe obstruction noted. Patient is compliant with Trelegy daily.

Had treadmill stress test yesterday - will send in copy of report. Continues to have shortness of breath. Unable to complete nitric oxide because of pain. Labs today to assess for biologics. Defer further recommendations pending review of results ordered. Alpha 1 swab at next visit.

[redacted] **MD. Pulmonology. Visit Notes. Pages 108-110.**

Vitals: **Weight**: [redacted] **BP**: 140/102. **Additional HPI**: Patient presents today for follow-up. Notes that he has been having headaches. Patient does not want Xolair as he is concerned about side effects. **Active Medications (Reviewed Today)**: 1) Ibuprofen 800mg tab. 2) Tylenol Extra Strength tab. 3) Memantine 5 mg tablet. 4) Trelegy Ellipta 200-62.5-25 mcg blister with device. 5) Ventolin HFA 90 meg/actuation HFA aerosol inhaler. 6) Xolair 150 mg/mL syringe. **Problems**: Added new problem of Fatigue. Added new problem of Aortic stenosis. Assessed Wheezing as comment only. Assessed Asthma, persistent, severe as comment only. Assessed Shortness of breath as comment only. Assessed Migraine headaches as comment only. Assessed Overweight as comment only. **Assessment**: **New Problems**: Dx of Aortic stenosis, Onset: [redacted] Dx of Fatigue, Onset: days. **Plan**: **Additional Plan Comments**: Continue with Trelegy. DC Xolair. Recommend cardiology follow-up per PTP. Follow-up visit for pulmonary function testing and FeNO to assess for allergy airway inflammation. CT chest recommended. Discussed increase exercise tolerance.

[redacted] **MD., Esq. Internal Medicine, Pulmonary and Critical Care. Panel Qualified Medical Evaluator's Supplemental Report. Pages 155-210.**

Diagnostic Impression: 1) History of Covid-19 infection and pneumonia (chest x-ray showed LLL subsegmental atelectasis). 2) Post-acute SARS-CoV-2 syndrome. a. Cognitive impairment. b. Hyposmia and ageusia. c. Restrictive lung disease. d. Headaches exacerbation. e. Anxiety and depression. f. Arthralgias. 3) Obstructive sleep apnea (severe) with improvement with CPAP. 4) History of migraine headache diagnosed in [redacted] 5) History of moderate to severe aortic regurgitation (no cardiology records). 6) Abnormal MRI brain (first diagnosed [redacted] 7) Restrictive lung disease. 8) Moderate obesity with BMI of 32.1. **Discussion**: **Rheumatology**: Review of the records reveal that on [redacted] the applicant had a telephone conversation with a rheumatologist (this is the only record), and stated that the workup revealed no evidence of rheumatoid arthritis, lupus, or fibromyalgia. Based on the records, there will be no ratings for any rheumatologic diseases. **Headaches**: The applicant is at maximal medical improvement for headaches. He had a history of migraine headache prior to the injury, which were minor. He was rated as 5% WPI by Dr. Merman (neurology). As this was a pre-existing condition, based on the severity pre and post injury, and the effects on the applicant's activities of daily living, in my opinion, this should be apportioned 80% industrial and 20% non-industrial. **Anosmia and Ageusia**: The applicant at maximal medical improvement for anosmia and ageusia (loss of taste and smell). Dr. [redacted]

rated these as 1% WPI, 100% industrial, and this will be incorporated into the findings. **Cognitive Impairment**: The applicant is at maximal medical improvement for cognitive impairment, based on a review of the medical records which indicate that since my initial evaluation, Dr. [redacted] has not documented any improvement in his condition. If the parties wish me to re-evaluate the applicant, I would be happy to do that; however, based on all the evidence available at the time of this writing, he is at maximal medical improvement to a reasonable medical certainty. Using Table 13-2, on page 309, Criteria for Rating Impairment of Consciousness and Awareness, the applicant is rated as Class 1, persistent limitation in state of consciousness and minimal limitation of ADL. The applicant is rated at 7% impairment of the whole person. There is no prior history of cognitive impairment, and in my medical opinion, apportionment is 100% industrial. **Hypertension**: Dr. [redacted] (cardiology) found that the applicant's valvular disease was non-industrial. He determined that the applicant's hypertension was industrial, AOE/COE, at maximal medical improvement with a rating of 30% WPI apportioned as 20% industrial and 80% non-industrial. **Respiratory Disorders**: The applicant is at maximal medical improvement for respiratory impairment. The rating is based on the applicant's DLCO, which was 67% of predicted. Pursuant to Table 5-12 on page 107, he is rated as Class 2, 20% whole person impairment. In my opinion, 100% of his permanent impairment is industrial as there is no prior history of respiratory impairment. **Sleep Disorder**: The applicant had a sleep study which showed severe obstructive sleep apnea, with an impressive response to CPAP. Although patients with sleep apnea have a higher risk of severe Covid-19, Covid-19 has not been reported to cause or aggravate sleep apnea. Although there may be cases where Covid-19 end-organ damage worsens sleep apnea, there is no evidence for this in this case based on the evidence in the record. Therefore, the applicant's sleep apnea is 100% non-industrial. **Combined Values**: **Headaches**: 4.00%. **Anosmia and Ageusia**: 4.96%. **Cognitive Impairment**: 11.61%. **Hypertension**: 16.92%. **Respiratory Disorders**: 33.53%. Applicant's combined rating is therefore **34% WPI. Future Medical Care:** In the future, the applicant should have access to a pulmonary specialist for treatment of their pulmonary industrial injury, treatment to include medications, as well as repeat diagnostic studies, with treatment dictated by the results of the diagnostic studies.

[redacted] **MD. Neurology. Workers' Compensation Reevaluation in Neurology. Pages 66-68.**

Current Complaints: Mr. [redacted] is not working at this time. He denies any new injuries or illnesses. He did have a CT scan of his chest and sees Dr. [redacted] **Neurologic Examination**: **Mental Status**: He still has problems with recent memory. He did not exactly know the address or the date. **Neurologic Diagnoses**: 1) Mr. [redacted] has a previous history of sleep apnea. 2) He experienced a COVID-19 infection, which is linked to 3) a cognitive disorder that may be secondary to the COVID infection and/or depression. 4) His headaches, likely migraine-like and possibly related to COVID-19, are also considered industrial. 5) Additionally, he suffered from a loss of smell or taste secondary to the COVID-19 infection, which is considered industrial. 6) His depression

and anxiety are deferred to psychiatry for further evaluation and treatment. **Discussion**: The patient did not receive his Qulipta for his headaches and he is not taking Namenda, and I would like to start him on Qulipta again and raise his nortriptyline to 30 mg at night. I warned him about excessive eating and increase nortriptyline as well as other side effects. **Plan**: 1) Nortriptyline 30 mg. 2) Qulipta 60 mg a day.

[redacted] **MD. Neurology. Workers' Compensation Supplemental Report in Neurology. Pages 69-72.**

Discussion: Main objection to my report was that home healthcare does not appear to be within the MTUS guidelines. I realize that the patient at MTUS guidelines selectively recommended on a short-term basis on hospitalization and major surgical procedure and rehospitalization to overcome deficits and activities of daily living and/or to provide nursing therapy and/or supportive care services for those who would otherwise require inpatient under deficits and activities of daily living. Although he does not fall into the exact guidelines, these are just guidelines and are not written on stone. If the patient falls while doing his activities of daily living, injuring himself such as causing a fracture or head injury, he might need hospitalization on that basis. He uses utensils and cuts himself. Therefore, if the patient's wife cannot help him out, he would probably need home healthcare. If the patient's wife and other family member cannot provide assistance, then home healthcare may not be necessary. Like I said this is kind of a borderline case.

[redacted] **MD. Neurology. Workers' Compensation Telehealth Evaluation. Pages 73-75.**

Current Complaints: Mr. [redacted] is still not working at this time and denies any new injuries. He still complains of headaches. He complains of forgetfulness. He has trouble multitasking. He is still depressed. He saw a psychologist two weeks ago, Dr. [redacted] He is supposed to see a psychiatrist next week. The patient sees Dr. [redacted] last time one to two months ago. He still has shortness of breath. He is not on oxygen treatment but takes albuterol and Trelegy. He did run out of Namenda. **Neurologic Diagnoses**: 1) Previous history of sleep apnea, 2) COVID-19 infection, 3) Cognitive disorder or brain fog secondary to COVID infection and/or depression, 4) Migraine-like headache related to COVID infection, 5) Loss of smell and taste secondary to COVID-19, industrial, and 6) Depression and anxiety, deferred to psychiatry. **Discussion**: The 10% of patients with COVID have headaches which generally clear up within three months but can last for months to years. Therefore, his headache is not inconsistent with his previous COVID infection. As far as his brain fog is concerned, there is no specific treatment for it, although cognitive behavioral therapy can be tried. No further workup is necessary for cognitive disorder or brain fog. The patient will need to be treated with medications; I am going to restart his Namenda 5 mg b.i.d. I also want to try him on Nurtec 75 mg every other day since he has not tried it. **Plan**: 1) Home health, 2) Namenda 5 mg, 3) Nurtec 75 mg. 4) Return in six weeks. 5) Exercise 150 minutes a week as tolerated, with walking being fine.

[redacted] MD. Neurology. Workers' Compensation Telehealth Evaluation. Pages 76-77.

Current Complaints: Mr. [redacted] is still not working at this time and denies any new injuries or received illnesses. He has not approval for his Namenda or Nurtec medications. He still complains of brain fog with forgetfulness. When he specifically goes into room, he cannot remember why he went in to the room or has problems with his computer. He also complains of headaches four to five days a week lasting one hour the entire day which are aching and throbbing, 7-8/10 in severity. There are no seizures or blackouts. He still complains of loss of smell. He denies any hearing loss or tinnitus. The patient saw a psychologist and psychiatrist. Dr. [redacted] is psychiatrist, he was started him on duloxetine 60 mg but it has not shown much change. **Neurologic Diagnoses**: 1) Previous history of sleep apnea. 2) COVID-19 infection. 3) Cognitive disorder or brain fog secondary to COVID infection and/or depression. 4) Migraine-like headache related to COVID infection. 5) Loss of smell and taste secondary to COVID-19, industrial. 6) Depression and anxiety, deferred to psychiatry. **Discussion**: The patient did get approval for acupuncture, although it has not seen how been started, however, we can he does on acupuncture for his headaches. Generally, acupuncture helps about 50% at a time. Therefore, I still think he needs to try medication for his headaches. This would include Nurtec, Namenda can also treat his headaches as well and may treat his cognitive disorder. **Plan**: 1) Namenda 5 mg a day. 2) Nurtec 75 mg. 3) Acupuncture as above. 4) Continued duloxetine 60 mg. 5) Return in one month's time.

[redacted] MD., Esq. Panel Qualified Medical Evaluator's Supplemental Report. Pages 212-240.

Discussion: (Same with [redacted] **Combined Values**: **Respiratory Disorders**: 20%. **Cognitive Impairment**: 26%. **Hypertension**: 30%. **Headaches**: 33%. **Anosmia and Ageusia**: 34%. Applicant's combined rating is therefore **34% WPI.**

[redacted] Results XR Right Foot. [redacted] – [redacted] MD. Imaging Center. XR Foot Right 3 + W. Page 1.

Impression: Posterior and plantar calcaneal spurs. No acute osseous abnormality.

[redacted] Results XR Left Foot. [redacted] – [redacted] MD. Imaging Center. XR Foot Left 3 + W. Page 1.

Impression: Calcific densities consistent with chronic sequela of plantar fasciitis. Posterior and plantar calcaneal spurs. Otherwise, no acute osseous abnormality.

[redacted] Results XR Left Knee. [redacted] - [redacted] MD. Imaging Center. XR Knee Left 3 VW. Page 1

Impression: No acute osseous abnormality.

[redacted]

[redacted] **Results XR Right Knee.** [redacted] **MD.** [redacted] **Imaging Center. XR Knee Right 3 VW. Page 1**
Impression: No acute osseous abnormality.

[redacted] **Results XR Left Hand.** [redacted] **MD.** [redacted] **Imaging Center. XR Hand Left 3 + VW. Page 1**
Impression: No acute osseous abnormality.

[redacted] **Results XR Right Hand.** [redacted] **MD.** [redacted] **Imaging Center. XR Hand Right 3 + VW. Page 1**
Impression: No acute osseous abnormality.

BLOOD PRESSURE EXTRACTED FROM RECORDS:	
Date	Blood Pressure (mmHg)
[redacted]	118/67
[redacted]	123/61
[redacted]	130/74
[redacted]	151/80
[redacted]	114/73
[redacted]	133/78
[redacted]	128/81
[redacted]	120/90
[redacted]	136/92
[redacted]	124/86
[redacted]	137/79
[redacted]	134/84
[redacted]	129/80
[redacted]	139/89
[redacted]	122/88
[redacted]	138/79
[redacted]	114/87
[redacted]	137/86

[redacted]

[redacted]	160/100
[redacted]	148/90
[redacted]	135/86
[redacted]	144/85
[redacted]	140/78
[redacted]	131/82
[redacted]	146/82
[redacted]	151/87
[redacted]	140/102

WEIGHT SUMMARY EXTRACTED FROM RECORDS:		
Date	Weight (lbs.)	-/+
[redacted]	[redacted]	
[redacted]	[redacted]	-6
[redacted]	[redacted]	+6
[redacted]	[redacted]	+20
[redacted]	[redacted]	-13
[redacted]	[redacted]	-6
[redacted]	[redacted]	-2
[redacted]	[redacted]	+3
[redacted]	[redacted]	+16
[redacted]	[redacted]	+1
[redacted]	[redacted]	+17
[redacted]	[redacted]	-15
[redacted]	[redacted]	+4
[redacted]	[redacted]	-1
[redacted]	[redacted]	
[redacted]	[redacted]	-2

[redacted]

[redacted]	[redacted]	+18
[redacted]		-4
[redacted]		-2
[redacted]		+13
[redacted]		+3
[redacted]		-2
[redacted]		-2
[redacted]		+3

FINAL DIAGNOSIS:

1. Evaluate for rheumatologic etiology of pain including autoimmune disease, connective tissue disease and myofascial pain syndrome (fibromyalgia)

2. Acute COVID-19 Infection

3. Long COVID, post-acute sequelae of COVID-19 (PASC): Symptoms include arthralgias, myalgias, shortness of breath, dyspnea on exertion, headaches, fatigue

4. Diabetes Mellitus

5. Hypertensive Cardiovascular Disease

SUMMARY:

In preparation for this report I was supplied medical records totaling 536 pages which I will now review with an emphasis on the rheumatology medical legal issues at hand.

On [redacted] Mr. [redacted] was seen by his family medicine physician Dr. [redacted] and was diagnosed with rhinitis. On [redacted] Mr. [redacted] was evaluated by Dr. [redacted] for upper respiratory infection. On [redacted] Mr. [redacted] had follow-up with his primary doctors for cough and chest discomfort. Chest x-rays were unremarkable. On [redacted] Mr. [redacted] was seen in the emergency room for right upper quadrant pain and diagnosed with biliary colic. Abdominal ultrasound demonstrated no ductal obstruction, positive Murphy sign, fatty liver and splenomegaly. Blood work demonstrated elevated ALT. He was discharged with plan to follow-up. On [redacted] he was seen by Dr. [redacted] general surgery. On [redacted] Mr. [redacted] had follow-up with nurse practitioner Aburto for congestion, sore throat and muscle pain and was diagnosed with influenza. [redacted] Mr. [redacted] was

seen by physician assistant dome for rhinitis. On [redacted] Mr. [redacted] was seen by Dr. [redacted] for acute bronchitis and treated with oral medications. On [redacted] Mr. [redacted] had follow-up with Dr. [redacted] for viral upper respiratory illness and was given medications including prednisone. Chest x-ray demonstrated no interval change. On [redacted] Mr. [redacted] saw Dr. [redacted] for elbow pain after a fall. He was given medications including naproxen and referred for x-ray which demonstrated soft tissue swelling. On [redacted] Mr. [redacted] had follow-up with Dr. [redacted] where he reported sleep difficulty. On [redacted] Mr. [redacted] underwent a home sleep test which demonstrated severe obstructive sleep apnea and he was recommended to start CPAP machine.

On [redacted] Mr. [redacted] was evaluated by family doctor [redacted]. Diagnosis included upper respiratory infection versus reflux. Blood work demonstrated elevated ALT and cholesterol as well as prediabetes. On [redacted] Mr. [redacted] was virtually evaluated by Dr. [redacted] for body aches and fevers and recommendations included COVID testing. On [redacted] COVID testing was positive. On [redacted] he had follow-up with his family doctor. On [redacted] Mr. [redacted] was evaluated in the emergency department for cough and chest pain. Of note his past medical history included obesity, allergic rhinitis, obstructive sleep apnea and back pain. He was prescribed albuterol and Tylenol. Chest x-ray demonstrated left lower lobe atelectasis. On [redacted] Mr. [redacted] had a follow-up phone appointment with family medicine where he reported improvement of symptoms. On [redacted] he had a follow-up phone appointment and was retested on [redacted] which was positive. On [redacted] had a follow-up with his family practice Dr. [redacted] who documented 2 negative tests but reported ongoing dyspnea on exertion. On [redacted] a CT chest demonstrated minimal lingular scarring versus atelectasis, splenomegaly and fatty liver. On [redacted] he had follow-up with Dr. [redacted] and reported easy fatigability and inability to work. On [redacted] a CT angiogram demonstrated no evidence of pulmonary embolism. On [redacted] he underwent spirometry which was normal. On [redacted] he was seen by occupational health Dr. [redacted] and was given light duty. Imaging was reviewed and he was clear from a pulmonology standpoint. It was recommended he undergo a cardiac evaluation as well as psychiatric.

On [redacted] Mr. [redacted] underwent a transthoracic echo which demonstrated normal systolic function, mild tricuspid regurgitation, trace mitral regurgitation, trileaflet aortic valve with mild aortic annular calcification, mild aortic regurgitation, no significant aortic stenosis. On [redacted] he had follow-up with Dr. [redacted] who stated to consider rheumatology evaluation. On [redacted] he had follow-up with Dr. [redacted] for he continued to report pain, headaches, joint pain, double vision. On [redacted] Mr. [redacted] was evaluated by Dr. [redacted] rheumatology by telephone. Assessment and plan included myalgias, arthralgias and fatigue post COVID. It was thought that his fatigue myalgia was due to post COVID. Blood work including complement, double-stranded DNA and lupus anticoagulant panel was negative. On [redacted] Mr.

[redacted] had follow-up with pulmonology Dr. [redacted] with plan to obtain pulmonary function testing, chest x-ray, venous ultrasound and D-dimer, echocardiogram and CK, oxygen walk study, consider CT chest and stress testing. On [redacted] pulmonary function testing was normal. Oxygen walk study was done without desaturation. On [redacted] Mr. [redacted] had follow-up with pulmonology with plan for MRI, increase activity as able, consider CT chest and proceed with stress echo due to ongoing symptoms. On [redacted] Mr. [redacted] had follow-up with rheumatology Dr. [redacted] There was no evidence of rheumatoid arthritis, lupus or fibromyalgia and he was encouraged to exercise. On [redacted] Mr. [redacted] had follow-up with rheumatology. He was referred to acupuncture for pain and follow-up with Dr. [redacted] for Elavil. On [redacted] Mr. [redacted] had follow-up with pulmonology. He was diagnosed with bronchospasm. Plan to return for methacholine challenge. On [redacted] Mr. [redacted] was evaluated by Dr. [redacted] neurology. Diagnoses included headache for which she was prescribed amitriptyline 25 mg at bedtime. For myalgia and fatigue he had been evaluated by rheumatologist. On [redacted] Mr. [redacted] had follow-up with Dr. [redacted] neurology. He reported to be started on Topamax but did not report a improvement. He also did not take amitriptyline for more than a month. Plan to restart amitriptyline, attend headache class, obtain MRI brain. On [redacted] Mr. [redacted] had follow-up with rheumatology Dr. [redacted]. Plan to continue acupuncture. On [redacted] Mr. [redacted] underwent MRI of the brain which demonstrated numerous nonspecific T2 hyperintense lesions which may represent demyelinating disease versus vasculitis versus migraine headache versus early chronic microvascular ischemic changes. On [redacted] Mr. [redacted] had follow-up with Dr. [redacted] neurology and he was recommended compliance with CPAP. Blood work demonstrated elevated cholesterol. On [redacted] he had follow-up with Dr. [redacted] family medicine. On [redacted] Mr. [redacted] had follow-up with Dr. [redacted] who recommended CT angio, pulmonary, pulmonary ventilation/perfusion imaging and cardiology referral. On [redacted] chest x-ray demonstrated no abnormality. On [redacted] he underwent a pulmonary ventilation/perfusion imaging which was normal. On [redacted] Mr. [redacted] underwent a CT angiography which did not demonstrate pulmonary embolism. On [redacted] Mr. [redacted] underwent a transthoracic echo.

On [redacted] Mr. [redacted] had follow-up with Dr. [redacted] neurology where he reported side effects including nightmares with amitriptyline. Plan was to wean amitriptyline and increase to max. MRI reviewed and noted to be incidental finding. On [redacted] an echocardiogram was reported to demonstrate severe aortic stenosis. On [redacted] Mr. [redacted] was evaluated by Dr. [redacted] family practice for ongoing joint pain and upper extremity paresthesias. Plan to refer to physical medicine. On [redacted] he had follow-up with his neurologist Dr. [redacted] He reported symptoms including headaches, brain fog, and joint pains. Recommendations included continue Topamax 25 mg daily, continue pulmonary and rheumatologic treatment, treat blood pressure. On [redacted] Mr. [redacted] had follow-up with Dr. [redacted] pulmonology. Plan included to repeat pulmonary function testing and chest x-ray, consider CT, oxygen

walk study, echo noted with valvular heart changes, assess for asthma and cardiopulmonary exercise testing. Cardiology follow-up recommended. On [redacted] Mr. [redacted] had follow-up with Dr. [redacted] neurology. Recommended rheumatologic evaluation for joint pain. On [redacted] Mr. [redacted] was seen by Dr. [redacted] neurology with plan for carotid ultrasound and consider continuation of aspirin. On [redacted] he underwent a carotid ultrasound which demonstrated normal carotid system of the right and left side. Antegrade flow in the vertebral artery. On [redacted] he had follow-up with Dr. [redacted] family practice. On [redacted] a repeat MRI brain was recommended by Dr. [redacted] neurology. On [redacted] Mr. [redacted] had follow-up with Dr. [redacted] neurology. Plan for neuropsychology testing and continue Topamax. On [redacted] he underwent an MRI which demonstrated multiple T2 hyperintensities in the subcortical region which appears to be stable. On [redacted] he had follow-up with Dr. [redacted] neurology. On [redacted] Mr. [redacted] had follow-up with neurology Dr. [redacted] with no changes to plan. On [redacted] Dr. [redacted] issued a record review for the pulmonology QME Where he was given 10 to 25% impairment of the whole person due to restrictive lung disease and 2% whole person impairment for pain. On [redacted] Mr. [redacted] had follow-up with pulmonology Dr. [redacted] with plan to start Trelegy, obtain CT chest with contrast, pulmonary function testing noted to be different from testing done in [redacted] On [redacted] he had follow-up with Dr. [redacted] neurology with plan to transition Topamax to Nurtec due to side effects. On [redacted] Mr. [redacted] had follow-up with pulmonologist Dr. [redacted] with CT chest noted to be clear. On [redacted] he had follow-up with Dr. [redacted] neurology who recommended to trial Qulipta and obtain rheumatology consult. On [redacted] he had follow-up with his neurologist Dr. [redacted] with plan to trial memantine. On [redacted] he had follow-up with his pulmonologist.

On [redacted] his neurologist Dr. [redacted] reviewed his medical records. In his discussion he noted that he has an history of stress and headaches preceding his [redacted] injury. On [redacted] he reported severe, constant, frontal and pulsating headaches. By [redacted] of a subsequent year he had a lower back injury. In [redacted] he complained of right knee pain. In [redacted] he reported pain in his right index finger. In [redacted] he expressed feeling overwhelmed tearful and sleep deprived. In [redacted] he experienced headaches, blurry vision, stress, shortness of breath. On [redacted] there was a report of occupational illness due to mental stress related to the [redacted] injury. He noted discrepancy in his reports particularly regarding the frequency of headaches before and after the COVID infection. Plan included a neuropsychological evaluation, psychiatric evaluation, continue memantine.

On [redacted] Mr. [redacted] underwent a cardiology medical legal evaluation by Dr. [redacted] On [redacted] a reported transthoracic echocardiogram demonstrated trileaflet aortic valve with likely focal calcification of the right coronary cusp. Echocardiogram performed on [redacted] revealed normal aortic valve structure with mild to moderate aortic insufficiency. Follow-up echocardiogram on [redacted]

revealed moderate to severe aortic regurgitation with the aortic valve being calcified with possible fusion of the left and right cusps. On [redacted] an echocardiogram at [redacted] revealed possible bicuspid aortic valve with probable fusion of the left and right cusps and severe aortic regurgitation. On [redacted] an echocardiogram showed severe aortic regurgitation, bicuspid aortic valve with mild to moderate calcification, normal left ventricular ejection fraction, trace mitral and tricuspid regurgitation and left atrial enlargement. In his discussion, Dr. [redacted] outlines that bicuspid aortic valves occur in 0.8 to 2% of European and North American populations. To date, COVID-19 research has not revealed evidence that COVID-19 infection accelerates the progression of disease in bicuspid aortic valves. There is growing appreciation of the association between COVID-19 infection and subsequent development of hypertension. In regard to causation for hypertension Dr. [redacted] stated it is within reasonable degree of medical probability that the applicant's hypertension was caused or aggravated by the emotional stress and alcohol responsibilities of his employment as a [redacted] with [redacted] He noted the applicant was MMI and permanent and stationary on [redacted] He stated it is within reasonable medical probability that a whole person impairment rating at 30% is accurate. He apportioned 20% of the applicant's hypertension impairment to the specific incident of COVID-19 infection while performing his duties as a pharmacy assistant. He apportion to 80% of hypertension disability to nonindustrial conditions to include sex, age, pre-existing obesity, family history and nonindustrial component of sleep apnea.

On [redacted] Mr. [redacted] had follow-up with his treating pulmonologist Dr. [redacted] Spirometry demonstrated ongoing severe obstruction. To continue Trelegy and discontinue Xolair based on concern for side effects. Recommend cardiology follow-up and CT chest.

On [redacted] QME Dr. [redacted] pulmonologist issued a supplemental report. Diagnoses included history of COVID-19 infection, postacute COVID syndrome, obstructive sleep apnea, history of migraine diagnosed in [redacted] history of moderate to severe aortic regurgitation, abnormal MRI brain, restrictive lung disease and moderate obesity with BMI of 32.1. For his headaches he was rated 5% impairment by his neurologist Dr. [redacted] with 80% industrial and 20% nonindustrial. For loss of taste and smell his neurologist rated 1% impairment and 100% industrial. For cognitive impairment he assigned 7% impairment of the whole person and apportionment is 100% industrial. He noted Dr. [redacted] cardiology impairment rating of 30% for hypertension. He assigned a combined value of 34% impairment rating.

On [redacted] Mr. [redacted] had reevaluation with his neurologist Dr. [redacted] Plan to start him on Qulipta and increase nortriptyline to 30 mg. On [redacted] Mr. [redacted] had follow-up with Dr. [redacted] with plan to restart Namenda, try Nurtec. On [redacted] he had follow-up with his neurologist. On [redacted] a supplemental report was issued by Dr. [redacted] who continued to assigned 34% impairment

rating. In [redacted] he underwent an x-ray of the right foot which demonstrated posterior and plantar calcaneal spurs, left foot which demonstrated calcific densities consistent with plantar fasciitis and posterior and plantar calcaneal spurs. X-ray of the left knee, right knee, left hand, and right hand with no osseous abnormality.

In summary, Mr. [redacted] is a [redacted] year-old male with a past medical history of obstructive sleep apnea, headaches, stress, hypertension, back pain, fatty liver, who developed symptoms of acute COVID-19 infection on [redacted] with initial manifestations including fever, body aches and fatigue. Over the next weeks to months, he developed escalating symptoms which included cough, shortness of breath, progressive headaches, musculoskeletal pain, diffuse joint pain, cognitive disturbances, escalation of depression and brain fog. He has been evaluated by multiple specialists including in the fields of neurology, rheumatology, pulmonology, cardiology, psychiatry and psychology. I initially evaluated him as a specialist in the field of rheumatology and have now been supplied with additional records. I will now outline my final recommendations based on my updated findings.

COMMENTS AND CONCLUSIONS:

1. Evaluate for rheumatologic etiology of pain including autoimmune disease, connective tissue disease and myofascial pain syndrome (fibromyalgia)

As previously outlined, as a board-certified rheumatologist I conducted a thorough evaluation to assess for any underlying rheumatologic autoimmune and inflammatory diseases which may be precipitated by infections and stresses including acute COVID-19 infection and long COVID. At the time of this writing Mr. [redacted] continues to not meet criteria for an autoimmune or inflammatory arthritis. His inflammatory markers including ESR and CRP are negative. His blood work demonstrated low titer and non-specific ANA, negative lupus panel, negative scleroderma antibodies, negative mixed connective tissue disease antibody, negative Sjogren's antibodies, and a negative rheumatoid arthritis panel. He does meet criteria for fibromyalgia which overlaps with many of the manifestations of Long COVID and which I will discuss in further detail below. As evidenced in the records, he previously underwent a rheumatologic evaluation with the same findings. As of the time of this writing there is no inflammatory rheumatologic disease however I believe there are several other medical diagnoses which explain many of his presenting symptoms including long COVID, obstructive sleep apnea, diabetes mellitus, and vitamin D deficiency which I will further detail below.

2. Acute COVID-19 Infection

Mr. [redacted] reports that during the COVID-19 pandemic, he was working fulltime in the [redacted] Mr. [redacted] states at the time of his diagnosis, employees were not to wear masks. Mr. [redacted] states that he interacted with multiple colleagues and patients

who were unmasked and coughing, sneezing, talking loudly, handling shares items and equipment (credit cards, medication bottles), and was within 6 feet for several minutes to hours at a time. On [redacted] Mr. [redacted] woke up with a fever of 101, body aches, feeling unwell. Mr. [redacted] called off sick from work and quarantined after. On [redacted] he was sent to the hospital for COVID testing which was ultimately positive. Mr. [redacted] was evaluated by urgent care virtually and was recommended to take Tylenol and over the counter medications. Mr. [redacted] reports he stayed at home and his symptoms and in the next few weeks developed symptoms of cough, headaches, recurrent fevers, brain fog, muscle pains, joint pain, brain fog, shortness of breath. Mr. [redacted] eventually went to the emergency department for his symptoms, where he underwent x-rays, and was told his vitals were stable and he was discharged. Mr. [redacted] reports he was not hospitalized acute COVID-19.

Severe acute respiratory syndrome coronavirus 2 (SARS-Cov-2) is a strain of coronavirus which was identified in 2019 and caused a pandemic of illnesses resulting in millions of deaths around the world as well as lasting health problems and many who have survived the acute infection. As of 2023 there have been over 762 million documented cases of COVID-19 worldwide. COVID-19 spreads from person-to-person via respiratory droplets. People infected with the virus release there are droplets of various sizes from their nose and throat during actions such as talking and sneezing. People become infected with viral particles when they inhale or swallow them. The risk of transmission of coronavirus is greatest when a person is within 3 to 6 feet of an infectious source, especially in situations in which many people are gathered in a crowd. Anyone can get COVID-19 but there are certain individual characteristics that place a person at higher-than-normal risk for developing this infection. Risk factors in this case include obesity, diabetes, chronic lung disease including sleep apnea. Acute symptoms of COVID-19 may include fever, headache, loss of taste, loss of smell, fatigue, muscle aches, body aches, diarrhea. Treatments for acute COVID-19 depend on the symptoms and severity of the infection. If a person has mild symptoms, treatments can be supportive in nature and include medication such as anti-inflammatory medications. Although many people with acute COVID-19 infection will get better, a substantial amount of those infected continue to experience a wide range of persistent, returning, or new symptoms which can last for many months or even years past the time that they have recovered from the acute stages of their illness. These individuals are being given the diagnosis of Long COVID.

3. Long COVID, post-acute sequelae of COVID-19 (PASC): Symptoms include arthralgias, myalgias, shortness of breath, dyspnea on exertion, headaches, fatigue

Mr. [redacted] presents with symptoms consistent with Long COVID or PASC. The average case of acute COVID-19 infection last between 5 days and 3 weeks. However as discussed above a substantial amount will continue to experience a wide range of persistent, returning or new symptoms which can last for many months or even years. These individuals are being given the diagnosis of long COVID, a term used to refer to

symptoms that extend or may develop 3 months beyond the initial COVID-19 infection and cannot be explained by other illness. Other terms to describe post-COVID conditions include post-acute sequelae of COVID-19 or PASC, Long COVID and post-acute COVID-19 syndrome. Risk factors for long COVID which are applicable in this case include individuals ages 35-69, overweight individuals, and individuals with pre-existing malnutrition such as elevated blood pressure or sleep apnea. Rates of Long COVID are lower in people who have been fully vaccinated.

Long COVID is a vacillating and sometimes debilitating condition in which more than 200 symptoms have been identified. While many are mild and reversible, moderate, and severely incapacitating health problems have been identified. PASC is associated with a wide range of physical, cognitive, mental, and functional abnormalities which can result in a substantial limitation in major life activities, impaired ability to work and deterioration in the overall quality of life. Fatigue and weakness and the most common symptoms experienced by individuals with Long COVID. Long COVID may also affect multiple organ systems of the body including the cardiovascular, musculoskeletal, neurocognitive, psychiatric, and gastrointestinal system. There is no specific test which can confirm whether someone has Long COVID. Therefore, Long COVID remains a diagnostic challenge for healthcare specialists who utilize a careful history, physical exam, and assortment of investigations to try to differentiate these conditions.

In this case Mr. [redacted] has several rheumatic manifestations consistent with Long COVID including chronic fatigue, neurocognitive dysfunction, and diffuse joint and musculoskeletal pain. Collectively, these features overlap with other medically unexplained disorders including chronic fatigue syndrome and fibromyalgia which are diagnosed and treated by rheumatologists. Due to the fact that Mr. [redacted] has failed treatments for his symptoms including physical therapy, gabapentinoids, non-steroidal anti-inflammatory drugs and duloxetine and symptoms have been present for more than one year with no significant changes, I would assign permanent and stationary status. In terms of whole person impairment utilizing the *AMA guides fifth edition* I would like to point out that Long COVID is not specifically rated in the *AMA guides*. However, systemic pain syndromes with many overlapping features with Long COVID and without measurable organ dysfunction are discussed in chapter 18. In order to determine a whole person impairment rating regarding Long COVID I will apply the Almaraz/Guzman principle by considering the major symptoms that interfere with activities of daily living.

In this case, the applicant has a sleep and arousal disorder that is partially due to the rheumatic manifestations of Long COVID. This is addressed in chapter 13 of the *AMA guides*, table 13-4 page 317. Based upon the available medical information, Epworth Sleepiness Scale, and fatigue severity scale Mr. [redacted] meets criteria for class II representing 10% to 29% impairment of the whole person. This is characterized by reduced daytime alertness interfering with ability to perform some activities of daily living that has increased after the diagnosis of Long COVID. I assign 15% impairment of

the whole person regarding sleep and arousal disorder. However, the diagnosis of obstructive sleep apnea is also likely contributing to his symptoms.

This applicant has been noted to have depression and states this is may be associated with the diagnosis of Long Covid. I defer to the medical legal evaluations in the field of psychiatry and psychology regarding this matter.

As extensively outlined above, this applicant has the complaint of diffuse and uncontrolled pain that is not otherwise explained. This is addressed in chapter 18 of the *AMA guides fifth edition*. This chapter allows additional impairment of 3% to be given to individual if the individual has a pain-related impairment that increases the burden of illness. He has been assigned 2% impairment for pain which I agree with at this time. I continue to recommend he be treated for diabetes and vitamin d deficiency which also contribute to diffuse pain, nerve pain, as well as cognitive symptoms.

For his neurologic symptoms he has undergone follow up with neurologist Dr. [redacted] For his headaches he was rated 5% impairment by his neurologist Dr. [redacted] For loss of taste and smell his neurologist rated 1% impairment. For fatigue and cognitive impairment Dr. [redacted] his pulmonologist assigned 7% impairment of the whole person. Fatigue is a dominant and bothersome symptoms for these patients and are often evaluated in the field of rheumatology. In this case I agree with this impairment assignment. Mr. [redacted] has severe obstructive sleep apnea and is not currently on treatment which I suspect may be contributing to his daytime fatigue and brain fog.

For his pulmonary symptoms of shortness of breath and dyspnea on exertion Mr. [redacted] has undergone a medical legal evaluation in the field of pulmonology by Dr. [redacted] and treatment with Dr. [redacted] He has undergone testing including pulmonary function test, chest x-rays, chest computerized tomography. I defer to his medical legal evaluators in the field of pulmonology for these recommendations. For his respiratory symptoms the applicant reportedly had an abnormal spirometry demonstrating restrictive disease and has been assigned 20% impairment. Of note, Mr. [redacted] has severe obstructive sleep apnea, is overweight is not currently on treatment which I suspect may be contributing to his symptoms. For further recommendations to the medical legal issues at hand in regard to his pulmonary system I defer to his qualified medical evaluator in the field of pulmonology.

Mr. [redacted] reported cardiovascular symptoms including shortness of breath, exercise limitations, and easy fatigability. He has undergone a medical legal evaluation in the field of cardiology by Dr. [redacted] and has the diagnosis of severe atrial regurgitation and bicuspid aortic valve. Dr. [redacted] cardiology has assigned an impairment rating of 30% for hypertension.

4. Diabetes Mellitus

Mr. [redacted] labs demonstrated Diabetes Mellitus which is a new diagnosis. His hemoglobin a1c is 7.4%. Diabetes may contribute to many of his reported symptoms including neuropathic pain, body pains, depressions, brain fog, and body pains. He should follow up with his treating internists to address this diagnosis.

5. Hypertensive Cardiovascular Disease

Mr. [redacted] has a history of hypertension as documented in the medical records, and has multiple risk factors for complications of cardiovascular and cerebrovascular disease including diabetes, obesity (BMI 39.2), elevated cholesterol, and fatty liver. He also has a diagnosis of aortic regurgitation and bicuspid aortic valve. I continue to recommend follow up with his treating internal medicine physicians and cardiologist for further evaluation and treatment.

PERMANENT AND STATIONARY STATUS

I believe that Mr. [redacted] has reached maximum medical improvement and is permanent and stationary status in regard to his rheumatologic symptoms of Long COVID. I recommend management of his co-occurring diagnoses of uncontrolled severe obstructive sleep apnea, diabetes mellitus, vitamin d deficiency, elevated cholesterol, and high blood pressure.

APPORTIONMENT AND CAUSATION:

I was asked to provide an opinion regarding the applicant's allegation of Long COVID and rheumatologic complaints including muscle pain, joint pain, fatigue, brain fog, depression, and cognitive difficulties. At this time, it appears that his COVID-19 exposure and current symptoms are in part industrially related as he reported no other sick contacts when he was diagnosed with acute COVID infection.

Based upon the available medical information, Epworth Sleepiness Scale, and fatigue severity scale Mr. [redacted] meets criteria for class II 15% impairment of the whole person regarding his sleep and arousal disorder. Mr. [redacted] reports that his symptoms have progressed significantly since his diagnosis and have impacted his activities of daily living. However, the diagnosis of obstructive sleep apnea is contributing to his symptoms. Therefore in my opinion the impairment for sleep disorder is 10% non-industrial due to severe and untreated obstructive sleep apnea and 5% industrial due to Long COVID.

As extensively outlined, above this applicant has the complaint of diffuse and uncontrolled pain that is not otherwise explained. He has been assigned 2% impairment for pain which I agree with at this time.

DISABILITY AND WORK RESTRICTIONS:

I was asked to address issues regarding disability and work restrictions in regard to his rheumatologic symptoms as it relates to Long COVID. In terms of disability and work restrictions, I agree with his medical legal evaluator in the field of pulmonology that this applicant should not engage in prolonged work (METS> 2), prolonged walking, lifting weights greater than 15 pounds, or walking up two flights of stairs. However, I believe in the future he may be able to trial work with some restrictions including trialing a sedentary job for a limited number of hours, as well as frequent breaks for 10 minutes every hour, with a one-hour lunch break.

FUTURE MEDICAL CARE:

I will now outline my recommendations for future medical care. My opinions regarding treatment of this patients industrially related Long COVID-19 include both nonpharmacologic and pharmacologic approaches. In terms of nonpharmacologic approaches, if his pulmonologist and cardiologist agree, this applicant would benefit from pulmonary rehab, physical therapy and acupuncture. In regard to the pharmacologic approaches to the rheumatologic manifestations of Long COVID I agree with the current treatment of duloxetine. Supportive treatment for diffuse muscle pain can be managed with acetaminophen and non-steroidal anti-inflammatory agents. Other medications which have not been trialed which may be considered based on the progression of symptoms include lyrica and muscle relaxants, however this would require close monitoring for side effects. The patient will require care from a treating pulmonologist, cardiologist, pain management, neurologist and rheumatologist as well as in the areas of internal medicine and psychiatry.

Medical records were placed in chronological order and preliminarily reviewed and transcribed by [redacted] Jr, RN. Final review of records by Dr. Nicole Zagelbaum Ward. Questionnaire forms filled out by the patient at the time of the evaluation may be included as an addendum at the end of the report.

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 the information 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 to be true.

I declare under penalty of perjury that I did not discriminate in any way against the parties to the action, or the injured worker in the evaluation process, or in the content of this report, in accordance to section 35(h).

I further declare under penalty of perjury that I have not violated Labor Code Section 139.3 of the California Labor Code, and the contents of the bill are true and correct to the best of my knowledge, in 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 referenced examination or evaluation.

Sincerely,

Nicole Zagelbaum Ward, DO
Internal Medicine & Rheumatology
Cedars-Sinai Medical Center

LACERA

April 22, 2026

TO: Each Trustee,
Board of Retirement
Board of Investments

FROM: Steven P. Rice SPR
Chief Counsel

Allison E. Barrett AEB
Senior Staff Counsel

Jessica Rivas JR
Staff Counsel

FOR: May 6, 2026 Board of Retirement Meeting
May 13, 2026 Board of Investments Meeting

SUBJECT: Updating LACERA's Code of Ethical Conduct

RECOMMENDATION

That, with the recommendation of the Audit, Compliance, Risk ,and Ethics Committee, the Board of Retirement and Board of Investment approve LACERA's updated Code of Ethical Conduct.

INTRODUCTION

LACERA's current Code of Ethical Conduct (Code) was approved in November 2021 and has a three-year review cycle. Since late 2024, staff has shared with the Audit, Compliance, Risk, and Ethics (ACRE) Committee and both Boards a vision for a reimagined code that is comprehensive in scope, has improved clarity, organization, and effectiveness, and is accessible through multiple channels. At its February 23, 2026 meeting, the ACRE Committee recommended approval of a proposed revised and restated Code to both Boards, with revisions that have now been made. A final draft is attached as *Exhibit A* for both Boards' review and approval.

BACKGROUND

A code of conduct is a fundamental component of an effective ethics and compliance program. Accordingly, the ACRE Committee and Ethics and Compliance Program Charters provide for Committee and Program oversight of LACERA's Code.[1]

The purpose of the Code is to set Board- and ACRE-approved expectations and norms in alignment with LACERA's Mission, Vision, and Values and serve as an ethical decision-

[1] ACRE Committee Charter, Section VII, B4; B5b; 7a-b; Ethics and Compliance Program Charter, Sections VII, D2; G; IX,A-B.

making guide for the entire organization. It also is essential for supporting and stating LACERA's commitment to an organizational culture rooted in ethics and compliance. Finally, maintaining and reviewing LACERA's Code is central to the implementation and success of the Ethics and Compliance Program.

PROCESS

The proposed Code incorporates best practices in ethics and compliance programs, based on the Ethics and Compliance Program team's research, which includes LACERA's Ethics and Compliance consultant, Rebecca Walker, the ACRE Committee's consultant, Larry Jensen, fiduciary counsel Ashley Dunning, and resources such as the Society of Corporate Compliance and Ethics (SCCE), Gartner, Inc. (a consultant service used by LACERA), as well as a wide-scale review of codes of conduct from other pension systems, American universities, and corporations on Ethisphere's "World's Most Ethical Companies in 2024."[2] Additionally, throughout the process, we worked with key internal stakeholders (Executive Team, Leadership Steering Council, Management Action Team, Supervisory Action Team, and the Ethics and Compliance Committee), held a staff focus group in November 2025, and worked closely with the ACRE Committee. The ACRE Committee reviewed final versions of the proposed Code at both its November 20, 2025 and February 23, 2026 meetings, making a recommendation for approval at the February meeting, with certain revisions.

A summary of changes made based on the ACRE Committee's feedback is attached as *Exhibit B*.

KEY CHANGES

Major changes from the prior version of the Code are as follows:

Organization

The proposed Code is organized around LACERA's Values – *Integrity, Inclusivity, Innovation, Accountability, Collaboration, and Transparency* (I ACT). LACERA is an organization guided by its Values (which are inherent to ethical conduct) and how we define our culture. Accordingly, the new Code directly reflects the I ACT model.

Style

Linguistically, the proposed Code uses simpler, less technical language to aid with comprehension. It avoids legalese where possible (considering LACERA is regulated by CERL, PEPRA, and other laws and regulations). The Code also uses Trustee and employee-centric language (as opposed to organization-centric language) to express that that the Code sets individual expectations that are jointly held and for which there is joint accountability. It also uses first person plural ("we," "us", and "our") where appropriate, which have both been shown to be more successful at affecting behavior and supporting

[2] https://ethisphere.com/worlds-most-ethical-companies/.

inclusivity and collaboration. Visually, the proposed Code seeks to strike a balance between being a visually appealing document that will encourage users to engage with it while still serving as a comprehensive reference with serious authority. The proposed Code also accompanies the text with aids to communication and application to make the Code relevant and accessible. Accordingly, the Code uses colors, headings, call out boxes, links, photographs, and other design elements throughout.

Content

The proposed Code continues to address and further define fiduciary duties, ethical judgment, conflicts of interest, confidentiality, reporting roles and responsibilities, and LACERA's investigative process for instances of misconduct. To that end and in furtherance of the Ethics and Compliance Program, we have added the following new topics that are not covered in depth in the current Code:

- Responsible Risk Management
- Values: I ACT
- General Ethical Guidance
- Material Non-Public Information
- Equity, Diversity, and Inclusion, and Accessibility
- Respectful Communication
- Responsiveness
- Anti-Discrimination and Harassment Policy
- Safe and Healthy Work Environment
- Drug and Alcohol-Free Work Environment
- Professional Attire and Appearance
- Speak Up, Listen Up
- Ethics Hotline/Reporting Channels
- Investigative Process for Misconduct
- Commitment to Non-Retaliation
- Telework
- We Always Bring Our Best
- Training & Education
- Transparent Communication (Accurate Information, Specific Guidance for Trustees, Media Policy, Social Media)
- Confidentiality and Privacy
- Public Records Act and Other Requests for Information
- Records Retention
- Artificial Intelligence
- Information Security and Acceptable Use

Key Substantive Changes

While the proposed Code largely re-states our existing ethics and compliance practices and addresses the additional topics set out above, there are two substantive changes that we would like to bring to your attention, in addition to the new elements of contact outlined immediately above:

First, the section on Gifts, Honoraria, Travel, Loans (page 10) in the proposed Code now sets a higher standard on gifts for staff. Rather than allow gifts up to the FPPC limit (currently $630 per source per calendar year), staff members are not permitted to accept

any gifts and LACERA must pay for all staff members' legitimate business expenses. The intent is to set a higher ethical standard that will greatly reduce the appearance of conflicts of interest and improper influence. Trustees are held to the standards and gift limits set forth in the Political Reform Act and Fair Political Practices Commission regulations.

Second, the proposed Code expands and clarifies the Nepotism Policy (page 15). The policy now applies to both hiring and contracting. The policy also applies not only to relatives, but also to "personal relationships," which include cohabitation, a romantic partnership or dating relationship, or a financial partnership unrelated to official job duties. Additionally, the proposed Code directs Trustees and staff who become aware that someone they know (beyond a relative or other personal relationship) is applying for employment or a contract with LACERA, to disclose that to Human Resources so that the situation can be evaluated and remediated if necessary. The intent with these changes is to ensure that we capture all relevant (potentially conflict-laden) relationships so that LACERA hires and contracts with the best candidates, without regard to any personal connection or relationship that might cause undue influence or the appearance of it.

NEXT STEPS

Following approval by both Boards, we will begin rolling out the Code to the entire organization in a deliberate and sustained effort to support staff's understanding of the Code and foster LACERA's culture of ethics and compliance. Roll-out will consist of the following:

Pre-Launch

- Engage with LACERA leadership (Board and ACRE Committee Chairs, Executive Team, Leadership Steering Council, Management Action Team, and Supervisory Action Team) to discuss plans and top-level support for launch activities.
- Identify staff-level champions throughout the organization to assist with Code adoption and ongoing engagement.

Launch Week

- Announce
    - At the beginning of the week, we will distribute the Code via an e-mail from the CEO to each LACERA trustee and staff member. We will also publish a page on our intranet (LACERA Connect).
- Socialize
    - Digital Campaign – We will coordinate with Communications on branding, use of slogan, and daily messages aligned with the five main sections of the Code based on LACERA's Values (We Serve with Integrity, We Are Inclusive and Collaborative, We Hold Ourselves Accountable, We Are Transparent, and We Are Innovative).
    - In Person Event – We will hold engaging activities and teambuilding focused on ethics and compliance. We plan to include distribution of a flyer highlighting

key ethics and compliance principles as well as limited distribution of hard copies of the Code.

- Train
  - Legal Staff will work with Communications and Human Resources to prepare a training video for all staff to view on NeoGov within a predetermined timeframe and which will include an attestation. Legal staff will provide live training to both Boards.

Ongoing Programming

- Socialize
  - Digital Campaign – We plan to send periodic e-mail messages, at least quarterly or as necessary based on new developments, focusing on one of the five sections of the Code based on LACERA's Values.
  - Engagement through Existing Channels – We plan to include items on periodic Code themes through the CEO's All Staff meetings (at least quarterly) and staff newsletter *The Pulse* (also quarterly).
- Train
  - Training will continue to be required annually for Trustees and staff and will include an attestation.

CONCLUSION

Based on this memo, the attached Code, and the recommendation of the ACRE Committee, staff recommends that the Board of Retirement and Board of Investments jointly approve the updated Code.

Considering policies are regularly updated between Code review cycles, we also request Board approval to update the links in the Code document as needed based on changes in Board or executive policy so that readers always have access to the most up to date version of the linked policies.

Attachments

C: Luis A. Lugo
Jonathan Grabel
JJ Popowich
Ted Granger
Chaitanya Errande
Leisha Collins
Carly Ntoya, Ph.D.
Christina Logan
Cynthia Martinez
Erika Heru
Veronica Yi-Martinez

EXHIBIT A



CODE OF **ETHICAL** CONDUCT

ETHICS FIRST, COMPLIANCE ALWAYS

LACERA
Los Angeles County Employees Retirement Association

ABOUT LACERA

The Los Angeles County Employees Retirement Association (LACERA) is a public pension plan organized under the County Employees Retirement Law of 1937 (CERL) and the California Public Employees' Pension Reform Act of 2013 (PEPRA). Under the California Constitution, we have a fiduciary duty to serve our members and their beneficiaries above all other interests.

Our **Mission** is to produce, protect, and provide the promised benefits to our members.

Our **Vision** is to empower our members to enjoy a healthy and secure retirement.

Our **Values** are Integrity, Inclusivity, Innovation, Accountability, Collaboration, and Transparency (I ACT).

RESOURCES FOR ETHICS & COMPLIANCE ISSUES

Always ask for help with any questions and consult any of these key resources: Legal Division, Ethics and Compliance Office, Human Resources, your supervisor, your division manager, or the Executive Office.

Anonymously report any concerns about ethical or compliance issues to the LACERA Ethics Hotline (844-794-9416 or lacera.ethicspoint.com).

To LACERA Trustees and Staff:

LACERA proudly performs its public service lawfully and ethically. In October 2024, we chartered a new Ethics and Compliance Program to further promote a strong and engaged culture of ethical conduct and compliance with all applicable laws, regulations, policies, and procedures. This Code is a foundational document for the program and our entire organization.

Together, we create a culture of accountability for ethics and compliance. No matter our position at LACERA, we each play a key role in fostering LACERA's institutional integrity and our standing as a well-managed public pension system for our members and their beneficiaries, our plan sponsors (the County of Los Angeles and other participating employers), and other stakeholders.

We have organized the Code around our Values—*Integrity, Inclusivity, Innovation, Accountability, Collaboration, and Transparency (I ACT)*—which guide our work and define our culture. The Code outlines the standards of ethical conduct required of LACERA Trustees and all LACERA staff, including temporary employees and contractors. This ensures that we live up to our Values, ethical responsibility, and comply with the law, regulations, policies, and procedures. *Please read the Code carefully and ask questions whenever something is not clear*.

By holding ourselves and each other accountable, we deliver on our promise to build a strong ethical and compliant culture at LACERA in service of our Mission to produce, protect, and provide the promised benefits to our members and their beneficiaries.

Very truly yours,



Luis A. Lugo
Chief Executive Officer

To LACERA Trustees and Staff:

This Code provides ethical standards for LACERA Trustees and all LACERA staff, including temporary employees and contractors. It provides guidance for common situations that we encounter, serves as an ethical decision-making guide, and establishes a values-based framework for approaching the issues that arise in our diverse roles as we perform our day-to-day operations.

Please review this Code carefully, remember to use it as a resource, and recognize the vital role that you play in promoting LACERA's culture of ethics and compliance in serving our members and meeting our Mission.

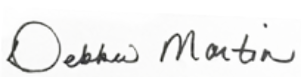
Thank you,



James P. Harris
Chair, Board of Retirement



Shawn R. Kehoe
Chair, Board of Investments



Debbie Martin
Chair, Audit, Compliance, Risk, and Ethics Committee

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INTRODUCTION

Purpose and Scope

This Code provides ethical standards for LACERA Board Trustees and all staff, including temporary employees and contractors. It guides us to:

- Use ethical judgment to do the right thing no matter the circumstances.
- Comply with laws, regulations, policies, and procedures.
- Create a culture in which everyone shares responsibility for being ethical and compliant.
- Earn and build trust and respect among LACERA Boards and all staff, members, and other stakeholders.
- Be aware of and take action to reduce risks that may disrupt our operations.
- Accomplish our Mission, Vision, and Values, act in service of our members, and continuously improve.

This Code and our Values are the foundation for everything we do. They provide a framework to guide us when we face challenges or change.

No matter our role at LACERA, we are each responsible for living by our Values and being professional, honest, and ethical. We review the Code, attend Code training, and make sure we understand it. We follow the Code, consult the links to the other policies and references throughout, and ask questions when we are unsure about anything.

We also have a duty to speak up and report issues that do not align with our Mission, Vision, and Values. We listen to those who report problems and take their concerns seriously. We can report concerns or suspected misconduct to our supervisor, division manager, the Legal Division, Ethics and Compliance Office, Human Resources, Internal Audit, or the Executive Office. We can also report issues to the LACERA Ethics Hotline (844-794-9416 or lacera.ethicspoint.com). Reports can be made anonymously. *LACERA absolutely prohibits retaliation for making a good-faith report of suspected misconduct.*

Fiduciary Duties

A fiduciary duty is a responsibility to act in the best interests of another. Each of us has a fiduciary duty to our members and their beneficiaries. This means ***we always act in the best interests of our members and beneficiaries, ahead of our personal interests and the interests of other organizations and individuals.***

The Board of Retirement (BOR) and Board of Investments (BOI) Trustees' fiduciary duties and other legal duties are set out in the California Constitution and CERL. LACERA and its staff support the Trustees in fulfilling these duties, which include:

- *Duty of loyalty*: We act in the overall best interest of our members and their beneficiaries when administering LACERA and investing its assets, so as to timely pay their benefits.
- *Duty of prudence*: We use the care, skill, prudence, and diligence that a prudent public pension trustee or employee would use when faced with similar issues or circumstances.
- *Duty to defray reasonable administrative expenses of administering the system and secondary responsibility to minimize employer contributions*: We have processes in place to control administrative expenses and minimize employer contributions. We understand that every dollar spent to administer LACERA is a dollar not invested to pay benefits.
- *Duty to administer the LACERA pension plan in accordance with plan terms and other applicable law*: We follow plan terms at all times, as found in CERL, PEPRA, Internal Revenue Code, and all other laws, regulations, and LACERA policies and procedures.
- *Duty to diversify investments*: The assets of the retirement system are trust funds. We diversify investments of the system to minimize the risk of loss and to maximize the rate of return, unless it is clearly not prudent to do so under the circumstances.

In addition to the Boards and all LACERA staff, some LACERA contractors have a fiduciary duty to LACERA under applicable law and/or the terms of their contracts.

In short, we always act in the best interests of our members and their beneficiaries, in all circumstances, regarding LACERA's business. This duty is the first and last consideration in every decision that we make. All that we do is in service of our members and their beneficiaries.

Responsibilities of Trustees, Leaders, Managers, Supervisors, and Staff

Every staff member has a responsibility to perform their job with the highest ethical standards, align their actions with LACERA's Values, and follow all laws, regulations, policies and procedures. Staff have a duty to understand risk and report activity or behavior that falls below LACERA's standards or may impede its operations.

LACERA trustees, leaders, supervisors, and managers are responsible for creating a team environment in which ethics and compliance are recognized and valued as performance expectations. Like our Values, ethics and compliance are not just words we say but are reflected in the decisions we make and actions we take. Our leaders model LACERA's Values, and LACERA's Values shape our culture. Managing risk is a central part of ethics and compliance and a core duty for all LACERA leaders and managers. They are responsible for ensuring that every member of their team is risk aware.

Responsibilities of Contractors

We expect our contractors, vendors, and other business partners to perform to the highest ethical standards and consistent with our Values and the Code in their work with LACERA. In addition, some LACERA vendors have a fiduciary duty to LACERA under applicable law or the terms of their contracts.

Other LACERA Policies

The Code provides standards and expectations but does not address the details of every legal and policy requirement that we follow. Please be sure to consult any other applicable policies, procedures, charters, or forms.



WE ARE GUIDED BY OUR VALUES

At LACERA, our Values guide us every day, in all that we do. Our Values define our culture and represent who we are as an organization. We strive to **do the right thing**, in every situation, following all policies, procedures, laws, and regulations that apply to LACERA and our operations. We always exercise good judgment in each of our roles as we perform our daily work. Together, through unwavering ethical conduct, we accomplish our Mission to produce, protect, and provide the promised benefits to our members and their beneficiaries.

GUIDE FOR ETHICAL DECISION-MAKING

When making a decision, exercising good ethical judgment requires that we:

1. Identify the issue.
2. Gather necessary information, including all relevant facts, and applicable policies, procedures, laws, and regulations.
3. Consider ethical principles and our Values.
4. Consider our fiduciary and other legal duties to do what is best for our members.
5. Work together with our team and other staff members with knowledge of who may be affected and seek guidance from our supervisor, manager, and other LACERA leadership for any questions.
6. Explore possible solutions and think creatively.
7. Evaluate consequences.
8. Make a decision.
9. Plan, implement, and document our decision and the supporting process with ethics and compliance in mind.
10. Reflect, review, and adjust our course when necessary to continually improve.

Values - I ACT

Our six core Values are not just words, but actions we model in the way we solve problems and interact with each other, members, and other stakeholders and business partners. LACERA's Values form the basis of our culture and guide us in fulfilling our fiduciary duties and accomplishing our Mission. This is why the Code is organized around these ethical guides. Each Value is principles-based. Please be sure to review the Values below and the link to the Organizational Guiding Principles that support each Value. Collectively, they establish expectations for our conduct.

- *Integrity*: We earn trust by our dedication to honesty, fairness, and ethical conduct in the service of our members and the way we treat each other.
- *Inclusivity*: We welcome all individuals, honoring and respecting their unique stories and perspectives, and celebrating the value that diversity adds to the organization and teams in meeting our Mission and strategic priorities.
- *Innovation*: We cultivate a creative, forward-thinking approach in seeking out new ideas and novel solutions to continually improve our operations and the member experience.
- *Accountability*: We take responsibility for our actions and operate with the highest standards of professionalism and respect in fulfilling our Mission and duty as prudent stewards of the pension funds.
- *Collaboration*: We are most effective when we work together across all levels of the organization.
- *Transparency*: We clearly communicate our knowledge, ideas, and expertise in an open, fair, and honest environment, resulting in better organizational outcomes and decision-making.



Our Organizational Guiding Principles

Ethics and Compliance

This Code is a foundational document for LACERA's Ethics and Compliance Program. Ethics and compliance support our Values and are an essential part of our fiduciary duties to our members and beneficiaries.

Ethics means using good judgment and applying LACERA's Values to do the right thing, even when it is hard or inconvenient. **Compliance** means following all applicable laws, regulations, policies, procedures, and LACERA's Code of Ethical Conduct.

Ethics guides compliance because we make decisions based on what ***should*** be done, not just on what ***can*** be done. We are all, at every level of the organization, responsible for upholding ethics and compliance at LACERA.



BEING ETHICAL AND COMPLIANT IN COMPLEX SITUATIONS

We understand that many situations can be complex. Ethics is not an excuse for non-compliance, and compliance is not an excuse for unethical behavior. Below are some ways to balance ethics and compliance so that we achieve both, no matter what type of law, rule, policy, or requirement we follow:

- If we are *required* to do something by law or policy, we must follow that requirement and speak up in advance with our manager, supervisor, or other leadership if we have questions about any ethical issues.
- If we are *allowed* to do something by law or policy and have a choice about whether or how to do it, we must apply ethical judgment and act in the best interest of our members, meaning that we will seek the most efficient and effective alternative in order to best align our conduct with our fiduciary duty and ethical responsibilities without regard to our personal preference.
- If we are *not allowed* to do something, we must obey that prohibition and speak up in advance to discuss any ethical concerns about compliance.



LACERA Ethics & Compliance Program Charter

General Ethical Guidance

This Code addresses various situations that may arise as we perform our duties. It cannot cover every possible scenario, so always ask for support when needed. The following lists provide general ethical guidance to live up to our Values.

General Ethical Standards

- Follow LACERA's Values, and all applicable laws, regulations, LACERA policies, and this Code
- Avoid conflicts of interest and the appearance of conflicts of interest
- Be respectful, professional, and courteous to all LACERA Trustees, staff, members, and all people and entities with which LACERA interacts or does business
- Maintain confidentiality of all confidential or privileged information
- Report actions of any person or entity that violate or may violate applicable laws, regulations, LACERA policies, or this Code

Unethical Acts or Omissions

- Using or allowing others to use any LACERA property, resources, information, or opportunity for personal gain or anything other than LACERA business
- Engaging in activities involving dishonesty, fraud, deceit, or misrepresentation
- Falsifying or failing to record proper entries in any LACERA records
- Engaging in outside employment or activities that interfere with our duties to LACERA
- Discriminating against, bullying, or harassing anyone
- Any other acts or omissions that conflict with our public service



WE SERVE WITH INTEGRITY

Value & Guiding Principles

INTEGRITY: We earn trust by our dedication to honesty, fairness, and ethical conduct in the service of our members and each other.

GUIDING PRINCIPLES

- We choose to do the right thing even when no one is looking.
- When we are aware of something that may be wrong, inappropriate, or create organizational risk, we speak up.
- We make decisions based on facts and the law.
- When presented with two or more valid choices on how to address a challenge or issue, we choose the one that is most beneficial to LACERA's members.
- When we make an error, we own up to it and work to correct it.

Integrity is the primary LACERA Value, on which the other Values depend. Integrity guides all our work and work relationships.

Avoiding Conflicts of Interest

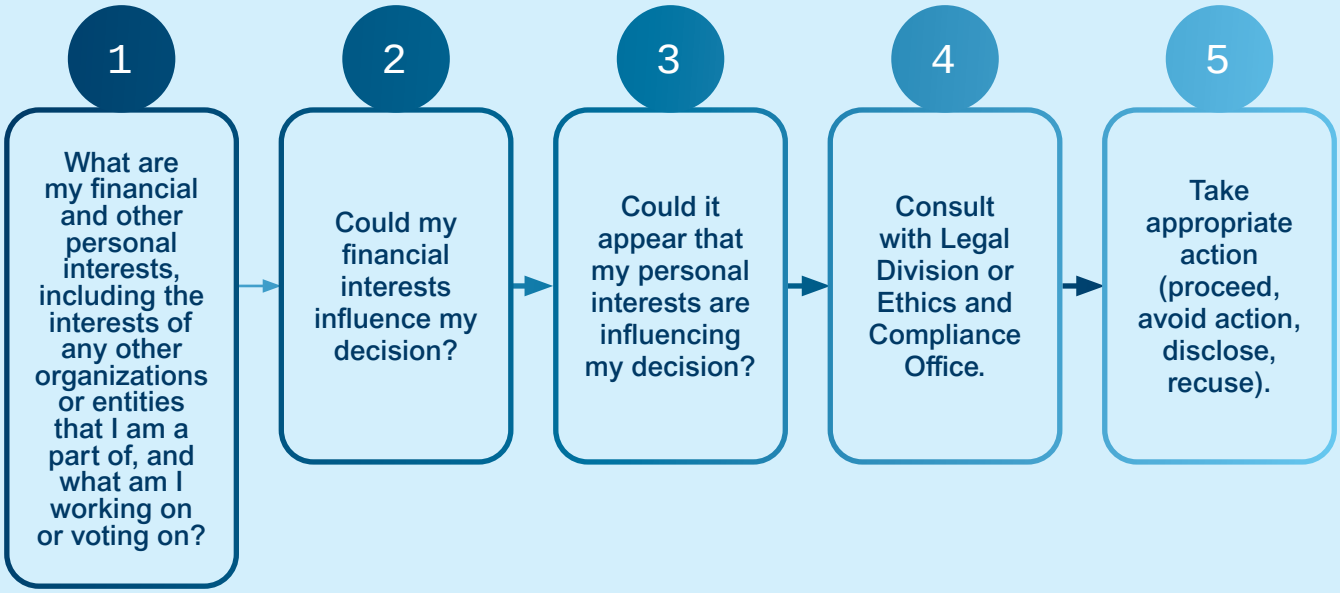
A conflict of interest means putting our financial or other personal interests of any kind, as well as the interests of any other organizations or entities, ahead of the interests of LACERA, our members, and their beneficiaries. There are *actual* conflicts, *potential* conflicts, and situations that give the *appearance* of a conflict.

LACERA Trustees and staff must avoid all three types of conflict in all aspects of our work so that members and their beneficiaries are confident that we act ethically and in their best interests.

Conflicts of interest are illegal under California law and carry significant penalties.

We remain aware of how our financial or other personal interests (including those of our family members) may interact with our work at LACERA, so we can readily identify conflicts and take appropriate action to evaluate, avoid, or remove the conflict as soon as possible. We look out for conflicts at the beginning and every stage of any project, all the way through to final approval by the Boards or other leadership and through project completion.

How to Avoid Conflicts



Conflicts of interest issues are complex and have high organizational risk, so always consult with the Legal Division or Ethics and Compliance Office about all actual, apparent, or potential conflicts.

FPPC Overview of Conflicts of Interest under the Political Reform Act

Contracts

We cannot participate in making any LACERA contract in which we have a financial or other personal interest, whether directly or indirectly. This includes any part of the contracting process, such as:

- Developing or identifying the need for the goods or services being purchased or the investment of LACERA funds.
- Issuing a Request for Proposals (RFP), Request for Information (RFI), purchase order, or other solicitation (set out in LACERA's Policy for the Procurement of Goods and Services and the separate Investment-Related Services Procurement Policy).
- Developing criteria used to select the provider of goods or services.
- Evaluating prospective contracting parties, selecting contracting parties, or negotiating the terms of the contract.
- Monitoring the implementation and performance of the contract.

Other conflict of interest issues related to contracts include:

- **Conflicts of Contractors**: We conduct due diligence with every contract and remain aware of contractors' conflicts of interest involving LACERA, its Trustees and staff, or other parties from solicitation through the entire term of the contract. During the contracting process, we require potential contracting parties to disclose actual and potential conflicts. We also conduct our own due diligence to identify any actual or potential contractor conflicts. LACERA's contracts include provisions requiring the contracting parties to represent there are no actual or potential conflicts of interest during the contracting process and the entire term and performance of a contract and to disclose any conflicts that arise later.



Policy for the Procurement of Goods and Services

Investment-Related Services Procurement Policy

FPPC Quick Guide to Section 1090

SERIOUS CONSEQUENCES OF CONFLICT-OF-INTEREST VIOLATIONS WITH CONTRACTS

Conflicts of interest during contracting can have serious consequences, such as:

- Preventing LACERA from entering the contract
- Causing the contract to become void

Undisclosed conflicts may result in staff discipline as well as lead to civil and/or criminal penalties. When in doubt, ask the Legal Division or Ethics and Compliance Office.

Q & A – VENDORS

Q: I am attending a conference and a vendor asks me to promote their company or give them access to other LACERA decision-makers. What should I do?

A: We should refer the vendor to follow the normal contracting process:

- For investments matters, they should email NewOpportunities@LACERA.gov
- For all other matters, they should email VendorManagement@LACERA.gov

Additionally, if there is a pending RFP, the party should be encouraged to follow the process set out in the RFP.

- **No Contact during Contracting Process (Quiet Period)**: We avoid all contact with people or companies responding to an RFP, RFI, purchase order, or other contract solicitation to maintain a fair and transparent process. LACERA's RFPs, RFIs, and other contract solicitations explain that a "quiet period" will be in place from the beginning of the contracting process until the selection of the successful party. During the quiet period, Trustees and staff are *not permitted to contact* potential contracting parties, and vice versa. Quiet period lists are available for Trustees and all LACERA staff in monthly Board meeting materials. Contact during the quiet period is only allowed as stated in the published terms of the contracting process or limited to contact necessary to carry out ongoing LACERA business under an existing contract.
- **Follow All Policies and Procedures**: We follow all LACERA policies and procedures and the published terms of the contract process. We avoid any action that could influence or attempt to influence LACERA to enter into a contract with anyone outside of established policies and procedures. Trustees and staff should refer people or companies to reach out to NewOpportunities@LACERA.gov for Investment matters and to VendorManagement@LACERA.gov for all other matters.

Gifts, Honoraria, Travel, and Loans

We hold ourselves to the highest standards to avoid actual conflicts, potential conflicts, and the appearance of conflicts. We make unbiased decisions to serve our members and their beneficiaries' best interests.

- **Gifts**: A "gift" is any payment or other benefit that confers a personal benefit for which a public official does not provide payment or services of equal or greater value. A gift includes a rebate or discount in the price of anything of value unless the rebate or discount is made in the regular course of business to members of the public.
  - Trustees: Trustees may only accept gifts subject to the FPPC limit (totaling no more than $630 in a calendar year from any single source for 2026). The $630 limit could change in future years. Please be aware that accepting gifts over the limit will require disclosure and recusal and could lead to an enforcement action by the FPPC. Any gift received over $50 must be disclosed on the Trustee's Form 700.
  - Staff: To avoid any appearance of actual or potential conflicts, we do not accept any gifts and pay our way for all legitimate business expenses.
  - Exceptions: Please note that there are numerous exceptions to the definition of "gift." Some of the most common exceptions are set out below. Please consult the *FPPC Fact Sheet on Limitations and Restrictions on Gifts, Honoraria, Travel and Loans for Local Officials* for other exceptions. Always ask the Legal Division and Ethics and Compliance Office

Q&A - GIFTS

Q: I am attending a conference and LACERA paid my cost of admission. An individual or organization at the conference offers me food, beverages, or other items. Can I accept?

A: Trustees – You can accept anything included with the cost of admission to the conference because LACERA has paid for those items. You may also accept small items (pens, notepads, light refreshments, etc.) made available to all attendees without regard to official status. Anything else that you receive must be disclosed on your Form 700 if it is from one source and more than $50 and cannot exceed the gift limit (currently $630 for 2025-2026).

Staff – You can accept anything included with the cost of admission to the conference because LACERA has paid for those items. You may also accept small items (pens, notepads, light refreshments, etc.) made available to all attendees without regard to official status. However, you cannot accept anything else. When in doubt, do not accept and consult with the Legal Division or Ethics and Compliance Office before accepting anything more than one of those small items.

regarding FPPC exceptions and any questions concerning gifts.

- *Gifts from Family* – Gifts from the public official's spouse (or former spouse), child, parent, grandparent, grandchild, brother, sister, current or former parent-in-law, brother-in-law, sister-in-law, aunt, uncle, niece, nephew, or first cousin or the spouse of any such person, unless they are acting as an agent or intermediary for another person who is the true source of the gift.
- *Employee Gift Exchange* – Items received by an employee during an employee gift exchange, as long as the items received are provided by another employee of the agency and the gifts are not substantially disproportionate in value.
- *Reciprocal Exchanges* – Reciprocal exchanges between an official and another individual that occur on an ongoing basis as long as the total value of payments received by the official within the calendar year is not substantially disproportionate to the amount paid by the official and no single payment is $630 or more. For example, if two people take turns buying lunch for one another so that overall each pays half the total value during the calendar year.
- *Dating Relationships, Long-Time Friends, and Existing Personal Relationships* – Please see the FPPC Fact Sheet and ask the Legal Division and Ethics and Compliance Office about any questions.

- **Honoraria**: We cannot accept any payment or benefit for any speech we make, article we write, or our attendance at any public or private conference, convention, meeting, social event, meal, or similar gathering. Any questions about whether something is an honorarium should be directed to the Legal Division.

- **Travel**: LACERA Trustees and staff may only accept payments or reimbursement from a third party for transportation, lodging, and related meals if LACERA is allowed to receive them under relevant Fair Political Practices Commission (FPPC) regulations and if we receive advance approval from the Legal Division, which verifies all legal requirements are met before the trip. In these situations, we complete FPPC Form 801 Payments to Agency Report. We must also follow LACERA's own policies when traveling for LACERA business.

- **Loans**: Trustees and staff may accept loans from commercial lending institutions made in the lender's regular course of business on terms available to members of the public without regard to our position at LACERA. For any other type of loan, consult the Legal Division.

Investments

LACERA Trustees and staff may not have any direct or indirect financial or other personal interest in any investment made by LACERA. We do not sell or provide any investment product to LACERA, whether directly or indirectly, for ourselves or as an agent or partner of others.

Bribes and Kickbacks

Giving or receiving any payment or gift as a bribe or kickback is absolutely prohibited.

Material Non-Public Information (MNPI)

MNPI is confidential information about a company that, if disclosed, would likely impact the market value of its securities. Using this type of information to buy or sell securities is illegal. It is "insider trading" and against the law. If circumstances require Trustees or staff to receive any MNPI as part of their LACERA duties, the Trustees and/or staff will receive instructions on their legal obligation to maintain the confidentiality of the MNPI and will be required to sign an acknowledgment form.

Form 700 Statement of Economic Interests

What: The California Fair Political Practices Commission (FPPC) Form 700 Statement of Economic Interests is how many of us are required to disclose our economic interests that could lead to a conflict. Form 700s are public documents and help promote transparency into public officials' potential conflicts. Filers complete their Form 700s on time and accurately.

Why: Form 700 is required by state law and regulations and is an essential tool to identify actual and potential conflicts of interest.

Who: Not everyone files a Form 700 or must disclose the same information on their form. Filing depends on our position at LACERA. LACERA's *Conflict of Interest Code* lists the positions that are required to file and the information that must be disclosed. To see the complete list of positions that file and the information required of each filer, please check our Conflict of Interest Code. The list includes all LACERA Trustees, Executive management and division managers, and certain other staff, as well as consultants advising the Boards and most financial managers.

When: Assuming office statements for required filers are due within 30 days of our first day with LACERA. Annual statements are due yearly on April 1. Leaving office statements are due within 30 days of our last day with LACERA. Any late statement can lead to fines of $10 per day, up to a maximum of $100, and referral to the FPPC Enforcement Division, which may investigate and impose additional penalties.

How: We use a convenient e-filing system that saves our information, so we do not have to re-enter everything each year. If we are required to file, we will receive timely notices and reminders with filing instructions at our LACERA email address.

Where: Some filers file with LACERA, while others must file with the FPPC. If we need to file a Form 700, we will hear from the applicable agency.

Disclosure and Recusal

Trustees and staff always look out for and **disclose** actual and potential conflicts of interest based on our own financial or other personal interests with any matters that we work on (or if we are a Trustee, that come before the Boards). To determine whether **recusal** or disqualification is required, please consult the Legal Division. LACERA is not allowed to enter into contracts that are impacted by Trustee and/or staff conflicts when such conflicts cannot be dealt with by disclosure and/or recusal.

Trustees and staff *must* consult with the Legal Division or Ethics and Compliance Office about any actual or potential conflicts of interest to ensure that the right steps are taken.

Outside Activities, Employment, and Offices

LACERA supports Trustees and staff serving as active members of our communities. However, we cannot engage in activities, employment, or hold other offices that are incompatible with our LACERA duties. This is to ensure we uphold our fiduciary duty of loyalty to our members and their beneficiaries. We always act in our members' best interests by avoiding

FPPC Fact Sheet on Limitations and Restrictions on Gifts, Honoraria, Travel and Loans

LACERA Conflict of Interest Code

conflicts of interest or any unreasonable interference with the performance of our duties. These prohibitions are statutory and apply to both Trustees and staff:

- **Incompatible Activities & Employment**: Activities, including outside employment, that are inconsistent, incompatible, in conflict with, or prevent us from performing our LACERA duties to the best of our abilities. An outside activity may be incompatible based on the time commitment required.
- **Incompatible Offices**: Two public offices (serving as an appointed or elected member of a governmental board, commission, committee, or other body) are incompatible when their functions are inconsistent or in conflict with one another.

Trustees and staff may contact the Legal Division or Ethics and Compliance Office if they have questions about their outside employment and activities. Please also closely review the next section on the use of LACERA position, resources, and information.

OUTSIDE ACTIVITIES Q&A

Q: I am a staff member and was asked to serve on the board of a charity, nonprofit, or other community organization. I may also be appointed to, or run for, public office. What should I do?

A: Please consult with the Legal Division, Ethics & Compliance Office, and Human Resources. They will discuss your specific situation to determine whether there will be any conflicts with your work at LACERA.

Use of LACERA Position, Resources, and Information

Our fiduciary duties include a responsibility to defray the costs of administering the retirement system LACERA's commitment to ethical conduct therefore extends to responsible, efficient, and sustainable use of our resources. We are committed to using only the resources necessary, in the judgment of the Boards and management, to administer the system in furtherance of LACERA's fiduciary duty. We avoid excessive costs and expenses when more economic options are available with equal or better quality. These considerations extend to organizational expenses, including agency operations, education and travel, contracts, and supplies procurement.

Our LACERA positions, resources, and information may only be used for LACERA business and not for personal gain or advantage. This includes:

- Our position, title, or status with LACERA;
- LACERA property, funds, or other resources, including LACERA's letterhead, logo and email addresses; and
- LACERA information, including plan member information, investment information (including MNPI), and any other information concerning LACERA's business. LACERA controls the use of and access to its information to support the performance of its fiduciary duty and the best interests of our members.

Trustees may send letters to non-LACERA individuals or entities using LACERA letterhead only if the communication is authorized by the Board on which they serve.

We only use LACERA funds or deposits to make authorized payments of the retirement system.

We do not speak for LACERA or give the appearance of speaking on behalf of LACERA while serving in any non-LACERA roles. *Please see Media Policy and Social Media in We Are Transparent on page 29 for more information*.

Political Activities

We are not just public servants, but active participants in our democracy. However, we keep our political activity separate from our LACERA work. Please note that nothing in this section restricts Trustees' and staff's political activities as allowed by California law.

Permissible Political Activities (Staff)

Permissible Political Activities (Trustees)

Allowed	Not Allowed
• Work on candidate and ballot campaigns during our *personal* time • Attend campaign events during our *personal* time • Make campaign contributions using our personal funds, subject to applicable campaign finance laws • Use our LACERA position only as required to *identify* ourselves when making an endorsement as long as we do not indicate that we represent LACERA or that the endorsement is the position of LACERA. We also include the disclaimer: "For identification purposes only." • Elected Trustees – work with the Legal Division and the Ethics and Compliance Office for any potential behested payments.	• We may not use LACERA time, funds, property, technology, letterhead, logo, or other resources in our personal political activities. • We may not use our influence or make any threats or promises relating to potential or current employment, promotion, or compensation to secure a vote, financial support, or other support for a candidate or ballot campaign.



Nepotism Policy

Nepotism means giving jobs, contracts, or other favorable treatment to someone because they are a relative or based on our personal relationship with them, not on merit. We avoid nepotism and the appearance of nepotism because it is unfair, creates conflicts of interest, and prevents LACERA from being an equitable workplace. Our goal is to select the best candidates, without regard to personal connection or relationship.

Definitions of Personal Relationship and Relative

For the purposes of this policy, **personal relationship** is defined as a current relationship between persons because they live together, have a romantic partnership or are dating, or have a financial partnership unrelated to official job duties.

For purposes of this policy, **relative** is defined as any known relationship formed by blood, marriage, or adoption, such as an individual's:

- Spouse, domestic partner
- Parent, stepparent, adoptive parent, legal guardian, foster parent
- Grandparent, grandchild, step or adoptive grandparent, step or adopted grandchild
- Child (including stepchild, adopted child, child of domestic partner, foster child)
- Sibling (including stepsibling, adoptive sibling, half-sibling)
- First degree aunt, uncle, spouse of aunt or uncle, cousin, niece, or nephew
- Any "step" or "in-law" variant of the above relationships

Trustees and Other LACERA Senior Leadership

LACERA does not employ (in full-time, part-time, or temporary positions) or contract with anyone who has a personal relationship or is a relative of:

- A Trustee
- The Chief Executive Officer
- The Deputy Chief Executive Officer
- Assistant Executive Officer
- Any staff reporting directly to the Chief Executive Officer or Deputy Chief Executive Officer
- Division managers

There are two limited exceptions to this rule. LACERA staff who already serve in a full-time and non-probationary capacity can continue their employment if:

- Their relative or someone they have a personal relationship with later begins serving as a Trustee or in a LACERA senior leadership position; or
- They later become related to a Trustee or an individual in a LACERA senior leadership position.

Even with these exceptions, if a LACERA employee is retained under these circumstances, any actual or potential conflict of interest must still be corrected or sufficiently mitigated.

Other LACERA Staff

LACERA may consider applicants who are a relative of or in a personal relationship with other LACERA staff for employment or as a contractor if the applicant meets all the stated qualifications for employment or the contract. However, we will still ensure there are no conflicts of interest and that the new hire or contractor is not given any preferential or unfair treatment based on any relationship. LACERA will not hire or award a contract to such an applicant if it results in any of the following:

- A direct or indirect supervisor/subordinate relationship with the LACERA staff member they are in a personal relationship with or a relative of; or
- An actual or potential conflict of interest or the appearance of a conflict of interest; or
- The applicant has control or inspection of the work of the person they are in a personal relationship with or a relative of, or vice versa. This includes, but is not limited to, control or inspection of the relative's work through Quality Assurance, Internal Audit, the Legal Division, Ethics and Compliance, or Human Resources.

These criteria are also considered when assigning,

transferring, or promoting staff or contractors to another position or division within LACERA.

Participation in Hiring or Contracting Process

Trustees and staff will not participate in any process—or attempt to influence any process—to hire, evaluate, promote, or award a contract to someone they are in a personal relationship with or a relative of under any circumstances. Trustees and staff may participate in the hiring process for any other person only in accordance with established LACERA policies and procedures and shall not participate outside of their individual hiring or contracting authority. Trustees and staff may refer individuals interested in potential employment or contracts to LACERA's Human Resources, NewOpportunities@LACERA.gov for Investment matters, or VendorManagement@LACERA.gov for all other matters.

Additionally, if a LACERA staff member is aware that someone they know (other than a relative or someone with whom they have a personal relationship) is applying for a LACERA position or contract, the staff member should disclose that relationship to Human Resources immediately so that the circumstances can be evaluated. Our goal is to ensure a fair hiring and contracting process, avoid giving unfair preference to anyone, and select the best candidates based on merit and what is in LACERA's best interests.

Late Discovery of Staff Member's Personal Relationship or Relative

If a staff member's personal relationship or relative is not discovered until after an applicant has been hired or promoted, or after a contractor has been engaged, the situation will be addressed as soon as possible to avoid actual or potential conflicts of interests, up to and including separation or termination.

Leaving LACERA

As public servants, our duties and responsibility to LACERA and our members and their beneficiaries continue after our service with LACERA ends.

Trustees and staff will continue to respect the confidentiality of LACERA information and will not share or use it for any purpose. Trustees and staff will comply with the following "revolving door" rules upon leaving our LACERA position:

Prospective Employment After LACERA

If, while still in service with LACERA, Trustees and staff begin looking for new employment with a non-governmental employer, we will not make or participate in any LACERA decision that directly relates to that prospective employer.

Additionally, please note that a new state law requires certain Form 700 filers to disclose prospective employment on their Form 700.

If these circumstances arise, contact the Legal Division or Ethics and Compliance Office for guidance.

Lobbying LACERA After Leaving Employment

Lobbying means attempting to influence decisions made by LACERA and is specifically defined by California law for these purposes as: *acting as an agent or attorney for, or otherwise representing, any person, by making any formal or informal appearance before, or by making any oral or written communication to LACERA, the Board of Retirement, the Board of Investments, any Trustee, any staff member, for the purpose of influencing action by LACERA, including any action involving the issuance, amendment, awarding, or revocation of a contract or the sale or purchase of goods or property.*

If we served as a Trustee or worked in certain positions, we cannot lobby LACERA for any form of compensation for two years after leaving our position. Those positions are: *Chief Executive Officer, Deputy Chief Executive Officer, Assistant Executive Officers, persons next in line to Assistant Executive Officers, Chief Counsel, Chief Deputy Legal Officers, the Chief Investment Officer, and persons next in line to the Chief Investment Officer.* However, this prohibition does not include acting on behalf of the County of Los Angeles.



WE ARE INCLUSIVE AND COLLABORATIVE

Values & Guiding Principles

INCLUSIVITY: We welcome all individuals, honoring and respecting their unique stories and perspectives, and celebrating the value that diversity adds to the organization in meeting our Mission and strategic priorities.

COLLABORATION: We work together across all levels of the organization to deliver on our strategic priorities and objectives.

GUIDING PRINCIPLES

- We welcome and encourage different views, creating a safe environment to share our thoughts.
- We are professionals and are courteous, patient, and empathetic.
- We recognize that almost no task can be accomplished alone and seek out those with knowledge and skills to help us be successful in our work.
- We work together to reach common goals—the essence of LACERA's success.

We are inclusive and collaborative because it leads to better solutions and the best outcomes for LACERA and our members and their beneficiaries. These two Values are central to our work culture and speak to the heart of teamwork—we welcome and respect everyone's contribution and recognize that our different experiences, views, perspectives, and areas of expertise make us stronger, more effective, productive, and innovative.

Inclusion, Diversity, Equity and Accessibility

Inclusion, diversity, equity and accessibility directly align with LACERA's Values and support our Mission to produce, protect, and provide the promised benefits to our members and their beneficiaries.

- **Inclusion** allows teams with diverse backgrounds and perspectives to work together, leading to innovative thought, better performance, and a welcoming and dynamic working environment.
- **Diversity** of background, experience, and ideas promotes well-informed decisions and better solutions, enhances problem solving, and improves our ability to navigate challenging situations, leading to the best operational results and work environment.
- **Equity** ensures that everyone is treated fairly and that Trustees and staff members are empowered to maximize their strengths and contributions to LACERA.
- **Accessibility** means that our working environment, policies, and systems may be used by everyone regardless of ability. We remove barriers that may prevent full participation in the workplace.

Statement of LACERA's Commitment to Inclusion, Diversity, Equity, and Accessibility



Responsiveness

We are a team working together to achieve the best results for our members and their beneficiaries. We communicate with our colleagues in a timely, professional, and mindful manner. We actively listen and thoughtfully engage when others seek guidance. Whether we are responding to a simple question via email or working on a larger team project, we are accountable to one another by always being responsive and respectful of each other's time and efforts. We recognize our common goal and serve as each other's advocates in promoting our Mission.

Respectful Communication

We are polite, respectful, thoughtful, and professional in all communications, spoken or written, with everyone—Trustees, staff, members, beneficiaries, contractors, and all other individuals and entities—even when we are expressing different points of view. We treat others as we would like to be treated. In meetings, we are present, engaged, prepared, and have a public service mindset. We are active listeners and encourage all perspectives. We welcome those with different backgrounds and experiences into every conversation. This creates a collaborative and inclusive environment where we work together to achieve the best results for our members and their beneficiaries in furtherance of our fiduciary duties. Respectful communication applies to all of us, no matter our division or position. We are all held to the same standard of respect and consideration.

Disrespect, profanity, crude language, and other inappropriate and unprofessional conduct are not only ineffective, but also disruptive, contrary to our Values, and interfere with our ability to accomplish our Mission.

DIFFICULT CONVERSATIONS

We sometimes must have difficult conversations, but we are always respectful of differing opinions and viewpoints. We do that by:

- Remaining curious and open minded to make the most informed decisions.
- Being mindful of our language and tone, even in stressful or complex situations.
- Assuming everyone is acting in good faith and raising legitimate issues that should be respectfully considered.
- Recognizing that we may have different perspectives on how to carry out our fiduciary duties to our members and beneficiaries, but we all share the same goal.
- Embracing that vigorous discussion leads to better solutions by ensuring that all perspectives and options are considered.

Anti-Discrimination and Prevention of Harassment Policy

LACERA is an equal opportunity employer. We are committed to providing a work environment where everyone is treated with respect and dignity, free of discrimination, harassment, and retaliation. LACERA does not tolerate discrimination, harassment, retaliation, or any mistreatment of staff or others in the LACERA workplace, including members, beneficiaries, applicants, contractors, volunteers, interns, and visitors. Such behavior goes against our Values.

Any staff member who believes they have been discriminated against, harassed, retaliated against, or subjected to inappropriate conduct or mistreatment is strongly encouraged to make a report (verbally or in writing) to any supervisor, manager, Human Resources, or LACERA's Internal Audit Division. The Ethics Hotline (844-794-9416 or lacera.ethicspoint.com), discussed in *We Hold Ourselves Accountable* on page 23, is another way to report.

LACERA has an absolute commitment to non-retaliation. Retaliating against anyone for reporting an incident, filing a complaint, or speaking up about unethical or noncompliant actions is grounds for discipline, up to and including discharge. Upon receiving a report, LACERA will conduct a timely, fair, and thorough investigation, and consider any needed discipline if a report is determined to be supported by the evidence. *Please see the following memorandum for additional information on the investigative process.*

Anti-Discrimination, Harassment, and Retaliation Policy and Complaint and Investigation Procedures

Safe and Healthy Work Environment

LACERA is committed to providing a safe, healthy, and accessible work environment for everyone, including Trustees, staff, members, beneficiaries, and visitors. We protect each other and our members. Please report any health or safety concerns to Administrative Services.

We do not tolerate any violent behavior or threats of violence, direct or implied. This applies whether at LACERA, off-site work-related activities, or LACERA-sponsored events. It also applies on any social media, other media, or electronic channel. Engaging in acts or threats of violence is grounds for discipline, up to and including discharge, along with a report to law enforcement if appropriate.

HOW TO REPORT WORKPLACE VIOLENCE

- If we witness, or become aware of a violent incident, threat (direct or implied), or any other workplace violence concern against ourselves or anyone else in the workplace or that arises from or relates to our work, we immediately report it to our Supervisor, Manager, the Executive Office, Workplace Violence Prevention Committee (WorkplaceViolenceCommittee@lacera.gov), the Director of Human Resources, or Human Resources' Employee Center.
- If there is an immediate safety threat or a serious injury has occurred, immediately contact 9-1-1 and report the incident to law enforcement, security, and/or emergency medical services.
- Reports of workplace violence are also covered by LACERA's strict non-retaliation policy.

Workplace Violence Prevention Plan Policy, and Procedures

Drug and Alcohol-Free Work Environment

LACERA has a strict, zero-tolerance policy against staff possessing, selling, using, or being under the influence of non-prescription intoxicating or illegal substances on LACERA time or property, including cars used for LACERA business, or abusing prescription medication in the workplace. Substance abuse in the workplace is extremely disruptive and harmful. It negatively affects our work and poses serious safety and health risks. LACERA requires all staff to report to work fit to perform their job duties (including while teleworking). We cannot use or have alcohol, non-prescription intoxicating drugs, or illegal drugs in the office. We also may not use alcohol, non-prescription intoxicating drugs, or illegal drugs at home or other off-site teleworking location during work hours. Finally, we follow all laws on drug and alcohol use at all times, including while not working.

Professional Attire and Appearance

Professional attire and appearance are essential to maintaining a business image that reflects LACERA's standards. LACERA allows staff members the flexibility to dress and maintain an appearance reflecting personal style as long as it is professional, respectful, and appropriate to the nature of the event and audience. *Please see the policy for more details.*

Professional Attire and Appearance Policy





WE HOLD OURSELVES ACCOUNTABLE

Value & Guiding Principles

ACCOUNTABILITY: We take responsibility for our actions and operate with the highest standards of professionalism and respect in fulfilling our Mission and duty as prudent stewards of the pension funds.

GUIDING PRINCIPLES

- We always show up for our colleagues and follow through on our promises to provide high-quality, efficient, and accurate service to our members.
- We recognize that we are human and make errors. When we make an error, we recognize it, correct it, learn from it, and look to find ways to prevent future errors.
- We take the initiative to continually develop and improve our skills to get the job done.
- We address performance, inappropriate conduct, or actions not in line with our Values in a timely manner.

Accountability means holding ourselves, and each other, to high standards and taking responsibility if we fall short of those standards. True accountability means we are all held to the same high standards, regardless of title, position, function, or division. Being accountable makes us better teammates, improves operations, and best serves the fiduciary duty we owe to our members and their beneficiaries.

Speak Up, Listen Up

We have a duty to speak up and report issues that do not align with our Mission, Vision, and Values. We have a duty to create a safe space for and listen respectfully to those who report problems and take their concerns seriously. We identify problems early so we can perform at the highest level, with the strongest ethical standards, and foster a work culture that embodies our values. We welcome and look for helpful ideas and feedback so we continually improve ourselves and our processes and create an accountable workplace.

Ethics Hotline/Reporting Channels

Our Ethics Hotline and reporting channels help ensure we have a workplace based on integrity, transparency, and accountability. We each have a duty to look out for and report misconduct or conduct unbecoming to the positions of trust we have as fiduciaries for our members and their beneficiaries.

Staff

Report misconduct and illegal acts of any kind (including, but not limited to theft, fraud, embezzlement, extortion, or misappropriation of property, as well as harassment, discrimination, bullying, or retaliation) as follows:

- Promptly discuss the situation with your manager, supervisor, Human Resources, or other LACERA management, including the Executive Office, Internal Audit, Legal Division, and Ethics and Compliance Office. Managers and supervisors are responsible for handling and escalating staff concerns, reports, and allegations. Managers' and supervisors' failure to follow up on staff reports and allegations may result in disciplinary action depending on the circumstances.
- If you are uncomfortable reporting misconduct or illegal acts to any of the above individuals or offices, or do not feel that your concern is adequately addressed, the following resources are available:
  - *Call the Toll-Free EthicsPoint Hotline (844-794-9416)*. The Ethics Hotline is hosted by EthicsPoint, LACERA's third-party service provider, dedicated to taking calls on an anonymous basis 24 hours a day, 7 days a week.
  - File a Report on-line with EthicsPoint (lacera.ethicspoint.com). You can use an external device to ensure anonymity.
  - Reports will be treated confidentially to the extent feasible in light of LACERA's obligation to conduct an investigation or review and otherwise follow up on any concerns.
  - Any staff member making a report through the hotline is protected by LACERA's non-retaliation policy.
  - Any LACERA staff member engaging in any form of retaliation in response to a report is subject to disciplinary action, up to and including termination.

Trustees

Trustees may make use of the hotline and may also report concerns to their Board Chair as well as the Chief Executive Officer, Chief Counsel, Chief Ethics and Compliance Officer, or the Chief Audit Executive. Board Regulations also provide procedures for censuring a Trustee.

Ethics Hotline Policy

Investigative Process for Claims of Misconduct

Management will promptly acknowledge receipt of reports, directly to the complaining party (if known) or through the EthicsPoint website for anonymous reports. All reports will be taken seriously. Actions taken will depend on the facts and circumstances of each report. The complaining party, and those against whom a complaint was made, will be informed of the outcome when the investigation is completed.

OUR ROLE IN INVESTIGATIONS

If someone reports misconduct and we are asked to participate in the investigation by giving an interview or producing records, we cooperate fully, respond truthfully and completely, and maintain confidentiality. This is part of accountability. Participating in investigations helps ensure LACERA can determine what, if anything, went wrong and how we can fix it or prevent it from happening again. You cannot be retaliated against for participating in any investigation.

Commitment to Non-Retaliation

Retaliation is *any kind of negative action* against a staff member that takes the form of punishment or creates a hostile, threatening, inequitable, or uncomfortable work environment as a result of the staff member reporting a concern or participating in an investigation. LACERA prohibits and does not tolerate any form of retaliation against staff for making reports in good faith or otherwise cooperating in an investigation. Staff who are found to have retaliated in any respect will be subject to disciplinary action that may result in termination.

LACERA's commitment to non-retaliation supports our ethical culture. We can confidently uphold our duty to report unethical behavior or illegal conduct, without fear of negative action being taken against us.

If you believe you have been retaliated against, you may file a complaint, and action will be taken where the complaint is substantiated.

Responsible Risk Management

We are accountable to LACERA, our colleagues, and our members by being risk aware. Risk is anything that may interfere with our ability to accomplish our Mission, Vision, and Values, and that undermines our culture and ethical standards. Cutting corners, failing to speak up or act promptly create operational risk. We are responsible for reducing risks that can disrupt our business or lead to mistakes, misconduct, harm to LACERA's members and their trust in us, or loss of funds. To manage risk, all staff:

- Are risk aware—we know about divisional and organization-wide risks.
- Identify, report, prioritize, and manage risks, and potential process improvements and other controls, related to our role.
- Follow controls and adjust them as needed to address risk. A control is a process, measure, or action that reduces risk. LACERA's Mission, Vision, and Values and its policies and procedures are examples of controls.
- Seek guidance on effectiveness of controls from Internal Audit, the Legal Division, the Ethics and Compliance Office, or the Executive Office.
- Report risks and mitigation efforts to your supervisor and manager, Human Resources, the Executive Office, ACRE Committee, or Boards when appropriate.
- Conduct continuous risk assessments because risks change and require that our controls to address them must also evolve.



Telework

LACERA has embraced hybrid work as a permanent part of our operations. It balances work quality, productivity, staff morale, disaster recovery and business continuity plans, air quality and traffic reduction goals. Telework is a privilege, not a benefit or right. This privilege may be granted, modified, denied, or terminated at LACERA's sole discretion. We hold ourselves accountable when working outside of the office by following all requirements in our Telework Policy. Whether in the office or working remotely, we work effectively, efficiently, and act in accordance with our Values and this Code. We are reliable team members and provide excellent service to each other and our members no matter where we work.

Telework Policy for LACERA Staff Members

TELEWORK DO'S AND DON'TS

- DO: Follow your telework schedule and use leave for personal activities
- DO: Be available during working hours
- DO: Be responsive to email, Teams calls, and Teams messages whether in the office or teleworking
- DO: Follow LACERA's Privacy and Confidentiality Policy while teleworking
- DON'T: Don't change your telework schedule without your supervisor's approval
- DON'T: Don't forget to immediately tell your supervisor about any connectivity or device issues





WE ARE TRANSPARENT

Value & Guiding Principles

TRANSPARENCY: We clearly communicate our knowledge, ideas, and expertise in an open, fair, and honest environment, resulting in better organizational outcomes and decision-making.

GUIDING PRINCIPLES

- We create a healthy work environment by sharing information, listening to each other's ideas, and giving constructive feedback.
- We recognize that good decisions are made based on knowledge and data and seek to share and provide both freely.
- We recognize that we are a public institution and freely share knowledge (when appropriate) with our peer organizations.

Transparency builds trust. We are transparent with our teams, our members, and all others with whom we interact. A transparent culture best serves our staff, members, their beneficiaries, and the public.

Transparent Communication

We are transparent in our communication and are committed to the free flow of information to the extent permitted by law and our Privacy and Confidentiality Policy, both internally and externally.

Internally, we readily share information between divisions and discuss all sides of an issue to best serve each other, our Mission, our members, and their beneficiaries, and to promote collegiality and collaboration. Transparent communication is an essential component of teamwork and working toward our common Mission.

Externally, we provide accurate, timely, and complete information to the extent allowed and legally required to carry out our important public service for our members and their beneficiaries.



Accurate Information

As fiduciaries, we give members accurate, complete, and understandable information so they can make informed decisions about their benefits. Trustees and staff do not provide information or advice about a member's rights, benefits, or obligations, unless we are knowledgeable about and authorized to communicate with members on such matters. LACERA has 16 divisions, each with its own roles, responsibilities, knowledge, and skill sets. We consult with or refer members to relevant divisions on any issues outside the scope of our own expertise and day-to-day duties to ensure members always receive the most up-to-date and accurate information from the most reliable source. We may also refer member questions and concerns to the Chief Executive Officer or their designee when necessary.

Specific Guidance for Trustees

Trustees may send letters to non-LACERA individuals or entities using LACERA letterhead only if the communication is authorized by the Board on which they serve.

When staff receives written communications addressed to the Boards or individual Trustees, they promptly open and review it if it is not marked "personal" or "confidential." Staff will determine the appropriate course of action in accordance with the *Board of Retirement Correspondence Policy*, provide a copy to the trustee, and indicate the division, process, or staff member assigned to respond.

Board of Retirement Trustees who receive written communications directly from members should provide the original correspondence to the LACERA Executive Office for processing by the appropriate staff member.

When Trustees make or receive any written communications regarding LACERA's business involving a current LACERA service provider or person or entity related to that provider, Trustees will provide a copy of that communication to the Chief Executive Officer or Chief Investment Officer for distribution to all Trustees of the Board on which the Trustee serves.

Board of Retirement Correspondence Policy

All communication with vendors, including meetings and phone calls, should also be disclosed to the Chief Executive Officer or Chief Investment Officer. Trustees do not need to disclose purely personal or social correspondence, routine announcements, generally distributed newsletters, and other similar correspondence.

Media Policy

LACERA accurately communicates the policies and actions of LACERA and the Boards of Retirement and Investments to legitimate representatives of the media.

The general spokesperson for LACERA is the Chief Executive Officer or their designee. For Board of Investments policies and practices, the Chief Investment Officer or their designee is the primary spokesperson. Staff forward all inquiries and requests from the media to the Chief Executive Officer, or to the Chief Investment Officer if the inquiry or request involves LACERA investments. Trustees are encouraged to do the same.

LACERA staff do not initiate any media contact without specific Board direction. LACERA staff share any written press releases with the relevant Board Chair(s) for review. Please see the full Media Policy for more detail.

Social Media

Whether we are a Trustee or staff member, we do not hold ourselves out as representatives of LACERA on social media. Our *Communications Division* is responsible for LACERA's social media presence. Nothing in this section prohibits Trustees or staff from sharing content posted by LACERA's social media accounts, though Trustees must be mindful of limitations imposed by the Brown Act to avoid participation by a majority of Trustees on either Board *(see Brown Act on page 31)*. We also do not use social media for any workplace discussions. We are mindful that we are public employees and our conduct on social media, even outside of our LACERA roles, can still reflect on LACERA and our reputation.

Media Policy

Confidentiality and Privacy

We protect the privacy of confidential information entrusted to us. Improper use or disclosure presents serious risks to our members, staff, Trustees, LACERA as a whole, the County of Los Angeles, our other participating employers, and those with whom we do business. We all access confidential information in our work, and we are each responsible for protecting it. Trustees and staff are responsible for reviewing and following the policy that applies to their role.

"Confidential Information" means any information not publicly available that belongs to LACERA or is related to LACERA business operations and includes the following:

- Member Records & Sworn Statements
- Personally Identifiable Information (PII)
- Protected Health Information (PHI)
- Security Information
- Proprietary Information, including Material Non-Public Information (MNPI)
- Privileged Information and Information Exempt from Disclosure under the Public Records Act
- Information shared during closed session meetings of the Board of Retirement and Board of Investments, unless the respective Board takes action to authorize disclosure

BOR & BOI Policy on Board Member Protection of Confidential Information

Q & A – CONFIDENTIAL INFORMATION

Q: I need to discuss confidential information with a colleague. How should I do that?

A: Make sure your colleague has a business reason to know the information, and find an area where you will not be overheard by others (avoiding hallways, restrooms, and other public areas of the building). If you have a conversation over the phone or Teams in the office, close the door to your office or the conference room. Trustees, and staff working with Trustees, should exercise care to avoid a serial meeting in violation of the Brown Act.

Public Records Act and Other Requests for Information

LACERA complies with the California Public Records Act and all other lawful requests for information (subpoenas, discovery requests, etc.). If we receive one of these requests, immediately refer them to the Legal Division. Messages on our own personal electronic devices about LACERA business are subject to disclosure under the Public Records Act.

Records Retention

Information and records, in all formats—electronic or physical—are important LACERA assets. They are used for ongoing operations and as a historical record of past business decisions, activities, member information, and transactions. We preserve the right information, in the right place, for the right period of time. We follow the Records & Information Management (RIM) Policy and Retention Schedule, which is another way we uphold our fiduciary duties and manage risk. We do not conduct LACERA business on messaging systems that automatically delete messages (e.g., WhatsApp) before the timeframes set out in our RIM Policy.



RIM Policy

Brown Act

The Ralph M. Brown Act (Brown Act) governs open meetings for local legislative bodies in California and guarantees the public's right to attend and participate in these meetings. It applies to the Board of Retirement, Board of Investments, and any standing committee of either Board.

The Brown Act requires our Boards and their standing committees to hold meetings in an open forum but recognizes the need to meet in private to carry out their responsibilities in the best interests of the public under limited circumstances (including personnel matters, anticipated and pending litigation, labor negotiation, purchase or sale of pension fund investments, information technology, and security issues). Trustees and staff shall not disclose information from a closed session of the Board unless the Board takes action to allow disclosure.

A serial meeting is a series of communications, each of which involves less than a quorum of the legislative body, but which taken together involves a majority of the body's members. Trustees should be mindful to avoid serial meetings when communicating amongst themselves, including electronically (via email, text, or social media). On social media, commenting, liking, or sharing the post of another Trustee constitutes communication between Trustees and could give rise to a serial meeting if a majority of the Trustees on either LACERA Board participates. Staff are mindful of this as well when communicating with Trustees about agendized items or other issues which may be subject to board deliberation because the Brown Act also prohibits staff and others from being a conduit of information between Board members that results in a serial meeting.



WE ARE INNOVATIVE

Value & Guiding Principles

INNOVATION: We cultivate a creative, forward-thinking approach in seeking out new ideas and novel solutions to continually improve our operations and the member experience.

GUIDING PRINCIPLES

- We challenge ourselves daily to develop new solutions, taking advantage of our diverse knowledge and perspectives.
- We are judicious and willing to take measured risks to test out new ideas.
- We are not afraid to fail, understanding that failure is a step toward better solutions.
- We make an effort to seek out new knowledge, remaining aware of what is happening in our industry and similar industries.

We continually find new and better ways to serve our members. Our culture is open to and welcomes change. We embrace and leverage new technologies and the latest ideas to stay ahead of the curve and evolve our operations.

We Always Bring Our Best

We bring our best ideas, creativity, and introspection to every task, decision, and interaction to fulfill our Mission, Vision, and Values. We make tomorrow our best day and are constantly improving, through our own initiative as well as through continual learning and collaboration with our colleagues.



Artificial Intelligence (AI)

AI is a new and rapidly evolving technology that requires safeguards. At a minimum, staff must obtain authorization before using AI for LACERA business. While staff may use AI (if authorized) as a research tool, AI is not a substitute for original thought, ideas, and individual skill sets.

Additionally, do not enter confidential or privileged information into online AI prompts, as it carries serious cybersecurity and privacy risks. *Please see LACERA's AI Policy for more information and contact the Information Security Office with any questions or concerns.*

Public Summary of LACERA's Artificial Intelligence Policy

Information Security and Acceptable Use

As we embrace technology and innovate new ways to effectively serve our members, we protect all confidential or privileged information from unauthorized access, use, or disclosure and manage any associated risk. We follow all applicable policies for using hardware and software. We use LACERA technological resources like computers, tablets, phones, email, and other systems for LACERA business purposes only, though incidental personal use is allowed as set out in our *Acceptable Use Policy*. Staff should always be sure to follow the *LACERA End-User Information Security Policies & Standards Manual*.

Non-LACERA Managed Devices (Bring Your Own Device (BYOD)) Acceptable Use Policy

INFORMATION SECURITY DO'S AND DON'TS

- DO: Have separate and distinct passwords for LACERA systems versus personal accounts. Commit passwords to memory or maintain them in a LACERA approved password management application on a LACERA device. Do not write them down.
- DO: If you use a personal device to access email or Teams, enroll in the Bring Your Own Device (BYOD) program. Any LACERA communications on a personal device are subject to disclosure under the Public Records Act.
- DO: If you suspect that your LACERA issued or personal device with access to LACERA information has been compromised, report the incident immediately to the LACERA IT Help Desk and your supervisor or manager.
- DO: Complete annual Information Security Awareness training.
- DON'T: Tamper with or change the settings for updates on LACERA issued devices.
- DON'T: Access personal email from any LACERA electronic equipment.
- DON'T: Use third-party cloud storage and sharing services such as Dropbox, Box, Google Drive, iCloud, etc.

Training and Education

We are each expected to attend training and educational programs for continuous professional development to improve ourselves, our knowledge, and skills and to effectively contribute to our colleagues, members and their beneficiaries.

LACERA encourages staff to undertake educational opportunities relevant to the performance of their duties and for career development. Travel by staff for education is governed by the *Staff Travel Policy*. LACERA's Employee & Organizational Development (EOD) unit in Human Resources facilitates staff education and training (eod@lacera.gov). If our position requires us to maintain professional licenses or certifications, those are kept current as well.

CERL requires Trustees to complete at least 24 hours of education biennially on topics relevant to public retirement system trustees in California. Trustees may pursue additional relevant education consistent with performance of their fiduciary duties. Trustees are governed by the *Trustee Education Policy and Trustee Travel Policy*.

Trustee Education Policy

Trustee Travel Policy

Staff Travel Policy



CODE ADMINISTRATION

Enforcement

Staff: LACERA's Chief Executive Officer and their designees are responsible for communicating, implementing, and enforcing the Code. Violations of LACERA's Values and any Code provisions, their spirit and intent, may result in disciplinary action as the situation may warrant, up to and including termination of employment.

Trustees and Chief Executive Officer: The Boards are responsible for enforcing the Code with respect to Trustees and the CEO in accordance with Board regulations, policies, and applicable law.

Training and Attestation

The Legal Division and Ethics and Compliance Office will provide training on the Code during each Trustee and staff member's orientation upon joining LACERA and annually thereafter. Representatives of other divisions may also participate in training to speak on their areas of expertise. With orientation and each training, Trustees and staff will attest to receiving, reading, understanding, and committing to follow the Code. Additionally, we all have an obligation to read periodic compliance updates and participate in compliance-related activities.

Review

The Chief Ethics and Compliance Officer will review the Code annually and report their findings to the Audit, Compliance, Risk, and Ethics (ACRE) Committee, Board of Retirement, and Board of Investments. The LACERA Legal Division, Ethics and Compliance Office, and Internal Audit monitor applicable laws, regulations, and best practices on an ongoing basis and will recommend amendments to the Code when necessary and appropriate. The Boards may amend the Code at any time. If you have any suggestions for the Code, please contact the Ethics and Compliance Office.

Exceptions

Nothing in this Code frees us from following all applicable federal, state, and local laws and regulations. In any situation where it appears there may be a valid reason for an exception to any requirement in the Code, contact your supervisor or manager, the Executive Office, Human Resources, the Legal Division, or the Ethics and Compliance Office. Final authority to grant exceptions belongs to the Chief Executive Officer or designee.

Any request for an exception to this Code must be in writing and demonstrate that the action taken is ethical, in compliance with applicable federal, state, and local laws and regulations, and would be in the best interest of LACERA, our members, and their beneficiaries, as pertains to LACERA business.

Disclaimer

The Code does not create any rights in members, beneficiaries, staff, Trustees, vendors, other stakeholders, or others.



LACERA

CODE OF ETHICAL CONDUCT

ETHICS FIRST, COMPLIANCE ALWAYS

300 N. Lake Ave., Pasadena, CA 91101

EXHIBIT B

Exhibit B to Memorandum on Updating LACERA's Code of Ethical Conduct

Summary of Revisions to Code Made Following the February 23, 2026 ACRE Committee Meeting

Formatting

1. Maintained organization without roman numerals or other numbering and removed references to sections with roman numerals.
2. Worked with Communications on adding embedded links throughout document.
3. Worked with Communications to ensure no sentences were cut off at the beginning or end of sections and addressed all other formatting or typographical error issues.

Substantive

1. *Gifts, Honoraria, Travel, and Loans* (page 10)
    - Returned to standard in current Code for Trustees (FPPC limits) and maintained "no gifts" standard for employees in draft presented to ACRE.
2. *Outside Activities, Employment, and Offices* (page 12)
    - Added language to clarify that these restrictions are statutory and apply to all Trustees and staff. Specifically, the language on incompatible activities and employment is from Government Code section 1126 and the language on incompatible offices is from Government Code section 1099.
    - Removed reference and link to the *Outside Employment and Activities Policy*, which will apply to staff, because it has not yet been finalized. This was previously included in the draft presented to the ACRE Committee.
    - In summary, this section in the proposed draft remains aligned substantively with the language in the current Code after the above revisions.
3. *Speak Up, Listen Up* (page 23)
    - Removed sentence: "We listen to and observe those around us and speak up to report any inappropriate behavior."
    - This section is an update from the draft presented to ACRE (and a core component of an effective ethics and compliance program with respect to "culture"); there is no Speak Up, Listen Up section in the current Code.
4. *Social Media* (page 29)
    - Added sentence: "Nothing in this section prohibits Trustees or staff from sharing content posted by LACERA's social media accounts, though Trustees must be mindful of limitations imposed by the Brown Act to avoid participation by a majority of Trustees on either Board (see *Brown Act* on page 31)."
    - This is an update from the draft presented to ACRE; there is no Social Media section in the current Code.
5. *Brown Act* (page 31)
    - Added sentence: "On social media, commenting, liking, or sharing the post of another Trustee constitutes communication between Trustees and could give

rise to a serial meeting if a majority of the Trustees on either LACERA Board participates."
    - This is an update from the draft presented to ACRE due to updates to the Brown Act that went into effect January 1, 2026, and is not in the current Code.
6. *Ethics Hotline/Reporting Channels* (page 23)
    - Revised language to clearly state that Trustees, not only staff, can use the Ethics Hotline.
    - This is a minor update from the draft presented to ACRE and is consistent with the current Code.
7. *Artificial Intelligence* (AI) (page 33)
    - Revised sentence: "AI is a new and rapidly evolving technology that requires ~~some~~ safeguards. At a minimum, staff ~~need~~ must ~~to~~ obtain authorization before using AI for LACERA business."
    - This is an update from the draft presented to ACRE; there is no AI section in the current Code.
8. *Being Ethical and Compliant in Complex Situations* (page 5)
    - Revised language for clarity.
    - This is an update from the draft presented to ACRE; there is no similar section in the current Code.
9. *Links to Other Policies* (throughout)
    - All policies referenced in the proposed Code have been added to LACERA.gov and links in the proposed Code now direct readers to documents on LACERA.gov. The reference to *Compass*, the internal staff policy library, has been removed.
    - Removed links to several policies that are not currently suitable (based on security, legal, or other business reasons) for publication on LACERA.gov [Employee Handbooks (Represented and Non-Represented), LACERA Written Information Security Program (WISP) Charter, and LACERA End-User Information Security Policies & Standards Manual, Privacy & Confidentiality Policy]. The link to the Artificial Intelligence Policy has been replaced with a public summary.
    - This is an update from the draft presented to ACRE; the current Code did not include links to other policies.
10. *Code Enforcement & Review* (page 35)
    - Updated timing of review of Code from every two years by ACRE Committee to annually by Chief Ethics and Compliance Officer, who will report their findings to the ACRE Committee.
    - This is an update from the draft presented to ACRE and the current Code.



Updating LACERA's Code of Ethical Conduct

Steven Rice, Allison Barrett, and Jessica Rivas
Legal Office

Background

- ***What is a Code of Conduct?***
  - Key document that establishes standards of conduct and internal controls designed to reduce ethics and compliance risk.

- ***Current Code***
  - Last updated in November 2021.

- ***Update Process***
  - Final draft ready for both Boards' approval, based on ACRE Committee's recommendation.

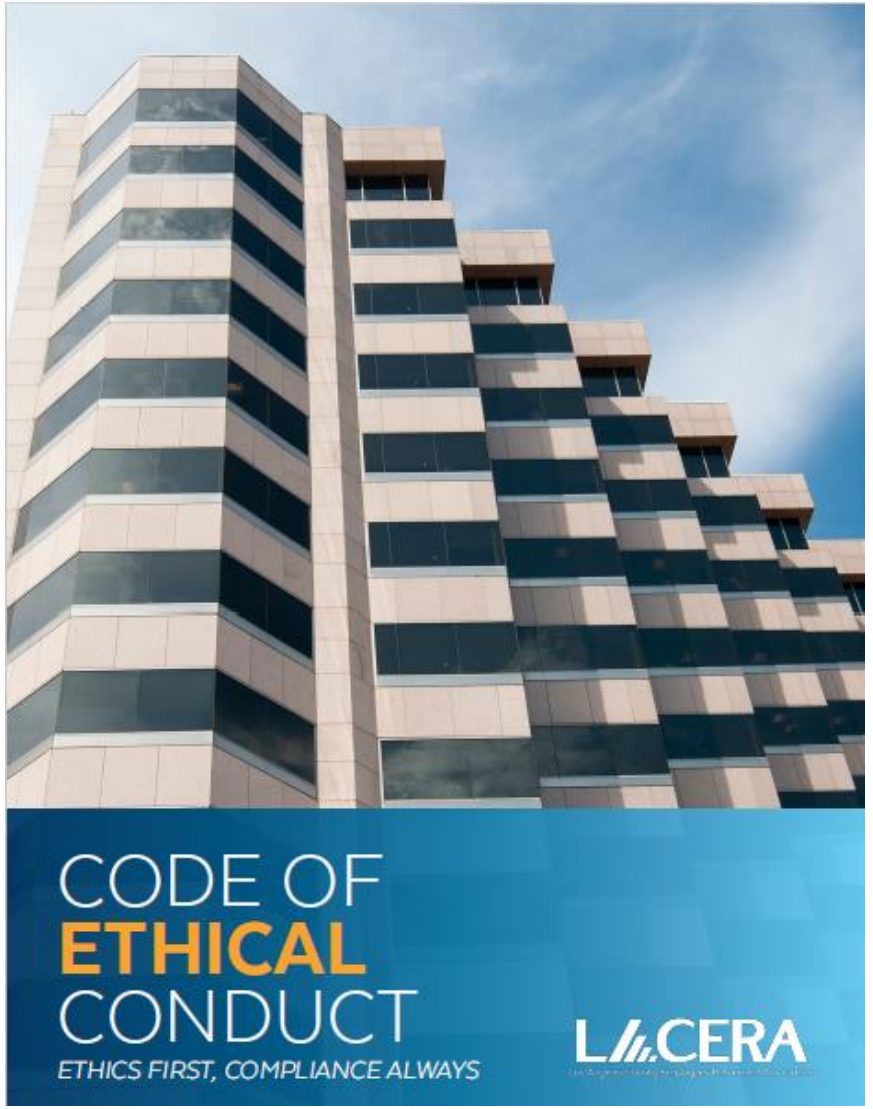
Process

- Review of best practices
- Review of samples across industries
- Complete re-write
- Extensive Collaboration
  - Internal stakeholders
  - External consultants, counsel, and other experts
  - Staff Focus Group
  - ACRE Committee

Final Draft

- Incorporates suggestions from a staff focus group ACRE Committee.

- Policy Links
  - Now to LACERA.gov, with some exceptions for those policies that are not yet ready for public posting.
  - Approval to update links as policies are updated.



Key Changes

Organization

- LACERA's Values

Style

- Linguistic
- Visual



LACERA

Telework

LACERA has embraced hybrid work as a permanent part of our operations. It balances work quality, productivity, staff morale, disaster recovery and business continuity plans, and air quality and traffic reduction goals. Telework is a privilege, not a benefit or right. This privilege may be granted, modified, denied, or terminated at LACERA's sole discretion. We hold ourselves accountable when working outside of the office by following all requirements in our Telework Policy. Whether in the office or working remotely, we work effectively, efficiently, and act in accordance with our Values and this Code. We are reliable team members and provide excellent service to our members no matter where we work.

We recognize that it may be necessary to be physically present in the office to complete our work, collaborate with others, and attend business meetings. We work in the office when we are required to do so and when, on our own initiative and with the permission of our supervisor, it is necessary to properly perform our work.

2022 Telework Policy for LACERA Staff Members

OUR ROLE IN INVESTIGATIONS

- ☑ Follow your telework schedule and use leave for personal activities
- ☑ Be available during working hours
- ☑ Be responsive to email, Teams calls, and Teams messages whether in the office or teleworking
- ☒ Follow LACERA's Privacy and Confidentiality Policy while teleworking
- ☒ Don't change your telework schedule without your supervisor's approval
- ☒ Don't forget to immediately tell your supervisor about any connectivity or device issues

LACERA | Code of Ethical Conduct 26

Key Changes

Content – New Topics

- Responsible Risk Management
- I ACT
- General Ethical Guidance
- Material Non-Public Information
- Diversity, Equity, Inclusion, and Accessibility
- Respectful Communication
- Responsiveness
- Anti-Discrimination and Harassment Policy
- Safe and Healthy Work Environment
- Drug and Alcohol Free Work Environment
- Speak Up, Listen Up
- Ethics Hotline/Reporting Channels
- Investigative Process for Misconduct
- Commitment to Non-Retaliation
- Telework
- Training & Education
- Transparent Communication (Accurate Information, Specific Guidance for Trustees, Media Policy, Social Media)
- Confidentiality and Privacy
- Public Records Act and Other Requests for Information
- Records Retention
- Artificial Intelligence
- Information Security and Acceptable Use

Key Changes

Content – Key Substantive Proposed Changes

- Gifts, Honoraria, Travel, Loans (p. 10)
  - Maintain standard on Gifts in current Code for Trustees (FPPC limits).
  - Establishes new no gifts standard for employees.

- Nepotism Policy (p. 15)
  - Applies to both hiring and contracting.
  - Applies to relatives and "personal relationships" – based on cohabitation, romantic partnership or dating relationship, or a financial partnership unrelated to official job duties.

- Review Cycle (p. 35)
  - From every 3 years to annually by the Chief Ethics and Compliance Officer.

Next Steps

Following Joint Board Approval:

- ***Pre-Launch***
  - Engage with LACERA leadership (Board and ACRE Chairs, Executive Team, Leadership Steering Council, Manager and Supervisor Action Teams) to discuss top-level support and participation.
  - Identify staff-level champions throughout the organization to assist with Code adoption and ongoing engagement.
- ***Launch Week***
  - Announce
  - Socialize
  - Train
- ***Ongoing Programming***
  - Socialize
  - Train

Questions

- Any questions?

Disability Management & Compliance (DMC): Alternate Work Search

Presented by
RaShae Walsh, Principal Analyst

Wednesday, May 6, 2026

Los Angeles County
DEPARTMENT OF
Human Resources

What is Disability Management and Compliance?

Disability Management and Compliance (DMC) is the process of supporting employees and applicants with medical conditions, injuries, or disabilities so they can remain at work, return to work, or receive reasonable accommodations — while ensuring the County complies with all federal, state, and local laws (such as ADA, FEHA, etc.)

Los Angeles County
DEPARTMENT OF
Human Resources

Understand the Laws that Govern DMC for Reasonable Accommodations

Americans with Disabilities Act (ADA):

Enforced by the EEOC

Federal law states that an employer cannot discriminate against an employee or job applicant based on their disability in hiring, advancement, discharge, compensation, training, or other conditions of employment. Requires employers to provide reasonable accommodations unless it causes undue hardship.

California Fair Employment and Housing Act (FEHA):

Enforced by the CA Civil Rights Department

California state law states that it is unlawful for an employer to discriminate against any person because of a mental or physical disability that impacts one or more major life activities. Offers even broader protections than the ADA.

Los Angeles County
DEPARTMENT OF
Human Resources

PPG 628 Medical Release or Reassignment

"**An employee may be reassigned to a different employment position** if a licensed healthcare provider finds, based on a Fitness for Duty Evaluation **or other competent medical or legal evidence***, that the employee is unable to fully perform the essential functions of their position, with or without reasonable accommodation and without risk of harm to themselves or others."

** This could come from the EE's Primary Treating Physician (PTP), Third-Party Administrator (TPA), LACERA, etc.*

Los Angeles County
DEPARTMENT OF
Human Resources

Long-Term Process:
(Permanent, Chronic, and/or >12 months)

Intake	Highly engaging!
Step One	Obtain medical clarification if needed using medical questionnaires (MQ)
Step Two	Explore accommodation options together
Step Three	Conduct the Interactive Process Meeting (IPM) and document the discussion
Step Four	Implement Decisions: Return to Work, Ergonomic Equipment, **Alternate Work Search**, **Disability Retirement, or Medical Release**

Overview of the Alternate Work Search (AWS) Process

When the department receives Permanent Work Restrictions (PWR) for an employee:

1. Review the PWRs and determine through the Interactive Process if they can be accommodated permanently. If not…
2. Establish that the next appropriate step is the AWS process.
3. Review departmental vacancies and identify available positions (DAWS).

   ✉ This step triggers submission of a Salary Supplement Application
4. Make a job offer to the employee, if possible (the vacancy must be approved to be filled, and the employee is minimally qualified).

Overview of the Alternate Work Search (AWS) Process - Continued

5. If unable to find a position after a three-month search, send a referral to DHR to begin the Countywide search (CAWS).

6. The CAWS process is for six months.

   ✉ This step triggers submission of a Salary Supplement Application if it was not previously sent in the DAWS process.

7. If unable to find a position Countywide, the case will be sent back to the department for the next steps - usually filing for disability retirement or medical release.

Criteria for Determining Appropriate Position(s)

The EE can be transferred to a vacant position if all the following criteria are met:

1) The position is vacant, funded, and approved to be filled
2) The position offers the same or less salary as the EE's previous job; it cannot be a promotion
3) The EE meets the minimum qualifications of the position and satisfies Civil Service requirements such as a typing test
4) The EE can fully and safely perform the Essential Job Functions of the alternate position with or without reasonable accommodation as determined in an IPM

Criteria for Determining Employee Qualifications

Per PPG 628, "The employee must qualify for the position, including meeting the minimum qualifications of the position and satisfying civil service requirements…"

- The employee's work history and resume (if available) will be reviewed to confirm qualifications.
- For positions with a typing requirement, such as ITC or Secretarial roles, the department will work with DHR to arrange a typing test for the employee.
- If the new position has a licensing requirement (e.g., LMFT), the employee must meet that requirement.

Common Questions (cont.)

- What happens if an employee is denied salary supplement or disability retirement by LACERA?
  - If a position is accepted, the employee is still placed in the position with a reduction in pay.
  - If the employee appeals the LACERA process but we have reached the end of the 6 months without finding a position, we proceed with medical release.



Common Questions (cont.)

- How are Plan E members handled through the process since they are not eligible for salary supplement?
  - The DMC process is the same.
  - We do not send a salary supplement application to LACERA.
  - If they accept a position that is a demotion, there will be a reduction in pay.
  - If they do not cooperate with the process or refuse an offer, generally, the process ends and the medical release process is triggered.



Los Angeles County
DEPARTMENT OF
Human Resources

Program Updates

- **AWS Cases accepted –** cases more than doubled in 25-26 fiscal year.
- **DHR oversight of the AWS process for LACP -** Increase in AWS cases due to work restrictions that cannot be accommodated.
- **Monitor adherence** - emphasizing the importance of accurate tracking, early engagement, and proactive follow-up.



Los Angeles County DEPARTMENT OF Human Resources

Questions



Los Angeles County
DEPARTMENT OF
Human Resources

FOR INFORMATION ONLY

April 24, 2026

TO: Each Trustee
Board of Retirement

FROM: Ricki Contreras
Administrative Services Division Manager

Elsy Gutierrez
Supervising Administrative Assistant II

FOR: May 6, 2026, Board of Retirement Meeting

SUBJECT: Contracting Activity Report – March 2026

The Board of Retirement (BOR) adopted the Policy for the Procurement of Goods and Services (PGS) on September 4, 2024, as revised by the BOR on February 4, 2026. The PGS requires the Vendor Management Group to provide the BOR a monthly report on all contracting activity. Below is a summary of the contracting activity for the month of March 2026.

Category	Total	Approximate Dollar Amount
New Contracts	12	$609,337.00
Renewals	7	$174,844.00
Amendment	1	$4,810.00
Extension	1	$0.00
Total	**19**	**$788,991.00**

Attachment

EG: eg

C: Luis Lugo, Chief Executive Officer
Jessica Baxter, Assistant Executive Officer
JJ Popowich, Assistant Executive Officer
Jon Grabel, Chief Investments Officer
Steven P. Rice, Chief Counsel
Leisha Collins, Chief Internal Audit
Carly Ntoya, Director of Human Resources

Summary of Contracting Activity: March 2026

Vendor	Division	Type	Term (Months)	New/Renewals	Total Contract Value
Identisys Inc.	Communications	Software License Agreement	12	N	$225.00
Carahsoft	Communications	Software Subscription Agreement	12	N	$2,323.00
Stafford HR Consulting	Human Resources	Consulting Services Agreement	12	N	$4,600.00
Segal Western States	Human Resources	Consulting Services Agreement	12	N	$130,000.00
The Center for Organizational Effectiveness	Human Resources	Training Agreement	12	N	$6,922.00
Goventmentjobs.com Inc.	Human Resources	Software Subscription Agreement	30	N	$20,685.00
The Institute Of Internal Auditors- The Los Angeles Chapter***	Internal Audit	Master Services Agreement	60	N	$0.00
The Institute Of Internal Auditors- The Los Angeles Chapter***	Internal Audit	Professional Services Agreement for Employee Training and Education Services	1	N	$6,737.00
Crowe LLP**	Internal Audit	Professional Services Agreement for Employee Training and Education Services	12	N	$46,945.00
Groom Law Group, Chartered***	Legal Office	Legal Services Agreement	12	N	$75,000.00
Eccentex Corporation	Systems	Consulting Services Agreement	1	N	$35,900.00
Eccentex Corporation	Systems	Consulting Services Agreement	12	N	$280,000.00
Sublime HQ PTY LTD	Communications	Software License Agreement	12	R	$80.00
The Law Office of Vivian Shultz***	Disability Litigation Office	Legal Services Agreement	60	R	As Needed
Carahsoft	Human Resources	Software Subscription Agreement	12	R	$90,106.00
Bitwarden, Inc.	Information Security	Software Subscription Agreement	12	R	$23,500.00
Pitchbook Data Inc.***	Investments	Software License Agreement	12	R	$48,978.00
Aspose Pty LTD*	Systems	Software Subscription Agreement	12	R	$8,067.00
Rocket Software Inc.	Systems	Maintenance and Support Agreement	12	R	$4,113.00
Total					**$784,181.00**

Vendor	Division	Type	Term (Months)	Amendment/Extension	Total Contract Value
Softchoice Corporation	Systems	Software License Agreement	28	A	$4,810.00
The Center for Organizational Effectiveness	Human Resources	Master Services Agreement	12	E	$0.00
Total					**$4,810.00**

Legend
*Sole Source Procurements
** Contract executed by Business Owner

LACERA

FOR INFORMATION ONLY

April 22, 2026

TO: Each Trustee
Board of Retirement
Board of Investments

FROM: Barry W. Lew
Legislative Affairs Officer

FOR: May 6, 2026 Board of Retirement Meeting
May 13, 2026 Board of Investments Meeting

SUBJECT: **Monthly Status Report on Legislation**

Attached is the monthly report on the status of legislation that staff is monitoring. Bills on which LACERA has adopted a position are highlighted in yellow. Bills from the 2025 legislative session that were enacted, vetoed, or died are no longer being tracked.

Reviewed and Approved:

Luis Lugo, Chief Executive Officer

Attachments
LACERA Legislative Report Index
LACERA Legislative Report

cc: Luis Lugo
JJ Popowich
Steven P. Rice
Jon Grabel
Scott Zdrazil
Tony Roda, Williams & Jensen
Naomi Padron, MKP Government Relations

LACERA Legislative Report
2025-26 Legislative Session
Status as of April 22, 2026

CATEGORY	BILL	AUTHOR	TITLE	BOR POSITION	PAGE
BROWN_ACT	AB 2498	Phillip Chen (R)	Exempt Surplus Land: Surplus Land		14
BROWN_ACT	AB 259	Blanca E. Rubio (D)	Open Meetings: Local Agencies: Teleconferences		1
BROWN_ACT	AB 409	Joaquin Arambula (D)	Open Meetings: Teleconferences: Community College		3
BROWN_ACT	AB 467	Mike Fong (D)	Open Meetings: Teleconferences: Neighborhood Councils		4
BROWN_ACT	SB 1159	Christopher Cabaldon (D)	Artificial Intelligence: Transparency and Governance		20
BROWN_ACT	SB 1187	Maria Elena Durazo (D)	Open Meetings: Majority		21
BROWN_ACT	SB 239	Jesse Arreguin (D)	Open Meetings: Teleconferencing: Subsidiary Body		17
PUBLIC_EMPLOYMENT	AB 1564	Patrick Ahrens (D)	Employer-employee relations: Confidential Communication		8
PUBLIC_EMPLOYMENT	AB 340	Patrick Ahrens (D)	Employer-Employee Relations: Confidential Communication		2
PUBLIC_INVESTMENT	AB 1439	Robert Garcia (D)	Public Retirement Systems: Development Projects: Labor		7
PUBLIC_INVESTMENT	SB 1319	Lena A. Gonzalez (D)	California Public Records Act: Public Investment Funds		22
PUBLIC_RETIREMENT	AB 1054	Mike A. Gipson (D)	Public Employees Retirement: Deferred Retirement Option		5
PUBLIC_RETIREMENT	AB 1383	Tina McKinnor (D)	Public Employees Retirement Benefits: Safety Members	Watch	6
PUBLIC_RETIREMENT	AB 1601	Chris Rogers (D)	County Employees' Retirement: Cost-of-Living Adjustment		9
PUBLIC_RETIREMENT	AB 1619	Avelino Valencia (D)	County Employees' Retirement: Administration		10
PUBLIC_RETIREMENT	AB 1660	Pilar Schiavo (D)	Public Guardians and Public Administrators		11
PUBLIC_RETIREMENT	AB 1844	Blanca Pacheco (D)	Judges Retirement System II: Beneficiaries		12
PUBLIC_RETIREMENT	AB 2336	Alexandra Macedo (R)	Personal Income Tax Law: Exclusions from Income		13
PUBLIC_RETIREMENT	AB 2780	Public Employment and Retirement	Public Employees' Retirement		15
PUBLIC_RETIREMENT	ACA 2	Corey Jackson (D)	Legislature: Retirement		16
PUBLIC_RETIREMENT	SB 538	Megan Dahle (R)	Public Employees' Retirement System: Teaching		18
PUBLIC_RETIREMENT	SB 850	Mike McGuire (D)	Prisons		19
SOCIAL_SECURITY	HR 1700	Valerie Hoyle (D)	Social Security Benefits		24
SOCIAL_SECURITY	HR 904	Jeff Van Drew (R)	Gross Income SS Benefit Inclusion Repeal		23
SOCIAL_SECURITY	S 1504	Bill Cassidy (R)	Social Security Administration		26
SOCIAL_SECURITY	S 1505	Bill Cassidy (R)	Social Security Beneficiaries		27
SOCIAL_SECURITY	S 770	Bernard Sanders (I)	Social Security Benefits		25

State Net **Search Results**

Term:

No term applied.

Tracking

Include tracked measures only

1.

California Assembly Bill 259 (2025-2026)

CA A 259 | Blanca E. Rubio (D-048) | Pending | Fiscal Committee (No) | Urgency Clause (No) | Senate Local Government Committee

Open Meetings: Local Agencies: Teleconferences

Provides that existing law, until the specified date, authorizes the legislative body of a local agency to use alternative teleconferencing under certain conditions. Extends the alternative teleconferencing procedures until the specified date.

Code:

An act to amend and repeal Sections 54953 and 54954.2 of the Government Code, relating to local government.

Status:

May 14, 2025: To SENATE Committees on LOCAL GOVERNMENT and JUDICIARY.

+ Show full status history

BROWN_ACT

No tags, commentary, or attachment applied

2.

California Assembly Bill 340 (2025-2026)

CA A 340 | Patrick Ahrens (D-026) | Pending | Fiscal Committee (Yes) | Urgency Clause (No) | Senate Appropriations Committee

Employer-Employee Relations: Confidential Communication

Prohibits a public employer from compelling a public employee, a representative of a recognized employee organization, or an exclusive representative to disclose confidential communications to a third party. Provides that this would not apply to a criminal investigation or when a public safety officer is under investigation and certain circumstances exist.

Code:

An act to ~~amend Sections 3506.5, 3519, 3543.5, and 3571 of the Government Code, and to amend Section 28858 of the Public Utilities~~ add Section 3558.9 to the Government Code, relating to employer-employee relations.

Status:

Aug 29, 2025: In SENATE Committee on APPROPRIATIONS: Held in committee.

+ Show full status history

PUBLIC_EMPLOYMENT

No tags, commentary, or attachment applied

3.

California Assembly Bill 409 (2025-2026)

CA A 409 | Joaquin Arambula (D-031) | Pending | Fiscal Committee (No) | Urgency Clause (No) | Senate Local Government Committee

Open Meetings: Teleconferences: Community College

Provides that existing law authorizes a California community college student body association or student-run community college organization to use alternate teleconferencing provisions if, among other things, at least a quorum of the members of the body participate from a singular physical location that is accessible to the public. Exempts from the quorum, physical location, and accommodation requirements the California Online Community College.

Code:

```
An act to amend Section 54953.9 of the Government Code, relating to open meetings.
```

Status:

June 23, 2025: In SENATE. Read second time and amended. Re-referred to Committee on LOCAL GOVERNMENT.

June 23, 2025: From SENATE Committee on LOCAL GOVERNMENT with author's amendments.

+ Show full status history

BROWN_ACT

No tags, commentary, or attachment applied

4.

California Assembly Bill 467 (2025-2026)

CA A 467 | Mike Fong (D-049) | Pending | Fiscal Committee (No) | Urgency Clause (No) | Senate Local Government Committee

Open Meetings: Teleconferences: Neighborhood Councils

Provides that existing law authorizes specified neighborhood city councils to use alternate teleconferencing provisions related to notice, agenda, and public participation if, among other requirements, the city council has adopted an authorizing resolution and 2/3 of the neighborhood city council votes to use alternate teleconference provisions. Extends the authorization for specified neighborhood city councils to use the alternate teleconferencing provisions until the specified date.

Code:

```
An act to amend Section 54953.8 of the Government Code, relating to local government.
```

Status:

May 14, 2025: To SENATE Committees on LOCAL GOVERNMENT and JUDICIARY.

+ Show full status history

BROWN_ACT

No tags, commentary, or attachment applied

5.

California Assembly Bill 1054 (2025-2026)

CA A 1054 | Mike A. Gipson (D-065) | Pending | Fiscal Committee (Yes) | Urgency Clause (No) | SENATE

Public Employees Retirement: Deferred Retirement Option

Establishes the Deferred Retirement Option Program as a voluntary program within the Public Employees Retirement System for employees of State Bargaining Units 5 (Highway Patrol) and 8 (Firefighters). Requires certain actions to occur, including completion of an actuarial analysis to determine the proposed program will be cost neutral, before the program becomes effective and applicable. Requires members who elect to participate in the program to meet certain requirements.

Code:

```
An act to add Chapter 20 (commencing with Section 21717) to Part 3 of Division 5 of Title 2 of
                        the Government Code, relating to retirement.
```

Status:

Jan 26, 2026: In ASSEMBLY. Read third time. Passed ASSEMBLY. *****To SENATE.

+ Show full status history

PUBLIC_RETIREMENT

No tags, commentary, or attachment applied

6.

California Assembly Bill 1383 (2025-2026)

CA A 1383 | Tina McKinnor (D-061) | Pending | Fiscal Committee (Yes) | Urgency Clause (No) | SENATE

Public Employees Retirement Benefits: Safety Members

Provides that existing law, the Teachers' Retirement Law, establishes the State Teachers' Retirement System (STRS) and creates the Defined Benefit Program of the State Teachers' Retirement Plan. Requires a retirement system subject to PEPRA to adjust pensionable compensation limits to be consistent with specified percentages of the contribution and benefit base under the specified federal law with respect to old age, survivors, and disability insurance benefits.

Code:

An act to amend Sections ~~7522.10, 7522.25, and 7522.30~~ 7522.10 and 7522.25 of, and to add Sections 7522.19 and 7522.26 to, the Government Code, relating to public employees' retirement, and making an appropriation therefor.

Status:

Jan 29, 2026: In ASSEMBLY. Read third time. Passed ASSEMBLY. *****To SENATE.

+ Show full status history

PUBLIC_RETIREMENT

Tags:

Staff_Recommendation: Neutral

IBLC_Recommendation: Watch

BOR_Position: Watch

Commentary:

Comment:

Jul 1, 2025 - 10:46 A.M. (PDT)
Bill was held in the Appropriations Committee and will not move for the rest of 2025. Bill will be reconsidered in the 2026 legislative year.

7.

California Assembly Bill 1439 (2025-2026)

CA A 1439 | Robert Garcia (D-050) | Pending | Fiscal Committee (Yes) | Urgency Clause (No) | SENATE

Public Retirement Systems: Development Projects: Labor

Requires the boards of Public Employees' Retirement System (PERS) and the State Teachers' Retirement System (STRS) to contract with the University of California Labor Centers to conduct an independent study to determine the impacts on public employee retirement funds of prohibiting the board of a public pension or retirement system, as defined, from investing in development projects in California that do not provide labor standards protections for workers.

Code:

An act to add Section 7513.77 to the Government Code, relating to public retirement systems.

Status:

Jan 29, 2026: In ASSEMBLY. Read third time. Passed ASSEMBLY. *****To SENATE.

+ Show full status history

PUBLIC_INVESTMENT

Commentary:

Comment:

Apr 25, 2025 - 2:03 P.M. (PDT)
The bill has been pulled from further consideration for 2025 and will be revisited in 2026.

8.

California Assembly Bill 1564 (2025-2026)

CA A 1564 | Patrick Ahrens (D-026) | Pending | Fiscal Committee (Yes) | Urgency Clause (No) | Assembly Appropriations Committee

Employer-employee relations: Confidential Communication

Prohibits a public employer from questioning a public employee, a representative of a recognized employee organization, or an exclusive representative regarding communications made in confidence between an employee and an employee representative in connection with representation relating to any matter within the scope of the recognized employee organization's representation.

Code:

An act to ~~amend, repeal, and add Sections 26071, 26321, 26322, and 26323 of, and to add and repeal Section 26072 of, the Business and Professions Code, relating to cannabis.~~ add Section 3558.9 to the Government Code, relating to employer-employee relations.

Status:

Mar 18, 2026: From ASSEMBLY Committee on PUBLIC EMPLOYMENT AND RETIREMENT: Do pass to Committee on APPROPRIATIONS.

+ Show full status history

PUBLIC_EMPLOYMENT

No tags, commentary, or attachment applied

9.

California Assembly Bill 1601 (2025-2026)

CA A 1601 | Chris Rogers (D-002) | Pending | Fiscal Committee (No) | Urgency Clause (No) | SENATE

County Employees' Retirement: Cost-of-Living Adjustment

Permits the county board of supervisors for Sonoma County to authorize a cost-of-living adjustment to the retirement allowances, optional death allowances, or annual death allowances payable by the retirement system. Requires the board of supervisors to take actions, including collaborating with the retirement board to identify the eligible retired members, survivors, beneficiaries, or successors in interest designated, or a subset of those benefit recipients, to receive the cost-of-living adjustment.

Code:

```
An act to add Section 31874.7 to the Government Code, relating to public employees' retirement.
```

Status:

Apr 16, 2026: In ASSEMBLY. Read third time. Adopted by ASSEMBLY. *****To SENATE.

+ Show full status history

PUBLIC_RETIREMENT

No tags, commentary, or attachment applied

10.

California Assembly Bill 1619 (2025-2026)

CA A 1619 | Avelino Valencia (D-068) | Pending | Fiscal Committee (No) | Urgency Clause (No) | Assembly Second Reading File

County Employees' Retirement: Administration

Authorizes the compensation rate for members of boards of retirement and boards of investment to be increased by the board of retirement to not more than $320 per meeting, and would provide that this provision would not be operative in any county until it is adopted by a majority vote of the board of supervisors.

Code:

An act to amend Section 31521 of the Government Code, relating to public employees' retirement.

Status:

Apr 22, 2026: From ASSEMBLY Committee on PUBLIC EMPLOYMENT AND RETIREMENT: Do pass as amended.

+ Show full status history

Hearing Dates:

04/22/2026 Public Employment and Retirement

PUBLIC_RETIREMENT

No tags, commentary, or attachment applied

11.

California Assembly Bill 1660 (2025-2026)

CA A 1660 | Pilar Schiavo (D-040) | Pending | Fiscal Committee (No) | Urgency Clause (No) | Assembly Third Reading File

Public Guardians and Public Administrators

AI-generated

This bill amends sections of the California Probate Code relating to public guardians and public administrators. It addresses the powers of public guardians to take control of property and issue written certifications, and the powers of public administrators to handle decedent estates. The bill modifies the enforcement mechanisms for compliance by financial institutions and other entities with requirements to provide information and surrender property.

Show more

AI-generated content should be reviewed for accuracy. Submit feedback

Code:

An act to amend Sections 2901, 2901.5, 7603, and 7660~~ and~~ of the Probate Code, relating to probate.

Status:

Apr 13, 2026: In ASSEMBLY. Read second time. To third reading.

+ Show full status history

Hearing Dates:

04/22/2026 Assembly Third Reading File

PUBLIC_RETIREMENT

No tags, commentary, or attachment applied

12.

California Assembly Bill 1844 (2025-2026)

CA A 1844 | Blanca Pacheco (D-064) | Pending | Fiscal Committee (No) | Urgency Clause (No) | SENATE

Judges Retirement System II: Beneficiaries

AI-generated

This bill addresses the Judges' Retirement System II by allowing judges to designate beneficiaries other than their spouse to receive retirement benefits and survivor allowances. The bill proposes to provide the same survivor benefits that are currently available to surviving spouses to designated beneficiaries. The bill also removes the minimum 20-year service requirement for certain survivor allowances.

Show more

AI-generated content should be reviewed for accuracy. Submit feedback

Code:

An act to amend Sections 75522.5, 75570, 75570.5, 75571.5, 75590, and 75591 of, and to add Section 75574 to, the Government Code, relating to judges' retirement.

Status:

Mar 26, 2026: In ASSEMBLY. Read third time. Passed ASSEMBLY. *****To SENATE.

+ Show full status history

PUBLIC_RETIREMENT

No tags, commentary, or attachment applied

13.

California Assembly Bill 2336 (2025-2026)

CA A 2336 | Alexandra Macedo (R-033) | Pending | Fiscal Committee (Yes) | Urgency Clause (No) | Assembly Revenue and Taxation Committee

Personal Income Tax Law: Exclusions from Income

Excludes under the Personal Income Tax Law, for taxable years beginning on or after January 1, 2026, and before January 1, 2031, from gross income the first $25,000 of overtime pay received by a taxpayer during the taxable year. Excludes from gross income the first $25,000 received by a taxpayer as proceeds from a defined benefit plan, as defined.

Code:

An act to add and repeal Sections 17147 and 17147.1 of the Revenue and Taxation Code, relating to taxation, to take effect immediately, tax levy.

Status:

Apr 13, 2026: In ASSEMBLY Committee on REVENUE AND TAXATION: To Suspense File.

+ Show full status history

Hearing Dates:

04/27/2026 Revenue and Taxation

PUBLIC_RETIREMENT

No tags, commentary, or attachment applied

14.

California Assembly Bill 2498 (2025-2026)

CA A 2498 | Phillip Chen (R-059) | Pending | Fiscal Committee (No) | Urgency Clause (No) |
Assembly Local Government Committee

Exempt Surplus Land: Surplus Land

AI-generated

This bill proposes to amend Section 54221 of the Government Code relating to local government surplus land disposal. The bill addresses the definition of exempt surplus land and specifically clarifies what constitutes valid legal restrictions. The amendment specifies that option agreement requirements are included among contractual obligations that can make surplus land exempt from certain disposal requirements.

Show more

AI-generated content should be reviewed for accuracy. Submit feedback

Code:

~~An act to amend Section 54952.2 of the Government Code, relating to local government.~~

An act to amend Section 54221 of the Government Code, relating to local government.

Status:

Mar 19, 2026: In ASSEMBLY. Read second time and amended. Re-referred to Committee on LOCAL GOVERNMENT.
Mar 19, 2026: From ASSEMBLY Committee on LOCAL GOVERNMENT with author's amendments.
Mar 19, 2026: To ASSEMBLY Committees on LOCAL GOVERNMENT and HOUSING AND COMMUNITY DEVELOPMENT.

+ Show full status history

BROWN_ACT

Commentary:

Comment:

Mar 17, 2026 - 2:06 P.M. (PDT)
Spot bill with nonsubstantive change.

15.

California Assembly Bill 2780 (2025-2026)

CA A 2780 | Public Employment and Retirement | Pending | Fiscal Committee (Yes) | Urgency Clause (No) | Assembly Appropriations Committee

Public Employees' Retirement

AI-generated

This bill modifies provisions of the State Teachers' Retirement System and the County Employees Retirement Law of 1937. The bill addresses retirement benefit calculations, investment duties, membership definitions, application procedures, and board composition requirements. Changes are made to notification timeframes, limitation periods for erroneous payments, and compensation limits for certain participants.

Show more

AI-generated content should be reviewed for accuracy. Submit feedback

Code:

An act to amend Sections ~~22156.07,~~ 22170.5, 22250, 22455.5, 24201.5, 24204, 24209, 24209.3, 24210, 25006, 25009, 26300, and 26606 of, and to amend, repeal, and add Sections 22164.5, 26004, 26113, 26135.7, 26139, and 26139.5 of, the Education Code, and to amend Sections 31520, 31520.1, 31520.2, 31621.7, 31622, 31639.3, 31641, 31641.2, 31641.6, 31641.20, 31641.21, and 31835 of, and to add Sections 31540.5 and 31789.6 to, the Government Code, relating to retirement, and making an appropriation therefor.

Status:

Apr 22, 2026: From ASSEMBLY Committee on PUBLIC EMPLOYMENT AND RETIREMENT: Do pass to Committee on APPROPRIATIONS.

+ Show full status history

Hearing Dates:

04/22/2026 Public Employment and Retirement

PUBLIC_RETIREMENT

No tags, commentary, or attachment applied

16.

California Assembly Constitutional Amendment 2 (2025-2026)

CA ACA 2 | Corey Jackson (D-060) | Pending | Fiscal Committee (Yes) | Urgency Clause (No) | ASSEMBLY

Legislature: Retirement

Creates the Legislative Diversification Act, to repeal a prohibition of members of the Legislature accruing any pension or retirement benefit as specified and instead require the Legislature to establish a retirement system for members elected to or serving in the Legislature on specified date.

Code:

A resolution to propose to the people of the State of California an amendment to the Constitution of the State, by repealing and adding Section 4.5 of Article IV thereof, relating to the Legislature.

Status:

Dec 2, 2024: INTRODUCED.

PUBLIC_RETIREMENT

No tags, commentary, or attachment applied

17.

California Senate Bill 239 (2025-2026)

CA S 239 | Jesse Arreguin (D-007) | Pending | Fiscal Committee (No) | Urgency Clause (No) | ASSEMBLY

Open Meetings: Teleconferencing: Subsidiary Body

Provides that the Ralph M. Brown Act requires that all meetings of a legislative body be open and public and that all persons be permitted to attend and participate. Authorizes a subsidiary body to use alternative teleconferencing provisions and imposes requirements for notice, agenda, and public participation. Requires the subsidiary body to post the agenda at each physical meeting location designated by the subsidiary body.

Code:

An act to add and repeal Section 54953.05 of the Government Code, relating to local government.

Status:

Jan 27, 2026: In SENATE. Read third time. Passed SENATE. *****To ASSEMBLY.

+ Show full status history

BROWN_ACT

No tags, commentary, or attachment applied

18.

California Senate Bill 538 (2025-2026)

CA S 538 | Megan Dahle (R-001) | Failed | Fiscal Committee (Yes) | Urgency Clause (No) | SENATE

Public Employees' Retirement System: Teaching

Authorizes member providing services as a substitute teacher, as defined, under certain circumstances to elect to retain coverage under the Public Employees' Retirement System.

Code:

```
An act to amend Section 20309 of the Government Code, relating to public employee's retirement.
```

Status:

Feb 2, 2026: In SENATE. Returned to Secretary of Senate pursuant to Joint Rule 56.

+ Show full status history

PUBLIC_RETIREMENT

No tags, commentary, or attachment applied

19.

California Senate Bill 850 (2025-2026)

CA S 850 | Mike McGuire (D-002) | Failed | Fiscal Committee (Yes) | Urgency Clause (No) | SENATE

Prisons

Requires a correctional officer or other prison staff member employed by the Department of Corrections and Rehabilitation who is a current member of a public retirement system, convicted of sexually assaulting an inmate within the prison system, to forfeit all rights and benefits in the retirement system. Requires an officer or staff member who first becomes a member of a system on or after the specified date, who is convicted of sexually assaulting an inmate, to forfeit all rights and benefits.

Code:

An act to add Section 7522.75 to the Government Code, and to add Section 5030 to, and to add Article 8 (commencing with Section 2049) to Chapter 1 of Title 1 of Part 3 of, the Penal Code, relating to prisons.

Status:

Feb 2, 2026: In SENATE. Returned to Secretary of Senate pursuant to Joint Rule 56.

+ Show full status history

PUBLIC_RETIREMENT

No tags, commentary, or attachment applied

20.

California Senate Bill 1159 (2025-2026)

CA S 1159 | Christopher Cabaldon (D-003) | Pending | Fiscal Committee (No) | Urgency Clause (No) | Senate Third Reading File

Artificial Intelligence: Transparency and Governance

AI-generated

This bill proposes to clarify that artificial intelligence systems, autonomous agents, robots, and other nonhuman entities are not included in the definition of 'person,' 'interested person,' 'participant,' 'member of the public,' and similar terms under California's transparency and governance laws. The bill addresses concerns that AI systems could overwhelm governmental processes through automated mass engagement such as submitting thousands of public records requests or generating mass public comments. The bill would modify multiple acts including the California Public Records Act, the Bagley-Keene Open Meeting Act, the Ralph M. Brown Act, the Political Reform Act of 1974, the Administrative Procedure Act, and the California Environmental Quality Act.

Show more

AI-generated content should be reviewed for accuracy. Submit feedback

Code:

An act to amend Sections 7920.520, 11405.70, 11500, and 82047 of, and to add ~~Section 17.5 to~~ Sections 11121.5, 11342.575, 11370.1.5, and 54951.5 to, the Government Code, and to amend Section 21066 of the Public Resources Code, relating to artificial intelligence.

Status:

Apr 8, 2026: In SENATE. Read second time. To third reading.

+ Show full status history

Hearing Dates:

04/22/2026 Senate Third Reading File

BROWN_ACT

No tags, commentary, or attachment applied

21.

California Senate Bill 1187 (2025-2026)

CA S 1187 | Maria Elena Durazo (D-026) | Pending | Fiscal Committee (No) | Urgency Clause (No) | Senate Local Government Committee

Open Meetings: Majority

Defines majority for purposes of the Ralph M. Brown Act to mean the number of members of the legislative body equaling more than half of the total number of seats on the legislative body. Specifies that if a seat on the legislative body is vacant, that seat is to still be counted as a seat on the legislative body.

Code:

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An act to add Section 54952.65 to the Government Code, relating to local government.
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Status:

Mar 4, 2026: To SENATE Committee on LOCAL GOVERNMENT.

+ Show full status history

Hearing Dates:

04/29/2026 Local Government

BROWN_ACT

No tags, commentary, or attachment applied

22.

California Senate Bill 1319 (2025-2026)

CA S 1319 | Lena A. Gonzalez (D-033) | Pending | Fiscal Committee (Yes) | Urgency Clause (No) | Senate Labor, Public Employment and Retirement...

California Public Records Act: Public Investment Funds

AI-generated

This bill amends the California Public Records Act regarding disclosure requirements for alternative investments made by public investment funds. The bill modifies what information must be disclosed to the public about alternative investment vehicles while maintaining exemptions for certain proprietary records. The bill adds new disclosure requirements and clarifies existing exemptions for records containing portfolio position information.

Show more

AI-generated content should be reviewed for accuracy. Submit feedback

Code:

An act to amend Section 7928.710 of the Government Code, relating to public records.

Status:

Apr 15, 2026: In SENATE. Read second time and amended. Re-referred to Committee on LABOR, PUBLIC EMPLOYMENT AND RETIREMENT.

Apr 15, 2026: From SENATE Committee on LABOR, PUBLIC EMPLOYMENT AND RETIREMENT with author's amendments.

+ Show full status history

Hearing Dates:

04/22/2026 Labor, Public Employment and Retirement

PUBLIC_INVESTMENT

Commentary:

Comment:

Apr 22, 2026 - 3:41 P.M. (PDT)
The SACRS Board of Directors adopted an "oppose" position on the bill on 4/17/2026. Plan sponsor organizations such as the California State Association of Counties (CSAC), Urban Counties Caucus (UCC),

and Rural County Representatives of California (RCRC) have also registered their opposition.

23.

United States House Bill 904 (2025-2026)

US H 904 | Jeff Van Drew (R-NJ 02) and 2 Co-sponsors | Pending | House Ways and Means Committee

Gross Income SS Benefit Inclusion Repeal

Amends the Internal Revenue Code of 1986 to repeal the inclusion in gross income of Social Security benefits.

Status:

Jan 31, 2025: To HOUSE Committee on WAYS AND MEANS.
Jan 31, 2025: INTRODUCED.
+ Show full status history

Related:

US S 2716

SOCIAL_SECURITY

No tags, commentary, or attachment applied

24.

United States House Bill 1700 (2025-2026)

US H 1700 | Valerie Hoyle (D-OR 04) and 35 Co-sponsors | Pending |
House Transportation & Infrastructure Committee

Social Security Benefits

Enhances Social Security benefits and ensure the long-term solvency of the Social Security program.

Status:

Feb 27, 2025: To HOUSE Committee on TRANSPORTATION AND INFRASTRUCTURE.
Feb 27, 2025: To HOUSE Committee on EDUCATION AND THE WORKFORCE.
Feb 27, 2025: To HOUSE Committee on WAYS AND MEANS.
Feb 27, 2025: INTRODUCED.

+ Show full status history

Identical:

US S 770

SOCIAL_SECURITY

No tags, commentary, or attachment applied

25.

United States Senate Bill 770 (2025-2026)

US S 770 | Bernard Sanders (I-VT) and 10 Co-sponsors | Pending | Senate Finance Committee

Social Security Benefits

Enhances Social Security benefits and ensure the long-term solvency of the Social Security program.

Status:

Feb 27, 2025: To SENATE Committee on FINANCE.
Feb 27, 2025: In SENATE. Read second time.
Feb 27, 2025: INTRODUCED.

+ Show full status history

Identical:

US H 1700

SOCIAL_SECURITY

No tags, commentary, or attachment applied

26.

United States Senate Bill 1504 (2025-2026)

US S 1504 | Bill Cassidy (R-LA) and 12 Co-sponsors | Pending | Senate Finance Committee

Social Security Administration

Requires the Social Security Administration to make changes to the social security terminology used in the rules, regulation, guidance, or other materials of the Administration.

Status:

Apr 29, 2025: To SENATE Committee on FINANCE.
Apr 29, 2025: In SENATE. Read second time.
Apr 29, 2025: INTRODUCED.
+ Show full status history

Identical:

US H 5284

SOCIAL_SECURITY

No tags, commentary, or attachment applied

27.

United States Senate Bill 1505 (2025-2026)

US S 1505 | Bill Cassidy (R-LA) and 3 Co-sponsors | Pending | Senate Finance Committee

Social Security Beneficiaries

Ensures that Social Security beneficiaries receive regular statements from the Social Security Administration.

Status:

Apr 29, 2025: To SENATE Committee on FINANCE.
Apr 29, 2025: In SENATE. Read second time.
Apr 29, 2025: INTRODUCED.
+ Show full status history

SOCIAL_SECURITY

No tags, commentary, or attachment applied

FOR INFORMATION ONLY

April 23, 2026

TO: Each Trustee
Board of Retirement
Board of Investments

FROM: Ted Granger
Chief Financial Officer

FOR: May 6, 2026 Board of Retirement Meeting
May 13, 2026 Board of Investments Meeting

SUBJECT: **Monthly Trustee Travel & Education Report – March 2026**

Attached for your review is the monthly Trustee Travel & Education Report. This report includes all events (i.e., attended and canceled) from the beginning of the fiscal year July 1, 2025 through March 31, 2026.

Trustees' attendance of monthly Board and Committee meetings at LACERA's office are considered administrative meetings per the Trustee Travel Policy. In order to streamline report volume and information, these regular meetings, category M, are excluded from the monthly travel reports but are included in the quarterly travel expenditure reports.

Staff travel and education expenditure reports are provided to the Chief Executive Officer monthly and to the Boards quarterly.

REVIEWED AND APPROVED:

Luis A. Lugo
Chief Executive Officer

TG/JT/EW/AC/SE/gj

Attachments

c: J. Popowich
J. Grabel
S. Rice
R. Contreras

LACERA

TRUSTEE TRAVEL AND EDUCATION REPORT

FOR FISCAL YEAR 2025 - 2026

MARCH 2026

Attendee		Purpose of Travel - Location	Event Dates	Travel Status
Nancy Durazo				
A	1	Edu - Harvard Business School Executive Education Program: Audit Committees in a New Era of Governance - Boston MA	07/23/2025 - 07/25/2025	Attended
V	-	Edu - National University: Ethics (Weekly Course) - VIRTUAL	08/04/2025 - 10/14/2025	Attended
	-	Edu - National University: Public Admin, Urban Planning, Redevelopment (Weekly Course) - VIRTUAL	09/02/2025 - 10/02/2025	Attended
	-	Edu - National University: Compensation and Benefits (Weekly Course) - VIRTUAL	02/02/2026 - 02/28/2026	Attended
Bobbie Fesler				
B	-	Edu - 2025 SACRS Fall Conference - Huntington Beach CA	11/11/2025 - 11/14/2025	Attended
Mike Gatto				
B	-	Edu - iGlobal Forum 28th Real Estate Private Equity Summit: West - Los Angeles CA	09/25/2025 - 09/25/2025	Attended
	-	Edu - 2025 SACRS Fall Conference - Huntington Beach CA	11/11/2025 - 11/14/2025	Attended
Elizabeth Ginsberg				
A	1	Edu - Harvard Business School Executive Education Program: Audit Committees in a New Era of Governance - Boston MA	07/23/2025 - 07/25/2025	Attended
B	-	Edu - 2025 SACRS Fall Conference - Huntington Beach CA	11/11/2025 - 11/14/2025	Attended
Jason Green				
A	1	Edu - 2025 SuperReturn Europe - Amsterdam Netherlands	11/04/2025 - 11/07/2025	Attended
B	-	Edu - 2025 SACRS Fall Conference - Huntington Beach CA	11/11/2025 - 11/14/2025	Attended
X	-	Edu - NCPERS Legislative Conference & Policy Day - Washington DC	01/26/2026 - 01/28/2026	Canceled
Patrick Jones				
A	1	Edu - Goldman Sachs the Garland Summit: Enduring Legacy - New York City NY	10/29/2025 - 10/30/2025	Attended
	2	Edu - Infrastructure Investor Global Summit - America Forum - New York City NY	11/04/2025 - 11/05/2025	Attended
	3	Edu - 2025 Public Funds - Austin TX	11/18/2025 - 11/20/2025	Attended
	4	Edu - 2026 Infrastructure Investor Global Summit - Berlin Germany	03/24/2026 - 03/27/2026	Attended
B	-	Edu - 2025 The Investment Diversity Exchange (TIDE) Spark - Dana Point CA	07/09/2025 - 07/10/2025	Attended
	-	Edu - Locust Point Capital INC Business Dinner - Los Angeles CA	08/07/2025 - 08/07/2025	Attended
	-	Edu - The Toigo Foundation Presents Industry Insights - Los Angeles CA	12/04/2025 - 12/04/2025	Attended
	-	Edu - 12th Annual Northern California Institutional Forum - Berkeley CA	12/08/2025 - 12/09/2025	Attended
	-	Edu - 2026 Forward Together Conference - Laguna Beach CA	03/18/2026 - 03/20/2026	Attended
X	-	Edu - Harvard Kennedy School - AI in Action (Weekly Course) - VIRTUAL	10/10/2025 - 11/10/2025	Canceled

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TRUSTEE TRAVEL AND EDUCATION REPORT

FOR FISCAL YEAR 2025 - 2026

MARCH 2026

Attendee		Purpose of Travel - Location	Event Dates	Travel Status
Shawn Kehoe				
B	-	Admin - Retirement Benefits Meeting with Professional Peace Officers Association - San Dimas CA	11/01/2025 - 11/01/2025	Attended
	-	Admin - Professional Peace Officers Association (PPOA) Board Offsite - Dana Point CA	01/30/2026 - 01/30/2026	Attended
V	-	Edu - 2025 CALAPRS Trustee Round Table - VIRTUAL	10/03/2025 - 10/03/2025	Attended
Aleen Langton				
A	1	Edu - IFEBP: Public Plan Trustees Institute – Level I - Chicago IL	07/15/2025 - 07/16/2025	Attended
	2	Edu - PREA's 2026 Spring Conference - Nashville TN	03/26/2026 - 03/27/2026	Attended
B	-	Edu - 2025 UC Irvine Audit Committee Summit - Irvine CA	09/19/2025 - 09/19/2025	Attended
	-	Edu - iGlobal Forum 28th Real Estate Private Equity Summit: West - Los Angeles CA	09/25/2025 - 09/25/2025	Attended
	-	Edu - NAIC Amplify Alts Forum 2025 - Los Angeles CA	10/01/2025 - 10/01/2025	Attended
	-	Edu - CFA Society Los Angeles (Conversations that Connect) - Los Angeles CA	11/06/2025 - 11/06/2025	Attended
	-	Edu - 2026 PPI La Jolla Roundtable - San Diego CA	02/25/2026 - 02/27/2026	Attended
	-	Edu - 2026 NASP Southern California "Day of Education in Private Equity Conference" - Los Angeles CA	03/18/2026 - 03/19/2026	Attended
V	-	Edu - Wharton Asset Allocation Program (Weekly Course) - VIRTUAL	08/01/2025 - 10/01/2025	Attended
	-	Edu - 2025 CALAPRS Trustee Round Table - VIRTUAL	10/03/2025 - 10/03/2025	Attended
	-	Edu - Wharton Fundamentals of Portfolio Management (Weekly Course) - VIRTUAL	01/01/2026 - 02/01/2026	Attended
	-	Edu - Wharton Investment Products (Weekly Courses) - VIRTUAL	01/02/2026 - 02/02/2026	Attended
	-	Edu - NCPERS 2026 Public Retirement Systems Study - VIRTUAL	02/24/2026 - 02/24/2026	Attended
	-	Edu - NCPERS Policy and Budget Outlook: What’s Ahead for Public Pensions in 2026 - VIRTUAL	02/26/2026 - 02/26/2026	Attended
	-	Edu - Nasdaq The New Proxy Playbook: Practical Board Oversight After the 2026 Regulatory Shift - VIRTUAL	03/16/2026 - 03/16/2026	Attended
X	-	Edu - 2025 SACRS Fall Conference - Huntington Beach CA	11/11/2025 - 11/14/2025	Canceled
	-	Edu - NCPERS Legislative Conference & Policy Day - Washington DC	01/26/2026 - 01/28/2026	Canceled
Debbie Martin				
A	1	Edu - Invest in Yourself SACRS Public Pension Investment Management Program - Berkeley CA	07/13/2025 - 07/16/2025	Attended
B	-	Edu - 2025 SACRS Fall Conference - Huntington Beach CA	11/11/2025 - 11/14/2025	Attended

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TRUSTEE TRAVEL AND EDUCATION REPORT

FOR FISCAL YEAR 2025 - 2026

MARCH 2026

Attendee		Purpose of Travel - Location	Event Dates	Travel Status
Alma Martinez				
V	-	Edu - Wharton Asset and Portfolio Management Certificate Program (Weekly Course) - VIRTUAL	07/01/2025 - 09/30/2025	Attended
	-	Edu - Wharton Executive Education - Investment Products (Weekly Course) - VIRTUAL	07/01/2025 - 09/30/2025	Attended
	-	Edu - Harvard Business School - Alternative Investments (Weekly Course) - VIRTUAL	08/13/2025 - 09/17/2025	Attended
Nicole Mi				
A	1	Edu - Invest in Yourself SACRS Public Pension Investment Management Program - Berkeley CA	07/13/2025 - 07/16/2025	Attended
	2	Edu - 2nd Annual AAPI LEAD Summit - Atlanta GA	07/23/2025 - 07/25/2025	Attended
B	-	Edu - 2025 The Investment Diversity Exchange (TIDE) Spark - Dana Point CA	07/09/2025 - 07/10/2025	Attended
	-	Edu - 2025 UC Irvine Audit Committee Summit - Irvine CA	09/19/2025 - 09/19/2025	Attended
	-	Edu - 2025 NACD PSW Corporate Directors Symposium - Los Angeles CA	11/13/2025 - 11/13/2025	Attended
	-	Edu - 2026 Pension Bridge Private Credit - San Diego CA	02/02/2026 - 02/04/2026	Attended
	-	Edu - 2026 PPI La Jolla Roundtable - San Diego CA	02/25/2026 - 02/27/2026	Attended
	-	Edu - 2026 NASP Southern California "Day of Education in Private Equity Conference" - Los Angeles CA	03/18/2026 - 03/19/2026	Attended
V	-	Edu - Wharton Asset Allocation Program (Weekly Course) - VIRTUAL	01/02/2026 - 03/02/2026	Attended
X	-	Edu - NCPERS Legislative Conference & Policy Day - Washington DC	01/26/2026 - 01/28/2026	Canceled
Lisa Proft				
B	-	Edu - 2025 SACRS Fall Conference - Huntington Beach CA	11/11/2025 - 11/14/2025	Attended
David Ryu				
B	-	Edu - Emerging Managers Summit 2025 - Laguna Niguel CA	12/07/2025 - 12/08/2025	Attended
	-	Edu - Pension Power - Sacramento CA	12/12/2025 - 12/12/2025	Attended

Category Legend:

A - Pre-Approved/Board Approved Educational Conferences
B - 1) Board Approved Administrative Meetings and 2) Pre-Approved Educational Conferences in CA where total cost is no more than $3,000 provided that a Trustee may not incur over $15,000 for all expenses of attending all such Educational Conferences and Administrative Meetings in a fiscal year per Trustee Travel Policy; Section III.A
V - Virtual Event
X - Canceled events for which expenses have been incurred.

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

April 17, 2026

TO: Each Trustee
Board of Retirement

FROM: Tamara Caldwell, Division Manager
Disability Retirement Services Division

FOR: May 6, 2026, Board of Retirement Meeting

SUBJECT: APPLICATION OF PLAN D MEMBER, HONG MEI

A member electing a prospective Plan D transfer must satisfy one of two waiting periods in order to apply for a disability retirement. The member must have either (1) Completed two continuous years of active service after his or her most recent transfer date, or (2) Earned five years of retirement service credit under Retirement Plan D after his or her most recent transfer date.

Disability Retirement Services and Legal Counsel have reviewed the file, and their analysis is attached. It has been concluded that the member failed to meet any of the filing requirements of Government Code section 31494.5 (e).

IT IS THEREFORE RECOMMENDED THAT the Board of Retirement reject the application of Hong Mei for processing.

NOTED AND REVIEWED:

JJ Popowich, Assistant Executive Officer

TLC:mc

Confidential Attachment

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

April 17, 2026

TO: Each Trustee
Board of Retirement

FROM: Tamara Caldwell, Division Manager
Disability Retirement Services Division

FOR: May 6, 2026, Board of Retirement Meeting

SUBJECT: APPLICATION OF PLAN D MEMBER, DAVID W. SMITH

A member electing a prospective Plan D transfer must satisfy one of two waiting periods in order to apply for a disability retirement. The member must have either (1) Completed two continuous years of active service after his or her most recent transfer date, or (2) Earned five years of retirement service credit under Retirement Plan D after his or her most recent transfer date.

Disability Retirement Services and Legal Counsel have reviewed the file, and their analysis is attached. It has been concluded that the member failed to meet any of the filing requirements of Government Code section 31494.5 (e).

IT IS THEREFORE RECOMMENDED THAT the Board of Retirement reject the application of David W. Smith for processing.

NOTED AND REVIEWED:

JJ Popowich, Assistant Executive Officer

TLC:mc

Confidential Attachment

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