

**ATTACHMENT A**

**RESPONDENT'S PETITION FOR RECONSIDERATION**

## Petition for Reconsideration Cal Pers 10-21-2016

Friday, October 21, 2016 10:14 AM

Petition for Reconsideration

OCT 21 2016

CALPERS Board Mail

Cheree Swedensky, Assistant to the Board Executive Office  
California Public Employees' Retirement System  
P.O. Box 942701  
Sacramento, CA 94229-2701

I am writing this letter to request a Petition for Reconsideration due to medical records submitted before the close of evidence dated July 5th 2016 and a updated Dr. Note regarding my current condition. I submitted all of the attached information to Preet Kaur and documents with email and dates attached requesting that they be submitted to Dr. Khasugain for review prior to evidence submission close date also before the Court Date. I don't want to think documents were purposely withheld, I hope they were just overlooked, however they were not noted in any list of Dr. Khasugain's

While reviewing the records that were submitted to Dr. Khasugain for the IME resubmission, I didn't see a note or mention of any of the attached documents. I feel the attached documents are pertinent to the evidence of this claim regarding my disability retirement decision that was submitted by my employer on my behalf along with the accuracy of documents regarding the Doctors conclusion and decision without correct and proper documentation/ MRI's and X-ray and notes.

I'm requesting a reconsideration due to facts he stated in his testimony, he mentioned there were no bulging disk, cord compression nor any signs of radiculopathy as well as many other things. My attached reports contradicts his decision. In fact the only MRI that's noted and mentioned to be viewed was one that was dated June 18th 2014 I have sent several to Preet Kaur with the latest dated June 27th 2016 that hasn't been addressed not mentioned.

The evidence attached shows those issues and much more are existing this very day  
The attached MRI's and current doctor notes will show that the finding that Dr. Khasugain stated does not exist in fact does exist.

With the attachments I am requesting a reconsideration hearing regarding my Disability Retirement decision due to the fact of omitting of medical evidence.

Also, I would like to address the no show issue on hearing date.  
I applied for a change of date due to the fact of a hardship I was unable to purchase travel and the request was denied, although I know this has no merit on your decision I felt the need to let you know the reason for not appearing to the hearing.

Thank you in advance for your help.

Nicole Collins  
Ref No. 2015-0026

## Attachments:

Dr. Mauricio Valdes, MD  
MRI's  
CT Scans  
Notes  
Arrash Kirkland MD  
EMG/NCS for carpal tunnel  
Also x-rays and MRI's of hands and wrist  
And notes

Current  
Doctor Report  
Dated August 3rd  
Follow up regarding  
MRI Dated June 27th 2016  
Cal Ref No: 2015-0826

Collins, Nicole

Valdes M.D., Mauricio A  
08/03/2016  
Follow up

HEDLEY ORTHOPAEDIC INSTITUTE  
10238 E. Hampton Ave. Suite 301A  
Phoenix, AZ 85016  
Phone #: (480) 354-5900

Collins, Nicole

MR#

Mauricio A. Valdes, M.D.

DATE OF VISIT: August 3, 2016

**HISTORY OF PRESENT ILLNESS:** Nicole Collins comes to see us. The patient is a African-American female who is well known to our office. We have been following her for recurrent neck issues and upper extremity symptoms. Previously, we have found on cervical spine MRI the presence of syrinx in the cervical spinal cord. There is degenerative disease of the cervical spine with disc protrusion at C3-4 and C4-5 without significant stenosis at this time. The patient has been evaluated by neurosurgery and did not want to pursue any further intervention or treatment.

Now she comes back complaining of worsening of low back pain. It is radiating towards the anterior thigh areas.

**PHYSICAL EXAMINATION:** On physical examination, the patient is alert and oriented. She ambulates with an antalgic gait. She has no focal neurologic deficits. There is a slight decreased sensation over L5 dermatome. There is pain on range of motion of the lumbar spine. He has hyperextension and lateral bending which produces pain radiating down the buttock area. There is decreased sensation over the right L3, L4-5 and S1 dermatomes and is only on the L4-5 on the left. There is weakness of the ankle evertors and extensor hallucis longus especially on the right at 3/5. On the left, the extensor hallucis longus is 3/5 muscle strength. Deep tendon reflexes are diminished and absent in the bilateral patella tendon areas and 1+/4+ in the bilateral Achilles tendon areas.

**RADIOGRAPHIC DATA:** We have reviewed the results of the MRI of the lumbar spine taken June 27, 2016. This MRI of the lumbar spine shows multilevel spondylosis of the lumbar spine. There is degenerative disease at L5-S1, with mild foraminal stenosis bilaterally.

**IMPRESSION:** The patient presents with degenerative disease that has slightly progressed at L3-4 and L4-5 with fissure close to the left foraminal areas. There are bulging disks at these levels and mild bulging disc at L2-3.

**PLAN:** With these findings, we have discussed with the patient the alternatives of treatment. At this moment, she presents with mild recess stenosis due to bulging disc and annular tears and most likely gave her new symptoms. Given the current findings and a diagnosis of L3-4 and L4-5 annular tears and lumbar stenosis and radiculopathy, we have therefore decided to refer her for evaluation and treatment and possible strengthening exercises of the lumbar spine. We have prescribed tramadol and tizanidine for pain control. In the future, she will also require long term follow up by neurosurgery given the presence of the syrinx found on the cervical spine. The patient understands and agrees with the current plan and will let us know if there is any worsening. We will see her back in our office on a p.r.n. basis.

Mauricio A. Valdes, M.D.  
MAV/plc

FOLLOW UP

Electronically signed on 08/09/2016 by Mauricio A Valdes M.D.

P. ①



Cal Pers REF: # 2015-20016

New Mri dated June 27th 2015 ~~it was an error~~ in mailing 2016  
4 messages

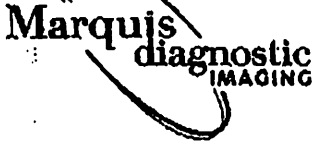
Wed, Jun 29, 2016 at 11:13 AM

To: Preet.Kaur@calpers.ca.gov

Here is another updated MRI.  
Please forward to Dr. For evaluation before court date.

Thank you

P. ②



Ref. NO. 2015-~~2026~~  
2026

Marquis Diagnostic Imaging - Gilbert  
1760 E. Pecos Rd., Suite 101  
Gilbert, AZ 85295  
Phone: 480-553-8999  
Fax: 480-553-8989

Patient Name: Collins, Nicole

Date of Birth:

Referring Physician: Daniel Ryklin

Date of Exam: 08/29/2015

Marquis MRN #:

Accession #:

Exam: MRI Lumbar Spine Without Contrast

EXAM: MRI Lumbar Spine Without Contrast

HISTORY: Lumbago

COMPARISON: None.

Technique: Sagittal T2, sagittal STIR, and sagittal T1-weighted images were obtained. Additional axial PD, axial T1 and T2 weighted imaging was also performed.

FINDINGS: Vertebral body height and alignment is maintained throughout the lumbar spine. There is a normal lumbar lordosis. No abnormal bone marrow signal is seen. The conus is in normal position without abnormal signal.

Remaining findings by level are as follows:

At the level of L1-L2, there is no evidence of disc bulge, neural foraminal narrowing, facet arthrosis, ligamentum flavum thickening, or nerve root compression.

At the level of L2-L3, minimal degeneration of the L2-L3 disc with slight loss of T2 signal and minimal bulge. No significant canal stenosis. Mild bilateral facet hypertrophy. No significant foraminal stenosis.

At the level of L3-L4, mild degeneration of the L3-L4 disc with slight loss of T2 signal and mild loss of disc height. Small broad-based disc bulge with no significant canal stenosis. Far left lateral disc protrusion appears to contact the extraforaminal left L3 nerve root. No significant canal stenosis. Mild bilateral facet hypertrophy. Mild-to-moderate narrowing of the left greater than right neural foramen.

At the level of L4-L5, minimal disc bulge with flattening of the ventral thecal sac. No significant canal stenosis. Mild-to-moderate bilateral facet hypertrophy with mild narrowing of both neural foramen.

At the level of L5-S1, degeneration of the L5-S1 disc with loss of normal T2 signal and moderate

P 5



**SimonMed**  
See Tomorrow Today

Ref # 2015-0026

Phone-480-584-4900 Fax-602-302-5914 Address-2680 S Val Vista Dr Bldg 7 Ste 135, Gilbert, AZ 85295

**FINAL**

SimonMed Spectrum  
DIAGNOSTIC IMAGING REPORT

Patient: Collins, Nicole Sex: F DOB: Age: Diag. Imaging #  
Status: Outpatient  
Referring Physician: Mauricio Valdes MD

Exam # - Sep 14, 2015 - CT - LUMBAR SPINE W/O CONTR & 3D RECON

CLINICAL HISTORY: Low back pain with lower extremity radiation

COMPARISON: None.

TECHNIQUE: Thin section images were reconstructed into all three planes.

CONTRAST: None.

COUNTING REFERENCE: Lumbosacral junction.

**FINDINGS:**

Vertebral alignment is anatomic. Vertebral height is maintained at all levels. The osseous structures are negative for destructive changes.

Paraspinal soft tissues are within normal limits.

T12-L1: Disc, facets, central canal and foramina appear normal.

L1-L2: Disc, facets, central canal and foramina appear normal.

L2-L3: Disc, facets, central canal and foramina appear normal.

L3-L4: Diffuse annular bulging. Normal facets. Central canal is minimally stenotic. Foramina are patent.

L4-L5: Minimal annular bulging. Normal facets. Central canal and foramina are patent.

L5-S1: Degenerative disc with vacuum phenomena and loss of height. Mild facet arthropathy. Central canal is patent. Mild bilateral foraminal stenoses secondary to osteophytes.

**IMPRESSION:**

L5-S1 mild bilateral foraminal stenoses. Mild spondylotic changes at other levels as described above.

2680 S. Val Vista Dr., Bldg. 7 Ste. 135, Gilbert, AZ 85295 T480-584-4900 F480-584-4910

P7

REF NO. 2015-0026

**Andrew L. Tievsky, MD**

**Diplomate, American Board of Radiology in Neuroradiology and Diagnostic Radiology**

**dd: Sep 15, 2015**

-----  
**Reported by: Andrew Tievsky M.D.**

**Electronically signed by: Andrew Tievsky M.D.**

**Thank you for your kind referral. If you require further assistance, please contact our Radiologist Hotline at 480-551-0264.**

## **FAX Tranmittal**

**TO: Cheree Swedensky, Assistant to the Board of Executive Office  
California Public Employees' Retirement Systems  
P.O.Box 942701  
Sacramento, CA 94229-2701**

**To Fax:  
(916) 795-3972**

**From:  
Nicole Collins  
Cal Pers Ref No 2015-0026  
Retirement Disability Claim**

**Attachments:  
29pages**

**Notes: please contact me to let me know the fax was  
received.**

**Phone:**

**Email:**



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Follow up Mauricio A Valdes M D - 08/03/2016

Current  
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Dated August 3rd  
Follow up regarding  
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Cal Ref No: 2015-0826

Collins, Nicole

Valdes M.D., Mauricio A  
08/03/2016  
Follow up

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MR# :

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MAV/plc.

FOLLOW UP

Electronically signed on 08/09/2016 by Mauricio A Valdes M.D.

P. ①



Gmail

Cal<sup>PER</sup>

REF: # 2015-2016<sup>2</sup>

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P. (2)



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Date of Birth:

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Exam: MRI Lumbar Spine Without Contrast

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HISTORY: Lumbago

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P 5



**SimonMed**  
See Tomorrow Today

Ref # 2015-0026

Phone-480-584-4900 Fax-602-302-5914 Address-2680 S Val Vista Dr Bldg 7 Ste 135, Gilbert, AZ 85295

**FINAL**

SimonMed Spectrum  
**DIAGNOSTIC IMAGING REPORT**

Patient: Collins, Nicole Sex: F DOB: Age: Diag. Imaging #  
Status: Outpatient  
Referring Physician: Mauricio Valdes MD

Exam # Sep 14, 2015 - CT - LUMBAR SPINE W/O CONTR & 3D RECON

CLINICAL HISTORY: Low back pain with lower extremity radiation

COMPARISON: None.

TECHNIQUE: Thin section images were reconstructed into all three planes.

CONTRAST: None.

COUNTING REFERENCE: Lumbosacral junction.

**FINDINGS:**

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**IMPRESSION:**

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P7

REF NO. 2015-0026

Andrew L. Tievsky, MD

Diplomate, American Board of Radiology in Neuroradiology and Diagnostic Radiology

dd: Sep 15, 2015

Reported by: Andrew Tievsky M.D.

Electronically signed by: Andrew Tievsky M.D.

Thank you for your kind referral. If you require further assistance, please contact our Radiologist Hotline at 480-551-0264.

NOTICE: This information has been disclosed to you from records protected by Federal and State confidentiality rules (42CFR Part 2 and/or ARS 36-3661). The rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by statute.

P8



**SimonMed**  
See Tomorrow Today

Ref NO. 2015-0026

Phone-480-584-4900 Fax-602-302-5914 Address-2680 S Val Vista Dr Bldg 7 Ste 135, Gilbert, AZ 85295

**FINAL**

SimonMed Spectrum  
DIAGNOSTIC IMAGING REPORT

Patient: Collins, Nicole Sex: F DOB: Age: Diag. Imaging # :  
Status: Outpatient ASAP  
Referring Physician: Mauricio Valdes MD

Exam # - Nov 04, 2015 - MRI 3T - CERVICAL SPINE W/O CONTRAST

CLINICAL HISTORY: M50.00: Intervertebral disc disorder with myelopathy, cervical region.  
M54.12: Radiculopathy, cervical region.

TECHNIQUE: Sagittal T1, T2, STIR and axial T2 and gradient echo images of the cervical spine were obtained without intravenous contrast.

COMPARISON: None

FINDINGS: There is mild levoscoliosis. Otherwise normal alignment. The bone marrow signal intensity is normal. No fractures. Disc heights are well-maintained. There is prominence of the central canal of the spinal cord from C2 through C5, most conspicuous at C5, with there is focal prominence of the central canal measuring approximately 2 mm in maximal axial dimension and 4 mm in craniocaudal length. There is associated hypointense signal visible on the sagittal T1-weighted images at the C5 level, consistent with a small focal cord syrinx. The visualized posterior fossa is normal, including normal position of the cerebellar tonsils.

At C2-C3, there is a small focal central disc protrusion mildly flattening the ventral cord without spinal stenosis or neural foraminal narrowing.

At C3-C4, there is a small focal central disc protrusion mildly flattening the ventral cord without spinal stenosis. There is mild right neural foraminal narrowing secondary to uncovertebral joint arthropathy.

At C4-C5, there is a tiny central disc protrusion without spinal stenosis, cord compression, or neural foraminal narrowing.

At C5-C6, there is a small left central focal disc protrusion with an annular fissure without spinal stenosis, cord compression, or neural foraminal narrowing.

At C6-C7, there is a small focal central disc protrusion without spinal stenosis, cord compression, or neural foraminal narrowing.

C7-T1 is unremarkable.

P.9



## IMPRESSION:

Ref. NO. 2015-0026

1. Small focal cord syrinx at C5, of uncertain etiology but possibly related to cord compression or a previous cord injury. No evidence of Chiari one malformation.

2. Mild multilevel disc degeneration with small disc protrusions at C2-C3 through C6-C7.

3. C2-C3: Mild ventral cord flattening without spinal stenosis.

4. C3-C4: Mild ventral cord flattening without spinal stenosis. Mild right neural foraminal narrowing.

Carrie P. Marder, M.D., Ph.D.

Diplomate of the American Board of Radiology

CAQ in Neuroradiology

dd: Nov 04, 2015

-----  
Reported by: Carrie Marder M.D. Ph.D.

Electronically signed by: Carrie Marder M.D. Ph.D.

Thank you for your kind referral. If you require further assistance, please contact our Radiologist Hotline at 480-551-0264.

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P10



**SimonMed**  
See Tomorrow Today

REF. NO. 2015-0026

Phone-480-584-4900 Fax-602-302-5914 Address-2680 S Val Vista Dr Bldg 7 Ste 135, Gilbert, AZ 85295

**FINAL**

SimonMed Spectrum  
DIAGNOSTIC IMAGING REPORT

Patient: Collins, Nicole Sex: F DOB: Age: Diag. Imaging #  
Status: Outpatient  
Referring Physician: Courtney K. Kelm PA-C

Exam # - Sep 26, 2016 - MRI 3T - CERVICAL SPINE W/O CONTRAST

HISTORY: Neck pain for 5 years.

TECHNIQUE: Sagittal T1, T2. Axial T2, GRE.

COMPARISON: MRI of the cervical spine from 11/4/2015.

FINDINGS: Minimal levoscoliosis, unchanged. Straightening of the normal lordotic curvature which appear stable. There is no evidence of spondylolisthesis. Craniocervical junction and C1-C2 level are normal. Diffuse disc desiccation. No disc space narrowing.

C2-C3 level: Small midline disc protrusion contacting the spinal cord. Minimal cord flattening. No evidence of myelomalacia. No spinal canal or foraminal stenosis. No change.

C3-C4 level: Tiny broad-based midline disc protrusion. No spinal stenosis or foraminal stenosis. No change.

C4-C5 level: Tiny midline disc protrusion. No spinal stenosis, cord compression or foraminal stenosis. No change.

C5-C6 level: Small left paracentral disc protrusion extending to the spinal cord without cord compression. No spinal stenosis or foraminal stenosis. No change.

C6-C7 level: Tiny midline disc protrusion. No spinal stenosis, cord compression or foraminal stenosis.

C7-T1 level: Negative

Normal position of the cerebellar tonsils. There is minimal prominence of the central canal again noted from C2 to C6 which is most pronounced at the upper C5 level measuring 1.6 mm in maximum diameter. Findings likely represent a persistent central canal which is a normal variant although a tiny syrinx at the C5 level cannot be excluded. No evidence of a spinal cord mass or myelomalacia. Normal bone marrow signal. Paraspinal soft tissues are unremarkable.

**IMPRESSION:**

1. Disc protrusions again noted from C2 to C7, unchanged compared to 11/4/2015. No

P. 11

significant cord compression.

*Ref. NB 2015-0026*

2. Minimal prominence of the central canal in the cervical spinal cord from C2 to C6, most pronounced at the C5 level. Findings likely represent a persistent central canal which is a normal variant although a tiny syrinx at the C5 level cannot be excluded.

dd: Sep 28, 2016

-----  
Reported by: Nicholas Rosati M.D.

Electronically signed by: Nicholas Rosati M.D.

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*P. 12*

Ref. NO - 2015 - 0026



**Please review attached regarding carpal tunnel**

2 messages

To: Preet.Kaur@calpers.ca.gov

Mon, Mar 28, 2016 at 2:27 PM

2016-03-28-1459200392-4806853490-9165429244.pdf  
97K

To:

Fri, Oct 21, 2016 at 8:32 AM

----- Forwarded message -----

From:  
Date: Monday, March 28, 2016  
Subject: Please review attached regarding carpal tunnel  
To: Preet.Kaur@calpers.ca.gov

Sent from Gmail Mobile

2016-03-28-1459200392-4806853490-9165429244.pdf  
97K

P-13

Ref. No. 2018-0026

# arizona patient treatment centers

## McDowell Ambulatory Surgery Center

1301 E. McDowell Rd. #100, Phoenix, AZ 85006  
4860 E. Boswell Rd. #103, Mesa, AZ 85206  
Phone: (602) 265-8900 Fax: (402) 265-8151

November 18, 2014

Re: Nicole Collins

To whom it may concern:

Nicole Collins has been under our care since 7/23/14. She has been on disability since October 29, 2013 per Dr. Myint (California). Patient presented to us with multiple pain complaints which when evaluated proved to be stemming from four main diagnoses: carpal tunnel syndrome, lumbar spondylosis, cervical spondylosis, and thoracicgia. She has undergone lumbar microdecompression ablations for her low back pain. She has undergone recent EMG/NCS testing which verified patient has bilateral median neuropathies at the wrist (carpal tunnel syndrome). I believe her carpal tunnel syndrome is directly attributable to her work as an accountant for many years. Due to her carpal tunnel syndrome she can no longer continue in her previous vocation. I believe that her thoracicgia, neck pain, and low back pain also preclude her from working in her previous occupation. She continues in our care and should you have any further questions, please do not hesitate to contact my office.

Respectfully,

Arun Kikkawa MD  
Physical Medicine and Rehabilitation Specialist

P. 114



arizonapain treatment centers

1301 E. McDowell Road, Suite 100  
 Phoenix, AZ 85006  
 602-265-8900 phone 602-265-8151 fax

Test Date: 11/12/2014

Patient: Nicole Collins	DOB:	Physician: Gregory Hunter, M.D.
Sex: Female	Height:	Ref Phys: Arrash Kirkland, M.D.
ID#:	Weight:	Technician: Leslie Daugherty, NCS, T

**Patient Complaints:**

The patient is a female who presents with neck and shoulder pain radiating to bilateral upper extremities, numbness and tingling in fingers, wrist pain. She has experienced these symptoms since 2010. She is not diabetic.

**Impression:**

**NERVES TESTED:** Median, and Ulnar motor and sensory and Radial sensory.

**EMG & NCV Findings:**

1. Evaluation of the Left median sensory and the Right median sensory nerves showed prolonged distal peak latency (Pain, L2.4, R2.4 ms).
2. All remaining nerves (as indicated in the following tables) were within normal limits.
3. All F Wave latencies were within normal limits.
4. Needle electrode examination (EMG) of the following muscles of the left and right upper extremities are normal.

**CONCLUSION:**

The findings on this electrodiagnostic study with NCV/EMG of the left and right upper extremity are consistent with minimal to mild bilateral carpal tunnel syndrome affecting the median nerve at the wrist. Correlation with the clinical history, examination and/or radiographic studies is recommended.

Gregory J. Hunter, M.D.

ELECTRONICALLY SIGNED  
 11/18/2014 2:26 PM

P-15

**Nerve Conduction Studies**  
Axial Sensory Summary Table

~~XXXXXXXXXXXXXXXXXXXX~~  
Ref # 2015-0026

<b>Left Radial Axial Sensory (Base 1st Digit)</b>									
Wrist	2.4	<3.4	24.3	>13	Wrist	Base 1st Digit	2.4	10.0	42
<b>Right Radial Axial Sensory (Base 1st Digit)</b>									
Wrist	2.4	<3.4	25.2	>13	Wrist	Base 1st Digit	2.4	10.0	42

**Ortho Sensory Summary Table**

<b>Left Median Ortho Sensory (Wrist)</b>									
2nd Digit	3.3	<3.5	28.3	>20	2nd Digit	Wrist	3.3	14.0	42
Palm		<2.2	46.4	>20	Palm	Wrist	2.4	7.0	29
<b>Right Median Ortho Sensory (Wrist)</b>									
2nd Digit	3.2	<3.5	31.0	>20	2nd Digit	Wrist	3.2	14.0	44
Palm		<2.2	34.2	>20	Palm	Wrist	2.4	7.0	29
<b>Left Ulnar Ortho Sensory (Wrist)</b>									
5th Digit	3.0	<3.5	20.9	>15	5th Digit	Wrist	3.0	14.0	47
Palm	2.2	<2.2	15.6	>15	Palm	Wrist	2.2	7.0	32
<b>Right Ulnar Ortho Sensory (Wrist)</b>									
5th Digit	3.1	<3.5	18.3	>15	5th Digit	Wrist	3.1	14.0	45
Palm	2.1	<2.2	16.5	>15	Palm	Wrist	2.1	7.0	33

**Motor Summary Table**

<b>Left Median Motor (Abd Pol Brax)</b>										
Wrist	1.6	<3.3	8.6	X	Elbow	Wrist	3.4	28.0	52	X#
Elbow	9.0		8.4							
<b>Right Median Motor (Abd Pol Brax)</b>										
Wrist	3.4	<3.5	9.1	X	Elbow	Wrist	3.4	28.0	52	X#
Elbow	8.8		8.7							
<b>Left Radial Motor (Ext Ind Prop)</b>										
4cm	1.6	<2.5	2.6	>1.7	Elbow	4cm	1.5	10.0	67	X#
Elbow	3.1		1.9		Up Arm	Elbow	3.1	16.0	32	X#
Up Arm	6.2		1.5							
<b>Right Radial Motor (Ext Ind Prop)</b>										
4cm	1.8	<2.5	2.1	>1.7	Elbow	4cm	1.5	10.0	77	X#
Elbow	3.1		1.6		Up Arm	Elbow	2.8	16.0	37	X#
Up Arm	5.9		1.3							
<b>Left Ulnar Motor (Abd Dig Minim)</b>										
Wrist	3.0	<4.3	6.5	X#	B Elbow	Wrist	4.5	26.0	58	X#
B Elbow	7.5		6.5		A Elbow	Wrist	6.9	40.0	58	X#
A Elbow	9.2		6.1							
<b>Right Ulnar Motor (Abd Dig Minim)</b>										
Wrist	3.4	<4.5	6.9	X#	B Elbow	Wrist	4.6	26.0	57	X#
B Elbow	8.0		7.5		A Elbow	Wrist	7.5	40.0	53	X#
A Elbow	10.2		6.8							

P. 16

~~XXXXXXXXXXXXXXXXXXXX~~  
 REF. NO. 2015-0026

F Wave Studies

Left Median (Median) (Abd Polt Bow)	27.54	<35	0.17
Right Median (Median) (Abd Polt Bow)	27.31	<35	0.17
Left Ulnar (Ulnar) (Abd Dig Mid)	28.20	<36	0.16
Right Ulnar (Ulnar) (Abd Dig Mid)	28.64	<36	0.16

EMG

Left	Opp Pollicis	Median	C8-T1	Normal	Normal	Normal	Normal	Normal	0	Normal	Normal
Left	1st Dext	Ulnar	C8-T1	Normal	Normal	Normal	Normal	Normal	0	Normal	Normal
Left	Flex Carpal	Ulnar	C8-T1	Normal	Normal	Normal	Normal	Normal	0	Normal	Normal
Left	Proneo/Tenar	Median	C6-7	Normal	Normal	Normal	Normal	Normal	0	Normal	Normal
Left	BrachioRad	Radial	C5-6	Normal	Normal	Normal	Normal	Normal	0	Normal	Normal
Left	Ext Car Rad Long	Radial	C6-7	Normal	Normal	Normal	Normal	Normal	0	Normal	Normal
Left	Biceps	Musculocut	C5-6	Normal	Normal	Normal	Normal	Normal	0	Normal	Normal
Left	Triceps	Radial	C6-7-8	Normal	Normal	Normal	Normal	Normal	0	Normal	Normal
Left	Deltoid	Axillary	C5-6	Normal	Normal	Normal	Normal	Normal	0	Normal	Normal
Right	Opp Pollicis	Median	C8-T1	Normal	Normal	Normal	Normal	Normal	0	Normal	Normal
Right	1st Dext	Ulnar	C8-T1	Normal	Normal	Normal	Normal	Normal	0	Normal	Normal
Right	Flex Carpal	Ulnar	C8-T1	Normal	Normal	Normal	Normal	Normal	0	Normal	Normal
Right	Proneo/Tenar	Median	C6-7	Normal	Normal	Normal	Normal	Normal	0	Normal	Normal
Right	BrachioRad	Radial	C5-6	Normal	Normal	Normal	Normal	Normal	0	Normal	Normal
Right	Ext Car Rad Long	Radial	C6-7	Normal	Normal	Normal	Normal	Normal	0	Normal	Normal
Right	Biceps	Musculocut	C5-6	Normal	Normal	Normal	Normal	Normal	0	Normal	Normal
Right	Triceps	Radial	C6-7-8	Normal	Normal	Normal	Normal	Normal	0	Normal	Normal
Right	Deltoid	Axillary	C5-6	Normal	Normal	Normal	Normal	Normal	0	Normal	Normal

P. 17



REF. NO. 2015-0026



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**MRI of right wrist** *this was for all wrist and*  
9 messages

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To: preet\_kaur@calpers.ca.gov

Mon, Feb 8, 2016 at 9:53 AM

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 2016-01-11-1452539320-4805538989-9165429244.pdf  
48K

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- Kaur, Preet <Preet.Kaur@calpers.ca.gov>  
To:

Mon, Feb 8, 2016 at 10:38 AM

Received.

From: I  
Sent: Monday, February 08, 2016 8:54 AM  
To: Kaur, Preet  
Subject: MRI of right wrist

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P.18



REF. NO 2015-0026

Marquis Diagnostic Imaging - Gilbert  
1760 E. Pecos Rd., Suite 101  
Gilbert, AZ 85295  
Phone: 480-553-8999  
Fax: 480-553-8989

Patient Name: Collins, Nicole  
Referring Physician: Allen M Germaine, MD  
Marquis MRN #:

Date of Birth:  
Date of Exam: 01/09/2016  
Accession #:

Exam: MRI Left Hand without

History: Bilateral hand pain and numbness. Joint pain, phalangeal pain. No history of trauma, surgery, nor cancer.

COMPARISON: Correlation is made to MRI left wrist also dated 1/9/2016 as well as to MRI right wrist and MRI right hand dated 1/9/2016. Correlation is also made to plain radiographs of the right and left hand dated 1/9/2016

TECHNIQUE: Multiplanar MR imaging of the left hand was performed without contrast. This was performed with a high-resolution 8-channel hand coil. Motion partially obscures T2-weighted images, despite multiple repeat sequences.

FINDINGS:

There is mild to moderate, likely posttraumatic osteoarthritis seen at the second carpometacarpal joint, with a small, likely posttraumatic ossification seen at the ulnar aspect of the base of the second proximal phalanx, measuring 3.1 mm in size. This was also seen on previous plain radiographs. Mild adjacent cystic change in the ulnar aspect of the base of the second proximal phalanx. Mild subchondral cystic change seen in the second metacarpal head.

Small joint effusion with mild synovitis at the second carpometacarpal joint.

No other areas of significant joint effusion nor synovitis nor osteitis appreciated throughout the carpus.

The flexor and extensor tendons of the hand are intact.

IMPRESSION:

1. Posttraumatic change as well as mild to moderate osteoarthritis at the left second metacarpophalangeal joint, as detailed above.
2. No other significant abnormalities appreciated.

P.19

Patient Name: Collins, Nicole

Ref # ~~100~~  
2015-0026

Page: 2

cc:

Thank You for Choosing Marquis Diagnostic Imaging

Patient Name: Collins, Nicole

Page: 2

P. 20

Patient Name: Collins, Nicole

Date of Birth:

Referring Physician: Allen M Germaine, MD

Date of Exam: 01/09/2016

Marquis MRN #:

Accession #:

Exam: MRI Right hand without

History: Bilateral wrist and hand pain. No history of trauma. No history of surgery or cancer.

COMPARISON: Correlation is made to plain radiographs of the right hand dated 12/22/2015.

TECHNIQUE: Multiplanar MR imaging of the right hand was performed without contrast. This was performed with a high-resolution hand coil.

**FINDINGS:**

There is mild intraosseous ganglion cyst formation in the radial aspect of the second and fourth metacarpal heads, degenerative. No osseous erosions appreciated.

No significant joint effusions nor synovitis appreciated.

The flexor and extensor tendons of the hand are intact.

No bone marrow edema is appreciated throughout the right hand.

**IMPRESSION:**

1. Mild degenerative intraosseous ganglion cyst formation seen in the radial aspect of the second and fourth metacarpal heads.
2. No other significant abnormalities appreciated on this MRI of the right hand.

*Marc Weinstein*

Interpreted by: Marc S. Weinstein, Md  
Electronically signed by: Marc S. Weinstein, Md

Transcribed by: DC    Technologist: EE

P.  
P. 21

Patient Name: Collins, Nicole

REF: NO 2015-0262  
Page: 2

*Marc Weinstein*

Interpreted by: Marc S. Weinstein, Md  
Electronically signed by: Marc S. Weinstein, Md

Transcribed by: DC    Technologist: EE

cc:

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Patient Name: Collins, Nicole

Page: 2

(P.22)



Ref. NO. 2015-0026

Marquis Diagnostic Imaging - Gilbert  
1760 E. Pecos Rd., Suite 101  
Gilbert, AZ 85295  
Phone: 480-553-8999  
Fax: 480-553-8989

Patient Name: Collins, Nicole  
Referring Physician: Daniel Kreutz, MD  
Marquis MRN #:  
Exam: XR Right Hand Limited 2 views

Date of Birth:  
Date of Exam: 12/22/2015  
Accession #:

**XRAY REPORT**

**EXAM:** Right Hand (Limited)

**INDICATIONS:** Pain in bil hands, pain in bil feet,

**ADDITIONAL CLINICAL DATA:**

**COMPARISON:** None

**TECHNIQUE:** 2 views

**FINDINGS:**

There is mild right first metacarpal phalangeal joint arthrosis. No evidence of acute fracture or dislocation. No definite soft tissue abnormalities..

**IMPRESSION:**

Mild first metacarpal phalangeal joint arthrosis.

Interpreted by: Marshall Kong, Md  
Electronically signed by: Marshall Kong, Md

Transcribed by: aa Technologist: DH

cc:

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P.23

Ref. NO. 2015-0626



Marquis Diagnostic Imaging - Gilbert  
1760 E. Pecos Rd., Suite 101  
Gilbert, AZ 85295  
Phone: 480-553-8999  
Fax: 480-553-8989

Patient Name: Collins, Nicole  
Referring Physician: Daniel Kreutz, MD  
Marquis MRN #:  
Exam: XR Left Hand Limited 2 views

Date of Birth:  
Date of Exam: 12/22/2015  
Accession #:

**XRAY REPORT**

**EXAM:** Left Hand (Limited)

**INDICATIONS:** Pain in bil hands, pain in bil feet,

**ADDITIONAL CLINICAL DATA:**

**COMPARISON:** None

**TECHNIQUE:** 2 views

**FINDINGS:**

There is a corticated osseous fragment at the ulnar side base of the second proximal phalanx, likely related to remote fracture. No definite acute fractures are identified. Joint spaces are preserved. No obvious soft tissue abnormalities.

**IMPRESSION:**

Remote appearing fracture deformity of the base of the second proximal phalanx. No definite acute osseous abnormalities.

Interpreted by: Marshall Kong, Md  
Electronically signed by: Marshall Kong, Md

Transcribed by: aa      Technologist: DH

cc:

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P.24



Ch Rrs Ref No. 2015 0026

Marquis Diagnostic Imaging - Gilbert  
1760 E. Pecos Rd., Suite 101  
Gilbert, AZ 85295  
Phone: 480-553-8999  
Fax: 480-553-8989

Patient Name: Collins, Nicole

Date of Birth:

Referring Physician: Allen M Germaine, MD

Date of Exam: 01/09/2016

Marquis MRN #:

Accession #:

Exam: MRI Right Wrist Without Contrast

Exam: MRI right wrist without contrast

History: Pain. No trauma. No history of surgery. No history of cancer.

Technique: Multiple MR imaging sequences of the [right wrist] were submitted for review. This was performed with a high-resolution 8-channel wrist coil.

Comparison: Correlation is made to plain radiographs of the right hand dated 12/22/2015

#### FINDINGS:

The triangular fibrocartilage is intact.

There is a chronic sprain seen through the interosseous scapholunate ligament, with mild to moderate surrounding degenerative cystic change and mild bone marrow edema.

The interosseous lunotriquetral ligament is intact.

On sagittal images, the alignment of the distal radius, lunate, capitate, and base of the 3rd metacarpal is preserved. There is moderate osteoarthritis at the triquetral pisiform articulation, with prominent subchondral cystic change in the volar aspect of the triquetrum.

There is mild to moderate osteoarthritis seen throughout the carpus. Adjacent, likely degenerative, scattered, mild to moderate intraosseous ganglion cystic change is seen.

The dorsal extensor tendons are intact.

The median nerve is seen to be hyperintense in the carpal tunnel. No tenosynovitis nor masses appreciated in the carpal tunnel. No fatty infiltration of the thenar musculature is appreciated. No thenar musculature edema appreciated.

PJS



The hook of the hamate is intact. There is an intact fat plane seen surrounding the ulnar neurovascular bundle at the level of Guyon's canal.

No significant joint effusions nor synovitis are appreciated.

**IMPRESSION:**

1. Chronic sprain seen through the interosseous scapholunate ligament, with mild to moderate surrounding degenerative cystic change and mild bone marrow edema. No widening of the interval.
2. Mild to moderate osteoarthritis of the triquetral pisiform articulation, with prominent subchondral cystic change seen in the adjacent volar aspect of the triquetrum.
3. Mild to moderate osteoarthritis seen throughout the carpus with adjacent, likely degenerative, scattered mild to moderate intraosseous ganglion cyst formation throughout the carpus.
4. Median nerve is seen to be hyperintense throughout the carpal tunnel.

*Marc Weinstein*

Interpreted by: Marc S. Weinstein, Md  
Electronically signed by: Marc S. Weinstein, Md

Transcribed by: DC      Technologist: EE

cc:

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*P. 26*



WU 1012 KOF# 2015-0026

Marquis Diagnostic Imaging - Gilbert  
1760 E. Pecos Rd., Suite 101  
Gilbert, AZ 85295  
Phone: 480-553-8999  
Fax: 480-553-8989

Patient Name: Collins, Nicole

Date of Birth:

Referring Physician: Allen M Germaine, MD

Date of Exam: 01/09/2016

Marquis MRN #:

Accession #:

Exam: MRI Left Wrist Without Contrast

Exam: MRI Left Wrist Without Contrast

History: Bilateral wrist and hand pain and numbness. No history of trauma nor surgery nor cancer.

Technique: Multiple MR imaging sequences of the wrist were submitted for review. This was performed with a high-resolution 8-channel wrist coil.

Comparison: None

Findings:

There is a mild sprain seen through the ulnar-sided fibers of the triangular fibrocartilage. No tear.

Mild chronic sprain of the interosseous scapholunate ligament is also seen without tear. There is no widening of the scapholunate interval.

The interosseous lunotriquetral ligament is intact.

On sagittal images, the alignment of the distal radius, lunate, capitate, and base of the 3rd metacarpal is preserved. The triquetral-pisiform articulation is unremarkable.

The dorsal extensor tendons are intact.

No masses nor tenosynovitis are appreciated in the carpal tunnel. The median nerve is however seen to be hyperintense through the carpal tunnel. The thenar musculature is normal in its signal and caliber.

There is an intact fat plane seen surrounding the ulnar nerve at the level of Guyon's canal. The hook of the hamate is intact. There is an intact fat plane seen surrounding the ulnar neurovascular bundle at the level of Guyon's canal.

P.27

There is mild osteoarthritis at the scaphoid trapezium trapezoid joint and first carpometacarpal joint.

Mild scattered intraosseous ganglion cyst formation, likely degenerative, is seen in throughout the carpus.

There is a small joint effusion seen in the carpus diffusely along with mild diffuse synovitis.

**IMPRESSION:**

1. Mild sprain seen through the ulnar-sided fibers of the triangular fibrocartilage, as well as, through the interosseous scapholunate ligament. No tear.
2. Median nerve is seen to be hyperintense through the carpal tunnel. No tenosynovitis nor mass is appreciated in the tunnel. Thenar musculature is normal in signal and caliber.
3. Mild osteoarthritis at the scaphoid trapezium trapezoid joint and first carpometacarpal joint.
4. Mild scattered, likely degenerative, intraosseous ganglion cyst formation seen throughout the carpus.
5. Small joint effusion seen in the carpus diffusely, along with mild diffuse synovitis.

*Marc Weinstein*

Interpreted by: Marc S. Weinstein, Md  
Electronically signed by: Marc S. Weinstein, Md

Transcribed by: DC    Technologist: EE

cc:

Thank You for Choosing Marquis Diagnostic Imaging

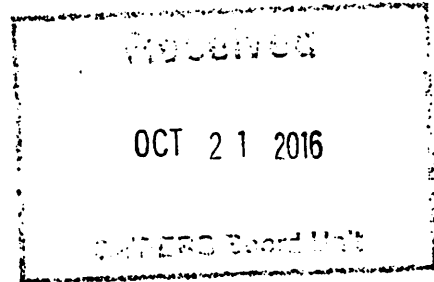
*(P. 28)*

## FAX Transmittal

**To: Cheree Swedensky, Assistant to the Board of Executive Office  
California Public Employees' Retirement Systems  
P.O.Box 942701  
Sacramento, CA 94229-2701**

**To Fax:  
(916) 795-3972**

**From:  
Nicole Collins  
Cal Pers Ref No 2015-0026  
Retirement Disability Claim**



**Attachments:  
29pages**

**Notes: please contact me to let me know the fax was received.**

**Phone:**

**Email:**