ATTACHMENT C

RESPONDENT(S) ARGUMENT(S)

November 3, 2016

Executive Board
California Public Employee's Retirement System
P.O. Box 942701
Sacramento, CA 94229-2701

Attn: Cheree Swedensky, Assistant

Re: 2015-0307, Respondent's Argument;

Dear Executive Board Members,

The strongly believe the pain and dexterity issues I currently suffer from is a mixture or combination of two industrial injuries, enhanced by the lack of proper and competent medical treatment and therapy for the State owned injury. The latter has interfered with, delayed and prolonged these lingering issues, which created an untimely and unsuccessful recovery.

I would like to clarify statements in the following areas of Judge Ahler's proposed written decision, dated October 11, 2016. In those same areas, I will make my rebuttal notes.

Medical Evidence:

12 & 13. On September 24, 2016, during my evaluation by Neil T. Katz, M.D., I explained to him that I had not progressed with healing given the type and style of physical therapy received from U.S. Healthworks, N. Ontario (USHW-O). Also, that the assigned surgeon, Bret Powers, M.D., showed no clinical interest in receiving on-going information about therapy. Powers made no treatment changes even after I relayed to him information about muscle treatments I had received from Physical Therapist Kristen Slaughter. Those treatments indicated to her and me that I did not have carpal tunnel, but a thoracic muscle and nerve impingement type injury, which mimicked the carpal tunnel syndrome, which caused my biceps, elbows, forearms, wrists and fingers to remain swollen, which limited manual dexterity and range of motion.

I further explained to Katz that Slaughter had taken measurements and provided nerve and muscle release treatments by manipulating thoracic muscles, which almost immediately relieved arm pressures and swelling, which allowed for the return of some wrist flexibility and finger dexterity. Slaughter created a progress note for that treatment, but the week after I last saw her, she had been removed from USHW-O. No one there would provide information as to why she was gone. Soon after, a third

physical therapist assigned directed me to return the treatment plan set by the initial physical therapist. I agreed, but told that person I would perform only some of the exercises originally assigned and would not perform exercises indicated by Slaughter, that would antagonize my truly unidentified injuries. That therapist had no comment.

I remained at USHW-O until August/September 2014, until such time I had my physical therapy transferred to U.S. Healthworks-W. Murrieta (USHW-M). There, "Michelle," the assigned physical therapist, reviewed my chart and told to me that I had received an excessive amount of non-progressive therapy, which indicated to her that carpal tunnel syndrome was not the injury in my case. Until such time State Fund was to rule on continued therapy and the selection of a second opinion doctor, "Michelle" could only provide stretching treatments and other home exercises to stave-off cramping and swelling. I completed my allotted physical therapy cycles after the time I saw Katz.

When evaluated by Katz, I also told him of my treatment history and the malpractice by Powers. Also, that I signed unrestricted release waivers for personal medical records possessed by Blue Shield, medical files owned by the City of Corona, possessed by Sedgwick Claims Management Services (#CCAM-423606), and State Fund (#0598068) in the current injury. Additionally, that I had the first Arthroscopic left shoulder surgery in 1995, with a second surgery during March 2013, and not during 2014, as indicated in the judge's report. I further told Katz that I had several cycles of physical therapy after the second shoulder surgery, where therapists from Murrieta Oaks Physical Therapy, Murrieta, CA had to first relief pain and pressure on and around the left elbow before I was able to gain a full range of motion at the shoulder.

During my hearing on September 26, 2016, I learned through trial that Katz in fact, had not reviewed all nexus medical files as expected, which Judge Ahler made seem was an acceptable practice. Through cross examination of Katz, the group learned that he did not receive all or critical reports, such as the ones created by Slaughter and "Michelle," which seemed pivotal then and now. Judge Ahler explained that Katz could only comment on those documents provided to him by PERS, which meant PERS failed to meet pre-trial disclosure requirements.

Katz' own statement during trial indicated that he surmised that I still suffered from bi-lateral carpal tunnel during September 2014, which validated my point, that I still suffered from an unidentified ailment, suspected to be bi-lateral carpal tunnel syndrome, for which I had not received proper and competent treatments or modalities between April 2014 and October 2014, one month into retirement.

During December 2014, went I first met with Roy Caputo, M.D., the second opinion surgeon in the matter, his own opinion was that I still suffered from minor bi-lateral carpal tunnel syndrome for which he requested to conduct surgery to relieve soon after our visit together. State Fund redirected him and asked that he only conduct an evaluation and report for future treatments. Between December 2014 and April 2015, Caputo, through his own treatment and diagnostics, determined that my suspected carpal tunnel syndrome was being affected by another ailment. He subsequently theorized Thoracic Outlet Syndrome (TOS) may be present.

I alone located a physical therapist in my area certified to conduct the Active Release Technique (ART), Upper Extremity treatments needed to help resolve my ailment. From between August 2015 and March 2016, I received a sporadic series of ART treatments, anti-inflammatory and minor pain medications, but truly never had them together, at the same time, in an attempt to recover. State Fund's Utilization Review (UR) Board took an average of seven weeks to render a decision regarding continued physical therapy and/or medications.

During January 2016, I was forewarned by Caputo that State Fund had been asking for a, "Permanent and Stationary" ruling in order to close their case, a routine widely known by most State employee's as being part of State Funds' practice. As in like many other cases, State Fund starved and questioned Caputo's work as the case neared the two year mark. State Fund closed the case in April 2016.

15. Judge Ahler limited the scope of the hearing from between April 1, 2014, Date of Injury (DOI) and the date of the first report was completed by Katz. Katz completed a second report for PERS to clarify opinions. A third review and report request to have Katz review reports by Bradley Baum, M.D. and Scott Holman, Doctor of Physical Therapy (DPT), was made by me through Christopher Phillips, Staff Counsel, PERS, Sacramento. Judge Ahler's decision did not clearly indicate that Katz had read any physical therapy progress notes made by Holman of All-Star Physical Therapy, Temecula, CA, and the one who provided ART treatments. Holman's last reports, just prior to State Fund closing the case, indicated continued therapy was needed.

16. It is understood Katz would not cause conflicts within his own observations and reports, or during a hearing, such as the one on September 26, 2016. However, it appeared to me that Katz was never fully supplied with all nexus medical documents by PERS Legal nor did Katz seek any other relevant documents from Blue Shield or Sedgwick in order to construct his reports. This lack of diligence by him and PERS Legal tends to indicate that a more complete or thorough opinion was not needed or wanted, except by me.

17. Katz indicated that he also read the medical opinion of Baum of Corona-Temecula Orthopedic Association (CTOA), surgeon chosen for my last left shoulder surgery, also the medical opinion of Michael Brecher, M.D., of Illinois, the doctor chosen by Sedgwick as part of their UR review. Automatically, I discounted Brecher's opinion because he did not work in California, and because his work was not published or widely known. Patients all know that an UR board or other third party insurance doctor will always defer or deny surgery. Baum's report to Sedgwick was clear as to the needs and benefits of surgery. On the date of surgery, Baum performed a surgical procedure requested and denied by Sedgwick UR, because he saw the medical necessity for the act (Attachment A-two pages).

I last saw Baum on October 24, 2016. My next appointment with him is on December 19, 2016. My 12 initial post-surgical physical therapy treatments were completed in-house at CTOA, which ended on October 26, 2016 (Attachment B-). Both offices are recommending 12 additional treatments to help return full arm range of motion, and arm/hand/finger dexterity and strength, which currently negatively affects by my left shoulder joint, left side ulnar nerve at the elbow, left scapula and upper chest ribs and joints linking the left shoulder and sternum region.

Therapists also now believe my left upper shoulder muscles and left arm ulnar nerve leading to the fingers, had been stretched during the on-duty physical altercation with a felony suspect in 1987, but had hidden itself until recently because of my reduced physical stature and other changes to my body, to include the loss of overall muscle mass since that date. It was possible that surgeons during 1995 and 2013 surgeries, may have overlooked those other areas of my body that were never dealt with during therapy as they were not prominent signs or symptoms during those treatment times, or enough to draw the attention of therapists and surgeons, or may have been deemed medically out of scope under insurance treatment rules or schedules. Baum commented that the ulnar nerve at the elbow may need to be surgically moved or reset.

The aforementioned situations lead me to believe that I still suffer from a combination or a cross-over of musculoskeletal system and nerve pathway industrial injuries, such as carpal tunnel syndrome, TOS or another type of impingement. I strongly believe that I can recover from these stubborn injuries over time. I am currently receiving proper therapy from CTOA in regards to the left shoulder injury.

I strongly believe that I was misdiagnosed and received malpractice from Powers related to the alleged carpal tunnel injury and proscribed therapy, which likely reinjured my left shoulder joint and related nerves. Powers was clearly aware of those prior

issues. His lack of proper treatment caused a broader systemic injury or damage to my body for which I am currently physically paying for, well into retirement.

Had Powers placed me off-work to recover quicker and appropriately, instead of allowing a 10 minute break for heat and ice therapy for every one hour of typing, I could have recovered correctly, timely and within insurance table guidelines. Proper and effective treatments could have also afforded me alternatives to retirement, since I was generally healthy and probably too young to retire. Powers and State Fund focused on meeting stakeholder rules by delaying actions and treatments instead of standing by their patients, which made me, believe there was no hope or remedy for the present situation, which played a factor in my untimely lack of a recovery period. This situation alone was half the reason I decided to retire, instead of working with constant pain, with no relief in-sight.

It was true that during September 2014, I was able to separate from State service under standard retirement rules. Leaving with an open injury claim forced me to cross-file for Industrial Retirement in order to preserve rights afforded to me under law. Additionally, family needed my assistance with caring for a dying father-in-law, living out of the area at the time.

During 2015, State Funds Inaction in resolving my medical affliction caused me to lose the ability to qualify for Long Term Care (LTC) family plan coverage with my wife by Genworth Health Insurance. That company initially approved my medical records and approved the separate medical exam I took for them. Ultimately, my wife was insured, but my end of the Genworth account was closed citing problems with State Fund. Because of the negative mark by them I cannot qualify for the same or similar LTC plan. In order to obtain anything close to what I negotiated, I must now pay higher fees because I am considered a risk.

Respectfully submitted,

Edward J. Stuckenschneider

ATTACHMENT A 2015-0307

THE OAKS SURGERY CENTER
40740 California Oaks Rd.
Murrieta, CA 92562
Tel: (951) 304-2200 Fax: (951) 304-2281

OPERATIVE REPORT

PATIENT NAME: STUCKENSCHNEIDER, EDWARD
PATIENT ID#: [redacted]
DATE OF OPERATION: 06/23/2016
SURGEON: Bradley Baum, M.D.
ASSISTANT:
ANESTHESIA: General.
ANESTHESIOLOGIST:

PREOPERATIVE DIAGNOSES:
1. Left shoulder SLAP lesion.
2. AC joint arthritis, left shoulder.

POSTOPERATIVE DIAGNOSES:
1. Type II SLAP lesion, left shoulder.
2. Impingement syndrome, left shoulder.
3. AC joint arthritis, left shoulder.

PROCEDURES PERFORMED:
1. Arthroscopic repair of labral SLAP lesion.
2. Arthroscopic subacromial decompression.
3. Arthroscopic Mumford procedure, left shoulder.

ESTIMATED BLOOD LOSS:
25 cc.

DETAILED DESCRIPTION OF PROCEDURE:
The patient was brought to the operating room, induced in general anesthesia, and intubated. He was given appropriate amount of IV antibiotics. He was placed in the right lateral decubitus position and an axillary roll was used. A beanbag was used to hold the patient in this position. The left shoulder was taken through full range of motion without signs of any instability or adhesive capsulitis. We were then able to prep and drape the left shoulder. We placed approximately 15 pounds of traction on the left shoulder. I made a posterior port and I entered the glenohumeral joint. Through the retrograde method, we selected the anterior port. There were signs of previous SLAP repair. The repair was mostly superior, which actually was still holding, but the more anterosuperior and extending down towards the anterior labral area was detached. There was some free floating suture noted in the glenohumeral joint. At this point, we spent a great deal of time roughening up the edges of the anterior labral and superior labral area. I actually placed multiple punch holes in this area to try to stimulate bleeding for a better healing. I was then able to place labral tape around the anterosuperior aspect of the tear. We then made a drill hole and placed a Arthrex PushLock using the labral tape to anchor the labrum. This held this area very secure. I did not take down the previous repaired area of the labrum, since it did appear it still be intact.

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There was some mild fraying on the undersurface of the rotator cuff tendon. This was all cleaned up. After this was completed, I was then able to remove the instrumentation. Through the posterior port, I entered the subacromial space. I made a lateral port. We performed a subacromial bursectomy from scar tissue. The acromion was still slightly hooked and there were signs of calciffe deposition over the anterior acromial area, which could have been from previous surgery or recent recalcification. At any rate, these were all removed. I then used a bur and we cleaned up the acromial decompression removing slightly more bone and making it more uniform. The AC joint did show sign that it had a previous Mumford, but there was some areas that were still quite prominent and I therefore, performed a formal Mumford procedure on this area. After this was done, we inspected the rotator cuff tendon and it appeared to be intact. Next, I removed the instrumentation. 4-0 nylon was used to re-approximate the skin edges. 0.5% Marcaine with epinephrine was injected. Xeroform, fluffs, and foam tape were applied. The patient was then awakened and extibated. He was placed in a sling. He was taken to the recovery room in stable condition.

PROGNOSIS, IMMEDIATE AND REMOTE:
Good.

BB Baum MD

Bradley Baum, M.D.

JOB#: 239737 BB: med: php/du DD: 06/23/2016 DT: 06/24/2016

ATTACHMENT B 2015-0307

Corona-Temecula Orthopaedic Associates Medical Group

Physical Therapy - Murrieta
28078 Baxter Road, Suite 330
Murrieta, CA 92563-1404
Phone: (951) 566-9001, Fax: (951) 566-9032

Edward Stuckenschneider ID: [redacted] DOB: [redacted] (53 years)

Date of Encounter: 08/22/2016

Stuckenschneider, Edward [redacted]

History of Present Illness

The patient is a 52 year old male who presents for an upper extremity intake. The patient is being seen for an initial upper extremity PT evaluation and is referred by an orthopedic surgeon. The condition involves the left upper extremity. The patient is right hand dominant. This condition is injury related. The injury occurred year(s) ago (incident occurred in 1987) at work (Pt reports that he was in a law enforcement fight where is L arm was pulled across his body and lifted up by another individual.). Symptoms include shoulder pain and arm pain. Pain scores include a current pain level of 7/10, a minimum pain level of 6/10 and a maximum pain level of 8/10. The pain is located in the left shoulder and left upper arm. The patient describes the pain as aching and burning. Sensory symptoms are located in the fingers of the left hand (very rarely in the ulnar distribution of the L hand). Onset was sudden immediately after the injury. The symptoms occur intermittently. The episodes occur daily. The patient describes symptoms as improving. Symptoms are exacerbated by use of the extremity (movement OH and pulling objects). The patient is not currently being treated for this problem. The patient is having difficulty with overhead activities and lifting. Occupation / Activities: Special agent. The patient's goals for physical therapy include decreasing pain and increasing strength. Past evaluation has included L shoulder MRI and orthopedic surgery evaluation. Past treatment has included corticosteroids and prescribed exercises. Note for "Upper extremity intake": S/p arthroscopic SLAP lesion labral repair, subacromial decompression, Mumford procedure on 06/23/2016.

PMH: Multiple L shoulder surgeries (see questionnaire for details).

Vitals
08/22/2016 04:08 PM
Weight: 165 lb **Height:** 69 in
Body Surface Area: 1.91 m² **Body Mass Index:** 24.37 kg/m²
Pulse: 67 (Regular)
BP: 137/100 Manual (Sitting, Left Arm, Standard)

Physical Exam
The physical exam findings are as follows:

POSTURAL/STRUCTURAL ASSESS: In static sitting, pt presents with B rounded shoulders, as well as flat thoracic kyphosis with B scapulae medial border "winging". The L humeral head sits anterior in the glenoid fossa.

AROM/PROM: R;L Shoulders
-Flex: 180°; 180°/180°
-Abd: 180°; 170 with c/o muscle tight in L tricep/170° with pain
-IR: T8/70°; T12/70°
-ER: T6;90°; T4/43° with pain

JOINT MOBILITY: Hypomobility L GHJ in posterior glide.

MUSCLE STRENGTH:
-MMT: R;L UE
-Flex: 4+/5; 4/5
-Abd: 4+/5; 4/5
-IR: 5/5; 4+/5
-ER: 5/5; 4+/5
-Bicep: 5/5; 4+/5
-Tricep: 5/5; 4+/5
-Observed weakness of B MT, LT and rhomboids

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MLT: R/L UE
-Hypoextensibility L>R pec minor; posterior acromion 3.5"/4.75" from table.
-Hypoextensibility L pec major; clavicular fibers: medial epicondyle 4" from parallel, sternal finers: 6" from parallel to table

PALPATION:
-TTP: L levator insertion of superior scapular angle, supraspinatus and UT muscle bellies, distal tricep tendon.
-Edema: None
-Muscle tone: decreased tone of B MT, LT, and rhomboids

NEUROMUSCULAR: (+)Ulnar nerve tension testing at 100° of shoulder abduction. (-)Median nerve tension testing.

FUNCTIONAL ASSESS: Pt does not facilitate MT and LT with elevation of the LUE, however there is no UT.levator compensatory pattern utilized as the L scapula does not elevate.

ATTACHMENT B 2015-0307

Assessment & Plan

PAIN IN LEFT SHOULDER

- THERAPEUTIC EXERCISES, EACH 15 MINUTES (97110) ; Routine (x15'; Instructed and demonstrated HEP: ulnar nerve glides, pec foam roller stretches, ER and Habd.)
- PHYSICAL THERAPY EVALUATION (97001); Routine (x45'; see eval for details.)

OTHER SYMPTOMS AND SIGNS INVOLVING THE MUSCULOSKELETAL SYSTEM

MUSCLE WEAKNESS (GENERALIZED)

PARESTHESIA OF SKIN

OTHER SPECIFIED POSTPROCEDURAL STATES

PAIN IN LEFT SHOULDER

ASSAULT BY UNARMED BRAWL OR FIGHT, SUBSEQUENT ENCOUNTER

CIVILIAN ACTIVITY DONE FOR INCOME OR PAY

PT IMPAIRMENTS/DIAGNOSIS:
-Decreased A/PROM in: L shoulder
-Decreased joint mobility in: L GHJ
-Decreased strength in: L scapular stabilizers and RC
-Decreased muscle length in: L>R pec minor/major
-Neural tension/Decreased light touch sensation: Ulnar nerve distribution
-Neuromotor deficits/Decreased coordination: L scapular stabilizers

FUNCTIONAL LIMITATIONS:
-Difficulty/unable to complete OH activities
-Difficulty/unable to complete lifting/carrying tasks
-Unable to participate in recreational activities like: hiking and mountain biking

PT IMPRESSION: PT initial evaluation reveals impairments contributing to his/her functional limitations with possible soft tissue compromise to ulnar nerve and distal tricep tendon. Edward will benefit from skilled PT to address the above deficits in order to decrease pain and improve ROM, strength, and functional ability so that they may return to mountain biking and lifting/carrying activities.

SHORT TERM GOALS:
-Pt will be independent with beginning level HEP.
-Pt will demonstrate full A/PROM in all planes.
-Pt's pain level will decrease to 0-4/10 intermittently.

LONG TERM GOALS:
-Pt will be independent with a comprehensive HEP in order to maintain functional ability.
-Pt will demonstrate > or equal to 4+/5 gross muscle strength in affected extremity to allow pt to return to functional and recreational activities.
-Pt will demonstrate improved coordination and kinetic chain mechanics to allow for increased ease with daily and recreational activities.
-Pt will be able to complete mountain biking and lifting/carrying activities without pain or limitations.

PLAN OF CARE:
1. Manual Therapy
2. Therapeutic Exercise
3. Neuro Re-education
4. Modalities
5. Pt. Education
6. HEP

PROGNOSIS: Good

FREQUENCY: 1-2 x/week for 6 weeks

Addendum Note *(Kaylee Smith, DPT; 08/31/2016 06:59:09 PM)*
Please add the following code: S43.432D.

ATTACHMENT B 2015-0307

Procedures

PHYSICAL THERAPY EVALUATION (97001) Performed: 08/22/2016 (Ordered)
THERAPEUTIC EXERCISES, EACH 15 MINUTES (97110) Performed: 08/22/2016 (Ordered)

, DPT

Signed electronically by Kaylee Smith, DPT