ATTACHMENT A

RESPONDENT'S PETITION FOR RECONSIDERATION

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FAX TRANSMITTAL FORM

TO: Matthew G. Jacobs, General Counsel ***FROM:*** Maribeth Aragones

COMPANY: CalPERS

FAX NUMBER: (916) 795 - ~~3972~~ 3659 .

___ **URGENT** **DATE SENT:** 5/6/21

✓ **FOR REVIEW** **TIME SENT:** _____

___ **PLEASE REPLY** **NUMBER OF PAGES** *(Including Cover)*: 7 Pages

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MESSAGE:

Petition for Reconsideration
Maribeth Aragones
Case # 2020-0667
OAH # 20200402 3C

Thank you very much.

Petition for Reconsideration

Maribeth Aragones
Case No.2020-0067
OAH No. 2020040236

May 6, 2021

Cheree Swedensky, Assistant to the Board
Executive Office
California Public Employees' Retirement System
P. O. Box 942701
Sacramento, CA 94229-2701
Fax (916) 795-3972

Dear Ms. Swedensky,

I am writing to you in response to the letter I have received from your office. The letter was dated April 23, 2021. I understand that the Board of Administration denied my application for industrial disability retirement. I am now requesting a reconsideration for my case to be reviewed by the Board members.

I had a surgery on my cervical spine on April 8, 2021, and I am still on recovery period. This injury was dated July 23, 2018. I had discectomy and fusion on C3, 4, 5. My post- surgery appointment will be on May 17, 2021. I have attached the surgeon's documentation of the procedure.

I have not been released for my lumbar spine injury yet, as I continue to experience pain on my lower back, legs, and feet. I am waiting to be scheduled for Aftercare visits with Functional Restoration Therapy Clinic.

Please, reconsider my petition. I need your help.

Thank you very much for your time and consideration.

Sincerely,

Maribeth Aragones, LVN
105 Dream Street
Crescent City, CA 95531
Tel.No. (707) 218-7257

Name: Maribeth Aragones | [redacted] | MRN: [redacted] | PCP: Dylan P. Deatrich, MD

Note From Your Admission on 04/08/21

What is open notes?

[redacted] gives you access to the health care notes that your doctors and other providers write during or after your appointment.

What can I expect to see in my clinic notes?

Clinical notes document the events and thought processes that occur during a medical office visit. These notes include medical terminology and abbreviations written in a standard format. The **Resource** button on **MyUCDavisHealth** offers multiple information sources including **Healthwise, Medline Plus** and additional **Health Education** resources to clarify information in the notes. The typical note outline contains four sections:

- **Subjective** - Patients and other sources provide the subjective information. This includes the reason for the visit, current symptoms, and may include other details, such as past medical information or medications.
- **Objective** - Vital signs, physical exam and test results are included in the Objective section.
- **Assessment** – The clinician describes their diagnosis, or potential diagnoses, based on the subjective and objective information from the visit. It may include a differential diagnosis, or discussion of possible diagnoses considered, including some discarded diagnoses, based on the information from the visit.
- **Plan** – Finally, the Plan may include: observations, behavioral or lifestyle changes, further testing, prescriptions or over-the-counter medications, and when to return to see the physician.

Clinic notes allow the efficient transfer of clinical thought processes and information between health care providers and now, patients. Some notes must include additional information due to various regulatory requirements. Physicians and care providers discuss your condition and treatments during your visit, provide an **After Visit Summary (AVS)** to summarize your visit, and now will add the **Visit Notes**.

If you are reviewing this progress note and have questions about the meaning or medical terms being used, please schedule an appointment or bring it up at your next follow-up appointment. Medical notes are meant to be a communication tool between medical professionals and require medical terms to be used for efficiency.

NOTE: not all visits will have the provider's note, in which case you may see the patient instructions below this is the same information you receive on your After Visit Summary (AVS).

Procedures signed by Kim, Kee Duk, MD at 04/09/21 1053

PATIENT: ARAGONES, MARIBETH
MR #: [redacted]
DOB: [redacted]
SEX: F AGE: [redacted]
OPERATION DATE: 04/08/2021
INPATIENT OPERATION RECORD

PREOPERATIVE DIAGNOSIS:

Cervical spondylosis and spinal stenosis with radiculopathy and cervicogenic headache.

POSTOPERATIVE DIAGNOSIS:

The same.

SURGICAL PROCEDURE:

1. Anterior C3-4, C4-C5 microdiskectomies and bilateral C3-C4, C4-C5 microforaminotomies.

2. Anterior C3-C5 arthrodesis instrumentation using zero profile cages x2 (6 mm x 14 at C3-C4 and 5 mm x 14 at C4-C5) packed with in situ autograft and screws x4.

INDICATIONS FOR SURGERY:

Maribeth Aragones is a 51-year-old woman with the chief complaint of neck and arm pain. She also has associated headache extending from her neck. Her symptoms arose after a work-related injury on July 23, 2018. She reports radiating arm pain, left worse than right. She reports worsening pain with any lifting with associated numbness of her hands. Cervical MRI showed spinal cord compression at C4-C5 with indentation of the cord, in addition to mild foraminal narrowing at that level. C3-C4 also showed foraminal narrowing with disk abutting the cord. Due to the fact that she has a significant radiographic finding with disabling pain, I felt surgical intervention was appropriate. Due to the fact that she has osteopenia on DEXA scan, I felt anterior C3-C4 and C4-C5 diskectomies and fusion would be the best surgery to optimize the improvement and reduce the risk of complications. I talked to her regarding the surgery, and the risks of the procedure and possible adjacent segment disease. She still wished to proceed and signed the informed consent.

DESCRIPTION OF PROCEDURE IN DETAIL:

The patient was brought to the Operating Room after general endotracheal anesthesia was administered. She was positioned supine with her neck extended to allow her chin to be out of the way. We used intraoperative fluoroscopy to mark out the transverse incision on the left side of the neck. Her neck was then sterilely prepped and draped.

After surgical pause and preoperative antibiotic administration was confirmed, local anesthetic was subcutaneously infiltrated.

A transverse incision was then made. Sharp dissection was carried past the platysma. Subplatysmal dissection was then carried out and we found the plane medial to the sternocleidomastoid and carotid sheath, and lateral to the airway and esophagus. We first localized the C3-C4 disk space with intraoperative fluoroscopy. Retractor blades were placed deep to the longus colli at C3-C4. Distraction pins were placed into the bodies of C3, C4, and C5.

A microscope was then brought in and, under magnification, the C3-C4 disk was incised first. A complete discectomy was performed with resection of the posterior longitudinal ligament. Posterior osteophyte centrally and out into the foramen were resected. A curved curette was utilized to ensure there was adequate room centrally and laterally out to the foramen. After good decompression was confirmed, the inferior endplate of C3 and the superior endplate of C4 were decorticated with a straight curette. Osteophyte that was resected at this level was packed into a 6-mm zero profile lordotic cage 14 mm in depth. The cage was then placed flush and secured with 14-mm screws through the cage into the body of C3 and 12-mm screws through the cage into the body of C4. Intraoperative x-ray showed adequate position of the implant.

The distraction pin was then removed from the body of C3 and retractor blades were removed and repositioned deep to the longus colli at C4- C5. The microscope was then adjusted to visualize C4-C5. The disk was incised and aggressive discectomy was performed. The posterior longitudinal ligament was then resected, and similar aggressive central and foraminal decompression was performed using curette and rongeur. The inferior endplate of C4 and the superior endplate of C5 were decorticated. A 5-mm lordotic zero-profile lordotic cage was packed with in situ autograft from osteophyte resection. The cage was then placed flush at C4-C5 and secured with 14-mm screws through the cage into the bodies of C4 and C5.

Hemostasis was achieved and the wound was thoroughly irrigated with antibiotic saline. We carefully looked with the microscope to ensure that there was no active bleeder. We felt the surgical field was fully dry and did not need a surgical drain. The wound was then closed in multiple layers.

OPERATIVE COMPLICATION:

None.

NAME OF SURGEONS AND ASSISTANTS:

Surgeon: Kee D Kim, MD
Assistant Surgeon: Harjot Thind, MD

Kee D Kim, MD
Professor and Chief Of Spinal Neurosurgery

KDK/hh
D: 04/08/2021 15:25:35 PDT/PST
T: 04/08/2021 19:07:10 PDT/PST
Job #:

cc: Dylan Hall Deatrich, MD