**Date:** June 19, 2024
**To:** Board of Retirement
**From:** Doris L. Rentschler, Executive Director
**Subject:** MMRO Contract & Disability Retirement Process

**Recommended Action:**

Approve renewal agreement with Managed Medical Review Organization (MMRO) for disability retirement administrative services. Give direction on whether to change MCERA's process for disability retirement applications.

**Fiscal and Financial Impacts:**

Changing from utilizing a generalist for the Medical Advisory opinion to a specialist in the particular field would result in an increase in fees of $150 per application. However, MMRO is also suggesting a change to the process that, if the Board approves, would lower MCERA's overall cost by minimizing the number of Independent Medical Evaluations (IMEs) performed.

**Strategic Plan Importance and Risk Assessment:**

This item does not directly relate to action items in the Board's strategic work plan. However, in general this matter relates to MCERA's goals regarding risk oversight and improving effectiveness.

**Background and Discussion:**

MMRO Contract Renewal

MCERA has contracted with MMRO since June 30, 2015, to provide disability retirement administrative services. The medical advisory services include claim administration, medical record review, IMEs, recommendations, and professional testimony services.

MMRO has performed satisfactorily and with the processing of more applications both for MCERA and other 37 Act systems, has gained a more comprehensive understanding of appliable laws. There are no substantive changes to the contract and staff recommends approval.

In addition to utilizing a specialist for the medical advisory, MMRO is suggesting changes to the process used in reviewing disability applications.

Provide Direction on Possible Change to Disability Retirement Process

Current Disability Process

For many years, the process for reviewing these applications has been to send applicants for a service connected (work related) disability retirement benefit to an independent medical examiner (IME). The IME is usually a medical expert who specializes in the type of disability involved. The

IME reviews the medical file, examines the applicant, and answers questions as to whether the disability is permanent, and if it is work related.

The entire file, including the IME report, is then sent to a medical advisor for review. This medical advisor is typically a general physician, who summarizes the medical opinions in the file and is asked whether he/she agrees or disagrees with those opinions.

All reports are shared with the Board in closed session to make an initial determination of whether to grant or deny the application. If it is denied, the applicant can request a hearing that would be held before an independent hearing officer

Proposed Changes to Disability Process

First, MMRO is proposing that the medical advisor be a medical expert who specializes in the type of disability involved, instead of a generalist. As there is not much of an increased cost for MCERA, staff supports this change.

Second, MMRO proposes changing the current process by not automatically sending the applicant to an IME in every case. Instead, since the medical advisor is now going to be an expert in the area involved, the application and medical records will be reviewed by the expert medical advisor. If the medical advisor feels there is sufficient objective medical evidence in the records provided, such that he/she can opine on whether the applicant is incapacitated, those reports would go to the Board in closed session for consideration. There would NOT be an IME report. However, if the medical advisor feels more information is needed to make a recommendation or recommends a denial, then staff would send the applicant to an IME. This change would result in cost savings by reducing the number of IME appointments.

MCERA would require an IME prior to the initial Board consideration if the Medical Advisor does not support granting the application to avoid being disadvantaged at a hearing. If MCERA only had medical records review, without a physician who saw the applicant in person, the hearing officer would likely give greater weight to the opinion(s) of the physician(s) who saw the applicant.

There are advantages and disadvantages to the proposed process changes. The advantages are: (1) Applications would be processed faster; (2) There would be less burden on the applicant as he/she would not automatically have to be sent for an in-person exam; and (3) There would be cost savings to MCERA, as fewer in person evaluations would be needed. The disadvantages are that: (1) There would be one less "check" in the process; and (2) A medical advisor may be more inclined to agree with the applicant's physicians since the medical advisor only reviews the applicant's records and does not see the applicant.

Staff is looking for direction as to whether the board wants to continue with the current IME/medical advisor review process, or only send the applicant to an IME if the expert medical advisor's opinion is to deny the application.

**Attachments:**

1. Draft Contract
2. MMRO Proposal dated May 24, 2024

**EIGHTH AMENDMENT**
**TO MEDICAL CONSULTING AGREEMENT**

This Eighth Amendment to the June 30, 2015 Medical Consulting Agreement Services Agreement ("Eighth Amendment"), which is made effective as of July 1, 2024 ("Effective Date") is made and entered into by the Mendocino County Employees' Retirement Association ("MCERA") and Managed Medical Review Organization, Inc. ("MMRO"). MCERA and MMRO shall collectively hereafter be referred to as the "Parties."

## RECITALS

**WHEREAS**, the Parties entered into a Medical Consulting Agreement as of June 30, 2015 (the "Medical Consulting Agreement"), setting forth the terms and conditions under which MMRO provides certain medical consulting services to MCERA; and

**WHEREAS,** the Parties entered into a First Amendment to the Medical Consulting Agreement, which was effective as of October 1, 2016, a Second Amendment to the Medical Consulting Agreement effective as of October 1, 2018, a Third Amendment to the Medical Consulting Agreement effective as of October 1, 2019, a Fourth Amendment to the Medical Consulting Agreement effective as of July 1, 2020; a Fifth Amendment to the Medical Consulting Agreement effective as of July 1, 2021; and a Sixth Amendment to the Medical Consulting Agreement effective as of July 1, 2022; and a Seventh Amendment to the Medical Consulting Agreement effective as of July 1, 2023; and an Eighth Amendment to the Medical Consulting Agreement effective as of July 1, 2024;

**WHEREAS**, the Parties now desire to amend the Medical Consulting Agreement, as is more fully set forth herein.

## AMENDMENT

**NOW THEREFORE**, in consideration of the foregoing premises and of the covenants, terms and conditions contained herein, and for other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the Parties do hereby mutually agree as follows:

1. The first sentence in Article 6, Section 6.1 shall be deleted in its entirety and replaced by the following:

   **General. The term of this Agreement shall be in effect from October 1, 2015 through June 30, 2025 but may be renewed for successive one-year periods upon the written agreement of the Parties executed no later than 30 days prior to the end of the then-current term, unless otherwise amended or unless terminated sooner according to the provision set forth below.**

2. STANDARD OF CARE: MCERA has relied upon the professional ability and training of CONSULTANT as a material inducement to enter into this Agreement. CONSULTANT hereby

agrees that all its work will be performed and that its operations shall be conducted in accordance with generally accepted and applicable professional practices and standards as well as the requirement of applicable federal, state and local laws, it being understood that acceptance of CONSULTANT'S work by MCERA shall not operate as a waiver or release.

3. PERFORMANCE STANDARD: CONSULTANT shall perform all work hereunder in a manner consistent with the level of competency and standard of care normally observed by a person practicing in CONSULTANT'S profession. CONSULTANT hereby agrees to provide all services under this Agreement in accordance with generally accepted professional practices and standards of care, as well as the requirements of applicable federal, state and local laws, it being understood that acceptance of CONSULTANT'S work by MCERA shall not operate as a waiver or release. If MCERA determines that any of CONSULTANT'S work is not in accordance with such level of competency and standard of care, MCERA, in its sole discretion, shall have the right to do any or all of the following: (a) require CONSULTANT to meet with MCERA to review the quality of the work and resolve matters of concern; (b) require CONSULTANT to repeat the work at no additional charge until it is satisfactory; (c) terminate this Agreement pursuant to the provisions of Article 4; or (d) pursue any and all other remedies at law or in equity.

4. Exhibit A – Fee Proposal is hereby added and incorporated into, and replaces Exhibit A, in the June 30, 2015, Medical Consulting Agreement

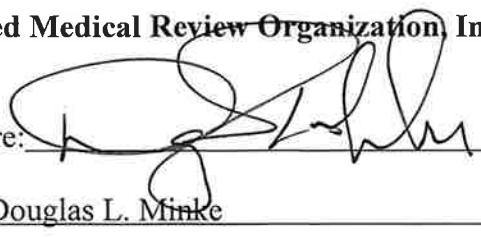
5. Exhibit C – Insurance Requirements is hereby added and incorporated into, and replaces Article 7.1 Insurance, in the June 30, 2015, Medical Consulting Agreement

6. Exhibit D – Privacy and Data Protection; Security Events and Artificial Intelligence is hereby added and incorporated into the June 30, 2015, Medical Consulting Agreement.

7. Other than the modifications made above, the terms of the Medical Consulting Agreement shall remain in full force and effect.

The authorized representative of each party has executed this Sixth Amendment, with the intention that it be considered effective as of the Effective Date.

**Managed Medical Review Organization, Inc.**

Signature: 

Name: Douglas L. Minke

Title: Vice President/General Counsel

**Mendocino County Employees' Retirement Association**

Signature: _____

Name: _____

Title: _____

# EXHIBIT A

FEE SCHEDULE

***Revised Fee Schedule for Specialist Medical Board Service Model***

**Revised Fees**

| | |
|---|---|
| New Claim Review; Completion of Specialist Medical Board Report[1]: | $1,950 per case |
| Appearance fee (Board Meetings, Disability Hearings, etc.)[2, 3] | $445-$490 per hour |

**Other Fees**

| | |
|---|---|
| • Independent Medical Evaluations (IME)[4] | Exam Cost + $400 |
| • Independent Psychiatric Evaluations (IPE)[4] | Exam Cost + $400 |
| • Recommendation Report Addendum fees | $ varies based on request |

[1] For claim files in excess of 600 pages, there will be an Excess Medical Record (EMR) surcharge of $125.00 for every 100-page increment above 600 pages of medical records.
[2] Upon request by MCERA, MMRO will provide an MMRO Medical Board Physician to participate in Board Meeting(s) at the hourly rates set forth above.
[3] Travel Expense Reimbursement. In the event that MMRO representatives appear at a Board meeting in-person, MCERA shall reimburse MMRO for all incurred travel expenses, including airline flight(s) (coach class), meals and lodging. Such reimbursements shall be made within thirty (30) days following MMROs submission of a travel expense reimbursement request, which shall include documentation supporting each expense.
[4] Only used when applicable to the circumstances of the claim.

# EXHIBIT C

INSURANCE REQUIREMENTS

Insurance coverage in a minimum amount set forth herein shall not be construed to relieve CONSULTANT for liability in excess of such coverage, nor shall it preclude MCERA from taking such other action as is available to it under any other provisions of this Agreement or otherwise in law.

CONSULTANT agrees to indemnify and hold harmless MCERA, its elected or appointed officials, employees or volunteers against any claims, actions, or demands against them, or any of them, and against any damages, liabilities or expenses, including costs of defense and attorneys' fees, for personal injury or death, or for the loss or damage to the property, or any or all of them, to the extent arising out of the performance of this Agreement by CONSULTANT.

CONSULTANT shall obtain and maintain insurance coverage as follows:

a. Combined single limit bodily injury liability and property damage liability - $1,000,000 each occurrence.
b. Vehicle / Bodily Injury combined single limit vehicle bodily injury and property damage liability - $500,000 each occurrence.
c. General and/or Professional Liability Insurance in the amount of $1,000,000.00.
d. Workers Compensation and Employers Liability Insurance with statutory limits as required by the Labor Code of the State of California, if the CONSULTANT has employees.
e. Professional (Errors and Omissions) Liability Insurance minimum limit $2,000,000

Standards for Insurance Companies: Insurers shall have an A.M. Best's rating of at least A:VII or equivalent.

Documentation: CONSULTANT is required to provide Evidence of Coverage for all required insurance policies. Required Evidence of Coverage shall be submitted for any renewal or replacement policy that already exist, at least ten (10) days before expiration or other termination of existing policy.

CONSULTANT shall provide immediate written notice if: (1) any of the required insurance policies are terminated; or (2) the limits of any required policy are reduced.

Material Breach: If CONSULTANT fails to maintain insurance coverage required pursuant to this Agreement, it shall be deemed a material breach of this Agreement. MCERA, at its sole option, may terminate the. Alternatively, MCERA may purchase the required insurance coverage, and without further notice to CONSULTANT, MCERA may deduct from sums due to CONSULTANT any premium cost advanced by MCERA for such insurance. This remedy shall be in addition to any other remedies available.

[END OF INSURANCE REQUIREMENTS]

# EXHIBIT D

## PRIVACY AND DATA PROTECTION; SECURITY EVENTS & AI.

### SECURITY EVENTS

CONSULTANT will ensure that its use of all MCERA information will comply with all applicable laws relating to the privacy of MCERA members or the protection of their personal data promulgated.

CONSULTANT acknowledges that certain information may contain personally identifiable information ("PII"), including sensitive data such as unique device identifiers or credit card information. CONSULTANT will be responsible for any unauthorized access, use, reproduction, distribution, disposition, disclosure, possession, damage, or other activity ("Unauthorized Use").

CONSULTANT will implement and maintain administrative, physical, and technical safeguards that are designed to prevent any unauthorized access ("Safeguards"). The Safeguards will include, at a minimum, a data security program which integrates technology-based security measures, policies, procedures, and practices, and ongoing education and awareness designed to protect the security of the information that includes PII and which meets the standards of general industry practice to safeguard such information.

CONSULTANT represents and warrants that the CONSULTANT has not suffered an actual or reasonably suspected security breach involving such information. CONSULTANT will transmit, transfer, and deliver all PII in accordance with applicable law and applicable industry standards. If member information is to be shared back and forth, all transfers of such information between MCERA and CONSULTANT will be in an agreed-upon secure format.

If CONSULTANT discovers or is notified of a security breach (a "Security Event"), CONSULTANT will immediately notify MCERA of such Security Event and of any data involved, and, if required by law or warranted under the circumstances, promptly notify applicable law enforcement and regulatory authorities of such Security Event. All such notices will be subject to MCERA's prior review and approval in each case. In addition, CONSULTANT will fully cooperate with MCERA; provide MCERA with a plan to remediate such Security Event and avoid its recurrence; and unless prohibited by an applicable statute or court order, notify MCERA of any legal process relating to any Security Event. The Parties will fully cooperate with each other in all respects regarding the Security Event, including (i) investigating and curing the Security Event, and (ii) assisting the other Party in investigating, remedying and taking any other action such other Party deems necessary regarding any Security Event and any dispute, inquiry, or claim that concerns such Security Event, and (iii) providing the other Party with assurances reasonably satisfactory to such other Party that such Security Event will not recur. CONSULTANT's actions under this Section will not limit its obligation to indemnify MCERA or any of MCERA's other rights or remedies under this Agreement or otherwise.

## ARTIFICIAL INTELLIGENCE

CONSULTANT shall not use any confidential data provided by MCERA with any Artificial Intelligence (AI) system or model. This prohibition includes, but is not limited to, the collection, processing, storage, handling, or utilization of data for the training, development, or operation of Large Language Models (LLMs), algorithms, or similar AI products.

In the event that MCERA data is inadvertently exposed to or processed by an AI system, the CONSULTANT shall immediately cease such processing and take all necessary steps to secure the data against further exposure. CONSULTANT shall also notify MCERA without undue delay and provide a detailed account of the incident, including measures taken to prevent future occurrences.

CONSULTANT commits to maintaining full transparency in the use of AI systems within the scope of services provided to MCERA. This includes providing detailed documentation of the AI systems employed, the nature of the data processed, and the decision-making processes influenced or carried out by AI.

CONSULTANT shall be fully accountable for all decisions made with the assistance of AI systems. This accountability extends to ensuring that such decisions are fair, unbiased, and in compliance with all applicable laws and ethical standards.

## GENERAL OBLIGATIONS OF CONSULTANT

a. Limit information system access to authorized users, authorized processes acting on behalf of authorized users, and authorized devices (including other information systems).

b. Limit information system access to the types of transactions and functions that authorized users are permitted to execute.

c. Verify and control connections to and use of external information systems.

d. Control information posted or processed on publicly accessible information systems.

e. Identify information system users, processes acting on behalf of users, or devices.

f. Authenticate (or verify) the identities of those users, processes, or devices, as a prerequisite to allowing access to organizational information systems.

g. Sanitize or destroy information system media (i.e., any device containing MCERA data) before disposal or release for reuse of the media for another purposes.

h. Limit physical access to organizational information systems, equipment, and the respective operating environments to authorized individuals.

i. Know and monitor visitor activity; maintain audit logs of physical access; and control and manage physical access devices (i.e., badges.)

j. Monitor, control, and protect organizational electronic communications (i.e., information transmitted or received by organizational information systems.)

k. Create a separate subnetwork for third party users to access specific information that does not allow the third-party users to access or provide any information beyond that network to contain exposure to an untrusted source. (This is also known as DMZ – demilitarized zone.)

l. Identify, report, and correct information and information system flaws in a timely manner.

m. Provide protection from malicious code at appropriate locations within organizational information systems.

n. Update malicious code protection mechanism when new releases are available.

o. Perform periodic scans of the information system and real-time scans of files from external sources as files are downloaded, opened, or executed to protect against malware.

**INDEMNIFICATION**

CONSULTANT shall indemnify and hold harmless MCERA from any claims, damages, or losses arising from the unauthorized use of its data in connection with any of the above. This indemnification includes any misuse of data, breaches of data security, and violations of privacy rights.

# ***PROPOSAL***

## *Provision of Specialist Medical Board Services by Managed Medical Review Organization, Inc.*

**Prepared for:**

**The Mendocino County Employees' Retirement Association**

**May 13, 2024**

*MANAGED MEDICAL REVIEW ORGANIZATION, INC.*
*44090 W. TWELVE MILE ROAD*
*NOVI, MI 48377*
*(866) 516-6676*
*www.mmroinc.com*

***Transition to Specialist Medical Board Services***

Managed Medical Review Organization, Inc. (MMRO) is pleased to have served as Medical Advisor to the Mendicino County Employees' Retirement Association ("MCERA") for nearly the past nine (9) years. Through its work for more than 75 state, county and municipal retirement systems, MMRO has reviewed its service offerings, and has concluded that shifting from the currently contracted model (which involves the completion of Recommendation Reports by MMRO's Executive Medical Director, Dr. Jeffrey Deitch, who is a generalist) to a specialist medical review model (which utilizes MMRO's extensive Medical Board Panel of more than 375 physicians to ensure that Recommendation Reports are completed by specialists who are board-certified in the condition(s) at issue), is an opportunity for a valuable process improvement for our clients.

MMRO has now been utilizing its Specialist Medical Board review model for more than a year with a number of its public retirement system clients. After reviewing these results, MMRO firmly believes that the Specialist Medical Board model can better serve MCERA and its disability retirement program. While the current Disability Nurse Case Manager (DNCM)/Medical Director (Generalist) model has served us well historically, the use of different specialists as the reviewing physician, based on the condition(s) at issue in each respective case, is gaining traction across the country.

***MMRO's Medical Board Panel***

MMRO utilizes an extensive network of specialists and subspecialists on our Medical Board Panel. MMRO's nationwide network is comprised of over 375 physician specialists, in virtually all major specialties and sub-specialties. Our dedicated credentialing team ensures that our Specialist Physician Reviewers meet the strict qualifications set by URAC (board-certified, actively practicing, no conflicts of interest, etc.).

When utilizing this model, our Specialist Physician Reviewers are assigned to cases in the specialty and/or subspecialties most suitable to the eligible disabling diagnosis(es) at issue. Our Specialist Physician Reviewers will be required to review medical and claim documentation in connection with a disability retirement application and provide a written report for each review performed.

MMRO's Medical Board Panel covers virtually all major specialties most suitable for review of disability retirement claims, including:

- Cardiology
- Gastroenterology
- Internal Medicine
- Neurology
- Occupational Medicine
- Orthopedics
- Physical Medicine & Rehabilitation
- Psychiatry

- Psychology
- Oncology

***Description of Specialist Medical Board Services***

As the current MCERA Medical Advisor, MMRO has the comprehensive understanding and knowledge to provide the disability retirement analysis needed to properly provide recommendations under your disability standard. In transitioning to this Specialist Medical Board model, MCERA should expect little to no change in its operational interactions with MMRO. The material difference will be in the composition of the Recommendation Reports, and who authors those reports. MMRO will still engage its DNCMs to clinically triage the claim file, and make their telephonic outreaches to discuss the claim with the member and gather additional medical information (if necessary).

The difference in this new service model will entail the claim being referred to a Specialist, based on the alleged disabling condition(s) at issue, for review and completion of the Specialist Medical Board Report. We believe that having a specialist complete the ultimate recommendation back to MCERA will lead to a decrease in the overall claim turn times and a potential decrease in the number of claims referred for IME or IPE.

***Program Document Revisions Needed***

In anticipation of this transition, MMRO has begun to prepare the revised documentation that will be needed to serve this new service model. Currently, we see the following revisions needed:

1. **Develop Report Questions Matrix.** To guide our Specialist Physician Reviewers through the analysis needed to address your unique disability retirement standard, we have proposed a set of questions that will be answered in every Recommendation Report, a copy of which are attached hereto as **Attachment 1.**

2. **Revised Specialist Medical Board Report Template.** Included as **Attachment 2** is the revised Specialist Medical Board Report template that MMRO proposes to utilize moving forward. The provided example is for another client with their system-specific questions. Of course, we would overlay the agreed-upon MCERA questions in this report format for your reports.

***Revised Fee Schedule for Specialist Medical Board Service Model***

| **Revised Fees** | |
|---|---|
| New Claim Review; Completion of Specialist Medical Board Report[1]: | $1,950 per case |
| Appearance fee (Board Meetings, Disability Hearings, etc.)[2, 3] | $445-$490 per hour |

| **Other Fees** |
|---|

- Independent Medical Evaluations (IME)[4] — Exam Cost + $400
- Independent Psychiatric Evaluations (IPE)[4] — Exam Cost + $400
- Recommendation Report Addendum fees — $ varies based on request

[1] For claim files in excess of 600 pages, there will be an Excess Medical Record (EMR) surcharge of $125.00 for every 100-page increment above 600 pages of medical records.
[2] Upon request by MCERA, MMRO will provide an MMRO Medical Board Physician to participate in Board Meeting(s) at the hourly rates set forth above.
[3] Travel Expense Reimbursement. In the event that MMRO representatives appear at a Board meeting in-person, MCERA shall reimburse MMRO for all incurred travel expenses, including airline flight(s) (coach class), meals and lodging. Such reimbursements shall be made within thirty (30) days following MMROs submission of a travel expense reimbursement request, which shall include documentation supporting each expense.
[4] Only used when applicable to the circumstances of the claim.

## ***Conclusion***

Thank you for your review and consideration of this Proposal, as well as for your continued partnership with MMRO. If acceptable, MMRO is committed to a timely and efficient transition to the Specialist Medical Board model, and believe that a transition to this revised review process can be implemented in an efficient order.

Please do not hesitate to reach out to Doug Minke (dminke@mmorinc.com) if you should have any further questions.

THANK YOU!

# MCERA
# MEDICAL BOARD REPORT QUESTIONS MATRIX

| MCERA DISABILITY STANDARD | MEDICAL BOARD REPORT QUESTIONS |
|---|---|
| | |
| **New Claim**<br>**Permanent Incapacity** | 1. Please provide the opinions of the other physicians in the record.<br><br>2. Please describe why you agree or disagree with the opinions in the file as to whether the applicant is permanently incapacitated.<br><br>3. Assuming the applicant is permanently incapacitated for the performance of any job duty, please address the following in your report: Please describe why you agree or disagree with the opinions in the file as to whether the applicant's incapacity is the result of any injury/illness arising out of and in the course of HIS/HER employment? If so, did the employment contribute substantially to the disability? |
| | |

# Medical Board
# Physician Reviewer Report

**Applicant:**
[redacted]

**Date of Report:**
[redacted]

**Claim Recommendation:**

☒ **APPROVE** ☐ **DISAPPROVE**

# MEDICAL BOARD
# PHYSICIAN REVIEWER REPORT

| MEMBER INFORMATION | | |
|---|---|---|
| **Applicant Name:** [redacted] | **[redacted] Claim #:** [redacted] | **DOB:** [redacted] |

| MEDICAL BOARD PHYSICIAN REVIEWER INFORMATION | |
|---|---|
| **Name of Medical Board Reviewer:** | [redacted], MD |
| **Medical Board Reviewer Specialty:** | Family Medicine |
| **Alleged Disabling Diagnosis(es):** | Chronic Low Back Pain and Sciatica, Morbid Obesity, Diabetes Mellitus, COPD/Recurrent Bronchitis |

**LIST OF MEDICAL DOCUMENTATION:**

1. Job Description: [redacted]
2. Informed Consent and Authorization, Signed and Dated by Member, 02/17/2020
3. Application for Disability Retirement, Signed and Dated by Member, 02/17/2020
4. Explanation of Disability, Signed and Dated by Member, 02/19/2020
5. Employer Information for Disability Application, [redacted], 03/23/2020
6. Initial Disability Claim Form – Physician's Statement, 04/08/2020
7. Physician's Report, [redacted], NP, 04/09/2020
8. [redacted], 01/04/2010
9. Cardiac Catheterization Report, 03/10/2011; 07/29/2019
10. Progress Notes, [redacted], MD, 01/05/2015; 09/30/2015
11. Progress Notes, [redacted], 01/29/2016; 03/10/2017
12. Progress Notes, [redacted], 04/06/2016 to 03/26/2020
13. Progress Notes, [redacted], 05/16/2016; 09/15/2016; 06/01/2017
14. Upper GI Endoscopy, 05/25/2016

15. X-Ray UGI, 05/25/2016
16. Lexiscan One-Day Nuclear, 06/01/2016
17. Progress Notes, [redacted], NP, 01/03/2017
18. ECG, 12/01/2017; 07/02/2019; 07/26/2019
19. Progress Notes, [redacted] Urology, 02/06/2018
20. X-Ray Chest, 04/11/2018; 11/29/2018; 05/17/2019; 01/19/2020; 01/21/2020
21. X-Ray Lumbar Spine, 08/29/2018
22. Emergency Department (ED) Provider Report, 11/29/2018; 01/19/2020
23. History & Physical, 11/29/2018; 01/19/2020; 01/29/2020
24. US Retroperitoneal, 11/29/2018; 01/22/2020
25. Electrocardiogram Report, 11/29/2018; 11/30/2018; 07/26/2019; 07/29/2019; 01/19/2020
26. Consultation Report, Acute Kidney Injury, 11/30/2018
27. Consultation Report, Sepsis, 11/30/2018
28. Infect Disease Consult Note, 11/30/2018; 01/22/2020
29. Clinical Note, Pulmonology, 11/30/2018; 01/19/2020
30. Medication List, 12/02/2018; 01/25/2020
31. Discharge Summary, 12/02/2018; 01/29/2020
32. Pathology Report, 02/14/2019
33. CT Chest, 05/17/2019
34. Progress Notes, [redacted], NP, 06/21/2019; 08/02/2019
35. Progress Notes, [redacted] Cardiovascular Specialists, 07/02/2019; 07/19/2019
36. Home Sleep Test Report, 07/06/2019
37. Study Log, [redacted] Cardiovascular Services, 07/29/2019
38. Discharge Notes, 07/29/2019
39. Consultation Report, Renal Failure, 01/19/2020
40. Consultation Report, Hypoxic Respiratory Failure, 01/19/2020
41. Transthoracic Echocardiogram, 01/20/2020
42. NM Lung Vent, 01/20/2020
43. Vasc Venous Duplex, 01/21/2020
44. PT Daily Documentation, 02/24/2020 to 01/30/2020
45. OT Daily Documentation, 02/24/2020 to 01/29/2020
46. New Medications Started, 02/25/2020
47. Clinical Discharge Summary, 02/26/2020
48. Cumulative Lab Report, 01/30/2015 to 05/21/2020

**SUMMARY OF MEDICAL DOCUMENTATION:**

The applicant is a [redacted]-year-old female applying for disability retirement from per position as a [redacted] due to chronic back pain with sciatica, diabetes, morbid obesity and chronic obstructive pulmonary disease with recurrent bronchitis.

The first medical document was a venous ultrasound of both legs on 01/04/2010, done for leg edema, which showed no evidence of a blood clot, although the study was noted to be limited by obesity.

The next document was an operative report of a cardiac catheterization on 03/10/2011 done for increased angina with a history of previous angioplasty. The study showed good patency of previously treated vessels, with a newly noted 95% stenosis in the posterolateral branch of the right coronary artery. This was treated with angioplasty with excellent improvement in flow. Also noted was a moderate elevation in the left heart filling pressures.

[redacted] first visit with primary care was on 01/05/2015 to establish care and for a two week history of cough. History provided at that time included mild heart attack in 2011 without current issues. She was stated to be on metoprolol but not lisinopril but was out of medications for her heart/blood pressure and was noncompliant with lipid lowering and diabetes medications and recommended eye exams. She was also noted to have chronic anxiety on benzodiazepines at bedtime. History of sleep apnea and depression as well as previous gastric bypass surgery were also noted. She was stated to have quit smoking earlier that year and to consume alcohol (amount unstated). Remarkable physical exam findings included morbid obesity with a body mass index (BMI) of 69, diminished breath sounds with oxygen saturations of 95%, and slowed gait. She was restarted on medications for her health problems, given antibiotics for her cough, and labs were drawn for her blood pressure, diabetes, lipids and history of gastric bypass. Three week follow-up was recommended.

Her next visit with primary care was on 09/30/2015 for a medication check. She was noted to have improving but still low vitamin D levels with medication noncompliance due to financial barriers to care. She was noted to be overdue for cardiology follow-up with occasional leg edema and shortness of breath with ambulation. She was noted to be noncompliant with lipid lowering therapy due to side effects. Additional issues included ongoing issues with incontinence despite medication therapy. On exam BMI was noted to be up to 71. Lab results from the previous week were provided and showed a hemoglobin A1c of 6.4% (good), low

vitamin D, and lipid levels at goal. Physical exam was unchanged. Medications were adjusted and repeat labs were ordered.

On 01/29/2016 she underwent a screening mammogram which was negative.

Her next primary care visit was on 04/06/2016 for routine medical follow-up. BMI was noted to be up to 73 and she was walking with a cane, exam otherwise unchanged. Medications were adjusted and she was referred back to bariatric surgery.

She was seen by bariatric surgery on 05/16/2016 for evaluation for possible gastric bypass revision. Lowest post-op weight from her initial surgery was 298 and she was noted to have had multiple postoperative complications from that procedure. She reported good dietary volume restriction after surgery but currently minimal restrictions. Prior to surgery, the surgeon indicated need for dietary modification, smoking cessation, nutrition evaluation and endoscopy.

On 05/25/2016 she underwent an upper GI endoscopy for preoperative assessment for bariatric surgery with noted previous Roux-en-Y surgery. The gastric pouch was noted to be large and the gastrojejunal anastomosis was dilated, however the findings were otherwise unremarkable. On the same date she also had an upper GI without air which revealed no delay in gastric emptying.

She had a preoperative nuclear cardiac stress test on 06/01/2016 which revealed no evidence of inducible ischemia and normal left ventricular ejection fraction of 75%.

On 06/02/2016 she was seen by primary care for a low blood pressure noted that morning when she went in for lithotripsy. She had taken her medications that morning and preoperative labs showed elevated creatinine and potassium levels. She was also noted to be a current ½ pack per day (ppd) smoker. Exam was unchanged, BMI noted at 67. Her medications were adjusted and additional same day labs were ordered.

Her next visit with bariatric surgery was on 09/15/2016. This was noted to be her nutrition visit prior to possible revision surgery. She was noted to have arrived in a wheelchair but to be able to ambulate with cane/walker. BMI was 74. Weight loss of at least 40-50 pounds was required prior to consideration for surgery.

On 09/23/2016 she was seen by primary care for three months of intermittent bilateral wrist pain, worsened with lifting and gripping. She was noted to have been off her maintenance medications for several months due to noncompliance. She had pain felt likely to be carpal tunnel and she was started on nighttime splinting and Tylenol.

On 10/07/2016 she was seen back by primary care. Labs ordered at the previous visit had showed possible urinary tract infection (UTI) and she was given antibiotics but was still having symptoms. There was associated history of kidney stones with stenting and lithotripsy also during this time. Regarding wrist pain, she was noted to complain of ongoing pain unrelieved by Tylenol, and orthopedic evaluation was planned for later that month. Copy of labs from 09/23 was attached and showed evidence of noncompliance with elevated A1c and lipids. Repeat urine culture was sent and she was given tramadol for pain pending orthopedic follow-up.

She saw primary care on 10/26/2016 for follow-up about her UTI. It was reported that urology stated she would have ongoing issues with urinary incontinence and occasional UTIs until successful weight loss was achieved.

Her next follow-up visit with primary care was on 12/28/2016 and she was noted to have gained more than 10 pounds due to intake of baked goods surrounding the holidays. Fasting labs were ordered and medications were refilled.

On 01/03/2017 she was seen for labs, results not provided.

On 02/28/2017 she saw primary care in follow-up and was noted to have some weight loss with Saxenda, and to also be having some flank pain with a known history of kidney stones. BMI was 65. She refused testing related to kidney stone.

Screening mammogram on 03/13/2017 was negative.

On 03/30/2017 she saw primary care for follow-up. She was noted to have finished Saxenda sample pen and stopped taking, with weight gain since last visit. She complained of ongoing hand pain but had not kept any appointments with orthopedics for further evaluation and treatment. Medications were refilled.

On 06/01/2017 she saw bariatric surgery for follow-up. She was noted to have quit smoking as of 06/2016 but not lost significant weight. Her surgeon noted that her BMI was still around 70 and that revision surgery would not be expected to produce more than 40 pounds of weight loss. As she was nearly 300 pounds overweight with multiple medical co-morbidities, he indicated that the risks of revision surgery currently outweighed the potential benefits.

On 09/12/2017 she was seen by primary care for a possible UTI. She also complained of low back spasms and cramping in the left calf with walking. Exam noted left-sided paraspinal tenderness without any spinal or sacroiliac (SI) joint tenderness. Left leg edema with an area of warmth and redness were seen on the left calf. She was started on antibiotics and muscle relaxers, but refused an ultrasound to rule out a blood clot.

On 12/01/2017 the applicant had an electrocardiogram (EKG) which showed sinus rhythm with borderline intraventricular conduction delay and occasional premature ventricular complexes.

On 02/06/2018 she saw urology in follow-up for recurrent UTIs with multiple stones in both kidneys. Lifestyle modifications, antibiotics, follow-up imaging and weight loss were recommended.

On 03/20/2018 she was seen by primary care for routine medical follow-up. Medication compliance noted to be fairly good. She was noted to be scheduled for carpal tunnel surgery.

Chest x-ray (XR) performed on 04/12/2018 for bronchitis was negative for any acute findings.

On 07/09/2018 she was seen by primary care for routine follow-up. She noted back pain. Exam with muscular but not spinal tenderness. Muscle relaxer restarted as needed.

On 08/29/2018 she was seen by primary care for a three week history of left hip pain. Exam noted left sacroiliac but no spinal tenderness, full range of motion of both legs, and a slowed gait (the latter not a new finding for her). She was given a steroid dose pack for sciatica and x-rays were ordered, which noted some mild degenerative changes of the lumbar spine.

On 11/29/2018 she was seen in the Emergency Room for dizziness and generalized weakness for about one week. It was noted in the history that she stated she could walk without assistance for short distances but otherwise used a motorized chair due to chronic shortness of breath attributed to obesity. She was found to be mildly hypotensive and in acute renal failure

with a presumed urinary tract infection with sepsis and was admitted for treatment. The admitting history and physical for this stay was also included but did not provide any new information. As part of this stay, she also had a renal ultrasound (weight exceeded CT scan ability) and bilateral renal stones were identified without hydronephrosis. During her stay she was seen by nephrology for her acute renal failure, who noted that she had a history of stage III chronic kidney disease based on old labs. She was also seen by the intensivist after transfer to the ICU for ongoing low blood pressures, though she did not end up requiring further support. She was also seen by infectious disease who suspected pyelonephritis because of her chronic renal stones. She was also seen by pulmonology due to her sleep apnea and they recommended nasal cannula oxygen with sleep during her hospital stay. Discharge summary indicated that there was no growth on urine or blood cultures and she was discharged with oral Levaquin.

She was seen by primary care for hospital follow-up on 12/07/2018. She was noted to be doing well. She was interested in surgery consult to excise her large pannus which was noted on exam to extend down between her legs. She was given a referral to surgery and repeat labs were ordered.

On 01/11/2019 she was seen by primary care for follow-up. She complained of left hip and low back pain with activity. Other medical issues without significant change. No abnormal exam findings noted. She was given gabapentin for her pain.

The next document was a pathology report dated 02/14/2019 for her renal stones. At least 15 noted to be present in the specimen, and they were forwarded for chemical analysis.

On 02/22/2019 she saw primary care for one month follow-up after restarting Ozempic. She had all her left kidney stones removed and was feeling better, with plans for removal of all the right-sided stones the next month.

On 05/17/2019 she had a chest x-ray for shortness of breath which was negative for acute findings, noted chronic enlargement of cardiac silhouette. She then had a CT of the chest which revealed mild ground glass airspace disease at both lung bases, as well as incidental vascular calcifications and a benign 2.5 cm right adrenal adenoma.

On 06/04/2019 she saw primary care for shortness of breath, which had been persistent despite oral steroids, Breo inhaler and nebulizer treatments. She also complained of a chronic

cough and heaviness in the chest. Oxygen saturations on room air at rest were 98% with exam noting coarse breath sounds diminished at the bases. She was referred for evaluation with cardiology and pulmonology.

On 06/21/2019 she was seen by pulmonology. She was noted to have been diagnosed with sleep apnea related to her morbid obesity 20 years previously but was never treated as she was unable to wear a CPAP due to claustrophobia. Home sleep study was ordered and she was started on albuterol for chronic obstructive pulmonary disease (COPD).

On 07/02/2019 she was seen by cardiology. She was noted to have been restarted on low dose metoprolol without any improvement in her daily chest pressure. Exam noted for mild lower extremity edema. Additional medications were ordered, with plan for repeat heart catheterization if this was not effective.

On 07/05/2019 she did her home sleep study with results showing severe obstructive sleep apnea.

On 07/19/2019 she was seen by cardiology and noted to have ongoing symptoms and the plan was to schedule cardiac catheterization as an outpatient.

She underwent her cardiac catheterization on 07/29/2019 and it revealed that all of her previously treated areas were widely patent. She did have two small areas of 50% stenosis, however these were examined further and not found to be flow-limiting.

On 08/02/2019 she saw pulmonology for follow-up and stated she was feeling well without any current symptoms. Her sleep study findings were reviewed and a prescription for a nasal pillow sleep device was sent to the medical supplier of her choice.

On 08/21/2019 she saw her primary provider for recurrent sciatica symptoms, which started after her heart catheterization lying on the table for several hours. It was noted that her daughter was also trying to get her an appointment with plastic surgery about having her pannus removed as it was impacting her mobility. She was noted to not yet have picked up her CPAP machine. On exam pannus was noted to have an area of serous drainage. She was also found to have left-sided SI tenderness with weakness upon attempted standing and need for assistance. She was given a steroid dose pack and her gabapentin was increased. Local care reviewed for pannus.

On 09/12/2019 she was seen by primary care for follow-up on her sciatica. She noted improvement but recurrent symptoms. She was given muscle relaxers and another round of steroids as well as a referral to orthopedics. She was also noted to have a recurrent superficial skin infection on her pannus and prescribed antibiotics.

On 09/20/2019 she was seen by primary care for follow-up on her multiple medical problems. She was noted to have been switched from gabapentin to Lyrica for her nerve pain. Her A1c was quite elevated at 9.7% but her labs were otherwise stable. Medications were adjusted and refilled. She was noted to have suboptimal compliance with her diabetes medications.

The next document was an admitting history and physical dated 01/19/2020 for increased shortness of breath and gait instability. She had reported multiple falls at home which had been progressive over several weeks. She was found in the Emergency Room to be hypoxic with abnormal blood gas levels on nasal cannula oxygen and she was admitted for evaluation and treatment. She was seen by nephrology for mild renal failure which rapidly resolved. She was felt to have volume overload, probably from the combination of pulmonary hypertension, sleep apnea and low albumin levels (presumably related to her previous gastric bypass). She was also noted to be anemic, likely secondary to chronic kidney disease and was started on Procrit. She was seen by pulmonology for her hypoxic respiratory failure which was felt likely to be due to pulmonary edema (congestive heart failure) with underlying chronic obstructive pulmonary disorder (COPD). She was started on nebulized steroids for the COPD and bipap for her sleep apnea. Echocardiogram was done and showed normal left-sided function with moderate to severe enlargement of the right ventricle with elevated pulmonary arterial pressure at 47, as well as a small pericardial effusion and a dilated inferior vena cava consistent with volume overload. She was also seen by infectious disease regarding her recurrent panniculitis, which was treated with vancomycin, clindamycin and ceftriaxone. Pannus was noted to extend nearly to the ankles with sitting position and inpatient wound care consult was obtained with plans for ongoing outpatient wound care after discharge. Numerous labs and imaging studies were obtained throughout the hospital stay but other findings are not relevant to this review. Hospital discharge summary indicated that she was being discharged to acute rehab and would likely require chronic oxygen therapy.

The next set of documents involved her stay at acute rehab, beginning with a history and physical dated 01/29/2020. This summarized her hospital stay and noted she was currently on 2-3 L of oxygen via nasal cannula. Her previous level of functioning was noted to be ambulatory

with a rolling walker around the house and use of an electric scooter in the community. She was still driving though that had been close to being stopped. Her current level of functioning was noted to be two person assist for bed mobility, maximal assist for standing from a seated position, ambulation with rolling walker for 3 feet with light assistance, moderate assistance with bathing and self-care and maximal assistance for dressing. Daily physical therapy progress notes were included for review. During her nearly one month stay at the facility, she demonstrated improvement in bed mobility, however she still required someone to lift her legs into the bed and to assist with movement in bed. She demonstrated improvement in ambulatory abilities, being able to walk 20 feet (from 3 feet) at time of discharge. She remained unable to step up or down. She was able to transfer from bed to her motorized scooter and into a vehicle but did require ongoing light assistance with getting from sitting to standing position. She was noted to require someone following behind with a wheelchair while she was ambulating for safety due to inconsistent abilities. She was able to maneuver her motorized chair/scooter independently. Aside from utilizing her power chair, she was noted to have not met her short or long term mobility goals of therapy. She also received daily occupational therapy in addition to her physical therapy. At discharge she was noted to stand pivot transfer herself to the toilet, but did require some assistance with bathing and dressing lower extremities. Both physical and occupational therapy reports consistently noted left-sided sciatic pain of patient-rated moderate severity as well as objective measures of generalized weakness. The discharge summary dated 02/26/2020 indicated that she was discharged to her daughter's home with ongoing physical and occupational therapy via home health as well as nursing services. Activity restrictions explicitly stated no driving and included a recommendation for 24-hour supervision for safety. She was noted to require ongoing light to moderate assistance with any mobility. The facility physician noted that although home health services were ordered, the applicant refused them. Other relevant medical events during her stay included developing a left lower lobe pneumonia and a urinary tract infection, both of which were successfully treated with antibiotics. It was also notable that she received as needed narcotic pain medication for her sciatica in addition to being started on Cymbalta.

On 03/26/2020 she was seen by primary care for paperwork for her wheelchair and for depression. She was still living with her daughter at that time, but had experienced some gains in mobility, being able to walk very short household distances with her walker and being able to get up from a seated position with the assistance of grab bars most of the time (as opposed to requiring another person to help her). She complained of ongoing significant left buttock pain radiating down the leg. She was noted to have been seen by orthopedics without any interventional options available due to her weight. Her daughter also voiced evidence of mild

confusion at times. BMI at that visit was 63 and oxygen levels were 96% on room air. She was noted to have an ongoing open abdominal wound as well. She was started on a daily inhaler and referred back to pulmonology. Her Cymbalta was increased and home health physical therapy and wound care were ordered. Labs for her diabetes and other chronic medical problems were ordered as well.

Lab results from 2015-2020 were included in tabulated form at the end of the medical records provided. Except as noted in the summary above, the findings were not relevant to this review.

The original application for disability retirement was provided and dated 02/17/2020 with a retirement date of 04/01/2020. It indicated that she had not applied for Social Security disability and that this was not a Workers' Compensation case.

The Explanation of Disability was signed by the applicant on 02/19/2020 and did not describe her job duties. She indicated that she was no longer able to sit for long periods of time and can only stand for short periods of time and was unable to walk any distances. She stated that she had lost 52 days in the last year due to her health problems, which she described as urinary tract infections with sepsis and kidney failure, diabetes, heart disease with stent placement and high blood pressure, a large mass between the legs with recurrent wounds and infections, morbid obesity with inability to sit comfortably in a regular chair, a pinched nerve in the neck and chronic temporomandibular joint (TMJ) pain requiring pain medications with side effects of drowsiness (which can impact ability to drive and concentrate), sleep apnea, hospitalization for respiratory failure requiring outpatient rehab due to inability to walk or to transfer from bed to chair independently. She indicated that her physician had referred her to numerous specialists and she had been prescribed a wheelchair, cane and walker for mobility assistance and that her physician had taken her out of work when her pulmonary and pain issues have dictated. She stated that her medical problems also limited her activities of daily living, preventing her from being able to shop or do household chores. She also stated that despite her assistive devices she intermittently required assistance with activities of daily living (ADLs). She provided information regarding her hospital, rehab center, and medical treatment team for her multiple medical problems.

The Employer Information for Disability Application was signed on 03/23/2020 and indicated that the applicant was still actively employed, but was not performing all the duties listed on the job description. She was taken completely off work on 01/21/2020 and had not returned, therefore no modifications had been made. The employer noted that over the last year she

had missed multiple days of work and when she did report to work, other staff had to assist her to get in and out of the building and/or her vehicle.

The Physician's Report was completed by her primary care provider on 04/08/2020 and indicated that the primary diagnosis for her disability was chronic low back pain with sciatica. Other contributing diagnoses were listed as morbid obesity (onset 2015 or prior), diabetes (onset 2015 or prior) and COPD (onset 2018 or prior). Functional limitations were described as worsening health, difficulty walking and back pain with functional decline due to recent recurrent hospitalizations. Symptoms were first noted to have occurred on 08/2018 and the first date of disability was 01/19/2020 with most recent visit on 03/26/2020. Initial objective findings included arthritic changes to the lumbar spine with pain and tenderness and a slowed gait requiring use of assistive device. It was also noted that the applicant had a very large pannus which limited her mobility. Her current treatment program included medications and home physical therapy. Her provider indicated that her chronic conditions were mostly stable but contributed to her limitations. Little to no functional improvement was expected over the next year, with most recent hospitalization noted 01/2020 due to respiratory failure. Her condition was noted to have worsened over the last year and the provider considered her disabling conditions likely to be permanent.

**SUMMARY OF JOB DESCRIPTION:**

The job description for a [redacted] with the [redacted] was provided for review. Essential responsibilities of the position included primarily secretarial/office tasks including providing information to individuals about programs, answering telephone calls and requests, distributing mail, data entry/computer tasks, and preparation of resources for the individuals served, including keeping appropriate records. The position also required providing support for the agency's disaster and emergency operations. The position required a valid driver's license and ability to operate a transportation vehicle, as well as willingness to obtain job-related certifications. Ability to use common office equipment, give oral and written instructions, prioritize tasks and maintain working relationships were required. The ability to maintain detailed records and communicate orally and in writing were also expressly required. The work environment was noted to be primarily indoors, but did require exposure to outdoor conditions with operation of motor vehicles and/or equipment and occasional outdoor activities. Physical requirements included stooping, crouching, walking, pulling, lifting, grasping, hearing, intact vision, kneeling, reaching, pushing, talking, standing, hand dexterity and repetitive motion and depth perception with lifting requirement of weight up to 25 pounds.

**CONCLUSION:**

**1. Based on review of the available medical evidence, is there support that the applicant is mentally or physically incapacitated for the further performance of her/his job as a [redacted]?**

Yes, based on the review of the available medical evidence, there is support that the applicant is physically incapacitated for the further performance of her job as a [redacted] due to low back pain with left-sided sciatica, COPD and morbid obesity.

The records indicate that the applicant has struggled with low back pain with left-sided sciatica since September 2017. She has taken multiple different medications and been evaluated by orthopedics for other interventions. Unfortunately, because of her morbid obesity, no other treatment options were available to her. There is documentation, even preceding her hospitalization in January 2020, that her symptoms were causing her to have significant difficulty in standing from a seated position and causing instability in her gait despite the use of assistive devices. She is currently on medications for her pain, which cause drowsiness as a common side effect. Her chronic pain is further complicated by deconditioning from her recent hospital stay, which resulted in temporary inability to live within the community. She underwent inpatient acute rehabilitation and continues to undergo physical therapy, however despite the use of medications, there is documentation that she cannot currently ambulate any distance without resting, and she sometimes requires assistance to get up and to transfer between furniture and her motorized chair. It is pertinent that her employer noted the need for coworkers to assist her with mobility and transfers even prior to her prolonged hospitalization and rehab stay. Although the majority of the applicant's job tasks are able to be completed from a seated position, the position of [redacted] does require the ability to stand, walk, stoop, bend and otherwise physically maneuver, as well as the ability to attend outdoor events and to operate a motorized vehicle, the latter of which the applicant's treatment team has not cleared her to perform.

The medical documentation also provided evidence that the applicant's severe morbid obesity impacted her mobility significantly, largely due to the presence of a very large pannus which hung between her legs affected her gait and mobility of her torso. The applicant had been referred to plastic surgery for possible excision of this, however those records were not provided so it is unclear at this time if she was ever evaluated, or if it was determined that

based on her underlying cardiopulmonary conditions, the risks of elective surgery outweighed the potential benefits.

The records clearly show a decline in respiratory function and overall functional capacity over the last several years, with persistent shortness of breath and ultimately hospitalization for hypoxia secondary to pulmonary edema from volume overload. There is evidence that she has tried multiple treatments for COPD without substantial improvement in her shortness of breath. Vital signs from clinic visits do not demonstrate residual hypoxia at rest at this time, however there is substantial documentation among the therapy records that the applicant is able to exert herself only minimally without stopping to catch her breath. She has been referred back to pulmonology, however inhaled medications are considered the mainstay of therapy for COPD and it is unclear that she will gain benefits from additional medication trials. Although the records did not reveal any formal diagnosis of pulmonary hypertension, the medical evidence provided documents significant right ventricular hypertrophy and elevated pulmonary arterial pressures, which are suggestive of this diagnosis (right heart catheterization with pressure managements is the gold standard for diagnosis). Given her long history of morbid obesity and severe sleep apnea, class 3 pulmonary hypertension would not be an unexpected finding. If present, this would contribute further to her refractory dyspnea. Additionally, although no formal pulmonary function studies were provided, the degree of her morbid obesity (BMI around 65-70) makes it likely that she has a component of restrictive lung disease secondary to poor compliance of the chest wall. These factors may explain her poor response to medical management of her COPD. Although the applicant's job duties are primarily sedentary, there are some exertional requirements as noted above, and the evidence provided indicates that it is unlikely she is able to consistently perform these duties.

Therefore, medical evidence provided supports that the applicant is physically incapacitated for the performance of her position as a [redacted] due to low back pain with left-sided sciatica, morbid obesity and chronic obstructive pulmonary disease.

**2. If the answer to Question #1 above is in the affirmative, is there evidence to support that the incapacity is likely to be permanent?**

Yes, there is evidence in the provided medical records to support that the applicant's current physical incapacity is likely to be permanent. It is notable that even in August 2019 before the applicant's prolonged hospital and rehabilitation stays, she was having difficulty standing up from a seated position due to her low back pain with left-sided sciatica and she was having

intermittent symptoms as early as September 2017. Additionally, there is ample documentation in the provided medical records that she was struggling with safe mobility for several years due to the size of her pannus and chronic shortness of breath despite both cardiac and pulmonary interventions.

Regarding her back pain with sciatica, the records establish that medical management is her only available treatment option given her body weight. She has tried several different medications for neuropathic pain and muscle spasms with limited benefit, and these medications are known to cause drowsiness as a common side effect, which would impact her ability to safely operate a motorized vehicle, which is a requirement of her job position. There is documentation in the medical records that she did note side effects, and had her medications were adjusted in attempt to manage this. As she is not a candidate for any type of orthopedic intervention, her symptoms are unlikely to undergo significant improvement to the degree that discontinuation of medication would be possible. This is especially true given the extent of documentation provided regarding the persistent moderately severe nature of her symptoms despite current physical and occupational therapy interventions and oral medications. Without improvement in her back pain with sciatica, the medical evidence provided suggests that it is also unlikely that she will experience adequate recovery of mobility to consistently transfer without assistance between a vehicle and her motorized chair, and between her motorized chair and her chair at work.

Regarding her respiratory function, there is ample evidence to support a permanent nature of her overall poor respiratory status. Although her hospitalization in January 2020 was caused by pulmonary edema, a treatable cause of shortness of breath and hypoxia, she does have multiple other contributors to chronic pulmonary dysfunction. She has been diagnosed with COPD, which is presumably secondary to tobacco use (she quit and restarted smoking multiple times during the course of the provided records). This condition is considered able to be managed with medications to minimize symptoms, however it is not reversible (and in fact is often progressive) and will cause her some degree of functional limitation for the rest of her life. Additionally, she has findings suggestive of probable pulmonary hypertension, which is a minimally treatable cause of shortness of breath – the only treatment is supplemental oxygen when needed for hypoxia, which the applicant does not currently have at rest. No exertional oxygen levels were provided for this review. The combination of these factors make it highly unlikely that the applicant will be able to adequately exert herself through physical therapy to recover the muscular function and cardiopulmonary endurance necessary to perform the non-seated duties required for [redacted] In fact, it is also unlikely that the

applicant will recover adequate strength and cardiopulmonary endurance in order to function in the community without assistance on a consistent basis. Further evidence of this was provided in the physical therapy notes, which frequently indicated need for pauses in the treatment session due to shortness of breath and/or pain.

Regarding her morbid obesity, there is substantial evidence provided in the medical records that the applicant has attempted to lose weight many times over the years. In addition to dietary modification and medications, she had previous gastric bypass surgery. It is remarkable that even with her initial surgery, her body weight did not get below 298 pounds. During the course of the provided records, she was evaluated for a revision, however the surgeon ultimately determined that the risk benefit ratio of this procedure was not in her favor, given her cardiopulmonary problems and expected weight loss of only about 40 pounds. Therefore, it cannot be expected that the applicant will be able to lose enough weight to substantially impact her mobility or her lung function at this time.

Therefore, this review finds that there is medical evidence to support that the applicant's physical incapacity is likely to be permanent.

**3. If the answer to Question #1 above is in the affirmative, has the applicant been continuously incapacitated through the date of this report?**

Yes, there is evidence that the applicant has been continuously incapacitated through the date of this report. There are medical records indicating ongoing back and leg pain, shortness of breath and very limited mobility as recently as April 2020. Given the applicant's complex medical conditions and average speed of improvement during rehabilitation, it is unlikely that she has experienced adequate improvement in physical functioning since that time to be able to return to her job duties as a [redacted].

**4. If the answer to Question #1 is in the affirmative, did the applicant's disabling condition exist as of the date she/he last became an active member of [redacted] on December 27, 1989? If yes, is there evidence to support that the pre-existing condition worsened substantially since the applicant last became an active [redacted] member?**

No, there is no conclusive evidence in the provided medical records that the applicant's disabling conditions were present on December 27, 1989 when she became an active member

of [redacted]

**5. If you do find the applicant to be incapacitated for the performance of her/his job, please identify the disabling diagnosis(es).**

Based on the available medical evidence, there is evidence that the applicant is permanently physically incapacitated for the further performance of her job as a [redacted] due to low back pain with left-sided sciatica, chronic obstructive pulmonary disease and morbid obesity.

**MEDICAL LITERATURE REFERENCES:**

[redacted] Sciatica p 1716-8, Obesity p 1287-94, COPD p270-5, Pulmonary hypertension p315-7.

[redacted] "Overweight and Obese in Adults: Health Consequences." UpToDate. Apr 2020

[redacted] "Lumbosacral Radiculopathy: Treatment and Prognosis." UpToDate. Jun 2019.

[redacted] "Stable COPD: Overview of Management." UpToDate. Apr 2020.

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**This reviewer declares, 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, this report accurately describes the information provided to me.**

**CONFLICT OF INTEREST ATTESTATION:**

**I attest to the fact that there is no conflict of interest with this review for referring entity, benefit plan, enrollee/consumer, attending provider, facility, drug, device or procedure.**

**I attest that my compensation is not dependent on the specific outcome of my review or that I have had any involvement with this case prior to this referral.**

**REVIEWER QUALIFICATION ATTESTATION:**

**I further attest that as a reviewer for this case:**

**(i)** **I have the appropriate license and Board Certification for practitioners who typically manage the medical condition/procedure/treatment or issue that is the subject of this review.**

**(ii)** **I have the knowledge and clinical experience to render a determination for the case under review.**

**(iii)** **I have at least five (5) years full-time equivalent experience (37.5-40 hours or more per week) providing direct clinical care to patients.**

**(iv)** **I have not been subject to any sanctions, disciplinary actions, or loss of licensure or certification.**

[redacted]

****REVIEWED BY:**
[redacted]
Board Certified Family Medicine
Licensed in the Following State(s): [redacted]

**Signature:** Signature Redacted

**Date:**