Case Study 1

Employee worked for Landscape Service. He claimed to have injured his low back when he lifted a heavy rock. He was a stone mason.

Employee claimed 50 percent permanent whole person disability; however, this rating appeared "extreme". First, he did not have surgery, and second, the treating orthopedist confessed in a letter, that he was not an expert in rating permanent disability. He wrote, "I think the best course of action would be to have the patient evaluated by a provider with expertise in the area of disability determination such as a rehabilitation or occupational medicine provider."

Respondent had an IME who opined that employee sustained a large disc herniation at L2-L3 producing central spinal stenosis. MRI scan also revealed foraminal narrowing at L5-S1 on the right. IME noted that employee's **left** leg pain eventually resolved. Subsequent MRI revealed resorption of the L2-L3 disc herniation. Employee had noted significant improvement. Consequently, IME opined employee reached end of healing. On that date, he was capable of returning to work full duty without restrictions as he had shown significant improvement. He had some residual back pain, but his radicular symptoms had improved. IME opined employee sustained five percent permanent whole person disability.

Employee returned to treating orthopedist 6 months later with complaints of **right** leg pain. This was attributed to disc herniation and foraminal stenosis at L5-S1. IME opined those changes were pre-existing; employee did not have any significant back or right leg pain initially. He had resorption of the L2-L3 disc; his right leg symptoms were reflective of the degenerative change and foraminal narrowing at L5-S1 on the right. This was a non-work-related condition.

There were contemporary medical records which supported IME opinion that the work-related L2-L3 herniated disc caused left leg symptoms, whereas, the right leg symptoms were caused by non-work-related L5-S1 disc disease. The treating orthopedist noted that employee felt as though he was having some radiating pain to his right hip, whereas, previously he was only having radiating pain to his left

side. Treating orthopedist noted straight leg raise testing was negative bilaterally. His review of employee's second MRI revealed significant disc resorption and no signs of new disc herniation.

In treating orthopedist's "To Whom It May Concern" letter, he wrote, "Unfortunately, at my most recent examination, employee reported worsening of his lower extremity symptoms with new right sided radicular symptoms. His MRI does show a right sided L5-S1 disc bulge and facet hypertrophy causing severe right foraminal narrowing and impingement of the right L5 nerve root as well as degenerative changes elsewhere in the lumbar spine."

A third lumbar MRI scan showed, among other things, "multi-level degenerative changes throughout the lumbar spine, most significantly at L4-5 with circumferential disc bulging causing severe canal stenosis, which has progressed from prior exam."

Finally, the treating orthopedist wrote, "there are multi-levels of arthritis noted throughout his spine as well as a new finding of a circumferential disc bulge at L4-5 causing central canal stenosis that has shown progression. The previous disc at L2-3 has greatly improved since initially being seen. It was discussed with the patient that his ongoing pains could be a reflection of some of these changes, and a natural progression of arthritis, osteophytosis, and degenerative disc disease."

Thus, we had a situation where a heavy lifting work-related incident caused a L2-L3 herniated disc which eventually resorbed and left leg symptoms improved. Then, several months later, employee began to complain of right leg radiating pain and this seemed attributable to an L4-5 or a L5-S1 herniated disc with severe narrowing.

Guide: How To Evaluate Permanent Disability Under Wisconsin Worker's Compensation Law

https://dwd.wisconsin.gov/dwd/publications/wc/wkc-7761-p.pdf

Page 12 – Guidelines to help doctors evaluate permanent impairment have been published by the American Medical Association and the American Academy of Orthopedic Surgery. These guides may be consulted for information and comparison purposes. They are *NOT*,

however, to be the basis for evaluation, the schedules are. (Emphasis in Original).

Case Study 2

Employee was driving a company vehicle when involved in an MVA. She sustained head, neck and low back injuries. Following the accident, she finished her day of work. A few days later, she complained of headache, blurred vision, neck and back pain. Within days, she retained a PI lawyer.

She saw a neurologist who diagnosed cervical and lumbar sprain. He recommended physical therapy, and advised the employee to continue working. She continued to see the neurologist who continued to recommend she continue working her regular job.

An MRI of the lumbar spine showed no disc herniation, spinal canal stenosis, or nerve root impingement. The neurologist said the MRI showed sacroiliac joint degeneration. She then had a sacroiliac joint injection. She reported significant improvement from the injection. A couple weeks later, the neurologist released her to return to regular duty with no work restrictions.

The employee then saw another neurologist, complaining of post-concussive symptoms and low back pain. An MRI of the brain was unremarkable. A CT scan of the lumbar spine showed mild multilevel degenerative changes. The new doctor recommended therapy. The employee attended two months of physical therapy. She was discharged from physical therapy reporting minimal to no pain.

A month later, employee reported persistent post-concussive symptoms and low back pain. She stated she was not working and asked to be placed on disability. She said therapy was not helpful. The second neurologist opined employee was disabled from all job activities and required assistance for activities of daily living and household chores.

Medical Opinions

The first neurologist completed a final report, noting employee experienced occasional discomfort that did not interfere with her activities; and had been able to tolerate full duty work. He assigned no

permanent restrictions, rated no permanent disability, and recommended follow-up as needed.

The second neurologist completed a WKC-16-B report, noting he treated employee for post-traumatic concussion syndrome, neck and lower back pain, resulting in paresthesias down the upper and lower extremities, episodes of falling and imbalance. He opined employee was permanently disabled due to neck and low back pain, severe headaches, dizziness, incoordination, and imbalance. He opined employee was unable to perform the activities of her job. He did not assign permanent work restrictions, and expected no further treatment. He stated employee was simply unable to work.

Employer had an IME who opined employee was status post-work-related MVA, resulting in subjective neck and back pain, a mild TBI and post-traumatic headaches. There was no radiologic evidence of structural injury to the cervical or lumbar spine. He concluded employee reached end of healing from MVA, and opined there was no permanent disability; no need for permanent work restrictions; and no basis for further treatment.

Issues

Employee sought compensation for permanent total disability and treatment expenses related to the alleged head, neck, and back injury from the MVA.

Employer relied on opinions of first neurologist and IME that employee reached end of healing, without permanent disability or restrictions, and without the need for further treatment.

Employer believed employee was motivated by secondary gain or she is malingering. She had no problem continuing to work the day of the MVA, and she did not report any symptoms until several days later. And, she asked her second neurologist to place her on disability.

The second neurologist has ignored the multiple tests including MRI of the low back, MRI of the cervical spine, and MRI of the brain, which

were all unremarkable. He noted the etiology of employee's complaints and symptoms is unknown.

Case Study 3

A middle-aged, high earning truck driver-employee claimed that while in the course of his employment, he sustained a right Achilles' tendon injury, when he slipped and did the "splits". Subsequently, he underwent two right Achilles' tendon repair procedures.

During the second procedure, he was placed in a Robert Jones splint with approximately 20 – 30 degrees of plantar flexion. He was to be on strict touchdown weight bearing for 6 weeks post-operative.

Later, he was placed in a short leg cast with 20 – 30 degrees of plantar flexion. He was to continue touchdown weight bearing. He was also given an order for 3 heel lifts to be worn in his shoe.

Ultimately, he claimed that he sustained lumbar spine injury due to an altered gait and/or immobility following the two Achilles tendon surgical procedures and initiation of physical therapy. Employee underwent numerous low back procedures, i.e., injections, lumbar medial branch blocks, ablations, etc. The treating pain doctor opined that Achilles' tendon procedures resulted in altered gait and/or immobility which precipitated, aggravated and accelerated employee's minor pre-existing degenerative condition beyond normal progression, noting that before the work injury, employee had no low back complaints, whereas, after, he had substantial pain complaints. Worse, the pain doctor imposed permanent restrictions of no lifting or carrying more than 5 pounds; no bending, twisting, turning, squatting; no sitting, standing, walking more than 10 minutes each at a time; no driving more than 15 minutes without a break; and finally, must take a break 20 minutes in each work hour. Based upon these restrictions, employee's vocational expert opined employee was "odd lot" permanent total disability. Exposure exceeded $1,000,000.

IME opined employee sustained a partial tear of the right Achilles tendon at the heel as a result of the work injury. He subsequently underwent a take down and repair of the Achilles tendon partial tear. He, however, sustained a complication of a rupture of the initial repair and was subsequently taken back to surgery where he had an otherwise successful re-repair from which he fully recovered.

IME opined employee had underlying and pre-existing mild facet arthropathy and degenerative disc disease in the lumbar spine. He was morbidly obese which caused ongoing lower back pain.

The partial rupture of the right Achilles tendon was directly and causally related to the work incident; the presence of mild degenerative changes in the lumbar spine was not caused by the work incident. Employee's subjective symptoms of ongoing lower back discomfort were not corroborated by objective findings on physical exam and were not related to the incident in question, nor to any subsequent temporary ambulatory restrictions following the surgical procedures. Any lower back discomfort he has is due to morbid obesity.

We questioned the employee's claim that post-operative casting, shoe lifts, altered gait and/or immobility caused lumbar spine injury.

We believed morbid obesity and pre-existing low back degenerative disease caused employee's alleged low back complaints.

First, on the date of alleged injury, employee was 5'10" tall and weighed 500 pounds. He weighed in excess of 475 pounds at all relevant times during this claim.

Second, employee attributed low back complaints to not only an altered gait, but also to immobilization or sitting. Immobilization and sitting were contrary and inconsistent with causation due to use of heel lifts, increased activity and an altered gait. In the post-operative physical therapy records, employee attributed low back complaints to driving 3 hours for a poker tournament; driving 3-4 hours; playing cards for a few hours; and driving 5-6 hours.

Third, employee had multilevel lumbar facet degeneration and degenerative disc disease.

We decided to have a record review by a spinal surgeon who is very thorough and supports his opinions with references to the medical records, and had the benefit of having all the medical evidence and "fresh eyes'"