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Office of Administrative Law Judges
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Issue Date: 17 May 2012

CASE NO.: 2010-LHC-01191

OWCP NO.: 06-204954

In the Matter of:

DARIN BRYANT,
Claimant,

v.

CERES MARINE TERMINALS, INC.,
(Self-Insured),

Employer,

APPEARANCES: Charles Raley, Jr.
Attorney for Claimant

G. Mason White
Attorney for Employer

BEFORE: KENNETH A. KRANTZ
Administrative Law Judge

DECISION AND ORDER

This proceeding arises from a claim filed under the provisions of the Longshore and Harbor Workers' Compensation Act, as amended ("Act" or "LHWCA"), U.S. Code, Title 33, § 901 et seq., and is governed by the implementing regulations found in the Code of Federal Regulations, Title 29, Part 18, and Title 20, Chapter VI, Subchapter A.

I presided over a formal hearing in Savannah, Georgia[1] on January 12, 2011, at which time the parties were afforded full opportunity to present evidence and argument. A representative for the Director was not present. At the hearing, Administrative Law Judge Exhibits 1–2; Claimant's Exhibits 1–26 and 28-3-33; and Employer's Exhibits 1–11 were admitted without objection. CX-25[2] was admitted over objection with the proviso that certain telephone notes would be withdrawn. CX 27, 28, and 33 were marked for identification in futuro and were received on February 11, 2011. (TR 6–13) Both parties submitted post-hearing briefs, as well as one post-hearing exhibit each (CX 2a; EX 12) without objection.

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[1] The facts of this case arose in the state of Georgia; therefore this claim is governed by the law of the United States Court of Appeals for the Eleventh Circuit

[2] The following exhibit notations apply: AX – Administrative Law Judge exhibit; CX – Claimant's exhibit; EX – Employer's exhibit; and TR – Hearing transcript page.

The findings of fact and conclusions of law which follow are based upon a complete review of the entire record, in light of argument of the parties, as well as applicable statutory provisions, regulations and pertinent precedent.

PROCEDURAL HISTORY

This claim was referred to the Office of Administrative Law Judges (OALJ) on April 2, 2010 and I issued a notice of hearing on September 17, 2010. (AX 1, 2) Employer filed a Motion to Compel Medical Examination on October 14, 2010, and on November 4, 2010, Claimant[3] filed a responsive brief. On November 17, 2010, Claimant submitted a letter from Dr. Roybal to supplement his brief, and Employer filed a reply brief on December 22, 2010. I reserved ruling on that motion until after the hearing and will address it herein. (TR 92)

STIPULATIONS

The parties have stipulated and I concur with the following: (TR 5, 14, 18)

1. The LHWCA, 33 U.S.C. § 901 *et seq.*, as amended, applies to this claim.

2. Claimant suffered a compensable injury on October 11, 2008.

3. Notice of the claim was timely.

4. Claimant's average weekly wage is not contested.

5. Employer has made some temporary total disability (TTD) payments.

ISSUES

The issues remaining to be resolved are (TR 14-19):

1. Whether Claimant must submit to a second independent medical examination (IME) at Employer's request, and

2. Whether Employer must authorize the medical treatment (surgery) recommended by Dr. Raphael Roybal.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

I. MOTION TO COMPEL MEDICAL EXAMINATION DENIED

A. Relevant Factual Background and Evidence

On October 15, 2008, Claimant reported to Dr. R. Dow Hoffman, his physician of choice, complaining of back pain. Dr. Hoffman performed an MRI and prescribed epidural steroid injections, ibuprofen and physical therapy ("PT"). (CX 2-5, EX 1) Dr. Hoffman approved Claimant for a return to full-time duty on January 12, 2009. (CX 2) On June 8, 2009, Claimant returned to Dr. Hoffman, complaining of continuing back pain. Dr. Hoffman referred Claimant to Dr. Raphael R. Roybal. *Id.* On June 18, 2009, Dr. Roybal found the conservative treatment had failed, recommended back decompression surgery, and placed Claimant on non-work status. (CX 5)

[3] "Claimant" is used in this decision vice the proper name of the individual who is subject to this decision.

On July 16, 2009, Claimant submitted to an IME by Dr. H. Clark Deriso, Employer's chosen physician. (CX 7) Dr. Deriso concluded that Claimant did not require decompression surgery. On August 25, 2009, Dr. Roybal authored a report reiterating that Claimant had a work-related back injury and was a candidate for decompression surgery, which he signed on November 17. (CX 10)

On August 18, 2009 the Employer ceased making TTD payments to Claimant and filed a Notice of Controversion. (CX 22-23) On November 20, 2009, Claimant notified Employer by letter than he wished to go forward with the surgery and reiterated a request for authorization. (CX 20) On December 15, 2009, Claimant asked by letter that Employer advise by December 22 whether it would authorize the surgery. (CX 31) At Claimant's request, the parties scheduled an informal conference on January 27, 2010 to discuss TTD payments and the authorization of further medical treatment, including surgery. The conference was then rescheduled for February 23 at Employer's request. (CX 12-13)

On February 25, 2010, the District Office issued a Memorandum of Informal Conference. (CX 14) The OWCP Claims Examiner ("Examiner") stated that she relied on the recommendations of Claimant's treating physician for medical care. The District Office recommended that

> Claimant be provided the medical care and medications recommended by his choice of treating physician….Since the issue of medical care continues to remain an issue, I recommend that the parties submit three names of physicians that could be used in an IME evaluation in an effort to resolve the issue of need for surgery.

(CX 14-2).

On March 1, 2010, Employer filed a LS-207 form contesting the District Office's findings. (CX 16) On May 7, 2010, Employer scheduled Claimant for a second IME by Dr. Kevin J. Brooks and notified Claimant. (EX 4) On May 10, 2010, Claimant notified Employer that he would not submit to the additional examination. (EX 5) Claimant asserted that Employer had already exhausted its right to request an IME under 33 U.S.C. § 907(d)(4).

On October 14, 2010 Employer filed a motion with this administrative law judge (ALJ) to compel Claimant to submit to the requested examination. Employer asserted that "nothing within the LHWCA or its implementing regulations prohibit[s] an employer from requiring an injured employee to submit to more than one independent examination by a physician of its choice." (Motion to Compel at 3) Employer argued that over a year had passed since Claimant's last examination. *Id.* It also argued that the District Office's recommendations supported its request. *Id.*

Claimant filed a memorandum in opposition to Employer's Motion to Compel on November 4, 2010. On November 17, 2010, Claimant submitted a supplemental letter from Dr. Roybal. In the letter, Dr. Roybal indicated that it remained his recommendation that Claimant undergo decompression surgery. Claimant maintained that this letter rendered Employer's claim that an updated examination was necessary moot.

Employer filed a reply brief on December 22, 2010. In its brief, Employer submitted three factors supporting the reasonableness its request: (1) the disagreement of medical opinions between Drs. Deriso and Dr. Roybal; (2) the fact that Claimant's last examination, by Dr. Deriso, occurred over one year prior on July 16, 2009; and (3) the existing disagreement over Claimant's entitlement to disability benefits. (Employer's Reply Brief at 3-4) Employer further argued in its brief that Claimant failed to provide any reasonable basis for his refusal to submit to Dr. Brooks' examination. (*Id.* at 4) It argued that a report signed by Dr. Roybal on November 17, 2010 did not actually indicate that Dr. Roybal had seen or evaluated Claimant since June 2009. (*Id.* at 4-5) Rather, the note simply reinforces the disagreement

between Drs. Roybal and Deriso and the reasonableness of Employer's request for examination. *Id.* I note that the evidence shows that Dr. Roybal did examine Claimant again on August 25, 2009, at which time he also reviewed Dr. Deriso's opinion, and, based on all of that information, again recommended that Claimant undergo the surgery. (CX 5)

The parties appeared for a hearing before me on January 12, 2011. On March 7, 2011, Claimant submitted a letter stating that, following the hearing, Claimant had seen Dr. Roybal for a follow-up examination. On March 25, 2011, Claimant submitted as evidence a letter from Dr. Roybal summarizing Claimant's examination on February 10, 2011. (CX 2a)

Dr. Roybal's February 10, 2011 report stated that on physical examination, Claimant had positive findings of tenderness to palpation of the right sciatic notch and right SI joint; increased pain with lumbar extension; and positive seated straight leg raise on the right; otherwise Claimant was normal. His continued diagnosis was degenerative spondylolisthesis and lumbar stenosis. Dr. Roybal took four x-rays of the lumbar spine that showed disk space collapse and anterior spondylolisthesis at L5-S1. The doctor stated that Claimant had experienced no significant relief of his pain with conservative treatment options. Therefore, he "would like to proceed with more definitive surgical intervention to address the level of L5-S1 which would require reconstruction of the disk space and stabilization for this segment with a fusion. I feel that he would most benefit from both an anterior and posterior approach." Dr. Roybal prescribed Norco 10, Ultram and ibuprofen to keep Claimant comfortable in the meantime. *Id.*

On May 13, 2011, Employer submitted EX 12, a letter from Dr. Deriso dated March 29, 2011. Dr. Deriso had reviewed Dr. Roybal's most recent letter and opined that Claimant was over two and a half to three years from his injury and "mainly has back pain." After reviewing the findings and video surveillance and in light of the relevant time frame, Dr. Deriso reiterated that he did not believe "it would be efficacious to approach [his] problem surgically. Doing this major type of surgery for back pain only with no significant radiculopathy would not be indicated." (EX 12)

B. <u>Law and Discussion</u>

Section 907(d) governs when a claimant under the Act shall be reimbursed by his or her employer when he or she has paid his or her own expenses. Section (d)(1), states, in pertinent part:

> (d) Request of treatment or services prerequisite to recovery of expenses; formal report of injury and treatment; suspension of compensation for refusal of treatment or examination; justification
>
> (4) If at any time the employee **unreasonably refuses** to submit to medical or surgical treatment, or to **an examination by a physician selected by the employer**, the Secretary or administrative law judge may, by order, suspend the payment of further compensation during such time as such refusal continues, and no compensation shall be paid at any time during the period of such suspension, **unless the circumstances justified the refusal**.

33 U.S.C. § 907(d) (emphasis added). The Benefits Review Board ("Board") has held that the analysis under § 907(d)(4) consists of two prongs. Under § 907(d)(4), the claimant's refusal to submit to medical treatment or examination must be both (1) unreasonable**,** and (2) unjustified by the circumstances. *Pittsburg & Conneaut Dock Co. v. Director, Office of Workers Compensation Programs*, 473 F.3d 253, 261 (6th Cir. 2007); citing *Malone v. Int'l Terminal Operating Co.,* 29 BRBS 109 (1995); *Hrycyk v. Bath Iron Works Corp.*, 11 BRBS 238, 240-41 (1979). This analysis is commonly known as the "*Hrycyk* test."

Under the test, the initial burden of proof is on Employer to show that Claimant's refusal was unreasonable. *Hrycyk*, 11 BRBS at 241-42. If Employer carries its burden, the burden shifts to Claimant to show that the circumstances justify the refusal. *Id*. The "reasonableness" of a particular refusal is an objective inquiry. *Id*. The principle question is: "what course would an ordinary person in the claimant's position pursue?" *Id*. On the other hand, "justification under the circumstances" is a subjective inquiry, focusing on the individual claimant's particular reasons for refusal. *Id*. The ALJ's determination of whether the refusal is reasonable or unreasonable is an issue of fact which will be upheld so long as it is "supported by substantial evidence in light of the whole record." *Pittsburg & Conneaut Dock Co.*, 473 F.3d at 261; *see also Gulf Best Elec. Inc. v. Methe*, 396 F.3d 601, 604-605 (5th Cir. 2004).

1. Employer has failed to carry its burden

Employer argues that Claimant's refusal to submit to an IME was not objectively reasonable because (1) at the time of the motion, Claimant's last physical examination had occurred over one year prior on July 16, 2009; (2) the District Office's recommendation supported its argument; and 3) it was necessary to resolve the disagreement of medical opinions between Drs. Deriso and Roybal.

The fact that on February 10, 2011, Claimant underwent a full physical examination by Dr. Roybal, with a set of x-rays, moots the argument that the current state of knowledge on Claimant's physical condition is outdated to July 2009. Further, Employer is actually incorrect in its assertion that Dr. Deriso performed the most recent exam because the record shows Claimant was examined again by Dr. Roybal on August 25, 2009. Dr. Roybal reviewed Dr. Deriso's report at that time and concluded that he still recommended the surgery. (CX 5) A physical examination by Dr. Brooks is not necessary to update the record on Claimant's current condition, therefore I do not find this argument convincing.

Employer's assertion that the District Office's recommendation supports its motion conveniently omits the particulars of that recommendation. On February 25, 2010, the District Office recommended "that **the parties submit three names** of physicians that could be used in an IME evaluation in an effort to resolve the issue of need for surgery." (CX 14-2)(emphasis added) It is clear from the language of the recommendation that both parties, Claimant and Employer, were to mutually submit three physicians as candidates to conduct an IME.[4] Rather that following this recommendation, Employer sent a letter to Claimant on May 7, 2010, announcing, "We have scheduled an IME for your client with Dr. Kevin Brooks." The letter provided the address and time at which Claimant was to report and enclosed a check for mileage reimbursement. (EX 4)

Employer did not consult with Claimant on the choice of physician, nor did it suggest three options. Very clearly, "the parties" did not "submit three names of physicians that could be used" to resolve the issue. Instead, Employer unilaterally scheduled Claimant for an IME with a doctor of its own choosing, who is located 70 miles away from Claimant. The recommendation from the District Office had the intention of creating a pool of three mutually-agreed-upon doctors for the IME, in an attempt to both resolve the issue and eliminate the problem of bias. Employer's one-sided actions did not serve this purpose, in letter or in spirit. Therefore the argument that Employer was complying with the recommendations of the District Office is unsupported and unpersuasive.

[4] I note that the District Office made this recommendation as far back as November 3, 2009, stating, "employer/carrier is reminded that Dr. Deriso is not the Claimant's authorized treating physician. They should submit Dr. Deriso's findings to the authorized physician, Dr. Raphael R. Roybal, to get his opinion regarding a return to work and future medical care. If he disagrees with Dr. Deriso, Claimant's benefits should be reinstated. If this dispute continues, the parties should attempt to identify a physician to conduct an IME." (CX 21; EX 6)

Employer argues that Dr. Brooks' IME is necessary to resolve the disagreement of medical opinions between Drs. Deriso and Roybal. The District Office recommended *an* IME by a physician suggested by *the parties* to help resolve the issue; the specific IME of Dr. Brooks, chosen by Employer alone, is not itself necessary. There were other methods to accomplish this objective; one of which would have been to follow the District Office's measured recommendation. I do not find this argument persuasive.

Employer also argues that the language of the statute refers to "an examination," which does not imply that it is limited to one and only one examination during the course of a claim. Claimant acknowledges that there is no limitation on the number of IMEs authorized by the Act, but counters that it does not provide for unlimited IMEs on demand. Claimant argues that Employer seeks another IME solely to shore up the opinion of Dr. Deriso, as a unilateral maneuver rather than an attempt to mutually agree upon a third physician. Claimant notes that Employer's selected physician, Dr. Brooks, is 70 miles from Claimant's home and that there are a number of qualified orthopedic and neurosurgical surgeons in Savannah, 11 miles from Claimant's home. Claimant specifically mentions Drs. Louis Horn and Cliff Cannon, noting that Dr. Deriso himself refers patients to Dr. Cannon. Claimant argues that the selection of Dr. Brooks shows bias on the part of Employer. This argument by Claimant is supported by Employer's decision to disregard the mutual solution recommended by the District Office.

Taking all of the above into consideration, I find that Employer has failed to carry its burden to show that Claimant's refusal was objectively unreasonable. An ordinary person in Claimant's position would pursue the course of avoiding an IME that shows a strong possibility of bias against him, especially when the Board recommended a more balanced approach.

The burden need not shift to Claimant, and he is not required to show that, subjectively, the circumstances justified the refusal.

In conclusion, Employer has failed the *Hrycyk* test and Claimant's refusal to submit to the IME with Dr. Brooks is not unreasonable. Under Section 907(d), I will not order the suspension of the payment of further compensation during such time as such refusal continues. Further, any suspension of such compensation that may have occurred at any time during the period of refusal was not justified under §907(d).

Therefore, I deny the motion to compel.

II. EMPLOYER MUST AUTHORIZE THE MEDICAL SURGERY RECOMMENDED BY DR. ROYBAL

A. Summary of Relevant Evidence

1. Claimant's January 12, 2011 Hearing Testimony (TR 20-90)

Claimant began working on the waterfront in 1996 or 1997. He was working shipside on the dock as a longshoreman for Employer on October 11, 2008, when he sustained a lower back injury. He reported the injury to the stevedore immediately; the stevedore was on site and saw the incident. Claimant was pretty sure he finished his shift, working for another four or five hours, but could not be certain of the details. His job involves unlocking containers on ships so that cranes can move the containers.

The pain started just after the incident at a 7 out of 10, and over the next couple of days escalated to being unbearable. The pain radiated down his right leg, and he reported it when he saw Dr. Hoffman

several days later. He also reported it to Drs. Roybal and Deriso. Claimant selected Dr. Hoffman, who had treated him for a prior work injury.

Claimant described two prior work-related injuries. The first was a dock accident in 1997 or 1998, and he was hit in the head by a forklift blade. That resulted in a neck fusion surgery, a nasal surgery, and pain in his left leg. In the second accident, he was dropped about 14 feet from a crane, resulting in surgery on both of his knees and mild pain in his left shoulder and the area of his back near that shoulder. Dr. Hoffman treated him after the second accident, including performing the knee surgeries.

When Claimant saw Dr. Hoffman after the 2008 accident, Claimant described the pain as severe. "I felt like I had a golf ball in my [right] buttocks and just sharp pain going all the way down [the front of my right leg] to the tip of my toes, which had numbness." (TR 32-33) On the day of the hearing, Claimant still had that numbness and the pain flared up often, but was not constant every day like it was at the beginning. He also had some pain in his left leg, which a doctor, possibly Dr. Roybal, told him was natural because he was favoring the right leg and therefore put more pressure on the left leg to compensate.

Dr. Hoffman prescribed epidural shots, and Claimant underwent two or three sessions which provided relief. He attended an estimated eight PT sessions and was prescribed Ultram (tramadol) and hydrocodone. Claimant returned to work around February 1, 2009, about two weeks after the last series of epidurals. He was feeling good and though he had a few weeks of disability left, Dr. Hoffman released him to work upon request. He took the medications as instructed until he returned to work, at which time he stopped because he could not function under the hydrocodone and he worried that it would result in a false positive on random drug tests. He was pain-free for about six months. While working he occasionally takes the tramadol but usually uses ibuprofen. The ibuprofen is by prescription from Dr. Roybal and perhaps Dr. Hoffman, at a dosage of 800mg. He feels comfortable working with the ibuprofen but testified that the tramadol sometimes impairs his ability to work. However, since it will not cause a false positive in drug testing, he is less hesitant to use it while working than the hydrocodone.

The pain returned gradually, but there was no new injury. Claimant described the symptoms as the "same from day one when I first got injured." He had been warned that the epidural shots would wear off and believes that this is what happened. He immediately called Employer's carrier representative, Kirby Ford, and told her he "couldn't hardly move" and needed to see Dr. Hoffman. (TR 36) Employer authorized treatment under Dr. Hoffman, and Claimant saw him on or about June 8, 2009. Claimant could not remember if he saw Dr. Hoffman once or twice before the referral to Dr. Roybal. He thought Dr. Hoffman prescribed some PT, with which Claimant complied to the best of his ability.

Dr. Hoffman or Roybal mentioned the possibility of another series of epidurals, but Claimant was concerned about the weight gain he had sustained during the last series and the temporary nature of the relief. He testified that he has not had another set of epidurals "[b]ecause Ms. Ford disabled my benefits." (TR 79) He has not used his health insurance for epidurals because he did not want a conflict and thought workers' compensation should be paying for them. Further, no doctor has recommended another set of epidurals. The last recommendation made to him was in June 2009, when Dr. Roybal recommended surgery. Claimant had been concerned about repercussions later in life because he was only 40 at the time and intended to return to work.

Claimant testified that he saw Dr. Roybal two or three times in 2009. Dr. Roybal recommended surgery, which Claimant agreed to undergo after asking some questions. He believed he saw Dr. Roybal a third time after he went to Dr. Deriso. He did not see Dr. Roybal in 2010 or 2011 because he was not authorized to do so and Ms. Ford "cut all my medical off." (TR 72, 88)

On the day of the hearing, he testified that he still wanted to have the surgery and return to work. He stated that he would be willing to pay out of pocket to see Dr. Roybal again if Employer wanted an updated opinion from that physician. However, he testified he does not have the money to afford that care. He stated his annual income is $72,000.

Claimant described his pain on a typical day at the time of the hearing. He stated he has to have the surgery because he has so much pain he can hardly function. He begins each day with a hot shower or bath to soak his back. This will sometimes loosen things up enough that he can make it through the day, but if it does not, he has to return to bed.

The degree of pain is not constant and some mornings he wakes up and feels good, but after 30 minutes standing up at work he cannot continue. When this happens, he usually has to quit and one of his coworkers, who knows what he is going through, will offer to help him. The coworkers will tell him to sit down and help him complete the work. In particular, Claimant has a partner who does as much of Claimant's job as he can when Claimant is unable to work due to pain. Claimant physically cannot work every day that he wants to. The pain problems occur with physical activity, particularly on the job, but he testified that even at a wedding four months earlier, he had difficulty serving as the best man because of the amount of standing required.

Claimant is covered by Cigna group health insurance through his union, and he thought it would cover the surgery. He has not gone to them to pay for the surgery because this is a work-related injury and he does not want to use his health insurance for it when it should be covered by Employer. To his knowledge, Cigna does not cover work-related injuries. He used his insurance for Drs. Cheng and Castrini, who treated personal health problems unrelated to work. He has used his insurance to pay for prescriptions from his primary care physician, Dr. Theodore Geffen. When Dr. Geffen was out, Claimant saw Drs. Miller or Griffin. None of these doctors treated him for anything related to work accidents.

Dr. Geffen prescribed medication for gout (hydrocodone, tramadol, and naprosyn), and a spider bite (antibiotic and hydrocodone). The hydrocodone made him too relaxed to function at work, and he missed work for both of these injuries. He does not contend that the gout or spider bite were work-related.

He testified that he received letters from Ms. Ford telling him he had to go back to work and that his benefits were being cut off. Employer terminated the prescription medication from Dr. Roybal, but Claimant did not know why. Sometime after his last visit to Dr. Roybal he went to obtain a refill he was told workers' comp would not allow it. He testified that he went to Dr. Roybal around June 8 and Employer would not authorize anything, including epidurals, physical rehabilitation, or surgery. He testified that for three months until August he had no treatment, but did receive workers compensation payments.

He is currently making as much money as he did before he was hurt because he has established sufficient union seniority that he can take jobs with overtime options; for example, working on the weekend pays overtime. However, he is not making the hours he would be able to make if he were healthy. He testified that other employees in his section made 2500 hours in 2010 but he only made 1328 hours. He'd like to work 45-60 hours per week, but cannot. Without the injury, he would be able to drive trucks and work on the shoring gang[5], a premier job. Those jobs are open to him but he cannot take them. He cannot work on the shoring gang because it requires too much lifting and bending. He would have to lift a two-high lashing rod, which weighs between 20 and 30 pounds; he has tried to lift this much and knows it is more than he can handle now. He wears a vest with a pad tied to it and has to constantly lean

[5] This assignment is also called the "lashing gang."

up against or sit on something. A doctor did not prescribe the padding. As a result of his pain, he has to be selective and limit the kinds of jobs he can accept.

Employer's carrier representative, Ms. Ford, sent Claimant to Dr. Deriso on July 16, 2009. He saw the doctor for about ten minutes, during which time he walked back and forth seven or eight feet and the doctor tested leg reaction and elevation. He told Dr. Deriso about the numbness in the right leg down to the top of his right foot. He testified that he asked the doctor questions but the doctor did not ask him questions. He described the numbness and pain as a constant sensation (or lack thereof). He has pain standing up straight, making it difficult to cook, wash dishes, or use the restroom without bending at the waist to get relief from the pain.

Claimant testified that he had not experienced any lower back pain before October 11, 2008, and testified that this injury did not exist before that date. He further stated that it did not result from anything occurring after he went back to work on February 1, 2009.

Claimant enjoys being active, walking in the park and deer hunting. He cannot walk for exercise like he used to. He testified that he attempted to do so a few times in the last year, but got halfway around the park and had to give up. He is single and has to go to the grocery store and take care of house chores. He has a valid driver's license without restrictions. The only time he left the Savannah area in the last year was to go to a football game in Atlanta, but his friend drove.

He is in a hunting club with his father, and continues to hunt as much as he can. He has hunted several times since the accident, but participates less in the actual hunting than he used to. He estimated going to the hunting club twice a week, but often it was not to hunt but for social reasons. He frequently waits in the camper for his friends and sometimes cooks for them if he feels well enough. Claimant clarified that he often goes out with his father as part of the hunting party not necessarily to physically hunt but because he has been doing it for 30 years and he prefers it to sitting around the house. He does not overnight on the hunting grounds anymore; his own bed is more therapeutic. He owns an ATV and often rides it to the deer stand because he cannot walk the distance of 300 yards.

He sometimes hunts from stands, which require him to climb an eight-foot ladder, but lately has been using ground blinds. He cannot climb into the fourteen-foot blinds anymore. Climbing the eight-foot ladder is like the climbing he does to get onto the ships at work. He succeeded in killing two deer since the accident, but his buddies helped him and he did not lift the deer on either occasion. He used to use the ATV to ride much longer distances like five miles before the accident, but now restricts himself. He noted that he is not and has never claimed total disability; he is partially disabled and in pain.

Claimant's counsel played part of a silent DVD video, and Claimant identified himself exiting a Wal-Mart pushing a grocery cart. The video is time stamped November 18, 2008 but because he is a frequent customer at this store, Claimant did not have a specific recollection of this visit. Claimant unloaded groceries from the cart into his car and closed the top. At this point a technical malfunction prevented further viewing in the hearing. Claimant went on to testify that he picked up this DVD, labeled "Inquest," from Dr. Deriso's office. On the same trip, he also picked up a disc labeled "Chatham Orthopaedics" and "x-rays" with Claimant's name. This errand was prompted by a request from his attorney to retrieve an MRI from Dr. Deriso's office.

2. Dr. R. Dow Hoffman (CX 2, 5, 29, EX 1)

Dr. Hoffman is a Board-certified Orthopaedic Surgeon. He served four years as an orthopaedic surgeon in the U.S. Navy, and has practice as a general orthopaedist with Chatham Orthopaedic

Associates since 2003. He specializes in knee and shoulder surgery and provides medical care to several local athletic teams.

October 15, 2008

Claimant reported to Dr. R. Dow Hoffman as a new patient to the clinic, with complaints of right leg and back pain. Claimant made a sudden move on October 11, 2008 and developed pain in the back radiating down his right buttock into his right leg. The pain had been "quite severe" and while Claimant had been able to bear weight, he was having difficulty working. Physical examination showed positive straight leg raise on the right and tenderness to palpation in the lower LS spine. Dr. Hoffman reviewed L-spine x-ray films but appreciated no significant abnormalities. Dr. Hoffman assessed Lumbar HNP and prescribed Lorcet and Tramadol. He recommended an MRI and epidural steroid injection, and took Claimant completely off work status.

Dr. Hoffman's conservative treatment October 2008 – January 2009

- 10/22/08: MRI of the Lumbar Spine without Contrast, administered by Coastal Imaging, ordered by Dr. Hoffman. The MRI was indicated by low back and right leg pain.

  The MRI was read by Dr. Jack Considine, whose impressions were:
  1. Moderate severe left and moderate right foraminal narrowing L5-S1 secondary to mild spondylolisthesis, spondylosis, and face degeneration
  2. Shallow, broad-based posterior protrusion L5-S1 without significant mass effect
  3. Very small L4-5 right foraminal protrusion

- 10/23/08: First epidural steroid injection. Dr. David Estle, the interpreting radiologist at SouthCoast Imaging Center, noted that Claimant had been referred by Dr. Hoffman for low back pain radiating down the right leg. Dr. Estle knew Claimant from prior facet joint injections in 2006. He reviewed the MRI and stated that it showed multilevel degenerative disc disease ("DDD") and a small right foraminal L4-5 disc protrusion. On examination, Claimant complained of pain in the right L4, L5, and S1 distributions.

- 10/31/08: Follow-up. Since his last visit, Claimant underwent an MRI and epidural examinations. He continued to report pain in his back and leg, but it was better since the injection. He was taking ibuprofen. Physical examination revealed minimal tenderness to palpation in the along the posterior element of the L-spine, and uncomfortable straight leg raise at 90 degrees bilaterally.

  The MRI of the L-spine revealed moderate to severe left foraminal stenosis and moderate right foraminal stenosis at L5-S1 with spondylolisthesis and degenerative changes. It also showed a shallow broad based disc protrusion at L5-S1 and a small L4-5 right foraminal protrusion.

  Dr. Hoffman assessed LS spondylosis with a herniated disc at L4-5, right. As Claimant had improved with the epidural, two more were scheduled, and he was prescribed ibuprofen 800mg.

- 11/14/08: Follow-up. One epidural steroid injection had taken place, but his symptoms were unchanged from the prior visit and he continued to complain of pain radiating down the leg. Physical examination revealed mild discomfort with straight leg raising. Dr. Hoffman assessed lumbosacral spondylosis. Claimant remained completely off work and was to start PT.

- 11/14/08 -12/12/08: Several physical therapy sessions. Pain level in low back stayed constant at 7/10, with only moments of relief. Claimant described pain as sharp burning in the low back and down the right leg, and numbness in the right leg.

- 11/19/08: Second epidural steroid injection. Dr. Estle commented, "Excellent relief of right S1 distribution pain since the previous injection[;] now with continued L4 and L5 region pain."

- 12/1/08: Follow-up. Two injections had taken place and Claimant was in PT. He continued to have pain in his back radiating into his leg, with slow improvement. Physical examination revealed minimal tenderness to palpation in the paraspinus muscles, and no pain with straight leg raising. Dr. Hoffman's assessment was unchanged. Work restrictions continued.

- 1/12/09: Follow-up. Three injections had taken place. Pain is resolving, almost 70% pain-free. Claimant still had some numbness in his foot and anterior shin, minimal tenderness to palpation in the paraspinus muscles, and no pain with straight leg raising. Dr. Hoffman assessed low back pain doing well with conservative treatment and Claimant will return to duty on 2/1/09. Dr. Hoffman's disability certificate noted that Claimant "was unable to work in December because no light duty work was available while he recovered from his injury."

June 8, 2009

Dr. Hoffman saw Claimant for follow up of back and right leg pain. Epidural steroid injections had been administered during the fall of 2008, and Claimant was doing "reasonably well" but over the past couple of weeks his pain had returned. His pain had become severe over the weekend and he was unable to go to work on June 7. Claimant described pain in the right buttock radiating down the right leg.

Dr. Hoffman reviewed Claimant's past medical, surgical, social, and family histories and took a complete review of systems. Physical examination revealed antalgic gait favoring the right side, pain with straight leg raising, and limp when ambulating.

Dr. Hoffman assessed L5-S1 DDD with central foraminal stenosis. He prescribed Medrol to help with the symptoms and scheduled a second opinion with Dr. Roybal.

3. Dr. Raphael R. Roybal (CX 2a, 5, 30, EX 1)

Dr. Roybal is a Board-certified Orthopaedic Surgeon with extensive experience in spinal surgery. His practice and continuing education revolve around spinal surgery. (CX 30)

June 18, 2009

Claimant reported injury in October 2008 when he made a sudden move pulling a box or crate and felt a deep pulling in his low back with pain radiating down the leg. Dr. Roybal summarized Claimant's prior course of treatment noting core strengthening with PT, two epidural steroid injections over the last few months, ibuprofen, and occasional Ultram. The PT yielded little to no benefit, and the injections helped significantly but temporarily and led to 12 pounds' weight gain. Claimant felt the injections had lost their effectiveness and was not really interested in pursuing this course further. Claimant tries to avoid narcotics.

The right leg radiculopathy was recurring and holding him back from work. Claimant had experienced significant right leg symptoms radiculopathy since October. He had been working until the pain and symptoms became unbearable two weeks earlier. At the time of the examination, his walking tolerance was less than one block, his legs fatigued easily, and he had pain with coughing. Bending forward, resting, sitting, and lying down gave some relief. The pain was exacerbated by standing or walking, and he was unable to perform any significant physical activity.

Dr. Roybal summarized Claimant's medical history, noting anterior cervical fusions by Dr. Wirthin in the 1990s, knee surgery in 2006 by Dr. Hoffman, and other epidural injections that were only

transiently helpful. Claimant was in consultation with Dr. Hoffman, and Dr. Roybal reviewed his chart, a back questionnaire, and his Oswestry Disability form.

Claimant noted on the back questionnaire, dated 6/18/09, that

- his low back pain was very severe at the moment
- It is painful to look after myself and I am slow and careful
- I cannot lift or carry anything at all
- Pain prevents me walking more than 100 yards
- Pain prevents me sitting more than 1 hour
- Pain prevents me from standing for more than 10 minutes
- My sleep is occasionally disturbed by pain
- Pain has restricted my social life to my home/I do not go out as often
- Pain restricts me to short necessary journeys under 30 minutes

Physical examination revealed no distress, but Claimant was holding his leg out to the right side in attempts to gain comfort and walked with a noticeable limp, dragging his right leg and favoring it. He had increased pain with extension at 5 degrees and his forward flexion reached only the mid-thigh. There was guarding of the paraspinal musculature, and increased pain with seated straight leg raise in the right side. Claimant described pain in the posterior buttocks and thigh, into the anterior aspect of the anterolateral tibia to the dorsum of his foot. He had normal muscle strength throughout except on the right side with ankle dorsiflexion. Right side knee reflexes were decreased compared to the left.

Dr. Roybal reported that x-rays of the lumbar spine show a sacralized lumbar S1 segment that is not fully segmented. L5-S1 had a grade 1 spondylolisthesis, significant facet arthropathy and what appeared to be body foraminal stenosis. It also showed disk height loss and some degenerative change in the lumbar spine.

The MRI report was available and confirmed grade 1 spondylolisthesis with a transitory lumber segment at L5-S1, significant disk height loss, and mild lumbar spondylosis throughout the rest of the lumbar spine. The MRI showed grade 1 anterolisthesis with significant bilateral neural foraminal stenosis.

Dr. Roybal assessed spondylolisthesis at L5-S1 with significant foraminal stenosis. He would like to review the MRI personally to make sure there is no pars defect and confirm degenerative spondylolisthesis. He prescribed Ibuprofen 800mg and Ultram. He noted that Claimant has no lumbar surgical history, and was interested in options at this point. They discussed the goal of surgical intervention: decompression of neural foramen and stabilization of the spondylolisthesis. Claimant was in agreement and wished to proceed with the surgery, and Dr. Roybal believed they would probably proceed with the decompression fusion.

Claimant "at this point is unable to work, light duty I believe would be appropriate if available."

<u>August 20, 2009</u>

Dr. Roybal was provided a copy of Dr. Deriso's IME with the notification from Employer that "per Dr. Deriso's report of 7/8/09, surgery is denied on [Claimant.]"

<u>August 25, 2009</u>

On this date, Dr. Roybal examined Claimant and authored a report. Claimant was born on November 8, 1960. The doctor noted Claimant's history of PT and epidural steroid injections that worked transiently but, after a course of three, Claimant still had persistent symptoms. The doctor described him as "suffering greatly with significant leg pain. Interestingly, he describes no back pain which is a good indicator of the fact that he is suffering from the apparent neural compressive lesion that is apparent on his MRI."

Dr. Roybal noted that his initial assessment of isthmic spondylolisthesis was "readily apparent on both [the] MRI [and] radiographs with significant foraminal stenosis which is also commented on by the neuroradiologist reading his MRI." The doctor noted that the second opinion of Dr. Deriso found a normal lumbar spine with age-related degenerative changes, pointing out that this opinion made no mention of spondylolisthesis or foraminal stenosis.

Physical examination revealed increased pain with forward flexion to the mid-thigh; some pain with extension seemingly originating into the posterior buttocks; some decreased strength with dorsiflexion of the left lower extremities at 4+ to 5/5, and described pain radiating through the buttocks, anterolateral aspect of the leg and into the anterior aspect of the shin to the dorsum of the foot.

Reviewing x-rays that were obtained that day, the doctor noted some progression of spondylolisthesis at L5-S1 with slight reduction with extension, where he found a grade 1 spondylolisthesis apparent. He noted a lumbarized sacrum that appeared to have a lumbar vertebra at S1 that was not fully segmented. The MRI was unavailable that day, but Dr. Roybal reviewed the radiologist's report, which indicated again an L5-S1 spondylolisthesis with neural foraminal stenosis bilaterally affecting the L5 nerve roots left worse than right.

Dr. Roybal concluded that his medical opinion as a spine surgeon was a diagnosis of isthmic spondylolisthesis at L5-S1 with significant neural foraminal stenosis and concordant pain through the lower extremities. "I would not consider this an age-related spine. I would consider this a spine with a structural abnormality that does appear to be symptomatic in this gentleman who has failed conservative therapy." Claimant had "proceeded with the symptoms for quite some time and has failed epidural steroid injections, as well as PT and time and has persistent pain."

The doctor stated Claimant was a candidate for decompressive stabilization surgery. Claimant was suffering through work and required pain medication. Dr. Roybal recommended L5-S1 circumferential stabilization and decompression with pain medication in the intervening time. He prescribed Norco and ibuprofen 800 mg.

<u>November 17, 2009 Statement (CX 10)</u>

Dr. Roybal confirmed in a statement signed on 11/17/09 that he had reviewed Dr. Deriso's report dated 7/16/09 and disagreed with the opinion that "there are no hard and fast objective findings to substantiate the chronicity of" Claimant's complaints. He also confirmed that he continued to opine that surgery is indicated as set forth in his 8/25/09 report, and that Claimant should discontinue working as a longshoreman pending surgery and recovery.

<u>November 16, 2010 Statement (CX 9)</u>

Dr. Roybal confirmed in a statement signed on 11/16/10 that he continued to hold the opinion that surgery is indicated as set forth in his 8/25/09 report, and that Claimant should discontinue working as a longshoreman pending surgery and recovery.

<u>February 10, 2011 Report (CX 2a)</u>

Dr. Roybal saw Claimant on this date for follow up of his degenerative spondylolisthesis and lumbar stenosis. On physical examination, Claimant had positive findings of tenderness to palpation of the right sciatic notch and right SI joint; increased pain with lumbar extension; and positive seated straight leg raise on the right; otherwise Claimant was normal. His continued diagnosis was degenerative spondylolisthesis and lumbar stenosis. Dr. Roybal took four x-rays of the lumbar spine that showed disk space collapse and anterior spondylolisthesis at L5-S1. The doctor stated that Claimant had experienced no significant relief of his pain with conservative treatment options. Therefore, he "would like to proceed with more definitive surgical intervention to address the level of L5-S1 which would require reconstruction of the disk space and stabilization for this segment with a fusion. I feel that he would most benefit from both an anterior and posterior approach." Dr. Roybal prescribed Norco 10, Ultram and ibuprofen to keep Claimant comfortable in the meantime.

4. Dr. Deriso (IME) (EX 2, 11; CX 7, 8, 33)

Claimant saw Dr. H. Clark Deriso, a Board-certified orthopedic surgeon, at Employer's request on July 16, 2009, for chief complaints of pain in his back and right buttock. Dr. Deriso has been in private practice as an orthopaedist since 1975.

Claimant reported that he was injured with a sudden bending move on October 11, 2008. Dr. Deriso noted that he was treated conservatively by Dr. Hoffman, who diagnosed lumbar strain and ordered an MRI. The MRI showed some spondylosis and DDD and "a questionable slippage" at L5-S1. Claimant got better after epidural injections and returned to work in February 2009 after "relief of some of his symptoms." Dr. Deriso stated there was a repeat occurrence in June 2009 and Claimant saw Dr. Hoffman again, who referred him to Dr. Roybal. Claimant was entertaining surgery due to some pain in the back and right buttock area. "He denies any true radiculopathy, has more numbness in his leg and an ache. I kept questioning him about this, and again, it is not radicular." Claimant reported relief when lying down, that he was on ibuprofen alone for pain, and had not worked since June 2009.

Physical examination revealed straight leg raising in the sitting position at about 90 degrees, causing some lateral thigh pain that did not appear to radiate down the back and down his leg "like true sciatica." Claimant's hip caused some discomfort on movement, but there was no evidence of arthritis. The figure four test on flexion of the hip and knee caused pain in the leg and back. Dr. Deriso stated that "this should relax his sciatic nerve." Neurologically Claimant was normal. Toe and heel walks were done with some difficulty, but it was not due to any abnormality of muscular strength. Claimant had some guarding on range of motion of his lumbar spine.

X-ray film showed "a possible 2mm spondylolisthesis at L5-S1 although it is very difficult to ascertain on these plain films." Dr. Deriso stated that it was not congenital spondylolisthesis. He reviewed the MRI, which revealed "evidence of some DDD which is normal for his stated age."[6] Dr. Deriso saw neither significant abnormalities nor slippage at L5-S1.

Dr. Deriso's impression was of chronic back pain, stating that Claimant was out of work for four months with a sprain, and now has had a recurrence. He did not think

> from the paucity of findings along with the MRI and his plain films[,] that there is a lesion that needs to be addressed from a surgical standpoint. In summary, there are no hard and fast objective findings to substantiate the chronicity of his complaints….I do not think surgery is indicated.

[6] Dr. Deriso's report and deposition vacillate between referring to Claimant as 38 and 48 years old. The latter was the correct age at the time of the examination.

(EX 11) On August 7, 2009, Employer wrote a letter to Dr. Deriso stating that his report did not indicate Claimant's work ability and asked for his medical opinion regarding a return to Longshore work.

On August 10, 2009, Dr. Deriso wrote a letter to Employer stating that he had reviewed the findings and surveillance video and did not think Claimant "has any significant problems and should have been able to return to work. I think that his return to work should have been two to three weeks following his accident, but he certainly can return after the evaluation of 7/16/09." (CX 25-6)

Deposition (CX 33)

Employer deposed Dr. Deriso on January 27, 2011.[7] Claimant was represented at the deposition. Dr. Deriso testified that he examined Claimant for 15-20 minutes. He stated that he has done some examinations for Ceres and Employer's counsel before, but he wasn't sure which entity paid him for the exam.

The doctor stated that the lateral thigh pain experience by Claimant on the straight leg raising was essentially almost normal. He testified that the back pain upon the Figure Four test was an incredulous response because usually, when someone with ruptured disc, sciatica, or nerve-root impingement flexes the hip and knee, the back relaxes. The muscle guarding on range of motion in the lumbar spine could have been voluntary or involuntary.

Dr. Deriso testified that a 2mm spondylolisthesis was very small and would not be sufficient to cause the symptoms complained of by Claimant. He stated that this takes time to acquire and was a pre-existing problem Claimant would have had for years. He testified that "a lot of MRIs have a lot of false positives. In other words, they're just findings. They have nothing to do with one's complaints." (CX 33-12) He testified that the MRI in this case does not tell the story, it is just a test. This MRI showed "DDD and possible mild spondylolisthesis and a protrusion, but all of these things really are sort of within normal limits in somebody of this man's age."

Dr. Deriso testified that about three percent of the population has the Pars defect he mentioned, which is a congenital defect that Claimant did not have. The doctor summarized that Claimant had been out of work with a sprain for four months, had a recurrence, and there was no pathology or evidence showing a need for surgery, especially a year and a half after his accident. "It's no question he historically may have had a strain, but it didn't seem to be anything more than just a strain." He believed that even if Claimant had aggravated a pre-existing condition, it should have returned to pre-injury level, but he did not think Claimant really had spondylolisthesis. He suggested that the longer a patient goes without getting the surgery, the better an indication that there were no significant findings in the first place.

Dr. Deriso testified that he had no reason to discredit the patient information form filled out by Claimant on July 16, 2009, and no reason to believe that the sudden bending move in October 2008 took place. He testified that he thought Claimant was credible as to the written history of the onset of his pain.

The doctor stated that this type of surgery usually occurs initially when there are significant findings, such as sharp radicular pain requiring narcotic treatment; when the patient does not get well with conservative treatment, bed rest, or time; and when there are positive findings on a test like an MRI, CAT scan, or myelogram.

Dr. Deriso defined "conservative treatment" with respect to back strain as

[7] Deposition testimony that is duplicative or irrelevant to the contested issue has been omitted in the interest of efficiency.

> it means different things to different people, but…usually – depending on the severity or the nonseverity, whether it's mild, moderate or severe, you would treat with let's say non-narcotic medications or narcotic medications if it's an acute strain or radiculopathy, anti-inflammatory medicines, some bed rest, heat and ice, and activity as soon as they can get up and move around.

(CX 33-20) He acknowledged that Claimant had medications, two or three epidural injections, and maybe heat, "but that's just one avenue of conservative treatment." He continued his definition of conservative treatment, saying that it runs a gamut

> from sprinkling owl feathers in a corner to chiropractic manipulation to heat and ice, injections, medication, therapy. You know, it's just really a lot of forms of conservative treatment.
>
> [Upon request for an explanation of owl feathers:]
>
> Well, I'm saying you can sprinkle them in the corner and do just as well with conservative treatment of lumbar disc strains as carrying out the other things. What I'm saying is, as I said in the beginning, it's a self-limiting[8] condition, and everybody who treats them, they generally get well. That's why everybody can tout that they treat back pains and they get such and such a relief, a percentage.

(CX 33 at 21-22). He agreed that Claimant's lumbar epidural steroid injections coupled with PT and staying off work constituted part of conservative treatment. Dr. Deriso himself did not use epidural injections, though he used to. He thought "literature is coming out that – that it's probably like a 50/50 deal" and '"not really strongly" recommended by the scientific, orthopedic, or neurological communities. He acknowledged that many doctors use them, but he did not feel the efficacy was worth the cost. (CX 33-25)

He stated that surgery makes people "in extreme pain better quicker," but carries the downside of the risk of surgery. When asked about this particular surgery, Dr. Deriso said he thought Dr. Roybal "was going to decompress and also instrument and probably fuse." (CX 33-27) He listed risks as: general complications, infection, anesthesia, pulmonary embolus, hitting nerve roots, and persistent back pain.

Dr. Deriso stated that if Claimant were willing to undergo the surgery even with knowledge of all those risks, as well as the risk of paralysis or death, that would still not be enough to illustrate that his complaints of ongoing pain were credible. "Without radiculopathy and really referred pain and numbness and tingling," Dr. Deriso did not believe there was enough to warrant the surgery. Dr. Deriso believed Claimant had "misinformed himself" because "a lot of times" with the symptoms described by Claimant, "we don't even know where the pain generators are, much less…whether or not they're going to be resolved." (CX 33 at 27-28) He reiterated that a lot of these surgeries do not make the problem better. The doctor testified that the success rate of this surgery is very low. He did not think any good studies showed more than a 50/50 chance, which he felt was "not a very good operation to do."

Dr. Deriso described true radiculopathy as radiating from the lumbar region down one leg or from the cervical area down one arm, and that it feels intense like a hot poking knife tearing down the limb. He stated that if a patient reported a dull, numb, or achy pain running down the leg from the buttocks, he would not consider that radiculopathy. He would have expected someone with this kind of pain to be

[8] Dr. Deriso defined "self-limiting" as meaning that the condition will go away on its own over time without treatment. (CX 33-73)

sweating with pain, holding himself a certain way, and experiencing quite a bit of discomfort on the straight leg raise. He stated that historically referred achy or numb pain do not do well with surgery. Dr. Deriso testified that Claimant reported pain in his back and buttocks mainly, but did not denote the hot poking knife type of pain. "He may have had some referred pain…achy and dull and numb…I think in the buttocks primarily. He could have had it down his leg but that doesn't denote anything significant." (CX 33-35) Dr. Deriso testified that true radiculopathy could be reduced with a heavy narcotic like morphine or Dilaudid, but Ultram (or Tramadol) was not strong enough but it could reduce pain. He was aware when he wrote his report that Claimant had tried Ultram. If there were true radiculopathy, the doctor would expect a "markedly straight leg raising test." He did not consider the 10/31/08 report of "straight leg raise uncomfortable at 90 degrees bilaterally" to be such a test, because uncomfortable was normal at 90 degrees. The doctor would look for significant back pain and radicular pain down the leg in this test. (CX 33 at 47, 49)

The doctor confirmed that there was some guarding during his examination, nine months after the original injury, but he could not tell how much was voluntary or involuntary. He was surprised by the guarding so long after the injury. He testified that he uses the terms 'sprain' and 'strain' interchangeably and could not remember if he culled that term from the reports he reviewed or it he was the first doctor to use it.

Dr. Deriso described a 'hard and fast objective finding' as something that can be clinically tested. He stated that he had the benefit of the MRI, x-rays, and radiologist's report dated 10/22/08 when he wrote his medical opinion, but it was "just a report…a radiologist's interpretation."

Upon his actual review of the MRI films Dr. Deriso did not disagree with the radiologist's report "except I'm not sure that this – this is not a congenital spondylolisthesis because he didn't have a Pars defect." (CX 33-42) He acknowledged that the radiologist did not mention a Pars defect anywhere in his report. He went on to state that he was not sure it was really a "true slip" because the slip was small at 2mm. Dr. Deriso clarified that 'spondylolisthesis' means slippage of the spine. He concluded that he had no suggestions to add to the interpretation of the MRI by the radiologist but that Dr. Considine's findings are not diagnoses. Only the "most obvious" findings are diagnoses, such as a Pars defect or a big herniated disc.

Dr. Deriso explained that the interpretation and findings of Dr. Considine was not a hard-and-fast finding that would warrant surgery because "I don't see anything from this, and…you don't operate on MRIs anyway. You operate on people. They have to have findings. The MRI is just sort of like a test that sort of substantiates what you're feeling." (CX 33-46)

Dr. Deriso testified that, disregarding the MRI and Dr. Roybal's findings, there is a paucity of findings on clinical exam and "it doesn't sound to me like a serious injury. You know, he recovered from one. He should recover from the other." (CX 33-24) He clarified the first injury he recovered from was the first sudden movement. Dr. Deriso was not sure of the date of the MRI. Though he had reviewed the records before writing his reports, he was not sure if Dr. Royal found radiculopathy the first time he saw Claimant. If Dr. Roybal had denoted that he found radiculopathy, "I've found out in looking at the records of a lot of physicians, it's just not a lot of differentiation maybe they make between referred pain and radiculopathy."

Dr. Deriso clarified that he and Dr. Roybal had a disagreement about whether the surgery is recommended, but Dr. Roybal has not violated any standard of care by recommending it. However, he did opine that Dr. Roybal's "judgment is not very good as far as operating on somebody with [DDD]." (CX 33-23) Dr. Deriso had performed this type of surgery for 35 years but stopped a year and a half earlier when he turned 65. He did sometimes refer patients to Dr. Louis Horn or Dr. Cliff Cannon for this

type of surgery. Overall, he felt that it was common for patients to undergo unnecessary neck or back surgery, leading to complications. He testified that if Claimant underwent the operation and got better, "it will be despite his surgery." (CX 33-59)

Dr. Deriso described the circumstances under which he would recommend the surgery. "If he had a herniated disc that just happened in the last few weeks and he's got radicular pain and change in his MRI that shows that he has a nerve-root encroachment, you know, I think after a trial of conservative treatment I think a laminectomy would be indicated." (CX 33 at 59-60)

Dr. Deriso testified with respect to the sacralized lumbar segment in Dr. Roybal's x-ray finding, "I think the transverse process [has] a pseudarthrosis with the sacrum. I mean that's all I know about it. I don't think – it's just an x-ray finding but not a lot that we put on it as causation of pain." (CX 33-62)

5. Pharmacy Records (CX 18)

Claimant's pharmacy records show that he was regularly prescribed pain medication from June 2009 through May 2010. Most often he was prescribed Ibuprofen 800mg and Hydrocodone, but occasionally his pain-related medications included Tramadol, Methylprednisone, and Naproxen 500mg.

6. Surveillance Video and Report (EX 8-9, CX 27)

Claimant identified himself in the video, which was ordered by Employer. The license plates show that the SUV and pickup truck are the same throughout. The dvd contains the following footage:

<u>11/18/08</u>

Claimant walks into a Wal-Mart and later emerges and pushes a shopping cart to an SUV. He opens the rear door and shifts contents to make room for his purchases. The items he moves include cases of water bottles and an umbrella. He unloads his purchases into the back of the SUV, including toilet paper and what appear to be two large bags of potting soil. He returns the cart and drives away. There is no visible limp or difficulty walking.

<u>1/3/09</u>

Claimant exits a pickup truck and slowly climbs steps to enter a mobile home. There are several shots zooming in on the bed of the pickup truck, which appears to contain a large cooler and a large plastic storage tub.

<u>1/4/09</u>

Claimant exits the SUV in a Wal-Mart parking lot, enters the store, and exits carrying toilet paper and two small plastic bags that appear to contain something the size of a half-gallon of juice, and perhaps paper plates and/or napkins. He returns to the SUV; the video cuts to Claimant exiting the SUV at the same mobile home about ten minutes later, slowly climbing the same steps and entering the home. The pickup truck from 1/3/09 is parked next to the SUV in front of the home.

<u>1/9/09</u>

This video is shot beginning at 5:02 a.m. and is so dark that for the first few minutes the only visible thing is a pair of headlights, which quickly turn off. After that, a vague light turns on and off in the distance; there is no clearly visible person. At 5:07 a person opens the rear door of an SUV, stands in front of it briefly, and then closes it. In darkness again, the person can vaguely be seen walking around the vehicle. Shortly thereafter the person opens the back door again and removes two small plastic bags, then shuts the door. At 5:09, the pickup truck, which was parked to the left of the SUV, starts up and drives off. At no time is the face of the person visible.

The video cuts to an hour later, and shows a few seconds of the cameraperson is driving down a road, still in darkness. It cuts again to 7:22 a.m., in daylight, and the empty pickup truck is parked next to another truck at the edge of a field, next to a dirt road. The contents of the bed of the truck do not appear to have changed.

The video cuts to an exterior shot of the mobile home at 7:29 a.m., showing the SUV parked alone in front of the home. The video cuts twice more to show the SUV parked alone in front of the home at 5:52 p.m., around 7:30 p.m., and after 5:00 a.m. on 1/10/09.

Report (EX 9)

InQuest, the company that performed the surveillance, wrote reports of their activities. It states that the purpose of the investigation was to determine and document the daily activities and employment status of Claimant. In summary, they found no indication that Claimant was employed. He was occasionally active away from the residence, perhaps hunting. On days at home, he remained inside and out of view.

Going forward into early January 2009, they observed indications that Claimant continued to be active in the sport of hunting, noting overnight absences, hunting clothing, the ATV and gun case, and early morning departures. Claimant appeared to move fluidly at all times and did not wear or use a visible orthopedic device.

They noted that the early morning January 9 footage they followed Claimant in the dark for 44 miles to a community where Claimant had parked his vehicle in a field near a wooded area where he appeared to be hunting. They later saw Claimant travel into the woods.

B. Law and Discussion

Section 7(a) of the Act provides that "[t]he employer shall furnish such medical, surgical, and other attendance or treatment, nurse and hospital service, medicine, crutches, and apparatus, for such period as the nature of the injury or the process of recovery may require." 33 U.S.C. § 907(a) (2006). The parties have stipulated that Claimant sustained a compensable injury on October 11, 2008. Accordingly, Employer is liable for all reasonable and necessary medical expenses arising from Claimant's October 11, 2008 work-related injury and its process of recovery. *Pernell v. Capitol Hill Masonry*, 11 BRBS 532, 539 (1979). Medical care must also be appropriate for the injury. 20 C.F.R. § 702.402 (2009).

Claimant seeks authorization of the medical surgery recommended by Dr. Roybal. However, Employer asserts that the surgery recommended is unnecessary and not related to the injury.

1. Related to the Compensable Injury

A claimant has established a *prima facie* case for compensable medical treatment where a qualified physician indicates treatment was necessary for a work-related condition. *Turner v. Chesapeake & Potomac Tel. Co.*, 16 BRBS 255, 257-58 (1984).

Dr. Roybal's opinion is based on three examinations on June 18, 2009, August 25, 2009, and February 10, 2011. He had reviewed the treatment records of Dr. Hoffman; Claimant's surgical and medical history; the x-ray films of 6/18 and 8/25/09; the 10/22/08 MRI, and Dr. Deriso's report. Dr. Roybal clearly considered the June 2009 pain to be part of the work-related injury. He referred to the initial failed conservative therapy that occurred directly after October 2008, and elaborated that Claimant had "proceeded with the symptoms for quite some time and has failed epidural steroid injections, as well

as PT and time and has persistent pain." Dr. Roybal opined that the surgery is necessary for this work-related condition.

Dr. Roybal is a qualified physician. He is a Board-certified Orthopaedic Surgeon with extensive experience in spinal surgery. His practice and continuing education revolve around spinal surgery.

The treatment notes of Dr. Hoffman also support the conclusion that the June 2009 pain was related to the compensable injury. Dr. Hoffman treated Claimant for his work-related injury of October 11, 2008 with conservative treatment through January 2009. When Claimant returned in June 2009, Dr. Hoffman reported that the pain "had since returned," assessed L5-S1 DDD with central foraminal stenosis, and referred Claimant to Dr. Roybal for a second opinion. (CX 2-24) The doctor also noted that epidural injections had helped with this pain in the past but only temporarily. Dr. Hoffman's choice of language does not suggest a new injury; the reference to treatment of the initial injury and the "return" of that pain intimates that the pain in June 2009 was related to the October 2008 work injury.

I find that Claimant has established a *prima facie* case for compensable medical treatment, because Dr. Roybal indicates the surgery is necessary for the work-related conditions of degenerative spondylolisthesis and lumbar stenosis.

Employer's argument

Employer argues that 1) Claimant's current condition is not work-related but is age-related, and 2) that the surgery is not medically necessary. In support of its claim, Employer has submitted the opinion of Dr. Deriso and a surveillance report. I do not find this evidence sufficiently persuasive to overcome the prima facie case.

All of the physicians of record agree that Claimant was out of work from October 15, 2008 through February 1, 2009 due to the compensable injury that occurred on October 11, 2008. Drs. Hoffman and Roybal opine that the return of pain symptomatology in June 2009 is related to and a continuation of the symptoms experienced during that out-of-work period. Only Dr. Deriso disagrees. The surveillance evidence does not address the etiology of the symptoms, and ends well before the recurrence of pain in 2009.

In his initial report, Dr. Deriso stated that Claimant was out of work for four months with a sprain, and "**now has had a recurrence**." (CX 2-14)(emphasis added) During his deposition, he testified "You know, he recovered from one. He should recover from the other." (CX 33-24) In effect, Dr. Deriso's testimony treats the October 11, 2008 injury and the June 2009 recurrence of symptoms as identical injuries that should resolve similarly. Taking these statements together, it appears that Dr. Deriso connects the June 2009 and continuing symptoms with the October 11, 2008 compensable injury.

However his opinion also suggests that the DDD, possible mild spondylolisthesis, and small protrusion seen on Claimant's MRI could just be attributed entirely to age. Dr. Deriso never actually states that any of Claimant's symptoms are not related to the work injury. He does dismiss the MRI as effectively meaningless because "all of these things really are sort of within normal limits in somebody of this man's age." Dr. Roybal specifically rejects this position: "I would not consider this an age-related spine. I would consider this a spine with a structural abnormality that does appear to be symptomatic in this gentleman who has failed conservative therapy."

Dr. Deriso's supports his age-related theory by disregarding the opinion of Dr. Roybal, dismissing the MRI findings, and with several broad generalizations and the assumption that Claimant and his MRIs fall into those general categories. I find this support unpersuasive, because extrapolating Dr. Deriso's reasoning would lead to the conclusion that any 48-year-old (or perhaps 38-year-old, as it is

unclear upon which of the varying ages listed in his report he is relying) with MRIs showing DDD should attribute the cause of the disease to his or her age, regardless of whether he or she has had a work-related back injury.

Claimant has presented a *prima facie* case and Employer presents no convincing evidence that Claimant's June 2009 symptoms and current condition are not related to the compensable injury**.** Accordingly, I find that Claimant's medical treatment, including the surgery if it is found necessary and reasonable, for degenerative spondylolisthesis and lumbar stenosis is related to the compensable injury.

2. Reasonable and Necessary

It is Claimant's burden to establish the necessity of treatment rendered for his work-related injury. *See generally Schoen v. U.S. Chamber of Commerce*, 30 BRBS 112 (1996); *Wheeler v. Interocean Stevedoring, Inc.*, 21 BRBS 33 (1988); *Ballesteros v. Willamette Western Corp.*, 20 BRBS 184 (1988). Under Section 7(a) of the Act, in order for a medical expense to be assessed against the employer, the expense must be both reasonable and necessary. *Pernell v. Capitol Hill Masonry*, 11 BRBS 532, 539 (1979).

Evidence supporting the surgery

The evidence shows that Dr. Hoffman administered conservative treatment for Claimant's injury from October 15, 2008 through February 1, 2009. Dr. Hoffman initially diagnosed Lumbar HNP based on: quite severe pain in the back radiating down his right buttock into his right leg, Claimant's difficulty working, positive straight leg raise on the right, and tenderness to palpation in the lower LS spine. He ordered an MRI, took Claimant off work and prescribed an epidural injection, Lorcet, and Tramadol. The MRI was taken four days after the work injury. Radiologist Dr. Considine found:

1. Moderate severe left and moderate right foraminal narrowing L5-S1 secondary to mild spondylolisthesis, spondylosis, and face degeneration
2. Shallow, broad-based posterior protrusion L5-S1 without significant mass effect
3. Very small L4-5 right foraminal protrusion

The next day, Claimant received his first epidural from Dr. Estle, who reviewed the MRI and stated that it showed multilevel DDD and a small right foraminal L4-5 disc protrusion. On examination, Claimant complained of pain in the right L4, L5, and S1 distributions.

After receiving the results of the MRI, Dr. Hoffman assessed LS spondylosis with a herniated disc at L4-5, right. As Claimant had improved with the epidural, two more were scheduled, and he was prescribed ibuprofen 800mg. Claimant still had uncomfortable straight leg raise at 90 degrees bilaterally.

Claimant complained of pain radiating from his back down his right leg on November 14, and had mild discomfort with the straight leg raise. He started PT that day, and described pain as sharp burning in the low back and down the right leg, and numbness in the right leg. After more PT and injections, on December 1, 2008 he continued to have pain in his back radiating into his leg but there was slow improvement. For the first time, there was no pain with straight leg raising. By January 2009, his pain was resolving, and Claimant was almost 70% pain-free. He still had some numbness in his foot and anterior shin and no pain with straight leg raising. He was released to return to work February 1, 2009.

He returned to Dr. Hoffman on June 8, 2009 and complained of pain in the right buttock radiating down the right leg, which had returned over the past couple of weeks, becoming so severe he was unable to go to work the day before. Claimant's testimony confirms this: "I felt like I had a golf ball in my

[right] buttocks and just sharp pain going all the way down [the front of my right leg] to the tip of my toes, which had numbness." (TR 32-33) He also testified that the pain recurred gradually until one morning it was back just as it had been and he could hardly move. He thought the epidurals had worn off. Dr. Hoffman assessed L5-S1 DDD with central foraminal stenosis. He prescribed Medrol a second opinion with Dr. Roybal.

Dr. Roybal recommended the contested surgery, a decompression of neural foramen and stabilization of the spondylolisthesis, on June 18, 2009 after a thorough examination of Claimant and review of his records and radiological studies. Claimant's description of the October 11 incident was consistent with his testimony and his report to Dr. Hoffman, of the sudden movement resulting in a deep pulling in his low back with pain radiating down the leg. Dr. Roybal summarized the failed conservative treatment under Dr. Hoffman: nearly four months' rest from work, core strengthening with PT that was ineffective, three epidural steroid injections that were temporarily helpful, ibuprofen, and occasional Ultram.

On June 18, Dr. Roybal noted that the right leg radiculopathy was recurring and holding Claimant back from work. He had experienced significant right leg symptoms radiculopathy since October. He had been working until the pain and symptoms became unbearable two weeks earlier. At the time of the examination, his walking tolerance was less than one block, his legs fatigued easily, and he had pain with coughing. This is consistent with and supported by Claimant's testimony and Dr. Hoffman's last treatment note. On June 18 Claimant was holding his leg out to the right side in attempts to gain comfort and walked with a noticeable limp, dragging his right leg and favoring it. During physical examination, he had increased pain with extension at 5 degrees and his forward flexion reached only the mid-thigh. There was guarding of the paraspinal musculature, and increased pain with seated straight leg raise in the right side. Claimant described pain in the posterior buttocks and thigh, into the anterior aspect of the anterolateral tibia to the dorsum of his foot.

Dr. Roybal assessed spondylolisthesis at L5-S1 with significant foraminal stenosis. This was based on physical examination, medical history, the x-rays and MRI that showed grade 1 spondylolisthesis at L5-S1, significant facet arthropathy, disk height loss, and some degenerative change (mild spondylolisthesis) throughout in the lumbar spine, and significant bilateral neural foraminal stenosis.

Dr. Roybal examined Claimant a second time on August 25, 2009. Claimant was still suffering greatly with significant leg pain, which appeared to originate from the buttocks and radiate down the leg to the foot. The doctor felt that the absence of back pain was a good indicator that Claimant is suffering from the neural compressive lesion that was apparent on his MRI. Upon this second examination of Claimant and the knowledge of his condition after five weeks, Dr. Roybal confirmed his diagnosis, noting that his initial assessment of spondylolisthesis was "readily apparent on both [the] MRI [and] radiographs with significant foraminal stenosis which is also commented on by the neuroradiologist reading his MRI." He added to his diagnosis, "concordant pain through the lower extremities." He again recommended the surgery, as conservative treatment had failed and Claimant's symptoms of persistent pain had continued for some time. He prescribed more pain medication to help Claimant in the meantime.

Dr. Roybal examined Claimant a third time on February 11, 2011. This is the most recent examination of Claimant in the record by 18 months. Claimant still had had positive findings of tenderness to palpation of the right sciatic notch and right SI joint; increased pain with lumbar extension; and positive seated straight leg raise on the right. Dr. Roybal continued his diagnosis of degenerative spondylolisthesis and lumbar stenosis. Dr. Roybal took four new x-rays of the lumbar spine that showed disk space collapse and anterior spondylolisthesis at L5-S1. Again, the doctor stated that Claimant had experienced no significant relief of his pain with conservative treatment options, and therefore he "would

like to proceed with more definitive surgical intervention to address the level of L5-S1 which would require reconstruction of the disk space and stabilization for this segment with a fusion. I feel that he would most benefit from both an anterior and posterior approach." Dr. Roybal prescribed Norco 10, Ultram and ibuprofen to keep Claimant comfortable in the meantime.

Claimant testified that he needs the surgery because of his current level of pain and its effect on his life. He stated he has so much pain he can hardly function and must begin each day with a hot shower or bath. Sometimes that is effective enough that he can make it through the day, but if it is not, he has to return to bed. The degree of pain is not constant; some mornings he wakes up and feels good, but after 30 minutes standing up at work he cannot continue. His coworkers help him finish his work when this happens. Claimant physically cannot work every day that he wants to, nor can he work the higher-paying, more physically demanding jobs.

In summary, all of the medical records except Dr. Deriso's report reveal a consistent story of Claimant's radicular pain going down the right leg. This pain began with the October 11, 2008 work injury, improved slowly with epidural injections until he could return to work in February 2009, and then recurred gradually until it was so severe that Claimant could not go to work on June 7, 2009. Claimant's testimony and the medical records of Drs. Hoffman and Roybal all reflect that the pain was radicular and significant. Nothing in these records suggests or supports any new injury or exacerbating event. The records all support Dr. Roybal's findings of spondylolisthesis at L5-S1 with significant foraminal stenosis and concordant pain through the lower extremities. Dr. Roybal recommends the surgery because the conservative treatment approach, applied through narcotics, PT, injections, and rest over four months, has failed and Claimant's symptoms and pain continue.

I further note that Drs. Hoffman and Roybal both examined and treated Claimant multiple times, and Dr. Roybal conducted the two most recent examinations. This experience gives these doctors the most informed (and, with respect to Dr. Roybal, the most current) perspective on Claimant's symptoms and progression. As a result, I accord additional weight to the opinion of Dr. Roybal regarding the surgery.

Dr. Deriso

Dr. Deriso opines that the surgery is unnecessary. Dr. Deriso examined Claimant once, for 10-20 minutes, at the request of Employer. He also reviewed medical records, though his testimony suggests he did not review them thoroughly. His primary arguments are that there is no true radiculopathy in Claimant and that the injury is self-limiting and will resolve on its own over time. For several reasons, I do not find Dr. Deriso's opinion persuasive.

Radiculopathy

Without radiculopathy, Dr. Deriso did not believe there was enough to warrant the surgery. Dr. Deriso stated that during the July 16, 2009 examination, Claimant "denied any true radiculopathy, has more numbness in his leg and an ache. I kept questioning him about this, and again, it is not radicular." The straight leg raising in the sitting position at about 90 degrees caused some lateral thigh pain that did not appear to radiate down the back and down his leg like "true sciatica." In his deposition, the doctor testified that he defined true radiculopathy as intense pain like a hot poking knife radiating from the lumbar region down the limb. He would expect a marked response to the straight leg raising test.

Straight Leg Raise

Dr. Deriso testified that he had reviewed Claimant's medical records. Those records contain the following straight leg raise results:

- 10/15/08: positive straight leg raise on the right
- 10/31/08: uncomfortable straight leg raise at 90 degrees bilaterally
- 11/14/08: mild discomfort with straight leg raising
- 12/1/08: no pain with straight leg raising
- 1/12/09: no pain with straight leg raising
- 6/8/09: pain with straight leg raising
- 6/18/09: increased pain with seated straight leg raise in the right side
- 7/16/09: Deriso's own exam: some lateral thigh pain on the right leg with seated straight leg raising at 90 degrees
- 2/10/11: positive seated straight leg raise on the right

Claimant's straight let raise history is consistent with an injury in October 2008, gradual improvement through January 2009, and a recurrence in June 2009 that continued into February 2011. Dr. Deriso did not define what "marked" results would satisfy his definition, though he thought "discomfort" was just normal for anyone. However, Drs. Hoffman and Roybal treated the straight leg test results as indicators of radicular pain, which they both diagnosed.

Locality of Pain

Though he stated that he reviewed the records before writing his report, Dr. Deriso was not sure during his deposition whether Dr. Roybal found radiculopathy the first time he saw Claimant. The records show the following reported symptoms and diagnoses of radiculopathy:

- 10/15/08: Dr. Hoffman: pain in the back radiating down his right buttock into his right leg
- 10/23/08: Dr. Estle (interpreting radiologist for epidural injection) noted that Claimant had been referred by Dr. Hoffman for low back pain radiating down the right leg.
- 10/23/08: Dr. Hoffman on examination noted there was still pain in the back and leg
- 11/14/08: Dr. Hoffman noted pain radiating down the leg
- 12/1/08: Dr. Hoffman: continued to have pain in his back radiating into his leg
- 6/8/09: Dr. Roybal noted a report of pain in the right buttock radiating down the right leg
- 6/18/09: Claimant described his October 2008 injury to Dr. Roybal as "a deep pulling in his low back with pain radiating down the leg." The doctor stated that the right leg radiculopathy was recurring and holding him back from work. Claimant had experienced significant right leg symptoms radiculopathy since October. Claimant described pain in the posterior buttocks and thigh, into the anterior aspect of the anterolateral tibia to the dorsum of his foot.
- 8/25/09: Dr. Roybal diagnosed "concordant pain through the lower extremities"

Despite these numerous diagnoses and mentions of exactly the localities of pain he defined as radicular, Dr. Deriso could not remember if Dr. Roybal found radiculopathy. While adhering firmly to his opinion that there was no true radicular pain, during his testimony, his memory of his own examination of Claimant was fuzzy: "He may have had some referred pain…achy and dull and numb…I think in the buttocks primarily. He could have had it down his leg but that doesn't denote anything significant." (CX 33-35) Claimant testified that he told Dr. Deriso about the pain in his back going down into his leg.

Finally, in his testimony, Dr. Deriso attempted to dismiss any other doctor's diagnoses with this generalization: "I've found out in looking at the records of a lot of physicians, it's just not a lot of differentiation maybe they make between referred pain and radiculopathy." In short, Dr. Deriso's opinion disregards the findings of the two physicians who treated Claimant multiple times for his injury based on a general and equivocal opinion that many doctors misdiagnose this condition.

Character of Pain

Even if the pain travels from the lumbar area down the leg to the foot, Dr. Deriso still does not accept this as radicular pain unless the character of the pain is like a "hot poking knife." Under his definition, the pain cannot be dull, numb, or achy and be true radicular pain. Claimant's treatment records show that he has reported both pain and numbness in his legs since his injury. Even on the day of his hearing, Claimant testified he still had that numbness and the pain flared up often, but was not constant every day like it was at the beginning. Throughout the record, it is clear that Claimant reported both of these sensations; not just one or the other.

When the nature of Claimant's pain is described in the record by anyone other than Dr. Deriso, the descriptions are:

- 7 out of 10 (Claimant's testimony, PT records)
- escalated to unbearable (Claimant's testimony)
- Severe (Claimant's testimony, Dr. Hoffman in 2009, the 6/18/09 questionnaire)
- "quite severe" (Dr. Hoffman in 2008)
- "Felt like I had a golf ball in my [right] buttocks and just sharp pain going all the way down [the front of my right leg] to the tip of my toes, which had numbness." (TR 32-33) (Claimant's testimony)
- so much pain he can hardly function or move (Claimant's testimony)
- sharp burning in the low back and down the right leg (PT records)
- "suffering greatly with significant leg pain" (Dr. Roybal 8/25/09)

The only mentions in the entire record of the words "dull," "ache," or "achy" are Dr. Deriso's descriptions of Claimant's pain. At no point does Claimant himself describe the pain that way, nor do any of his treating physicians.

I briefly address the surveillance evidence to note that I do not find that it is significant in this case. At most, it shows that Claimant goes hunting, that he goes to the grocery store, and that he is ambulatory. Claimant testified to all of these things, and pointed out that he is not claiming total disability; he is partially disabled and in pain. Claimant testified that he is able to engage in these kinds of activities to a limited extent and I find nothing in the videos or the report that contradict his testimony or discredits him in any way.

Conclusion

Dr. Deriso is the only physician who did not find radiculopathy. Even, assuming *arguendo* that his very narrow definition of 'true radiculopathy' is correct, the vast majority of the evidence shows that Claimant satisfies that definition. The record shows consistent reports of sharp severe pain radiating from the lower back all the way down the right leg to the foot; as well as positive straight leg raising test results. Dr. Deriso required "hot poking knife" pain, and Claimant described the pain as sharp and burning. If Dr. Deriso did indeed review these records, he must have disregarded all of this reported symptomatology, just as he equivocally dismissed other doctors' diagnoses of radicular pain. I find that

the vast majority of the evidence clearly establishes that Claimant was suffering from radicular pain. I reject Dr. Deriso's opinion that the surgery is unnecessary because there is no radicular pain.

Injury as self-limiting

Dr. Deriso argued that the surgery was unnecessary because the type of injury Claimant has is self-limiting; that is, it will heal itself given time. As discussed earlier in this decision, the record shows that Claimant's injury clearly has not healed over time but in fact, in the doctor's own words, "had a recurrence."

Dr. Deriso testified that conservative treatment in general was basically unnecessary and pointless; stating that it accomplishes as much as sprinkling owl feathers in the corner of a room. He suggested that doctors treat lumbar disc strains only so they can report successful treatment rates, because the injuries would heal on their own. He agreed that Dr. Hoffman's treatment of Claimant qualified as conservative treatment.

However, after decrying the value of conservative treatment for a back strain, Dr. Deriso stated that conservative treatment *should* occur before the surgery recommended by Dr. Roybal would be appropriate. Dr. Deriso provided the circumstances under which the contested surgery would be indicated: when there are significant findings, such as sharp radicular pain requiring narcotic treatment; when the patient does not get well with conservative treatment, bed rest, or time; and when there are positive findings on a test like an MRI, CAT scan, or myelogram. In this case, Claimant had significant findings of spondylolisthesis and stenosis, he had sharp radicular pain that required narcotic treatment, there are positive findings on his MRI and x-rays, and he did not get well after conservative treatment and many months off work.

Dr. Deriso testified that he did not disagree with and had nothing to add to the reading of Dr. Considine, the radiologist who administered and interpreted the MRI in 2008. Though Dr. Deriso saw these positive findings in the MRI, he did not consider them hard and fast objective evidence because he believes a lot of MRIs are false positives, and that MRI findings have nothing to do with the complaints of the patient. He described the MRI as a test that substantiates what a physician is feeling; not a diagnosis. He did not address the obvious contradiction between this philosophy and his testimony that he would require positive findings on an MRI or similar test before recommending surgery.

Dr. Deriso contradicted himself again on the value of MRIs and conservative treatment, when later in his deposition, he stated that a laminectomy would be indicated if there was a recent herniated disc, radicular pain, a change in his MRI showing nerve-root encroachment, and after a trial of conservative treatment. Again, the record shows Claimant has experienced all of these factors.

Dr. Deriso's testimony simultaneously rejects the value of conservative treatment and MRI findings but then twice describes those tools as necessary to diagnosing the need for the contested surgery. I do not find this equivocal and conflicting reasoning persuasive as a basis for rejecting the opinion of Dr. Roybal as to the need for surgery.

Unsupported by the record

Dr. Deriso's opinion is simply not supported by the evidence of record.

In his medical report, Dr. Deriso felt Claimant should have been able to return to work by late October or early November 2008. Dr. Deriso does not address why he believes this, when the records he reviewed from November 2008 show that Claimant had undergone only one epidural at that point, had

unchanged symptoms of pain radiating from his back down his right leg, and did not even start PT until mid-November. Nor does Dr. Deriso square his opinion with the fact that the records show Claimant's pain did not begin to resolve until December 2008 and the treating physician did not release him until February 1, 2009.

Dr. Deriso suggests that the other doctors' findings are erroneous by stating that the longer a patient goes without getting the surgery, the better an indication that there were no significant findings in the first place. This ignores the fact that the delay in getting the surgery in this case has been due to Dr. Deriso's own opinion and Employer's denial of the surgery; it has nothing to do with the timing of the treating physician's recommendation. Dr. Roybal recommended the surgery the first time he examined Claimant; within two weeks of the recurrence of pain.

Dr. Deriso testified that he had no reason to doubt Claimant's credibility as to his onset of pain, but his opinion rejects the notion that Claimant has any radicular pain, and that his discomfort and DDD are just normal for Claimant's age. Dr. Deriso stated that if Claimant were willing to undergo the surgery with knowledge of all its risks, he still would not find the complaints of ongoing pain to be credible. His explanation was that Claimant had somehow "misinformed himself" because "a lot of times" the doctors do not know where the pain generators are or if they are going to be resolved. Dr. Deriso specifically stated that Dr. Roybal had not misled Claimant, but did not explain how Claimant had misinformed himself. This logic is difficult to follow and actually seems to suggest that Claimant *does* have pain, but that he has deceived himself into thinking that the surgery will relieve the pain when it will not.

Several times during his testimony, Dr. Deriso returned to his belief that many unnecessary back surgeries take place. Whether this is true or not is irrelevant; the question at issue here is Claimant's specific situation. Dr. Deriso does not like the particular surgery recommended by Dr. Roybal and stated it "probably" has a 50/50 success rate. He provided no citations to support that statistic. He concluded with the unsubstantiated prediction that if Claimant undergoes the operation and improves, "it will be despite his surgery." (CX 33-59)

Dr. Deriso effectively ignored Claimant's ongoing history of reporting radicular pain, dismissed the MRI and many details in the records of Claimant's treating physicians, and applied broad generalizations to support his opinions without explaining how the specifics of this case fit those generalizations. He states that he can find no "objective" evidence substantiating Claimant's complaints, despite the MRI and x-rays with positive findings, as well as numerous medical reports and treatment records in which Claimant repeatedly sought relief for pain. Taking all of this together, I do not find Dr. Deriso's opinion to be persuasive or entitled to the same weight as the opinion of Dr. Roybal.

3. Conclusion

I find that Claimant has shown by a preponderance of the evidence of record that the surgery is reasonable and necessary. Claimant has also established that his degenerative spondylolisthesis with significant neural foraminal stenosis and concordant pain through the lower extremities is work-related. Accordingly, I find that under Section 7(a), Employer is liable for all reasonable and necessary medical expenses arising from Claimant's October 11, 2008 work-related injury and its process of recovery, including the surgery recommended by Dr. Roybal, which is reasonable, necessary, and appropriate for the injury.

ORDER

1. Employer is responsible for past, present, and future medical treatment of Claimant's work injury in accordance with Section 7 of the Act.

2. Employer must authorize and pay for the surgery recommended by Dr. Roybal.

3. Should Claimant's counsel seek attorney fees and legal costs associated with this case, Claimant's counsel, within twenty (20) days of receipt of this Order, shall submit a fully documented fee application, a copy of which shall be sent to opposing counsel, who shall then have twenty (20) days to respond with objections thereto.

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KENNETH A. KRANTZ
Administrative Law Judge

Newport News, Virginia
KAK/lec/mrc