BEFORE THE INDUSTRIAL ACCIDENT BOARD
OF THE STATE OF DELAWARE

KATHLEEN HELLSTERN,	)	
	)	
Employee,	)	
	)	
v.	)	Hearing No. 1426858
	)	
CULINARY SERVICES GROUP LLC,	)	
	)	
Employer.	)	

DECISION ON PETITION TO DETERMINE ADDITIONAL COMPENSATION DUE

Pursuant to due notice of time and place of hearing served on all parties in interest, the above-stated cause came before the Industrial Accident Board on Wednesday May 23, 2018, in the Hearing Room of the Board, in New Castle County, Delaware.

PRESENT:

ROBERT MITCHELL

MARK MUROWANY

Eric D. Boyle, Workers' Compensation Hearing Officer, for the Board

APPEARANCES:

Vincent J.X. Hedrick, Attorney for the Employee

Joseph Andrews, Attorney for the Employer

NATURE AND STAGE OF THE PROCEEDINGS

Kathleen Hellstern ("Claimant") was injured in a compensable work accident on February 26, 2015, while in the course and scope of her employment with Culinary Services Group ("Employer"). Injuries to Claimant's low back, specifically at L3-L4, right ankle and right hip were acknowledged as compensable. She received medical benefits and was placed on work restrictions. Claimant's compensation rate is $642.51 weekly based on an average weekly wage of $963.76. On December 12, 2017 Claimant filed the present Petition seeking acknowledgment for additional injury to the L2-L3 level in her lumbar spine. Claimant seeks to have the lumbar spine surgery at that level and related treatment deemed reasonable, necessary and casually related to the work accident. Employer disputes the claim that the L2-L3 level is causally related to the accident. A hearing was held on Claimant's Petition on May 23, 2018. This is the Board's decision on the merits.

SUMMARY OF THE EVIDENCE

Dr. Bruce Rudin, a board certified spinal surgeon, testified via deposition on behalf of Claimant. Dr. Rudin first saw Claimant for treatment unrelated to the work accident which included a lumbar spine surgery at L4-5. In preparation for his deposition testimony Dr. Rudin reviewed a number of Claimant's medical records including the defense medical reports of Dr. David Stephens as well as Dr. Smith's report. Dr. Rudin agreed that Employer had accepted injuries related to the fall at work on February 26, 2015 which included injury to the L3- L4 disc, surgery at that level and treatment for an ankle and hip injury. Dr. Rudin summarized the history of Claimant's treatment following her slip and fall on ice at work. She ultimately followed up with Dr. Rudin and an MRI showed a disc herniation at L3-L4. The initial surgery was

performed on April 28, 2015. Dr. Rudin indicated that it is also relevant that Claimant had a spinal fusion in 2009 at L4-L5 for a degenerative problem. Following that surgery Claimant was doing relatively well except for some pain related to her screws. Dr. Rudin pointed out that she then had an asymptomatic underlying condition in her lumbar spine which was subsequently made symptomatic by the work injury. That is what he has ultimately been treating.

Initially Dr. Rudin attempted to do a more minimally invasive procedure called a laminectomy at L3-4. They put in a device called a coflex which is designed to make a worn segment last longer next to a fusion. Over time Claimant deteriorated and got worse. Further scans showed that she had severe spinal stenosis. They removed the clamp and did a wide laminectomy at L3-4 putting in pedicle screws. Dr. Rudin pointed out that the defense examiner determined all this to be reasonable, necessary and related to the accident. This latest surgery was done on July 28, 2016. Claimant did have a complication called a hematoma following that procedure which resulted in further procedures. Claimant had a rough postoperative course but ultimately recovered. After about a year Claimant started to get worse with progressively worsening leg pain, thigh pain, heaviness, tiredness and fatigue in her legs. She had difficulty walking any distance. Dr. Rudin felt that these were symptoms of further problems. Dr. Rudin testified that Claimant was developing spinal stenosis at L2-3 the level above the fused level. The level above the fused level was absorbing all the stress from the fused level. This is either the level above or the level below the fusion and in Claimant's case it was the level above which started to go bad. Dr. Rudin noted you could see this progression in the various scans from 2015, 16 and 17. During the time of the surgery in 2016 Claimant had seen Dr. Downing for injections and was seeing Dr. Xing for pain management.

Dr. Rudin testified that up to that point Dr. Stephens, the defense medical examiner, had related everything to the accident and then he retired. His last examination was in December 2016. Then in 2017 Claimant had increasing low back pain and knee symptoms in her legs that Dr. Rudin mentioned. A CT scan done on February 23, 2017 indicated moderate to severe spinal stenosis at L2-3. An MRI done on March 8, 2017 demonstrated a disc protrusion at that level. She also had facet arthrosis which is a degenerative condition. The thickening of the facets and ligaments contributed to the spinal canal stenosis. Dr. Rudin testified that none of that existed in the years prior to the surgeries. In his opinion the diagnostic studies confirmed that Claimant had developed additional wear and tear at the L2-3 level which would not have happened had she not had the spinal fusion at L3-4. This diagnosis is called adjacent segment degeneration which is an accepted condition under the Delaware Healthcare Practice Guidelines. Dr. Rudin agreed that but for the fusion Claimant would not have had to get surgery at L2-3. He testified that ultimately all this was made symptomatic by the slip and fall at work. Dr. Rudin testified that this is a normal expectation of what happens to someone with a bad back and a spinal fusion. Ultimately the levels next to fused segment start having problems. Dr. Rudin further testified that they did try more conservative treatment to avoid the need for surgery; however, the injections that she had didn't work in the long-term. Following a visit in May 2017 Dr. Rudin noted that Claimant was continuing to be symptomatic and he recommended a removal of the hardware at L3-4 and an extension of her fusion. Essentially in order to operate on the L2-3 level they would have to also include the level below in that procedure, however Dr. Rudin did indicate that that extra level would be billed separately.

Dr. Rudin explained that when one level is fused you take 20% of the load that would be on each disc in the lumbar spine and distribute that among the remaining non-fused discs. An

older person who has bad discs to begin with may have problems in the adjacent disc segments relatively quickly. Dr. Rudin felt that this was a very legitimate diagnosis and he has had a lot of patients who have come back on work related injuries and this procedure is normally accepted as compensable. Dr. Rudin confirmed that he reviewed every film that's listed in his chart. He noted that he would never treat a patient without actually looking at the films. He further noted that the decision for surgery is based on many things but you're never operate solely based on the films because it is the patient's complaints that are what is important. He noted that even if the film showed stenosis if the patient didn't have any complaints they wouldn't do an operation. In this instance Claimant was having trouble walking and can't function so that's why they did the procedure. Following the procedure Claimant has been doing better.

Claimant had the latest procedure on October 3, 2017. He did a hardware removal at the level below the fusion. He did a laminectomy to take pressure off the nerves and extended the fusion of one level to stiffen the segment so that the likelihood of a reoccurring problem at that level was zero. Dr. Rudin did note that her recovery has been slow. At a visit on January 17 Claimant did state she was sick and improved from her preoperative state. Claimant has been unable to start therapy because of the denial of the coverage for procedure. More recently she has had problems with low back discomfort and burning in her left thigh but she is not limited in her activities. Dr. Rudin reviewed Dr. Smith's report and addendum noting that he has never seen a defense doctor not actually look at any films that had been taken in the last three years prior to the examination. Dr. Rudin indicates that it was somewhat insulting that Dr. Smith claimed that the x-rays were the same but didn't comment on the surgery or the progressive stenosis shown in the films. Dr. Rudin noted that Dr. Smith didn't look at the three CAT scans that have been done since 2015 or mention anything about Claimant claudicating when she walks. It almost

seems like the only factor that's important is that the x-rays didn't look different. Dr. Rudin felt that Dr. Smith cherry picked the two films he wanted to use for his argument. Dr. Rudin reviewed some of the medical bills from the surgery which were subsequently marked as an exhibit to the deposition. Dr. Rudin also commented on Claimant's potential ability to return to work however he noted she is still in rehabilitation. At this point her function is still poor, however they would have to get a functional capacity evaluation to determine if she's ever going to do anything more than a part-time sedentary job.

On cross examination Dr. Rudin agreed that Dr. Smith's physical examination did include a satisfactory gait and station however he noted on page 2 of the report Claimant complained of back pain, peroneal and lower extremity numbness and tingling. She reported that she does use a cane on occasion and has difficulty ambulating. This is what Dr. Rudin was referring to as neurogenic claudication. It is important question to ask someone how far they can walk. Dr. Rudin felt that Dr. Smith really didn't ask these relevant questions. Dr. Rudin conceded that what he mentioned were subjective statements by the Claimant as to her physical condition. Dr. Rudin ultimately agreed that the physical exam portion did say satisfactory gait. He went on to indicate what he does with his examinations and he asks patients how far they can walk. He doesn't take them out into the hallway, he doesn't take them out in the parking lot, they don't go run laps you just listen to what the patient says when you ask how far can you walk. Dr. Smith did not ask that question. Dr. Rudin went on to say that the exam room was probably not much bigger than 8 x 10. So saying that she has normal gait and station means that she standing there and probably walks three steps so Dr. Rudin didn't know what exactly that meant but it he felt it wasn't relevant to anything. Dr. Rudin did agree that Claimant has been on very high levels of narcotics for quite some time, too high he noted. Dr. Rudin didn't have any plan to

wean her off narcotics because she is treating with a pain management specialist. He is not managing her narcotics so Claimant would be talking to Dr. Xing about that.

Dr. Rudin agreed that spinal stenosis is the degenerative condition. Dr. Rudin noted that the stenosis that she had prior to the accident was dramatically different than even just after the accident, it was much worse after the accident. There really wasn't a development of substantial stenosis until after the 2016 surgery. There was a little bit there and a little bit of thickening of the ligaments as well as the bulging disc, but there was no treatment for that at that time. In the years that he had cared for her there was never any treatment directed at the L2-3 level. Dr. Rudin noted that it wasn't until 2017 that Claimant's ability to walk distances got shorter and shorter and there was clinically significant spinal stenosis. Dr. Rudin did agree that there was some stenosis at that level. Dr. Rudin noted that Claimant has been sent for an updated CAT scan to determine how well the fusion is healing and if it is healed then ultimately they'll sent her for a functional capacity evaluation. On the last visit in February 2018 there was no sign of any consolidation of the bone graft which means that the fusion had not yet healed. Dr. Rudin did indicate that was viewed with a regular x-ray which is not as good as a CAT scan. Dr. Rudin agreed that Dr. Stephens's last defense exam on December 7, 2016 indicated that Claimant had a waddling gait. From that time up until the time that Dr. Smith saw her in May 2017 Dr. Rudin noted that through multiple visits which indicated that Claimant was getting worse not better. Dr. Rudin noted that his notes in March 2017 indicating the symptoms that Claimant mentioned to Dr. Smith including heaviness and tiredness and her legs were walking. They were treating her for spinal stenosis that was worsening and to Dr. Rudin this is a simple problem and about 80% of the patients that they operate on have some degree of spinal stenosis. Dr. Rudin confirmed that the scans before the accident indicate disc bulging at the L2-3 level without disc herniation or

stenosis. Even scans that were done later didn't indicate a stenosis that needed to be treated until after the L3-4 fusion. The likelihood of Claimant needing an operation at the L2-3 level was substantially greater because she had the previous surgery. Dr. Rudin confirmed that the surgery that he did was not really designed to alleviate Claimant's pain it was designed to get rid of the symptoms in her legs and enable her to walk further. He confirmed that Claimant is now progressing slowly and seems to have plateaued which is why they sent her for a CAT scan because they don't think that she's doing particularly well.

Claimant testified on her own behalf. She is 50 years old and lives in Christiana Delaware. She has a high school diploma and one year of college in computers. Since 2014 she was an operations manager for Employer working 60 to 70 hours per week. Her work involved overseeing food service at three different state facilities. Prior to her position with Employer she worked for the State. Her job involved a lot of walking especially at the Emily Bissell State Hospital location. She used to walk 2 miles on her breaks as well. Prior to 2014 Claimant had low back pain and surgery on her L4-5 disc. In 2014 she slipped in her bath and went back to Dr. Rudin. By 2015 she was not having any problems and certainly not having any problems walking. Dr. Rudin thought she was having pain due to the hardware. In February 2015 she had a hardware block by Dr. Downing and her pain went away so Dr. Rudin scheduled her for a hardware removal procedure.

Later in February on the 20th is when she slipped on the ice at work, landing on her right side, hip and back. She went to an urgent care center for treatment and then followed up with Dr. Rudin. Before this fall she was doing okay and was able to walk. Afterwards she had enormous pain in her back and hip. She had a problem with her ankle and her legs felt heavy. Injections did not work this time. Dr. Rudin sent her for an MRI and CT scan. She had surgery including

placement of a device to open her spinal canal. She also had the hardware out at the L4-5 level. Claimant continued to have trouble with walking, her hips were hurting and she had problems lifting her feet and walking up steps. She had more testing in 2016. Ultimately Dr. Rudin performed surgery on the L3-4 disc. Claimant testified that she had complications following the surgery including a blood clot and diverticulitis. She spent a total of one month in the hospital.

Claimant continued with low back pain and heavy legs. It was hard to lift her legs she had no strength and has numbness and burning. Her low back pain is a constant burning pain. She has burning pain in her groin and thigh. She had further scans which showed that she had stenosis and the spinal canal was closing in on her nerves. Dr. Rudin told her this was because of the disc below. She has continued pain since her surgery. At the L2-3 level there has not been any bone growth and the pins are loose. Dr. Rudin has recommended more surgery which will be done from the front to put more clamps to hold the bones together. Claimant testified that Dr. Xing tapered her off morphine and now she is on diluadid.

On cross examination Claimant could not recall prior treatment with Delaware Neurology in 2011. She did not recall treating in 2010 for chronic low back pain at the L3-4 level. She did not remember having surgery in 2009 and the only surgery she recalls are those procedures that were done by Dr. Rudin. Claimant reviewed some of her pain levels from the notes. In 2014 she was describing daily pain at a 7/10 level. After the fall it was noted that she initially had complaints of 6/10 pain. Claimant testified that she at that time did not know how to judge pain but that following her surgery the pain became worse. In March 2018 Dr. Xing recorded a 7/10 as her normal pain. Claimant indicated that her pain can be a 4 to 5 out of over 10 and it fluctuates. Claimant testified that's while she is a smoker she has a prescription for Zantax and is trying to cut back. Claimant admitted that Dr. Rudin told her that smoking inhibits bone growth.

She has stopped smoking before and after her surgeries previously. Claimant noted that she also got the flu and had pneumonia after her surgery which she felt impacted the recovery.

On redirect Claimant testified that she did not have any back pain before her fall. She had no problems walking. In the March 2018 visit Dr. Xing's she was noted to be limping. Claimant does not remember treating in 2009 or 2010 and losing function in her right leg. She felt she might have treated because she had twisted her ankle. She does not recall details of treatment around that time frame. Claimant stated that her pain is usually a 7/10 and is constant. Claimant did not recall having a laminectomy in 2009. On the summary of Claimant's pain levels it was noted that in August 2011 she had fusion surgery. In 2012 and 2013 there were no pain complaints because there was no treatment. In February 2015 following her slip in the tub she had a hardware block. She was able to work in the kitchen at that time. She had a severe increase in low back pain after the fall and in March 2015 she was doing a little better because they gave her a hardware block.

Dr. Robert Smith a board certified orthopedic surgeon, testified by deposition on behalf of Employer. Dr. Smith provided some information regarding his background and experience. He noted that he was able to review the previous defense examinations from Dr. Stephens after he saw Claimant. In conjunction with his examination he also reviewed Claimant's medical records. He also reviewed the transcript of Dr. Rudin's deposition testimony. Dr. Smith testified that the type of surgery Claimant underwent at the L2- L3 level is supposed to stabilize this disc segment. When he says segment he means the disc and the two adjacent vertebrae above and below the disc that is called a segment. A fusion procedure is done to stabilize an unstable segment. After reviewing all the medical records going back to prior to the accident and to 2010 Dr. Smith did not review any records documenting instability at that level. Dr. Smith testified

that you would also perform surgery on this level if the patient had progressive neurological deficits from the nerve roots at that segment which in this case would be the L3 nerve roots on the left or right. If there was a progressive neurological injury from stenosis whether it was degenerative or traumatic you could do a wide laminectomy. Most doctors would try to do a regular laminectomy and leave the facets intact but sometimes you have to do a wide laminectomy and as a result a fusion would be necessary.

Dr. Smith testified that there was nothing in the records that specifically indicated there was a neurological deficit at L2-L3. He noted that Claimant had an EMG study of her lower extremities in April 2006 that only showed mild chronic L4 and L5 radiculopathy. There is no mention of any L3 pathology on that study. He did not recall seeing any clinical findings by physicians indicating that there was an L3 radiculopathy either. The two objective reasons why you would do surgery like this were the two that he mentioned, either instability or neurological defect. Dr. Smith also indicated that he did not see anything in the records indicating that there was instability at the L5-S1 level. This is significant to Dr. Smith because of Dr. Rudin's theory that Claimant developed adjacent segment disease at L2-3. Dr. Smith explained that the theory is that the adjacent segments to a fused segment take up the load and are overburdened and become an unstable and symptomatic. The reason the L5-S1 level is important is because it is between the fused L4-5 level and the sacrum which is actually fused. So in his opinion if Claimant was going to develop adjacent segment disease the L5-S1 segment would have been the first level to go bad. He noted that there is no evidence of disease or pathology at that level. He is unsure why Dr. Rudin is using this theory to claim that the L2-3 disc went bad as it is only adjacent to one fused segment and there is no fused segment above that level. Dr. Smith testified that not everybody who has a fusion develops adjacent segment disease but it would be much more likely

to occur at the L5-S1 level since that level is stuck between two rigid segments. Dr. Smith agreed that there was moderate stenosis at L2-3 which for him didn't set off any alarms. Someone with moderate stenosis usually doesn't have a lot of symptoms but Dr. Rudin indicated that is why he did the surgery. Dr. Rudin specifically testified that but for the fusion at L3-L4 Claimant would not have had stenosis at L2- L3.

Dr. Smith explained that stenosis essentially means narrowing. So any anatomical space that gets narrowed by whatever process is just called stenosis. Dr. Smith testified that the predominant reason that people develop lumbar stenosis is age related degenerative disease. In Dr. Smith's opinion the lumbar fusion at L3-L4 did not cause the stenosis at L2-L3. First he noted that not everyone who has a fusion develops adjacent segment disease. According to the literature it is likely to develop in between 5% and 20% of cases. When a patient does get it the cause is multifactorial. It depends on the pre-existing disease, how the fusion was done and in what position the segment was fused that might lead to this adjacent segment disease. Looking at the films the fusions in this case were in a neutral position which is what is supposed to happen. The fusion did not cause any increased or decreased lordosis of the lumbar spine. In cases with this good alignment patients usually don't get the adjacent segment disease. Basically the fusions were reasonable at the lower levels. The imaging reports that Dr. Smith saw seemed to show stenosis that was compatible with age related degenerative disease. Dr. Smith testified that he only saw two films one before the accident and one afterwards, both CT scans, and he noticed no real difference between the two. There was mild degenerative disease at L2-L3 before the accident and there appeared to be mild degenerative disease after the accident. This factored in to his opinion indicating that there was no acute structural change at that level of the spine based on the accident. Dr. Smith noted that Dr. Rudin never treated the L2-3 level until recently and after

the L3-L4 fusion. Then he came up with the adjacent segment disease theory requiring another fusion.

Claimant explained the mechanism of injury that she slipped on ice and fell on her right side. At the time of Dr. Smith's examination Claimant had numbness and tingling in her leg aggravated with walking and doing steps, bending and lifting. She also had some right hip and ankle pain. Claimant did tell Dr. Smith about her previous L3-4 surgery in 2009. Dr. Smith confirmed that Claimant's reporting of the mechanism of injury has been consistent between his exam and Dr. Stephens four prior exams. Dr. Smith noted that on physical exam Claimant did not have any abnormality in the adjacent soft tissues of the spine, no spasm or atrophy or something like that. She had the scars from the prior surgery that were well healed. Neurologic examination was essentially normal from an objective standpoint. Subjectively Claimant did complain of numbness and tingling in the legs. The hip and ankle basically were benign on exam as well. Essentially, Claimant had a normal neurological examination. Dr. Smith did muscle testing as well as reflex testing. She had normal strength, no muscle atrophy and reflexes were symmetrical. Based on the results of his examination there was no instability or neurological deficit that would require surgery. Dr. Smith also indicated that Claimant had normal gait and station on examination. She wasn't using a cane, and she walked in and out of the exam room with a normal gait. Claimant was able to stand with no problems when he examined her back. She wasn't bent over or listing. Dr. Smith testified if there was something significantly wrong in one of her spinal segments such as gross instability or a neurological deficit he would have been able to see it in a change in her gait and station without having to have her walk for a mile.

Claimant had a MRI on July 13, 2011 that found a small disc bulge at L2-L3 with non-compressive neural foraminal narrowing which was a degenerative condition. She had some

other evidence of degenerative disease such as central stenosis and disc bulging at L3-L4 as well. Another CAT scan was performed in 2014 noting a mild diffuse disc bulge and slight flattening of the ventral thecal sac at L2-L3 and moderate canal stenosis at L3-L4. Dr. Smith agreed that this would be a mild progression of her degenerative condition. Following the accident Claimant had an MRI on March 23, 2015 showing a disc bulge with facet arthrosis at L2-L3 with mild sub articular recess stenosis and minimal impression on the L3 nerve roots. Dr. Smith did not see any acute or traumatic findings just a continuing natural progression of the degenerative disease.

Dr. Smith agreed that Dr. Rudin was not attributing anything to do with the L2-L3 to the accident directly rather solely to the surgery at L3-L4. Dr. Smith agreed that the subsequent MRI study on April 8, 2016 found essentially the same thing as the one in 2015. The February 6, 2017 CAT scan at L2-L3 found moderate spinal stenosis with concentric disc bulge and hypertrophy of the ligamentum flavum. It was at this time that Dr. Rudin was relating these changes to the surgery at L3-L4. Dr. Smith disagreed and indicated this was a simple reflection of her pre-existing degenerative disease which had progressed over time. He did not see any evidence of instability at that level nor is there any evidence of nerve root compression causing radiculopathy at that level. Dr. Smith did not believe that there was any acceleration or structural aggravation at that level based on these images. He did not believe there was a significant progression of high-grade stenosis at that level that you could consider as an aggravation from the incident. Dr. Smith did not see how Dr. Rudin could be stating that the fusion caused some great deficit due to the adjacent segment disorder as the progressive changes were very mild.

Dr. Smith agreed with Dr. Rudin that Claimant was on a high level of narcotics. This included the dilaudid and morphine. He did not believe Claimant had any pathology in her spine to justify being on those types of medications. Dr. Smith felt that Claimant's pain intensity

levels probably would have changed over the years. He agreed that pain from degenerative disease does fluctuate up and down as people have good and bad days. Dr. Smith then ran through a list of claimant's treating records and catalogued her pain complaints over time beginning in 2011 and moving through the date of the accident to 2017. Dr. Smith agreed that Claimant's pain levels in that time had remained fairly consistent with moderate to moderately severe complaints of back pain over the course of several years. This was before the most current surgery. Dr. Smith also saw a potential problem with dependency because Claimant had complaints of back pain from degenerative disease and has also been on high-grade narcotics for a while. If she doesn't have the complaint of back pain she can't get that medication. Dr. Smith also took issue with Dr. Rudin's use of the term neurogenic claudication at the L2-L3 level. Dr. Smith noted this occurs when there is central and foraminal stenosis at the lower lumbar levels that affect the nerves that go down the leg. He noted that at L2-L3 the nerves come out of the segments and enervate muscles in your pelvis in the upper thighs. He felt it would be hard to explain these symptoms based on moderate stenosis at that level. Dr. Smith also agreed that chronic smoking is a problem whenever you're considering a fusion surgery. He also noted that being on a lot of narcotics it's hard to know exactly what Claimant's true pain level is because of potential drug seeking behavior. He's never seen any documentation of instability or neurological deficit so he does not think that the surgery at the L2-3 level is indicated. He agreed that based on Claimant's pain levels both before and after the accident she appears to be back at her pre-accident baseline.

On cross examination Dr. Smith agreed that he only saw Claimant on one occasion on May 16th 2017. When he examined Claimant on that date he did not have any of the imaging films to review. Dr. Smith agreed that he stated in his report that Claimant complained of back

pain, peroneal and lower extremity numbness and tingling. She used a cane on occasion, had difficulty ambulating on steps and couldn't lift, bend or stand without having increased pain. The accepted diagnosis for this case was derangement of the L3-4 segment, status post laminectomy, right ankle sprain, right hip contusion and a partial tear gluteus medias. Dr. Smith also indicated that the question of whether the L2-L3 level was related to the work incident could not be determined because he did not have the imaging studies to review. He agreed that he wrote this after he conducted a physical examination. Dr. Smith also agreed that he wrote an addendum report dated April 19, 2018. He agreed that he did not perform a second examination for this addendum. In the addendum he wrote that he compared CT scan done on July 7, 2014 with one done on March 23, 2015. He concluded that the study findings essentially identical indicating that no structural change had occurred in the lumbar spine, including at L2-L3 as a result of the work accident. He concluded that the L2-L3 fusion surgery was not indicated or related on that basis. Those were the only two films that he reviewed. He did not review any of the films that were done after the L3-L4 surgery.

Dr. Smith admitted that the only reason he obtained a Delaware license was so he could do defense medical examinations. He agreed that he did not mention any thing about symptom magnification in his report or addendum. He agreed that the last time he performed surgery was in 2004. Dr. Smith indicated that when he was doing surgery he did do spine surgery but his practice was a general orthopedic surgery practice. Dr. Smith also agreed that Dr. Stephens found no evidence of symptom magnification based on the Waddell criteria on his examinations. He agreed that Dr. Stephens found the treatment including surgeries to be reasonable, necessary and causally related to the work accident. After reviewing Dr. Stephens' December 7, 2016 report Dr. Smith agreed that the report indicated that there was severe stenosis at L3-L4 and Dr.

Rudin had recommended a removal of the co-flex implant with a wide laminectomy and fusion at that level. There was an MRI exam was done on July 31, 2016 demonstrating progression of spinal stenosis as well as the fusion aspects at the L3-L4 level. Dr. Smith agreed that he hadn't reviewed the actual films of that MRI. Dr. Smith agreed that on the physical exam at that time it was noted that Claimant had a waddling gait. She had a decreased range of motion and guarding, without spasm. There was no palpable tenderness present in the lumbar spine either. Straight leg raising exam was negative bilaterally. Dr. Smith agreed that Dr. Stephens opinion was that the treatment and problems related to the L3-L4 level were related to the work accident. Dr. Smith reviewed an appointment dated March 4, 2015 after the fall when Claimant had an injection that gave her 80 to 85% relief. The record also indicated that the fall at work on February 26 caused an increase of pain from 7 to 8/10 to 10/10. He agreed that a follow-up report in March 2015 indicated that Claimant still had severe pain rated as a 10/10 and was having trouble sitting.

Dr. Smith agreed that he had reviewed the MRI and CT scan that was done on April 8, 2016 and February 6, 2017 respectively. He agreed that in the conclusion of his report it was important for him to review imaging studies and he only reviewed two of them, one from 2014 and one from 2015. Dr. Smith agreed that there was not a use of the word stenosis at the L2-L3 level in the 2014 CT scan. They did describe stenosis at the L3-L4 level. The MRI that was done on March 23, 2018 noted that the images were not available for direct comparison to the 2014 CT scan. At the L2-L3 level it showed a disc bulge with mild facet arthrosis. A subsequent MRI was done indicating mild sub articular recess stenosis at the L2-L3 level. The CT scan of February 6, 2017 after the fusion shows that there was moderate spinal stenosis present at the L2-L3 level. The 2017 MRI showed mild disc bulge with a small right foraminal protrusion, facet arthrosis and ligamentum flavum hypertrophy resulting in moderate central canal stenosis

at the L2-L3 level. Dr. Smith agreed that stenosis was an important finding on a low back imaging study although he noted that many people have stenosis and are asymptomatic. Dr. Smith did review Dr. Rudin's report following the injection by Dr. Downing at L2-L3. Claimant had 50% improvement temporarily but continued to have daily low back pain and bilateral leg pain. There was radiation of pain to the left buttock, left lateral thigh and left calf. The patient rated pain of 7/10. Her symptoms had failed to improve with various conservative treatments. The report went on in great detail as to the stenosis at the other levels and what treatment was required at the L2- L3 level.

Dr. Smith agreed that none of the defense reports from Dr. Stephens had anything to do with the L2- L3 level. There was no mention of the theory about adjacent segment disease either. Dr. Smith testified that the two imaging studies that he reviewed ruled out any acute injury to the L2-L3 level. It was only later that he heard about the theory of adjacent segment disease which was analyzed during his testimony. Even Dr. Rudin's theory was that there was nothing acute but that it was the fusion on the level below that somehow caused the stenosis. The question then in Dr. Smith's mind was weather the adjacent segment disease theory was reliable and he did not think that was the case. Dr. Smith it did admit that the report from Dr. Rudin dated May 31st 2017 does raise the issue of adjacent segment degeneration.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Causation

The Delaware Workers' Compensation Act states that employees are entitled to compensation "for personal injury or death by accident arising out of and in the course of employment." DEL. CODE ANN. tit. 19, § 2304. If there has been an accident, the injury is compensable if "the injury would not have occurred but for the accident". *Reese v. Home Budget Center*, 619 A.2d 907, 910 (Del. 1992). The accident need not be the sole cause or even a substantial cause of the injury. If the accident provides the 'setting' or 'trigger,' causation is satisfied for purposes of compensability." *Reese*, 619 A.2d at 910. "A preexisting disease or infirmity, whether overt or latent, does not disqualify a claim for workers' compensation if the employment aggravated, accelerated, or in combination with the infirmity produced the disability." *Reese*, 619 A.2d at 910. *See also State v. Steen*, Del. Supr., 719 A.2d 930, 932 (1998)("[W]hen there is an identifiable industrial accident, the compensability of any resultant injury must be determined *exclusively* by an application of the 'but for' standard of proximate cause.")(Emphasis in original); *Page v. Hercules, Inc.*, Del. Supr., 637 A.2d 29, 33 (1994). Because Claimant has filed the current petition, she has the burden of proof. DEL. CODE ANN. tit. 29, § 10125(c).

Additionally, an employer is under no obligation to identify or prove the existence of a non-work cause of injury. To defend against a petition for benefits, it is sufficient for the employer merely to present evidence rebutting the claim that an injury was work related. *See Strawbridge & Clothier v. Campbell*, 492 A.2d 853, 854 (Del. 1985); *Alfree v. Johnson Controls, Inc.*, Del. Super., C.A. No. 97A-04-005, Goldstein, J., 1997 WL 718669 at *7 (September 12, 1997). In this case, Employer has accepted an injury to Claimant's lumbar spine at the L3-4

level and paid certain benefits for that injury including a surgical procedure. The main issue for the Board to determine is whether the L2-3 level of Claimant's lumbar spine was also injured as a result of the February 26, 2015 compensable accident. Specifically was this level subject to adjacent level syndrome as a result of the compensable surgery at the level below. Claimant is seeking acknowledgment that the surgery at the L2-3 level and resultant disability was reasonable, necessary and causally related to the work accident. After reviewing the evidence the Board finds that Claimant has not met her burden of proof to show that she suffered a compensable injury to the L2-3 level of the lumbar spine as a result of the work accident or a subsequent surgical procedure.

The Board relies on Dr. Smith's opinion in this matter and finds it to be more persuasive and credible than that of Dr. Rudin. *DiSabatino v. Wortman,* Del., 453 A.2d 102,106 (1988)(as long as substantial evidence is found the Board may rely one expert over another). When the medical testimony is in conflict, the Board, in the role as the finder of fact, must resolve the conflict. *General Motors Corp. v. McNemar*, 202 A.2d 803 (Del. 1964). The Board finds Dr. Smith's explanation of the adjacent segment issue to be more scientifically reasonable and credible. Dr. Smith explained that it would be unusual for this level to have been the one affected as opposed to the lower L5-S1 level which is taking more stress being in between two fused segments (the sacrum being immobile anyway). Additionally he noted that it is not a common problem, occurring in less than 20% of fusion cases. Putting these two factors together and noting that it is Claimant's burden to prove the existence of and causal relationship of the adjacent segment disorder, the Board finds insufficient evidence to conclude in Claimant's favor.

Further the Board notes that Dr. Rudin heavily criticized Dr. Smith for not reviewing all the films and he always reviews all the films personally. Yet Dr. Rudin himself did not appear to

rely on the films, rather mostly on the complaints of pain. That is all well and good but Claimant's pain and areas of complaint have remained fairly constant throughout her treatment and were present to an extent even prior to the accident. Claimant clearly has a degenerative condition in her back which already caused her to have a fusion prior to the work accident. She was scheduled to have a hardware removal to address continuing pain complaints as well. Dr. Rudin is justifying the failure of his prior fusion and the second one following the accident on what appears to the Board to be very thin evidence of this adjacent segment disorder. Further there does not appear to be a clear cut operative lesion at the L2-3 level which would justify the surgery and may reduce the chance of a successful outcome. Dr. Smith testified that you normally consider a fusion when there is instability or a neurological deficit, which in his opinion is absent in this case. Claimant has some subjective complaints in her lower extremities, which don't seem to have changed much during her course of care. It is also notable that an EMG was negative for lower extremity radiculopathy which supports Dr. Smith's opinion in this case. All things considered there is scant evidence that surgery at the L2-3 level was reasonable, necessary or causally related to the work accident. Consequently Claimant's Petition is hereby denied.

STATEMENT OF THE DETERMINATION

For the reasons set forth above, Claimant's Petition is **DENIED.**

IT IS SO ORDERED THIS 26th DAY OF JUNE 2018.

INDUSTRIAL ACCIDENT BOARD

for Odell M Wilson
ROBERT MITCHELL

MARK A. MUROWANY

I, Eric D. Boyle, Hearing Officer, hereby certify that the foregoing is a true and correct decision of the Industrial Accident Board.

Mailed Date: 6/27/18

OWC Staff