BEFORE THE INDUSTRIAL ACCIDENT BOARD
OF THE STATE OF DELAWARE

JORGE PADRO,	)	
	)	
Employee,	)	
	)	
v.	)	Hearing No. 1173922
	)	
FOREVER, INC.,	)	
	)	
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 ("Board") on July 23, 2018 in a hearing room of the Board in New Castle County, Delaware.

PRESENT:

PETER HARTRANFT

VINCENT D'ANNA

Julie Pezzner, Workers' Compensation Hearing Officer, for the Board

APPEARANCES:

Donald Marston, Attorney for the Employee
Joseph Andrews, Attorney for the Employer

NATURE AND STAGE OF THE PROCEEDINGS

On August 24, 2000, Mr. Jorge Padro ("Claimant") sustained compensable work injuries to his cervical spine, his lumbosacral spine, his right shoulder and his left knee during the course and scope of his employment at Forever, Inc. ("Employer"). He also sustained a depressive disorder as a result of the work accident. Claimant's average weekly wage at the time of the work injury was $340.00 yielding a weekly compensation rate of $226.68. On August 30, 2017, Dr. James Zaslavsky recommended a surgical procedure at the C4-5 level. On June 6, 2018, Claimant filed a Petition to Determine Additional Compensation Due in which he seeks a determination that the proposed surgery is reasonable, necessary and causally related to the work accident. Employer disputes the causal relationship of the proposed surgery to the work injury.

A hearing was held only on Claimant's petition on July 23, 2019. This is the Board's decision on the merits.

SUMMARY OF THE EVIDENCE

Dr. James Zaslavsky who is board certified in orthopaedic surgery and is a certified provider under the Delaware Workers' Compensation Healthcare Payment System testified by deposition to a reasonable degree of medical probability on behalf of Claimant. Dr. Zaslavsky opined that the surgery he proposed is reasonable, is necessary and is causally related to both the work accident and to the surgery performed by Dr. Fisher on April 17, 2009.

Dr. Zaslavsky highlighted Dr. Fisher's medical notes and the ample diagnostic test results Claimant had since 2003. The September 11, 2003 EMG demonstrated C7 radiculopathy in the left upper extremity with moderate involvement. The October 10, 2003 MRI demonstrated mild degenerative narrowing of both C5 neural foramen and demonstrated very mild cord compression at C4-5.

On January 30, 2006, Dr. Fisher indicated he suspected possible C5 and C6 radiculopathy. Claimant was in the hospital in September 2006 during which time Claimant continued to demonstrate cervical radiculopathy. A September 23, 2006 MRI demonstrated at C4-5, a broad-based soft disk herniation, mild cord compression and mild spinal stenosis. Far laterally there was hook osteophytes encroaching on the neural foramen, on the spinal canal and on the exiting C5 nerve roots.

On October 23, 2006, Dr. Fisher indicated he reviewed with Dr. Grahovac X-ray films Dr. Grahovac took that demonstrated very significant cervical pathology. Dr. Fisher expressed in his medical notes concern that there was signal change in the spinal cord coming from compression at the C4-5 and C5-6 levels. Although there was a very small disk osteophyte complex at the two segments, there was very large posterior osteophytes coming off the laminar structures at C4-5 and C5-6.

On April 9, 2007, Dr. Fisher documented that an MRI demonstrated profound canal compromise at the C4-5 and C5-6 levels. Claimant had a large calcification of the ligamentum flavum on the left side at C4-5 and at C5-6. There was severe entrapment of the spinal cord. There was a concern for signal changes at those levels as well as myelomalacia (an irritation of the spinal cord to the point of permanent damage). Dr. Fisher initially recommended a cervical surgery involving an anterior corpectomy at the C5 level with posterior decompression and instrumentation. Dr. Zaslavsky explained that a C5 corpectomy is the removal of the C5 vertebrae. A C5 corpectomy would allow for decompression of both C4-5 and C5-6 relieving pressure off the spinal cord.

Claimant returned to Dr. Fisher on December 9, 2008. Claimant continued to complain of his previous cervical pain symptoms specifically with difficulty rotating to the left. Claimant had

pain associated with left arm pain that extended down to the hand with dysesthesias. In response to whether anything had changed since April 2007, Claimant said his dysphagia was worsening and his headaches were becoming more frequent. Dr. Zaslavsky commented that the headaches were associated with Claimant's spinal cord compression.

Dr. Fisher proceeded with the cervical surgery on April 17, 2009. He performed a C5-6 discectomy, C5-6 interbody fusion, an interbody implant at C5-6, anterior plating at C5-6, a C5-6 laminectomy; a C5-6 posterior fusion; a C5-6 posterior instrumentation; and fluoroscopic imaging. On March 9, 2010, Claimant reported that after the surgery, his preoperative neck and arm symptoms had resolved for approximately three months. Thereafter, such symptoms were progressively returning and becoming more frequent and more severe. Claimant had left-sided neck pain that radiated up his scalp and down his left arm. He complained of left scapular pain that radiated into his axilla. He felt pinched, tightness and burning. He complained of a loud snapping noise that occurred sometimes when he turned his neck. Dr. Fisher documented concern about adjacent segment disease. Dr. Zaslavsky testified that adjacent segment disease would be a legitimate concern especially in light of Claimant's preexisting problems at C4-5 that resulted from the work accident.

On April 12, 2010, Dr. Fisher noted that the MRI demonstrated a syrinx behind the body of C5, more on the left than the right. Dr. Zaslavsky explained that a syrinx is an area in the spinal cord that has undergone death and atrophy and has filled with fluid. There was no recommendation for surgery to address the syrinx.

The March 17, 2010 MRI report identified the following findings. It noted the prior C5-6 decompression. At C5-6, there was no disk protrusion. Compression of the left posterior aspect of the thecal sac was present by an extradural defect. It was unclear if it was a surgical material

or a calcified fragment. The report noted that a CT scan could be helpful. At C4-5, there was a broad-based disk protrusion that effaced the ventral aspect of the thecal sac. Cord compression was not seen. There was no spinal stenosis of the neural foramen or pain.

Claimant underwent a CT scan of the cervical spine on March 25, 2010. The report compared the CT scan to the MRI. According to the report there was a reversal of the normal lordotic curve. A C4-5 broad based disk osteophyte complex impinged on the ventral aspect of the thecal sac with moderate narrowing of the thecal sac and spinal stenosis that was slightly more prominent than on the current study. There was degenerative narrowing of the left neural foramen to a moderate degree. There was narrowing of the right neural foramen. A September 20, 2010 EMG of the bilateral upper extremities was normal. There was no evidence of radiculopathy or of peripheral neuropathy.

According to Dr. Roberts' October 19, 2010 report, Claimant's neck symptoms started after a fall. The pain was located in the cervical region in the midline. There was radiation of pain into the bilateral upper extremities with the left greater than the right. Claimant described the pain as achy, constant, irritating, and straining. The pain improved by medications. Claimant reported weakness in the left upper extremity. He complained of numbness and tingling in the distribution of his pain.

Claimant was not clinically myelopathic which means that while Claimant showed spinal cord compression on his MRI, Claimant did not present with signs and symptoms of myelopathy. Claimant was not off balance. He was not having difficulty with his hands in terms of fine motor dexterity. He was not having trouble opening water bottles and jars. He did not show any handwriting changes. He did not have abnormal reflexes like a Hoffman's sign or hyperreflexia in his lower extremities. Dr. Roberts noted that the etiology of Claimant's pain was not entirely

clear. Dr. Zaslavsky testified that other possibilities could include adjacent level segment issues, discogenic pain or facet arthralgia.

On November 8, 2010, Claimant underwent a whole-body bone scan. Planar whole-body images and spec images of the cervical and thoracic spine showed diffuse increased activity in the lower cervical spine correlating with the fusion at C5-6. Such findings were suggestive of chronic bone remodeling from Claimant's fusion.

An MRI of the cervical spine from December 14, 2010 re-demonstrated evidence of the fusion at C5-6 with previous posterior decompression on the left. It demonstrated the myelomalacia with deformity of the spinal cord at C5-6 on the left side.

On March 24 or 25, 2011, Dr. Fisher characterized Claimant's care as a "challenge". Zaslavsky Depo., 7/15/2019, 25:23). Claimant had significant cervical and lumbar pathology. He had a clear syrinx that was centered behind the body of C5 due to impressive heterotopic bone formation coming off the ligamentum flavum with severe spinal cord injury. Claimant's decompression was complete. The syrinx was well defined. Claimant had adjacent segment disease at C4-5 and C6-7. The EMG was normal. Dr. Fisher indicated that Claimant was not a surgical candidate for the syrinx or for the adjacent segment disease.

A March 8, 2012 EMG report noted a possible cervical syrinx. The report stated that Claimant now presented with chronic cervical pain and weakness in the left arm. There was evidence of marked left acute and chronic C7 radiculopathy.

A May 29, 2014 MRI of the cervical spine without contrast demonstrated the following. At C4-5, there was a posterior extradural defect that appeared to represent a disk osteophyte complex as opposed to a disk protrusion. Effacement of the ventral aspect of the thecal sac was present along with flattening of the ventral aspect of the spinal cord.

The last time Dr. Fisher saw Claimant was on March 2, 2015. The appointment was scheduled to address the lumbar spine aspect of Claimant's work injury. Claimant wanted to defer intervention of the lumbar spine and to focus treatment on the cervical spine. Dr. Fisher wanted Claimant to undergo a CT scan of the cervical spine for adjacent segment disease or degenerative changes. Dr. Fisher also recommended Claimant undergo a C5 selective nerve root block. Dr. Zaslavsky represented that a C5 nerve root block would target the C4-5 level.

On May 19, 2015, Claimant underwent the CT scan and an MRI. The CT scan report compared this scan to a prior CT scan. According to the report, there was a broad-based disk osteophyte complex that impinged on the ventral thecal sac at C4-5, more prominently currently with at least moderate narrowing of the thecal sac. There appeared to be impingement on the ventral aspect of the spinal cord at C4-5. The report stated that slight cord compression could not be excluded. Uncovertebral joint hypertrophy was noted at the level with slight narrowing of the neural foramen. There was once again evidence of previous anterior interbody fusion at C5-6 and unilateral metallic hardware on the right side extending from C5 to C6 with ankylosis of the facet joints bilaterally.

The May 19, 2015 MRI report noted cervical radiculopathy and spondylosis. There was a comparison to the February 2012 MRI. At C4-5 there was broad-based posterior disk protrusion flattened to the ventral thecal sac, moderately narrowing the spinal canal. There had been a slight progression of volume loss involving the left aspect of the spinal cord at that level. Uncovertebral hypertrophy resulted in mild bilateral neural foraminal narrowing.

Dr. Zaslavsky first saw Claimant on July 19, 2017. Claimant complained of pain radiating from his neck down the left upper trapezial region to the left shoulder, left triceps, left elbow, and into all of Claimant's left hand and fingers. Location of weakness was in the left wrist, the left

trapezius, the left triceps, the left elbow, the left radial forearm, and left hand and fingers. He described his pain as severe, aching, and shooting. Claimant's symptoms increased with activities. Modifying factors included: changing positions; sitting; applying heat; exercising; taking medications; resting; and stretching. The symptoms improved with injections, time and medication. Claimant reported having problems falling because his left leg would give out.

Dr. Zaslavsky's clinical assessment was of cervical and lumbar radiculopathy. Upon physical examination, Claimant had tenderness upon palpation of the left upper trapezial and parascapular regions. He had decreased left cervical rotation range of motion of forty-five degrees to the left and seventy-five degrees to the right. Extension was limited to fifteen degrees. He had good sensation distally to light touch except at the ulnar aspect of his left arm. He had two plus reflexes for his biceps, brachial radialis, and triceps on the right side. He was absent triceps reflex in his left arm. He had a positive Hoffman's sign, a positive left-sided Spurling maneuver, two plus over four reflexes for the biceps and brachial radialis in his left arm. He was unable to tandem gait walk without losing his balance. He had hyperreflexia of his patellar and Achilles reflexes.

Dr. Zaslavsky explained that a positive Spurling's sign is indicative of cervical radiculopathy or of the pinching of the nerve in the neural foramen. A positive Hoffman's sign along with the balance disturbance and hyperreflexia distally is indicative of clinical cervical myelopathy. Dr. Zaslavsky acknowledged that consistent with Dr. Roberts' 2012 examination of Claimant, Claimant did not demonstrate clinical signs of myelopathy but was developing them.

An August 3, 2017 MRI demonstrated at C4-5 moderate central disk protrusion that was stable compared to the previous MRI. There were small posterior osteophytes and uncovertebral hypertrophy causing mild spinal canal stenosis, neural foraminal stenosis and minimal impression on the ventral aspect of the spinal cord without intramedullary edema.

Dr. Zaslavsky reviewed the films from this MRI. Dr. Zaslavsky's impression was of stable myelomalacia of the cervical spinal cord at C5-6 level resulting from prior cord compression. There was no new abnormal signal visualized in the thoracic cord. The posterior fusion at C5-6 was stable without stenosis. There were mild degenerative changes and moderate disk osteophyte complex at C4-5 causing mild spinal canal and neural foraminal stenosis at the C4-5 level.

On August 30, 2017, Claimant was about the same overall. Claimant continued to have significant pain in bilateral trapezial regions that radiated to his left arm. He continued to have weakness in the left arm and difficulty with grip strength. He had trouble opening water bottles and jars. He complained of back pain, of numbness and of tingling in his legs.

On physical examination, Claimant had palpable muscle spasms and trigger point nodules in his upper trapezial region, positive left-sided Spurling's sign and positive Hoffman's sign on the left. He had weakness in his left triceps. He had four out of five weakness in his wrist flexors and extensors. Grip strength was a four plus over five bilaterally. He had some mild wasting of his first dorsal interossea (between the thumb and the index finger). Dr. Zaslavsky represented that the latter is the first muscle to get weak with spinal cord compression.

Dr. Zaslavsky has recommended the anterior cervical discectomy and fusion at C4-5 – the surgery at issue. Dr. Zaslavsky explained that he was concerned by the compression on the spinal cord. He agreed with the radiologist that it was not severe, but it was enough compression to cause changes and symptoms consistent with cervical myelopathy evidenced by: the positive Hoffman's sign; the hyperreflexia distally; the multiple and more frequent falls throughout the past three years; the deterioration of his tandem gait walking; and the balance loss. Falling is one of the most common symptoms of cervical spinal canal stenosis and clinical myelopathy. Claimant had full strength in his left arm and now he has weakness in his grip strength. Claimant has difficulty

opening jars. His left upper extremity is absent of a triceps reflex. He has a positive Spurling's sign to the left. Dr. Zaslavsky represented that these symptoms evolved over the last three to four years. Dr. Zaslavsky did not attribute the symptoms to the syrinx or to the myelomalacia. The syrinx and myelomalacia were stable findings.

Dr. Zaslavsky saw Claimant on March 28, 2018 and most recently saw Claimant on June 18, 2019. Dr. Zaslavsky testified that there was no significant change at either visit. Claimant continued to complain that his left leg was giving out. He continued to report left arm radicular symptoms with numbness and tingling. He had trouble sleeping. He had difficulty opening water bottles and jars. He felt as if his left arm was weak. He continued to have similar findings on the physical examination to include left-sided weakness and a positive Spurling's sign. His symptoms continued to be consistent with cervical radiculopathy and adjacent segment disease.

Dr. Zaslavsky opined that Claimant would benefit significantly from surgery. He explained that Claimant has exhausted conservative care. When a person has thecal sac compression and clinical myelopathy, the accepted cervical treatment is to decompress the spinal cord. Claimant's disease process will continue to progress putting more pressure on the thecal sac. The primary purpose of the surgery is to stop the progression of the disease process and the progression of the myelopathic symptoms. Dr. Zaslavsky stated that the surgery hopefully will improve some of the lost function in terms of restoring some of the myelopathic changes that had occurred in the past three years.

The fact that the surgery involves C4-5 in addition to C5-6 does not break the causal relationship of the surgery to the work injury. Dr. Zaslavsky explained that as early as 2006, Dr. Fisher identified the C4-5 and C5-6 levels as the culprits. Dr. Fisher documented multiple times

in his medical notes that that compressive lesions at C4-5 and C5-6 were responsible for the myelopathic changes in the spinal cord and should be addressed.

Dr. Zaslavsky continued that an EMG was consistent with C7 radiculopathy. Dr. Zaslavsky represented that C7 radiculopathy correlates with the C4-5 level because the C7 nerve root passes past the C4-5 and C5-6 disk spaces. Dr. Fisher's initial contemplated surgery included the C4-5 level. Dr. Fisher specifically contemplated doing a C5 corpectomy that would have addressed C4-5 and C5-6. Ultimately Dr. Fisher proceeded with the conservative route by addressing the most severe level at C5-6 in hopes of restoring function and keeping the surgery as conservative as possible.

Dr. Zaslavsky stated that he and Claimant discussed the surgery multiple times. Claimant understands that the surgery is designed to stop the progression as opposed to removing his symptoms. Claimant has recognized the gradual decline. Dr. Zaslavsky did not detect any signs of symptom magnification or malingering. Claimant has been very consistent in his pain reports and very consistent in his physical examinations.

Claimant testified on his own behalf. He turned fifty-five years old on July 9. His neck symptoms started in 2002. He treated with Dr. Fisher for his neck and his back symptoms. Claimant testified that Dr. Fisher's surgery temporarily addressed the neck and arm pain. During the duration of benefit, Dr. Fisher's treatment focused on treating Claimant's back.

Gradually, Claimant's neck symptoms increased and became a priority over the back. In 2015, Claimant ruptured his intestines. From 2015 to 2017, Claimant was hospitalized six to seven times for a series of deathly infections. The latter episodes put his work accident-related treatment on hold – hence, the gap in treatment. Despite the gap in treatment, Claimant's neck and arm symptoms continued to gradually progress.

Claimant represented that Dr. Fisher discussed adjacent segment disease with him even though such discussion was not reflected in the medical records. Dr. Fisher did not recommend a second surgery.

Claimant's main issue is that he cannot sleep or function because of his constant pain. He once went two-and-a-half weeks without sleeping. At times, he can temporarily mentally block out the pain to enable him to fall asleep. When he sleeps, he usually sleeps two to four hours. He typically tries to sleep with two to three pillows between his legs. Sometimes he sleeps with three or more pillows between his legs.

Claimant testified that he is also afraid to fall asleep because of his nightmares. He awakens feeling trapped in his body. He was hospitalized for two weeks after a suicide attempt. He hears voices. Claimant represented that he never had psychological issues prior to the work accident. He did not recall seeking treatment when he was thirteen or twenty-five years old.

The sleep deprivation impacts his ability to drive, to think, and to have relationships particularly with his daughter and grandchildren. Sleep deprivation causes mood swings. He has had panic attacks while driving.

Claimant listed his medications. He testified that the medications only help him to a certain point. They provide an hour of relief. Claimant rated his pain during the hearing at a seven-point-five to an eight on a ten-point pain scale.

Claimant testified that he wears a compression sleeve over his elbow because he has difficulty grabbing things. He has headaches. He demonstrated his limited range of motion and showed the Board how crooked his left arm is as a result of the work accident. The Board observed that Claimant's arm was not as crooked during other parts of his testimony.

Claimant testified that he has lost weight since the work accident. He used to weigh between one hundred ninety-five to two hundred pounds and now he weighs one hundred forty pounds. He was doing fine leading up to the work accident.

Claimant wants to proceed with Dr. Zaslavsky's recommended surgery. He cannot deal with the pain any longer. It is driving him insane. Claimant understands that Dr. Zaslavsky would like to do a disk replacement and fusion to release the pressure off the cervical cord. The primary purpose of the surgery is to stop the progression of symptoms. He might experience some improvement in symptoms, but Claimant knows he will continue to have problems. He understands the surgery will reduce his already limited range of motion of the cervical spine. Claimant knows other people who have had similar surgeries that were successful.

Claimant acknowledged that in 2012, the Board in a decision after a hearing on the merits terminated his total disability benefits. Claimant has exhausted his partial disability benefits. He has not returned to work since the 2012 Board decision nor has he looked for a job. He is hopeful the surgery will enable him to return to work, even if only for four-hour shifts.

Dr. Lawrence Piccioni who is board certified in orthopaedic surgery testified by deposition to a reasonable degree of medical probability on behalf of Employer. He treats patients with neck problems including patients having complaints resembling Claimant's. He does not perform surgery. Dr. Piccioni opined that based on the history and on his defense medical examination, there was no objective evidence supporting C5 nerve root involvement or radiculopathy that would relate to the work accident or to Dr. Fisher's surgery. Dr. Piccioni stopped short of challenging the reasonableness and necessity of the proposed surgery. He stated that Claimant's subjective complaints and subjective physical examination findings might support the suggested surgery. However, he emphasized that if asking ten surgeons to opine about the reasonableness or necessity

of the proposed surgery, they might provide three or four different opinions. He testified, "I'm not going to argue that point, but the point I am going to state is, whether you think it's reasonable or necessary, it's just in no way, in my opinion, is it causally related to this industrial accident as far back as 2000." (Piccioni Depo., 7/16/19, 51:4-10).

Dr. Piccioni acknowledged that Claimant sustained an injury at C5-6 with myelomalacia as a result of work-accident related falls. Myelomalacia is an injury related to pinching of the spinal cord. The myelomalacia was primarily at the C5-6 level. There was also a disk osteophyte complex at C5-6.

Dr. Piccioni also acknowledged that Dr. Fisher initially considered performing a corpectomy at C5 which can affect the C4-5 and C5-6 levels. Ultimately, Dr. Fisher performed a discectomy and decompression on both sides of the spine at C5-6 and did a fusion at C5-6. On January 21, 2013, Dr. Fisher indicated that the cervical spine was stable post-surgery and that no additional surgery was indicated. Dr. Fisher noted that Claimant had a unique cervical pathology presenting with profound redundancy of bone of the posterior elements of the severe spinal cord injury. Dr. Piccioni explained that the latter statement indicates an unusual condition of a lot of arthritic changes out the back of the cervical spine that could potentially lead to some of Claimant's problems, but it was only at the C5-6 level.

On March 2, 2015, Dr. Fisher recommended that Claimant undergo a cervical MRI and a CT scan. Claimant did not follow-up with such diagnostic tests. Claimant stopped treating with Dr. Fisher because Dr. Fisher no longer was accepting Claimant's insurance.

Dr. Piccioni testified that Claimant underwent multiple diagnostic tests from May 9, 2001 through August 2017. Tests included multiple MRIs, plain x-rays, flexion/extension films and EMGs looking for instability and there was no confirmation. One EMG showed C7 radiculopathy

and one EMG showed a normal left upper extremity. Neither EMG demonstrated C5 radiculopathy. An MRI did not demonstrate C7 radiculopathy or left-sided nerve compression at C7. Dr. Piccioni speculated that either the C7 radiculopathy identified on the one EMG was an incorrect pattern or the C7 radiculopathy could not be seen on the MRI. Dr. Roberts at Christiana Spine Center after reviewing the MRI films felt that there could be some residual related to the myelomalacia at C5-6.

Claimant's most recent MRI occurred on August 3, 2017 MRI. The report compared this MRI to a May 19, 2015 MRI and to an October 10, 2003 MRI. According to the report, the findings appeared stable. There had been no progressive change radiographically.

At the October 19, 2018 defense medical examination, Claimant complained of neck pain that he rated at an eight on a ten-point pain scale. He had pain going into his left hand towards his middle finger that he rated at a seven on a ten-point pain scale. Claimant thought the pain going down his left arm into the middle finger related to when he had an IV in his arm from a GI problem. Claimant also complained of an unstable gait, lack of range of motion, and pain in his left leg. He was treating with Dr. Raisis for his pain and his range of motion deficits.

Dr. Piccioni testified that Claimant did not present with complaints involving the C5 dermatome distribution. The cervical nerves come above the disk of the same number. Hence, the C4-5 level relates to the C5 nerve, the C5 dermatome distribution.

Dr. Piccioni explained that the C5 dermatome can affect weakness in the rotator cuff and in the biceps. The pain relating to the C5 dermatome would extend from the neck to the left bicipital area but not below the biceps and not to the elbow. Hence, if Claimant's symptoms involved the C5 dermatome, Dr. Piccioni would expect to see biceps weakness, rotator cuff weakness, and/or atrophy in more severe cases. The EMG should also confirm C5 dermatome

involvement. The MRI or CT scan should demonstrate significant compression at the C4-5 level leading to C5 radiculopathy. On the other hand, Claimant's pain complaints into his left middle finger related to the C7 dermatome. C7 radiculopathy does not involve the C5 nerve root.

Dr. Piccioni noted that Claimant walked without a limp or list. He did not use any ambulatory aids. Dr. Piccioni commented that if the myelomalacia was causing a cord problem, the patient usually would have an ataxic kind of gait - an unsteady gait and/or a wide-based gait. Upon physical examination, Dr. Piccioni did not detect spasm (an objective sign) in the cervical spine. Flexion, extension, lateral rotation, and lateral bend were limited by Claimant. Range of motion is subjective. When undergoing the Spurling test, Claimant reported mild left-sided trapezial pain when turning his head to the left. Claimant did not have pain down the arm in the dermatomal pattern. A positive Spurling maneuver requires pain down the dermatomal pattern (down the arm), not just pain. Claimant had negative Spurling maneuver for arm pain.

Sensorimotor examination and deep tendon reflexes were intact in the left upper extremity. There was no sensory loss, no motor loss and the deep tendon reflexes were equal. Dr. Piccioni did not find evidence of fasciculations (muscle twitching on its own), evidence of atrophy or evidence of muscle wasting. The latter would be objective signs and fairly significant signs of denervation that could result from the spinal cord portion or from the radiculopathy.

With respect to the proposed surgery, Dr. Piccioni testified that there are two reasons to perform the surgery Dr. Zaslavsky is recommending: 1) the patient has segmental instability; and/or 2) the patient has neurological compromise. Dr. Piccioni testified that Claimant did not meet either of the two scientific criteria. Dr. Piccioni found no evidence of C5 radiculopathy or of active myelopathy. Dr. Piccioni did not find anything objective on physical examination or on any of the radiologic CT scans or MRIs to support C5 nerve root involvement or to support the

surgery being proposed. During the defense medical examination, Claimant had a negative Phalen's test. Claimant did not demonstrate impingement signs. He was negative on Crank's test and Speed's test. He had no evidence of adhesive capsulitis or of atrophy including atrophy of the neck, the shoulders, the lumbar region or of the legs. There were no progressive neurologic deficits other than subjective complaints and such complaints were not consistent with C5. Claimant only had one positive EMG for radiculopathy, but it was positive at C7 and not C5.

Dr. Piccioni concluded that the biggest part of the injury appears to be the myelomalacia of the cervical cord that has led to some neurological symptoms. C5 radiculopathy, on the other hand, is a peripheral nerve outside of the cord. These are two totally different locations. Dr. Piccioni acknowledged that the cervical spine could affect the lower extremities depending on the severity of impact at the cord level. In Claimant's case, there would have to be a new or worsening of the myelomalacia to cause lower extremity symptoms from the cervical spine. Diagnostic tests demonstrated a stable condition. The myelomalacia remained at four millimeters of scarring on the subsequent MRIs. It has not worsened. There was no MRI report stating that it was worsening or going to the next level. If it were extending to the next level, Dr. Piccioni opined that surgery would be reasonable, necessary and causally related. However, the myelomalacia is not in and of itself a need for the surgery being proposed at C4-5 and because of its stable condition, it does not require surgery.

Dr. Piccioni concluded that he did not see anything to relate any C4-5 surgery to the industrial accident. He explained that the only way to scientifically relate surgery at C4-5 to the work accident is if Dr. Fisher was wrong and that C4-5 was always compressing the spinal cord and Claimant never got better. The other reason would be if the C4-5 problem worsened to attribute the worsening to adjacent segment disease. The MRI findings were moderate but stable.

Dr. Piccioni recognized that he saw Claimant one time unlike Dr. Zaslavsky. Dr. Piccioni also recognized that Claimant was compensated for a thirty-nine percent permanent impairment of the cervical spine. Dr. Piccioni stated that a single fusion and myelomalacia can rate at a thirty-nine percent permanent impairment and neither involves the C4-5 level. No doctor has placed Claimant on total disability since the Board terminated his total disability benefits. Dr. Piccioni would limit Claimant to six-hour shifts.

Dr. Piccioni added that Claimant demonstrated signs of malingering but stopped short of calling Claimant a malingerer. He noted that Claimant would not move his shoulder for range of motion testing but when distracted by testing of the neck, he moved his shoulders.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

In order to be compensable, the injury must arise out of or be in the course of employment. 19 *Del. C.* § 2304. As this is the Claimant's Petition, Claimant has the burden to prove by a preponderance of the evidence that the injury was caused by the work accident. *Goicuria v. Kauffman's Furniture*, Del. Super., C.A. No. 97A-03-005, Terry, J., 1997 WL 817889 at *2 (Oct. 30, 1997), *aff'd*, 706 A.2d 26 (Del. 1998). The "but for" definition of proximate cause that is used in the area of tort law is the applicable standard for causation. *Reese v. Home Budget Center*, 619 A.2d 907, 910 (Del. Supr.1992). Hence, the Claimant must prove that "the injury would not have occurred but for the accident. 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.

When an employee has suffered a compensable injury, the employer is required to pay for reasonable and necessary medical services/treatment causally related to that injury. 19 *Del. C.* §2322. What constitutes "reasonable medical services" for purposes of Section 2322 is determined

by the Board on a case-by-case basis. *See Willey v. State*, Del. Super., C.A. No. 85A-AP-16, Bifferato, J., 1985 WL 189319 at *2 (November 26, 1985). "Whether medical services are necessary and reasonable or whether the expenses are incurred to treat a condition causally related to an industrial accident are purely factual issues within the purview of the Board." *Bullock v. K-Mart Corporation*, Del. Super., C.A. No. 94A-02-002, 1995 WL 339025 at *3 (May 5, 1995). The medical testimony is at direct odds. The Board is free to choose between conflicting medical expert opinions so long as there is substantial evidence to support the finding. *Reese v. Home Budget Center*, 619 A.2d 907, 910 (Del. 1992); *Scarberry v. Chrysler Corp.*, Del. Super., C.A. 96A-07-003 Herlihy, J. slip op. at 2 (Dec. 12 1996). Based on the entirety of the evidence incorporated herein, the Board accepts the opinions of Dr. Piccioni over the opinions of Dr. Zaslavsky.

The Board recognizes that Dr. Fisher initially suspected C4-5 and C5-6 levels to be the source of Claimant's symptoms. In March 2011, Dr. Fisher identified adjacent segment disease at C4-5 that was not surgical. Dr. Fisher initially considered incorporating into his surgery a C5 corpectomy. Ultimately, Dr. Fisher determined to surgically address only the C5-6 level. On January 21, 2013, Dr. Fisher indicated that the cervical spine was stable, and that no additional surgery was indicated. On March 2, 2015, Claimant's last visit with Dr. Fisher, the focus of medical attention returned to being on the cervical spine. Dr. Fisher ordered diagnostic tests to include an MRI and a CT scan that Dr. Zaslavsky testified were directed to the C4-5 level.

According to Dr. Piccioni there are only two reasons to warrant the surgery that Dr. Zaslavsky is recommending: 1) to address segmental instability; and 2) to address neurological compromise. Dr. Piccioni testified that Claimant did not meet either of the two scientific criteria. Claimant underwent multiple MRIs, X-rays and EMGs from 2003 through August 3, 2017. While

there were positive findings at the C4-5 level, according to Dr. Piccioni, none of the diagnostic tests confirmed instability. None of the diagnostic tests supported C5 radiculopathy. The report from the August 3, 2017 MRI compared its findings to the MRI findings from May 19, 2015 and October 10, 2003 and the report indicated that the findings, while moderate, appeared stable. There had been no progressive change radiographically. Hence, there was no worsening at C4-5 to attribute the worsening to adjacent segment disease.

Dr. Zaslavsky's surgical focus is on C5 radiculopathy. Dr. Piccioni testified that the MRI or CT scan did not demonstrate significant compression at the C4-5 level that would lead to C5 radiculopathy. Even Dr. Zaslavsky recognized that the diagnostic tests did not demonstrate severe compression although he testified that it still caused him concern. Dr. Piccioni found no evidence of C5 radiculopathy or of active myelopathy. Dr. Piccioni did not find anything objective on physical examination or on any of the radiologic CT scans or MRIs to support C5 nerve root involvement or to support the surgery being proposed.

During the defense medical examination, Claimant had a negative Phalen's test and Spurling's sign. Claimant did not demonstrate impingement signs. Claimant's Crank's test and Speed's test were negative. He had no evidence of adhesive capsulitis or of atrophy including atrophy of the neck, the shoulders, the lumbar region or of the legs. There were no progressive neurologic deficits other than subjective complaints and such complaints were not consistent with C5.

Dr. Piccioni explained that pain relating to the C5 dermatome would extend from the neck to the left bicipital area but not to the elbow. Instead, at the defense medical examination, Claimant's pain complaints extended down the left arm and into his left middle finger. Claimant's complaints to Dr. Zaslavsky consistently involved the extension down the left arm to the left hand

and fingers. Dr. Piccioni testified that pain extending to the middle finger relates to the C7 dermatome. Dr. Piccioni testified that C7 radiculopathy does not involve the C5 nerve root contrary to Dr. Zaslavsky's testimony. While there was one EMG that was positive for radiculopathy, such EMG was positive at C7 and not C5.

Dr. Piccioni testified that the biggest part of the injury appears to be the myelomalacia of the cervical cord at C5-6. The myelomalacia is at a different location than the origin of C5 radiculopathy. Myelomalacia occurs in the spinal cord whereas radiculopathy originates from the peripheral nerve outside of the spinal cord. Dr. Piccioni opined that had the myelomalacia worsened to go to the next level at C4-5, surgery at that level would be reasonable. If there was a new myelomalacia or a worsening of the present one, it could cause lower extremity symptoms. However, the myelomalacia has remained stable and has not worsened. The myelomalacia remained at four millimeters of scarring on the subsequent MRIs. There was no MRI report stating that it was worsening or going to the next level. Dr. Zaslavsky also testified that the myelomalacia does not require surgery.

The Board recognizes that Claimant was compensated for a thirty-nine percent permanent impairment of the cervical spine. Such permanent impairment relates to the C5-6 level. There was no evidence that the rating incorporated the C4-5 level.

The evidence that could support Dr. Zaslavsky's proposed surgery heavily relies on Claimant's subjective complaints and examination findings that have a subjective component. Claimant presented with credibility issues with respect to the extent of injury-related symptoms. He appeared to view himself as more limited than he is. Claimant demonstrated to the Board the extent of limited movement of his left arm. However, at another point in his testimony, his left arm movement exceeded what he testified was his limited range of motion. Similarly, Dr. Piccioni

noted during his defense medical examination that Claimant was unable to move his shoulder for range of motion testing but when distracted by testing the neck, Claimant moved his left shoulder. Pursuant to a 2012 hearing on the merits, a prior Board held that Claimant was capable of returning to work. However, Claimant acknowledged that he has not viewed himself as being capable of returning to work in any capacity. Claimant did not present forthcoming about medical issues pre-dating the work accident, particularly with respect to psychological treatment. Instead, he attributed his psychological issues exclusively to the work accident and either denied or could not recall pre-work accident symptoms and treatment. For the reasons stated above, the Board does not find that Claimant met his burden of proving the proposed surgery is compensable.

STATEMENT OF THE DETERMINATION

For the reasons set forth above, Claimant's Petition for Additional Compensation Due is DENIED.

IT IS SO ORDERED THIS 24th DAY OF OCTOBER, 2019.

INDUSTRIAL ACCIDENT BOARD

PETER HARTRANFT

VINCENT D'ANNA

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

Mail Date: 10/25/19

TP

OWC Staffing