STATE OF VERMONT
DEPARTMENT OF LABOR AND INDUSTRY

	)	State File No. K-15741
Richard Haggart	)	
	)	By: Margaret A. Mangan
v.	)	Hearing Officer
	)	
General Dynamics	)	For: Steve Janson
	)	Commissioner
	)	
	)	Opinion No. 11-00WC

Hearing held in Montpelier, Vermont, on October 13, 1999
Record closed on November 15, 1999

APPEARANCES:

Thomas C. Nuovo, Esq. for the claimant
John W. Valente, Esq. for the employer

ISSUE:

1. Does this Department have jurisdiction to review the Workers' Compensation Division's decision regarding permanency when the parties' ratings differ by less than ten percent or must the issue be taken to Superior Court?

2. If the answer to the first question is in the affirmative, what degree of permanent partial impairment did claimant incur as a result of his January 1997 work-related injury?

EXHIBITS:

Joint Exhibit I:	Medical records
Claimant's Exhibit 1:	Letter from Director of Workers' Compensation to AIG, 3/18/99
Claimant's Exhibit 2:	Attorney fee agreement
Claimant's Exhibit 3:	Medical articles (*Id*. only)
Claimant's Exhibit 4:	Curriculum Vitae of Charles McLean, D.C.
Defendant's Exhibit A:	Transcript of deposition of Victor Gennaro, D.O., 6/18/99
Defendant's Exhibit B:	Transcript of deposition of Christopher Brigham, M.D. 9/20/99

FINDINGS OF FACT:

1. On March 18, 1999, Charles D. Bond, Workers' Compensation Director, rejected the defendant's position that claimant was only entitled to a 5% permanency award and ordered AIG to pay the claimant permanency based on the 10% rating assessed by the

claimant's doctor, Charles McLean, D.C. Mr. Bond informed the parties that any appeal from his decision lay with superior court. In response to the director's order, AIG requested a hearing in this Department, not in superior court.

2. The instant permanency dispute stems from a January 1997 gradual onset injury at General Dynamics in Burlington that resulted in claimant's low back pain. Claimant told one of his treating physicians, Dr. Roland Hazard, that he attributed the problem to a good deal of bending at work.

3. The radiologist who studied the examination of claimant's lumbosacral spine in February 1997 concluded that claimant had "Mild DJD [degenerative joint disease] of the lumbar spine." A few months later, in May 1997, the MRI scan of claimant's spine at L-5 was interpreted as normal, with no evidence of disc herniation or spinal stenosis.

4. Claimant's medical records state repeatedly that he initially suffered pain in the right upper lumbar and low thoracic area. After a quick resolution of that problem, the primary problem became claimant's left lumbosacral pain, as documented in Dr. Hazard's July 17, 1997 office note. In that same note is the observation that claimant had no "fixed pain, power or sensory loss in his lower extremities."

5. After the claimant reached a medical end result, both parties obtained permanency ratings. Victor Gennaro, D.O., performed the first rating after examining the claimant and reviewing his records. Dr. Gennaro classified claimant as having a Diagnosis-Related Estimate (DRE or Injury Model) Category II: Minor Impairment with a 5% whole person impairment of the lumbar spine. Charles McLean, D.C., claimant's treating chiropractor, performed the second evaluation with the conclusion that claimant was more appropriately in DRE Lumbosacral Category III: Radiculopathy with a 10% whole person rating.

6. Later the employer asked Christopher Brigham, M.D., recognized expert in the use and application of the *AMA Guides to the Evaluation of Permanent Impairment (Guides)*, to review the records and assign a permanency rating. Dr. Brigham agreed with Dr. Gennaro that claimant's impairment fell within DRE Category II.

7. Dr. McLean has treated claimant for more than a year. According to the claimant, Dr. McLean was the first clinician who was able to provide pain relief for him. In all, Dr. McLean has seen claimant for chiropractic treatment more than 100 times. The claimant testified that within a week after he began treatment with Dr. McLean, he was off of drugs and back to work.

8. Dr. McLean testified that he could see how the claimant would react to certain stimuli on a repeated basis during manipulations and treatment. Dr. McLean also testified that he had seen the claimant get in and out of his car on numerous occasions and also watched him walk, sit, and stand up when he had appointments. Dr. McLean had access to all of claimant's medical records when he did his evaluation.

9. Dr. McLean's determination that claimant has a 10% permanent impairment is based on the premise that claimant has a sensory radiculopathy that places him in the DRE

Category III. He also arrived at a similar rating using the Range of Motion Model. Dr. McLean testified that under the Range of Motion Model claimant is suffering from an "unoperated on, stable, with medically documented injury, pain and rigidity associated with none to minimal degenerative changes on structural tests, such as those involving roentgenography or magnetic resonance imaging." *Guides,* Table 75 at 113. That description alone would correspond to a 5% rating under Table 75. Dr. McLean then added to that 5%, an additional 1% for decrease in right lateral flexion, 1% for a decrease in left lateral flexion and 2% for the decrease in lateral extension.

10. Dr. McLean concedes that claimant does not have a motor radiculopathy. The compromise that affects the claimant, he explained, is sensory. Dr. McLean acknowledged that he departed from a strict interpretation of the *Guides,* but that such departure can be expected because the "G*uides* do not supersede the art of medicine."

11. With regard to the choice between methods, the *Guides* at 99 provide:

> If the physician cannot decide into which DRE category the patient belongs, the physician may refer to and use the Range of Motion Model … . Using the procedures of that model, the physician combines an impairment percent based on the patient's diagnosis with a percent based on the patient's spine motion impairment and a percent based on neurologic impairment, if it is present. The physician uses the estimate determined with the Range of Motion Model to decide placement within one of the DRE categories. The proper DRE category is the one having the impairment percent that is closest to the impairment percent determined with the Range of Motion Model.

12. Dr. McLean, therefore, concluded that claimant had a 9% impairment under the Range of Motion Model, which most closely corresponded with a 10% rating under DRE, Category III.

13. On October 19, 1998, Dr. Gennaro evaluated claimant for purposes of obtaining a permanency. In the report that followed that visit, Dr. Gennaro inaccurately referred to the development of increasing right lumbar spinal pain, when in fact that pain was on the left. Dr. Gennaro took a history that revealed a history of pain radiating into claimant's legs. On examination, he noted that claimant's forward bending was limited, but that his side bending and rotation were normal or full. He diagnosed chronic low back pain and determined that claimant had reached maximum medical improvement. In his report he commented on the "unfortunate" lack of physical evidence and diagnostic studies to support claimant's "profound complaints of pain." At the same time, he found no evidence of exaggerated pain behavior or positive Waddell's signs.

14. Dr. Gennaro concluded that claimant fit into DRE Category II. He based that conclusion on medical records that showed non-uniform loss of range of motion, muscle spasm and guarding observed by other physicians and non-verifiable radicular complaints. That category corresponds with a 5% impairment.

15. Dr. Gennaro further explained that the 5% whole person rating was appropriate because claimant's physical examination was essentially normal. He had little restrictive motion, and although he had some complaints of left lower extremity radiation, radiculopathy

could not be verified objectively. Specifically he noted that claimant did not have the loss of a reflex, nor did he have significant muscle weakness or positive diagnostic testing. There was no frank herniation, no nerve root entrapment, no vertebral fractures, and no instability of the spine.

16. Dr. Gennaro testified that the primary differentiator between a Category II and Category III impairment is observable radiculopathy which must be present before a Category III determination can be made.

17. After reviewing claimant's medical records, Dr. Brigham observed that they contained a clear factual basis to conclude that there was "guarding." However, he found no factual support to support a conclusion that claimant had radiculopathy.

18. Dr. Brigham explained that the DRE is determined first by identifying specific differentiators. In this case, "guarding" is one such differentiator consistent only with a DRE category II. The differentiators associated with Category III and specific to radiculopathy, namely loss of reflexes, decreased circumference or atrophy of muscle and electrodiagnostic evidence, are absent in this case.

19. Dr. Brigham agreed that at times physicians appropriately go outside the *Guides* to assess impairment, but they should do so only when the *Guides* provide no specific methodology for a particular assessment, as would be the case for post traumatic epicondylitis. Otherwise, he explained, the Guides provide consistency and reliability in the assessment process.

20. All medical experts in this case agree that the impairment ratings in the various chapters in the *Guides* make allowance for the pain that might accompany the impairing condition.

CONCLUSIONS OF LAW:

A. Jurisdiction

1. The first issue for decision is whether this case can be decided in this Department, or whether only a superior court can decide whether the Workers' Compensation Division erred when it ordered the carrier to pay permanency based on a 10% impairment rating. The instant dispute is one involving a 5% difference.

2. Under 21 V.S.A. § 667 (a), and Rule 14 (g), "if a dispute involves permanent partial ratings which differ by 10 per cent or less, the rating shall be determined by the commissioner." In situations such as this case, before a case reaches the hearing docket, the commissioner's designee, typically the Director of Workers' Compensation or a Workers' Compensation Specialist, determines the permanency rating when the difference is less than 10%.

3. A Rule 14(g) determination by a specialist or the director is no different than an interim order "that payments be made in whole or in part." Rule 6(d). A party disagreeing with that order should follow Rule 4 and file a Notice and Application for Hearing with the Division, as was done here. Only after the hearing decision is issued, does the party have

the right to take the issue to superior court under 21 V.S.A. § 670 or to the Supreme Court under § 672. Accordingly, the employer properly requested a hearing in the Department in this case.

B. Permanency

4. Central to the employer's theory in this case is that the *Guides* must be strictly construed. In contrast, the claimant argues that departure from rigid rules is necessary if, in the best clinical judgment of the physician, a different rating is required.

5. The claimant urges this Department to defer to the judgment of the treating physician in this case, Dr. McLean, who has had the most contact with the claimant. However, such deference is not appropriate in a case that essentially turns on these two discrete distinctions: 1) whether the DRE or Range of Motion Model should be applied to this case; and 2) whether the *Guides* provide a permanency rating for sensory radiculopathy.

6. Of the two methods for assessing permanency of the spine, the *Guides* clearly provide that the DRE or Injury Model is the preferred method. However, in those cases in which there is disagreement about the appropriate category, then the Range of Motion Model may be used. *Guides*, § 3.3 page 94.

7. The *Guides* also provide that the "evaluator must use his or her clinical experience and judgment when assessing whether a deviation from 'normal' is or is not an alteration in a particular individual's health status. Deviation from these *Guides* is expected, and it is your prerogative when clinical judgment dictates." *Id*. at 8.

8. With the 4th edition of the *Guides*, the contributors elected to approach impairment to the spine with two methodologies. The first, which applies especially to patients' traumatic injuries, is the one known as the DRE or Injury Model. The second, the Range of Motion model, had been recommended in previous editions. *Id*. at 94. The *Guides* unequivocally provide that the "evaluator assessing the spine should use the Injury Model, if the patient's condition is one of those listed in Table 70 … . If none of the eight categories of the Injury Model is applicable, then the evaluator should use the Range of Motion Model." *Id*. at 94.

9. Of the eight categories in Table 70, the only patient condition listed for Category I is:

- Complaints or symptoms

The three conditions that apply to Category II are:

- Vertebral body compression, less than 25%
- Posterior element fracture, healed, stable, no dislocation or radiculopathy
- Transverse or spinous fracture with dislocation of fragment, healed, stable

Conditions listed for Category III are:

- Vertebral body compression fracture 25%-50%
- Posterior element fracture with spinal canal displacement or radiculopathy, healed, stable
- Radiculopathy

Guides at 108

10. In this case, the claimant's complaints and symptoms would place his condition within the first category in Table 70. But that does not end the analysis. To direct the practitioner further, the *Guides* list "DRE Impairment Differentiators" in Table 71, which are: 1) Guarding, 2) Loss of reflexes, 3) Decreased circumference, atrophy, 4) Electrodiagnostic evidence, 5) Loss of motion segment integrity, 6) Loss of bowel or bladder control and 7) Bladder studies. *Id*. at 109.

11. In Table 72, the *Guides* next assign a percentage impairment of the whole person to a DRE Impairment Category and corresponding description. DRE I, described as "complaints or symptoms" carries a 0% impairment. DRE II, with an impairment rating of 5%, is described as "Minor: impairment; clinical signs of lumbar injury are present." DRE III, with a 10% impairment rating, is described as "radiculopathy: evidence of radiculopathy is present." *Id*. at 110.

12. The text of the *Guides* specifies that radiculopathy corresponds to specific differentiators, namely loss of reflexes, decreased circumference or atrophy and electodiagnostic evidence.

13. Contrary to claimant's assertion, the Range of Motion Model is not the appropriate method for assessing permanency in this case. The *Guides* clearly and unambiguously specify that the DRE Model is the preferred method. The claimant's condition fits into the DRE list of conditions, albeit at a level lower than that advocated by either party. And, this Department's precedent favors the DRE approach. See, *DiBenedetto v. The Personnel Connection*, Opinion No. 12-98WC (Feb. 20, 1998).

14. Dr. McLean has proven himself a competent and effective practitioner, as well as a loyal advocate for this claimant. However, his creative assignment of sensory radiculopathy cannot be reconciled with this Department's precedent or any interpretation of the *Guides.* For this claimant to fall within DRE III he would have to have radiculopathy manifested by loss of reflexes, atrophy of muscles or positive electrodiagnostic evidence. Discomfort observed by a clinician cannot be categorized as the radiculopathy as that term is used in the *Guides.*

15. Because this case is one that can clearly be assigned to a DRE category, it is not permissible to depart from its specific requirements.

16. Accordingly, I conclude that claimant's has incurred a 5% whole person permanency rating under DRE Category II. His claim that he is entitled to more must be denied.

ORDER:

Based on the foregoing Findings of Fact and Conclusions of Law, claimant's claim for 10% permanency and attorney's fees and costs is DENIED.

Dated at Montpelier, Vermont, this 16th day of May 2000.

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Steve Janson
Commissioner