ANOTHER INSTALLMENT IN THE *GEORGE THE BARTENDER* SERIES

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RE: GEORGE THE BARTENDER AND THE DILEMMA BETWEEN RADIATING PAIN AND RADICULAR PAIN

FROM THE LOBBY BAR AT THE HYATT:

As I sipped my first Beefeater's martini, straight up with two olives, I looked lovingly at Kim, the Hyatt's breathtakingly beautiful cocktail waitress, who had just served me. I noticed that something was amiss!

I could not put my finger on it at first, but then realized that the bar was as quiet as a tomb, despite the fact that George the Bartender's attorney, Ron Summers, and George's primary treating physician, Dr. Nickelsberg, were seated in their usual seats down toward the end of the bar.

Usually the conversation from that end was pretty lively, but the sounds of silence were deafening.

I shifted my gaze to where Ron and Dr. Nickelsberg were seated and saw that they were pouring over a large green book, reading intently and making notes.

Suddenly, the light bulb went on in my head and I realized that the large green book was none other than the *AMA Guides,* Fifth Edition.

Ever since the passage of Senate Bill 899 on April 19, 2004, Ron and Dr. Nickelsberg had complained bitterly how the decrease in permanent disability awards was hurting their pocketbooks.

Curiosity got the better of me and I moved over to see just what chapter they were studying.

Not surprisingly, the book was open to Chapter 15 which deals with the lower back.

Applicant attorneys claim that this chapter alone had been the waterloo for their practice, as lower back claims were now rated for permanent impairment based on objective factors of permanent disability as opposed to prophylactic work restrictions and subjective complaints of pain.

The AMA Guides mandated that spinal injuries are rated for permanent impairment on either the diagnosis related estimate (**DRE)** or the range of motion method.

I knew that applicant docs, such as Dr. Nickelsberg, and applicant attorneys wanted all spine cases rated on the range of motion method, as this was more subjective and could certainly rate higher than the maximum 29% allowed under the five **DRE** categories.

Although the language in the Guides is somewhat vague and open to interpretation, basically the Guides tell us that we are to use the **DRE** method in almost all injuries (whatever that means) and the key here is whether or not the back injury results from an injury.[1]

Most applicant treating doctors, such as Dr. Nickelsberg, feel that they can use the range of motion (**ROM**) method if they can justify that the spinal disability is at two levels or more.[2]

However, the litmus test utilizing either the **DRE** or **ROM** method is making a determination as to whether or not the applicant has radiculopathy or actual radicular pain.

In other words, to move from Category I of the **DRE** (which is a zero) into Category II, objective signs of radiculopathy must be demonstrated on not only the appropriate MRI scan but also verified by clinical examination.

At this point in my thought process Ron excitedly turned to Dr. Nickelsberg and explained that most of his clients that had lower back injuries had radiating pain down their left leg and that as a majority of his clientele were over the age of 40, Dr. Nickelsberg's scanning laboratory, MRIs Are Us, would certainly reflect that his clients had disc protrusions at more than one level, which would qualify them for the more subjective **ROM** method of calculating their permanent impairment.

Ron went on to tell Dr. Nickelsberg that even if the MRI scan only showed a disc protrusion at one level, the fact that his clients complained of pain radiating down their left leg would certainly kick all cases into at least DRE Category II and hopefully all the way up to Category V. Although Dr. Nickelsberg was in agreement with Ron's **"new theory,"** I could tell that even Dr. Nickelsberg did not share in Ron's enthusiasm.

For good reason!

After Ron got through regaling me with his theory as to how to maximize his permanent impairment ratings, I seized this opportunity to rain on Ron's parade by pointing out what Dr. Nickelsberg already knew.

I told Ron that merely because an injured worker had disc protrusions at more than one level did not qualify the case for an **ROM** rating.

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[1] I have always appreciated the irony of the insistence in the AMA Guides that the DRE method be used if the spinal injury and resulting disability is caused by an injury. If the spinal disability is not caused by an injury, then it would certainly seem that we could close our file.

[2] This is now common as one of the criteria as mandated by the Guides, i.e that the spinal disability must be at more than one level in oder to use the ROM method.

I went on to tell Ron that in order to qualify for an **ROM** rating the impairment not only had to be at more than one level of the spine, but that radiculopathy also had to be at multiple levels.

Ron protested that his clients all had radiating pain down the left leg and that certainly qualified as radicular pain.

By now I could tell that Dr. Nickelsberg was becoming very uncomfortable, as he knew what I was about to explain to Ron.

I told Ron that radiating pain has nothing to do with radicular pain and/or radiculopathy and that any legitimate MRI showing a protrusion of a disc at a certain level of the spine would also indicate whether said disc was protruding so far that it was impacting the thecal sac or nerve root.

If the disc were protruding and/or impacting a nerve root, a provisional diagnosis of herniated disc would be made on the MRI scan. Any reputable MRI scan company would also add on to their report that the diagnosis of a herniated disc and/or radiculopathy must be verified on clinical examination.

Therefore, we need verification that the disc protrusion is so large that it becomes a herniation which impacts on the nerve root or thecal sac thereby resulting in true radicular, not simply radiating, pain.

Once the clinician has viewed the original of the MRI scan demonstrating the above, then radiculopathy must be verified by clinical examination as to whether or not there is a loss of reflex at the knee and/or ankle and whether or not there is a loss of muscle mass and/or atrophy.

I told Ron, who was becoming very depressed, that simply complaining of radiating pain down the left leg is far from qualifying as radiculopathy, as this diagnosis must not only be verified by the MRI scan but also by clinical examination.[3]

After inhaling his next cocktail, Ron told me that he was going to use this theory to go from Category I into at least Category II of the **DRE** method as outlined in Chapter 15. I advised a crestfallen Ron that the same would be true of the **DRE** method, i.e. in order to get into Category II, which would give him rateable impairment, the injured worker would have to have more than simply radiating pain - the applicant would have to have radiculopathy or true radicular pain (the Guides say clinically significant radiculopathy) verified by diagnostic testing and clinical evaluation and/or at least muscle guarding or spasm observed on examination.

DISCLAIMER

The above presentation and characters are a product of my boundless imagination, but the abuse of the clear meaning of the AMA Guides is not. Although I almost never use Agreed Medical Examiners, we have been subbed in on cases in which so-called popular AMEs are used. One of

[3] If the MRI report comes from a questionable laboratory, such as Dr. Nickelsberg's "MRIs Are Us" then the best practice is to subpoena the actual films for review by the clinician (panel QME, AME [not in my lifetime] or treating physician).

the most popular AMEs in Southern California has adopted Ron's method of rating permanent impairment.

Typically, these AME reports confirm that there is no radiculopathy and/or radicular pain on examination, but conclude that the applicant should be rated by the range of motion method or placed into Category II of the **DRE** because of radiating (not radicular) pain. Karen Kaiser of our San Diego office has recently obtained a panel decision dated December 2, 2008 in which the Board reversed a workers' compensation judge on this very issue. This panel decision held that in order to be assessed for permanent impairment on the **ROM** method an applicant must have radiculopathy at multiple levels - just not pathology as shown by MRI scans. The Board did a very good analysis on what constitutes true radicular pain and/or radiculopathy as opposed to radiating pain.[4]

Make mine a double, George

- Joe Truce

[4]The case referred to is *Jose de Jesus Martinez v. Solo Cup Company; Zurich North America* and can be entered into evidence pursuant to Labor Code §5703(g), which provides that relevant evidence includes prior decisions of the Appeals Board on similar issues. Anyone wishing a copy of this case should make a request to our office by e mail.