## ANOTHER INSTALLMENT IN THE *GEORGE THE BARTENDER* SERIES

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## RE: GEORGE THE BARTENDER AND THE DIAGNOSIS-RELATED ESTIMATE (DRE) QUANDARY OR *SURELY A SPINE INJURY CAN RATE ZERO SOMEDAY, RIGHT?*[1]

**FROM THE LOBBY BAR AT THE HYATT**

After a hard day denying benefits, I reached the Lobby Bar in the hopes of soothing my frustrations with my usual vice of choice, a Beefeater's martini[2], straight up with two olives – as well the sight of Kim, the Hyatt's breathtakingly beautiful cocktail waitress.

I was frustrated with a case I was litigating against George the Bartender's Workers' Compensation attorney, Ron Summers. Ron had designated his fellow duke of duplicity, Dr. Nickelsberg, as the applicant's primary treating physician in this case.

Before we set out loyal Lobby Bar patron I thought it might be best to share with you some useful definitions up front before I begin my discourse on my case. These definitions can be found in the AMA Guides to the Evaluation of Permanent Impairment, (Fifth Edition), aka the Guides, in Box 15-1 Definitions of Clinical Findings Used to Place an Individual in a DRE Category, on pages 382 and 383:

> **Muscle spasm** is a sudden, involuntary contraction of a muscle or group of muscles. Paravertebral muscle spasm is common after acute spinal injury but is rare in chronic back pain. It is occasionally visible as a contracted paraspinal muscle but is more often diagnosed by palpation (a hard muscle). To differentiate true muscle spasm from voluntary muscle contraction, the individual should not be able to relax contractions. The spasm should be present standing as well as in the supine position and frequently causes a scoliosis. The physician can sometimes differentiate spasm from voluntary contraction by asking the individual to place all his or her weight first on one foot and then the other while the physician gently palpates the paraspinous muscles. With this maneuver, the individual normally relaxes the paraspinal muscles on the weight bearing side. If the examiner witnesses this relaxation, it usually means that true muscle spasm is not present.
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> **Guarding** is a contraction of muscle to minimize motion or agitation of the injured or diseased tissue. It is not true muscle spasm because the contraction can be relaxed. In the lumbar spine, the contraction frequently results in loss of the

[1] For those new patrons to the Lobby Bar, George the Bartender's workers' compensation case involves an injury to his elbow, epicondylitis (tennis elbow), sustained from the repetitive serving of martinis to me. If there ever was an admitted industrial injury, this is it!

[2] A Beefeater's martini, straight up, is best served at 38˚ Fahrenheit.

> normal lumbar lordosis, and it may be associated with reproducible loss of spinal motion.
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> **Asymmetric motion of the spine** in one of the three principal planes is sometimes caused by muscle spasm or guarding. That is, if an individual attempts to flex the spine, he or she is unable to do so moving symmetrically; rather, the head or trunk leans to one side. To qualify as truce asymmetric motion, the finding must be reproducible and consistent and the examiner must be convinced that the individual is cooperative and giving full effort.
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> **Nonverifiable pain** is pain that is in the distribution of a nerve root but has no identifiable origin; ie, there are no objective physical, imaging, or electromyographic findings.

Now that I got that out of the way, let's begin. My case with Ron involved a straightforward lower back strain resulting in minimal pain of the cervical spine (the injured body part). Yet, by some miracle Dr. Nickelsberg had found a simple back strain was ratable pursuant to Chapter 15, entitled "The Spine," of the Guides. Chapter 15 states that a spinal injury can either be rated under the Diagnosis- Related Estimate (DRE) method, which is the preferred and most common method or the range of motion (ROM) method.

Despite noting in his examination report that the applicant's range of motion (ROM) with respect to his cervical spine was normal, Dr. Nickelsberg found that the applicant had muscle spasm in his cervical spine, which qualified the applicant as a DRE II.

The Panel QME (PQME) in our case, like Dr. Nickelsberg, found that the applicant had full range of motion of the cervical spine. Unlike Dr. Nickelsberg though, the PQME found that the applicant had no muscle spasms, no muscle guarding and no asymmetric loss of range of motion.

In addition, the PQME found that the applicant had no findings of radiculopathy in the cervical spine which was consistent with the negative MRI scan.

The PQME had rated the applicant under DRE Lumbar Category I (Table 15-3, page 384) which provides in relevant part as follows:

> No significant clinical findings, no observed muscle guarding or spasm, no documentable neurologic impairment, no documented alteration in structural integrity, and no other indication of impairment related to injury or illness; no fractures

A rating under DRE I represents a whole person impairment (WPI) of zero, nada, zilch. In other words, no money.

As we all know to get into the Promised Land, aka DRE II, the physical examination must uncover objective signs of any of the aforementioned definitions, to name to just name a few.

On the previous night at the Lobby Bar, I had a shouting match with Ron and Dr. Nickelsberg, where I pointed out to both of them that in every spinal injury case I had litigated against them, the good doctor somehow always managed to find that the applicant had muscle spasm. This of course conveniently pushed the applicant from DRE I (a zero WPI rating) to a DRE II (a WPI baseline rating of 5%).

I argued to Ron that since Dr. Nickelsberg had found full range of motion in the cervical spine and that the applicant complained to Dr. Nckelsberg of minimal pain, a finding of muscle spasm was unreasonable in this case.

My suspicions about the authenticity of Dr. Nickelsberg's diagnoses stemmed from a previous deposition I had taken of him, wherein Dr. Nickelsberg admitted that he almost never performed the examination himself. He stated that the examination was usually performed by one of the 50 chiropractors who contract with Dr. Nickelsberg.[3]

Tonight's heated discussion had to do with radiating pain and radiculopathy. Ron and Dr. Nickelsberg were now claiming that the applicant was found to have both. Flabbergasted, I pointed out to them that when a physician claims they found radiculopathy on examination and the imaging scans are negative (as our PQME report indicates), this can qualify as non-verifiable root pain, which admittedly can put the applicant into DRE II.

However, I added that the diagnosis of radiculopathy in a physician's report must be supported by the examination and tests conducted (also substantiated as negative by our PQME).

I told Ron and Dr. Nickelsberg that they should know that radiating pain is not the same as radiculopathy. If an applicant complains of radiating pain down the left leg, it must be verified on examination by an objective test, such as loss of reflex in the knee or ankle, or a straight leg raising test. Ron and Dr. Nickelsberg had submitted no evidence to date to back up their claim.

I reminded them that the applicant was stable, or P&S, at the exam with Dr. Nickelsberg and at the PQME exam a month later. The PQME had not found any of the other additional injuries that Ron and Dr. Nickelsberg were now claiming.

I stated that the PQME should be accepted as opposed to the exam of Dr. Nickelsberg per page 20 of the Guides, referring them to section 2.5d Interpolating, Measuring, and Rounding Off:

[3] Good food for thought for the cross examination of any applicant, loyal Lobby Bar patron. As per page 382 of the Guides, Dr. Nickelsberg or any other doctor cannot simply write in their report that they found muscle spasm when examining the applicant's spine. The Guides mandate that the spasm should be present when the applicant is standing as well as in a supine position. We also want to ask the applicant who actually performed the exam, i.e. was it the so-called PTP, a nurse, chiropractor or somebody else in the office? In some of my cases, applicants have testified at depositions that no one touched their spine at all and in this scenario, how could one find spasm?

> Measurements should also be consistent between two trained observers or by one observer on two separate occasions, assuming the individual's condition is stable.

I told them that Dr. Nickelsberg's finding of a spasm on examination was not consistent with the applicant's normal range of motion of the cervical spine and the applicant's history of minimal pain.

Ron's counterargument, after consulting with Dr. Nickelsberg, was that Dr. Nickelsberg conducted the examination himself (which, as I mentioned before, I had my doubts about) and found definite spasm and this put the applicant into DRE II.

At this point, a wide grin spread over my face as I reached into my trusted briefcase[4] and pulled out the panel decision of the Workers' Compensation Appeals Board in *Jose Camacho v. Aramark Sports & Entertainment* (ADJ6783209) filed on August 11, 2015. I handed a copy to Ron and Dr. Nickelsberg.

I pointed out to Ron that in *Camacho*, the applicant had also sustained a cervical injury (as Ron's client) and the appropriate impairment rating centered on whether or not to put the applicant into DRE I or DRE II.

The Panel QME in *Camacho*, Dr. Charles Schwarz, M.D., found that the applicant did not sustain any permanent disability for his cervical injury and places the applicant into DRE 1 with a 0% impairment rating.

Relying on the report of the Panel QME, Dr. Schwarz, the Workers' Compensation Judge (WCJ) found that the applicant did not sustain any permanent disability.

On his Petition for Reconsideration, applicant claimed that he did sustain permanent disability as per the reporting of his primary treating physician, Dr. David Soloway, M.D.

In affirming the decision of the WCJ, the Board noted that the report of Dr. Soloway did not constitute substantial medical evidence to place the applicant into DRE II. The Board pointed out that Dr. Soloway's report was internally inconsistent as follows:

> Dr. Soloway assigns the highest possible impairment rating to applicant's neck under a diagnosis related estimate category two (DRE II) and further increases the rating by three percent for applicant's pain. Dr. Soloway states that there is significant asymmetric loss of range of motion and significant muscle spasm in assigning this rating. (Ibid.) However, earlier in the report Dr. Soloway reports that applicant denies pain to palpitation of the cervical spine. (Id. at p. 7.) Dr. Soloway goes on to state that applicant has minimal paravertebral and trapezius pain and myospasm. (Ibid.) Further, Dr. Soloway's range of motion measurements

[4] Much like Mary Poppins's seemingly bottomless carpetbag (of Disney fame) and Hermione Granger's bottomless handbag (of Harry Potter fame), my briefcase possesses magical powers, granting me the ability to pull out any decision at a moment's notice. A copy of *Camacho* can be obtained by email request.

> of applicant's cervical spine, which are at or near normal, are not consistent with a finding of asymmetric loss of motion. (Id. at p.8.) The finding of asymmetric loss of motion is also inconsistent with a finding of minimal spasm. Dr. Soloway's clinical findings are inconsistent with his rating applicant in DRE II.

The Board concluded:

> Dr. Soloway also assigns a pain add-on of three percent whole person impairment. Again however, Dr. Soloway's clinical findings do not support a pain add-on. (See Id. at pp. 4-5.) Applicant reports pain as follows: "At this moment, he has no pain. Most of the time, he has no pain." (Id. at p. 4.) Dr. Soloway's report does not establish the criteria for a pain add-on. Dr. Soloway's report is not substantial medical evidence. If anything, Dr. Soloway's clinical findings support the findings of the QME, who found no permanent impairment.

After listening to my lecture on the AMA Guides and reading *Camacho*, the joy went out of Ron's face and he started muttering under his breath to Dr. Nickelsberg. I could not hear it clearly, but no doubt it was some disparaging remark. My job was clearly done.

**DISCLAIMER:**

Aside from Kim, George and I, all characters of the Lobby Bar are fictitious, as is the storyline, and are products of my vivid and warped imagination.

However, the dilemma of the bridge between DRE I (a WPI of zero) and DRE II (a WPI baseline of 5%) is an issue that we come across on a daily basis in our wonderful world of workers' compensation.

I suspect that there are several cases involving simple back strains which qualify for DRE I rather than DRE II. However, at least in my opinion, I find that the diagnosis of DRE I is extremely rare (if it occurs at all) by applicant primary treating physicians and *Camacho* gives us some useful tools to remedy what may be an abuse of the Guides.

Make mine a double, George.

-Joe Truce