BEFORE THE INDUSTRIAL ACCIDENT BOARD
OF THE STATE OF DELAWARE

LETITIA STAINBROOK,	)	
	)	
Employee,	)	
	)	
v.	)	Hearing No. 1477012
	)	
MILLCROFT SENIOR CENTER,	)	
	)	
Employer.	)	

DECISION ON PETITION TO DETERMINE 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 January 15, 2021 pursuant to 19 *Del. C.* §2301(B) *via* WebEx Meeting platform pursuant to the Industrial Accident Board COVID-19 Emergency Order dated May 11, 2020.

PRESENT:

ROBERT MITCHELL

IDEL WILSON

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

APPEARANCES:

Donald Marston, Attorney for the Employee
H. Garrett Baker, Attorney for the Employer

NATURE AND STAGE OF THE PROCEEDINGS

On August 18, 2020, Ms. Letitia Stainbrook ("Claimant") filed a Petition to Determine Compensation Due alleging that on September 8, 2018, she injured her neck and low back during the course and scope of her employment at Millcroft Senior Center ("Employer"). Prior to the alleged work accident, Claimant underwent a lumbar fusion at L5-S1 with hardware on February 12, 2018 by Dr. Mark Eskander. After the alleged work accident, Claimant underwent the following surgeries, also performed by Dr. Eskander: a cervical discectomy and fusion C4 through C7 on January 7, 2019; a hardware removal and exploration of lumbar fusion L5-S1 on October 13, 2020; and a cervical corpectomy, fusion C6-7, hardware removal C4-7 and exploration of fusion C4-5 and C5-6 on October 26, 2020. Claimant contends that all of the post-accident surgeries were reasonable, were necessary and were causally related to the work accident. Claimant seeks: acknowledgement of the compensability of her alleged injuries; payment of outstanding medical expenses; and payment for total disability benefits from September 8, 2018 through February 21, 2019. Employer disputes the occurrence of the work accident. Alternatively, Employer contends: that Claimant's neck and low back complaints are not causally related to the work accident; that the neck surgeries were not reasonable or necessary; and that total disability benefits are not warranted.

A hearing was held on Claimant's petition on January 15, 2021. This is the Board's decision on the merits.

SUMMARY OF THE EVIDENCE

Dr. Sean Feeney, a chiropractor certified under the Delaware Workers' Compensation Healthcare Payment System, testified by deposition to a reasonable degree of medical probability on behalf of Claimant. Dr. Feeney characterized Claimant as credible with respect to her

symptoms. Dr. Feeney opined that Claimant injured her neck and low back from the work accident and that the medical treatment and periods of disability at issue are reasonable, are necessary and are causally related to the work accident. He represented that the mechanism of having to push, pull and lift the prep table was competent to cause her injuries.

Dr. Feeney acknowledged that Claimant had a history predating the work accident of neck and low back complaints. Claimant treated for neck and low back pain at First State Health and Wellness from April, 2012 through April 27, 2015. Her complaints were similar on her first and last visits. On April 27, 2015, Claimant reported that she had an ablation in September 2014 and her pain got worse. She felt the need to take Tramadol "too often". (Feeney Depo., 12/18/2020, 10:2).

The medical notes from April 27, 2015 documented Claimant's employment as a chef during which she must stand on her feet all day and constantly flex her neck forward to look down to prepare food. Work aggravated her symptoms. She reported having problems with standing, with walking, with stooping, with kneeling, with bending, with lifting with exercising, and with sleeping. Her pain awakened her at night. On a ten-point pain scale, Claimant rated her neck pain at a seven out of ten and her low back pain at a nine out of ten. The diagnoses were: thoracic or lumbosacral neuritis or radiculitis unspecified lumbar brachial neuritis or radiculitis, cervical myalgia (muscle pain) and myositis (muscle inflammation) unspecified cervical thoracic and lumbar regions.

On June 30, 2015, Claimant treated with her family doctor. Claimant had physical therapy at ATI in 2017 for low back pain. The physical therapy discharge note indicated that Claimant's low back plateaued. Her problems were largely resolved with treatment but she would continue to experience flare-ups with prolonged work. The notes indicated they worked towards increasing

her tolerance to work activities but had been unable to resolve this. They directed Claimant to continue treating with a home exercise program.

On December 12, 2017, Dr. Eskander documented a chief complaint of low back pain that Claimant had had for many years but it was made worse after a motor vehicle accident on July 3, 2016 ("2016 MVA"). Dr. Eskander performed a lumbar fusion surgery at L5-S1 on February 12, 2018.

Claimant commenced treating with Dr. Feeney on March 28, 2018 per self-referral. Claimant presented with low back pain that radiated into both legs but was worse in the left leg. She rated her pain at an eight on a ten-point pain scale. She reported experiencing such pain seventy-six to one hundred percent of the time. Under history in his medical notes, Dr. Feeney documented that Claimant's treatment for the 2016 MVA low back injury included eight epidural treatments with Dr. Kim, ablations, physical therapy, needling, and lumbar fusion on February 12, 2018. Claimant also had a history of neck and upper back pain that were relatively clear and not bothersome at the time of this examination.

Upon Dr. Feeney's physical examination, Claimant's low back had reduced range of motion – twenty-five percent of normal. She had a lot of muscle spasm. Her nerve root tension was relatively minimal. She had a positive straight leg raise tests at thirty degrees on the left and forty-five degrees on the right. She had strength deficits. Her calf muscle on the left side was three plus out of five and on the right side was four out of five. The cervical spine examination was normal. The diagnosis remained of a lumbar disk condition. Claimant had a little left sciatica that was going away but still had a little residual from prior to surgery.

On May 21, 2018, Dr. Feeney documented a low back pain rating of five out of ten. Claimant had a normal neck examination with an age-appropriate slight reduction of range of

motion. On May 31, 2018, Claimant had returned to work. She rated her low back pain at a six out of ten.

Dr. Feeney highlighted the frequency of Claimant's visits and pain ratings leading up to September 8, 2018. He treated Claimant fourteen times from March 28, 2018 through May 24, 2018. He treated her again on May 31, 2018. He treated Claimant three times in June 2018 – on June 7, 24, and 27. On June 7, 2018, Claimant rated her pain at a six out of ten. On June 24, 2018, Claimant rated her pain at a seven out of ten. On June 27, 2018, Claimant rated her pain at a seven out of ten. Dr. Feeney treated Claimant one time in July 2018 at which time, Claimant rated her pain at an eight out of ten.

Dr. Feeney treated Claimant five times in August 2018 – on August 1, 8, 15, 21, and 28. On August 1, 2018, Claimant complained of constant significant radiating pain into her calves bilaterally with bilateral tingling with the right side worse than the left. On August 21, 2018, Claimant reported that work was aggravating her low back pain. She rated her low back pain at a seven out of ten. She did not have any neck complaints.

Dr. Feeney treated Claimant three times in September 2018 prior to the work accident – on September 4, 6, and 7. On September 6, Claimant rated her low back pain at a seven on a ten-point pain scale although she reported that her low back was worse than before. She presented with muscle spasm and reduced range of motion. Her constant radiating pain radiated bilaterally to her heels. She reported that her symptoms were aggravated by work. Dr. Feeney emphasized Claimant was still functioning. Her medications had been increased.

Upon physical examination, Claimant had increased muscle spasm at L4-5 and L5-S1. She had moderate to severe tenderness/hypertonicity in the lumbar and gluteal regions. There was a positive left-sided straight leg raise at forty-five degrees and a positive right-sided straight leg raise

at sixty-five degrees. She had calf weakness on the right side. Flexion was thirty-five degrees compared to normal being eighty degrees. Dr. Feeney noted that Claimant was never near eighty degrees. Extension was five out of thirty-five degrees with significant pain. Left lateral bending was ten out of twenty-five degrees. Right lateral bending was normal at twenty-five degrees.

On September 7, 2018 (the day before the work accident), Claimant rated her low back pain at a seven out of ten. She continued to complain of bilateral radiating symptoms throughout the course of his treatment. Dr. Feeney testified that there were times that the radicular complaints were minimal but could not point to a single record indicating as such.

Claimant's work accident occurred on September 8, 2018. On September 8, 2018, Claimant treated at MedExpress where she reported injuring her back that morning while moving a prep table at work. The assessment was of sprains of the ligaments of the lumbar spine. Although there were no documented neck complaints, the medical records indicated that the neck was normal and supple. They continued her medications and added Prednisone.

Claimant followed-up at MedExpress on September 11, 2018. Her pain was unchanged. She treated at MedExpress again on September 14, 2018 with the same complaints. Her upper back was normal. Dr. Feeney acknowledged that at no time did MedExpress document any neck complaints. He acknowledged that the records indicated a normal neck examination. Dr. Feeney questioned the lack of documented neck complaints because Claimant reported to Dr. Feeney that she had presented with neck complaints to MedExpress. He also questioned the extent of the neck examination. He surmised that in light of Claimant's recent lumbar fusion, it would make sense they would focus on the low back.

The first time Dr. Feeney treated Claimant after the work accident was on September 11, 2018. It was her regularly scheduled appointment. Dr. Feeney testified that Claimant presented

with a significant aggravation of her low back pain and with significant neck and upper back pain. Claimant reported that on Saturday, September 8, 2018, she had to move kitchen equipment (including plate pallets, plate warmers, a preparation table, and utility carts) at work that had been left on the floor before she could perform her regular responsibilities. In the process of moving the equipment, her low back pain intensified and she felt a series of sharp pains that appeared to shoot upwards from her low back up into her upper back and neck. The pain continued to intensify. She treated at MedExpress where she was given an intramuscular injection that most likely was Toradol. The injection helped temporarily but the pain returned.

On a ten-point pain scale, Claimant rated her low back pain at a seven to a nine and her neck and mid-back pain at an eight. She had increased radicular symptoms into her upper and lower extremities. She rated the radiating pain into her legs at a seven out of ten. Her symptoms were constant and worsening.

Upon physical examination, Claimant had a lot of muscle spasm in her low back and positive orthopaedic tests with significant nerve root tension bilaterally. She had pain through her hips and weakness into her left lower extremities, especially in her calf muscles.

Dr. Feeney admitted he created two versions on different dates of the September 11, 2018 chiropractic notes and the September 13, 2018 chiropractic notes. The first versions of the both dated notes were produced at the same time as the remainder of the medical records. The second versions were produced two months later.

The content of the second version of the September 11, 2018 notes was consistent with his above testimony. It also identified complaints of a very sharp pain across the shoulder blades bilaterally and in the region of the left arm. He acknowledged that the original version of the September 11 notes only identified low back complaints. It did not mention the neck. Dr. Feeney

testified that he purposefully excluded any mention of the neck in first version of his notes because he would need authorization from the pre-work accident insurance carrier to treat the neck. He did not want to risk having to undergo a reauthorization process. He eventually admitted that he could have included neck complaints in his notes without jeopardizing coverage but he wanted to keep the notes simple to avoid any confusion.

The low back pain rating in the original version of September 11 notes was also different than in the second version. The pain rating in the original version was a seven out of ten as opposed to a seven to a nine out of ten. Dr. Feeney testified that he could not explain why the low back pain ratings between the two versions were different other than to blame the discrepancy on the "sloppiness" of the girl in his office who inputted the information into the computer system from his handwritten note. (*Id.* at 72:6-12). Similarly, Dr. Feeney could not explain why the original version of the September 11, 2018 notes had more detail about the low back than the later version. He acknowledged that the level of detail should have been the same.

With respect to the two versions of his September 13, 2018 notes, the original version identified a low back pain rating of a seven out of ten. The later version identified a low back pain rating of a seven to an eight out of ten. The original version also referenced Claimant experiencing terrible neck pain when reaching in her closet for a shirt with her left hand. The later version of the September 13, 2018 notes cited reaching for a shirt as an example of an activity that aggravated her neck pain. Dr. Feeney in the subsequent version of the September 13, 2018 notes also cited Dr. Feeney's intention to conduct a full neck examination at the September 18, 2018 visit. Dr. Feeney testified that he had to wait until the September 18, 2018 visit to conduct a neck examination because he did not have sufficient time during the September 11 and 13 visits.

Dr. Feeney treated Claimant on September 18, 20, and 24, 2018. In October 2018, Claimant continued to have low back pain, mid back pain and neck pain. On October 5, 2018, Claimant reported having neck pain radiating into her arm.

On December 10, 2018, Claimant reported having neck pain with pain, numbness and tingling radiating down both arms to her fingers. On a ten-point pain scale, Claimant rated: her hand pain at a six to an eight; her arm pain at a seven; her low back pain at an eight; and her mid-back pain at a six. Dr. Feeney acknowledged that from March 2018 through December 10, 2018, Claimant also treated with Dr. Eskander and with Dr. Kim. Dr. Kim administered cervical spine injections.

Dr. Feeney opined that the work accident caused Claimant to be totally disabled. He explained that Claimant was not able to perform her job responsibilities in light: of her pain levels; of the types of her injuries; and of the significant dramatic change in her functional capacity. It would have been too risky for her to have returned to work. On November 26, 2018, Dr. Feeney placed Claimant on total disability for the first time since he commenced treating Claimant in March 2018. He backdated the effective date of total disability to September 11, 2018.

Dr. Feeney summarized his opinion as follows. Prior to the work accident, recognizing that Claimant's low back was never going to be one hundred percent, the goal of treatment was to stabilize her back. From March 2018 through September 7, 2018, Claimant's low back pain levels were decreasing. At times the pain ratings were as low as a five out of ten. Overall, the pain rating stabilized at around a seven out of ten. Even though she had radicular symptoms and a positive straight leg raise test, Claimant was treating less frequently. She did not have neck, mid-back or arm complaints. She was able to work. Dr. Feeney acknowledged that regardless of the work

accident, Claimant would have continued to require at least another two months of treatment after September 7, 2018.

After the work accident, Claimant's low back that had become stable dramatically worsened. Her range of motion decreased by half or more. She developed severe neck and mid-back symptoms. She was no longer able to work. Her treatment changed. The duration of her visits at Dr. Feeney's changed from fifteen to twenty-minute visits to ninety-minute visits. Dr. Feeney's treatment included therapeutic procedures to reduce inflammation and pain, including ultrasound with a strong hydrocortisone solution and muscle stimulation.

On cross-examination, Dr. Feeney admitted that Claimant's complaints and examination findings were similar at the September 11, and 13, 2018 visits to her complaints and examination findings at the September 4, 6, and 7 visits. He also admitted that leading up to the work accident beginning in August 2018, Claimant was returning for treatment at a greater frequency. She returned on August 21, and August 24 and then September 4, 6 and 7. Dr. Feeney contended that there is not necessarily a correlation between the number of visits and the amount of a patient's pain.

Dr. Mark Eskander 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. Eskander opined that Claimant injured her cervical and lumbar spines and that the medical treatment to include the surgeries and resulting disability periods were reasonable, necessary and causally related to the work accident.

Dr. Eskander summarized his opinions as follows. With respect to the cervical spine, Dr. Eskander opined that Claimant had preexisting cervical disk disease with some underlying

asymptomatic stenosis that became symptomatic and turned into radiculopathy as a result of the work accident. The injury required a C4 though C7 fusion. With respect to the lumbar spine, Claimant's lumbar spine was doing fine leading up to the work accident. As a result of the work accident, Claimant's complaints changed in character to include radicular complaints. Her pain ratings increased and her function significantly decreased. The mechanism of injury was competent to cause an irritation of the tissues and of the hardware around the prior fusion surgery and such irritation was consistent with Claimant's symptoms.

Dr. Eskander highlighted the Claimant's preexisting condition. From April 2012 through April 2015, Claimant treated at First State Health & Wellness for neck and low back complaints. In April, 2012, Claimant presented with severe constant low back pain that she rated at a six out of ten. Claimant rated her neck pain and stiffness at a five out of ten. Claimant rated her sciatic pain at a nine out of ten. Of significance, there was no mention of radiation in the upper extremities. A September 5, 2013 EMG did not demonstrate any evidence of cervical radiculopathy. It was positive for mild left carpal tunnel syndrome.

On April 27, 2015, Claimant presented with neck and constant low back pain. Her neck was constantly forward flexed and that aggravated her symptoms. She reported having problems with standing, with walking, with stooping, with kneeling, and with insomnia. Her pain awakened her at night. The pain did not radiate into her arms; she did not present with symptoms of radiculopathy. She rated her neck pain at a seven out of ten. She rated her low back pain at a nine out of ten.

Claimant underwent physical therapy from March 27, 2017 through July 10, 2017 with the goal of increasing her tolerance to work activities. On March 27, 2017, the documented diagnosis was of lumbar pain and lumbar radiculitis. Claimant presented with chronic low back pain status

post 2016 MVA. The July 10, 2017 discharge note indicated that the physical therapy reduced and largely resolved Claimant's symptoms but that her progress plateaued. She was about fifty percent improved. The notes indicated they projected she would continue to have flare-ups with prolonged work. She was to continue with a home exercise program and to explore if injections were a viable option.

Claimant treated with Dr. Kim twice in 2017 for low back pain. A March 3, 2017 CT scan of the lumbar spine demonstrated L5-S1 degeneration with vacuum phenomenon that raised concern about the possibility of instability.

Dr. Eskander commenced treating Claimant's lumbar spine on December 12, 2017. Claimant reported having had back pain for many years but the that back pain became worse after the 2016 MVA. She complained of back pain that radiated to the buttock bilaterally and to the left posterior thigh to the level of the ankle. She had numbness in the bottom of her feet that she rated at a seven to an eight out of ten. She did not present with any neck complaints. Dr. Eskander diagnosed Claimant as having L5-S1 spondylolisthesis.

December 29, 2017 X-rays demonstrated anterolisthesis of L5-S1 that progressed from four to six millimeters on flexion. The latter was evidence of instability at L5-S1. Another diagnostic test ordered by Dr. Eskander demonstrated mild scoliosis of the lower thoracic and lumbar spines with a Cobb angle of fourteen.

On February 12, 2018, Dr. Eskander performed an anterior lumbar interbody fusion at L5-S1 with correction of the deformity and stabilization of L5-S1 posteriorly. On March 22, 2018, Claimant reported having resolution of the nerve pain. Dr. Eskander recommended physical therapy.

On August 30, 2018 Claimant reported having fifty percent improvement in her symptoms. She continued to have low back pain that radiated down her leg. She rated her pain at a five out of ten. Dr. Eskander testified that Claimant did not have any neck complaints. She was working thirty hours per week.

The first time Dr. Eskander saw Claimant after the work accident was on September 26, 2018. Claimant complained of mid-back pain radiating into the lower back, into the hips bilaterally and into the legs. She complained of neck pain that radiated into the entirety of her bilateral shoulders, arms and elbows. She complained of numbness and tingling in the hands and the feet bilaterally. She stated that all of these symptoms began on September 8, 2018 due to lifting heavy equipment that was left out. She needed to put it away to get her job done. Claimant denied any history of neck pain, of mid back pain or of arm pain prior to the work accident.

Dr. Eskander testified that Claimant's complaints at this visit differed from her prior visits. She had not had neck complaints previously and at this visit she had neck pain radiating down the arms. Her lumbar symptomatology changed in character because it radiated to the mid-back and started to involve the legs and hips bilaterally. Her pain rating increased from a five to a seven out of ten. Her Oswestry Disability Index ("ODI") increased from a forty-four to a seventy-two.

Upon physical examination, Claimant's Spurling's test was positive for neck and arm pain. She had decreased sensation in her hands. She was weak in the finger flexors on the right side. Moving her shoulder decreased the pain on the right side – indicative of a nerve tension. Dr. Eskander diagnosed Claimant as having cervical spine pain with radiculopathy and low and mid-back pain with lumbar radiculopathy.

On October 18, 2018, with respect to the cervical spine, Claimant described her pain as sharp, throbbing, stabbing, tingling, stiff, locking and with numbness. She rated her pain at a seven

out of ten – the same as her last visit with Dr. Eskander. Her Neck Disability Index ("NDI") was forty-six percent and her ODI was sixty percent. The neurologic examination demonstrated weakness in the triceps with the wrist extensor on the right side. She had positive Hoffman's – indicating some spinal cord compression. Dr. Eskander summarized that things were evolving in the neurological examination of the cervical spine. There was evidence of an onset of cervical radiculopathy.

There was instability that started at C3 4 with increasingly progressing stenosis from C4-5 through C6-7. She had slippage at C3-4 and at C5-6. Dr. Eskander noted that Claimant experienced no relief from the cervical injections she had earlier that month. She had already treated with massage. She exhausted conservative treatment. Dr. Eskander concluded that based on all the findings and complaints to include radicular complaints, the next step would be to unpinch the nerves by performing a fusion surgery from C4 though C7. He explained that Claimant's condition was too far gone to be treated with a steroid injection or with other conservative measures. The timing to proceed with surgery was reasonable and necessary. He explained that the appropriate time to proceed with surgery is usually three to six months after the onset of the neurological change to lessen the risk of permanent damage to the nerve.

With respect to the lumbar spine, Dr. Eskander suspected that the inflammation and irritation of the tissues around the hardware was the source of Claimant's lumbar spine complaints. Dr. Eskander ordered a lumbar hardware block for verification. On December 6, 2018, Claimant reported a fifty percent improvement from the hardware block which confirmed the diagnosis and the need to surgically remove the hardware at L5-S1. However, Dr. Eskander wanted to address the cervical spine first.

Claimant underwent the cervical fusion surgery on January 7, 2019. On January 25, 2019, Claimant reported having fifty percent relief from the surgery. She no longer had radicular complaints. She had mild dysphasia that was improving.

On April 4, 2019, Claimant reported a twenty percent improvement in her neck symptoms and seventy percent improvement in her radiating arm symptoms. She was improving dramatically with respect to her nerve pain. Her NDI was down to thirty-two percent.

On May 30, 2019, Claimant's disability index was down to twenty-two percent and her pain was down to a five out of ten. On July 25, 2019, Claimant's disability index was down to twelve percent. She was released to increase her work hours to eight hours per day, four days per week.

On August 12, 2020, Claimant was having difficulty with her neck. She rated her neck pain at an eight on a ten-point pain scale. Her pain awakened her from sleep. Her NDI was up to forty-two percent. An MRI demonstrated pseudoarthrosis at C6-7. Dr. Eskander summarized that while the cervical fusion resolved Claimant's nerve pain and her NDI score had been trending down for many months, the bottom level (C6-7) did not fuse and was causing increasing symptoms and decreasing function.

On August 18, 2020, Dr. Rowlands administered medial branch blocks for the C6-7 joint to confirm the X-ray findings that demonstrated movement. Dr. Eskander testified that everything correlated with Claimant's pain.

On September 3, 2020, Claimant reported thirty percent relief from the cervical blocks. Dr. Eskander recognized that there should be fifty percent relief or more to proceed surgically. Dr. Eskander determined that since Claimant experienced some relief and the X-rays supported a nonunion, it was reasonable and necessary to proceed surgically. However, Dr. Eskander wanted

to address removing the hardware from the lumbar fusion before proceeding with the second cervical surgery.

On October 13, 2020, Dr. Eskander performed a hardware removal and exploration of the lumbar fusion at L5-S1. On October 26, 2020, Dr. Eskander surgically addressed the cervical spine by removing the plate and screws from the fused levels in the cervical spine and then refusing the C6-7 level which was loose and did not heal properly.

On December 11, 2020, Claimant's disability index was fifty percent. Her neurologic examination was normal. He released Claimant to return to work five hours per day four days per week as of December 14, 2020.

Dr. Eskander testified that there was sufficient evidence of cervical radiculopathy despite Dr. Schwartz's testimony. Dr. Eskander explained that the MRIs, the X-rays, the prior EMG and the injections all supported a new onset of cervical radiculopathy. There were multiple diagnoses of cervical radiculopathy. Furthermore, Claimant demonstrated signs of cervical radiculopathy during his examinations of Claimant to include: weakness; sensory deficits; Spurling's signs; abnormal reflexes; and complaints of radiating pain, numbness and tingling down the arms. Dr. Eskander testified that the surgery did not fail due to an incorrect diagnosis. The initial surgery failed because of the nonunion that required a revision.

On cross-examination, Dr. Eskander was repeatedly asked to support his frequent representations that Claimant's lumbar spine was doing nicely and fine leading up to the work accident. Dr. Eskander acknowledged Claimant's long history of back pain that was made worse by the 2016 MVA. He acknowledged that Claimant experienced increasing pain that started to radiate into the legs, particularly the left leg after the 2016 MVA. In 2017, Claimant treated it conservatively with ablations, a TENS unit, and injections. In February 2018, Claimant underwent

the lumbar spine surgery. He explained that despite the above, on April 27, 2018, Claimant's ODI was a thirty-eight down from fifty-eight. She had significantly improved.

Dr. Eskander admitted that he did not review Dr. Feeney's records predating the work accident. He was not aware until it was brought to his attention during his deposition that Dr. Feeney on August 28, 2018 documented symptoms radiating to the left leg and the right calf. Dr. Feeney's records indicated that Claimant rated her pain at a seven out of ten. Her pain was constant seventy-six to one hundred percent of the day. Dr. Eskander emphasized that when he saw Claimant on August 30, 2018, Claimant's pain rating was down to a five out of ten. Dr. Eskander also had not been aware until his deposition that Dr. Feeney treated Claimant on September 4, September 6, and September 7, 2018 during which visits, Claimant rated her lumbar pain at a seven out of ten.

Once brought to his attention, Dr. Eskander acknowledged that Claimant treated with Dr. Kim on September 6, 2018 - two days before the work accident. Claimant rated her lumbar spine pain at an eight out of ten. Claimant was still reporting radicular symptoms to include radiation to the bilateral buttocks greater on the left and occasionally down the left lower extremity. Dr. Eskander testified that while the latter may be indicative of a radicular component, Claimant did not have weakness, numbness or tingling. Dr. Kim increased Claimant's medication.

Dr. Eskander admitted that the pain scores were relatively flat before and after the work accident. He documented pain scores of a five, a seven and an eight out of ten. Dr. Feeney's records before and after the work accident mostly documented a seven out of ten pain rating. Dr. Kim's documented pain ratings ranged from a five to an eight out of ten. Dr. Eskander testified that pain scores are only one data point. Dr. Eskander admitted that a thirty-six percent ODI

equates to a moderate disability but stressed the decrease in scores and reiterated that Claimant was doing fine.

Dr. Eskander admitted that hardware pain can come from a variety of sources that does not necessarily have to be trauma-related. However, he maintained his opinion that in this situation it was trauma-related. The work accident wrenched the tissues around the hardware causing the irritation and inflammation around the hardware.

Although Dr. Eskander testified on direct examination that Claimant did not have neck pain prior to the work accident, during cross-examination, Dr. Eskander acknowledged from his records review that Claimant had had prior neck pain but testified it was "a decade ago". (Eskander Depo., 01/07, 2021, 71:14). He then stated Claimant treated her neck pain five years ago but there were only a "couple visits of -- or treatment for isolated neck pain". (*Id.*, 72:1-2). Employer's attorney pointed out to Dr. Eskander that Claimant treated for neck complaints for three years. Her treatment was not limited to a couple of visits.

Dr. Eskander did not believe Claimant was not forthcoming when she denied having a history of neck complaints predating the work accident. Dr. Eskander rationalized that there were no medical records documenting neck symptoms from 2015 to September 8, 2018. The fact Claimant did not treat for her neck for the three years preceding the work accident makes it understandable that Claimant probably was not actively thinking about it when reporting her history. Dr. Eskander testified that it would be more fair to say there was no history of recent neck pain, mid-back pain or arm pain as opposed to never having had such pain.

Dr. Eskander was asked to explain why his medical records from August 30, 2018 documented Claimant's report of intermittent symptoms of neck pain that she treated with ice, with heat, with rest, with exercise, and with over the counter medication. Dr. Eskander dismissed

the significance of the reference and characterized the reference as a "placeholder". (*Id.* at 69:23, 70:5). He emphasized that there was no cervical spine diagnosis or discussion in the medical notes from that visit. The only documented diagnosis on that record pertained to the lumbar spine.

Dr. Eskander acknowledged that the MedExpress records did not identify neck complaints and identified a normal neck examination. The latter did not change his causal relationship opinion. Dr. Eskander emphasized that Claimant consistently reported the work accident.

Claimant testified on her own behalf. She is sixty years old. She commenced working as a chef for Employer on March 1, 2008 and continues to work for Employer. On November 19, 2017, Claimant's work status changed from part-time to full-time. (Claimant Exhibit No. 3). Her new status was working thirty hours per week at $18.36 per hour and time-and-a-half for hours worked exceeding forty hours in a week. On June 17, 2018, Claimant received a raise. Her hourly rate became $18.72. (Claimant Exhibit No. 6).

Claimant described her job responsibilities. (Claimant Exhibit No. 7). It is a physically demanding job involving bending, stooping, lifting, carrying, stirring, reaching, walking and standing for extended durations. It also involves: exerting fifty to one hundred pounds of force occasionally; exerting twenty-five to fifty pounds of force frequently; and/or exerting ten to twenty pounds of force constantly to lift and move objects.

Leading up to the work accident, Claimant performed her job well. Her score on her March 30, 2017 performance review was forty-nine out of fifty-seven points – eighty-six percent. Such rating falls under the "Exceeds Expectation" category. (Claimant Exhibit No. 8). Claimant testified that she typically rates under the "Exceeds Expectation" category.

Claimant testified that from April 2012 to April 27, 2015 she treated for neck and low back complaints. Claimant continued to work and was able to perform her job. Claimant testified that

she stopped treating her neck in 2015 per her medical providers' direction. It was not her choice to stop treating. Claimant acknowledged that she rated her pain in April 2012 at a five out of ten and rated her pain on April 27, 2015 at a seven out of ten. When asked on cross-examination if it was fair to say that her neck pain had not resolved? Claimant responded that she did not recall having a lot of neck pain. She was then asked, so it was not that her neck pain went away? Claimant responded, "I can't answer that."

In 2016, Claimant injured her low back in the 2016 MVA. Her neck was not injured. On February 12, 2018, Dr. Eskander performed a lumbar fusion at L5-S1 with hardware. Claimant was placed on total disability for eight to twelve weeks after surgery but then returned to light duty work and worked less hours. Eventually, Dr. Eskander released Claimant to return to work without restrictions.

Claimant denied having neck or arm problems leading up to the work accident. When she saw Dr. Eskander on August 30, 2018, she was not having neck complaints. This was a post-surgical follow-up visit.

Claimant testified that she commenced treating with Dr. Feeney in March 2018 pursuant to post-surgical physical therapy. She was treating for low back with radicular symptoms into the leg. Claimant acknowledged that the end of August/beginning of September 2018 timeframe, she reported pain scores to Dr. Feeney of a seven out of ten. She saw Dr. Feeney twice at the end of August and three times in the beginning of September prior to September 8, 2018. Claimant remarked she was starting to see Dr. Feeney three times per week.

Claimant acknowledged that on September 6, 2018 when she treated with Dr. Kim, she rated her pain at an eight out of ten and Dr. Kim increased her medications. Claimant attributed the increase in medication to addressing the tingling in her feet.

Claimant testified that leading up to the work accident, her symptoms were not worsening and her overall her pain was not as high as the pain ratings reflected. She explained that her documented pain scores were high because she saw Dr. Feeney and Dr. Kim after work and her work duties aggravated her symptoms. She represented that typically, in the morning, her pain rating might be a three out of ten but by the end of the workday, her pain level would increase to a seven or eight out of ten. Claimant added that most of her medical appointments including were after work so her pain ratings would be higher.

Claimant emphasized that she was able to work as a chef prior to the work accident despite having low back pain that radiated to her feet. She explained that she grew accustomed to living and working with low back pain since she has had it since 2012. However, the work accident had caused her to become temporarily disabled.

Claimant testified that on September 8, 2018, she reported to work at 4:30 a.m. – her usual time. She started performing her routine of getting everything ready. After five minutes, Mr. Michael Fontello, (the overnight security guard) asked Claimant if Claimant could prepare a breakfast bag for a patient on dialysis. He explained that the night shift failed to do so even though it was their responsibility.

To honor his request, Claimant walked into the kitchen and saw the room was in disarray. There was a heavy utility cart that was out of place and had to be moved. Claimant testified that on the cart were cake warmers, metal palette heater/warmer and approximately seventy-five plates on each side. She estimated it weighed seventy-five pounds. Only one side of the cart had a handle. Although the cart was on wheels, the wheels were old and did not readily move when pushed. It required great effort. Between the weight of the cart and the poor condition of the wheels, the cart was so difficult to move that it normally remained in place. Even employees

responsible for mopping the area did not move the cart but rather mopped around it. Claimant testified that she "most certainly" would have asked for help to move the cart if help was available but it was not.

While Claimant was moving the cart, she noticed a change in her pain. She experienced a very sharp pain from the middle of her back and up. She had never experienced this before. She continued to do her work to the best she could despite the sharp pain. She has a duty to her residents. The food must be done at a certain time and she has no one to help her or to do her job. Ms. Norina Kirton, a coworker, witnessed Claimant holding her back in pain and asked Claimant what was wrong. Claimant told Ms. Kirton that she hurt her back moving equipment by herself.

Claimant stated approximately ten minutes later she could not manage the pain anymore. She called her supervisor and left a voicemail reporting the work accident. She then called the food service director and told him what happened. Thereafter, she left work and treated at MedExpress at approximately 8:30 a.m.

At MedExpress, Claimant reported the work accident and the symptoms she was experiencing to include low back pain radiating upward. She reported having had a fusion surgery in February 2018. There was added concern because of the fusion. Claimant rated her pain at a seven out of ten. Claimant was given steroids and was placed on temporary total disability until her next visit scheduled for September 11, 2018.

Claimant testified that while her pain rating was the same as prior to the work accident, it was not the same type of pain. Claimant acknowledged that the medical records from MedExpress did not identify neck complaints and stated that the neck examination was normal. Claimant remarked that the neck pain was not immediate. She experienced the onset of neck pain two days

after the work accident. She represented that there was not a full examination of the neck. They just asked her to turn her head in either direction.

On September 11, 2018, Claimant returned at MedExpress. Her low back complaints were about the same. She mentioned having a sore neck but that she was going to see Dr. Feeney immediately after this visit. They gave her an injection. The injection provided temporary relief but the relief was not immediate. Claimant acknowledged that the medical notes did not reference neck or mid back complaints.

Around thirty minutes to an hour after her MedExpress visit, Claimant treated with Dr. Feeney. It was a previously scheduled appointment. She reported the work accident and described her new symptoms to include low back pain, mid back pain and neck pain. She also reported having treated at MedExpress. She rated her pain at a seven out of ten. She reiterated that this was a different kind of pain than the pain predating the work accident.

Claimant returned to MedExpress for a last visit on September 14, 2018. She received another injection and continued to be placed on total disability. Claimant acknowledged that all of the treatment she received at MedExpress was directed only to the low back.

Claimant treated with Dr. Feeney on September 13, 2018. Dr. Feeney asked how she was feeling and if there was anything new to report. Claimant responded that when she reached for a shirt, she felt the same pain she felt when she was moving the utility cart at work. Claimant could not recall if the reaching incident occurred on the day of this visit or on the day before.

On September 26, 2018, Claimant reported the work accident to Dr. Eskander and specifically identified constant back, neck and arm pain with tingling. Claimant testified that she scheduled this appointment because MedExpress directed her to contact a surgeon and an attorney. She denied scheduling this appointment because of experiencing symptoms after reaching for the

shirt. She denied that reaching for a shirt caused an onset of new symptoms. She also denied reporting to Dr. Eskander that she did not have a history of neck pain. Claimant testified that Dr. Eskander never asked.

Claimant acknowledged that she completed an ODI questionnaire on December 12, 2017 at Dr. Eskander's office. Her score was a fifty-eight. (Claimant Exhibit No. 9). Claimant represented that while she was feeling bad, she was still functional. She recognized that Dr. Eskander testified that a score of fifty-eight would indicate that she was not doing well.

On March 22, 2018, Claimant's ODI was a seventy-four. (Claimant Exhibit No. 10). On April 27, 2018, Claimant ODI was a thirty-eight. (Claimant Exhibit No. 11). She was more functional. On August 30, 2018, Claimant's ODI was a forty-four. (Claimant Exhibit No. 12). Claimant represented that despite the higher ODI, she was doing better. She presumed her ODI was higher than the previous visit due to recent activities that would have been debilitating. Claimant left blank the section of a form she completed that related to the neck.

On September 26, 2018, Claimant's ODI was a seventy-two. (Claimant Exhibit No. 13). Claimant testified that she was in such severe pain. She believed she was totally disabled. On October 18, 2018, Claimant's ODI was a sixty. Claimant's NDI was a forty-six. This was the first disability form Claimant completed pursuant to the neck.

Claimant testified that she has benefitted from Dr. Feeney's treatment even though he testified that she has not had a positive response. She always feels better leaving his office after treatment and wants it to continue. Claimant did not know that Dr. Feeney produced two versions of his notes from her visits on September 11, 2018 and September 13 2018. She could not think of a reason he did not include references to the neck in his first version of the September 11, 2018 notes.

Mr. Michael Fontello who has worked for Employer for over twelve years and has worked in maintenance for over a year testified on behalf of Employer. On September 8, 2018, his shift started earlier than Claimant's shift but their shifts overlapped. When Claimant arrived to work, he asked Claimant if she would prepare a bag lunch for a resident on dialysis per request of a nurse who could not leave her station. Claimant did not appear to be in pain and did not report having had any symptoms.

Mr. Fontello noticed that the kitchen was unusually unorganized with a lot of things including carts out of place. There were small coffee cup carts that were outside of the kitchen. Inside the kitchen, there was a hot plate cart and a couple other small carts. He offered Claimant assistance with putting things away, particularly with moving carts but wanted to deliver the bag lunch first. After delivering the bag lunch, Mr. Fontello returned to Claimant's location. He moved two or three carts that were outside the kitchen. He estimated he assisted Claimant for approximately twenty minutes before he had to leave to return to his duties.

Mr. Fontello observed Claimant moving a hot plate cart. After fifteen minutes, Claimant put her hand on the right side of her low back/hip area. Although Claimant did not initially state she was in pain, she appeared to be in pain. Thereafter, Claimant mentioned that her right hip was hurting from moving the hot plate. He instructed Claimant to inform the manager and to go to the nurse. Mr. Fontello provided a signed written statement in which he stated that he saw Claimant move a hot plate cart by herself and that she hurt her back on the right side.

Ms. Narina Kirton who has worked for Employer for nearly six years testified on behalf of Employer. She works as a Dietary Aid in the kitchen and assists the residents. She arrived at work at 4:57 a.m. on the morning of September 8, 2018. Upon her arrival, she and Claimant said good morning. Ms. Kirton testified that typically she and Claimant helped each other.

Ms. Kirton started that morning tending to the residents for their breakfast needs. When she returned to the kitchen, Claimant appeared to be in pain in the area of her right low back and hip but Claimant continued to work. Claimant reported to Ms. Kirton that she (Claimant) had to move things that were not put away as they should have been. By the time Ms. Kirton arrived to the kitchen, all the equipment was in place.

At one point Claimant had to remove bacon from the walk-in refrigerator. Removing the bacon required bending. Claimant appeared in such pain, Ms. Kirton removed the bacon for Claimant. Ms. Kirton remained in the kitchen with Claimant until Claimant walked away and called the supervisor, Ms. Trina Rodgers. Claimant reported the need to seek medical treatment. Ms. Kirton remarked that Claimant had to have been in a lot of pain because Claimant would never just walk away from her duties and call the supervisor.

Claimant was recalled as a witness to rebut Employer's fact witnesses. Claimant testified that she did not see Mr. Fontello after she gave him the bagged meal. She stated that there were four pieces of equipment in the area of the kitchen that she moved by herself. There could have been carts in the back area of the kitchen that also had to be moved but that area of the kitchen was not visible to Claimant. Hence, Mr. Fontello could have returned to the back area of the kitchen and moved carts unbeknownst to her. Because she did not see Mr. Fontello, she did not instruct Mr. Fontello where to relocate the carts he testified he moved.

Dr. Eric Schwartz who is board certified in orthopaedic surgery testified by deposition to a reasonable degree of medical probability on behalf of Employer. He reviewed pertinent medical records. He examined Claimant on November 19, 2018 and on November 17, 2020. Dr. Schwartz questioned the occurrence of the work accident and opined that Claimant's symptoms and medical treatment were not causally related to any event on September 8, 2018. Instead, Dr. Schwartz

causally related all of the treatment with respect to the low back to the 2016 MVA for which Claimant had been receiving treatment leading up to September 8, 2018. With respect to the cervical spine, while the alleged mechanism of injury could have aggravated Claimant's cervical spine symptoms, the medical records did not support a cervical spine injury associated to a September 8, 2018 event.

Claimant had a long history of neck and low back pain. Claimant treated at First State Health & Wellness Center from May 8, 2013 through July 24, 2015 for neck complaints. Dr. Schwartz testified that although Claimant did not receive medical treatment directed to the neck between July 24, 2015 and September 8, 2018, he would expect that Claimant would have continued to have intermittent neck pain. He remarked that Claimant will likely continue to have intermittent neck pain for the remainder of her life in light of the extensive history of cervical spine treatment and the degenerative changes per X-rays. He noted that on August 30, 2018, Dr. Eskander documented references to intermittent cervical spine symptoms for which Claimant treated with ice, with heat, with rest, with exercise and with over-the-counter medications. Dr. Schwartz commented that the latter is not the type of reference an orthopaedic surgeon would just include in a back patient's records unless she made such complaints.

Dr. Schwartz testified that contrary to Dr. Eskander's testimony, Claimant's low back clearly was not doing "fine" leading up to September 8, 2018. Claimant had continued to treat her low back and to take medications for it. Claimant was going to have to continue treating her low back beyond September 8, 2018. Dr. Feeney had been treating Claimant from March 28, 2018 through September 7, 2018. Dr. Feeney consistently described complaints of nearly constant low back pain that radiated bilaterally. Her pain complaints fluctuated. At times, her pain rating was as low as a five on a ten-point pain scale but usually her pain ratings ranged from a six through an

eight. On September 4, 2018 and on September 6, 2018, Claimant rated her low back pain at a seven out of ten.

Overall, Claimant's complaints to Dr. Feeney on September 6, 2018 two days before the alleged work injury appeared worse than the prior visit. She had clinical radicular-type features in both lower extremities. Her radicular features extended down to her heels. Palpation was worse in the L4-5 region. At L5-S1, she had moderate to severe hypertonicity. She had significant range of motion deficits. Flexion was thirty-five degrees whereas normal is eighty. Extension was limited to five degrees whereas thirty-five is normal. Left lateral flexion was ten degrees whereas twenty-five is normal. Right flexion was normal.

Also on September 6, 2018, Dr. Kim documented bilateral low back pain radiating to the bilateral buttocks with occasional left lower extremity pain. Claimant rated her pain at an eight out of ten at its worst. She had weakness, numbness and tingling in her lower extremities. Palpation showed worse pain over L4-L5. Claimant's pain was worsened by lifting, standing, bending and twisting. The pain was relieved by changing positions, by applying ice and by applying heat. Dr. Kim increased the Gabapentin prescription to nine hundred milligrams to address the radicular-type pain.

On September 7, 2018 (the day before the alleged work accident), Dr. Feeney documented constant low back pain radiating bilaterally to the calves. Claimant rated her pain at a seven out of ten. She reported that her symptoms were present seventy-six to one hundred percent of the day. Palpation was found bilaterally at L4-5 and at L5-S1.

Dr. Schwartz summarized that in the days leading up to the alleged work accident, Claimant's pain ratings were a a seven to an eight out of ten. Such ratings were the same as they were in April 2018 – two months post-surgery. Claimant's frequency of treating her lumbar

radiculopathy pain increased. Two days before the alleged work accident, Claimant's medication dosage increased.

On the day of the alleged work accident, Claimant treated at MedExpress. She reported being injured moving a table. There was no reference in the MedExpress medical records to Claimant lifting heavy objects contrary to Dr. Eskander's account of the mechanism of injury. Claimant did not present with any neck complaints. The medical records indicated that Claimant had a normal neck examination. The neck was supple.

Claimant's low back complaints appeared the same as they were prior to the alleged work accident. There was no evidence of an aggravation. Claimant rated her low back complaints at a seven out of ten – the same it had been prior to the alleged work accident. The documented findings were not appreciatively different than they were prior to the alleged work accident. The assessment was of a lumbar strain. They placed Claimant on total disability.

Claimant returned to MedExpress on September 11, 2018. There was no mention of neck complaints. She had a normal musculoskeletal examination of the upper back. She had normal lower extremity motor function, normal tactile senses and normal reflexes. Her Achilles reflexes were normal. She had a negative straight leg raise. There was no evidence of any radiculopathy in her lower extremities. She received a Toradol injection for pain relief. Claimant's diagnosis continued to be of a lumbar sprain. They maintained her total disability status and recommended she follow-up with Dr. Eskander.

On September 14, 2018 at MedExpress, Claimant received another series of IV injections for pain that Dr. Schwartz commented should not to be confused with lumbar injections. Her pain complaints continued to be the same as prior to the alleged work accident. They continued Claimant's total disability status.

Dr. Schwartz took issue with the fact that Dr. Feeney produced two versions of his September 11 and 13, 2018 records. The first versions were produced at the same time as all of Dr. Feeney's other medical records. The second versions were produced two months later on February 16, 2019 and after Dr. Schwartz's initial testimony.

The first version of the September 11, 2018 notes indicated that Claimant still had low back pain that she continued to rate at a seven out of ten. Her symptoms continued to be constant seventy-six to one hundred percent of the time. She had pain radiating bilaterally to the calves. Palpation was found bilaterally at L4-5 that was worse at L4-5 than L5-S1. Dr. Schwartz summarized that the documented complaints were similar to her documented complaints prior to the alleged work accident. A main difference was that Claimant's positive straight leg raise on September 6 was worse than it was on September 11. On September 6, Claimant had a positive straight leg raise at forty-five degrees whereas on September 11, it was positive at sixty-five degrees. The documented difference would debunk an assertion that Dr. Feeney's September 11 notes were a carryover from earlier notes.

Dr. Schwartz added that of significance, there was no mention of neck complaints in the first version. Had Claimant presented with neck complaints, Dr. Feeney should have documented them. There would be no reason for Dr. Feeney not to include neck complaints if she presented with them. Sloppiness is not an excuse. Dr. Schwartz added that he has seen thousands of chiropractic records and the records do not just focus on the back. Instead, they include the neck, the midback and the low back; chiropractic notes are typically extensive.

The second version of Dr. Feeney's September 11, 2018 notes identified a low back pain rating of seven to nine out of ten compared to the original rating of seven. The second version also identified neck pain and mid-back pain. Claimant rated her neck pain at an eight to a nine out

of ten. There was no neck examination. Dr. Schwartz commented that if Claimant truly had neck complaints rating at an eight or nine out of ten, it would not make sense Dr. Feeney would not examine the neck.

There were also distinct differences between the first and second versions of Dr. Feeney's September 13, 2018 notes. The original September 13 note identified essentially the same low back with radiating left leg and right calf symptoms as previous notes with the same pain rating of a seven out of ten. In the first version, Claimant reported experiencing a sharp pain travelling across her back and down her left arm when she was reaching with her left arm for a shirt. Dr. Schwartz opined that in light of Claimant's preexisting neck condition, such mechanism of injury (a simple motion such as reaching) could produce an aggravation of her neck pain and produce radicular type symptoms.

The second version of the September 13, 2018 medical notes altered the reaching reference to reflect that Claimant reported sharp pain across the shoulder blades bilaterally while reaching. Dr. Schwartz testified that the difference is significant because the first version identified an event causing an onset of symptoms and the second version identified reaching as an example of when she experienced symptoms. Neither version included a neck examination. Dr. Schwartz remarked that the fact that there was no neck examination at this visit contradicts Dr. Feeney's explanation that he could not examine the neck at the September 11, 2018 visit because Dr. Feeney needed another visit with more time to conduct the neck examination. Dr. Schwartz remarked that if that were true, Dr. Feeney should have examined the neck at this visit.

Dr. Schwartz testified that there is never a valid explanation for multiple records over a different temporal time fashion relating to the same medical visit. Dr. Schwartz sits on a medical malpractice board for Pro Insurance and the number one thing is that medical records must be

temporal. If the record is not temporal, then it should be identified as an addendum with identification of the date the addendum was made. Dr. Feeney did not do this. A doctor should never change the medical record; the original medical record must remain intact.

At the first defense medical examination, Claimant reported that she was pushing and pulling equipment when she felt a sudden and sharp pain across her lower back. She stated that she did not injure her neck during the event. The neck pain developed later. Claimant presented with neck and back pains that she rated at a six to a seven out of ten. She reported having pain with all activities of daily living but she could perform them. Claimant reported not being on any new medication in association with the work accident. Dr. Schwartz compared the medications of record to the medications listed on September 6, 2018 and verified they were essentially the same.

Dr. Schwartz described his physical examination findings. There was no evidence of cervical radiculopathy. With respect to the low back, Claimant complained of weakness and numbness in both lower extremities in a nonspecific (a nondermatomal) pattern. Dr. Schwartz commented that complaints of global weakness are more subjective than objective. Pulses were normal. Claimant's straight leg raise was negative. A positive straight leg raise would require radicular pain down a dermatomal pattern, not merely a response of general pain. Dr. Schwartz concluded that there was no objective evidence of lumbar radiculopathy. Dr. Schwartz opined that Claimant could have returned to work by the first defense medical examination even though she was not working.

Between the first and second defense medical examinations, Claimant underwent the two cervical spine surgeries and the lumbar spine surgery at issue. At the second defense medical examination in November 2020, Claimant had neck pain with tingling in both hands and back pain

with tingling in both feet. She reported it was too early to determine if the surgery was helpful. His examination was consistent with someone who just had surgery.

Dr. Schwartz took issue with Dr. Eskander's decision to recommend and proceed with the first cervical spine surgery. Dr. Schwartz opined that the cervical spine surgery was not reasonable or necessary. There was no evidence supporting a cervical radiculopathy diagnosis; the majority of the medical records did not document cervical radiculopathy. Claimant may have had complaints of numbness and tingling but such complaints were intermittent and subjective, unsupported by objective findings. The neurologic examinations by multiple providers were objectively normal including at the defense medical examinations. On December 5, 2018, Claimant denied weakness in the bilateral upper and lower extremities. She denied tingling. Similarly, Dr. Eskander's note of January 2, 2019 did not mention any cervical radiculopathy.

Dr. Eskander did not conduct a neurologic examination of the entire upper extremity – an examination that should be performed prior to recommending surgery. Claimant did not experience any relief from the cervical epidural injection on October 18, 2019. The purpose of an epidural injection is specifically to relieve radicular symptoms. No one ordered an EMG to test for cervical radiculopathy or to test the impacted levels. On the other hand, Claimant did undergo a lumbar EMG on January 17, 2019 that demonstrated chronic right L5-S1 radiculopathy. Dr. Eskander's decision to operate appeared to be based on MRI findings as opposed to objective examination findings. Dr. Schwartz admitted that he does not perform spine surgery but he testified he recognizes when it is appropriate to refer patients to a spine surgeon. In this case, Claimant was not a prospective cervical surgical candidate.

Dr. Schwartz did not question the reasonableness or necessity of the lumbar surgery at issue but did not causally relate it to the work accident. He represented that it is more common

that hardware pain develops on its own rather than being triggered by something. Although Claimant consistently reported having to move a cart at work and developing immediate low back pain, there was not objective evidence of an acute aggravation from the work injury.

Dr. Schwartz acknowledged the lumbar sprain diagnosis at MedExpress and testified that if there had been a work injury, it would have only been a transient exacerbation of her back pain. The facts that MedExpress placed Claimant on total disability and referred Claimant to treat with Dr. Eskander did not change Dr. Schwartz's opinions. Dr. Schwartz added that while the medical treatment directed to the low back may have been reasonable and necessary, the reasonableness and necessity of its continuation is of question since Claimant is not deriving benefit.

With respect to the neck, the medical records do not support the neck being injured from a work accident. She never presented with neck complaints at MedExpress. The original version of Dr. Feeney's September 11, 2018 notes did not reference the neck. At MedExpress, examinations of the neck and the mid-back were normal. Dr. Schwartz remarked that the fact they examined her neck at MedExpress does not mean Claimant presented with undocumented neck complaints. They conducted a cardiac examination too on September 11, 2018 and she did not present with associated complaints.

FINDINGS OF FACT AND CONCLUSIONS AT 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 injuries were caused by the work accident, the assault. *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.

Based on the totality of the evidence incorporated herein, the Board finds that Claimant failed to meet her burden of proof that she sustained a work injury on September 8, 2018. The Board accepts the medical opinions of Dr. Schwartz over the medical opinions of Dr. Feeney and of Dr. Eskander. Dr. Schwartz's testimony was highly credible.

The Board acknowledges that on September 8, 2018 Claimant reported a work accident on the day she contends it occurred, reported the mechanism of injury consistently and sought medical treatment on the same day as the alleged work accident. However, neither Dr. Feeney nor Dr. Eskander were credible and the medical records weigh more in favor of Claimant's lumbar spine and cervical spine symptoms relating to her preexisting conditions. Furthermore, had there been a work accident, the medical records do not support a neck injury.

With respect to the lumbar spine, contrary to Dr. Eskander's testimony, Claimant's low back was not fine leading up to September 8, 2018. From March 28, 2018 when Claimant commenced treating with Dr. Feeney through September 7, 2018 (the day before the alleged work accident), Dr. Feeney consistently described complaints of nearly constant low back pain that radiated bilaterally. Although her pain levels on a ten-point pain scale fluctuated from a five to an eight, by the end of August/early September, Dr. Feeney documented a stable seven out of ten pain rating. Also, by the end of August 2018, Claimant started treating with Dr. Feeney with greater frequency – three times per week. Two days before the alleged work accident, Dr. Kim documented a pain rating of eight out of ten and increased Claimant's medication for nerve pain.

On September 6, 2018, Dr. Feeney documented worsened radicular complaints since the September 4, 2018 visit. Claimant's radicular features extended down to her heels. Her physical examination findings were worse. The latter contradicts Dr. Eskander's testimony stating that Claimant's post work accident symptoms changed in character because the symptoms started to involve her legs and hips bilaterally.

Dr. Schwartz testified that Claimant's complaints and pain ratings at MedExpress were the same as prior to the alleged work accident. The documented findings were not appreciatively different than they were prior to the alleged work accident. Claimant's complaints and findings had been fluctuating since the lumbar surgery in February 2018 which can account for any variations pre and post September 8, 2018.

Dr. Feeney's original version of his September 11 and September 13, 2018 notes identified complaints resembling the complaints prior to the alleged work accident. The pain ratings remained at a seven out of ten – the same rating as prior to the alleged work accident. The documented straight leg raise was worse on September 6 than it was on September 11. Dr. Schwartz testified that there were no objective clinical examination findings demonstrating a change after September 7, 2018. On cross-examination, Dr. Feeney admitted that Claimant's complaints and examination findings were similar at the September 11, and 13, 2018 visits to her complaints and examination findings at the September 4, 6, and 7 visits. Claimant's medications remained the same after September 7, 2018 with the exception of the injections administered at MedExpress. Overall, the course of medical treatment remained unchanged.

The Board shares Dr. Schwartz's concern about Dr. Feeney creating two versions of his September 11 and September 13 medical notes. The original versions were produced at the same time as the other medical records. The second versions were produced two months later. The

second versions made Claimant's back appear worse with higher pain ratings. The second version of the September 11 notes indicated that Claimant complained of neck pain with arm involvement. Dr. Feeney testified that in the process of moving the cart on September 8, 2018, Claimant experienced a series of sharp pains that appeared to shoot upwards from her low back up into her upper back and neck. Dr. Feeney testified that Claimant told Dr. Feeney she presented with neck complaints when she treated at MedExpress on September 8, 2018. To the contrary, Claimant testified to the Board and reported to Dr. Schwartz that she did not experience immediate neck pain. Claimant testified that the onset of neck complaints occurred a couple days after the alleged work accident. Employer's witnesses verified that Claimant's pain on September 8, 2018 appeared to be limited to the right side of her low back and hip area.[1] The Board acknowledges that Dr. Schwartz if giving Claimant the benefit of the doubt would limit Claimant's low back injury to the lumbar strain documented in the MedExpress records but he ultimately opined that the medical treatment at issue is treating the same low back condition preexisting September 8, 2018. The Board accepts Dr. Schwartz's ultimate opinion and denies Claimant's petition with respect to the low back.

The Board also denies Claimant's petition with respect to the neck. She had a preexisting neck condition for which she treated for three years from April 2012 through April 27, 2015. Claimant's neck pain rating was higher on her last treatment date than it was on her first treatment date. Claimant acknowledged that the medical providers terminated the neck treatment. Stopping neck treatment was not her choice. Dr. Schwartz testified that in light of Claimant's neck condition, Claimant will continue to have neck issues for the rest of her life. On August 30, 2018,

[1] The Board reiterates that just because Claimant had low back pain at work does not necessarily translate to Claimant having had a work accident. The Board finds that the treatment directed to the low back is treating the same condition Claimant had leading up to September 8, 2018.

Dr. Eskander documented neck complaints and cited how Claimant was treating them. The Board rejects that such notation was a placeholder. The Board agrees with Dr. Schwartz that especially in light of Dr. Eskander's treatment focusing on the low back, it would not make sense for Dr. Eskander to include neck complaints as a placeholder.

The MedExpress records at no time cited neck complaints. On September 8, 2018, the neck examination was normal. Her neck was supple. As stated above, the original version of Dr. Feeney's September 11, 2018 notes did not include any neck complaints. Dr. Feeney's original version of the September 13, 2018 notes indicated that Claimant experienced a sharp pain travelling across her back and down her left arm when she was reaching with her left arm for a shirt. Dr. Schwartz opined that in light of Claimant's preexisting neck condition, such mechanism of injury (a simple motion such as reaching) was competent to aggravate Claimant's neck pain and produce radicular-type symptoms. Dr. Feeney's second version of the September 13, 2018 notes changed the cited report to indicate that reaching for a shirt is an example of one activity aggravating Claimant's neck symptoms. The evidence does not support the occurrence of a work accident injuring or aggravating Claimant's neck. The Board denies Claimant's petition in its entirety.

STATEMENT OF THE DETERMINATION

For the reasons stated above, the Board finds that Claimant's neck and low back complaints are not causally related to a work accident. Claimant's Petition to Determine Compensation Due is denied.

IT IS SO ORDERED THIS 13th DAY OF MAY, 2021.

INDUSTRIAL ACCIDENT BOARD

Robert Mitchell/cs
ROBERT MITCHELL

Idel Wilson/cs
IDEL WILSON

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

Mailed Date: CMW 5/14/21
OWC Staff