SOUTH DAKOTA DEPARTMENT OF LABOR & REGULATION
DIVISION OF LABOR AND MANAGEMENT

JAMES V. LECKNER, **HF No. 79, 2011/12**

Claimant,

v. **DECISION**

ROCHESTER ARMORED CAR COMPANY, INC.,

Employer,

and

GENERAL CASUALTY COMPANY OF WISCONSIN,

Insurer.

This is a workers' compensation case brought before the South Dakota Department of Labor & Regulation, Division of Labor and Management pursuant to SDCL 62-7-12 and ARSD 47:03:01. The case was heard by Donald W. Hageman, Administrative Law Judge, on October 8, 2012, by Digital Dakota Network from locations in Pierre and Sioux Falls, South Dakota. Claimant, James V. Leckner, was represented by Michael Bornitz. The Employer and Insurer, Rochester Armored Car Company, Inc. and General Casualty Company of Wisconsin were represented by Charles Larson.

Legal Issues:

This case presents the following legal issue:

Whether James Leckner is entitled to Permanent Partial Disability Benefits (PPD) at an impairment rating of 15% or 25% of the whole body?

Facts:

The Department finds the following facts by a preponderance of the evidence:

1. James Leckner (Leckner) sustained a compensable workers' compensation injury while working for Rochester Armored Car Company, (Rochester) on October 21, 2009. He experienced neck and upper back pain shortly after lifting a heavy bag of money over a counter with his left arm and hand. The bag of money weighed more than 40 pounds.

2. Leckner initially sought treatment with Dr. Ashley Mayland at Harrisburg Family Chiropractic beginning in October 2009. Dr. Mayland noted that Leckner was suffering from “numbness in left arm” and “radicular pain in left arm.”

3. When Leckner’s symptoms continued, he saw Dr. Jason Knutson at Avera McGreevy Clinic in November 2009. Leckner again reported that he was suffering from pain and numbness and tingling in his left arm down into his left hand. Knutson diagnosed Leckner with “cervical radiculopathy.” Knutson initially treated Leckner with a regiment of steroids and pain medication. When that treatment did not prove effective, Knutson ordered an MRI.

4. The MRI indicated a left posterolateral disc protrusion at C6-C7 likely irritating the C7 nerve root as well as spondylolytic left C5-C6 cervical cord compression encroaching on the left C5-C6 neural foramen irritating the C6 nerve root.

5. Leckner met with Dr. Mitchell Johnson of the Orthopedic Institute in December 2009. Johnson is a board certified orthopedic surgeon who specializes in spinal surgery. Johnson examined Leckner and reported that he had “wasting of his left arm.” After reviewing the MRI, Johnson opined that the disc abnormalities at the C5-C6 and C6-C7 levels were likely causing the pain down into Leckner’s left arm. Johnson recommended surgery.

6. On December 14, 2009, Dr. Johnson performed two-level cervical fusion surgery at the C5-C6 and C6-C7 levels.

7. On April 5, 2011, Dr. Johnson assigned Leckner with a 25% impairment rating.

8. The first reason that Dr. Johnson provided to justify the 25 % rating is based on his opinion that Leckner has loss of motion segment integrity. He stated:

   > [m]otion segment integrity can be defined with two opposite extremes. One is that there’s some incompetency of the joint and it is loose or unstable. There’s the other extreme where the joint has been fused and is also no longer a joint in the traditional sense.

9. The second reason that Dr. Johnson provided to justify the 25% impairment rating is based on his conclusion that Leckner suffered a multi-level radiculopathy. Johnson explained:

   > I would summarize, basically saying, that the C7 radiculopathy was perhaps clinically more evident in the sense that we had weakness and we had reflex changes, but to discount the C6 nerve root MRI findings I think from a surgeon’s perspective would have been a huge mistake. And it’s my opinion, had we just operated at the C7 nerve root level, we would have had a patient continuing with arm pain referable to the C6 nerve.

10. On March 14, 2012, Dr. Thomas Ripperda of the Avera Medical Group performed an independent medical examination and permanent impairment evaluation of Leckner at the request of the Department. Ripperda is board certified in Physical Medicine and Rehabilitation. Dr. Ripperda assigned Leckner with a 15% impairment rating.

11. Both Dr. Johnson and Dr. Ripperda testified that they performed the impairment evaluation in accordance with the Guides to the Evaluation of Permanent Impairment established by the American Medical Association, Fourth Edition (Guides or AMA Guides, 4th Ed.)

12. Dr. Ripperda testified that the definition of the terms, "loss of motion segment integrity " and "radiculopathy", that Dr. Johnson used in his evaluation were commonly used in the everyday practice of physicians. However, the terms are more narrowly defined by the Guides.

13. Dr. Ripperda testified that Leckner did not have a loss of motion segment integrity as a result of his injury as defined in the Guides. He stated that the Guide's definition does not include a joint that has been fused and is no longer a joint, which is one of the criteria used by Johnson for his rating.

14. Dr. Ripperda also testified that Leckner suffered a single level C7 radiculopathy as defined by the Guides rather than the multi-level radiculopathy which Dr. Johnson had assigned. Ripperda found documentation of atrophy of the left tricep, loss of reflex in the tricep and weakness which is associated with a C7 nerve root involvement according to the American Spinal Injury Association. However, he testified that Leckner did not suffer a C6 radiculopathy as defined by the Guides because there was no documented atrophy, loss reflex or weakness in the left bicep which is associated with C6 impingement.

15. The Department takes judicial notice of Section 3.3 Spine, of the AMA Guides, 4th Ed. That document is marked as Exhibit 1. The Joint Medical Records is marked as Exhibit 2 and admitted into evidence. Dr. Ripperda's Deposition is marked as Exhibit 4 and admitted. Dr. Jonson's Deposition is marked as Exhibit 4 and admitted.

16. Additional fact will be discussed in the analysis below.

Analysis

Claimant has the burden of proving all facts essential to sustain an award of compensation. Darling v. West River Masonry, Inc., 2010 SD 4, ¶ 11, 777 NW2d 363, 367. The employee's burden of persuasion is by a preponderance of the evidence. Caldwell v. John Morrell & Co., 489 NW2d 353,358 (SD 1992). Claimant's burden of proof is not sustained when the probabilities are equal, and it is the duty of the

Department to deny compensation if Claimant fails his burden. King v. Johnson Bros. Canst. Co., 155 NW2d 183, 185 (SD 1967).

In this case, all parties agree that Leckner's PPD benefits are based upon his impairment rating as provided in the AMA Guides, 4th Ed. SDCL 62-1-1.2. The question then becomes whether Dr. Johnson or Dr. Ripperda properly interpreted the Guides while making their assessments.

The Guides states, "[t]he evaluator assessing the spine should use the Injury Model, if the patient's condition is one of those listed in Table 70 (p.108)."[1] Guides p. 3/94. The Injury Model is a diagnostic based form of evaluation. With the Injury Model the evaluation focuses on the condition resulting from the injury. The effects of surgery or treatment performed after the injury are not considered whether the results of the surgery or treatment are good or bad. (Guides p. 3/100).

"Radiculopathy" is one of the conditions listed in Table 70 (p.108). Both Dr. Johnson and Dr. Ripperda agree that Leckner suffered a C7 radiculopathy. Therefore, the Injury Model is the appropriate Model to be used in Leckner's evaluation. Table 70 also indicates that radiculopathy is rated as either a Category III or IV impairment.

Table 73 of the Guides describes Category III as"[r]adiocuiopathy: evidence of radiculopathy is present". Table 73 also identifies that conditions within Category III have a 15% rating. (Guides p. 3/110). Table 73 describes Category IV as "[l]oss of motion segment integrity or multilevel neurologic compromise". The Table indicates that conditions within the Category IV have a 25% rating. Id.

The Guides provide a more detailed description of Categories III and IV in Section 3.3h Cervicothoracic Spine under the headings titled DRE Cervicothoracic Category III: Radiculopathy and DRE Cervicothoracic Category IV: Loss of Motion Segment Integrity or Multilevel Neurologic Compromise. (Guides p.3/104). Category III states the following:

> Description and Verification: The patient has significant signs of radiculopathy, such as (1) loss of relevant reflexes or (2) unilateral atrophy with greater than a 2-cm decrease in circumference compared with the unaffected side, measured at the same distance above or below the elbow. The neurologic impairment may be verified by electrodiagnostic or other criteria (differentiators 2, 3, and 4, Table 71, p.l09).[2]

Id. Category IV states the following:

[1] The Guides goes on to state that the Motion Model may be used if the proper category cannot be assessed using the Injury Model. (Guides 3/94). However, in this case, the proper category can be determined using the Injury Model.

[2] The differentiators listed in Table 71 are: 2. Loss of reflexes; 3. Decreased circumference, atrophy; and 4. Electrodlagnostic evidence. These factors are describes much as they are in Section 3.3h, quoted above, except they contain more specifics with regard to the verification of the factors.

> Description and Verification: The patient has loss of motion segment or structural integrity or bilateral or multilevel radiculopathy (Table 71, differentiators 2, 3, 4, 5, p.109). Loss of structural integrity is defined as more than 3.5 mm of translation of one vertebra on another or angular motion at one motion segment that is more than 11° greater than the angular motion at an adjacent motion segment (Table 71, differential tor 5, and Figs. 62 and 63, p. 98).[3] Radiculopathy as defined in category III, if present, should be bilateral or involve several levels. A documented history of muscle guarding and pain should be present.

Id.

The Guides provides another definition of loss of motion segment integrity in Section 3.3b The Spine Examination. (Guides p. 3/98). That definition is essentially the same as the one quoted above from Section 3.3h for purposes of the cervical spine and this case.

Dr. Ripperda's observation, that the Guides dentition of loss of motion segment integrity is narrower that used by Dr. Johnson, is correct. Leckner's spinal fusions do fall within the criteria provided by the Guides. The Guides only recognize excessive joint movement not the lack of movement. Leckner does not qualify for the condition. In addition, the Injury Model does not consider the results of post-injury surgery or treatment in the evaluation and Leckner's C5-C6 and C6-C7 levels were not immobile prior to surgery. Therefore, Dr. Ripperda correctly determined that Leckner does not have a loss of motion segment integrity.

Dr. Ripperda's testimony that the Guides definition of "radiculopathy" is narrower than that used by Dr. Johnson is also correct. To find a multilevel radiculopathy, the Guides require documentation of atrophy or loss of reflexes of both the left bicep and tricep. Here, there is no record of atrophy or loss of reflexes in the left bicep nor does Dr. Johnson claim that there was.

Dr. Johnson justifies his determination of radiculopathy of the C6 nerve root based on his opinion that Leckner would have likely continued to experience pain in his left arm if the C5-C6 level had not been fused. While pain is a necessary component for a Category IV assignment, pain alone does not justify the classification. The Guides addresses pain in Section 2.1 Medical Assessment of Pain. There it states in part:

> In general, the impairment percentages shown in the chapters that consider the various organ systems make allowance for the pain that may accompany the impairing conditions.

Guides p. 2/9. Consequently, Dr. Ripperda correctly evaluated Leckner's condition as a single level radiculopathy.

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[3] Differentiator 5 of Table 71 is: Loss of motion segment integrity. This factor is described much as it is in Section 3.3h, quoted above for the cervical section of the spine.

In accordance with the analysis above, Leckner's condition falls within Category III of the Guides. Therefore, he is entitled to PPD benefits at an impairment rating of 15% of the whole body.

Leckner argues that Dr. Johnson's opinion should be given greater weight than Ripperda's because he is the treating physician and has more expertise in the field of spinal surgery than Dr. Ripperda. The Department disagrees. This is not a case where the subject judgment of the physician about the patient's condition is required like it is when the issue is medical causation or the necessary and reasonable treatment of the condition. The criteria used by the Guides to rate this impairments is purely objective. The issue here involves the interpretation of the Guides and Dr. Ripperda's ability to do that is superior to Dr. Johnson's in this case.

Conclusion:

Counsel for Employer and Insurer shall submit Findings of Fact, Conclusions of Law and an Order consistent with this Decision and if desired Proposed Findings of Fact and Conclusion of law, within 20 days of the receipt of this Decision. Counsel for Claimant shall have an additional 20 days from the receipt of Employer and insurer's Findings of Fact and Conclusions of Law to submit Objections and/or Proposed Findings of Fact and Conclusions of Law. The parties may stipulate to a waiver of formal Findings of Fact and Conclusions of Law. If they do so, Counsel for Employer and Insurer shall submit such stipulation together with an Order.

Dated this _11Th_ day of February, 2013.

__/s/ Donald W. Hageman___________
Donald W. Hageman
Administrative Law Judge