

FINDINGS OF FACT

Claimant is administrative captain at the Topeka Correctional Facility. On February 16, 2010, claimant was reading a document when his chair broke, causing him to fall backward and hit his head and neck on a ledge behind him. Claimant vaguely remembers being transported to the hospital, but does not recall his stay in the hospital. Thereafter, claimant received conservative treatment.

On May 25, 2011, claimant was seen by Adrian Jackson, M.D., at the request of respondent. Claimant complained of neck pain with headaches and pain across his shoulders and shoulder blades. Dr. Jackson reviewed an April 26, 2011 MRI as showing multi-level cervical spondylosis and a disc herniation at C6-7. Dr. Jackson recommended epidural steroid injections and indicated claimant could continue regular duties.

Claimant returned to Dr. Jackson on June 22, 2011, noting only temporary relief from the injections. Dr. Jackson recommended a two-level anterior cervical discectomy and fusion from C5-7 which was performed on July 28, 2011. Claimant was taken off work.

On August 22, 2011, Dr. Jackson evaluated claimant. Claimant testified that he told Dr. Jackson that prior to surgery, he experienced a lot of head and shoulder pressure, as though he was wearing football equipment that was too tight, but the pressure went away after surgery. Dr. Jackson recommended physical therapy and kept claimant off work.

Claimant was seen again by Dr. Jackson on September 14, 2011, with continued soreness at the base of his neck and across his shoulders and shoulder blades. Dr. Jackson provided light duty restrictions and recommended continued physical therapy.

On October 26, 2011, claimant returned to Dr. Jackson complaining of mild dysphagia and mild soreness. Dr. Jackson recommended claimant continue physical therapy for two more weeks and then be placed at maximum medical improvement effective November 9, 2011. Claimant was released to regular duties. He continues to perform the same duties as before the accident.

In his report dated November 14, 2011, Dr. Jackson provided claimant with a 15% whole person impairment for Cervicothoracic DRE Category III based upon the *Guides*.

On June 12, 2012, claimant was evaluated by Pedro Murati, M.D., at the request of his attorney. Claimant complained of stiffness in his neck, constant pain from neck down into shoulders and back, dizziness/loss of balance, headaches and high pitched noise in his ears. Dr. Murati diagnosed claimant with partial anosmia (loss of sense of smell), vestibular disorder (loss of balance and dizziness), post concussion syndrome, bilateral tinnitus (ringing in the ears), status post C5-6 and C6-7 anterior cervical discectomy and fusion, left shoulder sprain and myofascial pain syndrome of the bilateral shoulder girdles extending into the cervical and thoracic paraspinals, all due to the work-related injury.

Dr. Murati rated claimant as having:

- a 2% whole body impairment for partial anosmia;
- a 3% whole body impairment for tinnitus;
- a 5% whole body impairment for vestibular disorder;
- a 5% whole body impairment for post concussion syndrome;
- a 25% whole body impairment for Cervicothoracic DRE Category IV for claimant's cervical spine fusion; and
- a 5% whole body impairment for Thoracolumbar DRE Category II related to myofascial pain syndrome.

Dr. Murati indicated that these combined ratings equal a 36% permanent partial impairment rating to the body as a whole based upon the *Guides*.²

At the July 18, 2012 regular hearing, claimant complained of tinnitus, neck and shoulder pain, headaches, dizziness and loss of balance, as well as a constant lump in his neck accompanied by difficulty swallowing. Claimant testified he suffers from migraines about once or twice a week and dizziness about once every couple of weeks. Additionally, claimant has neck and shoulder pain every day and indicated the tinnitus is a constant issue which affects his sleep and causes him difficulty at work. Claimant denied having any of these problems prior to the accident.

The deposition of Dr. Murati was taken on July 9, 2012. Dr. Murati acknowledged that claimant did not make complaints about loss of sense of smell. However, he testified “[n]ot one examinee that comes in after a head trauma that I find anosmia, not one of them have told me any complaints about smell, not one of them. They find out after I test them and then they become aware they have a problem.”³ Dr. Murati indicated that either the ENT or Chapter 4 of the *Guides* can be used to rate anosmia and that he provided a 2% impairment rating, as he believes anosmia significantly interferes with claimant's daily activities in that there is the potential that claimant might not recognize the smell of smoke in his house until it is too late.

As for claimant's tinnitus, Dr. Murati testified that although it is a subjective condition, the *Guides* note “there's certain things, clinical conditions that you really don't have, like, an excerpt that shows them, but that doesn't mean they don't have impairment.”⁴ Therefore, he assigned a 5% impairment rating for claimant's tinnitus based upon page 224 of the *Guides*.

² The Board has combined these impairment ratings under the Combined Values Chart starting at pg. 322 of the *Guides*. The impairment ratings combine to be a 39% whole body impairment.

³ Murati Depo. at 23.

⁴ *Id.* at 25.

Dr. Murati assigned a 5% whole person rating for claimant's vestibular disorder utilizing Chapter 4, Table 11, Impairment Criteria for Cranial Nerve VIII (Auditory Nerve). Dr. Murati admitted that while the injury is not specifically the cranial nerve, it involves the hairs that attach the calcium inside the ear canal, and those attach to the nerve. When questioned regarding this, Dr. Murati testified as follows:

Q. And my question is, when you examined him on the cranial nerve examination, there wasn't any notation of any problems with cranial nerve eight; would that be correct?

A. . . . So, it's specifically not actually the cranial nerve, but it is very near to it. But it makes no difference, because an impairment is a medical condition that affects activities of daily living. In this case, let's say for the sake of argument it's not the nerve, it doesn't matter. It gives you the same effect. But if you look at the ENT, even the ENT chapter, the ear, and you look at page, under page 228, equilibrium. And it talks about the vestibular system. And it tells you, depending on the extent of adjustment, the percentage of permanent impairment of the whole person may range from zero to 95 percent whole person. And it tells you, criteria for vestibular impairment, class one, signs of vestibular dysequilibrium are present without supporting objective findings. That's not this case, he has a positive Romberg. Class two, one to ten percent. So, it really imitates the same table. So, again, if you look at page 229, the first paragraph, I gave him five percent impairment. I could have gone all the way to 10 percent, because he has signs of dysequilibrium with supporting objective findings, which is the Romberg test, and the usual activities of daily living are performed without assistance, except for complex activities such as bicycle riding or certain types of demanding activities related to the patient's work. . . .⁵

Dr. Murati testified that claimant suffers from headaches, which is a post concussive problem. Therefore, Dr. Murati provided a 5% whole person impairment under Chapter 4, Table 2, of the *Guides* for post concussive syndrome as he "couldn't imagine how somebody with a headache would be at just as good as somebody without a headache."⁶

Dr. Murati acknowledged that he did not do any type of measurements of claimant's cervicothoracic area in arriving at the 25% impairment under Category IV of the *Guides* as claimant had a fusion which indicated segmental instability. Dr. Murati testified that performing measurements would have been a "waste of time" as the fusion corrected the problem.

⁵ *Id.* at 27-28.

⁶ *Id.* at 29.

The deposition of Dr. Jackson was taken on September 25, 2012. Dr. Jackson indicated it is not uncommon that claimant was still experiencing soreness at the base of his neck and across his shoulders and should blades weeks after surgery because claimant had intrascapular and radicular symptoms before surgery. When questioned regarding how he arrived at his impairment, Dr. Jackson testified as follows:

Q. And your rating from the DRE-III category was based on the fact that [claimant] had undergone a two-level anterior-posterior fusion with implementation of hardware and bone?

A. No, that's not correct.

Q. Okay. I'm sorry.

A. First of all, he went through an anterior cervical discectomy and fusion; there was no posterior procedure performed, but the procedure is actually irrelevant to the rating. The rating is based on the injury model. His symptoms were cervical radiculopathy, which falls into an AMA Category III.

Q. So it was based on the cervical area of the body with the resultant radiculopathy?

A. It was based on the symptoms following the accident, that's correct.

Q. And those symptoms stemmed from the cervical spine?

A. Yes.

Q. And in that regard, the absence or presence of radiculopathy post-surgery would be irrelevant?

A. It's irrelevant.

Q. According to the Guides?

A. Correct.⁷

⁷ Jackson Depo. at 14-15.

PRINCIPLES OF LAW

It is claimant's burden to prove his right to an award of compensation by a preponderance of the credible evidence.⁸

K.S.A. 44-510e(a) states in part:

Permanent partial general disability exists when the employee is disabled in a manner which is partial in character and permanent in quality and which is not covered by the schedule in K.S.A. 44-510d and amendments thereto Functional impairment means the extent, expressed as a percentage, of the loss of a portion of the total physiological capabilities of the human body as established by competent medical evidence and based on the fourth edition of the American Medical Association Guides to the Evaluation of Permanent Impairment, if the impairment is contained therein. An employee shall not be entitled to receive permanent partial general disability compensation in excess of the percentage of functional impairment as long as the employee is engaging in any work for wages equal to 90% or more of the average gross weekly wage that the employee was earning at the time of the injury.

ANALYSIS

Nature and extent of disability

Claimant obtained impairment ratings for various conditions from Dr. Murati. Respondent had a cervicothoracic impairment rating from Dr. Jackson, but in lieu of obtaining medical opinions to counter Dr. Murati's ratings for tinnitus, vestibular disorder, and post-concussive syndrome, opted to attempt to impeach Dr. Murati's opinions through cross-examination, including various questions regarding Dr. Murati's use of the *Guides*.

Fused cervical spine and thoracic myofascial pain

Dr. Murati provided claimant a 25% impairment rating to the body as a whole for neck pain following a fusion, using DRE Cervicothoracic Category IV. Dr. Murati also provided a 5% impairment rating to the body as a whole for myofascial pain syndrome involving the thoracic paraspinals. Dr. Murati testified that claimant's myofascial pain affected both the thoracic and neck musculature.⁹ Dr. Jackson provided a 15% impairment rating to the body as a whole based on DRE Cervicothoracic Category III.

⁸ K.S.A. 2009 Supp. 44-501(a) and K.S.A. 2009 Supp. 44-508(g).

⁹ Murati depo. at 7-8, 10.

In this instance, the Board finds claimant's cervicothoracic impairment is best accounted for under DRE Cervicothoracic Category IV. While respondent argues claimant needs to prove loss of motion segment integrity to qualify for DRE Cervicothoracic Category IV on page 104 of the *Guides*, such section requires either loss of motion segment integrity *or* loss of structural integrity *or* bilateral radiculopathy *or* multilevel radiculopathy. Claimant had bilateral radiculopathy, which would qualify him for a 25% whole person impairment rating regardless of surgical outcome. The fact that claimant has a multiple-level fusion also means that he has multilevel motion segment structural compromise, which would qualify him for a 25% whole person impairment rating. Claimant qualifies for the 25% rating to the body as a whole for his cervicothoracic impairment.

However, Dr. Murati's 5% whole body rating for thoracic musculature impairment for myofascial syndrome (which also involved the neck or cervical area) appears to overlap the 25% impairment rating already provided for the cervicothoracic spine. The Board disregards this additional 5% impairment rating as doubling-up on claimant's impairment.

Tinnitus

According to page 224 of the *Guides*, "Tinnitus in the presence of unilateral or bilateral hearing loss may impair speech discrimination; therefore, an impairment percentage of up to 5% may be added to the impairment for hearing loss." This section limits impairment for tinnitus to situations where a claimant has underlying hearing loss or perhaps impaired speech discrimination. Page 146 of the *Guides* states, "Tinnitus in the presence of *unilateral* hearing loss may impair speech discrimination and adversely influence the ability to carry out daily activities. Therefore, up to 5% may be added because of tinnitus to an impairment estimate for severe *unilateral* hearing loss." Claimant does not have hearing loss. There is no proof that he has impaired speech discrimination. Dr. Murati's 3% impairment rating for tinnitus is not in accordance with the *Guides*.

Vestibular disorder

Page 146 of the *Guides* states, "Impairment of equilibrium and balance (Table 11, below) assumes significance, if the patient undertakes daily activities such as bicycle riding or working in high places or other hazardous locations." Table 11, Impairment Criteria for Cranial Nerve VIII (Auditory Nerve) provides a 1-9% impairment rating to the body as a whole where "[m]inimal impairment of equilibrium exists, with limitation required only of activities in hazardous surroundings." Dr. Murati acknowledged that claimant did not actually have impairment to cranial nerve VIII, but that claimant had impairment nonetheless.

Dr. Murati testified that page 229 of the *Guides* would provide an alternative method of assigning impairment for a vestibular disorder.¹⁰ Such section notes that a 1-10% whole person impairment rating for vestibular impairment may be assigned where the patient has “(a) signs of dysequilibrium are present with supporting objective findings *and* (b) the usual activities of daily living are performed without assistance, except for complex activities such as bicycle riding or certain types of demanding activities related to the patient’s work, such as walking on girders or scaffolds.” The *Guides* do not require that a claimant actually ride a bike or work in dangerous, elevated or hazardous places for the impairment to exist. Dr. Murati’s 5% whole body impairment rating for vestibular disorder is not contradicted or improbable.

Post-concussive syndrome

Dr. Murati’s 5% whole body impairment rating for post-concussive syndrome is based on the *Guides*’ Chapter 4, Table II, where a claimant may have a 1-14% whole body impairment rating where mental status “[i]mpairment exists, but ability remains to perform satisfactorily most activities of daily living.” Dr. Murati’s impairment rating for post-concussive syndrome is not contradicted or improbable.

Partial anosmia

Based on Chapter 4 of the *Guides*, Dr. Murati gave claimant a 2% whole body impairment rating because he misidentified the smell of rubbing alcohol. The Board cannot discern from the record what claimant misidentified the smell of alcohol to be. Dr. Murati concluded claimant’s cranial nerve I was not intact as a result of this test. Page 144 of the *Guides* indicates that an impairment for anosmia should only be given if it interferes significantly with activities of daily living.

The Board does not find Dr. Murati’s 2% whole body rating for partial loss of smell to be particularly reliable. The claimant did not testify that his activities of daily living were impacted at all by his partial loss of smell. When advised that the *Guides* require significant interference with activities of daily living to warrant an impairment rating for loss of smell, Dr. Murati theorized that claimant *might* not smell smoke *if* there was a fire in his house, that claimant would then die and his death would interfere with his activities of daily living. Dr. Murati’s “sky is falling” speculation does not amount to impairment or interference with claimant’s activities of daily living. There is no proof claimant lacks the ability to smell smoke. Moreover, gauging interference with activities of daily living presupposes that the claimant is alive.

¹⁰ The Board notes that pg. 146 of the *Guides* advises the reader to consult pg. 223 of the *Guides* where there is an issue with vertigo in the absence of known nerve dysfunction.

CONCLUSIONS

The Board concludes that claimant has an overall 33% impairment rating to the body as a whole based on combining a 25% whole person rating for cervicothoracic impairment with a 5% whole person rating for vestibular disorder and a 5% whole person rating for post-concussive syndrome. The Board finds Judge Sanders' Award should be modified to provide claimant with permanent partial disability benefits based on a 33% whole body impairment rating, but otherwise affirmed in all other respects.

AWARD

WHEREFORE, the Board modifies Administrative Law Judge Rebecca Sanders' Award dated October 25, 2012, as noted above.

The claimant is entitled to 11 weeks of temporary total disability compensation at the rate of \$546 per week or \$6,006.00 followed by 136.95 weeks of permanent partial disability compensation at the rate of \$546 per week or \$74,774.70 for a 33% functional disability, making a total award of \$80,780.70, all currently due and owing.

IT IS SO ORDERED.

Dated this _____ day of April, 2013.

BOARD MEMBER

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