01048-02195

BEFORE THE INDUSTRIAL ACCIDENT BOARD OF THE STATE OF DELAWARE

SHARON MORNINGRED,	)	
	)	
Employee,	)	
	)	
v.	)	Hearing No. 1321758
	)	
DELTA AIRLINES,	)	
	)	
Employer.	)	

DECISION ON PETITION TO DETERMINE ADDITIONAL 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 on July 25, 2013, in the Hearing Room of the Board, in Wilmington, Delaware.

PRESENT:

JOHN D. DANIELLO

MARILYN J. DOTO

Kimberly A. Wilson, Workers' Compensation Board, for the Board

APPEARANCES:

David A. Denham, Esquire, Attorney for the Employee

Kimberly A. Harrison, Esquire, Attorney for the Employer/Carrier

NATURE AND STAGE OF THE PROCEEDINGS

Sharon M. Morningred ("Claimant") was injured in a compensable work accident on May 29, 2008 while working for Delta Air Lines ("Delta" or "Employer"). Employer has accepted injuries to Claimant's cervical spine, lumbar spine and left lower extremity as compensable. Claimant has also already received compensation for a 7% permanent impairment to the cervical spine, an 8% impairment to the lumbar spine and an 11% impairment to the left lower extremity. Claimant is currently receiving ongoing total disability compensation at the rate of $429.39 per week based on a weekly wage of $644.98 at the time of injury.

On February 7, 2013, Claimant filed a Petition for Determination of Additional Compensation Due alleging that she has an additional permanent impairment to the left lower extremity, and that her total permanent impairment is now 100%. Likewise, she alleges that her cervical spine has suffered additional permanent impairment and that her total permanent impairment is now 14.2%. Claimant also seeks an acknowledgement that her brain has suffered a compensable injury in the form of migraines and depression and that she has a permanent impairment to the brain in regard to migraines in the amount of 4%. As to depression, Claimant maintains that she has a permanent impairment to the brain in the amount of 20%. Finally, Claimant seeks an acknowledgement that the right shoulder (right upper extremity) was injured in the work accident and that she has a 4% permanent impairment to the right shoulder, casually related to the original work accident.

Employer disputes most of Claimant's contentions. Employer agrees that Claimant has suffered an additional permanent impairment to the left lower extremity, but maintains that it is only a total impairment of 40%, as opposed to 100%. Employer further maintains that Claimant is not able to show that she suffered any additional loss of use of her cervical spine in that she has been rated by her current medical expert at the same level as her prior award. Employer also

disputes the causal relationship of Claimant's right upper extremity condition and level of impairment. As to Claimant's assertions in regard to the brain, Employer argues that Claimant's depression is causally related to the work accident but not a brain injury or ratable condition. Finally, Employer maintains that Claimant's migraines are not causally related to the work accident.

A hearing was held on Claimant's petition on July 25, 2013. This is the Board's decision on the merits.

SUMMARY OF THE EVIDENCE

Claimant testified first on her own behalf. She was injured in May of 2009 while moving luggage off of a carousel. She ultimately required a lot of treatment for complex regional pain syndrome ("CRPS") to the left leg since the work accident.

Claimant described her current difficulties in relationship to her work injuries. Her left leg is a major problem. She has problems with swelling in the calf as well as around the ankle and foot areas, as well as discoloration inside and outside of her leg. Her skin is very dry. Claimant feels burning pain and also a "frostbitten" sensation at times from her toes into her left hip. Sometimes it feels as if her toes are so cold they might break off. She has stabbing pain as if she is being cut in the ankle, arch of the foot, in the knee and calf. The leg can be ice cold or burning hot. Claimant's leg is also very sensitive and it hurts if it is touched. This includes shoes, clothes and any kind of air movement on it. When touched or hit by air movement, it feels like needles are going into the leg.

Claimant also has issues with strength and mobility in the left leg. Before the work injury, Claimant had no problems; now she cannot weight bear on it. She has spasm in the whole leg every night, usually in the evening. Claimant also does not have the movement in the left leg she had before the work accident. She could do anything before, now she feels as if she can

barely move her foot and her ankle is stiff. There is very little that Claimant can do with the left leg. She often has to use a motorized scooter to move around. She also requires two canes and a walker that has a chair on it to get around. The chair is so that Claimant can stop and sit when needed while walking. She cannot walk or rise from a sitting position without her assistive devices. She can walk for about twenty-five feet before she needs a break, depending on her level of pain.[1] When Claimant has to go up and down stairs, she uses the railing to pull her self up and let herself down. Claimant always has to have her canes close to her to help with her balance. She lives with her parents and occasionally someone will have to help her out of a chair. Claimant generally can get out of bed without help, though she uses her canes to help stabilize her once she gets up.

Claimant's pain level in the left leg is between a six and nine. Six is the lowest it has been, with the leg usually averaging an eight or nine. The days her pain is the lowest are the days when Claimant is inactive; she has higher levels of pain when she is more active. It is very unpredictable.

Claimant's left leg symptoms also affect her ability to sleep. She is in a bed most of the time but has a special setup so that her top sheet does not touch her leg, because even the light touch of a sheet causes her leg pain. She also has to use a side pillow to support her left leg if she lies on her side. At times, Claimant has to sleep in a recliner with a pillow under her left leg.

In terms of bathing, Claimant has to keep a chair in her shower and utilize a removable showerhead. This special showerhead has a pressure control that can be adjusted when Claimant is cleaning her left leg. The water hurts when hit with water.

Claimant's left leg symptoms also affect what clothes and shoes she can wear. She always has to wear sandals or slip on shoes that do not have a back to them. Her left foot's

[1] Claimant testified that although Dr. Meyers indicated she had walked across his parking lot with her walker, she was actually dropped off three feet from his building door.

swelling makes it tough to wear anything else. The swelling on top makes it so that she needs a shoe with an adjustable strap. Claimant also requires a separate tool to help her get her pants on so that the clothing will not touch her leg.

Claimant described how her everyday activities have been limited by her left leg condition. She cannot vacuum, garden, cut the grass, do the laundry, or clean the bathrooms. The dryer is too low for Claimant, so she cannot get the clothes out. Claimant requires seat risers on her toilet so that she can sit down and get up more easily.

Claimant addressed her neck condition. She has pain in her neck so that she cannot turn her head all the way. The pain radiates down into her shoulder slope area to the right side of her back. Claimant has neck pain daily. This causes her trouble with driving. Claimant has to put heat or ice on her neck to reduce her pain. She also uses a TENS unit.

As to Claimant's right shoulder, she injured it in the work accident. She had no problems prior to the work accident but now has pain. Her right hand is her dominant one. Claimant used crutches for well over a year after the accident and then transitioned to a walker, which she still uses. She also frequently uses canes. When Claimant uses her cane and walker, she notices an increase in her right shoulder pain.

Claimant gets a sharp pain in the right shoulder into the joint. It is like a knife stabbing in there and pain radiates down her arm into her elbow. Claimant does not believe that Dr. Meyers is correct that her right shoulder pain is radiating from her neck. Her pain from the neck seems to go more toward the back, not the shoulder. Claimant has pain pretty much every day, though the pain varies in degree.

Because of Claimant's right shoulder pain, she has trouble walking because she needs her canes to get around. Some days she can lift more weight than others; sometimes lifting a gallon of milk hurts. Claimant notices her pain is aggravated at times when brushing her hair or

brushing her teeth with her right hand.

Claimant addressed the gaps in treatment for her right shoulder. She always focused on the body part that was in the worst condition when she saw her doctors. If a body part was hurting but tolerable, she is not the type to bother to see a doctor and would not make an appointment over the issue. Claimant's worst body part is her left leg. Either her low back or upper back/neck area is her second priority. Claimant's right shoulder is fourth in terms of priority, unless it is flaring up.

Claimant also has experienced migraines more frequently since the work accident. She may have had one beforehand. In 2005, she saw Dr. Grossinger for migraines, but just that one time. She noticed that her head hurt and light was affecting her and friends that had experienced migraines recommended seeing a doctor. She did not have prescription medication for migraines prior to the work accident, though she takes medication as needed for the condition now.

Claimant is unsure when she first started having migraines after the work accident; she believes it was around the end of 2008. She thought that they had increased after ketamine infusion therapy. From the time of the work accident until the start of the infusion therapy, Claimant thought she was having migraines twice a week. Once she started ketamine infusion therapy, the migraines became a daily event. Claimant would have severe pain in the forehead, behind her eyes and extending back. This was from the area of her eyebrows across the forehead and around the crown of her head. She was sensitive to light and sound. Claimant often feels nauseated and occasionally has thrown up. When she has a migraine, she lies in bed and takes her prescription medication.

Claimant could not estimate how much time she has missed in the past three months due to her migraines, because she has missed work due to all of her ailments. It has reduced her functionality. She cannot single out what housework and activities she has missed because of

her migraines because it is a combination of all of her pain that is the cause.

Claimant also developed depression and anxiety after the work accident. She was never treated for anxiety or depression before the industrial accident. Claimant treated first with Dr. Silberman from 2009 through 2010 and since then has received treatment through Veterans Affairs ("the VA"). Claimant is depressed because she misses work and things she used to do. She cannot travel, hike or walk her dog anymore.

On cross examination, Claimant testified that she uses canes with handles but that she uses them more like crutches.

Claimant is not currently in physical therapy. She was told she should take a break from physical therapy and see how she does.

Dr. Alan Fink, a neurologist, testified by deposition on behalf of Claimant.[2] He examined Claimant in December 2012 and reviewed her pertinent medical records.

Dr. Fink discussed Claimant's medical history prior to the work accident. She did visit a doctor for migraines in November 2005; however, there was otherwise no real history of previous injury or significant medical illness occurring prior to her work accident.

As a result of the work accident from May of 2008, Claimant ended up with several areas of injury including her neck, her low back, her right and left shoulder, her left knee, left ankle, low back and legs. Claimant had chiropractic treatment with Dr. Cowan from July through December of 2008 for her neck and low back pain. She had been using crutches from the date of the work accident and soon after also used a wheelchair to get around. As early as August of 2008, Claimant began exhibiting signs of CRPS in her left leg. She was definitively diagnosed with CRPS in the left leg in December of 2008 and the diagnosis has been maintained since.

In June of 2011, Claimant saw Dr. Falco with complaints of headaches, neck pain,

[2] Dr. Fink's deposition was marked into evidence as Claimant's Exhibit #1.

bilateral shoulder pain, upper and lower back pain, lower extremity pain and left ankle and knee pain. She was placed on several medications including Oxycodone, Nortriptyline, Neurontin, Topamax and Maxalt. Dr. Falco further confirmed Claimant's CRPS diagnosis as well as neck and low back pain. Aqua therapy was unsuccessful for Claimant. Dr. Falco noted that Claimant was beginning to develop lymphedema as a complication of her CRPS. The fluid in Claimant's left leg was not appropriately draining and she was experiencing swelling as a result. Claimant was also treated from August of 2011 through the present at the VA Hospital for depression.

A Ketamine infusion treatment was recommended for Claimant's CRPS symptoms. Claimant began a series of IV Ketamine in December of 2011 that only provided her minimal and temporary relief. She complained of a burning right hand and shoulder in June of 2012.

When Dr. Fink saw Claimant in December of 2012, she complained that her headaches had continued and increased after the Ketamine infusions. She denied nausea with her headaches. Claimant had constant neck pain with radiation of pain into the right neck to the right suboccipital region, which is the area just below where the skull meets the neck. She had more pain on the right shoulder than the left. Claimant had limitation of right shoulder motion posteriorly, midback pain, chest pain, pain in the abdomen and low back.

Claimant was limited in standing and walking on her own seemingly due to severe pain in the left leg and ankle. Her pain was set of in contact with even the lightest touch of the left leg and foot. Claimant had almost a fixed left ankle with severe limitation of motion of the left ankle as well as the left knee.

Dr. Fink examined Claimant in December 2012. He noted clear signs of CRPS, including color changes, temperature changes, shiny skin and marked edema. Claimant had swelling from the knee to the foot of the left leg. She also had signs of atrophy, likely due to lack of use of the left leg. She had marked limitation of left ankle motion. She had was limited by ten degrees of

left foot flexion and internal and external rotation by ten degrees. Claimant also was limited by ten degrees of extension in the left knee. She had a full range of motion of the left hip.

Claimant's upper extremity revealed some decrease in the right shoulder motion specifically in external rotation by thirty degrees and extension by thirty degrees. Claimant had a full range of neck motion. She complained of some burning over the right elbow and wrist but also had a full range of right elbow and wrist motion. Claimant's upper extremity strength sensation and coordination were normal. Her strength was 4.5 over 5. Claimant had definite weakness in the left thigh, leg and especially in the foot. Her strength was rated a 3 out of 5, mainly due to the CRPS plus the limitation of her ankle motion. Claimant also had allodynia such that even the lightest touch, such as blowing on the left leg, created severe burning throughout the whole leg. Claimant further had a feeling of intense pain and burning just with simple touching even without pressure. She also displayed marked swelling of the left ankle. Claimant had weakness as well in the right leg, but the weakness in the left leg was much greater than that in the right.

Claimant reported that she drives using her right foot only. When she moves about an office, such as Dr. Fink's, she uses a walker as well as a cane. Claimant reported she uses a scooter if she is going to go any distance.

After the physical examination, Dr. Fink concluded that Claimant had various diagnoses causally related to her work accident: She had continuing headaches consistent with posttraumatic migraine headaches. Claimant suffered a ligamentous and muscular injury to the cervical spine. She had tendinitis of the right shoulder with limitation of right shoulder rotation. Claimant had a ligamentous and muscular injury to the lower back. She has CRPS of the left leg and marked restriction of her left ankle and knee.

Additionally, Dr. Fink opined that Claimant has depression secondary to CRPS. He

believes this to be a biological depression based on the degree of pain that an individual can sustain.

Dr. Fink rated Claimant for permanent impairment to the cervical spine. He referred to the Fifth Edition of the *AMA Guides to the Evaluation of Permanent Impairment.* Under Table 15 – 5, Claimant would receive a 5% whole person permanency involving the cervical spine. This is basically for pain and discomfort. Dr. Fink considered Claimant's subjective complaints and the degree of pain that she had coming from the neck as well as some changes of degenerative disease shown by MRI scans. When this is translated into a regional rating utilizing page 427, this yields a 14.2% permanency to the cervical spine.

Dr. Fink next rated Claimant's left leg for permanent impairment. His rating for the left leg is based on CRPS, using the Fifth Edition. He referenced Table 13 – 15, which rates lower extremity RSD. Claimant's physical exam contained if not all, nearly all, of the elements of CRPS/RSD. All eight of the objective findings mentioned in the *Guides* were present on exam.

Dr. Fink noted that the highest impairment in the applicable category reflects a patient who cannot stand or walk without the help of a mechanical support or an assistive device. The maximum whole person impairment allowable is 60%, which translates to a 100% regional impairment to the leg. In Dr. Fink's opinion, Claimant falls into Class 4 because she cannot stand without help, support and/or an assistive device. Assistive devices include crutches, walkers, scooters and canes, such as those that Claimant has often used. Dr. Fink placed Claimant at the highest end of the range with a rating of a 100% permanent impairment to the left leg.

Dr. Fink opined that Claimant has a compensable right shoulder injury causally related to the work accident. He disagrees with Dr. Meyers. Claimant's reported history was that she slipped and fell on her right side while at work. She complained of right shoulder, right elbow as

well as right wrist pain after the work accident in May of 2008. One of her diagnoses according to Dr. Lam was a right shoulder sprain. A right shoulder sprain is a discrete injury. Additionally, Dr. Lam prescribed crutches for Claimant because of her left ankle and knee injuries.

Claimant had an MRI the right shoulder in January 2010. The MRI report noted that Claimant had right shoulder pain, with limited range of motion following a May 2008 fall. The radiologist noted that the right shoulder revealed tendinitis of the subscapularis and supraspinatus tendon. Further, a May 17, 2012 office note from Dr. Malhotro from the VA Hospital states that Claimant was being referred for right shoulder pain. Dr. Malhotro noted that over the years Claimant had been walking with several ambulatory aids including canes, walkers and crutches. He documented that Claimant believed that these were putting strain on her shoulder and making her shoulder worse. Dr. Fink testified that tendinitis can develop from a single traumatic event such as falling onto a shoulder. It also can develop from repeated or extended use of crutches or other ambulatory assistive devices such as canes or walkers. Crutches are a known offender for causing tendinitis of the shoulder. There was no evidence in the records of Claimant having any problems with her right shoulder prior to the work accident; after the work accident, there was evidence of injury.

Dr. Fink rated Claimant's right shoulder for permanent impairment. He used a diagram from the *Guides* in the Fifth Edition, which measures three types of movement of the shoulder. These movements are flexion and extension, abduction and adduction as well as internal and external rotation. Claimant had limitation of motion in two of the six movements. Utilizing these range of motion limitations, Dr. Fink arrived at a 4% permanent impairment of the right shoulder.

Dr. Fink discussed Claimant's migraine headaches, which he relates to the work accident. While Claimant had somewhat of a history of headaches prior to the work accident, it was only

occasional prior to the work accident. There was no evidence in the records that Claimant was having frequent migraines after 2005. Dr. Fink testified that it is more than possible that her migraines had actually resolved and what we are seeing now is part and parcel only of the trauma that occurred when she fell. Claimant's migraines and headaches increased dramatically in frequency, severity and consistency after the work accident.

The most recent studies available indicate that migraines are essentially a function of the brain as opposed to a function of the head; thus, Dr. Fink rated Claimant's migraines in terms of the brain. In fact, migraines are considered a brain disease. Claimant has throbbing headaches that are often unilateral. She also has nausea as well as visual blurring associated with those headaches, which are characteristic of a migraine. Under the Sixth Edition of the *Guides,* Dr. Fink rated claimant at a 4% permanent impairment to the brain in regard to her migraine headaches.

Dr. Fink next addressed Claimant's depression, which he also related to the work accident. Claimant treated with Dr. Silberman in the 2009-2010 timeframe. Since then, Claimant has treated at the VA Hospital for depression.

Dr. Fink explained his rationale in raining Claimant for a permanent impairment to the brain secondary to depression; in so doing, he has made a differentiation in regard to her depression. Dr. Fink explained that there is depression that individuals have that is situational in nature, such as in cases of the loss of a parent or a sick child. Claimant's depression is different, it is a biological depression. The difference is that one can actually see the physical component of what is causing the pain. All the changes involving CRPS are physically visible. In Dr. Fink's opinion, to live with this pain, any individual would be depressed on a neurochemical or neurobiological basis because of the frequency of the pain itself. The human mind does not have the ability to be optimistic enough or resistant enough not to be depressed. Depression is a

biological natural consequence of her CRPS. Claimant does not have a psychogenic overlay, setting her apart from other cases. There is an organic basis for Claimant's depression, which is her severe and debilitating disorder (CRPS).

Dr. Fink rated Claimant with a twenty percent permanent impairment to the brain, secondary to depression. He used the *Guides*, where there is a dementia rating scale for patients who have a head injury. Claimant was given a CDR score for class 2, which correlates with a twenty percent permanent impairment to the whole person. Twenty percent indicates a moderate limitation of some activity to daily living and some daily, social and interpersonal functioning.

On cross examination, Dr. Fink clarified that Claimant would have a 22% permanent regional impairment in regard to the brain for depression. This is added on top of the 4% that he rated to the brain for headaches.

Dr. Fink agreed that Claimant's range of motion measurements to the left leg were limited by ten degrees. For example, a normal range of motion of left knee extension is about ninety degrees, so Claimant's was limited to about eighty degrees. Likewise, Claimant's external rotation and extension ranges of motion of the shoulder were thirty degrees short of normal.

Dr. Fink acknowledged that in rating the cervical spine for permanent impairment, he used the diagnostic related estimate ("DRE") Category. He assigned Claimant with a 5% whole person permanent impairment to the neck and utilized the cervical spine conversion factor in arriving at a 14.2% regional rating. Dr. Fink admitted that it is common practice in Delaware to utilize the lumbar conversion factor instead, though he explained that the *Guides* do not mention doing so. He agreed that if the lumbar conversion factor were used instead, Claimant would be rated with a 6.6% (7%) permanent impairment rating for the cervical spine. Dr. Fink admitted that this is the rating that Dr. Meyers assigned to Claimant for the neck. He further admitted that

this is the rating that Claimant has already been awarded in the past for her neck.

Dr. Fink agreed that Claimant's left leg rating is based solely on CRPS, not a limb length discrepancy or other measure. He testified that Claimant can walk without assistive devices; however, to sustain the amount of walking she can do, she has to have assistance. For example, if she went to a shopping mall, she would use a scooter or a cane. She also needs help getting up from a chair, for example, due to pain in her left leg.

As to the right shoulder rating, Dr. Fink agreed that he is unaware of the last time that Claimant used crutches. He knew that at the beginning of her injury, she used crutches. Dr. Fink testified that whether Claimant's cane or walker aggravates the shoulder depends on certain factors. He sees patients that have canes that are too short and they get shoulder pains. The same is true of a walker. If the walker has to be lifted up instead of rolled, it will also cause stress on the shoulder. Dr. Fink agreed that he did not assess Claimant's canes or walker in this regard.

Dr. Fink addressed questions about why Claimant's depression is not related to her CRPS condition as opposed to the brain itself. He clarified that the brain is an organ that is affected by the CRPS. The brain is a secondary complication of the injury itself. Claimant has a primarily biological injury that produced a secondary brain component in contrast to someone who just gets depressed over an event. Dr. Fink agreed that neuropsychological testing could be done to assess the degree of injury to the brain but because CRPS is so unique, it is unlikely if there are enough cases to make a statistical explanation. Such testing would not likely be very helpful because it would only show that the patient is depressed.

Dr. Fink agreed that there are other methods in the *Guides* to rate permanent impairment due to pain, but he rated Claimant specifically for the brain in terms of the pain of her depression.

Dr. Jeffrey Meyers, a physician board certified in physical medicine and rehabilitation, testified by deposition on behalf of Employer.[3] Dr. Meyers examined Claimant in May of 2010 and again in April of 2013. In May of 2010, she reported that she was injured in May of 2008 when she was carrying two heavy duffel bags and slipped on a wet spot on the floor and fell down, striking her left knee. She later noticed pain in areas including her low back, left lower extremity and right upper extremity, including the shoulder and wrist areas. At Claimant's initial workup, it was noted that Claimant had some swelling in her left ankle. She was referred to physical therapy. Claimant was subsequently diagnosed with CRPS of the left leg. Claimant had chiropractic care for complaints of pain in the low back and left lower extremity, alone with some improving symptoms in her neck and right shoulder area.

At the most recent visit in April of 2013, Claimant reported that she had continued complaints of pain in the neck, right upper extremity, low back, left lower extremity along with some persisting depression. At that time, she was following up for management of a spinal cord stimulator. Claimant was seen for mental health issues at the VA in 2010.

In late 2011, Claimant started treatment with Dr. Robert Schwartzman and he started Ketamine infusions in 2012. Unfortunately, Claimant had no relief. Claimant reported to Dr. Meyers that she had an increase in a preexisting migraine condition due to the Ketamine infusions. In late 2012, Dr. Schwartzman started Claimant on monthly lidocaine infusions. Claimant felt that she had temporary partial relief from them.

As of April of 2013, Claimant reported that she had continued neck pain with radiation to her head along with worsened migraine. She had right upper extremity complaints in her shoulder along with right upper extremity dysesthesias that radiated to her hand. Claimant also reported low back pain greater on the left into the buttocks and left lower extremity pain mainly

[3] Dr. Meyers's deposition was marked into evidence was Employer's Exhibit #1.

from above the knee radiating down distally that she related to CRPS. She further reported some intermittent radiation to the left thigh and groin. She was following up with Dr. Falco monthly for pain management and with Dr. Schwartzman two days a month for the lidocaine injections. Claimant was further seeing Dr. Jankovic, a chiropractor, two times per month. She continued at the VA for her psychological care.

Claimant reported that she was using a cane for ambulation at home, a rolling walker for some outside distances and used a scooter for most of the ventures outside of her home. She used lumbar and a left elbow support as well as a TENS unit. Claimant was taking Naproxen (anti-inflammatory), Maxalt (headache), Neurontin (neuropathic/CRPS pain), Nortriptyline (sleep, pain, anti-depressant), Lidoderm patch (localized pain), and Zofran (nausea).

Claimant noted that her right upper extremity pain was of a constant nature and would average between 2 and 6 out of 10 on a pain scale. She pinpointed the pain in the shoulder adjacent to the neck and radiating into her neck. Claimant also mentioned that the pain could also radiate to her wrist and hand areas at times.

Claimant reported left lower extremity pain from just above the knee down to the ankle and at times to the foot and the left inner groin. Claimant noted that the pain would average between 6 and 9+ out of 10.

Claimant described her mobility issues. She reported that she used a scooter for most outside mobility, a four-wheel rolling walker for some of her outside ambulation and a single point cane in the house. Her walking tolerance was stated to be less than a block with her standing tolerance ten to fifteen minutes before her pain increased. Claimant avoided bending and twisting and had to change positions often. She had difficulty with lower extremity dressing and wore slip-on shoes. She no longer did chores or yard work. Claimant stated that she could no more golf, perform photography, swimming, traveling or snorkeling.

Claimant's typical day was spent watching television, sitting in a recliner or napping. Occasionally, she would bake a cake. She also occasionally would go shopping with her scooter. Claimant had frequent doctor's appointments. She reported that she drives.

Dr. Meyers examined Claimant in April of 2013. He noted that she ambulated into the office with a four-wheel rolling walker over a hundred feet with a slow but continuous gait, before she had to rise up and maintain a standing position for a few minutes. There were clear signs of CRPS in the left leg in terms of color, temperature and appearance.

On the palpation exam, there was mild hyperesthesia to touch over the left lower extremity from above the knee down, which was strongest in the left foot. Sensation was normal and without reaction to touch of the left thigh above the knee and the medial thigh toward the groin. The left leg was significantly cooler than the right from just above the knee down to the foot. There was mild swelling of the left lower leg compared to the right. Claimant reported exquisite tenderness to palpation over the left sciatic notch and over the left sacral sulcus.

Cervical maneuvers were normal with reported baseline neck pain. Shoulder upper extremity maneuvers were normal bilaterally, except for report of pain with Hawkins maneuver on the right.

Dr. Meyers discussed Claimant's gait examination. For tandem walk, Claimant used a rolling walker and was able to walk with the walker at a slowed, but normal gait. She performed heel and toe walk for a number of steps with complaints of pain and performed five ankle pumps complaining of left lower extremity pain. Claimant's balance was intact. Her neurological exam noted report of hyperesthesia and allodynia in the left lower leg from just above the knee to the foot.

On manual motor testing, everything in the upper and lower extremities was five out of five; however, in the lower extremities it was breakaway. She did report pain and discomfort,

but her strength was five out of five. Claimant's neck range of motion was full. Her upper extremity range of motion displayed reports of some pain at end range in her neck with shoulder range of motion; on the right, there was a decrease of twenty degrees for internal and external rotation, which she said brought on neck pain. The rest of the upper extremity range of motion was full. The lower extremity range of motion was full except for some mild deficits on the left, including in the ankle; dorsiflexion and eversion were decreased by five degrees and inversion was decreased by ten degrees.

Following his review of the records and Claimant's physical exam, Dr. Meyers noted that Claimant had five diagnoses. She had neck pain with radiation that appeared to be work related; low back pain with radiation that appeared to be work related; left lower extremity pain/CRPS that was related to the work accident; migraine headache, which was not work related and a pre-existing condition; and right shoulder complaints, which were not a lingering discrete injury but instead were part of her neck condition radiating into the right shoulder.

Dr. Meyers reviewed Claimant's neck pain with radiation diagnosis. Her neck discomfort radiated into her head and into the right shoulder and upper extremity. It appeared to be soft tissue and degenerative in nature.

As to Claimant's migraines, Dr. Meyers explained his conclusion that Claimant had a preexisting history. She was seen by a neurologist for migraines in the past. Claimant admitted to Dr. Meyers that she had preexisting migraines, although she did indicate that she felt that had worsened after the treatment with Dr. Schwartzman.

Dr. Meyers addressed Claimant's right shoulder condition. There were no records to support an ongoing injury to the right shoulder. She had imaging of the right shoulder that initially showed some tendinitis, which would be a soft tissue irritation. Her exam was good. Claimant's pattern of pain up in the neck region was radiating into the shoulder and into the

head. This is why Dr. Meyers believes that her headache and shoulder complaints are actually related to the neck. When a patient has a cervical spine injury with radiating pain to an upper extremity, it can appear to the patient to be right shoulder pain. This is typically seen, pain in the shoulder slope. The muscles of the neck attach in the back of the head and the side of the head and they go down, attach to the distal end, the outside end of the clavicle as part of the shoulder. They are all the strap muscles of the neck. She may feel pain in her right shoulder, but that is very common with neck pain; however, this cannot be related to the right shoulder itself in terms of permanent impairment.

Dr. Meyers evaluated Claimant for purposes of permanent impairment. Beginning with the neck, Dr. Meyers used Table 15-5 in the Fifth Edition and placed Claimant in DRE Category II at the lower end. Based on her findings, he placed her at a 5% whole person impairment. Utilizing the lumbar conversion factor, which is typically what is used for doing a conversion for the cervical spine (due to the overly high ratings that are gotten with using the cervical conversion factor), Dr. Meyers arrived at a 7% regional impairment to the cervical spine. Dr. Meyers also rated Claimant in 2010 with a 7% permanent impairment to the cervical spine. She has had no change or worsening of her condition from 2010 to 2013 to warrant a change in rating. Dr. Fink also rated Claimant the same as Dr. Meyers at a 5% whole person; the only difference is he utilized the cervical conversion factor instead of the lumbar, which yields an artificially inflated rate. Dr. Meyers testified that the Board has accepted using the lumbar conversion factor for cervical spine ratings on many occasions. Further, Dr. Grossinger, Claimant's expert, rated Claimant with a 7% permanent impairment to the cervical spine in 2010, also utilizing the lumbar conversion factor. The 7% rating is more accurate and reasonable in describing Claimant's cervical condition.

Dr. Meyers also rated Claimant's left leg for permanent impairment. He used the Fifth

Edition of the *Guides*, Section 17.2m. This section states that when CRPS occurs in extremities, the evaluator should use the method described in Chapter 13, the central and peripheral nervous system. Section 13.5a and Table 13-15 is used, which is titled "Criteria for Rating Impairments Due to Station and Gait Disorders." Dr. Meyers placed Claimant into a Class 3 impairment. He based this on a number of things. First, Claimant walked into Dr. Meyers's office using a rolling walker. She was able to walk a hundred feet with it. Dr. Fink also noted she was able to walk in his exam of her. Claimant advised Dr. Meyers that she was able to stand for fifteen minutes and walk. She could stand to bake a cake occasionally and was able to go out and drive to different places. She was able to go out and do activities, even if most of the time she was using a scooter or other assistive device. She was able to stand and use a single point cane or assistive device for a significant number of activities. Class 3 and Table 13-15 states: "Rises and maintains standing position with difficulty; cannot walk without assistance." Dr. Meyers considers assistance to be assistive devices, which Claimant uses.

Dr. Meyers felt that Claimant fit well within Class 3. The example 13-39 used by the *Guides* for a patient that falls within Class 3 is a person who was unable to even get out of a chair without assistance or to walk unaided without falling. To him, Claimant is certainly in a better condition than that. She was able to get up and down, and in and out of a chair without difficulty, and able to walk a hundred feet with a walker, and by her own report, do some household tasks. Thus, she should not have a higher rating than a Class 3. Class 3 still is a significant impairment and 40% is a high impairment number. This does not mean that she is able to jump up and out of a chair without pain or difficulty.

Dr. Meyers likewise disagreed with Dr. Fink's placement of Claimant in Class 4, which is a range between 40% and 60%. Class 4 states: "Cannot stand without help, mechanical support, and/or an assistive device." Dr. Meyers finds the description "cannot stand without

help" to be vague. However, Clamant was able to stand with an assistive device in his and Dr. Fink's office and walk around and do activities. She is able to do community activities. This does not place her in a Class 4 impairment. Class 3 represents a significant impairment that best describes Claimant's condition.

Dr. Meyers addressed Claimant's right shoulder. In his opinion, Claimant does not currently have a discrete injury to the right shoulder that is ratable. He acknowledged that there was a right shoulder sprain diagnosis after the accident and that a January 2010 MRI showed a diagnosis of tendinitis; however, there were no records showing ongoing continued treatment for a right shoulder injury. If a patient suffers a sprain or strain of an area and it then gets better, then it is not a ratable body part for permanent impairment purposes. Additionally, Dr. Meyers opined that Claimant's neck injury is likely radiating into areas such as her head and shoulder, which is typical. This radiation was included in her neck rating. Dr. Meyers also does not agree with Dr. Fink that the tendinitis viewed on the January 2010 MRI continues today. He further does not equate Claimant's right shoulder complaints to her use of crutches or canes.

Putting the issue of causation aside, Dr. Meyers addressed the issue of Dr. Fink's permanent impairment rating for the shoulder. He referenced Figure 16-40, which measures flexion and extension. Claimant, at most, would warrant a 2% rating for having a thirty-degree loss of extension. She would not garner a rating at all for a sixty-degree range of motion for external rotation. Dr. Fink's 4% rating is an incorrect usage of the *Guides*.

Dr. Meyers turned to the issue of Claimant's migraines. He disagrees with Dr. Fink's opinion that because Claimant reported that the frequency of her migraines after the Ketamine infusion and work accident changed and that because Claimant reported double vision and nausea after the incident that her migraines are related to the work accident.

Dr. Meyers does agree with Dr. Fink that the Sixth Edition of the *Guides* now rates

migraines for permanent impairment, whereas the Fifth Edition did not. Causation aside, he disagrees with Dr. Fink's methodology for rating Claimant. Dr. Fink used Table 13-18 in the Sixth Edition. He assigned Claimant as a Class 3, resulting in a 4% permanent impairment rating. Dr. Meyers testified that the specific way to perform a migraine headache rating is use Section 13.11 and the MIDAS questionnaire of five questions. The questions relate to function and how often a person is impaired by their migraine headaches, including days missed from work and school, activity tolerance and the like. The answers to those specific questions are added up, giving the evaluator the range for the migraine impairment rating. Dr. Fink's report gives no indication that he asked this set of specific questions to rate Claimant. The report also includes no information that would allow answers to the MIDAS questions to be extrapolated. Without a MIDAS score, an individual cannot be placed into a proper range, based on the instructions listed in the Sixth Edition. This section of the *Guides* does not allow for that.

Finally, Dr. Meyers focused on Claimant's depression in terms of permanency. He does not believe that Claimant warrants a permanent impairment rating under the *Guides* based on her depression. Her depression is an adjustment type of depression due to her pain and the disability related to the work accident.

Dr. Meyers acknowledges that Claimant does have depression and adjustment complaints that arose since the work accident; however, as they are reactionary as opposed to traumatic in nature, they are not ratable by the *Guides*.

Dr. Fink testified that one way to determine if Claimant has a biological depression is through neuropsychological testing; however, Claimant had that testing done by Dr. Libon, on referral from Dr. Schwartzman. This testing was completed before the Ketamine infusion treatment. The findings were that Claimant displayed a moderate depression associated with the onset of pain. The testing made no suggestion that Claimant's depression had anything to do

with an injury to the brain. A depression associated with the onset of pain is what is considered to be a psychogenic overlay depression. That is typical for a person who has an adjustment reaction due to an injury, pain and disability. Claimant has an adjustment type of depression, which is situational or a kind of reaction to an event. She had an event, for which she is now having an adjustment reaction with some depressive symptoms. That is an appropriate reaction, but not ratable for permanent impairment using the *Guides.* In contrast, there are people who have depression that occurs due to a direct or physical injury to the brain, such as with a frontal head injury or injury to other deep parts of the brain. After the direct injury to the brain the person will get depressive symptoms because those areas of the brain are associated with depression. That would be a biological depression or a depression that arises from an injury directly to the brain.

Had Claimant had depressive symptoms as a direct result of brain trauma or injury, Table 13-8 would be utilized to rate her. Section 13.3f notes that persons with emotional disturbances originating in verifiable neurological impairments, stroke or head injury are compatible with this chapter. Claimant does not fit into those categories, and again, does not have a ratable impairment related to her depression.

On cross examination, Dr. Meyers agreed that Claimant's left leg permanent impairment was 24% to the whole person and a 40% regional rating once a ratio formula is applied.[4] He further agreed that Claimant used her walker while in his office. Dr. Meyers addressed a question about considering Claimant's ability to move around and "community activities" in the rating. He explained that she had used her walker to stand up during her exam. He observed her ability to walk from her vehicle with a walker, an assistive device. Her gait was slow, but not

[4] Dr. Meyers explained that not all the chapters in the *Guides* provide a conversion factor to convert a whole person rating to a regional rating because different authors write the chapters. A ratio is instead employed where no conversion factor guidance is provided.

labored. She did not require a rest when coming from the parking lot into the office and then back into the treatment room. That was about a hundred feet and Claimant walked it with her walker without difficulty. She was also able to stand on command without any labor or excessive time taken. Claimant also described occasionally picking up or dropping off a friend's child and that she would occasionally bake a cake, where she would have to stand for a period of time. She further reported that she could stand ten to fifteen minutes before she had increased pain. Her walking tolerance was described as less than a block at a time. She stated that she was able to dress herself, though she had difficulty with lower extremity dressing. Claimant used a single point cane in the home and a rolling walker for outside ambulation. Dr. Meyers agreed that Claimant did not report that she can stand without an assistive device, but she would still be placed within Class 3 even if she cannot. He reiterated that the example for Class 3 is a person that was unable to get out of a chair without assistance or to walk unaided without falling, and Claimant is in better condition than this. Claimant advised Dr. Meyers that she needed at least a single point cane to walk. Dr. Meyers explained that a 100% permanent impairment is as high as can be and in his opinion, he would assign this figure to a person with a whole amputation of the leg or a spinal cord injury where there is a total paraplegia to the limb. Claimant still has some functional ability and functional use, so she would not rate anywhere close to 100%.

As to the right shoulder, Dr. Meyers admitted that Claimant sustained a strain or tendinitis injury to the shoulder in relationship to the work accident, supported by the records immediately surrounding the work event. He agreed that tendinitis can be traumatically induced and that it is also possible for tendinitis to arise from the repeated use of crutches, canes and walkers. Dr. Meyers further agreed that Claimant has been using some sort of assistive device since the day of the accident. He explained, however, that he does not believe there is a current injury to the shoulder. Dr. Meyers admitted that Claimant reported to the VA Hospital in May of

2012 that she believes that her right shoulder symptoms are related to her use of assistive devices.

In his opinion, Claimant may have had a discrete problem in the work accident in which she suffered a sprain, but that seemed to have resolved. He believes that she now has a neck problem that is radiating into the right shoulder area. Dr. Meyers explained that while she had a positive impingement sign noted in May of 2012 that is not neck related, it is just one finding on exam. A diagnosis cannot be based on just one finding; many components are required to give a diagnosis. In his opinion, an impingement sign on its own does not mean that a patient has shoulder impingement. With a patient that has neck pain radiating into the shoulder and head, all the findings have to be put together to make a diagnosis. Claimant was not exhibiting any symptoms or showing findings that she had a current right shoulder injury in April of 2013 when Dr. Meyers last examined her. However, causation aside, Claimant was not ratable for a permanent impairment to the right shoulder under the Fifth Edition anyway, based on the exam findings that she had in terms of strength and range of motion.

Dr. Meyers agreed that there is just one treatment note for migraines for Claimant that predates the work accident; however, he explained that Claimant personally had indicated to him that she had migraines in the past that had gotten worse after the Ketamine treatment. Dr. Meyers does not believe that an increase in migraines can be specifically attributed to the Ketamine treatment. Claimant has neck problems with radiation into her head and that can make migraines feel worse. If she is having a migraine and a bad neck day, her symptoms could be worse.

Dr. Meyers already accounted for this increase in headache symptoms in Claimant's neck impairment rating because he relates the intensity of her headaches and/or migraines to her neck problems. He believes that Claimant is having some increase in headache relating to tension

headaches coming from her work injury coming out of the neck; however, a migraine is a separate diagnosis, unrelated to the work accident. When Claimant is having a migraine, she is also on top of that having a tension headache from her neck pain radiation into the head, which may make the intensity of her migraines feel worse. Dr. Meyers also noted that often when a patient reports having "migraine headaches," they are really describing something different. He admitted that Claimant stated that she had persistent neck pain with radiation to her head along with worsened migraine headaches that present intermittently.

Dr. Meyers agreed that Claimant has depression related to the work accident, though he clarified that this is an adjustment complaint, not due to a brain injury. The depression is reactionary as opposed to coming from an actual physical injury to the brain.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Permanent Impairment

Claimant alleges that she suffered permanent impairments to various body parts as a result of a compensable work injury that occurred on May 29, 2008. The Employer disputes the degree of the various permanencies alleged and whether certain impairments are causally related and/or ratable. The allegations are as follows:

Body Part	Claimant's Position/Dr. Fink	Employer's Position/Dr. Meyers
Cervical Spine	14.2%	7% (has already been awarded)
Left lower extremity	100%	40%
Right upper extremity (Shoulder)	4%	Not casually related; but if causally related, 0%
Brain (Migraines)	4%	Not causally related
Brain (Depression)	20%	Not ratable

A claimant injured in a compensable work accident is entitled to proper and equitable compensation for the loss or loss of use of any member or part of the body. *See* DEL. CODE ANN. tit. 19, § 2326. It is the function of the Board, and not the physician, to determine the degree of a

claimant's impairment, so long as the Board's findings are based on substantial competent evidence. *See Turbitt v. Blue Hen Lines, Inc.*, 711 A.2d 1214, 1215 (Del. 1998); *Poor Richard Inn v. Lister*, 420 A.2d 178, 180 (Del. 1980).

Cervical Spine

Claimant alleges that she has suffered an increase in permanent impairment to the cervical spine. She previously received an award for a 7% impairment to the cervical spine in October of 2010. Claimant maintains that her impairment has now increased to 14.2% based on the opinion of Dr. Alan Fink. Employer argues that Claimant's impairment has not changed in that her rating at a 5% whole person impairment is the same as it was back in 2010. The only change is in the conversion factor employed by the medical expert, yielding a higher regional impairment.

In regard to the cervical spine, the Board agrees with Employer and finds this issue to be *res judicata.* Claimant has not proven that she has suffered any additional loss of use in that she was adjudged by her prior medical expert in 2010 to have a 5% whole person impairment to the cervical spine (7% regional impairment according to Dr. Grossinger in 2010) and again was deemed to have a 5% whole person impairment to the cervical spine by her current medical expert, Dr. Fink. However, while both Dr. Grossinger and Dr. Meyers used the lumbar conversion factor to convert the whole person rating to a regional one in 2010 (as is common practice in Delaware), Dr. Fink used the cervical spine conversion factor. The lumbar conversion factor yields a 7% regional permanent impairment to the cervical spine while the cervical conversion factor yields a 14.2% impairment. As Dr. Meyers testified, it is very common in Delaware for the lumbar spine conversion factor to be used for the cervical spine as well because the cervical spine conversion factor yields what most evaluators consider to be an artificially high result. In any case, Claimant was rated with a 5% whole person impairment in

2010 and was again rated with the same impairment. Claimant already received an award for a 7% regional impairment. She has currently been found to have the same degree of permanent impairment to the cervical spine. The change here was not one of an additional loss of use, but instead, a change in the methodology used to rate the same degree of impairment to the cervical spine. It is for this reason that the Board declines to make any additional award for the cervical spine at this time.

Left Lower Extremity

Claimant alleges a 100% percent permanent impairment to her left leg as a result of the May 2008 work accident and her resulting CRPS condition. The Employer contends that Claimant has a much lower 40% impairment to the left leg related to the accident.

Based on the a thorough review of the evidence, the Board finds that Dr. Meyers was more persuasive than Dr. Fink in this regard. The 100% permanent impairment rating proposed by Dr. Fink appeared to be too high of a rating, given that Claimant still has some function to the leg. Dr. Fink testified that Claimant's range of motion measurements were limited by only ten degrees. Dr. Meyers found Claimant's range of motion of the left leg to be full except for some mild deficits. Her left leg strength was found to be five out of five, though she complained of discomfort and pain during the testing.

Dr. Meyers was persuasive that he reserves a 100% rating for patients with an amputation or with total paraplegia of the limb. He was also convincing that the descriptions of Class 3 and of Class 4 are somewhat vague in description. On a more cursory review, Claimant does appear to meet the criteria of the somewhat ambiguous descriptions of both classes.[5] However, Dr. Meyers was persuasive that Claimant's condition is better than the example put forth in

[5] Class 3 (a range of 20-39% whole person) states: "Rises and maintains standing position with difficulty; cannot walk without assistance." Class 4 (a range of 40-60% of the whole person) states: "Cannot stand without help, mechanical support, and/or an assistive device."

connection with Class 3. The example 13-39 used by the *Guides* for a patient that falls within Class 3 is a person who was even unable to get out of a chair without assistance or to walk unaided without falling. The Board agrees based on the totality of the evidence that Claimant is in a better condition than that. As Dr. Meyers testified, Claimant was able to get up and down, in and out of a chair without difficulty, and able to walk a hundred feet with a walker. By her own report, she is able to do some household tasks. She is able to drive and get around on her own, albeit she requires the help of assistive devices. However, even if Claimant were to have difficulty rising and maintaining a standing position, based on the example given, this also appears to fall within the purview of Class 3. The example given for Class 3 is an individual unable to even get out of a chair without assistance or to walk unaided without falling. Claimant appears to be safely placed within this category. Dr. Meyers confirmed that Class 3 still reflects a significantly high impairment at 40%. He testified that it is not one that indicates a patient that is able to jump in and out of a chair without difficulty.

The Board notes that it found Dr. Meyers's rationale for rating Claimant to be persuasive; however, the Board should also state that it was troubling that the 100% rating that Dr. Fink proffered appeared to be too high. Again, Dr. Meyers was convincing that a 100% loss of use rating, which is the highest possible, should be reserved for a patient with very little, if any, function left in the limb. This patient is typically one that has an amputation or paraplegia of that limb. Dr. Meyers testified that Claimant was observed walking 100 feet with her walker without difficulty. Her gait was slow but continuous and she could walk for a while before needing to take a break. Dr. Meyers also documented that Claimant was able to stand without labor or excessive time taken. The Board was simply not convinced that Claimant met her burden to show that she has a total loss of use of the left lower extremity.

In conclusion, the Board accepts the opinion of Dr. Meyers and finds that Claimant

suffered a 40% permanent impairment to her left lower extremity as a result of the work accident. A permanency to the left lower extremity is a scheduled loss (maximum of 250 weeks) under Del. Code Ann. tit. 19, § 2326. Claimant is therefore entitled to 100 weeks of benefits related to this injury (40 percent of 250 weeks). However, as Claimant has already received an a prior award of an 11% permanent impairment to the left lower extremity, pursuant to this decision, Claimant is entitled to 72.5 weeks of benefits (29% of 250 weeks).

Right Shoulder

Claimant further alleges that she has a 4% permanent impairment to the right shoulder that is causally related to the work accident. Employer disputes that Claimant has a ratable right shoulder injury.

The Board preliminarily notes that it did not find Dr. Fink's testimony to be convincing in regard to the right shoulder. Dr. Fink testified that Claimant's right shoulder tendinitis is causally related to the work accident in that it is related to her use of assistive devices, yet he admitted that this causal relationship depends on certain factors. Dr. Fink acknowledged that shoulder aggravation is not automatic just because a patient uses assistive devices. However, Dr. Fink admitted that although these shoulder problems are often related to patients using canes that are too short, he did not evaluate Claimant's canes. He was also unaware of the last time that Claimant used crutches. Additionally, he testified that shoulder problems often result when a walker has to be lifted up instead of rolled to be utilized; however, Dr. Meyers noted that Claimant was using a rolling walker when he examined her. She also had reported to Dr. Meyers that she utilized this same rolling walker when she ambulated. So while Dr. Fink testified that whether Claimant's crutches, cane or walker use aggravated her shoulder depends on certain factors, it appears that he did not actually assess these factors in rendering his opinion on causation of Claimant's right shoulder symptoms. His relating Claimant's right shoulder

symptoms to her use of assistive devices appeared weak to the Board in light of this very large oversight. The few records that state any relationship to Claimant's assistive device use and her right shoulder symptoms also appear to document that Claimant personally believes in this relationship, as opposed to a doctor's diagnosis in this regard. For these reasons, the Board was not convinced of a relationship between use of these assistive devices and any shoulder symptomatology. The Board notes that Dr. Meyers also did not support Dr. Fink's opinion in this area.

In the alternative, Dr. Fink related Claimant's right shoulder condition directly to trauma suffered in the work accident. The Board also found Dr. Meyers more persuasive in this regard. Dr. Meyers acknowledged that Claimant had imaging of the right shoulder that initially showed some tendinitis, which would be soft tissue irritation. He acknowledged that she likely suffered a sprain to the right shoulder in the work accident, consistent with her diagnosis of such. However, Dr. Meyers testified that he did not find that there were records to support an ongoing injury. There were large gaps in Claimant's treatment and subjective complaints in regard to the shoulder. Additionally, Claimant's shoulder exam in April 2013 with Dr. Meyers was good. Causation aside, in Dr. Meyers's opinion, her exam did not support a finding of any permanent impairment to the shoulder.

Dr. Meyers further opined that a lack of sign of actual shoulder injury on the most recent exam further supports that Claimant's perceived shoulder complaints actually represent pain radiating from the neck. Dr. Meyers testified that he believes that Claimant's headache and shoulder complaints are actually related to her neck condition. He testified that when a patient has a cervical spine injury with radiating pain to an upper extremity, it can appear to the patient to be right shoulder pain. Pain in the shoulder slope region is typically seen in these cases. Based on the anatomy of this area, Claimant may feel pain as if it is pain in her right shoulder, as

that is very common with neck pain. However, in Dr. Meyers's opinion, this cannot be related to the right shoulder itself in terms of a permanent impairment rating. So, to Dr. Meyers, while Claimant had a right shoulder sprain diagnosis after the accident and a January 2010 MRI included a diagnosis of tendinitis, there were no records showing ongoing continued treatment for a right shoulder injury.[6] He testified that if a patient suffers a sprain or strain of an area and it then gets better, then it is not a ratable body part for permanent impairment purposes. In Dr. Meyers's opinion, this is what happened with Claimant. He believes that Claimant's neck condition is likely radiating into other areas such as her head and shoulder, which is typical. Finally, Dr. Meyers testified that this radiation into the shoulder slope was already included in Claimant's neck permanency rating and that she does not garner any further rating for this same condition.[7] The Board found Dr. Meyers opinion to be most convincing in this area.

For these reasons, the Board declines to award Claimant permanent impairment in regard to the right shoulder.

Brain (Migraines)

Claimant alleges that she has also suffered a permanent impairment to the brain due to an increase in migraine headaches as a result of her work injury, especially following Ketamine infusion therapy. Employer disputes that Claimant's migraines are causally related to the work accident and/or the Ketamine infusion therapy; in the alternative, Employer disputes Dr. Fink's method of rating Claimant.

In regard to the issue of causation of migraine headaches in relation to the work accident,

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[6] Dr. Meyers testified that although there was a positive impingement sign found at one point, this is merely one sign to be considered in formulating a diagnosis. Clinically, Dr. Meyers saw no sign of an ongoing injury related to the work accident in his exam of Claimant's right shoulder in April of 2013.

[7] The Board further notes that it did not find Dr. Fink's testimony in regard to his actual rating of Claimant's right shoulder to be strong. His opinion as to her 4% permanent impairment rating was very brief and was not well explained in terms of the *Guides*. Additionally, the Board found Dr. Meyers persuasive that Dr. Fink's 4% rating was likely an improper use of the *Guides* based on Dr. Fink's findings in regard to Claimant's ranges of motion of the shoulder.

the Board again finds Dr. Meyers to be most persuasive. The Board did not find Dr. Fink's rationale persuasive for relating Claimant's migraines to the work accident. The presentation of his opinion on causal relationship in this area was very brief and appeared to largely be based on the fact that Claimant's migraines increased from occasional to more frequent at some point after the work accident. There was no evidence of actual head or brain trauma in this case or any medical opinion as to why there may be a medical connection between Claimant's work accident and an increase in migraine headaches. The Board recognizes that there are many causes of migraine headaches even in the absence of trauma. Dr. Meyers was more persuasive that if Claimant suffers from migraine headaches, their intensity may be heightened by tension headaches related to her neck condition. Dr. Meyers does not consider Claimant's migraine headaches to be related to a brain injury as there was no evidence of such. He instead relates this to Claimant's neck condition and noted that he already included this in her cervical spine rating for permanent impairment. In fact, Dr. Meyers was unsure whether or not Claimant actually suffers from migraine headaches or just tension headaches related to her neck condition. He testified that often patients refer to their headaches as migraines when they may not actually be so.

Further, the suggested causal link between Claimant's Ketamine infusion therapy and her migraine headaches was not sufficiently explained by Dr. Fink. All that was noted was that Claimant herself pinpointed an increase in her headaches to the timeframe of that treatment. Claimant was also inconsistent and vague in this area during her testimony. She testified that she was not even sure when her migraines started after the work accident, though she thought it was in late 2008. She then testified that she believed that her migraines increased after the Ketamine treatment, which occurred in December of 2011. The Board notes that according to Dr. Fink's testimony, Claimant apparently first complained of headaches and was prescribed

Maxalt in June of 2011, about three years after the work accident. Dr. Meyers testified that Claimant reported to him that Claimant had migraine headaches in the past that had gotten worse after the Ketamine treatment. In either scenario, Claimant's apparent increase in migraine or headache symptomatology occurred about three years after the work accident. The records, according to Dr. Fink's testimony, do not reflect a report of this problem until mid-2011. In any case, there was very little, if any, medical testimony on how the Ketamine treatment, which apparently was abandoned, would lead to an ongoing problem involving an increase of frequency and intensity of migraine headaches. The Board also heard no explanation as to how that specific treatment causes or aggravates migraine or headache symptomatology.

Further, the Board took note that Claimant and Dr. Fink stressed Claimant's lone 2005 pre-accident appointment for migraine treatment as proof that the condition was not pre-existing and/or just occasional in nature. However, Claimant's description of how she arrived at the point of seeking Dr. Grossinger's help for migraine treatment appeared inconsistent with a one-time migraine. Claimant explained that she described her symptoms to friends and that she was told that she should see a doctor for migraine treatment; this led to her scheduling an appointment with Dr. Grossinger. The way Claimant described this situation seemed to indicate that this was more of an ongoing issue that she found troubling at the time. Claimant's own testimony in regard to her gap in right shoulder treatment indicated that she is a person that does not tend to seek out treatment from a doctor unless there is a real nagging issue, suggestive that this would have been the case in 2005. Dr. Meyers also testified that Claimant informed him that she had migraines in the past but that she felt they had gotten worse and more frequent after the work accident. That also appears to suggest more of a history of migraine headaches prior to the work accident. Additionally, Claimant was not entirely credible when she testified that she has suffered migraines every day since the Ketamine treatment, but when later questioned if she

requires her migraine medication daily, she testified that she does not take it daily, she takes it only as needed. This was inconsistent.

Additionally, the Board simply did not find Dr. Fink's brief testimony in regard to causation of migraines to be persuasive. He opined that the records did not indicate that Claimant was having frequent migraines after 2005 and that it is possible that her migraines actually resolved after 2005 and "what we are seeing now is part and parcel only of the trauma that occurred when she fell." The Board was not convinced of this. Dr. Fink's opinion appears to suggest that Claimant suffered some kind of head trauma in the work accident though there was no indication of this whatsoever. In the alternative, if Dr. Fink means to suggest that there is some other cause of Claimant's current migraine headaches in relationship to the work accident, he did not adequately explain the cause. A mere suggestion that Claimant had more severe migraines more often and more severely because of the work accident is not sufficient absent a medical opinion of *why* this is the case. Dr. Fink's opinion appears to heavily, if not exclusively, rely on the fact that Claimant's migraines increased at some point in time after her work accident to tie the migraines to the incident. The first instances of complaints of a problem appear to have arisen three years post-accident. This was not sufficient proof for the Board, especially given the fact that the time factor itself was in question as there was suggestion that the work accident itself was the cause as well as a contention that the later Ketamine treatment was the cause.

For these reasons, the Board finds that Claimant failed to meet her burden to show that her migraine headaches are causally related to the work accident and thus, does not reach the issue of a permanent impairment award.

Brain (Depression)

Finally, Claimant contends that she has suffered a brain injury in relation to depression that developed in relationship to the work accident. Claimant argues that this is a "biological" depression that has manifested as a brain injury, resulting in a permanent impairment to the brain. Employer does not dispute that Claimant has depression that is related to the work accident, but argues that Claimant's depression is psychogenic in nature and therefore, not ratable.

Delaware case law has previously established that a general condition of psychosis or neurosis is not compensable under Section 2326 of the Workers' Compensation Act. *See, e.g., Ramey v. Delaware Materials, Inc.*, 399 A.2d 205 (Del. 1979); *Burton Transportation Center, Inc. v. Willoughby*, 265 A.2d 22 (Del. 1970). *See also Scott v. State of Delaware*, C.A. No. 96A-06-001, 1996 WL 769222 (Del. Super. Ct. Dec. 6, 1996) (reaffirming that Section 2326 does not allow for a permanency award for a psychological injury, after *State v. Cephas*, 637 A.2d 20 (Del. 1994) held that disability can be awarded under Sections 2324 and 2325 for psychological injury).

In regard to an alleged brain injury related to Claimant's "biological" depression, the Board notes that it found Dr. Meyers to be much more persuasive than Dr. Fink. Dr. Fink's opinion was not persuasive that Claimant's depression should qualify as a brain injury for purposes of permanent impairment under title 19 of the Delaware Code, section 2326. Dr. Fink did not convince the Board that Claimant does not suffer from a more typical type of depression with a psychogenic overlay that commonly develops as an injured worker adjusts to life after an industrial accident. Instead, the Board was persuaded by Dr. Meyers that Claimant's depression is an adjustment type of depression that arose due to her pain and disability related to the work accident. Dr. Meyers was convincing that her depression and adjustment complaints are reactionary as opposed to traumatic in nature, and are therefore psychogenic and not a ratable

brain injury in accord with the *Guides*.

Dr. Meyers noted that Dr. Fink testified that one way to determine if Claimant has a biological depression is through neuropsychological testing. Dr. Fink, however, did not appear to know that Claimant had already had this testing, as his testimony seemed to reflect that he did not refer Claimant to testing because he did not believe it would be worthwhile. Dr. Meyers, on the other hand, testified that Claimant actually had neuropsychological testing completed before the Ketamine infusion treatment. The findings of the testing were that Claimant displayed a moderate depression associated with the onset of pain. Dr. Meyers pointed out that the test results did not suggest that Claimant's depression had anything to do with an injury to the brain. He explained that depression associated with the onset of pain is exactly what is considered to be a "psychogenic overlay depression." Dr. Meyers testified that it is typical for a person to have an adjustment reaction due to an injury with resulting pain and disability. He opined that Claimant's depression is simply a situational reaction to an event. She had an event, a work accident that caused injuries, for which she is now having an adjustment reaction with some depressive symptoms. In Dr. Meyers' opinion, while her depression is an appropriate reaction, it is not ratable for permanent impairment using the *Guides*.

The Board additionally found Dr. Meyers's explanation of what type of depression would qualify for a permanent impairment rating to the brain to be very convincing. He testified that there are patients that develop depression due to a direct or physical injury to the brain, such as with a frontal head injury or injury to other deep parts of the brain. After a direct injury to the brain in the areas of the brain associated with depression, the patient will get depressive symptoms. That would be a biological depression or a depression that arises from an injury directly to the brain. This would be a depression that would qualify for a permanent impairment rating as a brain injury under the *Guides*. Dr. Meyers was persuasive that Claimant's depression,

in contrast, is psychogenic in nature and it is improper to assign a permanent impairment rating under the *Guides* as a result.

For these reasons, the Board declines to award Claimant a permanent impairment award for a brain injury in relation to her depression.

Attorney's Fee and Medical Witness Fee

A claimant who receives an award is entitled to a reasonable attorney's fee in an amount not to exceed thirty percent of the award or ten times the average weekly wage in Delaware as announced by the Secretary of Labor at the time of the award, whichever is less. 19 *Del. C.* § 2320. As a result of the Petition to Determine Additional Compensation Due, Claimant has been awarded compensation for a permanent impairment to the left lower extremity. At the current time, the maximum based on the average weekly wage calculates to $9,911.90.

The factors that must be considered in assessing a fee are set forth in *General Motors Corp. v. Cox*, 304 A.2d 55, 57 (Del. 1973). An award of less than the maximum fee is permissible and consideration of the *Cox* factors does not prevent the granting of a nominal or minimal fee in an appropriate case, so long as some fee is awarded. *See Heil v. Nationwide Mutual Insurance Co.*, 371 A.2d 1077, 1078 (Del. 1977); *Ohrt v. Kentmere Home*, Del. Super., C.A. No. 96A-01-005, Cooch, J., 1996 WL 527213 at *6 (August 9, 1996). Claimant, as the party seeking the award of the fee, bears the burden of proof in providing sufficient information to make the requisite calculation.

Such fees are not awarded, however, if 30 days prior to the hearing date the employer gives a written settlement offer to claimant or claimant's attorney which is "equal to or greater than the amount awarded." Delta tendered a timely settlement offer to Claimant which was "equal to or greater than" Claimant's award pursuant to this decision. Therefore, Claimant is not entitled to an attorney's fee taxed as a cost against Delta pursuant to title 19, section 2320 of the

Delaware Code.

A medical witness fee for testimony on behalf of Claimant is awarded to Claimant, in accordance with title 19, section 2322(e) of the Delaware Code.

STATEMENT OF THE DETERMINATION

For the reasons set forth above, Claimant's Petition for Additional Compensation Due is **GRANTED** in part and Claimant is awarded compensation for a twenty-nine percent increase in permanent impairment to the left lower extremity (72.5 weeks). For the aforementioned reasons, Claimant's request for permanent impairment awards relating to the cervical spine, right upper extremity, brain (depression) and brain (migraines) is **DENIED**. Having received an award, Claimant is awarded her medical witness fee; however, as a timely settlement offer was presented to Claimant by Delta that was equal to or greater than the Board's findings in this decision, Claimant is not entitled to an award of a reasonable attorney's fee.

IT IS SO ORDERED THIS 8th DAY OF AUGUST, 2013.

INDUSTRIAL ACCIDENT BOARD

JOHN D. DANIELLO

MARILYN J. DOTO

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

Karen Miller
OWC Staff

Mailed Date: 8-8-13