THE BOARD FOR ADMINISTRATION OF THE

SUBSEQUENT INJURY ACCOUNT

FOR THE ASSOCIATIONS OF

SELF-INSURED PUBLIC AND PRIVATE EMPLOYERS

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In re: Subsequent Injury Request for Reimbursement

Claim No.: 1141
Date of Injury: 6/5/98
Association Name: Construction Industry Workers Compensation Group
Association Member: Martin Harris Construction
Association Administrator: Nevada Risk Management
Third-Party Administrator: Construction Industry Claims Service
Application Submitted by: J. Michael McGroarty

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FINDINGS OF FACT
CONCLUSIONS OF LAW
AND DETERMINATION OF THE BOARD

On Tuesday, September 10, 2002, the above-captioned matter came on for hearing before the Board for the Administration of the Subsequent Injury Account for the Associations of Self-Insured Public and Private Employers. J. Michael McGroarty, Esq., of J. Michael McGroarty, Chartered, appeared on behalf of Construction Industry Workers Compensation Group, its Administrator, Nevada Risk Management, the employer, Martin Harris Construction, and the Third-party Administrator, Construction Industry Claims Service. The Department of Industrial Relations ("DIR"), State of Nevada, appeared by and through John Wiles, Esq., and Jacque Everhart. Smiddy Lamb, RN, from the DIR, appeared to testify. The Board's legal counsel, Charles R. Zeh, Esq., Zeh, Saint-Aubin, Spoo & Hearne, also was present.

This matter came on for a contested hearing before the Board upon the recommendation of the Administrator of the DIR that this claim be rejected for failure to satisfy the requirements of NRS 616B.578 (3) As a condition precedent to eligibility for reimbursement from the Subsequent Injury Account, NRS 616B.578 (3) requires proof that

the injured worker's pre-existing permanent "physical impairment" supports "... a rating of permanent impairment of 6% or more of the whole man if evaluated according to the American Medical Association's Guides to the Evaluation of Permanent Impairment as adopted and supplemented by the division (DIR) pursuant to NRS 616C.110." NRS 616B.578 (3). According to the Administrator, the 6% requirement was not met by the pre-existing permanent physical impairment in this case. The Administrator, therefore, recommended denial of the application for reimbursement.

Chairperson, Richard Iannone, called this matter to be heard. Mr. Iannone then recused himself because legal counsel for the Applicant, J. Michael McGroarty, is the attorney for Mr. Iannone's Association. Mr. McGroarty represents Mr. Iannone in connection with his personal business interest. As this was an ongoing relationship, the Chairperson handed responsibility for conducting the meeting to Gordon Hutting, Board Vice-chairperson, who then conducted the meeting. Gail Gibson, member, was absent from the meeting. Also, present were members Joyce Smith and Dennis Barton. A quorum of the Board was present to hear this matter.

The injured worker's first medical documentation of a lumbar spine injury was on February 25, 1996, when the injured worker suffered a lumbar strain/sprain. It was discovered at that time that the injured worker also suffered from spondylolysis at the L5-S1 level. *See*, report of treating physician, Dennis Compton, M.D., Exhibit "D." *See,* the DIR's staff report. According to the medical reporting in the file, the injured worker's injury of February 25, 1996, was an "acute lumbosacral strain without evidence of porreduculophy." Exhibit B. By x-ray, it was also discovered that he had a condition of pre-existing spondylolysis, with no evidence of spondylolisthesis. *See*, Exhibit "C," Compton 4/16/96, *see also*, DIR's staff report. By April 16, 1996, he was released to work without restriction to his former occupation as a sheet block worker. Exhibit "C," *see also*, DIR's staff report. There was no permanent partial disability (PPD) evaluation and/or rating for the injury.

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On June 5, 1998, the injured worker suffered another work related injury. When the worker was installing bolts and turned to retrieve more bolts for installation, his lower back went out. *See*, Exhibits "D" and "E," DIR report. He was employed as a carpenter for Martin Harris Construction at the time of the subsequent injury.

An MRI showed degenerative disc change at the L4-5 and L5-S1 levels. There was also mild-moderate right paracentral disc herniation or protrusion at the L5-S1 level together with a mild bulge, left posterolateral aspect of L4-5. The MRI also revealed bilateral spondylolysis at the L5 level with no spondylolisthesis. *See,* Exhibit "F," DIR report.

The treating physician, William Smith, M.D., released the injured worker to work without restriction on January 26, 1999. *See,* Exhibit "I," DIR report. Dr. Smith did not recommend a PPD evaluation for the injury.

The injured worker had a second MRI of the lower back. The impression was a degenerative disc change at the L4-5 and L5-S1 characterized by disc type narrowing and mild disc bulges. The MRI continued to reveal spondylolysis at the L5, without spondylolisthesis. *See,* Exhibit "G" DIR report.

Richard Kudrewicz, M.D., reviewed the injured worker's records for possible qualification for subsequent injury account reimbursement. His written report is an exhibit to the DIR report, *see,* Exhibit "H." The report from Dr. Kudrewicz is undated.

In his report, Dr. Kudrewicz concluded that the original injury could be evaluated only by use of the Range of Motion Model, Table 75, page 113, Fourth Edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment (the "*Guides*"). Based upon Table 75, Category III, Spondylolysis, Dr. Kudrewicz concluded that there was a clearly pre-existing situation which would rate out under the lumbar spine provisions in the *Guides* for a 7% impairment of the whole person. Exhibit "H," p.3, DIR report. Accordingly, Dr. Kudrewicz concluded that the pre-existing injury met the 6% rule and, therefore, the injured worker clearly qualified for subsequent injury consideration based upon a pre-existing 7% whole man impairment.

The DIR disagreed on the grounds that the Range of Motion Model may only be used if the Injury Model cannot be used because the pre-existing injury does not fit any of the categories set forth under Table 70, of the *Guides*. It was the DIR's position also, that the Range of Motion Model, Table 75, of the *Guides*, may be used only to assist the rater in "categorizing" the disability into the appropriate Injury Model or DRE category. Consequently, if the injured employee were provided a 7% whole person impairment, according to the Administrator, it would represent a Category II, Table 74, or a 5% whole person lumbar impairment. The 6% requirement of NRS 616B.578 (3) would, therefore, not be met.

With the DIR's analysis available, Dr. Kudrewicz provided a supplemental report, Exhibit "A" to the prehearing statement of Mr. McGroarty, the Applicant's counsel. The supplemental report of Dr. Kudrewicz has as a date of dictation, July 22, 2002. This report again applied the Fourth Edition of AMA *Guides* to the 1996 pre-existing condition. Dr. Kudrewicz repeated that the Range of Motion Model should be used to evaluate the pre-existing condition from Table 75, where according to Category III, Table 75, page 3/113, the kind of spondylolysis suffered by the injured worker would give rise to the 7% disability rating.

Dr. Kudrewicz, however, went further in this second report. As this was a records review, Dr. Kudrewicz explained, he could not examine the injured worker for loss of range of motion. He believed, however, there was evidence in the patient's record of a loss of range of motion which would support at least a 1% impairment of the whole person for the loss of range of motion in the lumbosacral spine. This 1% impairment of the whole person for the loss of range of motion of the lumbosacral spine prior to the June 5, 1998, accident combined with the 7% whole person impairment of Table 75, page 3/113, for spondylolysis, lumbosacral spine would then give rise to a total 8% whole person impairment at the very least according to Dr. Kudrewicz. The Range of Motion Model then requires conversion to the nearest Injury Model category. Table 72, lumbosacral spine impairment, is the relevant Table. It is found at page 3/110 of the Guide. A

Category II lumbosacral spine is a 5% impairment whole man. A Category III lumbosacral spine is a 10% impairment of the whole person. The 8% Injury Model impairment is closer to the Category III, 10% whole person impairment than it is to the Category II, 5% impairment of the whole person. Cobbling the 1% "loss of range of motion" from the record review, to the 7% impairment of the whole person from Table 75, page 3/113, for an 8% whole person impairment, Dr. Kudrewicz then arrived at a 10% impairment of the whole person by utilizing Category III of the Injury Model - the nearest category for assigning a disability or impairment value to the pre-existing spondylolysis combined with loss of range of motion. Dr. Kudrewicz, thus, concluded that NRS 616B.578 (3) was satisfied.

The DIR, through Smiddy Lamb, RN, and John Wiles, Esq., took the following position:

1. Dr. Kudrewicz's opinion is void and should be completely disregarded because he applied the Fourth Edition of the *Guides*. Because the pre-existing condition happened in 1996, he should have applied the Second Edition of the *Guides* because that was the Edition in effect at the time of the 1996 injury.

2. The pre-existing condition falls within the explicit categories of the Injury Model and, therefore, the Range of Motion Model should not have been used in the first place. There was no reason to even consider loss of motion. The opinion of Dr. Kudrewicz is, therefore, invalid.

3. There is no plausible basis for concluding that the injured worker suffered a 1% impairment of the whole person for loss of range of motion attributed to the 1996 injury. Therefore, even under the Range of Motion Model, which is to be used solely to categorize an injury under the Injury Model, a 7% disability rating under the Range of Motion Model equates to a Category II, 5% disability under Table 72, of the Injury Model and as a result, under the Applicant's own theory, NRS 616B.578 (3) has not been satisfied and the claim should be denied.

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On behalf of the Applicant, Mr. McGroarty argued spondylolysis is a condition of life. He, therefore, was uncertain which edition of the *Guides* should apply. The Injury Model should not be applied because the Injury Model had not been adopted by the Administrator as the primary method of rating, thus, superceding Table 75, until after claimant's date of hire. NRS 616C.425 provides that the amount of compensation benefits to which an injured worker is entitled must be determined as of the date of the accident or injury of the employee and the employee's right to compensation becomes fixed as of that date. Mr. McGroarty argued that the date of injury is controlling for purposes of subsequent injury fund analysis, even though it is not the employee's right to compensation that is at issue.

Finally, Mr. McGroarty argued that under the DRE Model, Dr. Kudrewicz factually added a 1% loss of range of motion to the Table 75 value of 7%, giving rise to a combined 8% total impairment which leads to a 10% DRE rounded impairment under Category III, Table 72, of the Injury Model.

In the prehearing statement, the Applicant indicated that Dr. Kudrewicz would be available by phone to testify. During the course of the hearing, Mr. McGroarty advised, Dr. Kudrewicz was unavailable to be present to testify. No continuance was requested by Mr. McGroarty in order to allow the matter to be heard at a time when Dr. Kudrewicz was available to testify.

The Board makes it Findings of Fact and Conclusions of Law as follows:

FINDINGS OF FACT

The Board sets forth its Findings of Fact below. To the extent that portions of the preceding section constitute Findings of Fact, those portions are incorporated herein by reference.

1. On July 3, 2002, the Appellants' written Notice of Appeal was received by the office of legal counsel for the Board for the Administration of the Subsequent Injury Account for the Associations of Self-insured Public and Private Employers.

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2. The application for a contested hearing was made by the Applicant within 10 days of service upon the Applicant's decision of the Administrator, DIR, to reject the application for reimbursement from the Subsequent Injury Account.

3. The injured worker was first injured on February 23, 1996, when, while employed as a sheet block worker, he injured his lower back. *See,* Exhibit "B", DIR report.

4. On February 25, 1996, he was seen by Dennis Compton, M.D., his treating physician, who diagnosed that the injured worker had suffered an "...acute lumbosacral strain without evidence of porreduculopathy [?]" *See,* Exhibit "B," DIR report.

5. The injured worker complained after the injury of back pain with radiation. He could swivel sideways but he felt like his hips were locked. *See,* Exhibit "B" DIR report.

6. Upon presentation to Dr. Compton, the objective findings were that the injured worker's straight leg raising was positive, on the right at 30° and on the left at 45°. His reflexes were 2+ and symmetrical, forward flexion was limited to 30° because of pain, lateral flexion was not limited and the lateral rotation was positive at 12° in both directions. The injured worker was able to heel and toe walk but with some difficulty. *See,* Exhibit "B," DIR report. He was given Loritab 7.5 and Valium 10 and allowed to return home. He was also prescribed with physical therapy, Ibuprofen 800 mg., three times daily, flexeril, 10 mg., three times a day, and Tylenol with Codeine. He was told to be reevaluated in two weeks. *See,* Exhibit "B," DIR report.

7. According to a note from Dr. Compton, it was discovered through x-rays, that the injured worker had spondylolysis, but no evidence of spondylolisthesis. His back might give him problems from time to time, according to Dr. Compton, but not to the extent that he needed to change careers. The plan, as of April 16, 1996, was to return the injured worker to work without restriction. *See,* Exhibit "C," DIR report.

8. Dr. Compton released the injured worker to full duty with no restriction as of April 22, 1996. *See,* Exhibit "C," DIR report.

9. On June 5, 1998, the injured worker, while employed as a carpenter for

Martin Harris Construction (Exhibit "D," DIR report), knelt down, and when turning side ways to grab a bolt, his lower back "went out." *See,* Exhibit "E," DIR report.

10. An MRI of July 7, 1998, revealed degenerative disc changes at the L4-5 and L5-S1 levels, "... characterized by disc height narrowing and disc dehydration." Additionally, the MRI revealed "[m]ild-moderate right paracentral disc herniation or protrusion L5-S1...[,]" "[m]ild broad based bulge left posterolateral aspect of L4-5...[,]" and "[b]ilateral spondylolysis of L5, no spondylolisthesis." *See,* Exhibit "F," DIR report.

11. By January 26, 1999, William Smith, M.D., concluded that the injured worker was medically stable, able to return to work without restrictions, and had no rateable impairment. *See*, Exhibit I, DIR report.

12. According to the DIR staff report, the injured worker was subsequently seen by Dr. R. Rumoldi because of increasing lumbar spine pain over the last 6 to 7 months. Another MRI was performed on November 22, 2000. The results were similar to the MRI of July 11, 1998. *See,* Exhibits "F" and "G," DIR report.

13. Richard Kudrewicz, M.D., conducted a records review of the injured worker for possible subsequent injury account coverage. *See,* Exhibit "H," DIR report. In his written report, Dr. Kudrewicz concluded that the pre-existing condition warranted a 7% impairment based upon the whole person.

14. In his report, Dr. Kudrewicz also stated:

> I would suggest that this gentleman had a relatively mild mechanism of injury. I do not think that there was much force involved. He simply turned to get more bolts and developed back difficulties. Clearly, the pre-existing difficulties in his spine are operative in terms of producing symptomatology from the 1998 accident. *See,* Exhibit "H" DIR report.

15. Dr. Kudrewicz also related: "[A]pproximately 80% of the cost of diagnosis, treatment, and subsequent disability... from the subsequent injury to the pre-existent consideration [prior condition] and no more than 20%.... to the subsequent injury itself." *See,* Exhibit "H," DIR report.

16. Dr. Kudrewicz relied upon the Fourth Edition of the "Guides to the Evaluation of Permanent Impairment" ("*Guides*") to arrive at the conclusion that the

injured workers' initial condition warranted a rating of a 7% whole person disability or impairment.

17. Dr. Kudrewicz also adopted or opted for use of the "Range of Motion" Model under the *Guides* to conclude that the initial condition warranted a 7% whole person impairment rating. Kudrewicz Supplemental Report dictated July 22, 2002, Exhibit "A" to the Pre-hearing Statement of Mr. McGroarty.

18. The Fourth Edition of the *Guides* includes Table 70, page 3/108, which describes the categorical impairments with the associated whole person impairment rating. If an injured worker cannot be placed in a particular diagnostic, categorical rated impairment, then, the rater is allowed to proceed with the Range of Motion Model, as distinguished from the Injury Model.

19. According to Smiddy Lamb, R.N., the Range of Motion Model is used only as an aid to help the rater categorize the injured worker into a DRE category set forth on Table 70, page 3/108.

20. According to Dr. Kudrewicz in his supplemental report, the Injury Model should not be used. He believed he could only proceed, given the information at his disposal, by using the Range of Motion Model, set out at Table 75, page 3/113, of the *Guides*.

21. The pre-existing condition, here, for the injured worker is spondylolysis. It is listed at Category III, on Table 75. The particular area of the back presenting spondylolysis, in this case, was the lumbar spine area. According to Table 75, a person with spondylolysis, the lumbar area, is assigned a 7% whole person impairment.

22. Dr. Kudrewicz believed according to the medical records that the injured worker "must" have had a Range of Motion deficit equal to at least 1% of a whole person impairment. Dr. Kudrewicz then took the 7% whole person impairment rating from Table 75, and enhanced it by the one percent impairment for the loss of range of motion which then would justify an 8% whole person impairment rating under the Range of Motion Model, according to Dr. Kudrewicz.

23. The 8% whole person impairment rating was the number Dr. Kudrewicz used to allow categorization under Table 70, of the Injury Model.

24. Turning to Table 70, page 3/108, the nearest category approximating an 8% whole person impairment is Category III, the designation for spondylolysis with "loss of motion segment integrity" or "radiculopathy." Category III, Table 70, amounts to a 10% whole person impairment disability rating for the lumbar spine. Thus, if Dr. Kudrewicz is right, that Category III, Table 70, is the correct designation for the pre-existing condition, a 10% whole person impairment is assigned to the pre-existing spondylolysis condition. The 6% whole person requirement of NRS 616B.578(3) would then be met for the pre-existing spondylolysis.

25. The analysis of Dr. Kudrewicz, therefore, turns in significant on part upon:

a His rejection of the Injury Model and use of the Range of Motion Model instead; and,

b Whether there exists in the record evidence of loss of range of motion within a reasonable degree of medical certainty to sustain the opinion of Dr. Kudrewicz that the injured worker should be assigned the 1% range of motion disability rating for this loss of range of motion, if any.

26. Dr. Kudrewicz analysis, therefore, turns upon whether or not the pre-existing spondylolysis suffered by the injured worker was of the type which revealed "segment integrity" or "radiculopathy" which are the two qualifiers describing the condition giving rise to a 10% whole person impairment under Category III, for spondylolisthesis at this higher Category III level.

27. The Board and respective counsel were presented with a copy of portions of the *Guides to the Evaluation of Permanent Impairment, Chapter 3.3, The Spine.* There it states:

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> The evaluator assessing the spine should use the Injury Model, if the patient's condition is one of those listed in Table 70 (p.108). That model, for instance, would be applicable to a patient with a herniated lumbar disk (sic) and evidence of nerve root irritation. If none of the eight categories of the

Injury Model is applicable, then, the evaluator should use the Range of Motion Model. *Guides*, p. 3/97, 4th Edition.

29. The *Guides* further state that the Injury Model is also called the "Diagnosis-Related Estimates (DRE) Model." The Range of Motion Model, according to the *Guides*, is also called the "Functional Model." Dr. Kudrewicz' Supplemental Report, dictated July 22, 2002, Exhibit "A" to the pre-hearing statement of Mr. McGroarty, was offered in response to the conclusion of the Administrator that the Range of Motion Model should not be used or if used, that a 7% impairment, rounded to 5%, for the pre-existing spondylolysis is the maximum whole person impairment warranted. In his report, Dr. Kudrewicz states as follows:

> I have received information that the Administrator agrees with the usage of Range of Motion Model as a qualifier for potential impairment in this particular case, as this patient based upon his pathology does not fit the DRE classification per se. He [the Administrator according to Dr. Kudrewicz] goes on to state that the 7% whole person should be rounded to the nearest DRE category, which is a DRE Category II, 5% impairment whole man, and, therefore, the patient does not qualify for subsequent injury consideration. Kudrewicz, Second Report, p. 1.

Dr. Kudrewicz states further: "The technique referred to by the Administrator is absolutely correct for performing the ratings under the 'Fourth Edition of the AMA Guides.'" Kudrewicz, Second Report, p. 1.

30. Dr. Kudrewicz also states in his report: "On examination, [the original examination when seen by Dr. Compton] the patient had range of motion limited. The exact values are not given, **but it is clear that some loss of range of motion was present at that time [the time of the first injury].**" (Emphasis added). Kudrewicz, Second Report, p. 2.

31. Also, according to Dr. Kudrewicz:

> As of 04/02/96, the patient had improved, but still had tenderness and had 70° of flexion, 20° of lateral bending, and pain with hyperextension. Therefore, **while we do not have exact measurements with the inclinometer, of this patient's lumbosacral spine range of motion** it is clear that on at least two occasions loss of range of motion in the lumbosacral spine was documented. Therefore, back in 1996, we can **comfortably state** that this patient had **some loss of range of motion,**

although we do not know exactly what it was. We can clearly state that his impairment for loss of range of motion was more than 0%. Even if we assumed 1% impairment whole man for loss of range of motion lumbosacral spine based upon the medical reporting from 1996 this is something that we can use to combine with the impairment Table 75. **I would therefore state that at the very least this gentlemen had a 1% impairment whole man from loss of range of motion lumbosacral spine prior to his 06/05/98 accident.** (Emphasis added). Kudrewicz, Second Report, p. 2.

33. Finally, Dr. Kudrewicz states:

...I think we all agree that the range of motion model is an appropriate tool to be used in this particular case...We have documentation of **at least some loss of range of motion in the lumbosacral spine before 06/05/98** and if **we conservatively chose a 1% whole impairment whole man for loss of range of motion** present prior to 06/05/98 then our total from the range of motion model would be at least 8% impairment whole man. (Emphasis added). Kudrewicz, Second Report, p. 2.

34. In Dr. Kudrewicz's original report, (Exhibit "H," DIR report) he noted there that upon presentment for the initial injury, the impression for the injured worker was "...acute lumbosacral strain **without evidence of radiculopathy**. X-rays apparently showed a spondylolysis L5-S1." Exhibit "H," Kudrewicz's original report, p. 1.

35. There is no evidence of radiculopathy associated with the injury or pre-existing condition.

36. There is **no evidence of segment integrity,** *e.g.*, spinal instability, associated with the original or underlying condition of spondylolysis or the pre-existing condition. The injured worker returned to work without restriction, almost immediately, and did not need to change his occupation from a sheet block worker. Compton chart, DIR Report, Ex. "C."

37. Mr. McGroarty admitted that in order for a physician's testimony to be considered as expert medical opinion, the medical opinion must be given within a reasonable degree of medical certainty and that this was the burden that Dr. Kudrewicz had to meet before his testimony should be accepted as medical opinion. According to Mr. McGroarty, this standard could be "inferred" from Dr. Kudrewicz's report.

38. It was also Mr. McGroarty's position that the evidence and the record should be viewed liberally in favor of the employer.

39. According to the DIR, the Fourth Edition of the AMA *Guides* was not in place in 1996, when the original injury and underlying spondylolysis condition were first discovered and that it was the Second Edition of the AMA *Guides* which was being utilized, then, in 1996. The DIR, therefore, argued that as the Second Edition was in effect, and that since the Second Edition of the *Guides* was not used by Dr. Kudrewicz, his opinion was totally invalid.

40. Mr. McGroarty argued, however, that spondylolysis is a condition of life. He then stated as a matter of fact that the did not know which *Guides* Edition should be used for conditions of life, but, that he would probably find out should the matter go up on appeal.

41. Mr. Wiles argued that since Dr. Kudrewicz used the Fourth Edition and not the Second Edition, his evaluation was improper and should be completely disregarded

42. It was also the position of the DIR, through Mr. Wiles, that the 1% recommendation on range of motion did not meet the burden of proof for expert medical opinion testimony because Dr. Kudrewicz's opinion that there was a loss of range of motion was not rendered within a reasonable degree of medical certainty.

CONCLUSIONS OF LAW

The Board sets out is Conclusions of Law as follows:

1. To the extent that portions of the preceding section constitute Conclusions of Law, those portions are incorporated herein by reference.

2. The Appeal was timely filed.

3. Only NRS 616B.578 (3) was at issue before the Board in this case. The parties are in agreement that the remaining eligibility criterion had been met for claim acceptance and reimbursement.

4. There is a paucity of case law in Nevada involving the State's various Subsequent Injury Accounts. Consequently, the Board must look to other jurisdictions for guidance. There, it is revealed that the remedial purpose in creating subsequent injury funds is three-fold. Such funds typically have been created to help prevent discrimination

against disabled persons by easing the impact which the threat of a subsequent injury holds by providing a pooled source of funds to underwrite the cost of the subsequent injury which might occur. Secure in the knowledge that the pooled subsequent injury fund exists, employers are thought to be encouraged to employ or retain in its employ the already disabled/injured worker.

5. The fund was also created or designed to relieve employers from the hardship of liability for those consequences of compensable injury not attributable to their employment.

6. Finally, it is the intent of the Subsequent Injury Account that "[e]ach employer's premium should reflect his own cost experience in order to reward, and thereby encourage, safety, as well as to avoid an unfair burden on other employers." *Jusssila v. Dept. of Labor and Industries,* 370 P.2d 582, 586 (Wash., 1962) *see also, Hernandez v. Gerber Group,* 608 A.2d 87, 89 (Conn., 1992); *Jacque v. H.O. Penn Machinery Co.*, 166 Conn. 352, 355-356, 349 A.2d 847 (Conn. 1974).

7. Applications for reimbursement under Nevada's Subsequent Injury Account should be considered with these premises in mind and applications approved which promote these remedial purposes.

8. It is well settled the Applicant has the burden of proof to show entitlement to reimbursement. *See, Franklin v. Victoria Elevator Co.,* 206 NW2d 555, 556 (Mn. 1973); *O'Reilly v. Raymond Concrete Piling, Inc.*, 419 N.Y.S.2d 475 (1979). Thus, in Nevada, the burden is upon the applicant to establish the requirements of NRS 616B.578. Furthermore there is no presumption favoring the employer in pursuit of this burden of proof. *Priscilla Jussila v. Dept. of Labor, supra* at 585.

9. NAC 616C.476(2) provides that: "...a rating physician or chiropractor performing an evaluation of a permanent partial disability that is related to the spine of an injured employee **shall** use the Injury Model, as described on page 3/94 of the Guide, to rate the disability if the condition of the injured employee is listed in Table 70, *The Spine Impairment Categories for Cervicothoracic, Thoracolumbar, and Lumbosacral Regions,*

on page 3/108 of the *Guides*. If none of the categories set forth in the Table are applicable to the condition of the injured employee, the rating physician or chiropractor **may** use the 'Range of Motion Model,' as described on page 3/94 of the Guide, **to assist** in categorizing the disability." (Emphasis added).

10. Table 70, page 3/108, Category II contains the following: Category II, "Spondylolysis *without* loss of motion segment integrity or radiculopathy." (Emphasis added).

11. Table 70, page 3/108 of the *Guides* also contains the following: Category III, "Spondylolysis *with* loss of motion segment integrity or radiculopathy." (Emphasis added).

12. The evidence before the Board is one of the absence of radiculopathy.

13. On the question of the "loss of range of motion," Dr. Kudrewicz states he does not know exactly what the loss of range of motion was for the initial injury. Dr. Kudrewicz states that "clearly" the loss of range of motion was more than 0%.

14. Dr. Kudrewicz "assumes" that there was a 1% impairment whole man and that he would, therefore, state that "at the very least," there was a 1% impairment whole man and that he could "conservatively choose a 1% impairment whole man for loss of range of motion." That is the extent of the evidence from Dr. Kudrewicz on whether the injured worker suffered at least a 1% impairment of the whole person for loss of range of motion.

15. Category III, Table 70, page 3/108 of the *Guides*, however, requires "loss of motion segment integrity" or "the presence of radiculopathy" to achieve a Category III rating for spondylolysis.

16. "Loss of Motion Segment Integrity" is defined, depicted and described at page 3/98-99 of the *Guides*.

17. A review of the MRIs of the injured worker's spine reveals no discussion or findings of "loss of motion segment integrity, " *e.g.*, that the injured worker suffered at the time of the original injury from instability of the spine.

18. The impression in each MRI was spondylolysis at L-5 without spondylolisthesis.

19. There is no evidence in the record to support or explain Dr. Kudrewicz's opinion that the DRE Injury Model, Table 70, page 3/108 could not be used to rate the underlying spondylolysis. Category II allows for a rating **without** loss of motion segment integrity or radiculopathy. Category III allows for the evaluation **with** the loss of motion segment integrity or radiculopathy.

20. Dr. Kudrewicz admits in his report there is an absence of "radiculopathy" in the medical records or charts of the injured worker. There is no discussion in the medical records about "loss of motion segment integrity." The two requirements of Category III, which Dr. Kudrewicz could use to justify assignment of the injured worker through the "Range of Motion Model," are not present.

21. It has been held "the testimony of a non–examining, non-treating physician **should** be discounted and is not substantial evidence [if it is] "totally contradicted by other evidence in the record. *Gordon v. Schweiter,* 725 F.2d 231, 235 (4th Cir., 1984).

22. Additionally, it is exclusive the prerogative of this Board to select those inferences which are most reasonable from the evidence.

23. As a non-treating physician, therefore, Dr. Kudrewicz's testimony is susceptible to being completely disregarded on the face of controverting evidence in the record.

24. The evidence before the Board on "loss of motion segment integrity" is that the original back injury, when the spondylolysis was first discovered, was of a very short duration. The injured worker was returned to work by his treating physician, Dr. Compton, without restriction. He was not counseled to change jobs. The injured worker was allowed to continue as "sheet block worker." There was no discussion by Dr. Compton, that the injured worker's spondylolysis was so severe his spine was unstable, much less, it was so unstable he could not work, at all, or at least as a sheet block worker.

25. Similarly, neither at the time of discovery of the spondylolysis nor at any

time thereafter does Dr. Kudrewicz mention "segment integrity" or that the spondylolysis was so severe, then, when discovered that the spine was unstable.

26. Given, Dr. Kudrewicz's failure to even mention loss of segment integrity or to discuss whether the injured worker's spine was unstable, the reasonable inference is the injured worker did not suffer "loss of motion segment integrity." Combining Dr. Kudrewicz's silence on the issue with the fact that the injured worker's treating physician did not mention an unstable spine and let him return to work without restriction as a sheet block worker only three (3) months after discovery of the spondylolysis and the occurence of the initial injury, it is reasonable for the Board to infer that at the time the injured worker's spondylolysis was discovered, it was not of the variety which is manifested by "loss of motion segment integrity," and that Dr. Kudrewicz' conclusion that the injured worker had spondylolysis of the variety, manifesting "loss of motion segment integrity" may be rejected.

27. The applicant must concede that the injured worker at the time the pre-existing condition was discovered did not suffer from radiculopathy since Dr. Kudrewicz arrived at this conclusion.

28. The record before the Board is that the injured worker did not suffer from an unstable spine and did not manifest symptoms of radiculopathy. Consequently, the spondylolysis presented by the injured worker was not of the Category III variety which requires proof of radiculopathy or "loss of motion segment integrity." Rather, the evidence before the Board is that the injured worker's spondylolysis was the Category II, type, which does not require proof of radiculopathy, or loss of motion segment integrity.

29. The Board, therefore, rejects the conclusion of Dr. Kudrewicz that the injured worker's spondylolysis was a Category III condition and is not required to follow it, given the ample evidence in the record that Category II is the correct classification of the pre-existing condition.

30. The assignment of a Category II level of spondylolysis is strengthened, given Dr. Kudrewicz's finding of a 1% loss of motion which he uses to bootstrap a find of

Category III spondylolysis is based upon conjecture.

31. Dr. Kudrewicz's assignment of Category III under Table 70, page 3/108, rises and falls upon the strength of his conclusion there was at least a 1% loss of range of motion experienced at the time of the original injury. Dr. Kudrewicz' finding of 1%, however, was a conclusion he could "comfortably state," while admitting, simultaneously, he did not know exactly what the loss of range of motion was in 1996 and that the 1% was an assumption on his part. These statements, whether taken individually or collectively, do not rise to the level of a medical opinion rendered within a reasonable degree of medical certainty.

32. The Board is compelled to disregard evaluation of Dr. Kudrewicz because the absence of proof of "loss of motion segment integrity" and "radiculopathy" argues against a finding of a 1% loss of motion because it was the 1% loss of motion finding which Dr. Kudrewicz used to elevate the spondylolysis to the Category III level which carries with it the 10% whole person impairment. The failure of proof in the record to support the distinguishing characteristics for a finding of a Category III level spondylolysis, therefore, requires rejection of a conclusion based upon "speculation" and "comfort" that there was at least a 1% loss of range of motion associated with the spondylolysis in 1996.

33. There is no justification, therefore, for elevating a condition of spondylolysis from a Category II to a Category III level by virtue of a claim of a 1% loss of range of motion, given the complete absence of a discussion of loss of motion segment integrity and the admission by Dr. Kudrewicz that there was no proof of radiculopathy.

34. The presenting condition for the pre-existing spondylolysis tracks more completely the definition of spondylolysis, DRE Lumbosacral Category II, minor impairment set forth at page 3/102 of the *Guides*.

35. Category II, Spondylolysis, Table 70, page 3/108, results under Table 72, DRE Lumbosacral Spine Impairment, in a 5% impairment of the whole person. *See*, *Guides*, page 3/110.

DRE Lumbosacral Spine Impairment, in a 5% impairment of the whole person. *See, Guides*, page 3/110.

36. The Administrator, DIR, correctly found that the Injury Model should have been used to categorize the pre-existing condition, that the pre-existing condition amounts to DRE impairment Category II, 5% impairment of the whole person for spondylolysis, without radiculopathy or loss of motion segment integrity, and that, therefore, the Administrator, DIR, correctly concluded that requirements of NRS 616B.578 (3) had not been met in that the pre-existing condition amounted to a 5% impairment of the whole person, an impairment less than the 6% impairment of the whole person requirement for eligibility under the Subsequent Injury Account

DETERMINATION OF THE BOARD

Based upon the Findings of Fact and Conclusions of Law set out above, the Board makes it decision as follows:

1. The determination of the Administrator of the Division of Industrial Relations is affirmed by the Board. The Applicant has failed to establish a claim by reason of the Applicant's failure to provide proof that NRS 616B.578 (3) was satisfied. Therefore, the application for reimbursement from the Subsequent Injury Account for the Associations of Self-insured Public and Private Employers is hereby denied. The Application was denied upon a motion by Dennis Barton, seconded by Joyce Smith to approve the Administrator's recommendation for rejection. The vote was unanimous, 3-0, for rejection of the claim, with Richard Iannone abstaining and Gail Gibson absent.

Dated this 14 day of March, 2003.

Joyce Smith, Acting Chairperson

CERTIFICATE OF SERVICE

Pursuant to NRCP 5(b), I certify that I am an employee of the Law Offices of ZEH, SAINT-AUBIN, SPOO & HEARNE, and that on this date I served the attached *Findings of Fact, Conclusions of Law and Determination of the Board*, on those parties identified below by:

√	Placing an original or true copy thereof in a sealed envelope, postage prepaid, placed for collection and mailing in the United States Mail, at Reno, Nevada: J. Michael McGroarty, Esq. J. MICHAEL MCGROARTY, CHARTERED 7381 West Charleston Blvd., Suite 130 Las Vegas, NV 89117-1571 John F. Wiles, Division Counsel Department of Business and Industry Division of Industrial Relations 1301 North Green Valley Parkway, Suite 200 Henderson, NV 89104
	Personal delivery
	Telephonic Facsimile at the following numbers: (775) 463-9182
	Federal Express or other overnight delivery
	Reno-Carson Messenger Service
X	Certified Mail/Return Receipt Requested

Dated this 6th day of March, 2003.

Karen Weisbrot

Karen Weisbrot