The social security number and dates of birth have been redacted from this opinion.

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
MICHIGAN ADMINISTRATIVE HEARINGS SYSTEM
WORKERS' COMPENSATION BOARD OF MAGISTRATES

Karen D. Garner,
SS# XXX-XX-XXXX,
Plaintiff,

vs.

General Motors Corporation,
Self-insured,
Defendant.
_____/

OPINION

APPEARANCES:
THE PLAINTIFF- Floyd Steele (P-45357)
THE DEFENDANT- Thomas Ruth (P-44634)

TRIAL:

Trial was held on October 31, 2017 in Okemos, Michigan. The record was closed on November 17, 2017, and the matter deemed submitted for Decision.

CLAIM:

By Application dated October 18, 2016, plaintiff alleges an injury date of June 28, 2013. Plaintiff alleges that heavy lifting and twisting, combined with repetitive bending, lifting, and twisting have caused, and aggravated and\or accelerated a disc herniation and subsequent need for surgery. Wage loss and medical are sought. Prolonged weight-bearing, standing and twisting caused and\or significantly aggravated a severe hip condition, requiring potential hip replacement and additional medical treatment. By Amended Application dated February 3, 2017, plaintiff added the allegation: "Repetitive use, gripping and grasping caused and/or significantly aggravated CTS/tendonitis."

STIPULATIONS:

For the injury date of June 28, 2013, the parties agreed they were subject to the Act and General Motors Corporation carried the risk. Employment was admitted, and personal injury was left to proofs. Notice and claim were admitted. The parties stipulated to an average weekly wage of $1,598.84 per week. The parties stipulated that the appropriate rate of compensation would be $798.00 per week. There was no dual employment. The parties stipulated that the employee received sickness and accident benefits and extended disability benefits which were subject to coordination. The parties left to proof whether the claimed disability was related to a personal injury. The parties stipulated to a tax filing status of married/joint with no dependents. No workers' compensation benefits were paid for the claimed personal injury.

ISSUES:

1. Did plaintiff prove that she sustained a personal injury arising out of and in the scope of her employment on June 28, 2013?
2. Did a disability arise as a result of the alleged injuries?
3. Did plaintiff prove that a wage loss occurred?
4. Is plaintiff entitled to medical expenses and treatment?
5. Is plaintiff's attorney entitled to attorney fees and interest?

LAY WITNESSES:
Plaintiff: Karen Garner
Defendant: None

WITNESSES TESTIFYING BY DEPOSITION:

Plaintiff:
Kevin Callaway, M.D., deposed on May 4, 2016 and June 28, 2017.
Michele Robb, MA, CRC, LPC, deposed on January 8, 2016 and September 5, 2017.

Defendant:
Stanley Lee, M.D., deposed on July 25, 2016.
Paul Drouillard, M.D. deposed on August 29, 2017.
Peter Schneider, CDMS, deposed on August 5, 2016 and August 28, 2017.

EXHIBITS:
Plaintiff:

Plaintiff's Exhibit #1: Deposition of Kelvin Callaway, M.D. deposed on May 4, 2016.

Plaintiff's Exhibit #2: Deposition of Kelvin Callaway, M.D. deposed on June 28, 2017.

Plaintiff's Exhibit #3: Deposition of Michele Robb, MA, CRC, and LPC, deposed on January 8, 2016.

Plaintiff's Exhibit #4: Deposition of Michele Robb, MA, CRC, and LPC, deposed on September 5, 2017.

Plaintiff's Exhibit #5: Michigan Neurosurgical Institute, P.C. records starting August 4, 2011 with updates (June 6, 2014 to January 20, 2015) and (January 20, 2015 to October 7, 2015).

On August 15, 2011, plaintiff presented with a chief complaint of low back pain. The onset was gradual following no specific incident, and has been occurring for eleven years. The pain was located in plaintiff's lower back, with pain which radiated to the lateral hips, right lateral thigh, right lateral calf and right foot (dorsal foot tingling). The course of the pain had been gradually worsening. The pain was aggravated by bending and twisting, but was relieved by sitting (except if it's for a long period). Plaintiff's low back pain was preceded by manual labor. The pain interferes with work severely and sleep moderately. Prior diagnostic tests have included MRI-lumbar spine and EMG. Previous evaluations included a neurosurgeon (Dr. Shah) and a pain management specialists (Dr. Kohn and Dr. Culver). Previous physical therapy included strengthening exercises and stretching exercises. Plaintiff had received epidural injections in the lumbar spine, but did not obtain any relief from the series conducted in 2008. The diagnoses included degenerative disc disease, HNP (Herniated Nucleolus Pulpous) without myelopathy, lumbago/lumbalgia, and spinal stenosis. The plan at that time included obtaining lumbar flexion/extension x-rays, and plaintiff was to start a course of core strengthening exercises. She was also to be scheduled for a discogram to rule out multi-leveled discogenic pain.

An x-ray study was compared to earlier examination of November 6, 2006. There was marked narrowing at the L3-L4 and L4-L5 interspace with moderate degenerative changes. Mild degenerative changes were also noted about the remainder of the lumbar spine.

A lumbar discography performed September 7, 2011 indicated low back pain radiating down the right leg into the foot. There was possible discogenic back pain. Plaintiff's typical back pain was sharp and burning in character; 5-8/10 in severity with radiation to the right leg and occasionally to the left leg. Comparison: MRI lumbar spine April 7, 2011. Equivocal lumbar discogram. Mild discogenic pain produced with injection of L4-L5 and L5-S1 intervertebral discs was not significantly worse than plaintiff's baseline, and was only weakly concordant with her typical symptoms.

GM's S & A (Sickness and Accident) claim form dated July 18, 2013 lists the first date of disability as July 2013.

Surgery (L4/5 & L5/S1 microdiscectomy) performed March 11, 2014 by Avery M. Jackson III, M.D.

On June 1, 2015, plaintiff complained of severe pain; a 9/10.

Plaintiff's Exhibit #6: Records of Advanced Physical Therapy Center.

Plaintiff had an initial evaluation on September 11, 2013. Her complaints of LBP (low back pain) were since July 2013, which she attributed to work. She treated twelve times between September 11, 2013 and October 21, 2013. Plaintiff's initial evaluation post-surgery was on May 29, 2014, where she still attributed her symptoms to work. She indicated her legs would give out. Plaintiff was treated thirteen times between May 29, 2014 and July 7, 2014.

Plaintiff's Exhibit #7: Records of Genesys MRI Center.

Plaintiff underwent an MRI of the lumbar spine (without contrast) on July 30, 2013. This was compared to an MRI dated January 8, 2004.

> "Impression: 1) Degenerative disc disease and degenerative joint disease are present greatest at L3/4, L4/5, and L5/S1 where there is mild central canal stenosis at L3/4 and varying degrees of neural foraminal compromise. See above for description of findings at each level. 2) Edematous changes within L3, L4, and L5 vertebral bodies described above most likely related to degenerative endplate marrow active changes. 3) Minor edema right pedicle of L4 and L5 may be related to stress reaction or secondary to adjacent facet hypertrophic degenerative changes."

There was also an MRI of the lumbar spine (with and without 8.5 cc intravenous contrast) dated May 15, 2014.

> "Impression: 1) Postsurgical changes are present L5/S1 through L3/4. See above for description of findings. 2) Decrease in size of left neural foraminal/lateral disc protrusion L3/4, component of central/left paracentral disc extrusion has slightly enlarged at L3/4. Thecal sac more narrowed at L5/S1, L4/5, and L3/4 compared to prior exam. Neural foraminal narrowing similar compared to prior exam except mild improved on the left at L3/4. See above for description of findings at each level."

Plaintiff's Exhibit #8: Records of Cora Rehabilitation Clinics.

Plaintiff had an initial evaluation on November 21, 2014. She was referred by Dr. Callaway for aquatic therapy. Her complaints at that time were low back

pain and radiating pain into the bilateral lower extremities. She treated on eight occasions with a discharge summary dated December 15, 2014.

Plaintiff's Exhibit #9: Defendant's Plant Hospital Records.

Although plaintiff did not report specific or significant injuries to her lower back, she nonetheless was seen at the plant hospital frequently over her years of employment. The defendant filed a Form 100 injury report listing a date of injury of May 28, 2002. The nature of the disability involved a sprain and strain of the lumbar spine. There are a number of treatment dates in 2004. In fact, Dr. Madden the plant physician at the time, authorized and referred the plaintiff for an MRI of the lumbar spine. Plaintiff completed a sickness and accident form dated February 13, 2007 alleging that her low back problems occurred after she repeatedly engaged in a lot of bending, twisting and lifting of heavy parts at work. Dr. Callaway completed the disability form in 2007. He listed diagnoses of lumbosacral spine arthritis with back pain and lumbosacral radiculopathy/sciatica. The second MRI of the lumbar spine was authorized in 2011, when again the plaintiff was receiving treatment.

Plaintiff reported to the plant hospital on April 30, 2013. She was complaining of bilateral hand symptoms, and reported she had been on the radiator set job for approximately one year. At that time she was noticing a worsening in the numbness and tingling since April 28, 2013. She reported that she had experienced these symptoms for approximately one year and had a history of carpal tunnel syndrome since 2004. She requested ice for her hands. It was also noted that she took Flexeril for her back condition. Elastic proflex support braces were issued for her hands. She also reported to the plant hospital on June 26, 2013 complaining of low back pain and bilateral leg pain. She stated that she had been experiencing low back pain since 2002. She had noticed radicular leg pain since 2007. She believed that both of these symptoms were aggravated by her work. She did not want to allege that the problems were work-related injuries, but the symptoms had become more severe during the previous two weeks, and she then felt she could not tolerate the standing and walking required to work at her position. The impression of the medical staff was ongoing chronic lumbar pathology. The defendant filed a Notice of Dispute (Form 107) on August 2, 2013, indicating that the injury was not work related.

Plaintiff completed an employer furnished claim form for extended disability benefits. Dr. Callaway, the plaintiff's primary care physician, completed and signed several of the sickness and accident and EDB (extended disability forms) forms. Dr. Callaway listed diagnoses of arthritis of the lumbar spine, lumbar radiculopathy and bilateral hip pain. He listed the first date that his patient was unable to work at all was July 8, 2013. Dr. Callaway also completed and signed disability forms on behalf of his patient on June 17, 2014, September 12, 2014 and November 12, 2014. On each occasion, Dr. Callaway stated that plaintiff was permanently disabled.

Plaintiff's Exhibit #10: Plaintiff's Job Log.

Plaintiff's job search log started February 1, 2016 and continued through the date of Trial; October 30, 2017. The highest number of weekly job searches consisted of ten. The lowest weekly number was zero. There were 225 job searches recorded, which would average out to 2.47 job searches per week. There were only thirteen employer contacts outside the City of Flint, even though it appears most contact was made by phone. During the first six months, there were just under five logged job searches per week. During the year preceding Trial, there were 1.3 job searches per week logged.

There were two job searches logged April 31, 2016. Plaintiff also represented she contacted human resources at Genesys Credit Union on July 4, 2016.

Defendant:

Defendant's Exhibit "A": Deposition of Paul Drouillard, D.O., deposed on August 29, 2017.

Defendant's Exhibit "B": Deposition of Peter Schneider, MSW, deposed on August 5, 2016.

Defendant's Exhibit "C": Deposition of Peter Schneider, CDMS, deposed on August 28, 2017.

Defendant's Exhibit "D": Deposition of Stanley Lee, M.D., deposed on July 25, 2016.

SUMMARY OF EVIDENCE

TRIAL TESTIMONY

PLAINTIFF

Plaintiff testified that on the date of Trial she was 55 years old. She testified she was married and had grown children. She testified she graduated from high school in 1980 and took some courses at Mott Community College for approximately one semester.

Following graduation from high school she worked at some light duty work including Wendy's and Toys "R" Us. She thought she made between $4.25 and $4.75 per hour. She thought she stopped working when she had her first child in 1982. She had five children "back to back." There did come a time when she returned to part-time work before going to work for GM.

She testified she went to work at the GM Coldwater Road facility in 1996. She was asked at the present time if she could perform any of the light, part-time work that she previously performed. She stated in her opinion she could not work anywhere. When asked why, she stated she was in a lot of pain with her low back and she had issues with her legs.

Plaintiff testified that when she was hired at GM she initially performed the window regulator job. She did general assembly work until she was transferred to the Metal Fab facility in Grand Blanc. She went to work for this facility in 1998. She performed worked as a press operator and as a machine operator. She was asked, if at some point in time she began having physical problems. She testified that she started having problems with her low back pain between 2000 and 2002. She described performing the dashboard job, which involved lifting dashboards weighing approximately 20 pounds. She would lift the dashboard off the assembly line and take it to a rack where she would hang it on a hook. Once the rack was completely full, she would pull the rack (it must have been on wheels) out into the aisle where a truck would come by and pull the rack away. She testified that there was a lot of repetitive bending, lifting and twisting. She also testified she performed the side panel job, which involved lifting parts weighing up to 40 pounds. There was another employee who would help her perform this job. Again, she described having to constantly bend, twist and lift in order to perform her job responsibilities. Plaintiff testified that in some of the jobs she would rotate every 30 minutes to perform either a different job or a different part of the same job she was performing. In all of her work she continued to stress the amount of bending, twisting and lifting she would have to perform.

She testified that she began having symptoms in her back radiating into her lower extremities in 2004. She went to the plant hospital frequently. She testified that the plant physician, Dr. Susan Madden, ordered an MRI of her back in 2004. She testified that following the MRI she was given a ten pound weight restriction. However, according to plaintiff, the restrictions were not followed on the floor. She testified that she last worked at the Metal Fabricating plant in 2004.

She testified that after leaving Metal Fab, she was hired at the Truck and Bus plant. Her classification was production worker. She stated the first job she recalled performing was the hood set job. This job required her to use a hoist to lift the hood up and to push the hoods to an area and then release them. She testified that she began experiencing severe back pain going down into her legs. She also noticed problems with her hands because she was constantly gripping the hoist as well as was using air guns.

Plaintiff also described performing a job on the chassis line. She testified that the job would literally require her to be bent over during the entire time that she performed the job. She would be required to connect sensors, and other wiring and parts. She stressed she was constantly bent over which was causing

significant problems with her low back. There were other jobs she performed on the assembly line which would require the use of air guns. She testified that her hands were constantly “locking up." She estimated that the production rate while working on the “big trucks" was 230 jobs per shift (29 per hour). She testified the last job she performed was the radiator job. This was a job that was performed by two people. She stated the other person would use a hoist to lift the radiator and bring it over to the assembly line to drop it into place in front of the engine. She testified that she would grab her side of the radiator and guide it into place. She then was required to get under the truck and connect the hoses, harnesses, and then bolt the radiator into place. She testified that this job constantly bothered her back. According to plaintiff, she performed this job for approximately the last two years of her employment. She was going to the plant hospital at this time and she agreed with the plant medical records that her symptoms were getting progressively worse. She testified that because of the low back pain she could hardly walk. She stated by June 28, 2013, she could no longer perform the work. According to plaintiff, she was also receiving treatment for her hands at the plant hospital.

She went to Dr. Callaway (her primary care physician) who put her out on sick leave. In addition, Dr. Callaway referred her to Dr. Avery Jackson. She testified that she initially saw Dr. Jackson in 2011. No surgery was performed at that time. When she saw him in 2013, Dr. Jackson recommended back surgery. According to plaintiff, she was in bad shape physically. Most of the time she stayed home in bed. She was experiencing severe pain and unable to walk. Dr. Jackson performed surgery March 11, 2014. Following surgery she did not do very well. She testified that she was “laid up a long time." According to plaintiff, she started physical therapy which was ordered by Dr. Jackson. She agreed with the physical therapy records which showed she had difficulty walking or standing for more than 15 minutes. In fact, she testified that since surgery was performed, she has always had a walker, cane or crutches. She testified that she did not believe the physical therapy was of any benefit.

Attention was then turned to any job search activity she participated in following the surgery. She could not recall exactly when she started looking for work other than it was sometime in 2015. She testified that she did not have access to a computer and therefore did not submit any applications online. She would submit applications in person or call prospective employers. She testified that she did not start recording or writing down her job search activity until January 2016. When asked why she started writing down the activity in January 2016, she pointed at her attorney and stated “you told me to." Plaintiff testified that even though she was looking for employment, she did not feel that she could perform any work. When asked why, she responded, that the pain in her legs and feet prevented her from walking without a cane. She also testified that her hands were bothering her and the pain in her right index finger prevented her from writing. She further testified that she could not lift anything nor could she sit for any extended period of time.

She testified that she contacted all of the employers listed in the defendant's vocational expert's report. She did not indicate that she applied for the positions, but she did testify there were no offers of employment nor were there any interviews granted by those employers.

She testified at the present time the only benefits she is receiving are Social Security disability insurance benefits. She testified that she contacted the plant about a return to work, but was told that she must be 100% before she could return. Furthermore, she testified that she would not be able to go back and perform any of her past jobs due to the amount of bending, lifting and twisting which would be required.

CROSS EXAMINATION OF PLAINTIFF

During cross-examination, plaintiff testified that she was bed ridden essentially from her last day worked until the time of surgery. When asked about each month during that period of time, plaintiff admitted that she was not totally bed ridden, rather only when she was in a lot of pain. She testified that she laid around a lot. When asked how she got to doctor office visits, physical therapy visits, etc., she responded that she drove to some of the appointments and her daughter drove her to some of these appointments.

Plaintiff admitted she did not recall if she told Dr. Callaway, Dr. Jackson, or Advanced Physical Therapy that she was spending approximately five hours per day in bed because of pain. She also testified that she did not recall if she was asked that question. She was then questioned regarding her last day worked and the reasons for leaving work. Although testifying that she was having symptoms in her hands, she finally agreed with defense counsel that she left employment mainly because of the low back pain. She admitted that Dr. Callaway signed disability papers for her because of her low back problems.

Plaintiff admitted that since her last day worked her pain has probably gotten worse. She also admitted that she was in a motor vehicle accident in 2014. She stated she was driving a vehicle when a lady hit her. However, she stated that the pain she was having in her low back and legs did not change in any fashion following the motor vehicle accident. She testified that she had the same pain after the accident that she had before the accident. She also stated there was no lawsuit filed in regards to that accident.

Plaintiff testified that she did not have any back problems prior to going to work for GM. She specifically denied having any back problems as a child. She testified that she saw a female physician (Dr. Moore) prior to seeing Dr. Callaway. According to plaintiff, Dr. Moore has been gone for a long time. She would see Dr. Moore for annual checkups. She was unaware that she "carried a

diagnosis of scoliosis." She also admitted that she treated with a chiropractor sometime in 2015 or 2016. She could not recall the name of the chiropractor.

Plaintiff admitted that she did not look for work in 2014. She stated she did not start keeping job logs until 2016, even though she was looking for work in 2015. She recalls seeing Mr. Schneider in July of 2016, but did not recall telling him that she had not looked for work since leaving GM until the present. She stated that would have to be wrong since she did have job logs in 2016 before she saw him.

She admitted activities outside of work would “irritate” her back.

VOC ATIONAL TESTIMONY

PLAINTIFF

Michele Robb, MA, CRC, LPC, was deposed on January 8, 2016 (plaintiff's Exhibit #3)

Plaintiff’s attorney took the deposition of Michele Robb on January 8, 2016. Ms. Robb has a Master’s degree in guidance and counseling. She testified she performed a vocational assessment of the plaintiff on December 28, 2015 and issued a report dated January 5, 2016. She testified that using medical records and reports of Dr. Callaway, she found that plaintiff was totally disabled as of January 5, 2016. She was asked questions about the specific vocational preparation (SVP) as well as the physical demand classifications. She testified that sedentary positions would include work lifting up to ten pounds, light would include lifting up to twenty pounds, medium would include twenty to fifty pounds, heavy would be fifty to 100 pounds, and very heavy would be greater than 100 pounds.

She acknowledged that she did not perform a job search as a vocational expert. According to Ms. Robb, plaintiff has been looking for work and maintaining a job search log. Michele Robb was again deposed on September 5, 2017 (plaintiff's Exhibit #4). Her report, dated August 14, 2017, was typed into the deposition transcript. Her report consisted of information she obtained from plaintiff via a telephone conversation held on August 14, 2017.

She testified that based upon Dr. Callaway's restrictions, plaintiff again did not have any residual wage earning capacity.

She testified that she did not have available for review Dr. Lee's report or Dr. Drouillard’s report.

DEFENDANT

Peter I. Schneider, MSW, deposed on August 5, 2016 and August 28, 2017.

Defendant took the deposition of Peter Schneider on August 5, 2016. Mr. Schneider is a certified disability management specialist. He testified that he met with plaintiff on July 6, 2016, and he issued a report dated July 15, 2016, which was typed into the deposition transcript. He testified that he had the report of Dr. Lee which suggested plaintiff was not in need of any work related restrictions. He also noted that plaintiff's last salary at GM paid her $28.70 per hour. He went over the plaintiff's past work history. He also looked at the transferable skills which plaintiff possesses.

According to Mr. Schneider, plaintiff had not looked for any work since leaving GM. He testified that on July 6, 2016, the date he conducted his labor market survey, there were five job openings available. These jobs paid anywhere from $10.00 to $13.00 per hour. He testified that in using Dr. Lee's report, there would be no loss of wage earning capacity. If he used Dr. Callaway (which by plaintiff's history completely disabled her), the plaintiff would not have any wage earning capacity.

The only medical available was the report from Dr. Lee and a short note from Dr. Callaway. Mr. Schneider testified again on August 28, 2017. He stated he performed a labor market survey on June 26, 2017. Based upon the restrictions issued by Dr. Drouillard (avoid prolonged walking and standing; avoid squatting, climbing ladders; no lifting greater than 10lbs), he felt plaintiff had a residual wage earning capacity of anywhere from $8.90 per hour to $9.50 per hour.

MEDICALTESTIMONY

PLAINTIFF

Kelvin Callaway, M.D., deposed on May 4, 2016 (plaintiff's Exhibit #1) and June 28, 2017 (plaintiff's Exhibit #2).

Plaintiff took the deposition of Dr. Callaway on May 4, 2016. Dr. Callaway practices internal medicine and is the plaintiff's primary care physician. He testified he has treated the plaintiff from October 17, 2006 through the present. He stated on the first date of treatment, plaintiff was complaining of chronic muscle and joint aches. She had spasms in her upper back and left shoulder and complained that working at GM for many years was quite physical. He testified that he reviewed an MRI of the lumbar spine performed January 8, 2004. The doctor was asked to describe the pathology present on the MRI. The doctor stated "This is an MRI dated January 8, 2004 and it says: "At L4-L5 in addition to degenerative central canal bilateral lateral recess stenosis there is moderate broad-based right paramedial, I'm sorry paramedian disc herniation leading to

further effacement upon the thecal sac and the right L4-L5 nerve roots sleeves." And it also states: "At L3-L4 there was also degenerative central canal and bilateral recess narrowing and diffuse disc bulge asymmetric to the right leading to effacement of the thecal sac and the right L-4 nerve root sleeve within its lateral recess." The doctor stated this was a degenerative process of the spine. The doctor was asked what affect repetitive bending, twisting, turning and lifting could have on the development of the findings on MRI. The doctor responded "Well, that's part of the process over many years of these type of activity. There will eventually be a degenerative process that will start causing these discs to fail, bones can deteriorate as well."

The doctor testified that when he saw plaintiff on November 23, 2010, she was complaining of low back pain which was radiating down the right leg to the right foot. Because of the symptoms the doctor ordered an MRI. The doctor reviewed the MRI which was performed April 7, 2011. The doctor testified that there was a clear progression in the pathology in the lumbar spine between 2004 and 2011. He stated that the report now described a "left lateral disc herniation and they talk about this ligament which has thickened, the hypertrophy." The doctor was asked to assume that plaintiff continued to work for GM between 2004 and 2011, and was still doing the repetitive work which had previously been described. The doctor was asked if there was any relationship between that work and the progression seen on MRI. The doctor testified: "Well, um, this type of activity is known to cause this kind of degenerative process so it obviously contributed to it." He felt between the MRI and plaintiff symptoms, that she would benefit from a surgical consult.

Defense counsel objected to the 2004 MRI report offered during Dr. Callaway's deposition on the basis it was hearsay evidence. The report may be hearsay, but I believe it is admissible under a number of the exceptions to that rule. First and foremost, the MRI was ordered and authorized by Dr. Madden, the plant physician. It would be admissible as a business record as well as a record the doctor reviewed in formulating a course of treatment for the plaintiff.

The doctor testified that he saw the plaintiff on July 12, 2013, and she was still complaining of low back pain. He again ordered an MRI which was performed July 30, 2013. The doctor was asked to review the MRI report. He testified that "the conclusion is that she's having more degenerative disease of her spine, varying degrees throughout her spine, still worse at this time L3-4-5 areas." The doctor was again asked what affect, if any, the types of job duties she was performing at GM would have on the development of these findings. The doctor responded, "This type of activity is known to produce degenerative changes."

On the office visit before surgery (February 4, 2014), plaintiff was, "complaining of chronic back pain obviously, limping, leg pain and she was waiting to have surgery with Dr. Jackson." The doctor noted the surgery was

performed March 11, 2014. The doctor saw plaintiff June 6, 2014, which was the first post-surgical visit. According to plaintiff she was no better. A postsurgical MRI was performed May 15, 2014. The last office visit the doctor recorded was November 12, 2015. He was asked regarding plaintiff's ability to work at that time. The doctor responded, “Well, I've long since said that she should be considered permanently disabled. This type of patient doesn't return to any kind of physical job.”

In response to the hypothetical (which for the most part was consistent with the trial testimony), the doctor stated, “I believe, um, that she, ah, that those type of activities would definitely aggravate any condition of the spine. Probably more likely than not that was the cause of most of it."

During cross-examination the doctor admitted that he could not measure the progression of the disease process in the spine. In other words, he could not state what was caused by work versus what was caused by the aging process.

The doctor also admitted that plaintiff had a scoliosis of the spine that was a condition which can create pain in the back. He acknowledged this was something that was not addressed at the time of surgery.

The doctor’s office chart was attached to the deposition transcript. During the office visit November 17, 2006, plaintiff stated she did not want surgery. It was noted she was complaining of low back pain radiating into the right hip. The office visit of January 30, 2007 states she was complaining of paresthesia in the right leg. The impression was sciatica. Plaintiff went to the emergency room, where they recommended nerve blocks for sciatica. During the office visit March 13, 2007, it was reported her pain was improved following series of injections.

At the office visit August 18, 2008, plaintiff complained of low back pain radiating into her right leg. She stated she could not work at that time and may need surgery. An MRI of the lumbar spine was ordered, as well as an EMG. At the office visit of September 9, 2010, x-rays were performed showing arthritis. The office visit of November 23, 2010 stated plaintiff was complaining of low back pain radiating to the right leg. An MRI was to be performed and referral to neurosurgeon was suggested. A discogram performed September 7, 2011, was mildly positive.

Dr. Callaway’s deposition was taken again on June 28, 2017. His office notes as well as the report of an EMG performed February 20, 2017 were attached as deposition exhibits. The doctor was reminded at his previous deposition he felt plaintiff was permanently disabled, and he was asked whether that remained his opinion. He responded “yes,” and when asked to elaborate stated, “she continues to complain of her symptoms of pain. I don't think it would be feasible for her to sit for a prolonged period of time, stand for a prolonged

period of time, certainly not lift or do any significant repetitive work." The doctor opined that the EMG study showed moderate right carpal tunnel syndrome (the left upper extremity was not tested). The doctor said going forward he would recommend that the patient abstain from the activity which caused the problem. In addition he stated, “I would avoid repetitive use of the upper extremity, particularly the wrist, hands, fingers."

DEFENDANT

Stanley Lee, M.D. deposed on July 25, 2016 (defendant’s Exhibit “D”)

The defendant took the deposition of Dr. Stanley Lee on July 25, 2016. Dr. Lee is a board-certified orthopedic surgeon. He performed an independent medical evaluation of plaintiff on May 23, 2016.

According to the history the doctor received, plaintiff performed repetitive work from 2000 until her last day worked, June 28, 2013. There was no specific traumatic injury. Plaintiff complained that the repetitive production work caused pain in her lower back and into the lower extremities. She was hired in 1997 and worked in production her entire employment.

Additional history indicated that plaintiff underwent a lumbar laminectomy in 2014. Plaintiff denied having symptoms in the upper extremities. Dr. Lee stated he did not perform a record review. He testified plaintiff refused to heel walk and toe walk and forward flex or extend her spine because of severe back pain. The doctor diagnosed, “Chronic non-specific back pain that is unrelated to the occupational exposure.”

When asked if plaintiff had reached maximum medical improvement, the doctor stated in his report, “Yes. I did not find evidence in the records or in her history of any objective evidence to support any work related injury or condition”. The court would not he did not review any records prior to issuing his report. Dr. Lee was asked to assume that Dr. Callaway diagnosed scoliosis. The doctor admitted that such a condition would be painful, but it would not be work related. The doctor also acknowledged that his physical examination was consistent with degenerative disc disease. Again, the doctor testified that in his opinion the pathology would not have been aggravated based upon the history. Dr. Lee was asked to assume that the plaintiff would testify at Trial that the back pain has not changed since her last day worked. Dr. Lee testified that assuming Dr. Callaway's records showed no change in symptoms, this would suggest no work relationship.

During cross-examination, Dr. Lee acknowledged that there were no records at the time of his examination. He testified that he then reviewed records and issued an addendum report dated June 17, 2016.

The doctor admitted the initial report contained his complete understanding of the plaintiff's work. Namely, she worked in production her entire career. The doctor had no idea of the weight of the parts, the bending, twisting, turning, repetitiveness, etc., of the job. The doctor was not furnished with the plant hospital records.

In June, the doctor reviewed MRIs dated April 7, 2011 and July 30, 2013. The doctor stated there may have been disc protrusions, but they did not rise to the level of clinical significance. He believed these to be related to the aging process.

Plaintiff's counsel objected to the addendum report being admitted on the basis the report was not provided in a timely fashion. It appears from the transcript exchange, the defense attorney was unaware of the existence of the report. I find the plaintiff's attorney was not unduly prejudiced. The report was only two (2) pages in length, the records reviewed consisted of records contained in other subpoenaed records, and the doctor could have been questioned in such a fashion as to elicit the same information in his report had it not been admitted.

Paul Drouillard D.O. deposed on August 29, 2017 (defendant's Exhibit "A")

The defendant took the deposition of Dr. Drouillard on August 29, 2017. Dr. Drouillard is a board-certified orthopedic surgeon. He performed an independent medical evaluation of plaintiff on April 12, 2017.

According to the history he received, plaintiff attributed her symptoms in her low back to her work. She stated that she was required to repetitively bend, twist, etc. She stated that she stopped work because "her legs were wobbly."

Plaintiff complained of pain in the lateral aspect of both hips. She stated that her fingers would lock on her; particularly her right thumb and right ring finger. Pain was constant, throbbing and shooting, sharp and severe. She reported experiencing tingling in her toes.

The doctor reviewed medical records including the MRI dated July 30, 2013 and May 15, 2014. There were a significant number of findings on the MRIs. The MRIs showed degenerative disc disease and degenerative joint disease present at L3, L4, L4-5 and L5-S1 where there was also mild canal stenosis at L3-L4 and varying degrees of foraminal compromise. Also present was degenerative marrow changes at L3, L4, and L5 and mild edema right pedicle at L4 and L5 may be related to stress reaction or adjacent fat degenerative changes. The MRI report of May 15, 2014 shows post-surgical changes from L3 through S1. It does indicate a decreased size of the foraminal protrusion at L3-L4, and indicates a component of central left paracentral disc extrusion slightly enlarged L3-L4, and indicates the thecal sac is more narrowed from L3 through S1 than on prior exam. The operative note dated March 11,

2014, shows Dr. Jackson performed bilateral L3-L4, L4-L5 and L5-S1 foraminotomies and partial medial facetectomies.

Physical examination of the hands and wrists showed full range of motion. Clinical findings were consistent with degenerative changes and she has obvious degenerative changes about the CMC joint of both thumbs.

The doctor's diagnoses included: 1) post L3 through S1 lumbar laminectomy 2) severe degenerative joint disease right and left hips 3) tenosynovitis A1 pulley right thumb and right ring finger 4) degenerative joint disease CMS joint bilateral thumbs, and 5) narcotic habituation.

The doctor was asked whether the plaintiff's subjective complaints were supported by objective medical evidence. The doctor responded, "Yes. She has advanced degenerative changes in both hips and got subjected to multilevel lumbar spine surgery for degenerative process, which she tells me has not helped her. She also has degenerative changes in both hands."

As to restrictions, the doctor stated, "Because of the multilevel degenerative changes that she has, the type of restrictions which would be appropriate for her would be to avoid prolonged walking and standing, avoid squatting, climbing ladders and no lifting more than 10 pounds. Within those restrictions, she is capable of working, should there be something available to her. These restrictions are prophylactic in nature related to her polyarticular arthritic changes and her multilevel lumbar spine surgery. She does not need restrictions for work-related injury. Her problems are degenerative in nature." Furthermore the doctor stated, "She has multiple levels involved. That's classically what occurs in a degenerative process." Cross-examination elicited the doctor's admission that the work may have aggravated the symptoms. The doctor admitted that by way of history, the plaintiff was still having complaints of pain in the low back and therefore he would not consider the surgery performed successful.

The doctor testified that he did not find any atrophy in the thenar muscles which is generally present in individuals with advanced carpal tunnel syndrome. The doctor stated, "She does not have that." On the other hand, Dr. Drouillard admitted during cross-examination that he did not perform any clinical testing for carpal tunnel syndrome since the plaintiff did not have any complaints consistent with that diagnosis.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The plaintiff has the burden of proof to establish a compensable workers' compensation claim by a preponderance of the evidence for each element of the claim. Aquilina v General Motors, Corp., 403 Mich 206 (1978). Those elements

include proving an injury or disease arising out of or in the course of employment, and proving that the injury or disease has placed a limitation on the claimant's wage earning capacity in work suitable to his or her qualifications and training. MCL 418.301 (1) & (4).

In June 2008 the Supreme Court issued their Decision in Stokes v Chrysler LLC, 481 Mich 266 (2008). In that case, the Supreme Court noted:

> "The claimant bears the burden of proving a disability by a preponderance of the evidence under MCL 418.301(4), and the burden of persuasion never shifts to the employer. The claimant must show more than a mere inability to perform a previous job. Rather, to establish a disability, the claimant must prove a work-related injury and that such injury caused a reduction of his maximum wage-earning capacity in work suitable to the claimant's qualifications and training. To establish the latter element, the claimant must follow these steps:
>
> (1) The claimant must disclose all of his qualifications and training;
> (2) The claimant must consider other jobs that pay his maximum pre-injury wage to which the claimant's qualifications and training translate;
> (3) The claimant must show that the work-related injury prevents him from performing any of the jobs identified as within his qualifications and training; and
> (4) If the claimant is capable of performing some or all of those jobs, the claimant must show that he cannot obtain any of those jobs.
>
> If the claimant establishes all of these factors, then he has made a prima facie showing of disability satisfying MCL 418.301(4), and the burden of producing competing evidence then shifts to the employer. The employer is entitled to discovery before the hearing to enable the employer to meet this production burden. While the precise sequence of the presentation of proofs is not rigid, all of the steps must be followed."
> Stokes v. Chrysler LLC, 481 Mich 266 (2008).

The Workers Compensation Appellate Commission recently summarized their Opinion concerning Stokes v. Chrysler LLC, 481 Mich 266 (2008) and the status of the law in the case of Heider-Hagen v. Select Medical Corp, 208 ACO#165 by stating:

> "In *Stokes,* the Supreme Court then reversed the Court of Appeals and provided clear guidelines for future cases. In so doing,

the decision specifically states that certain Appellate Commission decisions accurately reflect the *Sington* standard, but criticized the abandonment of the standard when analyzing cases. The Supreme Court *Stokes* decision also mandates discovery, including vocational rehabilitation expert interviews with plaintiff. Finally, the decision outlines plaintiff's obligations when proving disability. It states:

> First, the injured claimant must disclose his qualifications and training. This includes education, skills, experience, and training, whether or not they are relevant to the job the claimant was performing at the time of the injury. It is the obligation of the finder of fact to ascertain whether such qualifications and training have been fully disclosed.
>
> Second, the claimant must then prove what jobs, if any, he is qualified and trained to perform within the same salary range as his maximum earning capacity at the time of the injury. *Sington, supra* at 157, 648 N.W.2d 624. The statute does not demand a transferable-skills analysis and we do not require one here, but the claimant must provide some reasonable means to assess employment opportunities to which his qualifications and training might translate. This examination is limited to jobs within the maximum salary range. There may be jobs at an appropriate wage that the claimant is qualified and trained to perform, even if he has never been employed at those particular jobs in the past. *Id.*, p 160, 648 N.W.2d 624. The claimant is not required to hire an expert or present a formal report. For example, the claimant's analysis may simply consist of a statement of his educational attainments, and skills acquired throughout his life, work experience, and training; the job listings for which the claimant could realistically apply given his qualifications and training; and the results of any efforts to secure employment. The claimant could also consult with a job-placement agency or career counselor to consider the full range of available employment options. Again, there are no absolute requirements, and a claimant may choose whatever method he sees fit to prove an entitlement to workers' compensation benefits. A claimant sustains his burden of proof by showing that there are no reasonable employment options available for avoiding a decline in wages.
>
> We are cognizant of the difficulty of placing on the claimant the burden of defining the universe of jobs for which he is qualified and trained, because the claimant has an obvious interest in defining that universe narrowly. Nonetheless, this is required by the statute. Moreover, because the employer always has the

opportunity to rebut the claimant's proofs, the claimant would undertake significant risk by failing to reasonably consider the proper array of alternative available jobs because the burden of proving disability always remains with the claimant. The finder of fact, after hearing from both parties, must evaluate whether the claimant has sustained his burden.

Third, the claimant must show that his work-related injury prevents him from performing some or all of the jobs identified as within his qualifications and training that pay his maximum wages. *Id.*, p 158, 648 N.W.2d 624.

Fourth, if the claimant is capable of performing any of the jobs identified, the claimant must show that he cannot obtain any of these jobs. The claimant must make a good-faith attempt to procure post-injury employment if there are jobs at the same salary or higher that he is qualified and trained to perform and the claimant's work-related injury does not preclude performance.

Upon the completion of these four steps, the claimant establishes a prima facie case of disability. The following steps represent how each of the parties may then challenge the evidence presented by the other.

Fifth, once the claimant has made a prima facie case of disability, the burden of production shifts to the employer to come forward with evidence to refute the claimant's showing. At the outset, the employer obviously is in the best position to know what jobs are available within that company and has a financial incentive to rehabilitate and re-employ the claimant.

Sixth, in satisfying its burden of production, the employer has a right to discovery under the reasoning of *Boggetta* if discovery is necessary for the employer to sustain its burden and present a meaningful defense. Pursuant to MCL 418.851 and MCL 418.853, the magistrate has the authority to require discovery when necessary to make a proper determination of the case. The magistrate cannot ordinarily make a proper determination of a case without becoming fully informed of all the relevant facts. If discovery is necessary for the employer to sustain its burden of production and to present a meaningful defense, then the magistrate abuses his discretion in denying the employer's request for discovery. For example, the employer may choose to hire a vocational expert to challenge the claimant's proofs. That expert must be permitted to interview the claimant and present the employer's own analysis or assessment. The employer may be

> able to demonstrate that there are actual jobs that fit within the claimant's qualifications, training, and physical restrictions for which the claimant did not apply or refused employment.
>
> Finally, the claimant, on whom the burden of persuasion always rests, may then come forward with additional evidence to challenge the employer's evidence. [*Stokes, supra*, pp 281-284; footnote omitted.]
>
> The Supreme Court also reiterated that plaintiff must prove wage loss. While the Worker's Disability Compensation Act clearly defines wage loss in MCL 418.371, the courts have interpreted wage loss differently. In *Haske, supra*, the Court required plaintiff to prove that he suffered an actual loss of wages after a work injury and that the work injury caused the subsequent wage loss. While the *Sington* Court overruled the *Haske* interpretation of disability, it upheld the need for plaintiff to prove wage loss. Further, the Court in *Sington* failed to offer any different interpretation of the wage loss requirement. In *Stokes* the Court of Appeals did not address wage loss other than expressly vacating the Appellate Commission majority view of wage loss. Finally, the Supreme Court *Stokes* decision mandates that plaintiff prove wage loss, but did not expound further. Thus, we must apply the two-part *Haske* requirement."

DISABILITY AND EXPERT CREDIBILITY

I find plaintiff has proved by a preponderance of the evidence that she suffered a personal injury as defined by MCL 418.401(2) (b) while working for the defendant. She testified that during her tenure of employment with the defendant, she performed general assembly work which was repetitive in nature. She testified as to the requirements of specific jobs including the bending, twisting and lifting which would be involved. Her testimony was unrebutted by the defendant and I therefore find as fact the accuracy of each of her job descriptions. Although plaintiff alleged injuries to her back, upper extremities and hips, my finding is limited to her low back. She was treated periodically for complaints and symptoms regarding her upper extremities, but I do not believe that she has proven by a preponderance of the evidence that she suffered a personal injury. I found little support in the plant medical records or in Dr. Callaway's records and treatment to establish a work related personal injury involving either the right or left hip.

Dr. Callaway, the plaintiff's primary care physician, was deposed on two occasions. He was asked to review the MRI of the lumbar spine performed January 8, 2004 (after plaintiff had worked for eight years). The doctor acknowledged that the MRI findings revealed a degenerative process of the

lumbar spine. He was then asked what affect repetitive bending, twisting, turning and lifting would have on the development of these findings. The doctor testified that this is a process which occurs over many years, but with these types of activities, the degenerative process will start causing these discs to fail as well as for bones to deteriorate. The MRI in 2004 was ordered by the defendant's plant physician. When Dr. Callaway saw plaintiff November 23, 2010, she was complaining of low back pain which was radiating down the right leg to the right foot. The doctor ordered an MRI which was performed April 7, 2011. The doctor testified that there was a clear progression in the pathology in the lumbar spine between 2004 and 2011. The doctor was again asked his opinion as to what affect the plaintiff's work activity would have had on this underlying process. The doctor opined that the activity “obviously contributed to it."

The records reflect Dr. Callaway took plaintiff off work in July 2013. When he saw her on July 12, 2013, she was complaining of low back pain and he again ordered an MRI of the lumbar spine which was performed July 30, 2013. Again the doctor was asked during his deposition to review that MRI report. He noted that the findings particularly at the levels of L3, L4 and L5 were worse than in prior studies. The doctor was asked again what affect plaintiff's work at GM would have had on the development of these findings. He responded “this type of activity is known to produce degenerative changes." Dr. Callaway again referred plaintiff to Dr. Jackson who performed surgery on her lumbar spine on March 11, 2014.

Dr. Stanley Lee saw plaintiff on May 23, 2016. When Dr. Lee was asked if plaintiff had reached maximum medical improvement, he stated in his report that she had and that he “did not find evidence in the records or in her history of any objective evidence to support any work related injury or condition." The doctor later admitted that he did not review any records prior to issuing his first report, and furthermore his total understanding of plaintiff's work at GM was that she performed repetitive work from 2000 until her last day worked. He acknowledged plaintiff complained that the repetitive production work caused pain in her lower back and into her lower extremities.

Dr. Paul Drouillard examined plaintiff on April 12, 2017 at the request of the defendant. Dr. Drouillard did review a number of medical records and reports prior to issuing his report. Dr. Drouillard testified plaintiff had a number of objective pathological findings in the lumbar spine, both hips and both hands to support her subjective complaints of pain. Dr. Drouillard opined that the degenerative process in his opinion was not related to plaintiff's employment. Based upon the totality of her medical conditions, he nonetheless recommended that she avoid prolonged walking and standing, avoid squatting, climbing ladders and no lifting more than ten pounds.

WAGE LOSS

I find plaintiff has established a wage loss which is due to her disability that started June 28, 2013. She testified she attempted to return to work at GM, but was advised she could not return until she was 100%. Dr. Callaway completed disability forms for plaintiff certifying that she was totally and permanently disabled in 2013 and 2014. I find plaintiff's work at GM established her maximum wage earning capacity. Dr. Callaway was asked about plaintiff's ability to return to work as of November 12, 2015. He responded that this type of patient does not return to physical work. During his second deposition, he was asked to elaborate. He testified that plaintiff should not be required to sit for prolonged periods of time, stand for prolonged periods of time, and not lift or do any significant repetitive activity. Based upon these facts, plaintiff had an affirmative duty to look for employment. The job log suggested plaintiff was submitting approximately five employment applications per week to prospective employers. In my opinion, this would be considered a marginal good-faith effort at best.

Mr. Schneider's labor market survey performed July 6, 2016 showed five job openings available paying anywhere from $10.00 to $13.00 per hour. This was the first labor market survey available to the Court. I believe such jobs were representative of the labor market in the calendar year of 2016.

I believe plaintiff was capable of performing such work, and I therefore find that plaintiff retained a residual wage earning capacity consistent with the wages paid for these jobs, and have reduced the weekly workers' compensation benefits payable by this residual wage earning capacity.

I find plaintiff's job search activity log documented in the year prior to Trial was totally inadequate and did not represent a good-faith job search on plaintiff's part. I have therefore chosen to terminate any responsibility defendant has to pay weekly wage loss benefits as of October 10, 2016.

MEDICAL AND RELATED EXPENSES

IT IS HEREBY ORDERED that the defendant shall be responsible for reasonable and necessary medical expenses, pursuant to MCLA 418.315, pursuant to cost containment relative to the treatment for plaintiff's back (lumbar), its sequelae, including surgery.

ATTORNEY FEE

IT IS HEREBY ORDERED that plaintiff's attorneys are entitled to a fee of 30% of amounts recovered under this Application, in accordance with and in conformity with the statutes and rules of the Workers' Compensation Agency.

IT IS HEREBY ORDERED that the defendants shall pay interest in accordance with MCLA 418.801(6) on any unpaid amount.

THE ABOVE FINDINGS ARE INCORPORATED BY REFERENCE INTO AN ORDER ISSUED THIS DATE AND THE ATTACHED ORDER IS ALSO INCORPORATED HEREIN BY REFERENCE. IT IS SO ORDERED.

WORKERS' COMPENSATION
BOARD OF MAGISTRATES

_____
J. WILLIAM HOUSEFIELD, Magistrate (255G)

Signed this 21st day of December, 2017 at Okemos, Michigan.