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

STATE OF MICHIGAN
DEPARTMENT OF LABOR AND ECONOMIC OPPORTUNITY
WORKERS' COMPENSATION BOARD OF MAGISTRATES

Maurice McCowin,
SSN: XXX-XX-XXXX,
Plaintiff, Respondent

-vs-

United Technologies Corporation/Otis Elevator-Midwest,
Insurance Co. of the State of Pennsylvania,
Defendant, Petitioner.
_____/

OPINION

APPEARANCES

William W. Watkinson, Jr. (P-53733) for plaintiff – Maurice McCowin
Arthur G. Kirchner, (P-26875) for defendant – United Technologies Corporation/Otis Elevator-Midwest/Insurance Co. of the State of Pennsylvania

TRIAL DATE(S)

Trial in this matter commenced on November 17, 2022 in Detroit, Michigan. The record was closed on December 13, 2022 with the parties submitting briefs.

CLAIM

This claim arose out of an Application for Mediation or Hearing (Form C) Petition to Determine Rights filed on December 19, 2013 by the Defendant/Employer United Technologies Corporation/Otis Elevator.

In this application, the date of injury was January 8, 2009. The Petitioner requested a hearing to determine claimant's residual wage-earning capacity.

A subsequent Application for Mediation or Hearing (Form C) was filed by Defendant on February 9, 2015. The Petitioner sought a hearing on the issue as to whether claimant's ongoing treatment was reasonable, necessary and related. The Petitioner also alleged non-compliance with medical treatment. The relief requested was the termination of benefits.

On August 2, 2015, an Application for Mediation or Hearing (Form C) was filed by Defendant. The Petitioner was requesting a hearing and seeking an order that claimant has recovered from his work injury and no further benefits were due and owing. This was a Petition to Stop.

Lastly on November 10, 2022, an Amended Application for Mediation or Hearing (Form C) Petition to Stop was received by the Agency. The requested hearing and relief were unchanged from the prior Petition to Stop filed on August 2, 2015. In addition to that application, the Petitioner attached a Form 701 indicating payment of benefits and a report dated August 4, 2015 from Mary K. Kneiser, M.D.

HISTORY OF CLAIM

Trial was previously held in this matter on February 9, 2010, February 24, 2010, and March 16, 2010 in front of Magistrate Joy Turner. A corrected Decision was mailed on January 26, 2011 granting an open award of benefits. The initial Decision was mailed on December 13, 2010.

In that Decision, Plaintiff established a date of injury of January 8, 2009 and was granted weekly benefits at the rate of $723.58 based on an average weekly wage of $1,405.33. The Magistrate also ordered medical for his injury to his back which included radiculopathy, a disc herniation, and traumatic low back pain. The Magistrate found that Plaintiff did not establish an injury to his knees or legs. He also failed to establish the date of injury of January 13, 2009 regarding his back condition. The Magistrate found no further aggravation of the condition.

On August 7, 2012, the Workers' Compensation Appellate Commission mailed their Decision affirming the Magistrate's Order.

WITNESSES TESTIFYING AT TRIAL

Plaintiff – Maurice McCowin

Defendant – None

EXHIBITS

Plaintiff/Respondent:

1. Deposition testimony of Abiola Dianne Obayan, M.D. taken on August 24, 2016.
2. Deposition testimony of Steven Newman, M.D. taken on June 27, 2017.
3. Deposition testimony of Dr. Newman, M.D. taken on Sept.9, 2022.
4. Deposition testimony of James Fuller, MA, CRC taken on April 17, 2017.
5. Deposition testimony of James Fuller, MA, CRC taken on Oct.7, 2022.
6. Records from Michigan Head and Spine Institute.
7. Records from Pain & Rehabilitation Physicians.
8. Claimant's Resume.
9. Job Search Logs commencing January 2022.

Defendant/Petitioner

A. Deposition testimony of Mary K. Kneiser, M.D. taken on April 24, 2017.
B. Deposition testimony of Louis I. Jacobs, D.O. taken on January 25, 2018.
C. Deposition testimony of James Fuller, MA, CRC taken on April 17, 2017. (same as Plaintiff's Exhibit #4)
D. Deposition testimony of James Donoghue taken on February 23, 2018.
E. Deposition testimony of Nathan Gross, M.D. taken on September 6, 2022.
F. Deposition testimony of Dr. Kneiser taken on September 6, 2022.
G. Deposition testimony of Michael Fontaine taken September 9, 2022.

TESTIMONY

Plaintiff - Mr. McCowin

Mr. McCowin testified he had continued symptomatology in the back. He did have sleep problems. He would sleep on the floor and bed. He rotated depending on whether his back hurt. Sleeping on the bed or floor changed per day.

He described his pain as sharp and stabbing. He did have radiation into the butt to the left foot. He did have good and bad days. If he had radicular symptoms, he could be out for a couple of days. The pain would usually stop after a week and he would be better. The severe pain would occur approximately 2 to 3 times per month.

His pain does go up/down. On his best days, it was a 3-4/10. On those days he was able to do chores. The worse was 8-9/10. He testified laying down and resting did alleviate the pain. He would do exercises at home 2 to 3 times per week for 30 minutes. Those exercises included crouching, bending, standing, bending over, thrusts and laying on the floor. Those exercises were provided by Pain Management.

On a bad day, he would lay down from half the day to a full day.

Activities can increase his pain. Those activities included bending, stooping, standing and sitting too long. He felt on a good day he could sit 20 to 30 minutes. At the time of trial, he was having a good day. If he was having a bad day, he could not sit very long. It varied and was for approximately 10 to 20 minutes.

If he stood too long, he did have low back pain. He approximated he could stand for 20 minutes. His current medications were Gabapentin and Norco. He took Gabapentin one time at night. He was taking Norco two times a day.

He testified his symptoms were the same for the last 10 years.

Mr. McCowin testified he Resume' (Plaintiff 's Exhibit 8) was accurate and up to date. He used his Resume' for his job logs. His job search logs (Plaintiff's Exhibit 9) were from January 2022 to present. He testified they were accurate and complete. They were done this year (2022). He did apply online. The notes in his logs describe the position he applied for. Those logs were in his own writing.

He did not get a job within Dr. Newman's limitations. He also testified the Defendant/Employer had not offered him a job within Dr. Newman's restrictions.

He lastly testified on direct examination that Mr. Fontaine did not assist in his job search.

On cross-examination, he testified he has treated with Dr. Obayan since 2009. He continues to treat with that physician. He does see the doctor's nurse or physician's assistant. He tells them what is bothering him at the time of the visit. He would tell the doctor if he had issues in regard to sitting, standing, sleeping on the floor, etc. He did have Telemed visits during Covid. There was no physical exam. Physical therapy did examine him. He continued to attend physical therapy during Covid.

He has been taking Norco and Gabapentin since 2009. His current treatment is medications and physical therapy. Surgery has not been recommended. He did see Dr. Diaz who recommended he continue physical therapy.

He has seen Dr. Kneiser on 3 or 4 occasions. He also saw Mr. Fuller on 3 or 4 occasions. He testified he would report his symptoms to the doctor and what was bothering him.

In regard to the job logs, the first application was on January 2, 2022. This was an online application. All of his searches were online. He would look for job openings. When he found an opening, he would send his Resume' and complete an online application.

His skills were in maintenance, equipment repairs, and use of hand tools. His past jobs were in construction and at the Defendant/Employer. He had no experience in the other jobs that were in his logs.

He did not apply to jobs within the restrictions set forth by Dr. Newman. He testified he had to apply for jobs. The only job within his past experience was as a maintenance technician. All other jobs he applied to he did not have any experience.

He was uncertain as to how he came under the care of both Drs. Obayan and Newman. Dr. Obayan is prescribing his medications and physical therapy. His condition is the same since 2009. It has not gotten worse.

He has not performed any jobs for pay since 2009. His current activities are shopping, limited driving due to vision issues and various housework including cleaning and cooking. He testified he is up and down during the day and not in bed all day. He does walk as recommended by his doctor.

His exercises do help with his symptoms. Walking does make him feel better. It does help for him to move around except he cannot move around too much.

Lastly, on redirect exam, he testified the jobs he applied for, experience was not necessary.

EXHIBITS

Plaintiff

Exhibit 1 – This is the deposition of Abiola Dianne Obayan, M.D. taken on August 24, 2016. Dr. Obayan is Board-Certified is physical medicine and rehabilitation. She is also certified in pain management and sports medicine.

The doctor first saw Mr. McCowin in 2009. She continues to treat him. She was treating him for a work-related injury/backpain. (p11) His complaints were left low back pain radiating to the buttock and down the posterior lateral thigh. The doctor did not feel he had any symptom exaggeration. His diagnosis was acute lumbar radiculopathy. (p12) The doctor testified she did have records through May 2016. There has been no change in the diagnosis or his condition. (p12)

She ordered an MRI. The MRI was consistent with his subjective complaints. (p13) The doctor opined the medications she was prescribing were reasonable and necessary. She felt they were “absolutely” reasonable and necessary. (p12)

There has been no change in pathology. There has been no intervening events or accidents since 2009. She felt his prognosis was very guarded. He could return to work that did not require significant lifting or physical exertion. (p14) He was restricted from significant physical exertion, repetitive bending, lifting greater than 5 to 10 pounds, and no prolonged sitting. (p15)

There have been periods where his pain has improved but did not fully resolve. Physical exertion will cause a significant increase in pain. (p15)

On cross-examination, the doctor testified the 2012 MRI showed a disc displacement abutting the descending left L4 nerve root. She reviewed the radiologist report. She was unsure if she reviewed the actual films. (p17) She does sometimes review the films. She stated she rarely has a difference in conclusion with the radiologist. (p17) She again did not note whether she reviewed the actual films and a copy of such would not have been in her chart. (p17) However, she would have made a note if she disagreed. A 2009 EMG showed denervation in the left lumbar paraspinal muscles. This was suspicious for a left lumbosacral radiculopathy. (p18) Denervation of the muscles can be evidence of an impingement of the nerve root. (p18) The study did show peripheral neuropathy which affects the nerves in the extremities. This was not related to the work incident. The effect of this is numbness in the toes/feet. (p18) The peripheral neuropathy symptoms were not similar to his complaints he had over the last 7 years. Again, the peripheral neuropathy causes symptoms in the distal extremities, toes/feet. There are no symptoms in the back from peripheral neuropathy. (p19)

The MRI from 2009, 2012, and 2014 did show multi-level degenerative changes. It was possible the degenerative findings could have caused a disc herniation and nerve impingement. It is also possible the degenerative changes could cause complaints and symptoms. (p19)

She noted the patient was concerned about the side effects and risks involved in surgery. His quality of life was managed with pretty potent pain medications and other medications. The condition has not resolved but the medications are helping. (p20) The treatment helping relies on the clinical presentation of the patient and physical examination. (p21)

On her physical examination, she is examining the lumbar spine. She continues pushing motion forward past where the patient reports pain. She is just not relying on the patient's response in regards to range of motion testing. (p22)

The doctor testified the initial exam report from Concentra records showed no complaints of radicular symptoms. This would not cause her to change her opinion. (p22-23) In an acute lumbar radicular injury, few patients will just present with back pain. The radicular symptoms can develop as it progresses. About 30 to 40 percent of patients will present with just back pain. (p23)

She testified degeneration can be progressive. It can get worse over time. (p23) The majority of patients will worsen over time. (p24)

Lastly, she testified in regards to the 2014 MRI. She did rely on the radiologist report. (p26)

An attached exhibit to the deposition included the doctor's office notes. These showed that she treated Mr. McCowin's back and knees. The electrodiagnostic study from June 12, 2009 showed peripheral neuropathy and a suspicion of left lumbosacral radiculopathy.

The notes also show her treatment included prescription medications, physical therapy, and home exercise. The medications included Klonopin, Percocet, Vicodin, and Neurontin. Over the course of treatment, the medications did change and in December 2015, he was prescribed Gabapentin. She also recommended he lose weight. For the most part, he was on a home exercise program. The MRI of the lumbar spine from August 11, 2014, showed multi-level annular disc bulging, endplate spondylosis, facet arthropathy, and a disc herniation superimposed on prominent epidural fat contributing to multi-level thecal sac and neural foraminal stenosis.

Exhibit 2 – This is the deposition of neurologist Steven E. Newman, M.D. taken on June 27, 2017. He initially saw Mr. McCowin on July 7, 2009. There had been 8 visits with the last being on May 16, 2017. He had seen him 4 times in 2011, 2 times in 2016, and the last visit in 2017. (p7-9)

His complaints were pain in the low back and lower extremities. He had pain in the low back, numbness, and pins/needles sensation to the left foot. (p10) The doctor's diagnosis was low back pain, pain going into the legs, and complaints of numbness left greater than right in the foot. He did review the MRI CD from February 23, 2009. He found disc displacement at the left L4 displacing the left L4 nerve root and right nerve root. There was disc herniation/protrusion at the left L2-3 and L4-5 greater than the L5-S1. (p11-12)

The doctor opined his problems were consistent with a compressed L5/S1 nerve root to the left. The doctor was not clear in regards to the right lower extremity. The doctor noted there were periodic problems with the right foot. (p12) The doctor placed various restrictions on Mr. McCowin of no sitting greater than 30 minutes, no standing greater than 20 minutes and no walking greater than a half block. He could not do repetitive lifting greater than 20 pounds. He limited reaching, stretching, pushing/pulling, twisting/turning, climbing ladders/stairs, squatting, kneeling, crawling and bending on a repetitive basis. (p13-14) The doctor felt these restrictions were related to the January 2009 work injury. The doctor felt he could drive 2 hours at a time.

When the doctor saw plaintiff in 2011, he had undergone left knee surgery performed by Dr. Gilyard. He did have complaints of pain in the shoulder girdle. These were the only changes in information from the initial 2009 visit. (p15)

The doctor noted no significant change in the back. There was also no significant change or difference in his symptoms. He did not change the restrictions in 2011. (p15-16)

He saw Mr. McCowin in 2016. There was again no change in his low back symptoms. Plaintiff reported difficulty with sitting/standing. He had numbness in the left foot. He reported an increase in symptoms when sitting. There was no significant change in the physical examination of April 2016. (p16)

Plaintiff did undergo surgery performed by Dr. Gilyard on the right knee in the spring of 2014. He had also had the hardware removed from the left knee. There were no other

injuries in the interim from 2011 through 2016. The doctor was not aware of any vocational or vocational activities contributing to Mr. McCowin's symptoms/pathology. (p17)

The November 2016 physical examination had some variations over the prior. The doctor's findings were some better some worse in regards to range of motion but overall the low back was very similar. The doctor noted there was a reported history that approximately a week prior to the November 2016 exam, he had bent over throwing out his back. He reported increased stiffness. (p18)

The doctor felt that he did not appear to have improved. The underlying problem persisted. (p19) Again, the doctor last saw plaintiff in May 2017. The physical examination showed he was able to bend a little further because he was not in any acute stage as he was in November 2016. The symptoms stayed the same. (p19)

The May 2017 physical examination was consistent with left-sided problems. The MRI showed impingement of the left nerve roots, facet arthropathy, central canal stenosis at the L5-S1 and impingement of the right L5 nerve root. However, it was still predominantly on the left. (p20-21) The doctor felt the MRI was consistent with his symptoms. However, the doctor did testify the MRI findings may have exceeded his symptoms that he was experiencing because it was primarily to the left, not bilateral. (p21) Plaintiff symptoms were dependent on his activity level. The doctor felt he should avoid repetitive activities. He also felt he should avoid strenuous activities involving weight. (p22)

The doctor noted his overall range of motion was less inhibited due to pain on the May 2017 visit compared to the November 2016 exam. (p23)

The doctor's physical capacity assessment (PCA) on May 16, 2017 showed limited walking, standing, sitting, repetitive or strenuous lifting, pushing/pulling, bending, climbing, kneeling, squatting, and crawling. The doctor felt these restrictions were secondary to the underlying pathology on physical exam and MRI. (p24) Plaintiff could not return to work as elevator repair man. The doctor felt he had a work-related disability. (p25-26)

The doctor left Mr. McCowin's treatment to Dr. Obayan. She was doing pain control with medications. The doctor noted injections and physical therapy were done in the past. Physical therapy was not particularly helpful. (p26)

The doctor felt that with the absence of further improvement with medications or physical therapy, the patient could consider injections or surgery. This was based on the persisting residual problems found on the MRI. (p27)

Lastly, on direct examination, the doctor felt plaintiff did need ongoing restrictions as outlined in his May 2017 PCA.

The doctor testified Mr. McCowin did return to him for treatment. The doctor was uncertain if this was on the referral of the treating physician or an IME. (p28) The doctor again first saw plaintiff about 6 months after his date of injury in 2009. (p29)

Dr. Newman had the CD of the MRI from February 23, 2009. The MRI showed multi-level desiccation. The doctor felt plaintiff was relatively young for this finding. The doctor also felt it was hard to relate this finding to the incident because of the short period of time between that incident and the MRI, 6 to 7 weeks. (p29) It was likely not related to the incident however, the finding would have made plaintiff more prone to a back injury. The doctor opined symptoms and further care would be indicative of a pathological change, aggravation. (p30-31)

The desiccation does progress over time. The doctor noted in the absence of additional arthritic like changes within the joint, this was suggestive of a more recent or less severe condition. (p31)

Desiccation is the drying out of the disc. There is a degree of narrowing in the disc space. This may indicate duration. The doctor felt it was recent because there was still a significant amount of water in the discs. The doctor noted with old desiccation there maybe calcification which was not in Mr. McCowin's case. (p32) There was a reduced signal in the MRI which indicated desiccation in the L2-3, L4-5, and L5-S1. (p32)

The protrusion/herniation, the doctor opined that the activity plaintiff was involved in was a significant contributing factor to that finding if not the causative factor. There was no previous MRI and he felt this finding was related to the heavy physical activity. (p33) There was the possibility the herniation/protrusion was prior to the injury in January 2009. (p33)

The note from the April 18, 2016 visit indicated plaintiff's attorney suggested returning to see the doctor at that time. The doctor did not know if the attorney recommended the visit. Again, he continued to treat with Dr. Obayan. The doctor felt he was sent back to him because he was experiencing more problems. (p34)

The doctor felt the changes on the MRI from February 2009 would increase over time and could use the term degenerative/progressive. The degenerative changes can result in developing a herniation/protrusion. (p35-36)

The doctor felt for a nerve root problem (EMG) you need both nerve and paraspinal. A pinched nerve needs a finding in the paraspinals and extremity muscles involved in that nerve root. (p37)

The doctor did review a report dated November 29, 2016 from CMI. This did demonstrate progression of the degenerative changes. (p38-39)

Lastly, on cross-examination, the doctor testified the supine straight-leg raising was better than the seated position. This is objective but dependent on a person's response of radicular pain along a distribution of a specific nerve. (p40)

On redirect examination, the doctor testified you have to have clinical exam corroboration of the MRI. You have to relate the findings back to the patient. (p43) Dr. Newman felt Mr. McCowin's symptoms were consistent with the MRI's. The findings on those studies do tend to progress over time even if the patient is not engaged in any vocational activities. (p44)

Exhibit 3 – Dr. Newman's deposition testimony was taken on September 9, 2022. He had records since 2019. The last date in those records was July 18, 2022. (p8) The doctor had 16 visits with Mr. McCowin since May 16, 2017. (p9)

There was not much change in the lower back complaints. He had pain with activity, stretching exercises resulted in increased pressure. He reported aching sensation of left greater than right. He had radicular complaint in the toes of the left foot. He was numb with low back pain. He reported problems with the lower back muscles. He was taking muscle relaxants. Dr. Obayan was prescribing medications including pain. (p10)

There had been a gradual progression since June 2017. The doctor felt this permanent and worse as reflected in his exam. (p10) He had persistent complaints requiring additional studies, MRI and EMG. (p11)

The MRI from November 2016 showed moderate stenosis, protrusions left L4, right L5 and left greater than right S1 nerve root impingement/displacement. (p11) There were additional MRI/EMG's with Dr. Diaz, February 18, 2021. The first EMG, June 2009, suggested left-sided lumbar and lumbosacral radicular complaints. He did undergo an EMG done in February 2021 by Dr. Tong suggesting a chronic left L5 radiculopathy. The doctor felt the imaging, electrodiagnostic studies and clinical demonstrated gradual progressive changes. (p11)

The doctor did not request electrodiagnostic studies. Dr. Tong's report did have the raw data. Dr. Newman relied on that report. (p13) The study did show chronic left L5 radiculopathy. The doctor opined this is the type of findings with chronic/long-term irritation of the nerves, L5 muscles. (p14) The nerve conduction study did suggest peripheral neuropathy. The doctor noted that with peripheral neuropathy you should not have problems with the buttock or the buttock muscles. The findings in the anterior/posterior division of the nerve root would occur in radiculopathy not peripheral neuropathy. (p 14-15)

The imaging and electrodiagnostic studies were consistent with left greater than right S1 nerve problems and left L4 descending nerve roots. The doctor felt he needed the Diaz MRI to draw any further confirmation. (p15)

Dr. Newman felt the EMG/nerve conduction study was consistent with the ongoing back complaints. The back complaints worsened with Mr. McCowin's level of activity. He also noted that the persistent numbness was suggestive of more sensory than motor fibers. (p15-16)

The physical examination from July 2022, showed painful and limited mobility. The doctor noted stiffness while attempting to change positions. Mr. McCowin had an inability to stand fully upright which was, in the doctor's opinion, consistent with nerve root impingement. (p16) Plaintiff did have worsening complaints with hyper-extension. (p17)

The clinical evaluation varied over time but did show gradual progression over the 10 to 12 years. The doctor felt this showed persistence, perseverance and progression. (p17) The doctor felt the progression was the nature of the injury. The discs protrude and begin to dry out as a result of damage. This resulted in further compression of the exiting or descending nerve roots. (p17-18) The doctor's diagnosis did not change. Mr. McCowin had sequela of the January 8, 2009 injury and the disc displacement was permanent. He had progression with the spinal stenosis reflected by his studies. (p18)

The doctor felt plaintiff should follow-up with continued treatment with Dr. Obayan. The doctor noted that the problems were permanent and could be treated with muscle relaxants, pain medications, and activity restrictions. He did not feel surgery, after 2 years, would improve plaintiff's condition. (p19)

The doctor opined Mr. McCowin had recovered to the extent he is going to from his 2009 injury. The underlying problems were permanent and progressive. (p19-20)

Based on his FCA, the doctor noted restrictions of sit/stand/walk one-third of an 8 hour workday. This was needed because of the disc narrowing due to the loss of water and protruding which were abutting/pressure on the nerve roots at the left L3, L4, L5 and L5-S1. He could lift no greater than 10 pounds 10 percent of the time. (p 20) The doctor felt he could reach one-third of the time, this was dependent on the weight and the extent of the reaching. That would be whether it was at shoulder or overhead. Overhead reaching did put increased pressure on the facet joints. He could push/pull 10 percent of the day. This would depend on weight and the incline. Downhill weight was not as important as uphill or on an even surface. Also, it would be dependent on whether there was resistance in the push/pulling. (p21-22)

The handling noted in his FCA was not related to the back. He did have other issues in regards to his fingers. He would leave that to Dr. Obayan. The restriction on climbing was related to the back. This had the same issues as involved in the push/pull/lifting. Lastly, he felt he was restricted in regards to stairs, ramps, ladders, squatting and crawling. This had the same reasoning as in regards to bending. (p 22-23)

The doctor felt Mr. McCowin was disabled because of the clinical examinations, as well as the imaging studies. The doctor testified he was disabled from any job because of the sit/stand. He felt the duration of that activity without constant ability to change positions

was the major factor. The restrictions were permanent because the pathology was permanent and progressive. (p23-24)

In the doctor's practice, not all patients with similar findings as Mr. McCowin are totally disabled. (p 24) The doctor was not restricting plaintiff from activities of daily living except to the extent they resulted in a symptom change. The doctor decreased his activities due to his low back pain. He was to avoid/limit activities of daily living that resulted in pain. (p24) Mr. McCowin was not restricted in his driving and was not bedridden. (p25)

He had no symptoms or complaints in the upper extremities except decreased sensation. There was no reason to restrict his use of the upper extremities. The doctor's evaluation was limited to the low back and lower extremities. (p25)

The doctor felt that over the years that he saw Mr. McCowin his physical exam was consistent. Limitations/findings have progressed. (p26) He continued to get medications from Dr. Obayan. She was directing his treatment in regard to his medications. (p26)

The doctor's restrictions were based on physical examination, diagnostic studies, and plaintiff's subjective complaints. He did take into consideration the complaints related to the diagnosis and the additional medical records. (p27) The doctor performs his PCA reflective of reviewing all details. He notes the patient's difficulties, 24 hours per day, seven days per week, 365 days in addition to the diagnostic studies. (p27)

The doctor felt treatment should include encouraging an individual to be as active as possible without causing any further physical injury. Being active is good mentally in addition to physically. (p28)

The physical examination straight-leg raising was not technically positive. There was no report of pain going into the leg below the knee. Muscle reflexes were symmetric and normal. His reflexes were intact to pinprick and touch. (p29) The physical examination is an essential part of the neurological evaluation. The doctor noted history was also essential. Plaintiff has shown variability over time. (p30)

Dr. Tong's studies did show chronic radiculopathy. This referred to it being long-term, at least 3 months, if not longer. The doctor could not say how long. The polyphasic activity may be 3 to 6 months but any longer Dr. Tong could not say on the basis of that exam alone. (p31) The study can show active radiculopathy. Dr. Tong could not say active. He referred to chronic, ongoing/long period of time. (p31) The EMG can show peripheral neuropathy. (p31)

There could be progression without working and restricting activities since 2009. (p32) Degenerative changes can progress without/regardless of activities, if the damage has occurred. (p33) The damage to the disc does not get better. The pressure on the nerve root might improve. Damage discs shrink due to drying out of the gelatinous material. Pressure on the nerve maybe alleviated. (p33)

Symptoms and findings that are acute can improve and get better over time. (p34) The doctor felt he could work within the restrictions relative to sit/stand/walk, duration of time, part-time basis, intermittently based upon the variability and changes that occur with the nerve root irritation. (p34) Dr. Obayan is his primary treating physician. Dr. Newman did not recall if plaintiff was referred by attorney Charters. He has seen Mr. McCowin every 3 to 4 months, sometimes 6 months. There have been various gaps. (p35)

Over the time the doctor has seen the patient there has been no major neurological issues. (p36) He did not have a problem with Dr. Obayan's treatment except that Mr. McCowin is still getting opioids. (p36)

The underlying pathology has progressed. (p37) Plaintiff is a large man and this does place stress and strain on the weight-bearing lumbar spine. This could be a factor in the progression. (p37)

Exhibit 4/Defendant Exhibit C - This is the deposition testimony of James Fuller, MA, CRC taken on April 17, 2017. Mr. Fuller has been a vocational rehabilitation counselor for 38 years. (p4)

Plaintiff had a phone interview with Mr. Fuller on May 30, 2017, because the joint meeting with Barbara Feldman set by attorney Charters did not materialize. He also met with Mr. McCowin on February 24, 2017, at plaintiff attorney's office. (p5) Mr. Fuller was Mr. McCowin's vocational counselor in 2012. That case was closed that year because plaintiff was having a medical procedure. (p5)

Mr. Fuller attached the O*Net documents to his reports. This is a federal government publication which describes work. He used electrical and electronic equipment assembler. The job postings from March (2017) were also attached to his report. (p6)

Educationally, Mr. McCowin was a high school graduate. He went through an electronics program and received certification in electrical readiness. This resulted in him being hired as an elevator mechanic. He was a mechanic prior to his injury. (p7)

His prior vocational activities were that of a barber. He did complete training as a barber and worked at Hair Salons. He was never licensed. (p7)

The transferable skills analysis (TSA) was looking at not only jobs available and the type of work performed but other types of employment. There are some different types of electrician jobs and electronic type jobs. (p7-8)

Mr. Fuller looked at the medical restrictions. Those ranged from released without restrictions to Dr. Newman's restrictions. He looked at the jobs within the doctors' restrictions. Those restrictions were no lifting greater than 25 pounds but did not take into consideration Newman's "rarely" sit/stand without breaks. He needed clarification as to what the doctor meant by "a break" that is rare and would eliminate all work. Therefore,

he used the 25 lb. lifting restriction, occasional standing, climbing stairs, squatting, crawling, kneeling, bending, stooping, or walking. (p8-9) He did find technician jobs available. He found jobs such as a panel wire electrician. (p9) The wages would be from $15 to $30 an hour. (p9) The labor market survey (LMS) was done on March 5, 2017. Mr. Fuller noted that the jobs were available or assumed to be available. (p9) Mr. McCowin told Mr. Fuller that he was looking for jobs in 2016. He was using Michigan Works. He did have a job log. (p9)

In February 2017, he continued to be looking for work. He did not provide Mr. Fuller with his job logs. (p9-10) Mr. Fuller did receive the logs on the day of his deposition. He was not sure if he was looking for work in the last six months.

Mr. McCowin did have a resume at one point in time. Mr. Fuller did not know how current that resume was. (p11)

Lastly, based on Dr. Kneiser's opinion, Mr. McCowin could return to work at his prior employment. (p11)

On cross examination, Mr. Fuller, when he first met with Mr. McCowin, was his vocational counselor actively helping him find gainful employment. (p12)

His most recent report had restrictions from Drs. Kneiser and Newman. He did not have any restrictions from Dr. Obayan. (p13) His understanding was that Dr. Obayan had kept Mr. McCowin completely off work. (p13) At one point, Dr. Kneiser had a 25 lbs. weight restriction but later felt that he did not need any further treatment and could return to work at his former job. (p13)

Mr. Fuller could not answer a question regarding Mr. McCowin's eye condition. He was not a doctor/physician and did not have restrictions for that condition. (p14) Mr. Fuller felt that if he had blurred vision, he could not be an electrician or electrical technician. He did not receive restrictions regarding the knees and again he closed the original case because of the knee surgery in 2012. (p15)

Prior to the injury, plaintiff reported making around $32.00 per hour. The electrical assembly job/surgical instrument technician position paid $15 per hour. (p15-16)

He did not contact the employer regarding availability. In his LMS he did not contact the employers to see if the jobs were within Dr. Newman's restrictions. (p16)

Prior to the injury, plaintiff worked 40 plus hours per week. He did not specify exact numbers. (p16) He assumed the jobs were based on a 40-hour work week. The electronics engineering technician had a median wage of $29.39 per hour. He did not contact the employers regarding hours. (p17)

Mr. Fuller testified that "off task" was not attending to do work tasks or details. Acceptability depended on the type of employment/work. Unskilled work was about 10%

for nonphysical type work. Construction laborer, unskilled, can't work 54 minutes without breaks. (p17-18) Based on Dr. Newman, if he sits/stands without breaks less than 10% of the time, this would have eliminated all work. Mr. Fuller did not know what the doctor meant by "rarely". (p18)

Electronics technician or electronic equipment assembler, benchwork could be done sitting or standing but could not walk around. Wages for these positions were generalized and based on Bureau of Labor and Statistics/O*Net online summary. Electronic equipment assembler had a median wage of $14.84 an hour or $30,860,00 annually in 2015. A panel wire electrician would have wages of $15 to $20 per hour. He did not know if this would be within Dr. Newman's restrictions. This would not have accommodated Dr. Obayan's restrictions. (p19) The panel electrician position required an associate's degree or equivalent. Mr. Fuller felt that the nine years with Otis and his training with Career Works would be suffice but that would be up to the employer. (p20)

The machine tooling electrician paid $18 to $22 per hour. Again, he did not know if this was within Dr. Newman's restrictions. It did require Mr. McCowin to have his own tools. He was not sure if plaintiff had tools. (p20)

The lead production electrician paid $22 to $28 per hour. He was not sure as to what they would have paid Mr. McCowin. Again, he was not sure if this accommodated Dr. Newman's recommendations. (p20-22)

The ball screw assembler did not list wages. He did not know if this would have accommodated Dr. Newman's restrictions. With the surgical instrument technician position found, he did not know if it would accommodate Dr. Newman's restrictions.

He did not find jobs that paid a minimum of $32.00 an hour. However, he found jobs that paid between $28 and $29 per hour. (p21)

The consumer electronics device driver builder paid $60,000.00 per year. He was uncertain as to the requirements of the job and did not know if it accommodated Mr. McCowin's restrictions. (p21-22)

Mr. Fuller did not have evidence, one way or the other, whether Mr. McCowin was actually looking for a position. Again, if he was to be off task for 10 or 20% of the time, he was unemployable. (p22-23)

On re-direct examination, Mr. McCowin's logs showed "not hiring". Mr. Fuller felt that there was not a very good likelihood of being hired if they were not hiring. (p23) An effective job search uses the internet, going to Michigan Works website, fairly regularly, using Craigslist, Monster and Career Builder. Also, sending resumes to as many potential employers as possible and contacting employers who recently had positions. Plaintiff was using the internet and Michigan Works only. (p24)

Exhibit 5 - This is the deposition testimony of Mr. Fuller taken on October 7, 2022. He had reports dated April 30, 2012, May 30, 2016, February 24, 2017, and August 23, 2022. (p16) The report from August 23, 2022 (p43-47) noted that he has not worked in 13 years. He saw Dr. Newman on July 18, 2022. His restrictions were stand/walk/sit occasionally, half time; reach, bend occasionally; handle occasionally; rarely lift up to 10 pounds and never 25 pounds and rarely push/pull. Mr. Fontaine attended that meeting.

Educationally, he was again a high school graduate. He attended the Virginia Farrell School. He never passed his state licensing to become a cosmetologist. He attended Career Works through a Chrysler program. This training was for the "elevator union" in 2000. He did become a journeyman-elevator installer/repairer. His work history showed that he worked for Otis Elevator. He constructed, installed, upgraded, and remodeled elevators. He was also a construction laborer and a non-licensed hair stylist. He had done retail stock work.

Mr. Fuller felt he was unemployable. This was based on plaintiff's description, a very clean description by Dr. Newman and 13 years out of the work force. His rate of pay at the time of his injury was $32.70 per hour. Mr. Fuller noted that if he could do sedentary work lifting 10 pounds. rarely, sit/stand/walk one-third of the day, he may earn the minimum wage of $9.87 per hour.

He was a high school graduate, he attended beauty school but no license and attended Career Works. He secured employment at Otis Elevator in 2000. (p47) He studied electronics at Career Works/Chrysler. (p48) Mr. Fuller testified that his work at Otis was skilled. (SVP 7) with medium exertion. His work as a cosmetologist/hair stylist was skilled (SVP 6) and light. The construction laborer position was unskilled (SVP 2) and very heavy. (p48)

He testified that the specific vocational preparation (SVP) was on a scale from 1-9. 1-2 was unskilled, 3-4 was semiskilled, and 5-9 was skilled labor. Physical demand went from sedentary to very heavy. Sedentary was defined as sitting 6 out of 8 hours per day and lifting less than 10 pounds. Light was stand/walk 6 to 8 hours per day with lifting up to 25 pounds. Medium was standing at least 6 hours and lifting up to 50 pounds. Heavy was lifting over 100 pounds and very heavy was greater than 100 pounds. (p49)

Current earnings, based on the Bureau Labor Statistics, for an elevator repairman was $97,860.00 annually. Construction laborer is $28.00 per hour, union and cosmetologist is $40,000.00 per year. (p49-50)

Cosmetologist, if found to be light work, would require more than occasional standing. You also need a license to legally do that work. (p50) Mr. McCowin does not have that license. (p50) There would be no jobs close to what he earned as an elevator repairer/installer with his transferable skills. (p51)

Based on Dr. Newman's restrictions from July 18, 2022, he could not do his past work. Those jobs would require more than occasional sit/stand/walking. Past work required

standing greater than 1/3 of the day. He would not be able to do work with a maximum wage-earning capacity. (p51-52) Mr. Fuller felt that it was difficult/hard to find jobs allowing a sit/stand/walk requirement. This would preclude bench work. He could potentially do work as a greeter, a desk attendant. This would pay minimum wage. (p52) Based on Dr. Gross' restrictions of no lifting greater than 25 pounds and no repetitive bending or twisting, he could not do his past work. The hair stylist position required bending and twisting. The other jobs required lifting greater than 25 pounds. He could not do a job within his maximum wage-earning capacity. (p53)

Those restrictions would allow light work including cashier, gate house attendant, etc. this work would be unskilled at the minimum wage, $9.87 per hour. (p53)

Dr. Kneiser's restrictions of 25 pounds frequently and 35 pounds occasionally, he could do the cosmetology job but not legally. He could not earn his maximum wages. He would have the full range of light jobs. The pay would be minimum wage. (p53-54)

In regard to his symptoms, Mr. Fuller noted that if he was required to miss work more than one day per month or off task more than 10% of the time, he would be precluded from all work, skilled or unskilled. (p 54)

On cross examination, Mr. Fuller did not consider Drs. Gross or Kneiser's restrictions in his August 23, 2022, report. He did mention Dr. Kneiser. He did not do a labor market survey in August 2022. (p 55) The basis of his conclusions was Dr. Newman's statement that plaintiff was disabled from present job, any job and was permanently disabled and not a candidate for rehabilitation. Mr. Fuller noted that if this was true and described by the treating doctor, there would be no jobs available. (p56)

There was potential wage-earning capacity if he could engage in activities/work within his restrictions. The minimum wage was not necessarily what the market would pay. The current labor market and often times employers will pay greater than minimum wage. They may also give more accommodations than in the past. (p56)

The LMS may have shown jobs, unskilled and light paying greater than minimum wage. Jobs are paying from $9.87 per hour up to $12 or $13 per hour. He has seen fast food restaurants paying $15 per hour. (p57)

He again, did not do an LMS. (p57)

His previous testimony in April 2017 was consistent with his reports, May 30, 2016, and February 24, 2017. (p58) He previously found bench type jobs based on Dr. Newman's restrictions. In May of 2016, he found an electronic equipment assembly position which had a median wage of $29.39 in 2016. (p59) His May 2016 conclusion with previous skills and training, plaintiff could perform electronics assembly type employment, $15 an hour. If capable of the full range of light, he could earn a median of $29 an hour as an electronics technician. This was based on Newman's restrictions. (p60)

He testified that jobs would pay somewhat more six years later. He did do a LMS on the day of the deposition and found electronics repair would pay $18 to $25 an hour for assembler and repair type jobs. This was less than 2016. (p61) In 2016, plaintiff had a wage-earning capacity up to $29.39 per hour.

For an effective job search, one should apply to places where there are openings. Searching multiples times with the same employer on the same day would serve no purpose. Mr. Fuller testified that the same position/same day would not change. (p62) The February 2017 report indicated Mr. McCowin could perform electronic technician type jobs and the earnings would have been comparable to his job on the date of injury. He could earn the same range in electrical/electronic employment. The median was $29.39 per hour. (p62) Mr. Fuller was unsure if you can count his skills as still available. His training was 22 to 23 years prior, and he had been off work for 13 years. He may need further training or updating of his electronics skills. There have been significant changes in the last 23 years. It would be best to do an updated electronics technician course. (p63-64)

There have been somewhat dramatic changes in the hi-tech industries. He would require at least some update of his skills. (p64) However, he did not know if plaintiff had the skill set or not. (p65)

He testified that based on Dr. Jacob's and Dr. Kneiser's opinions in his May 30, 2016 report, plaintiff would have no wage loss. Mr. McCowin was released in 2015 to return to work at his former job. In 2022, based on Dr. Kneiser, plaintiff would have no loss of wage-earning capacity. He was again released without restrictions. (p65-66)

Mr. Fuller testified that the reports from 2016 and 2017 and his opinions were based on the information provided at that time. The opinions were based on restrictions that were not necessarily agreed upon by the doctors. (p67-68) Dr. Kneiser's restrictions in 2016 were different than now. At that time, she did give restrictions. (p68)

The opinion in 2017 was based on Dr. Kneiser not Dr. Newman. (p 69) He believes that Dr. Newman's restrictions changed. They were not the same in regards to lifting. They were now, rarely 10 pounds. and no lifting up to 25 pounds. He did not recall occasional walking/standing/sitting. He felt they were more restrictive. (p69)

On re-cross-examination, Mr. Fuller testified that fringes are not dependent on the position being skilled or unskilled. Unskilled work can provide fringes. (p70-71) He did not know why Dr. Newman and Dr. Kneiser changed their restrictions. (p71)

Exhibit 6- These are the records from Michigan Head and Spine Institute/Fernando Diaz, M.D. Dr. Diaz saw Mr. McCowin on February 15, 2021.

Historically, plaintiff told the doctor that on June 5, 2010, he twisted his back at work moving heavy equipment. He sustained low back pain. He has had back pain since the

injury. He has had bilateral osteotomies completed by Dr. Gilyard to try to help the back pain.

His complaints when he saw the doctor were lower lumbosacral area pain with no radiation. He had numbness in the lateral left three toes. He had no bladder or bowel incontinence. His medications were Norco, Gabapentin and Cyclobenzaprine

Physical examination showed decreased sensation in the left S1 nerve root. The doctor observed that he inverted his left foot when walking. Deep tendon reflexes were symmetric. Strength was symmetric. His gait and stance were normal. He could heel/toe walk. He had decreased range of motion in the lumbar spine.

He recommended therapy to be supervised by Dr. Obayan, updated lumbosacral films, electric diagnostics studies of the lower extremities and an MRI.

The doctor reviewed the MRI from April 5, 2012. He noted herniations at the L3-4, L4-5, and L5-S1 with the greatest being in the L5-S1. Dr. Diaz' assessment was lumbar disc herniation, facet hypertrophy, foraminal stenosis and obesity.

Dr. Diaz saw plaintiff in follow-up on February 24, 2021. The physical exam showed significant obesity. He was ambulatory and in no acute distress. His tandem heel/toe walk was limited by back pain. Movement in the upper and lower extremities was symmetric. He had some decrease range of motion in the lumbar spine.

The MRI done on February 18, 2021, showed significant degenerative disc disease from the L1 through the S1 with facet and ligamentous hypertrophy. He had a relatively narrow spinal cord with short pedicles. The doctor noted the disc herniations at the L3-4, L4-5 and L5-S1. They were small to moderate with some narrowing of the spinal cord but no definite encroachment on the nerve roots.

An EMG study from February 18, 2021, showed chronic left L5 radiculopathy. The doctor felt for a long-term benefit, he should continue physical therapy and lose a minimum of 50 pounds. He then could consider possible surgery. The doctor noted he may require surgery in the future due to radiculopathy on the electrodiagnostic studies. He was returned to Dr. Obayan for further treatment.

X-rays of the lumbar spine were taken on February 15, 2021. They showed spondylosis with no acute fracture or instability.

On February 18, 2021, he underwent electrodiagnostic studies done by Henry Tong, M.D. The study was abnormal with chronic left L5 radiculopathy but no right sided findings. He did not have any peripheral neuropathy. Dr. Tong could not rule out right lumbar sensory radiculopathy.

Exhibit 7 - These are medical records from Pain and Rehabilitation Associates/Dr. Obayan. These records were contained on a flash drive. There is approximately 542 pages of those records.

Those records are mainly from Dr. Obayan. There are also physical therapy records from her facility. These records are from December 2017, February 2018, and March 2018. At that time, plaintiff was being treated for low back pain, sciatica and lumbosacral radiculopathy. There are also additional physical therapy records from February 2021 through May 2021. These records are from physical therapist Matthew Groth. The working diagnosis was other intervertebral disc displacement lumbar, low back pain, left sciatica and post laminectomy syndrome.

I am going to summarize/highlight records not already reviewed or testified to. Those records have some significance. The records from Dr. Obayan go from October 26, 2012 through January 25, 2021. There are additional telemedicine visits with the doctor in March 2021, April 2021, and May 2021. Further there are records from Dr. Diaz and Dr. Newman from 2021.

On October 26, 2012, the doctor diagnosed a herniated disc, lumbar and sciatica. She prescribed home exercise and medications. Those medications were Klonopin and Percocet. Her physical examination showed a negative straight leg raising test. There was no limitation of range of motion. Plaintiff was nontender. Lumbar facet loading was negative. His motor exam was normal. Sensation was decreased in the entire left thigh. Reflexes were normal. His Waddell's signs were negative.

An exam on February 1, 2013, showed restrictive range of motion due to pain on extension and flexion of the spine. He had decreased sensory in the lower left extremity.

An Exam on March 12, 2013, again showed restricted range of motion due to pain. He had a positive left straight leg raising test. His sensation was decreased in the left thigh to pin prick. He was not performing stretches or his home exercise program on a consistent basis. The doctor returned him to work with no activity through April 12, 2013. There were numerous disability slips with no activity in 2013.

He was seen on September 13, 2013, for osteoarthritis in the right knee.

He was seen on November 8, 2013. He reported he was doing his home exercises on a sporadic basis. He did complain of intermittent numbness in the left leg.

In a visit on December 6, 2013, he complained of pain localized to the spine. He had underwent knee surgery, a distal femoral osteotomy performed by Dr. Gilyard. His physical examination showed a negative straight leg raising test. He was tender and had tightness in the paravertebral muscles on the left.

In early 2014, his visits with the doctor were mainly for his knee. He also saw the doctor sporadically throughout 2014 for his knee.

On July 1, 2014, his back pain had increased in the last couple of days. He had got up from a chair and heard a noise in his back. Physical exam showed weakness in the left leg on motor strength. Straight leg raising test was negative. He did have decreased range of motion on flexion and extension due to pain. The complaints at that time were localized to the back. He had no radiating symptoms into the legs. He did report constant numbness in the left leg. He was restricted to no activity.

There was a return-to-work slip on July 29, 2014. He was returning to no activity through August 26, 2014. The diagnosis was facet joint arthropathy.

An MRI was completed at CMI on August 11, 2014. The reason for the study was pain and to assess the facet joint arthropathy. The radiologist noted multilevel annular disc bulging, end plate spondylolysis, facet arthropathy and disc herniation superimposed upon prominent epidural fat and contributing to multilevel thecal sac and neural foraminal stenosis.

The doctor saw Mr. McGowan on August 18, 2014. He had no current radiation into the legs. She felt the MRI did show significant disc pathology. She was considering an injection. He was placed on no activities through September 18, 2014.

On January 5, 2015, he reported more back pain. The pain was mainly in the back area. He did report paresthesias and numbness in the toes. Physical exam showed a bilateral positive straight leg raising test in a seated position. The doctor's diagnosis was herniated disc and sciatica. He was on no activity through February 5, 2015.

On February 10, 2015, plaintiff reported a decrease in pain with Norco. He was exercising more consistently, three times per week. His pain/complaints were unchanged. They were in the back, and he had paresthesias and numbness in the toes.

He had increased spontaneous pain on the left side on a visit, March 10, 2015. He had no pain extending down the legs. His physical examination showed a negative straight leg raising test. He was prescribed Cyclobenzaprine.

He was showing improvement with his early course of rehabilitation on March 24, 2015. The doctor recommended that he continue physical therapy. He did have a decrease in his pain. He reported his quality of life had improved but his sleep was poor.

The records from 2015 also show that he had some treatment in regards to the knee(s). He was seen on June 16, 2015. He reported a spontaneous increase in sharp, achy back pain. He reported no new injury. The pain was in the left paralumbar area. He had no radiation in the leg but had numbness in the left foot. He was taken off on no activity until July 16, 2015.

A visit on October 19, 2015, showed that he had gained weight. He was up to 308 pounds. He had joined a local gym to improve his back pain and help him become more fit. He

reported no new symptoms. The diagnosis was other intervertebral disc disorder and displacement. On December 28, 2015, he had an episode of increased back pain with radiation into the left leg. This lasted approximately four to five days. Physical examination showed positive lumbar facet loading, bilaterally. He was placed on no activity through January 26, 2016.

On January 26, 2016, he reported that he improved. The location of the pain stayed the same. It was mainly back pain with radiation down the buttock. He reported no numbness or paresthesias down the leg. He had started regular gym exercises which included aerobics and light lifting. Physical exam showed a positive left facet loading sign. The doctor recommended a healthy diet, continued home exercise program and lose weight.

Plaintiff was seen with moderate back pain on June 27, 2016. This pain worsened with physical exertion. The pain continued to be mainly in the back. He did have intermittent numbness in the thigh. He limited lifting, prolonged walking and prolonged standing due to his condition. He continued to have difficulty sleeping. Dr. Obayan opined that his back condition was permanent. She felt it was highly unlikely he would be able to return to activity requiring physical exertion, rapid sitting, lifting, prolonged walking or prolonged standing. She also felt he would require medications for his back for the rest of his life.

He was seen on August 1, 2016, with more pain. He reported that the pain came on after he attended an event involving prolonged sitting. The pain was left sided. He denied paresthesias into the legs. He did have intermittent numbness in the left leg. It was recommended that he have no activity through September 1, 2016.

On September 1, 2016, he had a decrease in pain. He reported medications as effective. He had complaints in the lower back and neck. He had no new injury except a bumper-to-bumper accident three month prior. He also was doing prolonged sitting at the computer. He denied consistency with his home exercise program.

He did have increased back pain and left buttock pain in November 2016, November 8, 2016. He reported he bent over to tie his shoes. He had no radiation into the legs. His activities were more limited. Physical exam showed that his gait was normal. He was tender in the left posterior superior iliac spine and spinous process, L4, L5 and S1. He did have decreased range of motion. He had positive sitting straight leg raise and facet loading to the left. His reflexes were decreased in the quadriceps, right versus left. He had sensation decreased in the left leg. His motor strength was decreased in the left versus the right. The doctor's diagnosis remained unchanged except for left sciatica. The doctor felt that he was totally disabled from employment.

An MRI was done at CMI on November 29, 2016. The radiologist noted degenerative disc disease and fact arthropathy compromising the spinal cord throughout the lumbar spine. There was paracentral disc protrusions on top of existing bulges at the L3-4 impinging the left L4 nerve root, L4-5 impinging on the right L5 nerve roots and L5-S1 impinging on the left S1 nerve roots. The radiologist also noted asymmetric arthropathy with mild to moderate foraminal stenosis throughout the lumbar spine.

He was seen by the doctor on December 5, 2016, with mainly left lower back pain but occasional right. There was some extension into the left buttocks. He described this as throbbing. There was no numbness or paresthesias in the legs. Symptoms worsened with prolonged standing. He had challenges with lifting and bending. He had sleep issues. He reported depression and anxiety, which the doctor felt was likely related to his pain and limited function. There was no change in his physical examination. The diagnosis with other intervertebral disc disorder/displacement, dysthymic disorder, major depressive disorder, arthropathy, radiculopathy, left sciatica, low back pain and post laminectomy syndrome. The doctor recommended restricted movement since there was significant pain with flexion. He should attend therapy on a regular basis. He was totally disabled.

When he saw the doctor on January 9, 2017, it was noted that he was responding quite well to physical therapy. His functioning and activity levels had improved.

On February 20, 2017, his pain had decreased and was improving. He had increased his activity and exercise at physical therapy. The meds were effective. He reported his sleep as normal. He was using a CPAP machine. His pain was localized to the left lower back. There were no radiating symptoms into the legs. He denied numbness or paresthesias in the lower extremities. Physical examination showed his gait to be normal. There was no tenderness in the entire spine. Straight leg raising and fact loading was negative. Dr. Obayan felt that he was doing quite well. He should continue physical therapy. When he was discharged, he should do a home exercise program.

On May 15, 2017, his pain was unchanged. He reported constant lower back pain. His activity level had increased. He was doing a home exercise program. Physical examination showed abnormal reversal of the lumbopelvic rhythm. Doctor noted that his movements were jerky and nonfluid. He was tender in the spinous process, L4, L5 and S1. He had a positive facet loading test, bilaterally and a negative straight leg raising test. The doctor noted that he had limited back functioning. She felt that his current disability was lifelong. She did encourage him to perform stretching and strengthening exercises on a regular basis. He would need analgesics on a lifetime basis.

His pain increased on June 20, 2017. He reported pain in the lower back, left buttock, left hip and left thigh. His activities had decreased. He was not doing any exercise. He reported his quality of life as worsening. His sleep was poor. He was experiencing more intense left buttock pain. He had spasms in his left buttock/thigh. He had lost weight and felt that this contributed to his increase in back pain. The doctor felt that his pain was more intense and related to his lumbar radiculopathy.

He was seen on July 18, 2017, with a decrease in his pain. The intensity had decreased by 50%. It was located in his lower hack. He had increased his activities and was doing his exercises/home exercise program. His quality of life had improved. He denied any radicular symptoms.

On September 19, 2017, the doctor had prescribed a lumbar sacral back brace. The diagnosis was lumbago, lumbosacral disc degeneration and spondylosis.

His pain had increased in a visit on December 12, 2017. He reported constant lower back and left foot pain. The back pain was achy with numbness in the left foot. He had some neck pain. The doctor noted that he was likely permanently disabled due to his condition. On physical examination, the doctor noted an audible popping with reversal of the lumbopelvic rhythm movement. He had a positive facet loading sign on the left. The doctor recommended he start therapy to improve strength in his left leg and movements of the lumbosacral spine. She also felt that this may reduce his overall pain.

On a visit of March 6, 2018, his pain had decreased. He continued to complain of constant low back pain and numbness in the left foot. He had increased his activities. He was exercising in physical therapy. However, his attendance was spotty. His overall condition was better. His physical examination showed a negative facet loading test. The doctor noted that he had definite improvement. He was to complete therapy and then transfer to a home exercise program. He was to use Norco judiciously since his overall pain was better. She did feel that his total disability from employment was long term.

Physical examination on April 10, 2018, showed a positive facet loading test. The doctor noted that plaintiff had lumbar radiculopathy affecting his left leg. This condition was due to the original work injury. She felt that he was unable to perform activities requiring physical exertion or his condition would get more painful. He was on a fairly strong narcotic analgesic for pain control. This was to be lifelong. She felt his disability was permanent.

On June 14, 2018, his pain was unchanged. He did report some pain in the right knee. He had bilateral knee surgeries. Physical exam showed a left mid-strike antalgic gait. His gait was also slow. She recommended he lose weight, do a home exercise program and use the back brace. She reduced his Norco quantity. She again felt he was disabled from employment activity requiring physical exertion. In her note from August 14, 2018, she described the physical exertion as “significant”.

He was unchanged when he was seen on November 8, 2018. He continued to have complaints in the lower back and bilateral knees. His current toxicology test was positive for Hydrocodone and THC. The doctor noted he did have a medical marijuana card. Physical exam showed a slowed gait. There was a straightening of the lumbar spine, loss of curvature. A straight leg raising test was negative. Facet loading was positive, bilaterally. The doctor’s diagnosis was other intravertebral disc disorder/displacement, arthropathy, post laminectomy syndrome and low back pain. She also noted the dysthymic disorder and major depressive disorder. She strongly encouraged increased daily exercise and stretching. He was to resume physical therapy. He was to use his back brace. She did refill his medications, Norco, Gabapentin and Robaxin. She again felt that he was disabled from employment activities requiring any significant physical exertion.

He did have increased back pain on a visit, July 27, 2020. The pain was constant and localized at the back. He had increased his activity. He was doing his home exercise program three times per week, walking. He was also riding a bike regularly. He reported the medications to be partially effective. His quality of life had improved. His sleep was fair. The doctor noted that he may need a lumbar epidural. He should quit smoking by the next appointment. She wanted him to continue his exercises.

On January 25, 2021, he was seen for constant, aching lower back pain. He denied any radiation. He was getting relief with outpatient rehabilitation. She noted a slowed gait. He did have decreased range of motion due to pain. He was tender in the posterior superior iliac spine, bilaterally. The facet loading test was positive, bilaterally. Straight leg raising was negative. He did have decreased strength, left versus right. Her diagnoses remained unchanged. She recommended continue physical therapy and home exercise program. She prescribed medications. She recommended that he lose weight, stop smoking and have a healthy diet. She did refer him to a neurosurgeon, Dr. Diaz.

The records also contain the EMG/nerve conduction study and MRI done on February 18, 2021. The electrodiagnostic studies were done by Henry Tong, MD. Dr. Tong noted an abnormal study with chronic left L5 radiculopathy. He found no right lumbar motor radiculopathy or peripheral neuropathy. The study could not rule out right lumbar sensory radiculopathy.

The MRI was done at Premier MRI. The study was compared with a 2012 MRI. The study showed worsening from the L1 through the S1. There was worsening of the neural encroachment at the L1-2 with central canal and foraminal stenosis. There was worsening of the foraminal narrowing at the L2-3 and worsening of the central canal and foraminal narrowing at the L3-4. There was further worsening of the central canal and foraminal narrowing at the L4-5 and L5-S1.

Exhibit 8 - This is Mr. McCowin's resume. It is undated. Educationally, it shows he did receive a high school diploma in 1992. He finished at Career Works for electrical journeyman readiness in March 1998. He graduated from the Virginia Farrell Beauty School for hair styling in May 1994. His work history showed that he worked at Otis Elevator from 1999 to current as a mechanic's helper and that he worked at O'Laughton Construction from May 1997 – January 1999 as a laborer.

Exhibit 9 – Job Search Logs for the year 2022.

There are numerous entries. Those indicate various job descriptions including jobs as a receptionist, front desk representative/clerk, cashier, retail associate/customer service, sales, restaurant, barista, stocker, greeter, valet parker/attendant, maintenance technician, security, quality control, assembly, general laborer, warehouse work and production.

Defendant

Exhibit A – Deposition of Mary K. Kneiser, M.D. taken April 24, 2017. Dr. Kneiser is Board-Certified and specializes in physical medicine and rehabilitation. Dr. Kneiser first saw Mr. McCowin on April 4, 2015. There were 2 subsequent visits June 20, 2016, and March 21, 2017. (p 4-5)

The physical examination in April 2014 of the low back showed well preserved range of motion for his body habitus. He did have pain with forward flexion. The rest of the physical examination was benign. He did have full extension. He could tolerate pressure. He did have some focal tenderness from the L4 through the sacrum. He had glove/stocking-like distal loss of sensation which was consistent with peripheral neuropathy. Peripheral neuropathy is the drying out of nerves periphery. This starts with a stocking-like distribution sensory loss pattern. It feels like you are wearing a sock. (p6) Dr. Kneiser opined that the peripheral neuropathy was idiopathic with an unknown reason. The common causes of this condition are diabetes and alcoholism. (p7)

Physical examination did show incisions where plaintiff had knee surgery/osteotomy. Dr. Kneiser found no limited range of motion on her initial exam. Later there was some limitations. (p7) There was a contracture of the right quadricep which was related to the knee. The quadricep is the thigh muscle. Tightness of the quadricep is due to the knee problems. (p8)

She did not review films of the MRI of the low back from 2009 or 2012. The MRI's did report progression in the low back. (p8) The MRI from 2012 shows multi-level degenerative disease and displacements. This was increased from the 2009 based on radiologist report. There was disc desiccation found at the L2-3 and L3-4. There was a protrusion which abutted the descending L5 nerve root, bilaterally and abutted the S1 nerve root. This was more conspicuous on the 2012 evaluation compared to the previous study. (p9)

Age-related degenerative process will increase over time regardless of activities. This is consistent with that kind of process. (p9)

After the first visit/evaluation, Dr. Kneiser restricted plaintiff to no lifting greater than 25 pounds frequently and no lifting greater than 35 pounds occasionally. (p9)

The doctor's impression was lumbar strain. The restrictions were not related to the work injury. They were related to the degenerative disc disease. The doctor did not find any exacerbation or aggravation of that condition. (p9-10)

The plaintiff does have significant ophthalmology condition. This was reported by Mr. McCowin. The doctor noted this is a precursor to macular degeneration. This was not work related. (p10) The doctor did not feel he required any restrictions regarding his knees. The knees were better.

When the doctor saw plaintiff on June 20, 2016, there was nothing significant regarding the back. He was doing home exercises. He reported good and bad days. (p11) His physical examination showed a mild reduction in motion/flexion. There was some tenderness in the back. There was no signs of active radiculopathy. He could tolerate the sitting position. The doctor felt he could not tolerate this posture because it stretches the sciatic nerves. (p11) The doctor did not place any restrictions on Mr. McCowin in 2016. (p17)

The last visit was in 2017. He did have a more recent MRI due to his symptoms progressing on the right side. They were more prevalent on the left in the past. (p12) His physical examination showed that he had restricted knee motion. This was not as good as previous. The doctor felt this looked like some arthritis in the knees was progressing. (p12)

The MRI from November 29, 2016, showed multi-level degenerative disc disease. The doctor was not surprised by this finding. He has protrusions at multi-levels. There was one to the right at the L5. There was wearing out arthropathy of the joints with mild to moderate foraminal stenosis. The doctor felt the combination of the findings were starting to compromise the cord. There was narrowing because of the degenerative changes and progression. (p13)

The physical examination in 2017 showed no significant change. He had good range of motion with pain on flexion with relief on extension. He was more tender in the midline along the sacrum at L4, actually L5. This was the first time for the L5. He had decreased reflexes and loss of reflexes. He had decreased sensations with no atrophy. (p14) He had good strength. He could heel/toe and flat walk. His quadriceps were tight and could not extend the knees.

The reflex changes were due to the peripheral neuropathy and progression of the lumbar spine disease causing narrowing and compression. There was no acute radiculopathy found. The straight-leg testing in the supine and seated positions was negative. The doctor felt that he could have episodes of irritated nerves on top of the peripheral neuropathy. She testified that diseased nerves are more sensitive to the sites of entrapment. (p14) Plaintiff had ongoing age-related degenerative changes despite not working. He did not need restrictions as a result of his work-related condition. She did not find residuals of the workplace injury which required restrictions. Dr. Kneiser also felt he did not require any treatment for his work-related condition. (p15-16)

On cross-examination, the doctor testified she did not have records that predated 2009. By way of history, plaintiff reported he was able to work unrestricted until his date of injury. The doctor did not note any records which contradicted this report. (p16-17)

The records from Drs. Newman and Obayan did not show a back injury prior to 2009. (p17)

The MRI from November 2016 indicated a paracentral disc protrusion which impinged the L4, L5, and S1 nerves. (p17) Protrusions impinging can cause radicular symptoms. Dr. Obayan did diagnosis sciatica. (p17)

The doctor testified that if Dr. Obayan or Dr. Newman on physical examination showed a positive straight leg raising, it was possible he had symptoms of radiculopathy on/off or intermittently. (p18)

The degenerative changes were at multiple levels. You do not see multi-level annular tearing from a single event. (p18) The doctor testified that lifting episodes can cause symptoms. The patient was not aware of the underlying condition. The doctor testified that 90 percent plus of back injuries are strains not an aggravation of the underlying degeneration. (p19)

The doctor first saw plaintiff in 2015, 6 years after the original injury. (p19) She does depend on accuracy of the records contemporaneous of the injury to find objective findings. She does rely on this for her opinion. (p20)

She was not aware of plaintiff being a diabetic. (p20) She relied on the accuracy of 2009 EMG report finding peripheral neuropathy. There were no sensory studies completed. (p21)

Her impression was left-sided lumbar strain related to work. This was documented by Concentra records. He has a congenitally narrowed canal and multi-level disc displacement based on the February 2009 MRI. (p21) The doctor opined that the strain had resolved and that his symptoms were related to the congenitally narrowed canal and the multi-level degenerative disc disease which likely will progress over time. The doctor felt the degenerative changes and the congenitally narrowed spine could not have occurred within a month of the injury, therefore, would not be related. (p21-22)

Again, the lumbar strain from 2009 had resolved. He did have a problem with the degenerative disc disease. He did require restrictions. This condition does cause pain. The symptoms will usually wax and wane. (p22)

The doctor performs Waddell's signs to see if she can rely on subjective symptoms. If those signs are positive, you cannot rely. If they are negative, then there are no inconsistencies, and you can rely on symptoms. She did not doubt Mr. McCowin's credibility. (p23) She did not review any specific job description. He did describe his job at the first evaluation as being very heavy. Based on the restrictions, the doctor did not think he was capable of performing that job. (p24)

The doctor felt that Dr. Obayan's recent off work with no activities was inconsistent with her opinion, but something could have happened since the last time she saw Mr. McCowin, (p24)

There was no other injury then what he described as his first strain to his back. (p25) He has described exacerbations when he gets up from a chair. He does not have any heavy activities setting off his symptoms. On two occasions, he described minor activities as increasing his symptoms. (p25)

He has not worked. He has discussed the possibility of doing something in the personal training area with his son, starting a fitness business. Fitness activity was his hobby and he has started to lose weight. He did lose weight between the second and third visits. This showed some signs of motivation. (p25-26)

The doctor opined that the original injury was very minor compared to the underlying degenerative process. He was eventually going to have a problem with his back especially since relatively minor things were responsible for increased symptoms. The narrowed spine and multi-level degenerative discs are likely to cause more back pain then the average person. (p27)

Again, plaintiff reported back pain since the injury. He did not have reported back pain prior to that injury. (p27)

Attached to the doctor's deposition are reports of her examinations. The first one was on August 4, 2015. At that time, he reported he was off work since the injury. He had pain on the left side of his back. He had intermittent radiating pain into the left groin. He had numbness in the left foot and his pain increased with yard work and cleaning the house. Exercise somewhat alleviated the pain. He had intermittent episodes of his back going out. They last up to 3 weeks before the back pain reduces. He does have good and bad days.

Prior to the injury, he did have a motor vehicle accident in 2007. This involved the neck and shoulder. His current medications were Norco and Restoril.

The physical examination showed he was 280 pounds. He could heel/toe walk. He had no gait deviation. He had relatively preserved range of motion based on his body habitus. He reported pain on forward flexion in the left lower lumbar paraspinal. He had slight hamstring mobility, left compared to right. His reflexes were symmetric. His sensory was decreased in a glove/stocking distribution. There was no atrophy. He was tender in the left lumbosacral paraspinals, L4 – sacrum. The doctor's impression was lumbosacral strain, work-related based on history. He had multi-level degenerative disc disease, not work aggravated. This was age related. This had progressed not improved despite not working. The EMG neurological exam was consistent with peripheral neuropathy, also not related. The EMG was not diagnostic for radiculopathy. Findings in the paraspinals without limb involvement are usually attributable to degenerative spondylosis.

The doctor felt there was poor motivation to perform exercises. His physical therapy was limited due to poor attendance.

The doctor felt that it was unlikely that he would return to his former employment due to his ophthalmology diagnosis. She felt he should be more active with his home exercise program to improve his function.

She did return him to work with the restriction of no lifting greater than 25 pounds frequently and no lifting greater than 35 pounds occasionally. There was again no objective residuals from his work-related injury requiring testing, treatment, or restrictions.

The doctor next saw Mr. McCowin on June 20, 2016. He had been following up with Dr. Obayan regarding his medications. He was seeing Dr. Newman for updates on his condition but no treatment. He was doing his home exercise program. He was walking longer now approximately a mile in 20 minutes. He also did sit-ups and bridges.

His complaints were intermittent low back pain once every other month for two weeks. He reported 6 good and 2 bad weeks. His pain was worse with sitting or standing too long. The medications alleviated the pain. He reported the pain as stabbing and varied from 4-8/10. He had weakness in the back. He had numbness on the top of his toes on his left foot. His medications were Norco and Gabapentin.

Physical examination showed he was 290 pounds. He could easily heel/toe/flat walk. He had mild decrease in flexion with end range pain and lateral right bending. He was tender in the left lumbar paraspinal and left lateral glutes. On neurological exam he had trace reflexes. The Achilles was absent. He had decreased sensation in the left plantar foot/lateral foot. His strength was normal. Straight-leg raising in the seated position was negative. He had no atrophy. Her impression was reported low back pain and no signs of active radiculopathy. He could tolerate the seated posture. He was at MMI for his work-related lumbar injury. She felt he required no restrictions.

She recommended or noted that his activities were minimized by his subjective residuals. She did not recommend opioids. She also did not recommend the Gabapentin, but he does have a non-work-related condition that would respond to Gabapentin. Current limitations were related to his knees/surgery.

The doctor next saw plaintiff March 21, 2017. He continued treating with Dr. Obayan and had periodic follow-ups with Dr. Newman. He had just completed physical therapy which was helpful. He had an MRI because the symptoms were spreading to his right side. He complained of low back pain. He denied radicular leg pain. He described the pain as “pressure”. Pain varied from 3-10/10. He reported no knee pain. He reported left leg being weak and numbness of the left toes. His pain was worse with standing or sitting too long. Sitting was more bothersome. The pain was relieved with movement. He was sleeping on the floor.

Physical examination showed his weight was 260 pounds. He had good range of motion in the lumbar spine. He did have pain with flexion and relief with extension. He had tight quadricep muscles. Straight-leg raising test was negative in the supine and seated positions. He was tender in the left lumbar paraspinals. He had discomfort on the right

midline greater than the left. His reflexes were symmetric with absence in the Achilles. His sensation was decreased in the plantar left foot. He had no atrophy. He was able to heel/toe/flat walk.

The impression was multi-level degenerative disc disease, age-related. He was more active with weight reduction. She recommended a home exercise program. She continued to feel a return to work with restrictions for his degenerative disc disease and facet disease. There were no objective residuals from his work-related injury.

Exhibit B -Is the deposition testimony Lewis I. Jacobs, DO taken January 25, 2018. Dr. Jacobs is Board-Certified and specializes in neurosurgery. He saw plaintiff on November 30, 2017. (p5) He did author a report based on the medical records dated October 30, 2014, and reviewed MRI films and completed a report on April 30, 2015. (p6)

Mr. McCowin gave a history of a work-related injury on January 8, 2009. There was no surgery according to the records reviewed. (P8)

The doctor reviewed the imaging studies and MRIs from February 23, 2009 and April 5, 2012. (p9) The first study showed extensive and diffuse degenerative disease, approximately one month after the injury. There was no acute injury, no bone edema, fracture or subluxation. There was no focal herniation or significant acute findings. He did have disc bulges. (p9-10)

He has not worked since January of 2009. He did review the scans from 2012. The doctor felt they were pretty similar with a slight degree of degenerative disease progression. (p10) The doctor opined that the progression was age related and with that degree of degeneration it is going to keep progressing, each year, a little more. (p10)

The doctor's physical examination in 2017 showed no nerve injury or radiculopathy. There was no neurological deficits. The doctor felt that he embellished on the exam and his findings were not physiologically organic. He felt that he was trying to impress that he was hurting. (p11) The doctor noted that the sensation was non-organic. He had increased pinprick in the right leg. That was the whole leg globally. There is no neurological lesion that could account for this response. The doctor also found no difference in any nerve root which is again non-organic/non-physiological response. (p11-12) His reflexes were symmetric. Straight-leg raising was without complaints in the back or legs. The doctor noted that if he had a positive finding he should have had pain and tingling if the nerve was impinged. (p12)

The doctor reviewed the reports of the MRIs from August 11, 2014 and November 19, 2016. Those studies showed the degenerative process was slowly progressing as expected. There were no acute changes. (p13)

Based on the doctor's November 30, 2017 evaluation, he felt that plaintiff was not disabled. He could go back to work in his former employment. He saw no reason why

plaintiff could not return to work without restrictions based on his exam. (p14) He was not a surgical candidate and did not require any further treatment as a result of his work-related condition. (p14-15)

On cross-examination the doctor testified that he was not a pain management doctor but in reviewing the records, he did not understand why plaintiff was still being seen by a pain doctor. He did not feel he needed to be seen by Dr. Obayan monthly or Dr. Newman every six months. (p17) The doctor felt that he was embellishing because he had no deficits. The imaging studies showed no neurocompression. Therefore, he did not need those doctors, (p17)

The doctor felt that he could give his assessment based on the 2017 exam. He surmises that the doctors seeing him were for secondary gain and getting paid. He did not believe he needed these kinds of doctors anymore. It did not make any sense to Dr. Jacobs. (p18) The doctor vehemently disagreed with Dr. Obayan that he has continuing lumbar radicular symptoms. (p18) Plaintiff did not have radicular symptoms. He did not report pain radiating down his leg. He specifically told the doctor “No.” (p18)

He does have age related degenerative disease. This was not caused by the work injury. (p19) He had a lumbar strain not radiculopathy. This did not lead to or cause the degeneration. The doctor opined that the strain did not cause degeneration. This study was one month later and showed excessive and diffuse disease that is not caused by one injury. This was age related more/less genetic. This had nothing to do with the strain. (p19)

The degenerative condition will worsen on an age-related basis not the original injury. He again had a strain. The records point to this condition. This gets better in six weeks to three months. No one takes eight to nine years to get better from a strain. (p20-21)

Anyone who has arthritic disease will have symptoms that wax and wane. This is a normal course of the disease. (p21)

The doctor agreed that he had a work-related lumbar strain but nothing else. (p21) The doctor felt he could return to his prior work he just needed to be detoxified because he was most likely addicted to the narcotics. However, he was not sure he was an addict. (p22)

By his physical exam, he showed he was embellishing. There was no evidence of symptom embellishment on Dr. Obayan’s records or Dr. Newman’s. There were no non-organic findings for Dr. Obayan. Dr. Obayan incorrectly found lumbar pathology. (p22) He did not review plaintiff’s job description. He used what Mr. McCowin personally told him. He again felt he could return to work as an elevator repair person, if motivated. The doctor did not believe plaintiff was motivated or he would have been back to work a long time ago. (p24)

He was not sure he was looking for work. It's not the doctor's duty to quiz plaintiff on that information. He knew plaintiff had not worked since 2009. He did not know what his job search efforts were. (p24) The doctor had no reason to ask a question about seeking a job. (p25)

Lastly, the doctor testified that he did not agree with the other physician's statements regarding the MRI being consistent with plaintiff's subjective complaints. (p25)

Attached to the doctor's deposition was his reports including his medical record review from October 30, 2014. The doctor's opinion was that he had a work-related injury in January 2009. He had transient musculoskeletal dysfunction, a lumbar strain. The doctor felt this was self-limiting and would resolve in six weeks or could occasionally treat up to three months.

The imaging from the MRI from February 24, 2009, showed extensive, pre-existing degenerative disease without acute traumatic abnormality. There were no radicular symptoms reported to Upfall/Concentra. There were no objective neurological deficits consistent with radiculopathy.

Based on the records, the doctor felt that he was at MMI within three months. Any care after that time would address the degenerative, unrelated conditions. The doctor felt that the pain clinic treatment was excessive for his injury and after three months it would have been for the degenerative process.

The doctor's second diagnosis was chronic pain syndrome secondary to degenerative changes and habituated, if not addicted to Percocet (narcotics). The doctor found no objective abnormality resulting in physical impairment or disability that would preclude a return to work without restrictions. Lastly, the only limitations would be due to his persistence of subjective pain.

The report from the April 30, 2015 was a review of the MRI CD studies from February 23, 2009 and April 5, 2012. The study from February 2009 showed a small central canal due to short pedicles. He had diffuse degenerative disease throughout the lumbar spine, disc desiccation. There was no fracture/edema. At the L5-S1, there was a concentric broad based bulge with associated posterior central annular fissure, no herniation. There was moderate symmetrical facet hypertrophy with mild biforaminal narrowing.

The doctor's review of the April 5, 2012, MRI showed a slight progression of the degenerative changes with further desiccation. The small disc protrusion at the L3-4 had regressed and there was no significant neurocompression. The doctor's impression/ opinion was unchanged.

The report from November 30, 2017, was the doctor's evaluation of plaintiff. the doctor noted that the history was the same as records previously reviewed. The only alteration was that he provided a history that after the injury, he "fell to his knees". His complaints were less low back symptoms. He had occasional/same discomfort in the right lower

lumbar. He denied radicular leg pain in either extremity.

Physical examination showed 90 degrees on seated and supine straight leg raising without back or leg pain. The strength was symmetric in the L5-S1. The sensory exam was non-physiological. Reflexes were trace but symmetric. He had mild general tenderness in the left lower lumbar muscles. There was no atrophy. He had normal gait and station. He could easily heel/toe walk. The doctor's opinion was non- physiological sensory exam suggestive of symptom embellishment. His opinion was unchanged from his prior records review. He opined that he could return to work in his previous capacity. There was no need for treatment for his work injury. Diagnosis was pre-existing chronic degenerative disease. He was not a surgical candidate.

Exhibit C inclusive Exhibit 4 – Included above in plaintiff's exhibits

Exhibit D – This is the deposition testimony of James Donoghue taken on February 23, 2018. Mr. Donoghue is a licensed counselor. He met with plaintiff back in 2010. He authored a report dated February 7, 2010. (p5) He did have updated/additional reports November 15, 2013 and January 19, 2018 with Labor Market Survey (LMS). (p5-6) He did account for additional medical and looked for jobs currently available.

Plaintiff's education was a high school graduate. He did attend Virginia Ferrell Cosmetology School and completed training. He went to Career Works for electrical readiness. (p7) His employment was that he worked as a stock person at Crowley Department Stores and KBee Toys. He was an unlicensed hairdresser from 1994 through 1996. He did construction work for several years. He worked at Otis Elevators from 2000 through his date of injury. He has not returned to work in any capacity since 2010. (p7)

The doctor performed a TSA. He looked at plaintiff's education and vocational history. This does identify any other skills an individual has so they can seek work in alternative fields. In 2013, the TSA identified six occupations that were realistic. (p8)

Mr. Donoghue did perform an LMS in 2018 which took into account his physical restrictions. He used the restrictions set forth by Dr. Kneiser in 2015 and Dr. Newman in 2013. (p8)

He personally contacted the employers for what the job entails. He did give a perspective employer information on an individual so the employer could tell if the restrictions prevented them or not for a job. (p9) He found 13 jobs in 2013 that could be performed within Dr. Newman's restrictions. (p10) In 2018, he performed a new LMS which utilized Drs. Kneiser and Newman. Dr. Newman's restrictions fall between sedentary to light work. It was greater to the sedentary side but not all the way to the light. Dr. Kneiser's restrictions were light to medium (p10-11).

He again did personally contact the employers in 2018. The jobs were available on the day of contact. He found 15 jobs that were within Drs. Kneiser and Newman's restrictions. (p11)

He was confident the wage range was $10.00 to $12.00 per hour (p11-12).

On cross-examination, he knew that plaintiff's wage before the injury was around $32.00. (p. 12) He did not review Dr. Obayan's records. (p12) If she gave a no work restriction, the opinion would not be the same (p13). Dr. Jacobs felt plaintiff did not require restrictions. Therefore, plaintiff could return to regular and customary work. He did not incorporate Dr. Jacobs opinion in his findings. (p13)

When Mr. Donoghue did interview plaintiff, he had not gone or was not doing a job search. He did not have any job logs to review. (p. 13) He was not aware of any job search in 2010. (p14) He has not had any contact with Mr. McCowin since 2010. (p14)

He felt with Drs. Newman and Kneiser's restrictions, his wage-earning capacity was $10.00 - $11.00 per hour. (p. 14) He only looked at specific jobs not the whole universe of jobs. (p15)

Attached to Mr. Donoghue's deposition was his report dated February 7, 2010. He did meet with Mr. McCowin on October 20, 2009.

Mr. McCowin did have a valid driver's license and reliable transportation. The records he reviewed were from Drs. Mayer and Plagens. Both doctors felt that Mr. McCowin could return to work full duty/unrestricted.

Educationally he was a high school graduate. He did attend Virginia Farrell Beauty School but did not get a license. He did get a certificate from Career Works as an electrical journeyman readiness 1998.

Vocationally, he worked as a stock person, hairdresser, construction laborer and at UTC/Otis as an elevator mechanic.

Mr. Donoghue felt that based on his high wages, his best option was to return to work at Otis in an unrestricted position as noted by Drs. Mayer and Plagens. The other work he could look at was construction.

He could return to the construction field making $20.00-25.00 an hour. Mr. Donoghue contacted employers and found available positions.

There is the report of November 15, 2013, which was a wage-earning capacity evaluation/LMS. The medical used for that was Dr. Newman's report from July 7, 2009. The restrictions were sitting 20 minutes, standing 20 minutes and walking less than half a block. There was no lifting, reaching above shoulder level or pushing. He could not drive greater than 2 hours. The TSA showed cashier-self-service gas station,

cashier/checker, front desk, security guard, small parts assembler and receptionist.

He performed the labor market survey in October and November of 2013. He found 13 positions which included cashier, light assembly, circuit board assembler, micro assembler, gate/front desk security and receptionist/front desk worker. His conclusion was that he could return to work making $9.00-14.00 an hour. Realistically he felt, at that time, he could make $9.50 per hour.

The last report was from January 19, 2018. He used medical records from Drs. Jacobs, Kneiser and Newman. Dr. Jacobs report's were from 2015 and 2017 and noted plaintiff could return to full duty work unrestricted. The Kneiser report was from March 21, 2017, with restrictions of no lifting greater than 25 pounds frequently and no lifting greater than 35 pounds occasionally. He reviewed Dr. Newman's restrictions from September 13, 2017, which he noted did not change from the previous May 16, 2017.

He did use those restrictions in is labor market survey from January 2018. He found 15 jobs that were available including front desk clerk, receptionist, assembler, gas station attendant, cashier, customer service associate and appointment setter.

His conclusion, based on Newman and Kneiser, was he could perform an entry level position. The wages would be $10.00-11.00 to start.

Exhibit E – This is the deposition testimony of Nathan Gross, M.D. taken on September 6, 2022. Dr. Gross is Board Certified and specializes in physical medicine and rehabilitation. The doctor authored 2 reports; October 15, 2020 and August 11, 2021. Those reports were based on the doctor's record review. It is noted that most, if not all, of the records reviewed by the doctor have been summarized or testified to in this matter.

The report of October 15, 2020 (p13-20) indicated that he again reviewed medical records and a CD of MRIs. The records included Drs. Obayan, Newman, Kneiser, and Jacobs. He also reviewed the MRI report from radiologist Stephen Pomeranz for the MRI of February 23, 2009. He reviewed the MRI studies of April 6, 2012 and August 11, 2014.

The doctor noted that Dr. Obayan diagnosed post laminectomy syndrome. Dr. Gross was unsure/unclear why she made this diagnosis since the records did not show any surgery. (p 18)

After reviewing the records and studies, Dr. Gross came to the opinion that plaintiff had a lumbosacral strain that would have resolved. The imaging studies showed multilevel degenerative changes. The doctor felt that if Mr. McCowin developed a short-term nerve root irritation, that would have also resolved. The reports do not corroborate consistent, objective neurological findings that were work related. He felt the work incident did not require restrictions. Multilevel degenerative changes, which were consistently documented by the MRI scans, did require restrictions because of poor tolerance to

unrestricted work. Dr. Gross felt that he should avoid repetitive twisting or bending at the waist and no lifting greater than 25 pounds. (p19-20)

The doctor did not feel plaintiff required any ongoing treatment for his work incident. This included doctor visits, physical therapy or injection/opioid medications.

The doctor opined that if plaintiff was using opioids for chronic pain or nonmalignant musculoskeletal conditions, there should be documentation of overall increase in his functional capacities. Unfortunately, that was not the case. (p20)

The next report was dated November 11, 2021. (p20-24) The doctor reviewed additional records from Dr. Diaz, Dr. Tong's EMG on February 18, 2021, the MRI from February 18, 2021, and subsequent Dr. Newman records. (p22-23)

The doctor found no change from his original opinion/record review. The doctor expected changes when comparing MRIs done in 2021 versus 2012. He would not quarrel with Dr. Tong's EMG. This did show chronic radiculopathy. It does not indicate the onset of radiculopathy to the specific work incident. (p23) In his review of additional records, he felt that there was no reason to change opinions previously stated in October 2020 records review. (p24) He did do an exam of plaintiff on August 16, 2022. He authored a report of August 16, 2022 (p25-32)

Mr. McCowin's complaints were chronic low back pain related to an incident in January 2009. He had minimal improvement. He saw Dr. Newman every 3 months. He sees Dr. Obayan one time per month. He does feel good at times but has no long-term improvement. He is taking Norco three times per day and gabapentin one time at night. He also takes Flexeril at night. He has had no significant improvement in pain reduction or functional gains.

In addition to his back pain, he reported numbness in the left toes, all five. His back pain is greater than his leg symptoms. The pain is worse with sitting or standing greater than 30 minutes. If he bends, he will have increased pain. He has no radicular or numbness in the right leg. He does home stretches periodically. He did return to work with restrictions after the incident, "for a minute." He was laid off.

Physical exam showed plaintiff to be 6 feet tall and 270 pounds. His gait was stable. There was no significant limp. He reported pain in the lumbar spine with palpation and all planes of movement. The doctor saw a reasonably good range of motion. Straight leg raising caused low back pain but no radicular symptoms on the left and no pain on the right. His sensation was equal in both legs. There was no major weakness detected. He had hyperactive quadricep reflexes, but they were symmetric. His ankle reflexes were absent, bilaterally. (p29-30)

The doctor's impression was a physical examination with no post traumatic spinal abnormality. Initially, plaintiff may have had a strain and nerve root irritation. Objectively, the doctor found no findings of strain or irritation of the spinal structures. There was no

lumbar radiculopathy. The MRI showed multilevel degenerative changes. The doctor felt he may have poor tolerance to perform unrestricted work. This was not work related. He did not agree with ongoing treatment. He did not require injections or physical therapy. He questioned the medication regiment because there was no significant pain reduction or functional gains. (p30-31)

The doctor testified on physical examination, plaintiff had complaints of pain, reasonable range of motion, no muscular tightness and no focal neurological deficits. The doctor found no active ongoing radiculopathy. (p32) The doctor's diagnosis was degenerative lumbar spine without findings of active nerve root irritation. There was no active spinal musculoskeletal type strain. (p32) The doctor gave restrictions of avoidance of repetitive twisting/bending at the waist and to avoid lifting more than 25 pounds. (p32)

The doctor did not detect any residuals of a post traumatic nature. (p33-34) The doctor would not exclude a potential back strain or nerve "irritation." Mr. McCowin does have a congenitally narrow spinal cord. He does not have discogenic changes but has degenerative changes in the spine. The MRI showed nontraumatic type but multilevel degenerative changes that do not date back to the 2009 injury. (p34)

Dr. Tong's EMG did show chronic L5 lumbar radiculopathy. The doctor felt that plaintiff's degenerative spine, stenosis, bone spurs and less space due to congenital issue can result in periodic nerve root irritation. This can diminish or resolve over time. (p 35) The doctor found chronic changes as opposed to active loss of the nerve supply. EMGs and MRIs are helpful but cannot negate the importance of the physical examination. (p35) The physical exam did not detect asymmetric deficits. Straight leg raising is provocative for irritable nerve root but did not cause pain to radiate into the leg. He had equal sensation in both legs. There was no motor weakness or asymmetric reflexes. The doctor opined that plaintiff did not have exam findings of radiculopathy or nerve root irritation. (p35)

The doctor noted that the electrodiagnostic studies were done almost a decade after the injury. He could not date Dr. Tong's chronicity back to something from 2009. (p36)

The doctor did not feel he needed ongoing treatment for his 2009 injury. In regards to treatment, work related or not, the doctor does not prescribe chronic opioid therapy. He feels that you need to keep the core strong and recommended a course of full directed physical therapy for strengthening. He also noted that chronic back pain with leg pain does not respond favorably to epidurals. He felt people with bad spines are hard to treat. (p36) He believes they should stay active and may need some limitations. Medications can be helpful, but you want improved function and less pain. (p36)

Lastly, on direct exam, he did not agree with Dr. Obayan's treatment. He did not feel opioids were preferable for chronic back ache with multilevel degenerative changes. If you are to use opioids, there should be documentation of improved function and less pain. Plaintiff did not report that he was feeling much better. Again, he should stay active within his limitations. (p37-38)

The doctor testified that he has been doing IMEs for a long time. This was at the request of defendant. (p38) Plaintiff did report symptoms in the legs but the doctor did not find radiculopathy on exam. (p40) The records showed back and leg pain. They were worse with activity. (p40) He does have pathology in the lower spine. He has disc desiccation, amongst other things from the L2-S1. (p40) He did have a protrusion at the L4-5 abutting the L5 nerve roots bilaterally. This appeared on the February 23, 2009 and February 18, 2021 MRIs. (p41) The doctor noted there has been some decrement in the amount of disc herniation or protrusion. He does have an abnormal structure at multiple levels in his spine. (p41) He had a protrusion at the L4-5 but also pathology higher up earlier on. (p41) He had multilevel annular disc bulging and multilevel stenosis. Multilevel degenerative type changes regardless of causation can cause back pain and to some degree, leg pain. (p42) He again feels he does need restrictions. He did not want the essential job function to require repetitive bending and twisting. Occasional could be done if it was not a major function of the job. (p42)

The doctor did not exclude a back strain occurring in 2009. He thought this is what he had, a muscular strain. (p43)

The doctor did not believe plaintiff has any problems related to the 2009 injury currently. The strain resolved and that is part of his opinion. (p43)

The doctor testified that a disc injury, herniation or annular tear can lead to degenerative changes, but degenerative segment with innervating disc will never appear normal. Narrowing and innervating disc will typically show some loss of hydration or desiccation. Loss of hydration/desiccation, outer annuals usually will show some visual tearing. An individual can have degenerative changes and then discs show protrusions and tears. (p43-44) An annular tear can lead to degeneration, but also you can have degenerative tears with a degenerative spine. (p44)

Plaintiff had an incident in January 2009 with an MRI on February 23, 2009. That study showed facet arthropathy, spondylitic changes and desiccation. The doctor testified that you cannot necessarily date the findings, but the narrowing, desiccation and arthritis to the facet joints infers chronicity. (p44-45)

You can have degeneration and then sustain annular tears or herniations on top of that. (p45)

On re-direct examination, the doctor testified that the physical examination did not support a diagnosis of active nerve compression or irritation. This was showed through the straight leg raising test and other things. (p46) An abutment does not necessarily mean there is nerve compression or radiculopathy. (p46)

The doctor again felt that plaintiff had recovered from his disc injury. He now has a multilevel degenerative spine. This was brought out on the serial MRIs over the years. (p47) The imaging study did show an abutment of the L5 nerve root. The doctor testified

that plaintiff did have complaints of bilateral lower extremity pain. The doctor also confirmed that the February 20, 2021 EMG did show a chronic L5 radiculopathy. (p48) The doctor testified that even considering the imaging abutment and EMG findings, he did not detect those types of post traumatic residuals from the 2009 injury. The doctor testified to the importance of the physical exam. The doctor noted that subsequent to the 2009 incident, there was not an isolated disc change. He again had facet arthropathy and disc desiccation infer chronicity. (p48)

The doctor testified that degenerative narrowing, arthritis of the facet joints and drying out of the discs, does not usually go away. They will progress over time. Sometimes, they will remain stable. Protruded discs can recede in size. They can spontaneously desiccate over time. The discs can improve, but bone spurs, narrowing, dehydration remain stable, but usually as a person gets older, they can progress. (p49) Plaintiff's degenerative changes have persisted and to some degree, progressed. (p49)

Exhibit F – This is the deposition testimony of Dr. Kneiser taken on September 6, 2022. Dr. Kneiser's most recent exam of plaintiff was on June 4, 2019. (p12-30).

Plaintiff was continuing treatment with Dr. Obayan every month and was following up with Dr. Newman 3 times per month. He had no intervening physical therapy. He continued to take medications. There was no interval injury or surgery. He had knee surgeries by Dr. Gilyard. His vision loss was progressing slowly.

His complaints were low back pain. He denied radicular leg pain. He reported the pain as "pressure." The pain was 4-8 out of 10. He reported no knee pain. He had weakness in the bilateral legs. He had numbness in the left foot. Pain was worse with sitting/standing too long. Sitting was more bothersome. His pain was alleviated with moving. He does sleep on the floor. He reports this as most comfortable. (p 13-14) His medications were Norco, Gabapentin, Flexeril and Restoral. (p14) Socially, he had quit smoking in the interval. (p15) He was not working. (p15)

His physical exam (p15-17) noted that he was 6 feet tall and weighed 258 pounds. He had a mild thoracic lumbar scoliosis. He had good lumbar range of motion. He had pain with flexion and relief with extension. There was tightness in the quadriceps. His seated and supine straight-leg raising test was negative. He was tender in the left lumbar paraspinal musculature extending over the SI joint, along the posterior sacrum and L5 posterior spinous process. He had discomfort right midline greater than left. He was tender in the left ischial tuberosity but no tenderness in the right. Reflexes were symmetric. Sensation was diminished in the plantar aspect of the left foot. There was no atrophy. He could toe, flat and heel walk.

The doctor reviewed various medical records from Dr. Newman, physical therapy and Dr. Obayan. (p 17-27)

Her impression, (pp 27-29) was history of a lumbosacral strain on the left which was work-related based on plaintiff's accuracy of history. He had multilevel degenerative disc disease without work aggravation. He had age related ongoing degenerative changes which should have improved, not progressed, since being off work. His neurological findings were consistent with peripheral neuropathy. The EMG study noted this condition which was not work related. His data was not diagnostic for radiculopathy. He had isolated findings in the paraspinals without limb, which is usually attributable to degenerative spondylosis. She found he was more active with weight reduction in the interval. Lumbar injections did not provide any long-term benefit. She felt the opioids were not indicated for any work-related injury, and that they were not recommended for chronic non-malignant pain.

The doctor recommended a home exercise program and a return to work with no lifting greater than 25 pounds frequently, and no lifting greater than 35 pounds occasionally. These restrictions were for the lumbar degenerative disc and facet disease. She found no objective residuals of any work-related injury which would require further testing, treatment or restrictions.

On direct examination, the doctor testified that plaintiff denied any radicular leg pain. (p 30) The physical examination showed a good range of motion with more pain with flexion and more relief with extension. Straight leg raising was negative seated and supine positions. His Trendelenburg sign was negative. She was looking for weakness in the L5 nerve root such as chronic radiculopathy – L5 nerve root involvement. He was tender in the low back but not at the greater sciatic notch. This would have been tender with active radiculopathy. She found no tenderness in the iliotibial bands on the side of the leg and found tenderness in the ischial tuberosity; the bone that you sit on. The doctor noted that the bone would not be symptomatic with a pinched nerve or radiculopathy. He had tender muscles on the left side, in the back of the sacrum and the L5 posterior spinous process. The reflexes were symmetric with trace in the patella, absent in the medial hamstring and Achilles. He had diminished sensation on the bottom (plantar) of the foot only. He could walk on his toes, flats and heels. He could do partial knee bends consistent with no weakness attributable to a pinched nerve. (p 30-31)

Her impression was a history of a lumbosacral strain to the left. This was work related based on history. He had multilevel degenerative disc disease with no aggravation but could have been exacerbated back then. He had age related ongoing degenerative changes. This was due to age not work. The doctor felt that if this was aggravated, he would have improved upon stopping work and it would not have progressed. Clinical/neurological exam was consistent with peripheral neuropathy, which was not work related. The data reviewed was not diagnostic for radiculopathy. He had isolated findings in the paraspinal muscles attributable to degenerative spondylosis or facet arthritis. This was not diagnostic for radiculopathy. He had no clinical radiculopathy. His weight loss was good for function. He did have knee surgeries hoping it would make a difference in his back pain, but it did not. Opioids were not indicated for a work injury and not recommended for chronic nonmalignant pain. (p31-33)

When the doctor saw Mr. McCowin on June 4, 2019, there was no active radiculopathy. If he had chronic ongoing radiculopathy, the clinical findings would have been different. There would have been weakness in the L5 innervation muscles. There would have been a positive Trendelenburg sign. This sign is done by standing on one leg. It shows weakness. There was no hip or pelvis drop. There would have also been/expected a positive straight leg raising test. The doctor felt the exam was consistent with no dramatization and no evidence of radiculopathy. (p34)

Plaintiff did have multilevel degenerative disc disease. The doctor felt that if this was work caused, one of those levels would be worse, then you would have seen active radiculopathy which occurs and would have improved, got worse or stayed the same. There is no evidence of worsening clinically. There was a negative Trendelenburg for weakness. The doctor found good strength in the muscle groups around the hip that innervated the L5 nerve root. (p35-36)

The doctor testified that prior exams, August 2015, the Trendelenburg was negative. His reflexes were symmetric. They did show evidence of a distal neuropathy. He had a negative exam in 2015. (p36) The doctor recommended for his degenerative disc disease, active home exercise program, a walking program and core strengthening with extension exercises. (p37) There was no interval injury. The doctor felt steroids should not be used repeatedly because of their side effects. Those side effects included atrophy/loss of muscle. They should be avoided, but with active radiculopathy, an individual can respond to an epidural but not for long term benefits. (p37-38)

The doctor did put restrictions of no lifting greater than 25 pounds frequently or 35 pounds occasionally. (p38-39) The doctor opined the gabapentin is appropriate for treating the peripheral neuropathy. However, the Norco was ineffective for chronic use and patients tend to have more side effects than good results. The body gets used to the medications and they can reduce testosterone. She noted the symptoms would be the same with or without their use. (p39)

On cross-examination, the doctor testified that this exam was at the request of defendant. (p40) Plaintiff did have a history of low back pain attributable to a work injury in 2009. He did not report any interval injury. (p41) She did review records from Drs. Newman and Obayan. (p42)

Having complaints and radiculopathy are two different things. Complaints themselves do not make the diagnosis. (p42) He again denied any radicular/radiating leg pain. There was noted some radiating leg pain in other records. (p43)

The records showed objective pathology, degenerative disc disease at multiple levels in the spine. (p43) The MRI from November 2016 showed degenerative disc disease at all levels, L1 through S1. (p44) The MRI showed a broad central and left foraminal disc protrusion on top of the bulge. The report stated S1 nerve roots not several. (p45) The MRI does not tell if someone is hurting or not. Findings can be there without symptoms. (p45) The MRI is a roadmap for the surgeon. It does not answer questions on whether

the patient has symptoms related to disc pathology. This is for the clinical exam. (p45-46) History and physical exam required to see if correlation to the MRI findings. By age 60, everyone has disc bulging and one third of people have herniations and have never had back pain per MRI.

The doctor testified that the back MRI is not normal. The doctor felt that the findings on the MRI are likely not explained by history and physical examination because bodies can show age related degenerative findings in the absence of symptoms. (p47-48)

Plaintiff has reported back pain and at times, leg pain. (p48) The records show a variety of diagnoses. They included intervertebral disc displacement, dysthymic disorder, major depression disorder, arthropathy, post laminectomy syndrome, low back pain, and left sided sciatica. This was on one visit with Dr. Obayan. (p48) At that visit, the word radiculopathy was not used for a diagnosis. (p49) The records were not consistently stating radiculopathy but using a variety of diagnosis to imply irritation of the nerve root. Sciatica is not really a diagnosis of radiculopathy that is based on the patient's subjective complaint. (p50)

Plaintiff does need restrictions. "Frequent" is approximately thirty percent or less of the time defined by the occupational board/definition. However, the doctor testified that actually, 33 percent is occasional, and 66 percent is frequent for the 25-pound restriction. (p52)

The doctor again felt that plaintiff had a back strain in 2009. He could have exacerbated the degenerative disc disease, but not aggravated it. There was no work-related aggravation. The disc condition has not worsened by what happened in 2009. (p53)

Back strains, about ninety five percent, will resolve within one month. A lumbar disc exacerbation would recover/resolve within 3 to 4 months. (p54) Lastly, the doctor testified that peripheral neuropathy is a diagnosis made by both clinical and EMG. If a large fiber neuropathy, it will show up on standard EMG but small fiber will not. (p54)

On re-direct exam, the doctor noted that Dr. Obayan diagnosed post laminectomy syndrome. There was no history of a laminectomy. Dr. Kneiser felt that this could be a typo. (p55)

The doctor testified that sciatica is based on subjective complaints of leg pain. A sciatic nerve injury would look different than radiculopathy. The word is not specific. (p55-56)

Clinically, plaintiff did not have signs of radiculopathy and not at the time she saw Mr. McCowin. He does not have one pinched nerve on one side. The straight leg raising tests were negative. He would have had symptoms with an L5 or S1 radiculopathy. There was no atrophy in the muscles of the hip. He again had a negative Trendelenburg. He could not have held up his hip due to weakness caused by a pinched nerve/damage over time. (p56-57)

The doctor felt that you could not make a diagnosis based on MRI findings in the absence of physical exam. The diagnosis is based on the patient's exam, clinical exam; not what an MRI shows. You need to correlate and need to recognize that sometimes an MRI might be sending you in the wrong direction. (p57-58)

Clinically, this pathology is not showing up on exam. There is not anything on exam to support a disc pathology causing his symptoms now. (p59)

Exhibit G – This is the deposition of vocational rehabilitation consultant, Michael Fountaine taken on September 9, 2022. Mr. Fountaine did an employability and wage-earning capacity evaluation on August 18, 2022. (p6) From that evaluation he produced a report dated August 29, 2022. (p7-31)

Plaintiff was last employed as an elevator repair/installer with Otis. He reported his wages were $32.78 per hour. (p11) He does have a current/valid driver's license. (p11) Mr. Fountaine reported his return-to-work activities as a job search over the last 3 or 4 years. He uses the Michigan Talent Bank through Michigan Works. The past year he relies more on Indeed.com. The positions he was looking at were greeter, security, cashier, and electronics technician. He does apply online. This year he had applied for 100 different positions with no phone or in person interviews. (p12)

His educational background is he is a high school graduate. He did go through cosmology training at Virginia Farrell School of Beauty. He did not pass the state licensing exam. He did go through residential electrician training with Career Works. He received journeymen ready training for elevator installation/repair through the union. In 2000, he had a 4-year apprenticeship and obtained his journeymen's card. (p12-13)

He does own a tablet and uses email and the internet. He can use basic documents such as a resume'. He uses visual/single digit method for keyboarding. (p13-14)

His vocational history is he last worked for Otis Elevator in January 2009. He was an elevator repair person/installer. He was making $32.78 per hour. Prior to that he worked for O'Loughlin Corporation as a construction laborer. He did work at Emaurice hair salon as a hair stylist. He also worked as a stocker at McCory's Department and KB Toys. (p13-14)

Mr. Fountaine reviewed medical restrictions and recommendations for a back injury back in 2009. He utilized the PCA from Dr. Newman dated July 20, 2021. This was consistent with sedentary physical demand type work. He did make some recommendations in terms of environmental restrictions and also for vibratory and machinery with moving parts. The last visit with the doctor was July 18, 2022, and plaintiff reported his restrictions were unchanged.

Mr. Fountaine reviewed the restriction from Dr. Obayan from February 24, 2022. Mr. McCowin believed those restrictions were consistent with Dr. Newman. He reviewed

Dr. Gross' restrictions from October 15, 2020, August 11, 2021, and August 16, 2022. Those restrictions were to avoid repetitive twisting or bending at the waist and no lifting greater than 25 pounds. Those restrictions were not for the work injury. In the 2021 report the restrictions were reiterated. The doctor in August 2022, stated there was no post-traumatic abnormality. (p14-16)

Mr Fountaine did a skills profile based on Mr. McCowin's vocational history, his previous positions held. The skills profile systematic process was developed in conjunction with O*Net and Career Onestop sponsored by the US Department of Labor, Employment and Training Administration. (p16) As a result of the skills analysis, Mr. Fountaine identified occupations as vocationally appropriate. (p18-19) There was numerous occupations listed. (p19-20)

He did do a TSA. The jobs that he utilized were elevator repairer, construction worker I, hairstylist and stock clerk. He identified sedentary to light work which included team assembler, bench assembler, electronic mechanic, machine feeder tender, polisher/grinder, solder, production operator, general, janitor, tester, sorter, sampler, weigher and hand packer/packaging. He noted entry level jobs do not require significant training or the employer will train. Those positions included lot attendant, ticket taker, gate guard, and greeter. (p20) Mr. Fountaine for reliability and validity of the labor market findings, utilized the Occupational Employment Stats (OES) for the State of Michigan, Metropolitan areas using the US Bureau of Labor Statistics for 2021. He listed positions based on plaintiff's knowledge and skills profile. (p20-22) These included occupational titles, employment and wages. Included were 9 occupations including elevator, machine operator, construction, assembler, hairdresser, inspector, stocker, production helper, and packer/packager. (p22-23)

Mr. Fountaine also looked at long-term employment projections, 2018-2028. He looked at the job numbers and the change of the prior occupations identified. (p23)

He conducted a Labor Market Survey on August 26, 2022. (p25-27) In regards to Dr. Newman's restrictions he found 5 positions. They included quality control inspector, light bench assembler, electronic assembler and entry level bench assembler. In using Dr. Gross' restrictions, he identified 4 additional positions, in the quality inspector field and the circuit board assembler field.

His summary and vocational conclusion was based on Dr. Newman's restrictions. There was again 5 available full-time positions. Four of the reported entry level wages were $14.00 to $15.00 per hour. It could go up to $17.00 per hour. (p29) With Dr. Gross' restrictions, he found 4 additional available positions. The entry level wages were $14.00 to $17.00 per hour and could go up to $20.00 per hour.

Mr. Fountaine came to 2 conclusions regarding plaintiff's wage-earning capacity. Based on Dr. Newman's he could earn $14.00 to $15.00 per hour with a maximum of $17.00 an hour and that Dr. Gross' was slightly higher at $14.00 to $17.00 per hour, up to $20.00 per hour. (p31)

He testified he did not agree with Mr. Fuller's conclusion. Mr. Fuller did not believe plaintiff was employable. Mr. Fountaine did a Labor Market Survey and found entry level positions consistent with the restrictions. He also did not agree with Mr. Fuller's minimum wage of $9.87 for sedentary work. He did not find positions starting at that wage. He found wages consistent with entry level and plaintiff's labor market area. He also evaluated the major markets around Michigan. (p31) Mr. Fuller did not believe plaintiff was unemployable. He does Labor Market Surveys week in and week out with very similar circumstances for different individuals. (p33) Mr. Fuller did not do a Labor Market Survey. Mr. Fountaine felt that you need one unless you are giving a vocational opinion off the cuff. You are looking at the labor market to see what exists and is available. You need this for availability and wage data. (p33-34)

He felt Mr. Fuller's original findings in 2016 would be fairly consistent with his findings regarding the type of positions. Mr. Fountaine noted that wages have increased significantly since that time. The types of positions he found were consistent with the recommended restrictions. (p35)

He testified that if the jobs are not available, the job search would not be targeted and systematic. Michigan Works and Indeed.com, as one of their conditions, requires that a job is available. He felt focusing on the same employer over and over again maybe systematic but not a recommended practice by himself as a vocational counselor. (p36)

Mr. Fountaine noted plaintiff had applied for jobs online. Those jobs included greeter, security, cashier and electronic technician. He had applied for about 100 different positions over the past year. He had not been contacted by any prospective employers by phone and/or interview. (p36-37) He was not sure why Mr. McCowin was not contacted by at least one employer given the type of positions and current demand. (p37) He could not account for plaintiff's information on the applications. He felt it made no sense that not even one of the employers contacted plaintiff. (p37) He feels that motivation and presentation are important. This can be sometimes more important than a person's actual vocational qualifications. (p37) Lastly, on direct examination, Mr. Fountaine testified that he had all the information to do a thorough and complete wage-earning capacity evaluation. (p38)

On cross-examination, Mr. Fountaine testified this was a one-time request of defense counsel on August 18, 2022. (p38) Mr. Fountaine noted the Otis Elevator job was his maximum wage. It was his understanding at the time plaintiff stopped his employment in 2009 he was making $32.78 per hour. (p38-39) He was not sure of Mr. McCowin's benefit package. He did testify that fringes of $22.00 per hour would be a significant benefit package. (p39)

Currently, wages would likely be higher for an elevator repair/installer but Mr. Fountaine did not have those statistics. (p40) His wage-earning capacity was based on Drs. Newman and Gross and would be below the maximum wage. (p40)

In the TSA, positions are based on transferable skills. While Mr. McCowin has not done these positions, they were consistent with his transferable skills. (p41)

In regards to the jobs, you are going to have some on-the-job training. The jobs are very entry level with short demonstration up to 30 days for semi-skilled. There is a wide range of training, and this is why you need an Labor Market Study. Mr Fountaine looked at entry level unskilled work for plaintiff. (p41-42)

Again, learning could take a day or so, possibly up to 6 months. You can't tell unless it is a specific position at a specific employer. Again, training less than 30 days is not skilled. (p42)

The Labor Market Study showed 5 jobs within Dr. Newman's restrictions and 4 jobs with Dr. Gross' recommendations. All 9 positions were with Dr. Gross' restrictions. Only the first 5 were within Dr. Newman's. (p43) These were examples of jobs that plaintiff was capable of performing. They were also available on the date of the Labor Market Survey. Mr. Fountaine checked the posting and confirmed the availability. There is no guarantee that an applicant will be hired for a job. Those jobs were not offered to plaintiff. (p44)

Plaintiff has not done the work based on the job titles. (p45) Employees reliability is important. This boils down to how much absenteeism and the tolerance of the employer. (p45) If a person was to miss 3 days per month unannounced, that would be an issue. (p46) Mr. Fountaine did not review plaintiff's job logs. He did not discuss his job search back in 2016. Plaintiff told him he had applied for about 100 jobs in the last year. (p46)

Lastly, Mr. Fountaine did not have any first-hand or second-hand knowledge on how Mr. McCowin presented himself to prospective employers. (p47)

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Plaintiff has the burden 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 arose out of and in the course of employment and proving that the injury or disease has placed a limitation on a claimant's wage-earning capacity in work suitable to his or her training and qualifications. MCL418.301(1) & (4).

This case only involves applications filed by the defendant/petitioner. The defendant again filed 4 applications, Form C. The first was filed on December 19, 2013. This was a determination of rights. The petitioner requested a hearing to determine claimant's residual wage-earning capacity.

The second application was filed on February 9, 2015. This petition requested a hearing on the issue as to whether claimant's ongoing treatment was reasonable, necessary and

related to the work/personal injury. In that application the defendant also alleged non-compliance with medical treatment.

The defendant/petitioner filed 2 petitions to stop. The first was on August 2, 2015 and an amended application was received at the Agency on November 10, 2022. Since this case only involves applications/petitions filed by the defendant/petitioner, they will have the burden of proof. *Krastes v Haseley Construction Co. Inc., 2007 ACO 18.*

The initial issue in this case involves the petitions to stop. If defendants petition to stop is denied, then the issue regarding residual wage-earning capacity and treatment would be relevant.

The basis for a petition to stop according to Rule 10, R408.40(1)(b), is that the employee has returned to gainful employment or the employee is able to return to employment. Effective December 10, 2021, Rule 10 added in Section (2)(ii)(C) a physician's statement stating that the conditions found to be work-related cease to exist and are no longer a cause of the current wage loss. This is consistent with MCL 418.301(4) & *Sington v Chrysler Corporation*, 467 Mich 144 (2002), where the loss or reduction in wage-earning capacity must be related to a personal injury under MCL418.301(1).

Under *Sington*, the employee must prove a work-related injury and the injury resulted in a reduction of the employee's maximum wage-earning capacity in work suitable to his qualifications or training. Under Section 4, disability was defined as a limitation of a employee's wage-earning capacity in work suitable to his or her qualifications and training resulting from a personal injury or work-related disease. Therefore, even if plaintiff has a loss or reduction in his wage-earning capacity, it needs to be related back to the medical conditions upon which he was awarded benefits, namely a disc herniation and/or radiculopathy

It should be noted that since Mr. McCowin's date of injury, January 2009, is prior to the December 2011 amendments, the court is utilizing the language in MCL 418.301(4) prior to those amendments and the *Sington* decision in regards to disability.

This case will come down to the "battle of the medical experts". On the one side we have Drs. Obayan and Newman. On the Defendant/Petitioner's side we have Drs. Kneiser, Gross and Jacobs. The Plaintiff's doctors opine that Plaintiff continues to suffer from the condition(s) (disc herniation/radiculopathy) found by Magistrate Turner in her decision. The Defendant's doctors opine that Plaintiff's current condition is unrelated. That it is mainly degenerative disc disease/disc desiccation and facet arthropathy/arthritis. They did not find any active/ongoing radiculopathy and Dr. Gross in his opinion, based on MRI studies found that any disc herniation diminished or decreased in size. The Defense doctors also believe that any ongoing disability/loss of wage-earning capacity is secondary to the non-work related degenerative/arthritic changes.

In careful review of all the medical testimony and records, I find Defendant's doctors more

persuasive. Specifically, I gave the greatest weight to Dr. Gross. I found Drs. Obayan and Newman's opinions to be less persuasive and therefore gave them less weight in the final decision.

In regards to Dr. Obayan's records and testimony, it shows that Mr. McCowin has treated with her for over a decade without any significant improvement. The records show that his condition/symptoms did wax and wane over the years. There was also a question in regards to her opinion because one of her diagnosis /impressions was post-laminectomy syndrome. The medical show no evidence of any laminectomy or back surgery. Dr. Kneiser was kind in her opinion that this might have been a typo however the doctor's records never corrected that impression. The only surgery Mr. McCowin has underwent was on his knees, which are unrelated. This brings her credibility into question. Also, previously she found a strongly positive SLR test but not currently. It varies from one to another exam. Also noted in her previous testimony, there were degenerative findings on MRI.

Additionally, it appears he did not even have a surgical consultation until he saw Dr. Diaz in 2021. At that time, Dr. Diaz did not feel he was a surgical candidate. Therefore, there are questions in regards to the doctor's impressions and treatment. She has shown little or no positive results with her treatment in over a decade of treatment. Therefore, her impressions are in question.

In regard to Dr. Newman, he is essentially a consultant. He is not prescribing any treatment for Mr. McCowin. His records and testimony indicate that he allows Dr. Obayan to render treatment. Dr. Newman also testified that there has been no significant changes in his condition or symptoms over time. There has been some variations in his presentations however, the conditions continue without any improvement in symptoms. Dr. Newman also testified that Mr. McCowin does have multilevel degenerative changes including desiccation. He felt that it was hard to relate this to the injury. He testified that these findings will progress over time whether Plaintiff is active or not. This is consistent with the serial MRIs.

Additionally, the doctor was unclear in regard to plaintiff's right-sided/leg/foot complaints. An EMG done in 2021 did show chronic left L5 radiculopathy. There has not been consistent findings of active radiculopathy by any of the doctors on physical exam. Again, I have accepted Dr. Gross' opinion as most persuasive and given the greatest weight in regard to the radiculopathy and herniated disc(s).

In regard to the Defendant's medical, it has been consistent. All three of the doctors found degenerative disc disease and arthritic changes. They opine Plaintiff's symptoms of waxing and waning is consistent with those conditions. Plaintiff himself testified he does have good and bad days. This is consistent with the medical records and the findings of a progressive degenerative condition.

Dr. Kneiser's opinion was consistent with Dr. Gross. She opined that his condition was degenerative/arthritic not related to the found personal injury. She did, at one point, place

no restrictions on Mr. McCowin. Later, she gave restrictions, however, those restrictions were for those unrelated degenerative changes. This was also true of Dr. Gross. Again, to have a disability, one must have a loss or reduction in their wage-earning capacity due to a work-related condition. In this case, Plaintiff has a back condition which does restrict him, however it is not related to the conditions found by Magistrate Turner in 2010.

Lastly, in regards to Dr. Jacobs opinion, I only gave him weight in regards to his impression/diagnosis. This was consistent with Drs. Gross and Kneiser. However, I did not find plaintiff was exaggerating his symptoms. There is medically known conditions that can cause his symptoms. Those conditions again are degenerative, throughout the lumbar spine and arthritic in the facets. These are not related to his work injury. I have found he has recovered from those conditions and his ongoing wage loss, if any, is not related to the work injuries. The multilevel degenerative changes are progressing/worsening over the years. This is also contributed to by his congenitally narrow cord. This is the cause of his stenosis. Therefore, Defendant has met their burden of proof for their amended Petition to Stop. Plaintiff's work-related condition has ceased or resolved to the point where it is no longer causing the current wage loss/disability.

CONCLUSION

Defendant has met their burden of proof for their Petition to Stop. Plaintiff's current disability, if any, is not related to his prior found work conditions.

Attached Order is incorporated herein.

WORKERS' COMPENSATION BOARD OF MAGISTRATES

_____

Keith Castora, Magistrate 251G

Signed this 19th day of January, 2023 at Detroit, Michigan