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

Angela Carper
SS# XXX-XX-XXXX

Plaintiff,

v

Lake Huron Medical Center,
Safety National Casualty Corporation
Defendant,
_____/

APPEARANCES:

Francesco L. Partipilo Sr. (P31650), attorney for the Plaintiff
Randall MacArthur (P47917), attorney for the Defendant

TRIAL DATE:

November 1, 2022 and November 14, 2022; briefs filed December 19, 2022 (record closed)

OPINION

STATEMENT OF CLAIM:

The Plaintiff by way of Application for Mediation or Hearing, signed by the claimant on February 20, 2019, received by the Agency on February 25, 2019, alleged the following dates of injury: August 29, 2016 and September 15, 2016 (LDW), claiming the following:

> "On or about 8-29-16 Plaintiff tripped on a mat injuring right/left knees, right/left wrists, neck and back. Nature of disability – Right/left knees, right/left wrists, back, neck and sequelae thereof. Claimant seeks all benefits she may be entitled to under the Workers' Compensation Act, including specific loss."

STIPULATIONS:

The parties stipulated that both were subject to the Act at the time of the alleged injuries; the insured carrier was on the risk; and that the Plaintiff was employed by the Defendant at the time of the alleged personal injuries. Plaintiff was left to her proofs that personal injuries arose out of and in the course of employment; that Plaintiff is disabled as a result of the personal injuries; and that notice and claim were timely made. It was also stipulated that Plaintiff's average weekly wage was $397.10; that fringe benefits were $262.74 and were discontinued on November 15, 2016; and that Plaintiff files her taxes single with no dependents.

WITNESSES TESTIFYING PERSONALLY:

Plaintiff:

Angela Carper, Plaintiff

Defendant:

None

WITNESSES TESTIFYING BY DEPOSITION:

Plaintiff:

Ryan Pollina, MD
Marwan Shuayto, MD
James Fuller, MACRC

Defendant:

Geoffrey Seidel, MD
Stanley S. Lee, MD
Nathan Gross, MD
Karen Grossberg

EXHIBITS:

Plaintiff:

1. Deposition transcript – Dr. Ryan Pollina taken on December 16, 2021
2. Deposition transcript – Dr. Marwan Shuayto taken on December 15, 2021
3. Deposition transcript – Mr. James Fuller taken on September 28, 2022
4. Medical records – Dr. Cory Zieger
5. Withdrawn
6. Withdrawn

7. Medical records – Premier Surgical Center of Michigan
8. Medical records – Lake Huron Medical Center
9. Medical records – St. John Medical Center Macomb Township
10. Medical records – Michigan Neurology and Spine – Dr. Shuayto
11. Job description for a food service worker dated April 28, 2016
12. Withdrawn
13. Plaintiff's job search form from January 4, 2020 through July 21, 2021
14. Medical records – Dr. Igor Nedic

Defendant:

A. Deposition transcript – Dr. Geoffrey Seidel taken on May 12, 2022
B. Deposition transcript – Dr. Stanley Lee taken on June 3, 2022
C. Deposition transcript – Dr. Nathan Gross taken on May 11, 2022
D. Deposition transcript – Ms. Karen Grossberg taken on October 21, 2022
E. Medical records – Dr. David Montgomery
F. Medical records – Dr. Todd Murphy
G. Medical records – Dr. Ryan Pollina
H. Medical records – Pure Healthy Back
I. X-ray report dated April 16, 2018
J. MRI report dated August 22, 2018
K. Claim Payment Form
L. MRI report dated October 21, 2019
M. Nerve conduction study/EMG report dated February 3, 2020
N. X-ray report dated October 18, 2019
O. MRI report May 21, 2021
P. Spinal cord stimulator (SCS) report – June 24, 2021
Q. Operative report dated October 15, 2021 – SCS implantation
R. SCS adjustment report – February 24, 2022
S. Fusion operative report – June 3, 2022
T. Agency Form 105A dated October 25, 2019
U. Plaintiff's job search forms commencing February 27, 2019 through September 27, 2022
V. Plaintiff's job search forms commencing September 29, 2022 through October 31, 2022

DISCUSSION

ANGELA CARPER, PLAINTIFF

NOVEMBER 1, 2022

Plaintiff was born on @@. She was hired by Defendant in May 2014. She was employed as a dietary clerk. This job involved stocking materials in different pantries, working on a "tray line" which involved getting meals ready and delivering them to patients. She would also see patients three times a day

checking for food allergies, etc. She worked 30 to 40 hours per week. She worked 10-hour days with two breaks, one for 15 minutes and the other for 30 minutes. Otherwise, she worked standing. Her job involved lifting 20 to 50 pounds. Her routine was to go to each patient in the morning to see what the patient wanted for breakfast. She then would spend time stocking 13 pantries and then would go back to patients for lunch. She also served patients at dinner. The facility was on three floors. She saw 35 to 60 patients at least three times per day. Her job also involved pushing a cart with food on it.

Plaintiff was shown Plaintiff's Exhibit 11 which she identified as the job duties that she performed on each day. Her job did not involve sitting but instead constant standing. She also had to occasionally lift items overhead. Her job also involved reaching, pushing and pulling. It involved occasional squatting but no crawling.

Prior to August 29, 2016, Plaintiff had no back problems and received no treatment for any back problems. Her activities prior to her alleged injury on August 29, 2016 involved normal housework as well as walking with friends two or three miles per day, bowling and dancing. She had no difficulties in performing any of the above activities and no problems involving the performance of the activities of daily living. She had no restrictions with regard to social activities. She did do limited yard work such as gardening. Her only medication was for a thyroid condition.

On the date of alleged injury, Plaintiff was walking through the cafeteria at which time she was asked to carry a large pan of vegetables. She tripped on what she described as a "anti-fatigue" mat. She fell forward and as she did so, she did not let go of the pain. She felt pain in her wrists, knees and back immediately. She testified that the incident was witnessed by the dietitian whom she identified as Tony who she also said wrote an "affidavit." Plaintiff's supervisor was also present, Helen Yancey. The incident took place at approximately 11:30 am. It was reported to Ms. Yancey. Plaintiff was sent to the Defendant's emergency room. She believes that she was given a CAT scan as well as x-rays.

Plaintiff described her pain as "intense" and stabbing with numbness in the lower back and right leg. She did not finish her shift. She was sent to Dr. Tony and had 10 days off work. When she did return to work, she only worked a half a day and was again sent to the ER by her supervisor Ms. Yancey at which time pain medication was given. Her last day of work was September 15, 2016.

She was then treated by Dr. Zieger who sent her to Dr. Pollina who gave her injections, medication, as well as prescribing physical therapy.

She has never returned to work for the Defendant after September 15, 2016 nor has she had any other work for any other employer. She testified that her back pain is “miserable.” She testified that she always had an off work note. Plaintiff testified that her back pain has never abated and got worse over time.

She was then treated by Dr. Shuayto. Her last visit to Dr. Shuayto was two weeks prior to the hearing. She testified that the treatment she receives from Dr. Pollina, Dr. Zieger, and Dr. Shuayto was only for her back.

Plaintiff was involved in a motor vehicle accident in 2017. She rear-ended a semi on her way to a physical therapy session. She sustained a broken elbow and fracture in her right hand and a fracture in her right foot. She did not injury her back and she had no increase in symptoms in her back because of the accident. She did continue treatment for her back.

Since the time of her injury in August, 2016, Plaintiff could not return to her job duties for the Defendant. Her job as testified to above involved bending, lifting, twisting, and pushing. She would have difficulty standing and was in constant pain. She could only stand for 30 minutes and then would have to sit with her feet up and would have to change positions frequently. She would have difficulty squatting which would be almost unbearable. She testified further that her difficulties had become worse in the last few months. She cannot sit more than 30 to 45 minutes without her back getting stiff. She is limited to walking only two blocks because of her back problems. She has difficulty sleeping and some days cannot drive. These back problems have continued even after the motor vehicle accident. She does not go bowling or do any gardening nor does she walk with friends.

She takes hydrocodone daily as well as Flexeril. The medications make her tired. Dr. Shuayto has given her injections in her low back. She had a spinal cord stimulator implanted in 2021. She also had a fusion in her back in either May or June, 2022 and still undergoes physical therapy. She testified that at the time of the hearing, her pain was at a level of 6 on a scale of 0 to 10.

Medical bills have been paid by either Medicare and/or Medicaid after her workers’ compensation benefits were stopped in February, 2019. She was awarded Social Security Disability Benefits retroactive to August 29, 2016.

Plaintiff identified Plaintiff’s Exhibit 5 which was her job log. She was also shown Plaintiff’s Exhibit 12 which were additional searches of employment which occurred more recently based upon the jobs set forth in the vocational expert report from the Defendant.

On final direct examination, Plaintiff testified that she did work as a receptionist some 26 years ago and was a grocery store clerk approximately 15

years ago. She had a gap in her employment history in approximately 2002 because of her daughter's medical issues. She also worked at Port Huron Hospital in a dietary job. Those duties were substantially the same as the duties she performed for Defendant.

On cross-examination, Plaintiff produced her drivers' license which indicated no restrictions. Plaintiff had a different residence in 2013. She moved to her current address subsequent to that time. Her children helped her move.

Plaintiff is currently 5 feet 6 inches tall, weighing 200 pounds. She weighed as much as 265 pounds at one time, gaining weight after the injury. She weighed approximately 190 or 200 pounds at the time of her injury. She has had no criminal convictions within the last 10 years.

She identified her primary care physician as Dr. Igor Nedic. Before Dr. Nedic, she had a PCP she described as Dr. Canto and prior to that, Dr. Mitchell. She had no prior treatment with an orthopedic surgeon prior to her injury nor any treatment from a physical medicine expert. She also did not have any treatment from a pain specialist. The only hospitals she was in within 5 years were Port Huron Hospital and Lake Huron Medical Center.

Plaintiff confirmed being hired by Defendant in May, 2014 and identified Form 105A. She worked for Port Huron Hospital between 2009 and 2012 or 2013. She was terminated from that job because she was missing too many days. She received Unemployment Compensation Benefits until she was hired by Defendant.

Plaintiff testified she has not testified in any proceeding in the past nor has she filed any previous workers' compensation claims or any "subsequent workers' compensation claims." She has not filed any PIP Benefit claims including any claim for the 2017 motor vehicle accident. Bills for medical treatment because of the motor vehicle accident were sent to her auto insurance company. She did not receive any wage loss benefits. The only other claim she has filed is for Social Security Disability Benefits.

Plaintiff was again shown Plaintiff's Exhibit 11 which was her job description consisting of three pages. She confirmed that on many of the job duties, the word "less" is used regarding certain sections such as bending.

Plaintiff was presented with a portion of the deposition of Dr. Seidel regarding history given to him at the time of his deposition. She agreed that the history recorded by Dr. Seidel indicating that injuries to her wrists, knees and neck resolved within a matter of weeks as it related to her alleged injury of August, 2016. Her only remaining problem was with her back.

Plaintiff began treatment with Dr. David Montgomery in early 2017. She was referred to Dr. Sciotti who gave her several injections. She then returned to Dr. Montgomery who is a physician with Oakland Orthopedic Surgeons. Plaintiff was shown Defendant's Exhibit E which was a record of Plaintiff's visit with Dr. Montgomery on June 26, 2017. Plaintiff did not dispute this record.

Plaintiff acknowledged being seen by Dr. Lee for an independent medical examination in October, 2017. Plaintiff testified that Dr. Lee did not talk to her. Plaintiff was aware that Dr. Lee had indicated that Plaintiff could return to work without restrictions.

Plaintiff again reiterated the details of her 2017 motor vehicle accident which occurred somewhere on I-94. She was driving a 2010 Pontiac minivan. There was front end damage to the minivan. The airbag did deploy. Police came and an ambulance was called. Plaintiff was treated at McLaren Hospital for injuries she sustained. Defendant's Exhibit F is the record of the visit with Dr. Murphy which occurred on December 29, 2017 wherein Plaintiff presented a history of the accident. Plaintiff indicated her agreement with the history given in that record. She also agreed with the portion of the record indicating the doctor's impressions as well as the treatment plan. The record revealed a fracture of the right wrist, right elbow and right ankle. Plaintiff reiterated that she did not injure her back.

Plaintiff acknowledged that she saw Dr. Ryan Pollina on January 15, 2018. Plaintiff testified that she told Dr. Pollina about her motor vehicle accident. She did not know why Dr. Pollina testified that she did not. Plaintiff also acknowledged the record of Plaintiff's visit with Dr. Pollina on January 15, 2018 which was shown to Plaintiff as Defendant's Exhibit G. Defendant's Exhibit H was a record of an office visit with Dr. Pollina on March 16, 2018. Plaintiff testified that she had no reason to dispute the information contained in that exhibit. Plaintiff was also shown Defendant's Exhibit I which was an x-ray taken of Plaintiff's lumbosacral spine on April 16, 2018. Plaintiff was also shown Defendant's Exhibit J which is an MRI report of Plaintiff's lumbar spine dated August 22, 2018.

Plaintiff acknowledged that she was seen by Dr. Nathan Gross for an independent medical examination on January 24, 2019. Plaintiff testified that she did provide Dr. Gross with a history of her injury. She further testified that Dr. Gross "did not lay a hand on" her. She was aware that Dr. Gross did not impose any restrictions upon her return to work. She further acknowledged that she was paid workers' compensation benefits until February, 2019.

Plaintiff was then shown Defendant's Exhibit K which are claims payment forms indicating payment to Plaintiff in the amount of $457.37 per week in workers' compensation benefits. Plaintiff agreed with the amount indicated in the

exhibit. Plaintiff further testified that she began treatment with Dr. Shuayto in August, 2019. Plaintiff was shown Defendant's Exhibit L which is an MRI report dated October 21, 2019. Plaintiff was also shown Defendant's Exhibit M which is an EMG report of the lower extremities done on February 3, 2020. Plaintiff further acknowledged that Dr. Seidel did not impose any restrictions upon her as of October 23, 2020.

Plaintiff was questioned about a further motor vehicle accident on February 5, 2021 which she described as a "bump." She estimated that the speed of the vehicles was about 2 MPH. No claim of any sort was filed with regard to that accident.

Plaintiff was shown Defendant's Exhibit N which is an x-ray of the Plaintiff's lumbar spine dated April 17, 2021. Plaintiff was also shown an MRI report identified as Defendant's Exhibit O done on May 21, 2021.

Plaintiff further testified that she was treated by Dr. Pollina between August, 2017 until February, 2019. While it appears Dr. Pollina testified that he never gave Plaintiff restrictions during his time of treatment, Plaintiff testified that she was given an off work note. She further testified that she did not ever get a copy of the off work note but further testified that the nurse case manager went in with her to Dr. Pollina's appointment on every occasion. She testified that she never received any documents from Dr. Shuayto.

As to her job search through October, 2021, Plaintiff did not have any restriction slip from either Dr. Pollina or Dr. Shuayto.

A spinal cord stimulator was implanted initially on June 24, 2021 by Dr. Shuayto and then permanently implanted on October 15, 2021. Plaintiff was unaware that Dr. Shuayto testified on December 15, 2021 that Plaintiff's physical ability would improve with the adjustment to the spinal cord stimulator. Plaintiff further testified that she did not receive any updated restrictions from Dr. Shuayto. She also testified that she had no updated restrictions from Dr. Shuayto since June, 2022. She did undergo a sacroiliac fusion on June 3, 2022. Defendant's Exhibit P is a record of Dr. Shuayto with regard to the first implantation of the spinal cord stimulator on June 24, 2021. Defendant's Exhibit Q is the record of the permanent implantation of the spinal cord stimulator by Dr. Shuayto on October 15, 2021. Defendant's Exhibit S is the record of Dr. Shuayto's operative procedure on June 3, 2022 performing a right sacroiliac joint fusion.

The Plaintiff also testified that she had no documents from either Dr. Shuayto or Dr. Pollina which requires her to take unscheduled breaks.

Plaintiff testified that she has not received short term disability benefits nor long term disability benefits nor any sickness and accident benefits or wage continuation benefits. Plaintiff also testified she has not received any sort of pension benefits nor any profit sharing benefits. Plaintiff did acknowledge receiving Social Security Disability Benefits beginning in August, 2020. Plaintiff further testified that she has not received workers' compensation from any employer other than Defendant. She further confirmed that she has not received any PIP benefits other than those received with regard to the 2017 motor vehicle accident. There were no "settlements" with regard to any motor vehicle accidents.

She was on Part A Medicare effective February 1, 2019 and Part B effective September 1, 2020. Before that time she was on Medicaid for approximately three to four years.

NOVEMBER 14, 2022

Defense counsel resumed cross-examination of Plaintiff on Monday November 14, 2022. Plaintiff was shown Defendant's Exhibit T which is the Form 105A. Plaintiff identified the form confirming the information contained on the form. She did not receive any associates degree from either institution that she attended after high school. Plaintiff also confirmed that the information she gave to Mr. Fuller and Ms. Grossberg needed no corrections with the exception of some dates stated in their reports which she may have been unsure.

Defense counsel then questioned Plaintiff with regard to her employment prior to her job with Defendant. The information was elicited from the job duties form as part of Form 105A. She worked as an assembler on a production line at Plumlee Rubber. She was a receptionist at Paslin Company which included clerical work such as timecards and filing. She worked as a cashier at Plumb's Convenience Store. Between 1996 and 2000 Plaintiff was unemployed during which time she had children. Her employment with Vinker Foods between 2008 and 2009 was also as a cashier. She did not work between 2002 and 2008 because her daughter was diagnosed with brain cancer. At Vinker Foods she worked also as a cashier and also in the deli department. Her final employment before her job with Defendant was at Port Huron Hospital as a full time dietary technician. Her job duties involved seeing approximately 50 patients per day in order to take food orders and check for allergies and whether patients were eating. She would place that information on a chart. She also delivered food trays to patients. Her computer involvement was limited. She also worked as a dishwasher and stocking the pantry with items such as cups and bowls.

With all the jobs she held prior to her employment with Defendant, she was not terminated for any performance issues.

Her employment with Defendant was as a dietary clerk. Her job duties with Defendant were substantially the same as her employment with Port Huron Hospital. The Defendant's operation was smaller than Port Huron Hospital. She did do more computer work when she worked for Defendant. She had no performance problems with Defendant. She has had no employment since she left her job with the Defendant with the exception of one day when she worked at a factory.

Plaintiff was then questioned with regard to Defendant's Exhibit U which was the same as Plaintiff's Exhibit 5 and ultimately Exhibit U was substituted for Plaintiff's Exhibit 5 which was withdrawn. Defendant's Exhibit U are the job search forms which Plaintiff indicated that she received from her attorney. The first date on Defendant's Exhibit U is February 27, 2019. Defense counsel pointed out various gaps in time on the forms where Plaintiff did not record any job search. For example, between January, 2020 through September 18, 2020, there appeared to be only 5 contacts in May, June and September. The last page of Exhibit U is dated February 1, 2022. Plaintiff also acknowledged that some dates were incorrect on some of the entries in Exhibit U.

Plaintiff was then questioned on Defendant's Exhibit V which was identical to Plaintiff's Exhibit 12. Plaintiff's Exhibit 12 was withdrawn and Defendant's Exhibit V substituted for Exhibit 12. As with Exhibit U, the pages were paginated. Plaintiff testified that the job search records on Exhibit V began on September 29, 2022 with the last entry on October 31, 2022.

Plaintiff further testified that she has had no contacts with vocational consultants other than Michigan Works. She believes that this occurred in February, 2019. She did not recall when she received Ms. Grossberg's report.

Plaintiff further testified that on most occasions she did not fill out a written application when she applied for positions but simply sent her resume. She did not have a copy of her resume available at the time of the hearing. On some occasions she did submit applications but testified that she has no copies of any. She did supply Indeed.com with her resume in 2019. She has no documentation indicating whether the prospective employers confirmed receipt of her resume and/or job applications.

Defense counsel then questioned Plaintiff with regard to the locations of the employers that she submitted either an application or resume. Five of the employers that she listed were within 5 to 10 miles from her residence in Port Huron. The other locations were between 33 and 40 miles from her residence.

On re-direct-examination, Plaintiff's Exhibit 14 was admitted over defense counsel's objection.

Plaintiff was questioned with regard to Dr. Nedic's records. The exhibit was received only with reference to three office notes contained in those records, i.e., June 15, 2016, May 24, 2016 and October 10, 2017. Plaintiff testified that her visit with Dr. Nedic on May 24, 2016 was for a thyroid condition and fatigue. There were no back complaints at that time. Likewise, on June 15, 2016 Plaintiff reported no back complaints and also none on October 10, 2017.

Plaintiff further testified that she treated with Dr. Murphy with regard to the motor vehicle accident which occurred in December, 2017. Dr. Murphy did not treat her for any back problem but only for her elbow, hand and foot.

Plaintiff testified that the Defendant did not offer any vocational rehabilitation either before or after the cut off of weekly benefits.

With regard to the jobs which she held prior to employment with Defendant which are set forth in Defendant's Exhibit T, Plaintiff testified that she could not return to any of those jobs because they required lifting and bending and walking and in fact even sitting too long which she could not tolerate.

With regard to the jobs set forth in Defendant's Exhibit U, Plaintiff testified that almost every employer required online applications and as set forth earlier, on many if not most occasions the application simply meant Plaintiff would submit her resume.

RYAN POLLINA, MD

Plaintiff offered the deposition testimony of Dr. Ryan Pollina taken on December 16, 2021. Dr. Pollina is a board certified anesthesiologist. He has been in practice since 2013. He practices solely pain management. His curriculum vitae was attached to the deposition transcript as Exhibit 1. Plaintiff's Exhibit 2 are records of Dr. Pollina's treatment of Plaintiff from August 20, 2017 to February 25, 2019. The records were attached to the deposition as Exhibit 2 subject to defense counsel's objection as to any hearsay contained in the records and further objecting in the event the records are not complete.

Plaintiff's original treatment occurred on August 20, 2017 at which time she related a fall in 2016 with complaints of lower back pain without radiation into her legs. Dr. Pollina testified with reference to x-rays that he reviewed indicating that the x-rays were read to show no stenosis or no spinal stenosis with lumbar degenerative disc disease at L5-S1 and less so at L4 and L5. He interpreted the x-rays to indicate no narrowing in the canal that would indicate impingement of the nerve roots and arthritic changes at L4 and L5 and L5-S1. He also seemed to recall that Plaintiff had some spondylolisthesis. However, he did not make a reference to it in his note. Dr. Pollina was asked to read a portion of Dr. Gross' report which referred to an interpretation of a lumbar MRI of October 8, 2016. Defense counsel objected on the basis of hearsay which I overrule inasmuch as

Dr. Gross' deposition was taken and his report was inserted into the record of his testimony. Dr. Pollina then read that portion of Dr. Gross' report which referenced the listhesis at L4 and L5. The report indicated that the degree was 2 mm of L4 on L5.

Dr. Pollina also ordered x-rays taken on April 16, 2018. Dr. Pollina read the entire x-ray report into the record which appears on page 14 of his deposition. The x-ray reported a mild anterolisthesis of L4 on L5 with approximately 5 mm of anterolisthesis. When asked the significance of the change from 2 mm to 5 mm, Dr. Pollina responded that the change indicated that there had been a shift further in the lumbar spine over that timeframe. Dr. Pollina would classify that as an abnormal finding.

As to his physical examination of Plaintiff, he found that Plaintiff essentially had no neurological deficits and no significant abnormalities consistent with a neurological injury of the spine. Dr. Pollina's impression after looking at the imaging and doing the clinical examination was that Plaintiff did not have any neurological injury that could progress. He believed the pain Plaintiff was experiencing was from intervertebral discs. His diagnosis was discogenic pain. He explained his diagnosis as follows:

> A. A normal, healthy disc is what we would say avascular and without a nerve supply. Discogenic pain happens when you take the disc itself, which typically in a normal, healthy disc is not painful. When discs are damaged, they can get what's called neovascularization which means there's blood vessels that grow into the disc, usually in the posterior part of the disc and the annulus, which is the cartilaginous portion.
>
> When this happens, you get nerves that can grow in there and become painful. This is essentially where discogenic pain comes from. This is always a disease process. Normal, healthy discs are not painful. That's essentially what I was operating under the assumption with, this patient had pain stemming from the discs themselves.
>
> (Pollina dep., pg. 17)

He agreed that Plaintiff had degenerative disc disease including spondylolisthesis or facet arthropathy, bony overgrowth which are "chronic degenerative changes that happen over a long period of time."

Dr. Pollina was asked whether he had any indication that Plaintiff had back pain before her fall in August, 2016 to which defense counsel objected as hearsay. I overrule that objection since Plaintiff testified that she did not have back pain before the August, 2016 injury. Dr. Pollina testified that based on the history he took from the Plaintiff there was no back pain prior to the fall.

As far as his course of treatment, Dr. Pollina indicated at the outset that part of the problem with discogenic pain is that you cannot rely solely on imaging or an examination. He further testified that the two most common causes of the pain are sacroiliac joint pain or pain stemming from the lumbar facet joints. He therefore began treatment with an SI joint injection. If the patient does not report any improvement, then he testified that it would be unlikely that the sacroiliac joint pain is the source. Plaintiff reported no improvement with the injections.

He also treated Plaintiff with nerve blocks again which did not result in any significant improvement from the Plaintiff. He felt that the diagnostic and therapeutic treatment for both the SI joint pain or facet pain resulting in no improvement lead him to conclude and confirm that the diagnosis of discogenic pain was the best that he could do. He believed that Plaintiff's pain generator was stemming from the disc itself.

The mode of treatment Dr. Pollina administered throughout the course of his treatment was medications to treat the pain. He also spoke to her about "bio psychosocial mechanisms" and referred her to a book that can help people to cope with the pain and also discussed the possibility of a spinal cord stimulator. He also referred her to a surgeon for a second opinion on potential surgical options. No surgery was planned. Dr. Pollina opined that between the date of his first treatment through the date of his last treatment Plaintiff did not get significantly better with the treatment he was giving her. As to restrictions, Dr. Pollina indicated that he did not recall specific restrictions that he gave to the Plaintiff. If asked what his restrictions would be, he indicated that Plaintiff should avoid heavy lifting, bending or twisting with a sit/stand modifications and being able to stretch on a regular basis. In general he would recommend lifting no more than 15 pounds but he did not specifically recall that recommendation.

Deposition Exhibit 2A was one page of Dr. Pollina's office notes dealing with a visit of February 25, 2019. I would overrule defense counsel's objection to the marking of that page inasmuch as Dr. Pollina's records were made part of the record at the time of the hearing. Dr. Pollina read into the record of his deposition the entire office note of February 25, 2019 which is set forth on pages 25 and 26 of his deposition. He further testified that this part of the office note indicates that he disagreed with the independent medical exam which indicated that Plaintiff's pain was purely degenerative. Dr. Pollina indicated in his office note that Plaintiff's pain is directly related to the fall in 2016. Plaintiff did not show any signs of malingering or secondary gain. Plaintiff had no previous history of back pain and was a good candidate for a spinal cord stimulator trial. At the time of his deposition, he further testified he had no reason to change any of his opinions.

Plaintiff's counsel presented a hypothetical question to Dr. Pollina which set forth Plaintiff's job duties as well as the slip and fall which Plaintiff sustained

on August 29, 2016 and following which Dr. Pollina was asked whether it was "more probably than not that the fall of August 29, 2016 caused damage to the disc at the L4 on L5 causing her chronic pain." Defense counsel objected on the basis of hearsay and as well as facts not in evidence at the time and would not be proven at the time of trial. The objection further was made on the basis that the hypothetical omitted other information that the doctor would need. I would overrule the objection. The hypothetical question did substantially conform to Plaintiff's testimony. Dr. Pollina answered by indicating that the patient had an acute injury, most likely the L4-L5 disc that caused discogenic pain that had been the primary pain driver from that point forward.

On cross-examination, Dr. Pollina indicated that he did not recall any conversation regarding the specifics of how Plaintiff fell or the mechanics of her fall. He further testified that he had no recollection of what Plaintiff may have said as to whether she struck her back or twisted her back. He further was unaware of the exact date of Plaintiff's fall. He likewise did not see any treatment records contemporaneously with the time she fell. He further testified that a delay between the time of Plaintiff's fall and the onset of low back symptoms could change his opinion as to the cause of her discogenic pain. He further agreed that if Plaintiff indicated that the onset of her back pain was gradual and not a sudden event, that could alter his opinion as to causation depending on how gradual the onset of pain was.

Dr. Pollina further testified that throughout the time of his treatment, he did not believe that Plaintiff had any evidence of radiculopathy. He further testified that negative EMG testing would be something he would expect in the timeframe that he saw her. A negative EMG would be consistent with his clinical examination and his review of imaging.

As to his physical examination of Plaintiff's musculoskeletal system, he concurred that he found no edema nor any muscle atrophy on the left side or right side. Lack of atrophy in the extremities would be consistent with a lack of nerve damage. Plaintiff exhibited a normal gait with no limping and was not ambulating with any assistive devices which was consistent with no nerve damage. He further noted no paraspinal region tenderness and no SI joint tenderness. He confirmed that the neurological examination was normal.

With regard to the MRI performed on October 8, 2016 showing a mild degree of listhesis at L4 on L5, Dr. Pollina was asked whether he could determine whether that was part of the degenerative changes in the Plaintiff. His response was as follows:

> A. Truthfully at this date I wouldn't have a strong opinion on whether that was a degenerative or an acute finding, and acute process. This certainly could be considered a degenerative change; however, it doesn't necessarily indicate the cause of

> that listhesis. Shifting of the vertebrae can happen acutely or chronically or a combination of both.
>
> (Pollina dep., pg. 36)

He continued to testify that Plaintiff did have degenerative changes on both the MRI and x-rays. When asked if the changes pre-dated the fall, Dr. Pollina testified that arthritic changes to the facet joints or osteophytic overgrowths in the bone happen over a prolonged period of time. As far as spondylolisthesis, it can happen both on a chronic episode or acute or subacute. He also testified that throughout the time of his treatment it appeared that the spondylolisthesis of L4 on L5 seemed to be worsening with time which would support a diagnosis of damage done to that spinal segment. He agreed that across all patients seen with spondylolisthesis on imaging, it is more common to see degenerative spondylolisthesis as opposed to acute spondylolisthesis. He also testified that it is more common to see stable spondylolisthesis rather than progressive spondylolisthesis.

Plaintiff also had degenerative disc disease which is typically a chronic finding but can be associated with acute injuries and can happen relatively quickly. Facet changes were definitely chronic degenerative findings. Regarding the facet arthropathy at L4-L5 and L5-S1, Dr. Pollina indicated that it was difficult to comment on that. He did testify however that the condition did not get better between 2018 and 2019.

He went on to testify that degenerative changes are often caused or related to the aging process and that heredity plays a role as well.

As to Plaintiff's level of activity, it was his impression that her activity levels at the time he saw her were significantly restricted. He recommended physical therapy to get her more active. Dr. Pollina was presented with his office note of October 10, 2017 which was read to him as set forth on page 46 of his deposition. Dr. Pollina's comment regarding his office note would indicate that he was not entirely sure just exactly what the note meant. He agreed that he saw the Plaintiff for the first time approximately a year after the event that she was complaining about and that he would have expected a muscle strain to have resolved by the time he saw her. He confirmed a portion of another office note in which he discussed with Plaintiff the importance of core strengthening and agreed he was referring to a home exercise program which he very often advises patients to do. Plaintiff did begin physical therapy but discontinued the therapy in January, 2018 as the result of a motor vehicle accident. Sometime later she did resume the physical therapy. Dr. Pollina agreed that his office note for January 15, 2018 included palpation of the lumbar spine and still showed no paraspinal region tenderness. He confirmed that the findings on that visit were not inconsistent with previous physical findings which were basically a negative neuromuscular examination. He also on some later visits did straight leg raising

examinations and at all times they were negative. He further testified that with discogenic pain, core strengthening can help and would be his first line of treatment.

His records also revealed that Plaintiff's pain level generally ranged between 4 and 8 on a scale of 0 to 10. Dr. Pollina testified that his assessment was that she was not making progress. He agreed that he had no way to objectively measure what Plaintiff's pain level was and had to rely totally on the patient.

Dr. Pollina also indicated that assuming Plaintiff had a spinal cord stimulator implanted which had to be reprogrammed. He could not say whether a spinal cord stimulator would be helping Plaintiff's condition.

Dr. Pollina was asked to clear up some confusion about Plaintiff's condition.

With regard to Dr. Pollina's last office note of February 25, 2019, he testified that based upon the available history that he obtained with no pain before the fall and developing pain afterward, he believed that the patient had preexisting degenerative changes and that the fall created disruption to the L4-L5 discs that ultimately lead to the patient's pain.

Dr. Pollina was asked whether it was fair to say that a fall in general can cause preexisting degenerative changes to become symptomatic without causing any change in the pathology. He responded that preexisting arthritic or degenerative changes can become symptomatic after an injury and further that they can become symptomatic without trauma.

When asked whether there was any objective evidence that there is a disruption in the L4-L5 disc directly related to the fall, Dr. Pollina answered as follows:

> A. The indirect evidence would be the advancing spondylolisthesis. Two millimeters turning into five millimeters points towards that. To prove that it's from the fall, I can't say that.
>
> (Pollina dep., pg. 55)

On final cross-examination, Dr. Pollina was asked questions with regard to any restrictions that he previously testified on direct examination. He first indicated that it would be difficult for him to comment on her current situation. He agreed that when he was treating her he was not asked to evaluate her nor did she ask him as to whether she needed restrictions at work or activities at home. He also agreed that he was not asked to do a disability evaluation in terms of what she could and could not do. He agreed that he did not assess what she could do during the time she was seeing him in terms of physical activity but did

encourage her to become more active. He did agree that he would have encouraged her to walk and stand as part of core strengthening.

On re-direct examination, Dr. Pollina testified that with regard to Plaintiff's automobile accident, she only reported an injury to her right wrist.

Dr. Pollina also testified that with regard to his diagnosis, he would not expect a positive straight leg raising test or even a positive EMG and in fact would expect both to be negative. He further testified that nothing defense counsel raised on cross-examination would change his assessment that it was more probably than not that the fall in August, 2016 caused damage to the disc at the L4 on L5 level causing pain.

On final re-direct examination, he identified a portion of his records indicating that Plaintiff stated that her pain was work related.

On re-cross examination, Dr. Pollina was shown the portion of the electronic record for December 10, 2018 indicating that there was no work related injury. Dr. Pollina responded that his staff may have incorrectly transcribed the patient's information.

Deposition Exhibit 1 is Dr. Pollina's curriculum vitae. Deposition Exhibit 2 are the medical records of Dr. Pollina from the dates of service of August 20, 2017 through February 25, 2019. Document number 01389 appears to be an intake form wherein Plaintiff indicates that the condition is work related. The document bears the Plaintiff's signature of August 20, 2017. Document number 01390 indicates Plaintiff's pain beginning on August 29, 2016 in a sudden manner. It appears that on the diagram Plaintiff indicated the problem to be with her back. Document number 01392 indicates Plaintiff's back pain to be the area where symptoms are occurring. Document number 01396 indicates Plaintiff's pain intensity is severe at that time. She also indicates that she cannot lift or carry anything at all. Her pain prevents her from walking more than one quarter mile and her pain from prevents her from sitting more than a half hour. Plaintiff cannot stand for more than a half hour and because of pain she has less than 4 hours of sleep. Pain has restricted her social life and restricts her to short necessary journeys under 30 minutes. It appears that Dr. Pollina's first treatment of the Plaintiff occurred on August 21, 2017. Plaintiff was seen a total of 13 times from that date through February 25, 2019. On each occasion the Plaintiff reported her chief complaint to be low back pain. In November, 2017 Plaintiff began reporting hip and buttock pain. Plaintiff reported having been involved in a work related fall in 2016 and having continuous lower back pain without radicular features. On each occasion Plaintiff was seen by Dr. Pollina, a physical examination was performed including the musculoskeletal system, motor exam and neurological system. On all occasions the examinations did not disclose any abnormalities with regard to all aspects of the examination. It is to be noted that

on the initial examination in August, 2017, Plaintiff reported no paraspinal tenderness in the lumbar spine. In September, 2017 Plaintiff did report tenderness in the lumbar area. The examinations as referenced above did not disclose any abnormalities. Dr. Pollina's diagnosis remained the same throughout the time of his treatment of the Plaintiff which included medial branch blocks and steroid injections. The diagnoses were degeneration of lumbar interverbal discs and solitary sacroiliitis. On the final office visit on February 25, 2019 Dr. Pollina indicated that he believed Plaintiff's pain was a direct result of the work related injury. It appears one of the reasons he came to this conclusion was because Plaintiff had no history of pain prior to her fall and further the MRI disclosed more degenerative changes however he also noted that her pain has not changed since the fall.

MARWAN SHUAYTO, MD

Plaintiff also offered the deposition testimony of Dr. Marwan Shuayto taken on December 15, 2021. Dr. Shuayto is a physician with Michigan Neurology and Spine Center. The doctor's curriculum vitae was marked as Plaintiff's deposition Exhibit 1 and attached to the transcript of the deposition without objection from defense counsel. He is board certified in neurology.

Plaintiff was first seen at the doctor's facilitate on August 12, 2019. The Plaintiff gave a history of chronic low back pain for approximately 3 years. No other history was given to the doctor at that time.

Dr. Shuayto described his clinical examination of the Plaintiff as "most abnormal in the lumbar spine" with signs of radicular pain, facet joint pain and sacroiliac joint pain. Dr. Shuayto ordered an MRI of the lumbar spine which was completed on October 21, 2019. The doctor came to a diagnosis of chronic pain syndrome with chronic lumbago and a possible intervertebral disc disorder with radiculopathy.

Following the completion of the MRI on October 21, 2019, Plaintiff was seen on November 6, 2019. Dr. Shuayto testified that the abnormalities were primarily in the L4, L5 and S1areas. There was facet joint degenerative changes at L4-L5 and L5-S1 with a broad disc protrusion at L4-L5 and L5-S1 with spondylolisthesis at L4 on top of L5. With regard to the spondylolisthesis, Dr. Shuayto testified that it could be caused by trauma or degenerative changes and certain daily activities. Also, someone is more susceptible to having spondylolisthesis if there is a significant family history of it.

As to the degenerative changes on the facet joint, Dr. Shuayto testified that they can occur due to either widespread inflammatory processes like osteoarthritis or sometimes due to trauma. He found no evidence of widespread osteoarthritis. As to the cause of disc bulges at L4-L5 and L5-S1, Dr. Shuayto testified that trauma can cause a bulge.

Plaintiff received treatment in the form of SI joint injections and medial branch blocks. The doctor testified that there were two injections in 2020 and 2021. He described the medial branch blocks as diagnostic procedures to diagnose an issue to see the pain is coming from the facet joints. Only one block was performed on December 4, 2019. It did not help Plaintiff's pain. The significance of the failure to help Plaintiff indicated that most of the pain was not directly due to the facet joints. He concluded that the disc displacements and the anterolisthesis or spondylolisthesis could be causing more of the pain that the patient was feeling.

Dr. Shuayto attempted a spinal cord stimulator trial on June 24, 2021. The Plaintiff reported a 50% resolution of her pain and therefore Dr. Shuayto proceeded with a permanent implant on October 15, 2021. At the time of the doctor's deposition, the spinal cord stimulator needed reprograming which had not yet occurred.

As to restrictions, Dr. Shuayto testified that with the kind of findings Plaintiff had and symptoms, if restrictions were asked for it would usually be a 10 pound weight lifting limit and avoidance of bending, twisting, heavy lifting, heavy pushing and pulling of anything more than 25 pounds. Standing and walking would not be one of the limitations.

Dr. Shuayto was given an extensive hypothetical question beginning on page 19 of his deposition which included a history of the injury occurring in August, 2016 as well as the type of employment in which Plaintiff engaged for the Defendant. The hypothetical also included the specifics of the fall that occurred and the treatment she received from various providers. The hypothetical also included reference to various diagnostic studies that were undertaken during the course of treatment to the Plaintiff. The doctor was then asked whether within a reasonable degree of medical certainty if he believed that the incident that took place when she fell in August, 2016 was the cause of the problems that he diagnosed and saw when he first saw her and then through the entire period of time that he treated her. Defense counsel placed an objection to this hypothetical question based upon facts not in evidence and that the hypothetical question was not complete. I would overrule the objection at this time. The doctor's answer will be taken subject to the other evidence that appears in the case which would affect the weight to be given to the doctor's answer. The doctor simply responded that in his professional opinion it could be related to the fall. On further questioning with regard to his opinion, Dr. Shuayto was asked whether there was anything else in the history that would indicate that anything but the fall could have caused the issue. Dr. Shuayto responded that the patient did not have any symptoms prior to this incident and never complained of any low back pain. He further answered that it was more probable than not that the fall caused the issues that he was able to see and diagnose.

On cross-examination, Dr. Shuayto agreed that Plaintiff did not give any description of a specific activity or traumatic injury that caused the onset of her low back pain. He went on to answer that Plaintiff filled out a form which indicated that the pain started specifically on August 29, 2016. He went on to say that it was his understanding that the pain was gradually getting worse.

Dr. Shuayto further testified that he had not received any records from Dr. Ryan Pollina. He was unaware that Dr. Pollina had also given injections to the Plaintiff. He was aware that Plaintiff received injections from Dr. Sciotti.

Dr. Shuayto testified that it was not uncommon for patients to fail all injections which is apparently what happened with regard to Plaintiff. It was for that reason that a spinal cord stimulator was discussed with the Plaintiff.

As to Dr. Shuayto's diagnosis to radiculopathy, he agreed that the opinion was based on Plaintiff's complaints of pain. He agreed that there were no findings on physical examination indicating radiculopathy other than a straight leg raising sign. Plaintiff did report pain in the lumbosacral region on the straight leg raising test.

Dr. Shuayto performed an EMG of the lower extremities on February 3, 2020 which did not show evidence of radiculopathy. He agreed he dropped the diagnosis of radiculopathy at that time. He agreed that a negative EMG is a strong indicator of no radiculopathy. He agreed that there was no notation in his office charts of other findings such as abnormal asymmetrical reflexes or any atrophy of the lower extremities. He further testified that Plaintiff had a mononeuropathy which is not related to the injury.

Dr. Shuayto further testified that Plaintiff did give him a history of being a diabetic and was taking Metformin.

With regard to the MRI study performed on October 21, 2019, Dr. Shuayto only reviewed the report. Dr. Shuayto agreed that the MRI study showing a small focal disc protrusion at T12 and L1 was not a pain generator. As to the facet degenerative changes at L4-L5, Dr. Shuayto agreed that the change could be due to osteoarthritis. Dr. Shuayto agreed that it takes time for boney changes to show up on an x-ray study. He went on to testify that if there is acute trauma to facet joints, inflammatory changes in the facet joints can occur within weeks. He agreed that spondylolisthesis is most often a degenerative condition. He further agreed that spondylolisthesis can progress on its own without trauma.

As to the MRI finding of a ligamentum flavum hypertrophy bilaterally effacing the posterior thecal sac, Dr. Shuayto indicated that it was not traumatic

in nature. He agreed that the disc bulges were not reported as herniations which was consistent with the negative EMG study.

As to Plaintiff reporting pain, he agreed that he relies on the report from the patient.

Dr. Shuayto further agreed that if Plaintiff experienced more relief from the reprograming of the spinal cord stimulator, he would anticipate that she would be more functional. He also agreed that there was no medical contraindication to Plaintiff walking or standing.

On final cross-examination, Dr. Shuayto testified that he was unaware that Plaintiff had been involved in two car accidents. He also agreed that he did not treat Plaintiff for her knees, hands and/or neck.

On re-direct examination, Dr. Shuayto testified that diabetes did not cause Plaintiff's back problem and that his treatment was reasonable and necessary.

Deposition Exhibit 1 is Dr. Shuayto's curriculum vitae.

JAMES FULLER, MACRC

Plaintiff also offered the deposition testimony of Mr. James Fuller taken on September 28, 2022. Mr. Fuller is a vocational rehabilitation counselor. Mr. Fuller's curriculum vitae was typed into the record of the deposition without objection from defense counsel. Mr. Fuller was asked by Plaintiff's counsel to conduct an analysis of Plaintiff's work capability, transferable skills and earning potential. Mr. Fuller met with the Plaintiff on May 5, 2022. He prepared a four page written report dated May 9, 2022. Mr. Fuller's report was also typed into the record as his deposition testimony together with attachments subject to defense counsel's objection as to hearsay regarding medical information and treatment. I would reserve ruling on this objection pending completion of all of the evidence submitted in this case.

The Plaintiff reported an injury occurring to her when she tripped on a fatigue mat. She briefly set forth the problems with her lower lumbar spine and some limited information regarding the treatment she received from some of the physicians. The report also sets forth in a little more detail the medical treatment she received. This treatment included spinal cord stimulator surgery on June 24, 2021. Mr. Fuller also reported receiving and reviewing independent medical evaluations from Drs. Lee, Gross, and Seidel which all indicated no restrictions for the Plaintiff. He also had Dr. Shuayto's restrictions as set forth in his deposition of December 15, 2021 and restrictions imposed by Dr. Ryan Pollina.

Mr. Fuller reported that Plaintiff was observed to be in obvious pain at the time he met with her at which time she required the ability to alternate between

sitting, standing and walking around. She disclosed that she is receiving Social Security Disability Benefits and has a valid drivers' license. She reported having access to the internet with an email address. She advised Mr. Fuller that her computer skills are "not good" and her keyboarding skills were limited. She further advised Mr. Fuller that she is actively seeking employment using Indeed.com with her resume on the internet website.

Plaintiff's educational background as given to Mr. Fuller is substantially the same as her testimony at the hearing. Mr. Fuller had available to him Plaintiff's Agency Form 105A.

As to Plaintiff's transferable skills and universe of jobs, Mr. Fuller indicated in his report that her work as a receptionist was performed over 25 years ago and any skills from that work would not longer be transferable. Her work as a deli clerk, cashier, machine feeder and kitchen helper/food service worker were all unskilled and as a result there are no transferable skills from education, credentialing or work history. The universe of jobs would be the 3,125 unskilled jobs in the Dictionary of Occupational Titles. The universe of jobs does not take into consideration restrictions and/or physical limitations.

Mr. Fuller's labor market survey indicated that there are unskilled sedentary jobs in the Port Huron regional economy which are found to be available. The wage expectation would be a minimum of $9.87 per hour which is minimum wage, not the $13 per hour with overtime at time and a half and benefits including vacation and sick pay, life insurance and 401K benefits that the Plaintiff was able to get at Lake Huron Medical Center.

Mr. Fuller's conclusion was that Plaintiff was at best capable of unskilled sedentary work. He further concluded that Plaintiff had no transferable skills to that level of employment and if acceptable employment could be found under the restrictions which were provided to her by her treating physicians, she would be able to earn minimum wage. He further concluded that based on the fact that Plaintiff described the need to laydown and recline throughout the day and based upon the fact that she would be undergoing an SI fusion on June 3, 2022, she is unemployable and no vocational options and wage earning capability.

On further direct examination, Mr. Fuller confirmed that Plaintiff informed him that she tripped on an anti-fatigue mat and that she injured her low and mid back. As to her job duties, Plaintiff informed Mr. Fuller that she was a kitchen worker and delivered trays of food to patients. She informed him that she lifted up to 40 pounds and delivered 60 to 70 trays walking up to 10 miles a day and working out of 10 different pantries in the hospital. Mr. Fuller further testified that under the DOT listing as a kitchen worker, the job would be classified as unskilled performed at "medium" meaning that the employee would be on his or her feet at least 6 of the 8 hours and would be lifting up to 50 pounds. He

reiterated in his further testimony that here are over 3,000 skilled jobs at all levels. The universe of jobs for Plaintiff would be in the unskilled category. He reiterated that Plaintiff had no transferable skills.

Mr. Fuller testified that he did have an opportunity to read the depositions of Dr. Pollina and Dr. Shuayto. He testified that based upon Plaintiff's physical complaints and upon the restrictions given to her by Drs. Pollina and Shuayto, Plaintiff would not be able to do any work. He went on to testify that based upon Dr. Pollina's restrictions, Plaintiff would be placed at a limited range of sedentary work. Dr. Shuayto's limitations which included the need to lie down and recline and that she needed a lot of breaks throughout the day would eliminate all employment. Mr. Fuller also testified that absence from work of more than 1 day a month for any reason would initially eliminate all work as well as absences for good excuses. He further testified that taking medication such as narcotic pain medication can be a barrier to many different types of employment depending on the side effects.

Mr. Fuller again reiterated that Plaintiff's work as a receptionist over 25 years ago would not be relevant because of technology that has dramatically changed for receptionists.

Mr. Fuller was asked whether Plaintiff would be qualified to perform a customer service representative job which was set forth in the report of Defendant's vocational expert. Mr. Fuller responded that it is a "SVP 5 job" and so she would not have the skills to that level. As to an appointment clerk, Mr. Fuller characterized that as SVP 3 which would call for a lot of computer use and capability requirements. He also testified that other positions referred to in Ms. Grossberg's report such as receptionist and appointment clerk would likewise be jobs that Plaintiff did not have the skills to perform.

On initial cross-examination by defense counsel, there were questions and answers with regard to the materials in Mr. Fuller's file. Eventually it was determined that his file contained the depositions of Dr. Pollina and Dr. Shuayto with whatever exhibits were attached to those depositions as well as IME reports of Dr. Seidel, Dr. Gross and Dr. Lee. In addition, there was also a Form 105A and the Indeed.com and Onet attachments to his report.

On further cross-examination, Mr. Fuller confirmed that with regard to the restrictions testified to by Drs. Pollina and Shuayto, Plaintiff would be capable of a range of sedentary work. He also noted that in Dr. Shuayto's testimony, standing and walking were not contraindicated. Mr. Fuller testified that Plaintiff might be capable for a range of light duty work depending on the restrictions of sitting/standing and with 6 or more hours of standing. Lifting restrictions would be 20 pounds for the light duty category. He further testified that he was aware that Drs. Lee, Gross and Seidel did not find Plaintiff in need of any restrictions

based upon a work related condition. He agreed that if Plaintiff had no restrictions, she would have no loss of wage earning capacity.

Mr. Fuller confirmed that one of the reasons he found Plaintiff unemployable was based upon Plaintiff's scheduled surgery on June 3, 2022. He based his knowledge with regard to the surgery solely on the information provided to him by Plaintiff.

With regard to Plaintiff's former job duties as a receptionist, Mr. Fuller agreed that much of reception work involves greeting the public. He also agreed that as described by the Plaintiff she also did filing or work with files. He agreed that filing is sometimes part of the receptionist's job. He further stated however that file clerk falls under a different DOT listing. It is considered semi-skilled and is light physical demand. He agreed that receptionist work has changed over the years because of computers. He agreed that in many places employers train new employees on specific software that they use to run the office. He agreed that Plaintiff indicated that she did light typing as a receptionist years previously. He agreed that a cashier's job might be appropriate for Plaintiff if the job could accommodate the use of a stool or a chair. He also considered appropriate jobs as a gate or desk attendant. He agreed that the job market his changed over the last couple of years and agreed that many entry level jobs now pay more than minimum wage which was $9.87 per hour.

In his labor market survey, Mr. Fuller agreed that he used the Indeed website to search for jobs and no other sources besides the internet website. He agreed that use of the website involves typing a search term or a keyword in order to find a list of job openings. He agreed that the keyword that appeared first in the copy of the labor market survey provided to Defendant was "attendant jobs" in different categories. He agreed that the first job on the list was a gas station attendant cashier but was not able to determine the pay scale for that position. The following job was a parking booth attendant in the City of Port Huron listing a wage of $11.50 to $15 per hour. He agreed that the job typically involves sitting in a booth and taking parking tickets from people who have parked and collecting their money and lifting the gate so they can exit. He was unable to say whether he considered it a sedentary job because many of these jobs require a person to stand in order to reach in and out of the window to deal with customers.

He agreed that another keyword entered was "greeter" in Port Huron and the Indeed website suggested use of words other than greeter such as clerk, front desk job, service jobs, part time weekend job or receptionist jobs. He did not use any of the job titles or keywords when conducting his labor market survey. When asked whether jobs such as clerk, front desk and receptionist could be considered sedentary, Mr. Fuller replied that he had no idea what the individual jobs would require. He agreed that the DOT classified hotel front desk

as sedentary. There are many different types of clerks that would be semi-skilled or administrative clerks in the SVP 3 and SPV 4 category. He agreed he would have to see the job descriptions to determine whether the job was in the light or sedentary category.

The Indeed website indicated with regard to greeter jobs that 63 jobs were in the Port Huron area. There were 32 front desk jobs in the Port Huron area for front desk clerk and 49 jobs in the Port Huron area for customer service representative. There were 12 jobs for a receptionist in Port Huron.

Mr. Fuller agreed that Plaintiff would not have the qualifications to be a personal care attendant which would fall within the home health aide or nurse aide. Both of them are semi-skilled jobs and are physical.

As to customer service jobs, there are no listings in the DOT of any customer service jobs that are at an unskilled level.

He agreed that a labor market survey is a snapshot in time. He agreed that with the restrictions indicated by Dr. Shuayto and Dr. Pollina, Plaintiff could perform sedentary work at minimum wage of $9.87 per hour. He also agreed that there are many jobs that are paying more than the minimum wage including sedentary jobs based upon changes in the labor force since the pandemic.

On further direct examination, Mr. Fuller testified that Plaintiff's capability of performing sedentary work because of the restrictions by Drs. Pollina and Shuayto would reduce the number of available jobs. He agreed that not all employers will allow use of a stool. This would be a further limit on the available sedentary jobs.

Mr. Fuller further testified that if Plaintiff needed to lay down and recline throughout the day, there would be no work which Plaintiff can perform. Mr. Fuller further testified that in his 44 years as a vocational rehabilitation counselor he has never come across an employer that would allow someone to lie down.

On further cross-examination, Mr. Fuller conceded that some of the jobs which are sedentary such as receptionist, parking booth attendant or others already are accommodated with a chair. He also agreed that positions such as receptionist or costumer service representatives or desk attendants are often provided with a desk and a chair.

On final cross-examination, Mr. Fuller indicated that he had never seen a written restriction from either Dr. Pollina or Dr. Shuayto.

GEOFFREY SEIDEL, MD

Defendant offered the deposition testimony of Dr. Jeffrey Seidel taken on May 12, 2022. Dr. Seidel is board certified in physical medicine and rehabilitation and electrodiagnostic medicine. He also treats patients at the office where his deposition was taken as well as Henry Ford Hospital Macomb Back Clinic where he is the Medical Director. He is also a clinical professor at Michigan State University and Wayne State University teaching medical students and residents. His curriculum vitae was attached to the deposition as Exhibit 1 without objection.

Approximately one percent of Dr. Seidel's practice involves performing independent medical examinations. He did evaluate the Plaintiff on October 22, 2020. He obtained a history, performed a physical examination and rendered an opinion set forth in a report of October 22, 2020. He thereafter reviewed medical records as well as images and offered a second report dated October 23, 2020. Both reports were typed into the record of his deposition subject to Plaintiff's counsel's objection as to hearsay and without agreeing to the doctor's conclusions and findings.

The Plaintiff's occupational history provided to Dr. Seidel is substantially the same as her testimony at the time of the hearing. Likewise, the medication she reported to Dr. Seidel is substantially in accord with her testimony. Significant past medical history relative to the claim would indicate no cervical pain lumbar pain prior to the fall at work on August 29, 2016. She likewise had no hip pain prior to that injury. She did report the motor vehicle accident which she indicated occurred in 2018 which caused a right wrist fracture. She reported that she recovered from the accident and that the accident did not worsen her lumbar condition. The history given to Dr. Seidel regarding the fall that she had on August 29, 2016 is substantially the same as her testimony at the time of the hearing. She also provided a history of her treatment with physicians as she did at the time of her testimony. She reported the same symptoms as she did at the time of the hearing. The pain in her back includes numbness in the left buttock, pain in both groins. Dr. Seidel performed a physical examination upon Plaintiff. He indicated that approximately 20 minutes into his history taking, Plaintiff changed her position from sitting to standing and then sat down again. She indicated that her low back pain was the reason for her body position change. It appears that Dr. Seidel's physical examination included the entirety of Plaintiff's spine from the thoracic level right through the S1 level. The entirety of his physical examination findings are set forth on pages 14 through page 20. In addition to his physical examination of Plaintiff Dr. Seidel reviewed three CD ROM discs one of which was an MRI report, one of which was an MRI lumbar spine film of August 22, 2018. The impression portion of Dr. Seidel's report included several conclusions the most significant of which were a completely normal clinical neuromuscular examination, complaints of bi-lateral hip pain with a normal clinical muscular skeletal examination, and no reported complaints of

knee pain or wrist pain with a normal clinical musculoskeletal examination. He also commented as follows with regard to the mechanism of injury:

> The mechanism of injury was interesting. If an individual holding a pan, trips and falls without the tray or pan flying, the items being thrown off the pan, I would consider this to be a controlled fall with minimal traumatic forces involved.
>
> (Seidel dep., pg. 20)

The doctor's report of October 23, 2020 involved his review of the lumbar MRI film taken on August 22, 2018, x-rays obtained on April 16, 2018, and x-rays dated August 29, 2016. Dr. Seidel also reviewed records from Ascension St. John's Hospital. He also reviewed records from Blue Water Pain Specialists, Blue Water Surgery Center, records of Dr. Matthew Sciotti and records of Dr. Coly Zeiger. He also reviewed records of Dr. David Montgomery and reports of Dr. Nathan Gross and Dr. Stanley Lee as well as Lake Huron Medical Center Radiology and Lake Huron Medical Center records. He also reviewed therapy notes, nurse practitioner evaluation of David Kocenda as well as further records of Dr. Todd Murphy, St. John Medical Center and St. John Hospital records.

The impressions that Dr. Seidel came to following his review of these records were the same as his impressions at the time of his physical examination and as previously summarized. He specifically commented that he found no basis to alter his opinions as documented in his October 22, 2020 report. He further concluded that daily work activity as well as the incident described on August 29, 2016 did not result in an anatomical change within Plaintiff's lumbar spine and did not cause or aggravate the underlying lumbar spondylosis, grade 1 interior spondylolisthesis at L4-L5, minimal disc bulging that was seen in the lumbar spine and did not result in fracture or any abnormality of the sacroiliac joints, wrists or cervical spine or knees. He further commented that Plaintiff had a personal medical condition of obesity, degenerative arthritis of the lumbar spine and mild peripheral polyneuropathy that would not restrict her from returning to work in any way. He went on to opine that the fall on August 29, 2016 as she reported did not aggravate or accelerate her pre-existing degenerative lumbar spine condition. Plaintiff may return to work without restrictions and required no treatment of any kind as it related to work or the fall as described.

On further direct examination, Dr. Seidel testified that Plaintiff did not report any symptoms relative to her neck, wrists or knees. Further there was no clinical abnormalities or pathology on the clinical examination for both wrists and knees. There was no objective abnormalities detected regarding the neck, and her range of motion was normal and consistent with her age. Furthermore, he found no diagnosis of work-related abnormality in either hip or groin and no disability related to the hips or groin.

He testified that Plaintiff did report pain during portions of the examination but she did not report pain with palpation of the musculature. He found no "ropiness" muscle spasm when palpating the thoracic and lumbar and gluteal regions.

His examination of the feet and ankles disclosed findings consistent with a peripheral neuropathy, but nothing related to spine concerns. He further testified that the most common cause of peripheral neuropathy is diabetes. He also testified that there was no clinical evidence of radiculopathy.

Dr. Seidel reviewed an EMG report dated February 3, 2020 performed by Dr. Cirato and testified there was no evidence of radiculopathy in either lower extremity. He further testified that there were findings in the EMG that could be interpreted as peripheral neuropathy which is not a post traumatic process so it would not be related to the fall described by Plaintiff. The EMG report was consistent with his clinical conclusions that there was no lumbar radiculopathy in either lower extremity.

Dr. Seidel was questioned after his review of various records describing Plaintiff's treatment between the time of her alleged injury and his examination as to whether there would be a basis to continue injections and indicated that such a treatment would not be reasonable any longer. He further testified that based upon his experience, after two epidural injections performed without any improvement, there should be no further injections attempted.

He further testified that based upon his examination of Plaintiff of October 22, 2020 and the totality of the information that he had available, Plaintiff would not be in need of any further physical therapy beyond that date. As to her medication, and his treatment practice, he would not authorize opioid management in this instance.

Dr. Seidel was advised that Plaintiff did have a spinal cord stimulator implanted in the fall of 2021 by Dr. Shuayto. He testified that at the time of his evaluation on October 22, 2020, he would not have recommended a spinal cord stimulator indicating further that the spinal cord stimulator with degenerative changes have a low probability of being effective.

Dr. Seidel's conclusion that Plaintiff had degenerative changes in her spine was based upon his review of medical records, interpretations of radiologists, and reviewing actual MRI images himself. There were several questions by both counsel clarifying just exactly what images Dr. Seidel reviewed as opposed to just reports. Dr. Seidel indicated that he did review actual x-ray films and CAT scan CDs and also actually reviewed and had available to him at the time of the deposition an MRI film dated October 8, 2016. Dr. Seidel

indicated that the confusion lay in his error in placing the review of the film in a different section of his report which indicated review of records.

At the time of the deposition, Dr. Seidel did have available the x-ray images taken on August 29, 2016. He testified that the x-ray image disclosed anterior positioning of L4 on L5 approximately 2mm grade 1 anterior spondylolisthesis. The disk which Dr. Seidel reviewed also contained images of the October 8, 2016 MRI. Dr. Seidel testified that the findings on the October 8, 2016 MRI disclosed the same finding as the x-ray image of August 29, 2016. The CD which was also reviewed by Dr. Seidel contained a CT scan from September 15, 2016. The findings on the CT scan were also consistent with the findings set forth on the August 29, 2016 x-ray and October 8, 2016 MRI. Dr. Seidel testified that the imaging studies that he reviewed indicated facet arthropathy at L4-5 and L5-S1. There was also a loss of vertical disc height at L5-S1 and a degenerative anterior positioning of L4 on L5 which is spondylolisthesis. The October 16 lumbar spine MRI revealed what the doctor described as “pseudo bulging” of the disc at L4-L5 which is a tiny bulging and also at L5-S1 there is a bulging of the disc. He further testified that the nerves at those levels are free and clear in the central canal and in the neural foramen. These findings were degenerative changes. The degenerative changes are normal age-related changes. Age related changes are multifactorial including body habitus, obesity, genetics, and smoking.

Defense counsel asked the following hypothetical question to Dr. Seidel:

> Q. Now, this lady described to you a fall that she said occurred on August 29th. She said that she fell forward while carrying a tray. She had tripped on a mat. She did not, as I see it from your report, describe any direct blow to the spine or any direct contusion or injury like that. She said she fell forward on her elbows and hands. She also indicated to you that she did not trip or spill the tray. Is that type of injury, the mechanism as she described it to you, the type of injury that could cause or lead to the spondylolisthesis?
>
> (Seidel dep., pg. 51-52)

Plaintiff’s counsel objected to the hypothetical question on the basis that it would not conform with the proofs at the time of trial. Plaintiff counsel’s objection is overruled. This hypothetical question does conform to the Plaintiff's testimony at the time of the trial regarding the method of her fall. Dr. Seidel responded that the mechanism of the injury as described by Plaintiff would not cause an anterior spondylolisthesis. Dr. Seidel further amplified on his answer indicating that a direct trauma causing an anterior spondylolisthesis would require direct forces of a high velocity to the back, such as an individual falling out of a second story building and landing on a bar or also being thrown from a motorcycle. He further testified that a post traumatic spondylolisthesis would have resulted in fractures

of several bones and ligament tears that would have been evidenced on imaging in the x-rays, CT scan and lumbar MRI. He further testified that he did not see any imaging findings on the x-ray, CT scan or MRI of the lumbar spine in the same timeframe as the incident that would be consistent with trauma.

As to the changes in the degree of spondylolisthesis between 2016 and 2018 showing a change in the slippage of the spondylolisthesis, Dr. Seidel testified that the changes over that timeframe were not due to the trauma or work.

As to the August 22, 2018 MRI of the lumbar spine, Dr. Seidel interpreted the images as a small central disc bulge. He further said that he could see how a radiologist may say that it was a disc protrusion, but he believed it was something "very small". He would not attribute the change over time at the L5-S1 disc to the incident described at work resulting in a fall.

Dr. Seidel was also presented with the history of Plaintiff's involvement in a motor vehicle accident in December 2017 indicating that she was driving 70 miles per hour and hit a semi-truck which involved fractures to the wrist, elbow, and foot. Dr. Seidel testified that an accident at that speed producing force strong enough to fracture bones such as Plaintiff described could have an impact on the lumbar spine. It could also affect disc herniations in the lumbar spine and possibly bugles.

Defense counsel presented a lengthy hypothetical question to Dr. Seidel which involved a description of the fall which Plaintiff had on August 29, 2016 as well as treatment that Plaintiff had received. The hypothetical question begins on page 57 of Dr. Seidel's deposition and continues through page 59. Plaintiff's counsel objected to the hypothetical question on the basis that it would not conform to proofs at the time of trial. I would overrule Plaintiff's counsel's objection because I believe a review of Plaintiff's testimony and the other records admitted at the time of the hearing indicate that the hypothetical question presented to Dr. Seidel is substantially in conformity with the proofs submitted. Dr. Seidel opined that as of August 22, 2020 there was no definable objective musculoskeletal abnormality involving Plaintiff's neck, elbows, wrists, low back, hips and knees. He further testified that as of the time of his examination on October 22, 2020 there were no residuals for the same diagnostic considerations and further that Plaintiff could return to work without restrictions and would need no further treatment as of the time of his examination.

On cross examination, Dr. Seidel testified that he would not restrict Plaintiff based upon any other condition which she had. He conceded that his independent medical examinations are for the defense bar and/or insurance companies. He further agreed that the only information he had regarding

Plaintiff's job was what was given to him by the Plaintiff as set forth in his report as well as information in the hypothetical question.

Dr. Seidel agreed that he had no record of treatment or records documenting back pain prior to the incident of August 29, 2016. He agreed that while Plaintiff gave a history of injuries to her wrists, neck and back, she also indicated that she recovered from her injuries with reference to her neck and wrists. He agreed that Plaintiff indicated that her back pain was not immediate but gradually came on. Dr. Seidel also indicated that the mechanism of injury he described in his report was based upon his interview of the Plaintiff on October 22, 2020. He further testified that he did not see a description of the mechanism of injury similar to that in the records. He has no other information other than what was provided to him by the Plaintiff.

Dr. Seidel also had available to him at the time of the deposition a CT scan image dated September 17, 2014 which Dr. Seidel indicated was focused primarily on the abdomen but did include the hips front to back. Dr. Seidel was asked whether he was able to determine from reviewing that CAT scan whether or not the L4-L5 level showed any slippage or spondylolisthesis to which he replied that the image did not include a sagittal view or similar view and he could not determine the listhesis status.

Dr. Seidel also testified that he reviewed various tests and images and agreed that from the earliest images there was a 2mm slippage at the L4-L5 level which would be spondylolisthesis. As far any change in the slippage by reviewing the MRI of August 28, 2018 and the CAT scan of April 16, 2018, he noted and would agree that there was a 2mm further slippage. Plaintiff's counsel pointed out to Dr. Seidel that his report of October 2020 referenced his review of the August 22, 2018 MRI and reported that there was a 4mm listhesis. He further pointed out to Dr. Seidel that the x-ray CD disk performed on April 16, 2018 was reported by Dr. Seidel to indicate a 5mm figure as opposed to the 4mm figure in August. Plaintiff's counsel asked whether the condition improved or whether he couldn't determine accurately because the CD x-ray was an x-ray and the other study was an MRI. In response, Dr. Seidel testified as follows:

> A. When you're measuring with the radiographic imaging software you're measuring through pixels and one of the challenges is that the x-ray image could be rotated slightly or where there - - the angles are - - I would say there's no appreciable difference between a four millimeter and five millimeter measurement when you're comparing different types of images.
>
> Q. And that's my point, there's no change there, correct? It's not getting better.
>
> MS. TICE: Let the doctor finish.
> MR. PARTIPILO: Go ahead, Doctor?

> A. I would say it's the same amount. It's not better, it's not worse. The x-ray beam is little farther away than the MRI image. They're not apples to apples comparison.
>
> (Seidel dep., pg. 71)

He went on to testify that the slippage did not get better and that the images on the April 16, 2018 x-ray and the August 22, 2018 MRI are the same. He also testified that the spondylolisthesis either stays the same or progresses, but he has never seen it get better.

Even though Dr. Seidel's examination occurred two years after the 2018 MRI, based upon the history and physical examination he performed upon Plaintiff he did not feel other images were needed. Dr. Seidel did not order any imaging studies on the examination date of October 22, 2020.

Dr. Seidel agreed that he did not see the Plaintiff in the four years before his examination of October 22, 2020. He also testified that he has no knowledge directly of Plaintiff's condition since the examination of October 22, 2020. He further testified that he spent 20 minutes taking a history from the Plaintiff and the remainder of the time doing the physical examination. The Plaintiff was booked for an hour and a half (1-1/2) but was 15 minutes late.

Dr. Seidel agreed that he did not have any imaging study that documents anterior listhesis prior to her fall at work. He agreed he could not say whether or not there was any slippage before that date.

Dr. Seidel acknowledged that he reviewed a copy of Dr. Montgomery's report which indicated that the Plaintiff's symptoms were consistent with spinal stenosis and that Dr. Montgomery gave Plaintiff an option of a lumbar laminectomy. Dr. Seidel defined spinal stenosis as a narrowing of the spinal canal size and space. Dr. Seidel admitted that he did not make a notation on what date Dr. Montgomery made that statement and recommendation.

With regard to the records of Dr. Todd Murphy which Dr. Seidel reviewed dealing with the motor vehicle accident, he agreed that Dr. Murphy's records did not indicate any involvement of the low back as an injury. The injuries from the accident included the right wrist, the right fifth metatarsal, the neck portion of it and the radial head fracture right elbow.

Dr. Seidel agreed that it was possible that spondylolisthesis could cause back pain and could also possibly cause chronic back pain. When asked whether the diagnosis of spondylolisthesis is a more specific type of arthritis, Dr. Seidel responded as follows:

> A. I would state that degenerative changes in the lumbar spine occur in a variety of descriptive terms and we've talk about facet joint arthritis, today we've talked about loss of vertical height of disc and we've talked about anterior positioning of L4 and L5, the spondylolisthesis, they're all part of a degenerative cascade.
>
> (Seidel dep., pg. 78-79)

Dr. Seidel agreed that someone can have degenerative disc conditions such as spondylolisthesis and be asymptomatic. He also agreed that an introduction of trauma to a person that has an underlying asymptomatic degenerative condition could bring on symptoms such as pain in the back.

On re-direct examination Dr. Seidel testified that the anatomical imaging findings that he reviewed were degenerative in nature and take years to develop and were present prior to the fall which was described by the Plaintiff.

On re-cross examination, Dr. Seidel agreed that the imagining study done in 2018 showed a progression of degenerative changes.

On further re-direct examination, Dr. Seidel testified that he attributed the changes between 2016 and 2018 referencing the Plaintiff's lumbar spine to the natural history of degenerative changes occurring and not due to the trauma.

Deposition Exhibit 1 is the curriculum vitae of Dr. Jeffrey Jake Seidel. Deposition Exhibits 2 and 3 are Dr. Seidel's narrative reports of October 22, 2020 and October 23, 2020 which have been summarized in the body of the deposition testimony of the doctor.

STANLEY S. LEE, MD

Defendant also offered the deposition testimony of Dr. Stanley S. Lee taken on June 3, 2022. Dr. Lee is a board-certified orthopedic surgeon. Dr. Lee also testified that he treats patients at multiple locations in the Detroit area. Dr. Lee's curriculum vitae was attached to the deposition as Exhibit 1 without objection. Dr. Lee conducted an independent medical examination of the Plaintiff on October 6, 2017. The doctor's report of the same date was typed into the record and also attached to the deposition transcript as Exhibit 2 subject to Plaintiff's counsel objection as to hearsay that may be contained in the report. Plaintiff's counsel also indicated that his agreement to allow that procedure did not necessarily indicate his agreement to the doctor's findings or conclusions.

Plaintiff provided Dr. Lee with a history of the work incident occurring on August 29, 2016 indicating that while at work she tripped on a mat. She did also disclose medical treatment she received as of the time of Dr. Lee's examination in October 2017. Her symptoms were limited to her back which radiates into her groin. She provided a very brief employment history at Lake Huron Medical

Center. Dr. Lee personally reviewed x-rays of August 29, 2016 as well as a CAT scan from September 15, 2016 which he indicated were negative for osseous injury or significant post traumatic pathology. He reviewed an MRI report of October 8, 2016 which did not document evidence of spinal instability or neurological compression. He also reviewed other treatment notes from Lake Huron Medical Center, Dr. Antwan Hall, Dr. Corey Zieger, Dr. David Montgomery, Dr. Matthew Sciotti, and Dr. Ryan Pollina. He also reviewed notes from Team Rehab Physical Therapy and notes from Orthopedic Associates.

Dr. Lee conducted a physical examination of Plaintiff's lower extremities including the back. He diagnosed an injury not exceeding a spinal strain which had resolved. He further indicated that Plaintiff had ongoing subjective symptoms with an absence of objective findings. Plaintiff was at maximum medical improvement without further need for diagnostic testing, treatment, or activity restrictions. He further concluded that any injury Plaintiff sustained to her spine would be limited to a soft tissue strain which would be self-resolving and expected to heal within the first 4 to 6 weeks of the injury.

On further direct examination, Dr. Lee indicated Plaintiff's complaints were in her back and denied neck symptoms, arm symptoms or significant leg symptoms. Dr. Lee did not believe the Plaintiff had radiculopathy because she didn't have significant symptoms into her extremities and her pain was primarily in her back. He performed a comprehensive lower extremity neurological examination. Based upon the results of his examination, he found that Plaintiff was able to exert full strength in all different muscle groups. He reiterated that his findings on his physical examination of Plaintiff did not indicate any positive results.

Dr. Lee did confirm that he reviewed several medical records. He further confirmed that he reviewed the actual images of the x-rays and the CT scan. He only reviewed the report of the MRI. When asked whether he saw evidence of a herniated disc on either the CAT scan or the MRI report, Dr. Lee responded as follows:

> A. I don't specifically remember seeing a herniated disc. What I'm looking for are findings that are clinically significant, which includes spinal instability or neurological compression. Neither of those were present. And therefore, while she may or may not have had a disc bulge or disc herniation, it would not have risen to the level of clinical significance had they been there.
>
> (Lee dep., pg. 18)

Dr. Lee was shown a copy of the CT report dated September 15, 2016 and testified that the findings indicated mild disc bulges at L4-5 and L5-S1 but no evidence of gross extrusion or migration of the disc fragments and most importantly there wasn't any significant nerve compression. There was also

evidence of hypertrophic changes which Dr. Lee said are arthritic changes and not traumatic changes. He concluded that the CT scan disclosed no evidence of post traumatic pathology.

As to the MRI report of October 8, 2016, Dr. Lee testified that the report uses terms which are descriptors of the patient's spine that do not represent any sort of pathology. As he reviewed the report, Dr. Lee found no evidence of post traumatic change nor any evidence of clinically significant pathology. As to the MRI report of a 2mm slippage of the L4-L5 disc over the L5-S1 disc, Dr. Lee testified as follows regarding that finding:

> A. That means L4 is slightly slipped forward to L5 by approximately 2 millimeters. Based on this report there is no spinal stenosis that's noted at this level, and therefore, I would consider this to be an incidental finding of no clinical significance.
>
> (Lee dep., pg. 21)

Dr. Lee went on to testify that while there are numerous causes of spondylolisthesis, he did not believe that the 2mm spondylolisthesis noted on the MRI was the result of the fall described by Plaintiff. He further stated that the finding of the 2mm slippage would not be pathological or traumatic or even degenerative but rather just an incidental finding. If the spondylolisthesis was traumatic, he would have expected to see marked soft tissue damage and potentially a fracture that would thoroughly compromise the stability of the spine.

Dr. Lee was questioned with regard to the studies showing hypertrophic arthritic changes in the facet joints of the lumbar spine. He testified that those changes are degenerative, and are a result of a natural process of aging. They are not related to the incident of August 29, 2016. He found no signs of pathology or residual injury related to the trip and fall as of the time of his examination. Dr. Lee further concluded that Plaintiff did not need any additional treatment from a surgical standpoint or non-surgical standpoint as it relates to the accident in question.

Dr. Lee was presented with a hypothetical question by defense counsel which sets forth the description of the fall which Plaintiff sustained on August 29, 2016 as well as treatment she received thereafter up to the time of Dr. Lee's examination. I would overrule Plaintiff's counsel's objection because I believe the hypothetical question does substantially conform to the proofs presented at the time of the hearing as well as Plaintiff's testimony. Dr. Lee responded that based on his physical examination of Plaintiff and the review of records and the history taken on the date of his examination, he found no evidence to support ongoing injury or impairment as it relates to the accident in question. Dr. Lee also testified that while he did not know the qualifications of Plaintiff's job or training, he could testify that there was nothing objective to warrant any type of activity restrictions.

On cross examination, Dr. Lee indicated he only examined the Plaintiff on one occasion and did not recall how long the clinical part of his examination took. He agreed that the majority of his independent medical examinations are conducted for defense attorneys and insurance companies. He further testified that he still does back surgery and in fact was scheduled to perform surgery the very day of the deposition.

After several questions from Plaintiff's counsel regarding what was in Dr. Lee's file as to whether there was anything in the doctor's file that was not in the report, Dr. Lee agreed with Plaintiff's counsel's statement that the extent of the information concerning how the fall occurred was in his report and it did not matter to the doctor however the injury occurred. He confirmed that he did not see the Plaintiff prior to the date of his examination.

Dr. Lee testified that he had no knowledge of any pre-existing back issues. Dr. Lee did agree that the mechanism of the injury was not important and that any injury she may have had was not causing her any problems at the time of his examination. He further stated that at the time of his examination Plaintiff was objectively normal and he didn't find any evidence for ongoing pathology or impairment. He confirmed that he was unaware of any interceding injury between the date of the injury and his examination.

As to Plaintiff's job duties, he agreed that the extent of his information is the history he placed in his report that Plaintiff worked at Lake Huron Medical Center in dietary. He did not go into any specifics as to how she performed her job.

Dr. Lee confirmed that he reviewed the actual films of the x-rays and the CAT scan but only reviewed the report of the MRI of October 8, 2016. When asked whether the MRI report indicated something more than the CT scans and/or the x-rays such as spondylolisthesis at L4-L5, Dr. Lee responded as follows:

> A. None of the three imaging studies showed anything of clinical significance. How the radiologists, the different radiologists chose to describe the film certainly can differ in terminology and words chosen; but the bottom line is, none of these three studies show anything out of the ordinary.
>
> (Lee dep., pg. 34-35)

He did not recall whether the CT scan indicated a spondylolisthesis at 2mm anterior of the fifth lumbar area. He went on to further state that he recalled normal findings on all three of the studies and that there was nothing that he would consider pathological or post-traumatic on any of the three studies. Dr. Lee also testified that if the injury is an osseous issue such as alignment or

spondylolisthesis, a CT and x-ray is just as sensitive as an MRI. Dr. Lee described what spondylolisthesis is and further testified that he had seen no other MRI studies after his examination. He agreed that it is possible that someone can have spondylolisthesis at one level with no slippage and then have a trauma and then have some slippage. He further testified that the 2mm anterior fifth vertebrae spondylolisthesis is within physiological normal. He agreed that if the slippage were 4mm, it would be "more concerning on a relative scale." As to whether spondylolisthesis at 2mm could be asymptomatic, Dr. Lee continued to testify that most of it is normal and that it is a normal pathologic finding. He agrees that if spondylolisthesis continues to progress for whatever reason, it can certainly become a problem.

Dr. Lee confirmed that his report indicated that Plaintiff had four epidural lumbar injections that were performed before the date of his examination. His report also indicated that Plaintiff had undergone physical therapy.

On re-direct examination, Dr. Lee testified that at the L4-5 level far and away the most common cause of spondylolisthesis is degenerative. The condition can progress with or without trauma.

Defense counsel posed a question to Dr. Lee asking the doctor to assume that a 2mm spondylolisthesis was found in 2016 and thereafter was involved in an accident where she was rear ended, or if she hit something from the front end and whether that type of trauma can affect spondylolisthesis. Plaintiff's counsel objected to the question as confusing as to the terms and the mechanism of the injury. Based upon the evidence introduced in this matter I would sustain Plaintiff's counsel's objection as to the nature of this hypothetical. I would therefore also strike the answer provided by Dr. Lee on page 41 beginning on line 17 through line 23.

On final re-direct examination, defense counsel questioned Dr. Lee assuming there were other imaging studies that showed an increase in the slippage which were done in 2018 and asked whether changes that appeared in 2018 could related back to the injury of August, 2016. The doctor was not presented with any of the 2018 studies and therefore I would sustain Plaintiff's counsel's objection that without providing the doctor with the records to review he would not be competent to render an opinion and therefore I would strike the answer provided by the doctor on page 43 of the deposition.

Deposition Exhibit 1 is Dr. Lee's curriculum vitae.

Deposition Exhibit 2 is Dr. Lee's narrative report of October 6, 2017 which has already been discussed in the body of the deposition.

NATHAN GROSS, MD

Defendants also offered the deposition transcript of Dr. Nathan Gross, MD taken on May 11, 2022. Dr. Gross is a board certified physician in physical medicine and rehabilitation. His curriculum vitae was attached to the transcript to the deposition as Exhibit 1 without objection.

Dr. Gross conducted an independent medical evaluation on Plaintiff on January 14, 2019. His narrative report of January 24, 2019 was typed into the record of the deposition and also marked as Exhibit 2 and attached to the transcript of the deposition. Plaintiff provided a description of her injury on August 29, 2016 along with her description of her lower back pain and treatment with several physicians, most if not all of whose records have been introduced into evidence at the time of the hearing. Dr. Gross did conduct a physical examination on the lumbar region of Plaintiff's spine as well as her lower extremities. He also reviewed records that were supplied to him by defense counsel set forth beginning on page 13 of his deposition and continuing though page 17. The records reviewed by Dr. Gross have been introduced into evidence. These records include imaging studies which have also been introduced into evidence in this matter.

Dr. Gross' impression and comments indicated the presence of degenerative changes to Plaintiff's lumbar spine. He further commented that Plaintiff's history and the records he reviewed are compatible with the incident of August 29, 2016. He further commented that the incident may have caused a time limited lower back sprain, strain, or contusion. He also concluded that during the physical examination, Plaintiff exhibited a "number of pain behaviors/positive Waddell findings." He concluded further that he could not detect post traumatic abnormalities that would be attributable to the incident. Sprains and/or strains and/or contusions would have resolved by the time of his examination and he could not detect findings of spinal radiculopathy. He had no reason to impose restrictions relative to the work injury. He further commented that Plaintiff did have a degenerative lumbar spine including L4 on L5 listhesis which was low grade. He believed the listhesis would be the result of degeneration and not related to the incident of August 29, 2016. He also concluded that Plaintiff was not in need of any further treatment relative to the work incident.

Upon further direct examination, Dr. Gross was asked whether the mechanism of the injury described by Plaintiff to him would have caused the spondylolisthesis which has been referred to in several imagining studies. Plaintiff's counsel objected to the question based upon it being a hypothetical and also did not conform with the proofs at the time of the trial. I would overrule this objection. I believe that the testimony of the Plaintiff was substantially the same as the history provided to the doctor at the time of his examination; also,

the imaging studies that were referred to in the hypothetical question have all been introduced into evidence at the time of the hearing.

In response to the question posed by defense counsel, Dr. Gross responded as follows:

> A. Well, typically when there's arthritis to the facet joints, the L4 and L5 listhesis would be a degenerative slip. If it's traumatically induced, usually you're in a situation where there is a violent hyperextension, back bending, arching backwards of the spine. For example, in skeletally immature persons that are growing, they can get athletic induced slippages. For example, a gymnast where they hyperextend after they dismount repetitively, that can do that. Football players who come out of a three or four point stance and arch their back to make a block get the listhesis.
>
> And people that are mature, they're not growing any more, you know, for a traumatically induced listhesis, usually it's a violent hyperextension force. And then if you really were to hypothesize that, the pars, or the area of the bone develops an acute traumatic lysis or defect, typically a subsequent CAT scan or MRI will show fracture findings in that area.
>
> And so I'm aware of the serial imaging, but I didn't think that Ms. Carper had a traumatically induced slip.
>
> (Gross dep., pg. 21-22)

Dr. Gross went on to testify that the imaging studies from 2016 with regard to the facet joints indicated Plaintiff had arthritis. He also testified that women are more likely to have a listhesis from a degenerative slip of the vertebra. Dr. Gross read a portion of the MRI report of August 2, 2018 as "there is grade 1 anterolisthesis L4 on L5 with severe facet arthritis." A grade 1 anterolisthesis would represent a slip anywhere up to 25% of the distance of the vertebra below.

Dr. Gross testified that Plaintiff did not disclose to him that she was in a motor vehicle accident in December, 2017. Defense counsel described the motor vehicle accident to Dr. Gross on page 25 and 26 of the deposition including the nature of the injuries sustained. Defense counsel asked Dr. Gross whether it appeared the injuries were significant from a medical standpoint. I would overrule Plaintiff's counsel's objection because I believe the testimony of the Plaintiff as well as the records introduced at the time of the hearing are consistent with the question provided to the doctor. Dr. Gross responded that it looked like Plaintiff had a serious injury to her arm and foot. When asked whether the injuries occurring in the motor vehicle accident would impact Plaintiff's back, Dr. Gross' response was very equivocal and not very responsive to the question.

Dr. Gross further testified that his impression that Plaintiff had degenerative changes in the lumbar spine was based upon the imaging studies which he reviewed which included MRI scanning and CAT scanning. Defense counsel also presented Dr. Gross with the spinal x-ray of August 29, 2016 and read certain portions to him asking whether the findings in that x-ray would have developed within a day or a few days to which Dr. Gross responded in the negative. He further indicated that the changes occurred over the course of time, months and possibly years. Dr. Gross testified that he did not review actual films but only the reports of the x-ray, CAT scan and MRI report. The reports did not reflect what he thought to be post traumatic changes. He did not detect contusions or sprains or strains or nerve compression at the time of his clinical evaluation of Plaintiff. He likewise found no objective indication that Plaintiff had any pathology that was related to the injury that she described. Likewise, he did not find any evidence of radiculopathy. Likewise, he found no evidence of post traumatic arthritis.

Dr. Gross also testified that he did not find the need to recommend restrictions on Plaintiff's physical activities with regard to the incident which she described. He likewise did not feel any further physical therapy would be indicated. He did not think that more treatment from interventional treatment to medical management would be efficacious.

Defense counsel provided a hypothetical question to Dr. Gross regarding Plaintiff's anticipated testimony at the time of trial with regard to her job duties as well as brief information regarding treatment with Drs. Pollina and Shuayto. Defense counsel specifically asked the following question:

> Based on her history, your physical examination and your review of the records including the radiology reports, did the work or the incident that she described cause or aggravate any pathology that you were able to identify at the time of your examination?

Plaintiff's counsel objected to the hypothetical question believing that it left out essential elements about Plaintiff's job function as well as the mechanism of the injury and the limited information regarding the treatment with Dr. Pollina. Plaintiff's counsel's objection is taken under advisement at this time. I will allow the doctor's answer which was in the negative subject to my re-examination of the answer following completion of review all the proofs.

On final direct examination, Dr. Gross testified that he would not restrict the Plaintiff with regard to activities as it related to the incident Plaintiff described.

On cross-examination, Dr. Gross confirmed that he did not examine Plaintiff until two and a half years after her fall. He has not examined nor spoken to Plaintiff before the date of his examination on January 14, 2019. He confirmed further that he did not see the Plaintiff following her examination on the above

date. The physical examination itself would take approximately 15 to 20 minutes. He had no other information regarding Plaintiff's job duties other than the information provided to him by the Plaintiff. He confirmed that the records he reviewed were summarized and contained in his report. The last date of treatment that he reviewed were records of Dr. Pollina dated December 12, 2018. He has not reviewed any reports or testing done subsequent to that date.

Dr. Gross also confirmed that Plaintiff's history indicated that she never had symptoms of the type she had as a result of the fall that took place in August, 2016. He also confirmed that he did not have any records that would reflect prior treatment including for prior back pain before the work incident. Dr. Gross further testified that by history, Plaintiff indicated that she did not have any similar claims and that she was able to carry out her job duties without restrictions.

Plaintiff's counsel directed questions to Dr. Gross based upon Dr. Zieger's record of September 23, 2016 to which defense counsel objected as hearsay. Defendant's objection is overruled since Dr. Zieger's records were introduced and admitted as an exhibit at the time of the hearing. Dr. Gross confirmed that Dr. Zieger opined that Plaintiff had a lumbar herniated disc. He confirmed that the MRI of August 22, 2018 did include a reference to a small disc herniation at L5-S1. He confirmed that Dr. Mark Jacobson to whom Plaintiff was referred for surgical evaluation did not believe Plaintiff was a surgical candidate but he would consider a spinal cord stimulator. Dr. Gross confirmed that Dr. Pollina indicated Plaintiff should try injections. Dr. Gross was aware that Dr. Shuayto had implanted a spinal cord stimulator and reiterated that Plaintiff did not need a spinal cord stimulator. He further indicated that even if there was no issue of causation or work injury, he would not have recommended a spinal cord stimulator for Plaintiff.

As to restrictions, Dr. Gross reiterated that he would not impose restrictions as it related to Plaintiff's work injury, but with a degenerative spine with some degree of listhesis, he would limit performance of strenuous work with repeated twisting, bending or heavy lifting. Dr. Gross agreed that Plaintiff had degenerative arthritic changes within the disc, within the bone, the facets. He reiterated that he reviewed various records and reports but did not review any films.

Dr. Gross reiterated that Plaintiff's degenerative arthritis pre-dated the incident at work in August, 2016. He agreed that based upon the information he had, Plaintiff was not symptomatic prior to the work incident. He agreed that someone with arthritis can be asymptomatic. He agreed that someone with degenerative arthritis who has a traumatic event can make the degenerative arthritis symptomatic. He also stated that it may happen for a period of time, but

it depends on the facts. Dr. Gross agreed that chronic pain has multiple reasons but historically it dates back to the incident of August 29, 2016.

Dr. Gross confirmed that in response to the first question posed to him in the referral to him for an evaluation, Plaintiff had chronic low back pain but he did not detect any post traumatic abnormalities. His response to the third question indicated that Plaintiff did have a degenerative condition. He confirmed that Plaintiff had listhesis at L4 on L5 which was from degenerative issues and not caused or aggravated by the August, 2016 incident. He confirmed that the only information he had regarding the mechanism of injury was what was told to him and appears in his report which is the history he was given by Plaintiff. He agreed that his answer to the firth question indicated that he could not identify a need for more treatment relative to the work incident. He further testified that whatever other physicians may have opined with regard to the need for epidurals or a spinal cord stimulator, he would disagree with those opinions.

On re-direct examination, Dr. Gross was asked whether the spinal cord stimulator was a good recommendation in light of the fact that Plaintiff got no relief from the implantation since its implantation. The response to the question appearing on page 66 on the whole is simply non-responsive to the question asked. He agreed that none of the records he reviewed disclosed any physician who recommended surgery. He testified further that he agreed that Plaintiff would not be a surgical candidate based on his examination. As far as his physical examination was concerned, Dr. Gross found no muscle spasm nor atrophy. He reiterated that there were no objective abnormalities on physical examination. Based upon Plaintiff's complaint of pain since the time of her accident which was two and a half years prior to his examination, he classified the pain as chronic. He reiterated that a patient becoming symptomatic does not necessarily indicate a change in pathology.

On final re-direct examination, Dr. Gross reiterated that Plaintiff's degenerative spine with a listhesis would result in limitations involving twisting, bending or lifting.

Defendant's Exhibit 1 is Dr. Gross' curriculum vitae.

Deposition Exhibit 2 is Dr. Gross' narrative report of January 24, 2019 which has been discussed in the summary of his testimony.

KAREN GROSSBERG

Defendant offered the deposition testimony of Karen Grossberg taken on October 21, 2022. Ms. Grossberg is a vocational rehabilitation counselor. She has a national certification as a disability management specialist. She is also a diplomat of the American Board of Vocational Experts. Her curriculum vitae was marked as Deposition Exhibit 1 and attached to the transcript of the deposition.

She conducted a vocational assessment, employability and wage earn capacity evaluation of the Plaintiff as well as a transferable skills analysis and a labor market survey. She prepared a reported dated May 31, 2022 with an addendum dated October 17, 2022 regarding an updated labor market survey. The reports were attached to the deposition transcript as Exhibits 2 and 3 subject to Plaintiff's counsel's objections as to any hearsay.

Ms. Grossberg testified that she was given reports of Dr. Stanley Lee, Dr. Nathan Gross and Dr. Jeffrey Seidel. She was also provided the deposition transcripts of Dr. Pollina and Dr. Shuayto. Drs. Lee, Gross and Seidel opined that Plaintiff could return to work without restrictions. Ms. Grossberg testified that with those opinions being accepted, Plaintiff would have no wage loss. Based upon the restrictions imposed by Dr. Pollina, Ms. Grossberg testified that Plaintiff would be in the category of sedentary but perhaps some light work.

Ms. Grossberg testified regarding Plaintiff's employment prior to her job with Defendant as well as her educational background.

Ms. Grossberg further testified that she disagreed with Plaintiff's vocational expert, Mr. Fuller, who indicated that Plaintiff's past experience as a receptionist was not relevant because it occurred over 25 years ago and many changes with computers and computer software made Plaintiff's skills not appropriate. She further testified that by way of educational background and avocational activities Plaintiff did have the background and training to be a receptionist. Plaintiff indicated to Ms. Grossberg that with regard to her schooling, she had to use computers to write her papers and use Word. Plaintiff also indicated that she took an online course in 2009 to get her high school diploma. Ms. Grossberg further testified that the kind of positions she was looking at in this particular case involved very light typing with scheduling appointments. She was not looking at someone who would have a 50 word per minute typing speed. Ms. Grossberg also testified that in reviewing Agency Form 105A she noted that Plaintiff indicated that she used computers at her job such as entering patient diets, allergies, etc.

Ms. Grossberg testified that Plaintiff's background would make customer service work suitable for her. She further testified that Plaintiff's job as a dietary clerk involved greeting patients and filling out forms with regard to their needs. She agreed that customer service work is an SVP 4/5 and a semi-skilled position. According to the Plaintiff's prior employment, she did work at semi-skilled positions such as receptionist, stock clerk and machine operator. Plaintiff also had transferable skills as an appointment clerk which is a sedentary light clerical job interfacing with patients to schedule appointments and doing light data entry.

Applying Dr. Pollina and Dr. Shuayto's restrictions Ms. Grossberg testified that there were many sedentary job descriptions or titles that would be part of the

Plaintiff's universe of jobs. She agreed that Plaintiff could perform jobs found by Mr. Fuller's report such as desk attendant and cashier.

Ms. Grossberg testified that the labor market surveys that she performed on May 31, 2022 and October 17, 2022 produced several positions which she identified at the time of her deposition. One of the positions was a customer service messaging agent and representative for Morley Company which could be done from home. All of the positions were within Plaintiff's geographic area and all of the positions would fall within the restrictions outlined by either Dr. Pollina or Dr. Shuayto. The wage range would be between $12 per hour up to $14.50 per hour. The jobs listed in Ms. Grossberg's first report had a wage range of $12-$14.50 per hour. With regard to her second labor market survey the wage range was $13 to $17 hourly. Ms. Grossberg testified that when she lists a job in her labor market survey it means that she has spoken to the employer and confirmed its availability, and, if she can, the wage. She further testified that where she does list a wage, she has spoken to the employer directly who provides the information. All of the positions were full time and come with benefits. She reiterated that based upon the restrictions imposed by Dr. Pollina and Shuayto, she placed Plaintiff's return to work wage as falling between $13 hourly which translates to $520 weekly and $16 per hour which translates to $640 weekly. She also reiterated that based upon the opinions of Drs. Lee, Gross and Seidel, Plaintiff would have no loss of wage earning capacity.

On cross-examination, Ms. Grossberg confirmed that her analysis was made at the request of defense counsel. She confirmed that Plaintiff was a dietary clerk when she worked for Defendant. With regard to Plaintiff's job as a dietary clerk, Ms. Grossberg testified that she used the description of a position called food preparation worker found from ONET. She pulled off the generic job description and reviewed each item with the Plaintiff and indicated whether she said yes or no to those items. Plaintiff's counsel followed up asking Ms. Grossberg whether she obtained a job description directly from the Plaintiff as opposed to going through a list of duties from a description on ONET. After objections by defense counsel and responses by Plaintiff's counsel, Ms. Grossberg answered in the negative. She went on to explain how she determines what the job description for Plaintiff was with the following answer:

> A. I do a variety of things when I meet with people. One thing I do is I review job description - - which I agree with you, doesn't necessarily encapsulate everything someone does, but why I do it is so that I get a very solid understanding of what someone did. I began by reviewing dietary aide/food preparation worker with her that displayed 31 job tasks that she would have to perform, assuming that all of these fit. I went through all of those, and of all of those, only six didn't fit. So, 25 of them she said were things that she did.

> Additionally, we talked about what she had done, and I reviewed the 105A which talks about how she, you know, worked with patients and aides and that she used computers and logged diets, and we talked in the meeting about how much walking she did. So, I mean, there's a lot of things that she did. Did I see a job description? No. Did I ask her about every task she performed? I asked her about 31 that she could have performed, and she said she did 25 of them. Do I think I understand what she did? I used to work in hospitals. I've observed people do this. I've had 20-plus years' experience as a vocational counselor. I think after reviewing this list and seeing everything she does, I've got a solid understanding of what she did. Am I missing something? Maybe a little task I'm missing, but I think I have a good understanding of what she did.
>
> (Grossberg dep.)

She also testified that according to the Dictionary of Occupational Titles, a dietary clerk is medium physical demand and a vocational preparation of 2. She went on to indicate that medium physical demand is lifting up to 50 pounds and also usually requires significant ambulation throughout the work shift. She further testified that Plaintiff did not indicate to her how many miles she walked.

Ms. Grossberg agreed that given the restrictions of Dr. Pollina, Plaintiff would not be able to return as a dietary clerk. Likewise, with regard to the restrictions of imposed by Dr. Shuayto, she would not be able to return to the dietary clerk job. Plaintiff indicated that she earned $13 per hour as a dietary clerk. Ms. Grossberg further testified that the information regarding Plaintiff's wage rate for Defendant was from the Form 105A.

Ms. Grossberg testified that she has not testified for Social Security Disability cases. She was asked how far back the Social Security Administration goes when dealing with the relevant work. Defense counsel objected to this as irrelevant because Social Security has a different standard. I would sustain the objection to this question because I do find that the Social Security Administration's rules are not relevant in a Workers' Compensation case.

Ms. Grossberg was asked how many absences during a month would be tolerated by an employer. She was further asked whether missing two days a month or more would be permissible for employers in Michigan without regard to the Social Security standard. Ms. Grossberg indicated that an employer would not allow that. Ultimately, Ms. Grossberg testified that if Plaintiff missed two or more days per month she would not be employable in Michigan.

Ms. Grossberg testified that all of the jobs that she found available would allow Plaintiff an opportunity for a sit/stand option. With regard to the need for three unscheduled breaks or more, Ms. Grossberg testified that she could not

definitively say that Plaintiff could find work. With regard to the need to lie down during the work day, Ms. Grossberg indicated that if Plaintiff did it on a scheduled break she might be able to find employment, but if Plaintiff had to do it throughout the day, she would be unemployable.

She confirmed that she performed two labor market surveys which she agreed are snapshots in time which could change from day to day or even hour to hour.

Ms. Grossberg testified further that she was provided Defendant's IME reports but not the depositions of the physicians who prepared those reports.

She defined sedentary employment as no ambulation more than a third of the day and no lifting greater than 10 pounds. She further stated that the definition would also mean no standing or walking more than a third of the day and no lifting more than 10 pounds. Light work would allow ambulation up to two thirds of the day and lifting up to 20 pounds.

Ms. Grossberg testified that Plaintiff's credit hours in college were prerequisite classes for nursing and that Plaintiff did not receive any degree.

Plaintiff's prior employment at Plumb's Convenience Store as a cashier and stock work and clerk would be in the medium category as well as the job Plaintiff had at Vinker Foods. Likewise, her prior employment as a machine operator at Paslin Company would be in the medium category.

Plaintiff further advised Ms. Grossberg that she had been looking for work and had applied for at least 100 positions on Indeed. Plaintiff also indicated that she went on Facebook for jobs at Amazon. Plaintiff further indicated that she was applying for three to four jobs per week. Ms. Grossberg also testified that in her report she indicated Plaintiff advised her that she did not believe that she was physically able to manage any of the positions that she applied for. Plaintiff also indicated that she did not list any of her restrictions on her resume nor did she disclose any of the restrictions on any applications that she submitted.

On re-direct examination, Ms. Grossberg testified that Plaintiff was looking for job postings including cashier, secretary and health care worker which she indicated she felt qualified in terms of background and training. She further testified that the jobs that she listed were primarily in either health care facilities or manufacturing machine shop facilities which she felt Plaintiff was qualified to perform.

Ms. Grossberg further testified that her labor market surveys did not include any jobs that were in the medium or even light category. All of the jobs were in the sedentary category. She reiterated that all of the jobs that she

posted in her report and labor market surveys fit the restrictions of either Dr. Shuayto or Dr. Pollina or both.

Deposition Exhibit 1 is Ms. Grossberg's curriculum vitae. Deposition Exhibit 2 is Ms. Grossberg's report of May 31, 2022 which was extensively covered under examination at the time of her deposition. Deposition Exhibit 3 is Ms. Grossberg's report of October 17, 2022 which was also extensively covered in the testimony of the witness.

EXHIBITS

Plaintiff's Exhibit 1 is the deposition transcript of Dr. Pollina which has previously been summarized.

Plaintiff's Exhibit 2 is the deposition transcript of Dr. Shuayto which has previously been summarized.

Plaintiff's Exhibit 3 is the deposition transcript of Mr. Fuller which has previously been summarized.

Plaintiff's Exhibit 4 are the records of Dr. Cory Zieger. These records are for treatment with Dr. Zieger at the Zieger Orthopedic Bone and Joint Institute from September 23, 2016 through February 6, 2017. The records in this exhibit are not in sequential order but I will attempt to summarize them in sequential order. Plaintiff was first seen on September 23, 2016. She provided the doctor with a history of tripping over a mat in August, 2016 and had low back complaints thereafter. She denied any history of injury or trauma to her low back prior to that time. Physical examination was performed at that time. X-rays were reviewed. The assessment was herniated nucleus pulposus "HNP" lumbar spine, degenerative disc disease lumbar spine, facet arthropathy lumbar spine. An MRI was recommended. Plaintiff was to remain off work for a minimum of the next two weeks. It appears that on that same date an intake form was prepared indicating the reason for consultation was a fall at work and having lumbar bulging discs. There is an MRI report of October 8, 2016 with five impressions indicated by the radiologist:

1. Spondylosis throughout the lumbar spine with hypertrophic changes of the posterior facets more noticeable at the lower lumbar spine and lumbosacral junction. Mile degree of subarticular stenosis more noticeable at the L5-S1 level.
2. Minimal loss of height at the L5-S1 intervertebral disc space.
3. 2 mm anterior position of L4 over L5 indicative of very mild degree of spondylolisthesis. No defects through the pars interarticularis.
4. Preservation of the signal arising from the marrow intervertebral bodies without compression fracture or marrow edema.

5. No evidence of focal disc extrusion or migration throughout the lumbar spine and lumbosacral junction.

The CT scan of the lumbar area was performed on September 15, 2016. It was compared to the x-ray of the lumbar spine dated August 29, 2016. The impression indicated arthritic changes more noticeable at the lower lumbar spine; circumferential discogenic bulges at L4-L5 and L5-S1 with no extruded disc fragment; there was no malalignment or subluxation. The office note of October 19, 2016 repeats the same history. The doctor reviewed the MRI with the final assessment being as follows: degenerative disc disease lumbar spine; facet arthropathy lumbar spine; spondylolysis lumbar spine; spondylolisthesis L4-L5 indicating to be 2 mm anterior position of the L4 over L5 indicative of a very mild degree of spinal listhesis. Plaintiff's final visit to this physician was on December 7, 2016 for a follow up of back pain. The physical examination was unchanged from the previous visit in October and the assessment/diagnoses were the same.

Plaintiff's Exhibit 5 was withdrawn.

Plaintiff's Exhibit 6 was withdrawn.

Plaintiff's Exhibit 7 are records from Premier Surgical Center of Michigan. This exhibit contains an operative report with regard to the implantation of a spinal cord stimulator on October 15, 2021. The exhibit also contains a 2 page history and physical with illegible writing and an illegible nurse manager's signature dated October 5, 2021. The exhibit also contains an operative procedure report dated June 3, 2022 with regard to a right sacroiliac joint fusion performed by Dr. Marwan Shuayto. The final document in this exhibit is a further history and physical form also dated June 3, 2022 with reference to the procedure.

Plaintiff's Exhibit 8 are records of Defendant Lake Huron Medical Center. The first document is an emergency department report dated October 29, 2016. Historical information was recorded in this record as well as vital signs and medication. The history portion of the date of service indicates Plaintiff's fall. Plaintiff was carrying a tray and tripped over a mat falling forward. Plaintiff's only complaint is lower back pain. Plaintiff briefly complained of bilateral wrist pain and left knee pain. A physical examination was performed at that time. As far as the back is concerned, it is reported as "non tender." Midline diffuse tenderness was noted in the lumbar spine but no vertebral point tenderness. There was no swelling or ecchymosis. There was a normal range of motion of the lumbar spine and full range of motion of the wrists bilaterally. Gait was steady and equal. X-rays of the thoracic and lumbar spine indicated negative for acute fracture. The impression at that time was lower back pain. Plaintiff was discharged. The radiology report regarding the thoracic spine showed no acute osseous lesions and mild degenerative change. As to the lumbar spine, vertebral body height and alignment are maintained. There was no spondylolysis or spondylolisthesis.

The disc space was reasonably well maintained. The final impression was not acute osseous lesion and mild degenerative change. There is also a document as part of this exhibit that included home care instructions and back exercises.

There is a visit to the emergency department by Plaintiff on September 15, 2016. Vital signs were taken as well as previous medical history and medication lists and social history. Plaintiff reported increased pain indicating that it never went away and now it was worse. Plaintiff indicates she feels like her legs are going to give out. Plaintiff underwent a CT of the lumbar spine on September 15, 2016. There was a comparison with the x-ray of the lumbar spine dated August 29, 2016. The impression by the radiologist was arthritic changes with hypertrophic changes of the posterior facets more noticeable at the lower lumbar spine and lumbosacral junction; circumferential discogenic bulges posteriorly at the L4-L5 and L5-A1 with no extruded disc fragment; no malalignment or subluxation. Once again, home instructions and back exercises were provided to the Plaintiff.

Plaintiff's Exhibit 9 are records of St. John Medical Center Macomb Township. The exhibit contains an initial record of an examination date of April 16, 2018. The x-ray report of the lumbosacral spine was reported to show mild multilevel degenerative changes and disc disease with mild anterolisthesis of L4 on L5. An MRI of the lumbar spine was also performed on that same date with the impression being grade 1 anterolisthesis of L4 on L5 from severe bilateral facet changes; small disc protrusion/herniation at TL to T12 and L5-S1. The exhibit also contains a bilateral sacroiliac joint injection performed on October 6, 2017. The procedure was performed by Dr. Ryan Pollina. Other records in this exhibit in connection with the injection on that date are records which cannot be read being illegible. This exhibit also contains an x-ray report of the lumbosacral spine dated April 16, 2018 ordered by Dr. Pollina. The impression was mild multilevel degenerative changes and disc disease with mild anterolisthesis of L4 on L5. The final medical record in this exhibit is an operative report dated September 17, 2018 at which time Dr. Pollina performed a bilateral L3-4, L4-5 and L5-S1 diagnostic lumbar medial branch block under fluoroscopy. The pre and post operative diagnosis was the same, i.e., lumbar spondylosis without myelopathy.

Plaintiff's Exhibit 10 are the records of Michigan Neurology and Spine, Marwan Shuayto, MD. The first document in this record is dated November 6, 2019. Plaintiff at that time presented with low back pain which was described as stabbing and sharp. Plaintiff also indicated limited activities because of pain with episodes occurring with activity and symptoms alleviated by lying flat. Musculoskeletal examination revealed Plaintiff's complaint of hip pain, neck pain and low back pain. The examination of the lumbar spine revealed weakness and bilateral tenderness at the facet joints and decreased lumbar extension and flexion with a positive straight leg raising on both right and left. The diagnosis at

that time was chronic pain syndrome, pain in the right and left leg, intervertebral disc disorders with radiculopathy in the lumbosacral region and low back pain. Plaintiff was seen and treated on December 4, 2019 with a lumbar medial branch block performed by Dr. Shuayto. Plaintiff was next treated by Dr. Shuayto on January 8, 2020 for a sacroiliac joint injection on the left. Plaintiff was seen on February 10, 2020 complaining of low back pain in the lower lumbar region described as stabbing and sharp. Plaintiff reported no relief from the lumbar medial branch block or the sacroiliac joint injection. Musculoskeletal joint examination revealed the same findings as previously recorded on prior visits. The diagnosis at that time remained the same. A visit on August 12, 2019 involved the same complaint of low back pain described as stabbing and sharp. Musculoskeletal examination was the same as previously reported. Examination of the lumbar area revealed the same findings. The diagnoses remained the same. On February 3, 2020 nerve conduction studies and an EMG of the lower extremities were performed. The conclusion was left sural nerve mononeuropathy. There was no electrophysiological evidence of peripheral neuropathy or lumbosacral radiculopathy. The record also indicates that a negative needle EMG may not preclude lumbosacral radiculopathy. On October 26, 2021 a urine drug screen was performed. Plaintiff was treated on October 14, 2020 with the same low back complaints described as stabbing and sharp. Musculoskeletal complaints were the same as previously reported in the hip and low back with muscle spasms. Examination of the lumbar spine once again revealed weakness and tenderness in the lumbar spine with decreased extension and flexion and positive bilateral straight leg raising. The diagnoses at that time continued to be chronic pain syndrome with pain in the right and left leg, intervertebral disc disorders with radiculopathy in the lumbosacral region and spondylolysis without myelopathy or radiculopathy in the lumbar region. Plaintiff was again seen on January 8, 2021. Plaintiff presented herself with the same complaints regarding the hip and low back with muscle spasms. Examination of the lumbar area revealed the same findings and the diagnoses were the same. On February 17, 2021 a sacroiliac joint injection was performed on the right. The diagnosis was low back pain and sacroiliitis, not elsewhere classified. A treatment dated of March 4, 2021 indicates the Plaintiff is recovering poorly “zero percent.” Plaintiff was then seen on April 6, 2021 again with the same complaints in the lower back, the same complaints in the hip with muscle spasms and the same physical examination findings. The diagnoses remain the same as previously recorded in this exhibit. Plaintiff was seen on June 24, 2021 at which time a scheduled procedure described as a neuromodulator trial lead placement was to be done. The procedure was performed by Dr. Shuayto. On June 29, 2021 it is reported that the Plaintiff was recovering poorly. Plaintiff indicated only 50% improvement in pain. Plaintiff was treated on July 2, 2021 again with the same complaints in the lower back, the same musculoskeletal examination in the lumbar area and the same diagnoses. An MRI report is part of this exhibit performed on May 21, 2021. There was a comparison with plain radiograph of October 18, 2019 and April 17, 2021. The first impression at the L4-5 level was

grade 1 anterolisthesis resulting in moderate canal stenosis at the junction with facet anterolisthesis. There was no evidence of neuroforaminal encroachment. At the L5-S1 level there was a 3 mm broad disc based herniation effacing the ventral surface of the thecal sac resulting in mild to moderate right and left neuroforaminal encroachment and left exiting L5 nerve impingement in conjunction with the facet arthrosis. The third impression was "no significant interval change in intervertebral disc pathology." There is an MRI report of April 17, 2021 which was compared with the October 18, 2019 MRI. The impression was mild lower dorsal and minimal mid to lower degenerative disc disease; moderate bilateral mid and lumbar degenerative joint disease; grade 1 anterolisthesis with minimal worsening upon flexion and minimal improvement upon extension; and moderate L5 canal stenosis.

Plaintiff's visit on October 26, 2021 indicates that the neuromodulator permanent implant had occurred on October 15, 2021. The Plaintiff reported zero improvement in the post procedure pain. Plaintiff was again seen on November 15, 2021 again with the same low back pain described as stabbing and sharp. Musculoskeletal complaints were the same in the hip and low back with muscle spasms. The lumbar spine examination revealed the same findings as previously recorded in prior visits. The diagnoses remained the same. Plaintiff's next visit occurred on January 4, 2022. Once again, Plaintiff presented the same low back complaints. The examination of the lumbar area revealed the same findings as previously reported. The diagnoses remained the same. Plaintiff's visit on February 14, 2022 once again involved the same complaints in the lumbar area, the same physical examination findings, as well as the same diagnoses. On February 22, 2022 a sacroiliac joint injection was performed on the right side. Plaintiff reported continued lower back pain on February 24, 2022 at which time the Plaintiff's lumbar spinal cord stimulator was reprogramed and/or adjusted. Plaintiff was seen on March 8, 2022 for a post-op visit referencing the sacroiliac joint injection performed on February 22, 2022. A further sacroiliac joint injection on the right was performed on March 16, 2022. The diagnoses contained at the time of this visit was as follows: sacroiliitis, not elsewhere classified; spondylolysis without myelopathy or radiculopathy, sacral and sacrococcygeal region; spondylolysis without myelopathy or radiculopathy in the lumbosacral region; low back pain, unspecified. On March 28, 2022 Plaintiff is seen for what appears to be a more complete physical examination again complaining of the same type of low back pain with the same findings on physical examination and the same diagnoses.

An MRI report of November 15, 2021 was read to show a 9 mm L4 anterolisthesis without definite pars defect identified; multilevel mild to moderate interspace narrowing as detailed above; surgical clips and gallbladder fossa.

The final document in this exhibit is an operative report of October 15, 2021 with regard to the implantation of the spinal cord stimulator on both the right and left side.

Plaintiff's Exhibit 11 is a job description for a food service worker dated April 28, 2016.

Plaintiff's Exhibit 12 was withdrawn.

Plaintiff's Exhibit 13 are job search forms from January 4, 2020 through July 21, 2021. The exhibit consists of 30 pages. Each page, with the exception of one page, discloses the names of two prospective employers. The overwhelming number of job searches were made by forwarding a resume through Indeed.com. There are a total of 59 prospective employers. A variety of types of employment was sought by Plaintiff on these forms. Plaintiff sought employment for positions such as secretary, cashier, behavioral tech, costumer service rep, personnel office assistant, medical assistant with what appears to be a majority of the types indicated as customer service. Most of the positions disclose what the pay range would be. The rates of pay appear to be somewhere between $10 per hour up to $17 per hour. On several of the prospective employers contacted, Plaintiff indicates she received no response or the position had been filled.

Plaintiff's Exhibit 14 are the records of Dr. Igor Nedic. It appears Plaintiff was first seen by Dr. Nedic on May 24, 2016 complaining of fatigue, headaches and leg cramps for two to three months. There appears to be no treatment for any musculoskeletal problem. Plaintiff's next visit was on June 15, 2016 for lab follow up. Once again there is no treatment for any musculoskeletal problems. Plaintiff was next seen on October 10, 2017 with a chief complaint of hypothyroidism. Included in this visit was a note indicating that patient had fallen 13 months ago injuring her back. Musculoskeletal examination at that time revealed no abnormalities with the exception of limited range of motion in the lumbar region. The neurological examination appeared to be normal. The doctor made several assessments but none included any reference to a musculoskeletal or low back problem. The last visit in this exhibit occurred on November 7, 2017 for lab follow up. Problems at that time were indicated to be hypothyroidism, polycystic ovaries and chronic back pain. Musculoskeletal examination was the same as in October as well the neurological examination.

Defendant's Exhibit A is the deposition transcript of Dr. Seidel which has previously been summarized.

Defendant's Exhibit B is the deposition transcript of Dr. Lee which has previously been summarized.

Defendant's Exhibit C is the deposition transcript of Dr. Gross which has previously been summarized.

Defendant's Exhibit D is the deposition transcript of Ms. Grossberg which has previously been summarized.

Defendant's Exhibit E is a record of Dr. David Montgomery dated June 26, 2017 wherein the Plaintiff was seen in follow up care of back pain with intermittent milder leg discomfort. The doctor conducted a physical examination with an assessment of spondylosis grade 1 and spinal stenosis of the lumbar region. He recommended continuation of non-operative treatment.

Defendant's Exhibit F is a record of Plaintiff's treatment by Dr. Todd Murphy dated December 29, 2017 with regard to Plaintiff's injuries sustained in the motor vehicle accident occurring in October, 2017. Plaintiff sustained injuries to her wrist, foot and elbow. It appears the treatment was non-surgical regarding all the injuries.

Defendant's Exhibit G is the record of Dr. Ryan Pollina regarding a visit by Plaintiff on January 15, 2018 regarding Plaintiff's low back. The record does indicate that Plaintiff reported being involved in a work-related fall in 2016 that has continued her lower back pain without radicular features. The impression by Dr. Pollina was degeneration of lumbar intravertebral disc and solitary sacroiliitis.

Defendant's Exhibit H is the record of Dr. Ryan Pollina for a patient visit on March 16, 2018. Treatment was for Plaintiff's low back pain.

Defendant's Exhibit I is the x-ray report of Plaintiff's lumbar spine performed on April 16, 2018 with the impression being mild multi-level degenerative changes and disc disease with mild anterolisthesis of L4 on L5.

Defendant's Exhibit J is the report of an MRI of Plaintiff's lumbar spine performed on August 22, 2018 with the impression being grade 1 anterolisthesis of L4 on L5 from severe bilateral facet changes and small disc protrusions/ herniations at T11-T12 and L5-S1. The L5-S1 finding is described as a small central disc protrusion/herniation causing indentation of the ventral thecal sac without significant spinal canal or neuroforaminal stenosis. Small posterior annular fissure.

Defendant's Exhibit K is a claim payments form showing the payment of workers' compensation benefits to the Plaintiff beginning in August, 2016 at the rate of $457.37 continuing until February 5, 2019.

Defendant's Exhibit L is the report of an MRI performed on October 21, 2019 with regard to the lumbar spine. The impression is stated to be multi-level

degenerative changes most prominent lower lumbar spine as detailed above. The most significant finding is at the L4-L5 and L5-S1 discs. The findings are indicated to be multi-level disc desiccation with mild to moderate disc space narrowing L4-L5 and L5-S1 levels.

Defendant's Exhibit M is a nerve conduction study and EMG of the lower extremities with the conclusion being left sural nerve mononeuropathy with no electrophysiological evidence of peripheral neuropathy, mono neuropathy or lumbosacral radiculopathy. The conclusion also indicates that a negative needle EMG examination may not preclude lumbosacral radiculopathy.

Defendant's Exhibit N is an x-ray report of the lumbar spine dated April 17, 2021 indicating a comparison with an MRI of the lumbar spine performed on October 18, 2019. The impression on this x-ray report is mild lower dorsal and mild mid to lower lumbar degenerative disc disease; moderate bilateral mid and lower lumbar joint disease; grade 1 L4 anterolisthesis with minimal worsening upon flexion and minimal improvement upon extension; and moderate L5 canal stenosis.

Defendant's Exhibit O is the MRI report of Plaintiff's lumbar spine performed on May 21, 2021 with the impression being grade 1 anterolisthesis with moderate canal stenosis in conjunction with facet arthrosis at L4-L5 with no evidence of neuroforaminal encroachment. Also at L5-S1 there is a 3 millimeter broad based disc herniation resulting in mild right and mild to moderate left neuroforaminal encroachment and left exiting L5 nerve impingement in conjunction with facet arthrosis. The final impression is "no significant interval change in interverbal disc pathology."

Defendant's Exhibit P is a record of Dr. Marwan Shuayto with regard to the implantation of a spinal cord stimulator on June 24, 2021.

Defendant's Exhibit Q is a further operative report dated October 15, 2021 with regard to a further surgery for the implantation of a spinal cord stimulator performed also by Dr. Shuayto.

Defendant's Exhibit R is a record of treatment by Dr. Shuayto of Plaintiff on February 24, 2022 referencing Plaintiff's low back pain. The record indicates that Plaintiff did have a spinal cord stimulator implanted which needs some "reprogramming." The Plaintiff's neuromodulator was adjusted at that time and the Plaintiff's symptoms have improved.

Defendant's Exhibit S is the record of the right sacroiliac joint fusion performed by Dr. Shuayto on June 3, 2022.

Defendant's Exhibit T is Agency Form 105A dated October 25, 2019 signed by the Plaintiff. The information contained in this form is substantially consistent with the testimony adduced at the time of the hearing.

Defendant's Exhibit U are job search forms commencing February 27, 2019 through September 27, 2022. This exhibit consists of approximately 122 pages disclosing the names of prospective employers and the dates on which applications for employment were made by Plaintiff. Each page with the exception of three discloses the names of two employers. There are a total of approximately 241 employers listed on these forms. The types of jobs Plaintiff was applying for and the pay rates were substantially the same as set forth in Plaintiff's Exhibit 13. The method of application was almost entirely by submission of a resume with some applications being filed. The variety of jobs applied for were numerous. Plaintiff noted on these forms on many occasions that she did not receive a call back or the employer hired someone else.

Defendant's Exhibit V are job search logs beginning on September 29, 2022 through October 31, 2022. The exhibit consists of 13 pages with the names of two employers on each page. As with the previous exhibit, the application was made by resume. The type of jobs sought is essentially the same as the previous exhibit. The logs do disclose substantially the same wage information as previous exhibits. The logs also show notations by Plaintiff indicating there was no contact made back from the employer or that the position was no longer available or someone had been hired in place of the Plaintiff.

ANALYSIS AND FINDINGS

It is Plaintiff's burden of proof by a preponderance of the evidence that she sustained an injury arising out of and in the course of her employment with Defendant Lake Huron Medical Center (Aquilina v General Motors Corporation, 403 Mich 206 (1997); and Section 851 of WDCA). Once an injury has been established, it is Plaintiff's further burden to prove a disability pursuant to Section 301(4) and/or Section 301(5) of the WDCA.

The operative facts regarding Plaintiff's alleged injury are really not in dispute. Plaintiff was employed as a dietary clerk for Defendant. She described her job duties as set forth on page 3 and 4 of this Opinion. She identified Plaintiff's Exhibit 11 as her job duties. She testified that prior to August 29, 2016, she had no back problem nor any treatment for back problems. She had no problems performing her job or the activities or daily living (see, this Opinion, pg. 4).

On August 29, 2016 while carrying a large pan of vegetables, Plaintiff testified she tripped on a "anti fatigue mat" causing her to fall forward at which

time she experienced immediate pain in her wrists, knees and back.[1] She received some medical treatment after the injury, took 10 days off from work, returned to work for only a half a day and last worked on September 15, 2016. As set forth at the outset of this Opinion, Plaintiff's Application for Hearing alleged injuries to her knees, wrists, back, and neck. However, Plaintiff testified that the injuries to her wrists, knees, and neck resolved within a matter of weeks as reported by Dr. Seidel (see, this Opinion, pg. 6). Her only remaining problem is with her back (see also, Plaintiff's Trial Brief, pg. 1).

Given the above scenario, it is clear that Plaintiff claims her disability stems from her back problem caused by a specific event occurring on August 29, 2016, i.e., an injury "attributable to a single event."[2] Plaintiff has sought treatment from or been examined by five different physicians whose depositions were taken and admitted into evidence. All five physicians testified that Plaintiff had degenerative spinal disease. Their disagreement was with regard to causation and/or aggravation and disability. Therefore, I believe the appropriate analysis of Plaintiff's claim is pursuant to Section 301(1) of the WDCA which states in pertinent part the following:

> A personal injury under this Act is compensable if work causes, contributes to, or aggravates pathology in a manner so as to create a pathology that is medically distinguishable from any pathology that existed prior to the injury.[3]

Defendant's Trial Brief correctly points out that the above language was intended to codify Rakestraw v General Dynamics Land Systems Inc., 496 Mich 220 (2003) which held in pertinent part the following:

> A symptom such as pain is evidence of injury, but does not, standing alone, conclusively establish the statutorily required causal connection to the workplace. In other words, evidence of a symptom is insufficient to establish a personal injury "arising out of and in the course of employment
>
> …
>
> Where a claimant experiences symptoms that are consistent with the progression of a preexisting condition, the burden rests on the claimant to differentiate between the preexisting condition, which is not compensable, and the work-related injury, which is compensable."

---

[1] Plaintiff's description of her fall was provided to Dr. Corey Zieger on September 23, 2016 (Plaintiff's Exhibit 4), and Defendant's medical facility on October 29, 2016 (Plaintiff's Exhibit 8). These records pre-date Plaintiff's Application for Hearing by well over two years lending more credence to Plaintiff's account of the event.

[2] Plaintiff's Trial Brief states the following: "In this case it is Plaintiff's contention that the fall of August 29, 2016 was the sole cause of her back injury, pain and disability." (pg. 4)

[3] See also, Workers' Compensation in Michigan; Law and Practice, 6th Edition, Section 6.4, pg. 121.

(469 Mich at 230-231)

Therefore, Plaintiff must prove that her post injury condition is "medically distinguishable from her pre-existing back condition to establish a personal injury."

An examination of the medical evidence submitted becomes mandatory and, indeed, dispositive.

The medical evidence indicates that Plaintiff's lower back has a condition described as spondylolisthesis at L4-L5. An x-ray was performed upon Plaintiff on the very day of her alleged injury, i.e., August 29, 2016. Dr. Jeffrey Seidel testified regarding his review of the actual x-ray films indicating that there was "anterior positioning of L4 on L5 approximately 2mm grade 1 anterior spondylolisthesis." (Seidel dep., Defendant's Exhibit A). An MRI of the lumbar spine performed on October 8, 2016 was read, in part, to show the same finding and almost identical terminology (see, records of Dr. Zieger, Plaintiff's Exhibit 4).[4] An x-ray of Plaintiff's lumbar spine was performed on April 16, 2018 which revealed "a mild anterior listhesis of L4 on L5 with approximately 5mm of anterior listhesis" (Polina dep., Plaintiff's Exhibit 1).

The issue then becomes two-fold: was the spondylolisthesis evidenced in 2016 caused by the alleged injury of August 29, 2016; secondly, was the change in the spondylolisthesis evidenced in 2018 the result of the 2016 injury or any employment activities.[5]

The second question is clearly answered in the negative.

Plaintiff testified that she only worked a half day following her alleged injury on August 29, 2016, last working on September 15, 2016. There is simply no evidence presented by Plaintiff by the way of either medical records or medical testimony that indicates half day of employment caused or aggravated Plaintiff's spondylolisthesis. As to the first issue, let us closely examine the medical evidence.

Defendant's medical experts were all physicians chosen by Defendant to examine Plaintiff. Each physician only examined Plaintiff on one occasion. Dr. Stanly Lee examined Plaintiff on October 6, 2017; Dr. Nathan Gross saw her only on January 14, 2019; Dr. Jeffrey Seidel examined Plaintiff on October 22, 2020. While I believe treating physicians' opinions are generally to be given more

[4] All of the radiologist's impression of the October 8, 2016 MRI are set forth on page 47 of this Opinion. No acute findings are reported.

[5] The Appellate Commission has held that the rulings in Rakestraw, supra, and Fahr v GMC, 487 Mich 929 (2007) must be applied even when Plaintiff alleges a specific incident (Merchant v Grow With Us Ventures Otsego, Inc., 2013 ACO # 10).

weight than examiners chosen by a party to the case, nevertheless their opinions must be given some consideration.

Dr. Stanly Lee is a board certified orthopedic surgeon. He testified that there are numerous causes behind spondylolisthesis including congenital, degenerative, and post-traumatic. In the instant case, Dr. Lee further testified that the fall described by Plaintiff did not cause the 2mm spondylolisthesis. He explained his answer as follows:

> A. Because 2 millimeters of anterior listhesis or spondylolisthesis is considered an incidental finding in a normal variant. I would not consider this to be at all pathological be it traumatic, degenerative or otherwise.
>
> (Lee dep., pg. 21-22)
>
> A. Yes. If there were true traumatic spondylolisthesis, I would expect to see marked soft tissue damage, potentially a fracture, something that would thoroughly compromise the stability of the spine.
>
> (Lee dep., pg. 22)

Dr. Jeffrey Seidel, board certified in physical medicine and rehabilitation and electrodiagnostic medicine, also testified that the alleged injury of August 29, 2016 did not cause Plaintiff's spondylolisthesis. He further amplified his reasoning for so finding:

> A. The direct trauma causing an anterior spondylolisthesis requires direct forces of a high velocity to the back of the spine like an individual falling out of a second story building and landing on a bar or like being thrown from a motorcycle at a high rate of speed into a tree or something like that.
>
> (Seidel dep., pg. 52)

Finally, Dr. Nathan Gross, also board certified in physical medicine and rehabilitation, testified that Plaintiff's alleged injury of August 29, 2016 did not cause her spondylolisthesis:

> My first question to you is: Based on her history, your physical examination and your review of the records including the radiology reports, did the work or the incident that she described cause or aggravate any pathology that you were able to identify at the time of your examination?
>
> A. No.
>
> (Gross dep., pg. 39)

I would now turn to Plaintiff's medical experts, both of whom were treating physicians. As alluded to above, I have generally given more weight to the opinion of treating physicians as opposed to examiners chosen by one of the parties. Plaintiff's Trial Brief quoted extensively from the deposition of Dr. Ryan Polina (Plaintiff's Trial Brief, pgs. 2-3). Plaintiff's counsel has accurately quoted from Dr. Polina's testimony. He diagnosed "discogenic pain stemming from the fall in 2016." However, Dr. Polina also testified that his musculoskeletal examination of Plaintiff found no abnormalities (Polina dep., Plaintiff's Exhibit 1, pg. 33-35). More significantly, Dr. Polina was asked if he could determine whether the listhesis at L4 on L5 was degenerative. He responded as follows:

> A. Truthfully at this date I wouldn't have a strong opinion on whether that was a degenerative or an acute finding, and acute process. This certainly could be considered a degenerative change; however, it doesn't necessarily indicate the cause of that listhesis. Shifting of the vertebrae can happen acutely or chronically or a combination of both.
>
> (Pollina dep., pg. 36)

Furthermore, when asked whether there was any objective evidence that the disruption at L4-L5 was directly related to Plaintiff's fall, he responded:

> Q. So you are saying that without looking at the imaging studies that were done at the time you can't have an opinion or don't have an opinion as to whether there was an acute change or not? Is that fair to say?
>
> A. I apologize, I'm just having a little trouble with the question. On my initial evaluation it was difficult for me to say whether any spondylolisthesis was from a fall or not because that's just a finding that you will see on imaging. I'm seeing a snapshot of the patient's back at a time and without a previous image it's really difficult to say whether that's definitively a chronic change or something that happened acutely. That would be I guess the best way I can answer. I don't know if that answers your question.
>
> (Pollina dep., pg. 38)
>
> A. The indirect evidence would be the advancing spondylolisthesis. Two millimeters turning into five millimeters points towards that. To prove that it's from a fall, I can't say that.
>
> (Pollina dep., pg. 55)

Dr. Shuayto did not see the Plaintiff until August 12, 2019, almost three years after Plaintiff's alleged injury. He acknowledged that his clinical examination of Plaintiff was essentially normal, except for Plaintiff's complaint of radicular pain. However, he acknowledged that the EMG performed on February 3, 2020 showed no evidence of radiculopathy. He also admitted that

spondylolisthesis could be caused by degenerative changes or trauma. He agreed that spondylolisthesis is most often a degenerative condition.

It is critical in my opinion that neither Dr. Pollina nor Dr. Shuayto were asked whether the change in the degree of spondylolisthesis from 2 mm to 5 mm was related to Plaintiff's fall. Dr. Pollina's records and testimony, even the position cited by Plaintiff in her Brief, references "pain," not any change in pathology. Likewise, Dr. Shuayto, in response to Plaintiff's counsel's lengthy hypothetical question, answered rather ambiguously:

> Q. Go ahead, Doctor. You can answer my question.
>
> A. In my professional opinion, it could be related to the fall.
>
> Q. Okay. When you say - -
>
> MS. TICE: Wait. Oh, go ahead. I object as it's a vague answer, we don't know what it was related to.
>
> MR. PARTIPILO:
>
> Q. Okay. Doctor, we're going to need more specifics here. Is there anything else there in this history that would indicate that anything but the fall would have caused the issue?
>
> A. By history, no, so the patient did not have any symptoms prior to this accident, never complained of any low back pain according to her.
>
> Q. Okay.
>
> (Pollina dep., pg. 24)

For the above reasons I choose to accept the opinions of Defendant's medical experts rather than those of Dr. Pollina and Dr. Shuayto.[6] I find that Plaintiff has not sustained her burden of proof that her fall on August 29, 2016 resulted in a personal injury as set forth in the provisions of Section 301(1) of the WDCA. Her claim for benefits is denied.

Having found that Plaintiff has not proven a compensable injury, the issue of disability is moot.

Defendant filed a Petition to Recoup dated March 29, 2019. The body of the Application for Hearing – Form C simply indicates "Defendants seek

[6] "The magistrate's choice of which medical expert opinion or opinions to adopt is within his or her discretion and we defer to that choice if it is reasonable. The magistrate need not adopt expert opinions in their entirely but may give differing weight to differing portions of testimony." (*Isaac v Masco Corporation,* 2004 ACO #81)

determination of liability." It was stipulated at the time of the hearing that Plaintiff received weekly benefits from August 30, 2016 through February 5, 2019. It appears Defendant's Application for Hearing – Form C is requesting reimbursement of the benefits paid to Plaintiff during that period of time. I would note that Defendant's post hearing trial brief did not make any claim for a recoupment. Nevertheless, since it is an issue that was raised by an Application for Hearing by Defendant, I will decide Defendant's request.

While it appears Defendant's Application was timely filed as it relates to the one year back rule under Section 833(2) of the WDCA, Defendant's request for reimbursement in this instance is denied. Agency Rule 408.40 Rule 10(6) states that: "Except as provided under Section 354 of the Act, where the carrier…has voluntarily paid benefits or paid benefits pursuant to a voluntary pay agreement, no reimbursement of previously paid benefits may be ordered against the employee unless the employer or carrier establishes that the employee concealed post injury earnings or establishes that benefits were over paid as the result of a mathematical, technological or clerical error." Defendant has established none of the factors set forth in this new Agency Rule. This Rule further indicates that "a Magistrate may, in his or her discretion, waive reimbursement of an overpayment upon an employee showing undue harm. The magistrate may take into consideration whether recoupment of an overpayment would not serve the purposes of the Act." In this case, I so find and therefore as indicated above, the Petition for Recoupment is hereby denied.

CONCLUSIONS

For the reasons set forth above, Plaintiff's claim is hereby denied. Defendant's claim for recoupment is likewise denied.

WORKERS' COMPENSATION
BOARD OF MAGISTRATES

_____
E. LOUIS OGNISANTI (246G)

Signed on January 19, 2023 at Saginaw, Michigan.