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THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM THE SOUTH CAROLINA WORKERS' COMPENSATION
COMMISSION

Case No.: 2012-213610

Norge L. Gonzalez Torres, Employee, Claimant, Appellant,

v.

World Fiber Technologies, Inc., Employer, and The Standard Fire Insurance
Company, c/o Travelers, Carrier, Respondents.

RECORD ON APPEAL

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SC Court of Appeals

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DECISION AND ORDER OF THE
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

WCC FILE NO. 1002408

Norge L. Gonzalez Torres,
Employee,
Claimant,

vs.

World Fiber Technologies, Inc.,

Employer,
and

The Standard Fire Insurance Company,

Carrier,
Defendants.

DECISION AND ORDER

HEARING:

Held in Columbia, South Carolina on January 27, 2012.

APPEARANCES:

Claimant represented by C. Daniel Vega, Esquire of Columbia, South Carolina.

Defendants represented by S. LeAnne McCormack, Esquire of Willson Jones Carter & Baxley, P.A., Columbia, South Carolina.

PURPOSE OF HEARING:

To determine the issues as set forth on the Form 21.

DECISION AND ORDER:

By Gene McCaskill, Commissioner

FILED:

April 23, 2012.

Appeal
05/04/12

I. APA SUBMISSIONS

Under the Administrative Procedures Act, the following records were submitted into evidence at the time of the hearing:

Defendants' APA Submissions:

- APA #1: Records of Jacksonville Orthopaedic Institute, dated 3/30/2010 – 9/19/2011, consisting of pages 1-19.
- APA #2: Records of Signet Diagnostic Imaging Services, dated 4/28/2010, consisting of pages 20-21.
- APA #3: Records of Bruce A. Hartwig, M.D., P.A., dated 10/21/2010, consisting of pages 22-25.
- APA #4: Records of Work Strategies, dated 8/31/2011, consisting of pages 26-40.

II. STIPULATIONS

Counsel for the respective parties stipulated at the time of the hearing to the following issues:

1. The purpose of the hearing is to determine the issues as set forth in the Form 21 and any other issues which may timely come before the Commission;
2. That the Claimant's accident occurred on February 26, 2010;
3. Notices were timely and properly served upon all parties of interest;
4. Venue, set in Richland, is proper as agreed by all parties;
5. That the South Carolina Workers' Compensation Commission has jurisdiction over the parties and issues involved;
6. The issues for determination are whether the Defendants are entitled to stop payment of temporary total disability compensation, whether Defendants are entitled to a credit for overpayment of temporary total disability from the date of maximum medical improvement, the proper amount of Claimant's average weekly wage and corresponding compensation rate, whether Defendants are entitled to a credit for overpayment of temporary total disability up to the date of maximum medical improvement due to an incorrect compensation rate, to what extent the Claimant is entitled to permanent partial disability benefits, medical benefits and/or disfigurement, if any, and any other issues which may timely come before the Commission.

Without objection, the Commission's file was made a part of the record in this matter with the exception of any self-serving declaration or unstipulated medical reports.

III. STATEMENT OF THE CASE

This case was heard by the undersigned Commissioner in Columbia, South Carolina, on January 27, 2012.

It is Defendants' position in this matter that the Claimant reached maximum medical improvement (MMI) on September 19, 2011, and Defendants seek a credit for overpayment of benefits from that date. Defendants allege the Claimant suffered a 12% permanent partial disability to his back and seek a determination and award on the extent of the Claimant's permanent disability. Defendants object to the compensation rate of \$304.02 and contend that the appropriate average weekly wage is \$327.00 with an associated compensation rate of \$218.01. Defendants request an adjustment of the compensation rate and a credit for overpayment of the incorrect compensation rate from March 1, 2010 until September 19, 2011, the date the Claimant allegedly reached MMI. Defendants also object to the Claimant testifying at the hearing because the Claimant did not submit a pre-hearing brief, and as such, the Claimant is not listed as a witness. Lastly, Defendants object to any award of further medical treatment or award of a second medical opinion for the Claimant's injuries.

It is the Claimant's position in this matter that the Claimant suffered permanent disability to his back in excess of the 12% impairment rating. The Claimant contends that \$304.02 is the correct compensation rate and he would be prejudiced by any award of credit for overpayment of the alleged incorrect compensation rate. The Claimant contends he would be prejudiced by not being allowed to testify at the hearing and asserts that there is no prejudice to Defendants if Claimant is to testify because Defendants expected the Claimant's testimony. Lastly, the Claimant

submitted a medical bill to Defendants at the hearing and request that the bill be paid in full.

Following the hearing, the undersigned Commissioner requested further information from the parties regarding the Claimant's appropriate average weekly wage and compensation rate. After hearing from both parties, the undersigned Commissioner found the correct average weekly wage to be \$390.23 with a corresponding compensation rate of \$260.17.

IV. EVIDENCE OF THE CASE

The claimant testified at the hearing in this matter, and his testimony allowed this Commissioner to observe the Claimant, to ask questions to the Claimant and to judge his credibility as a witness. The Claimant testified he lived in Jacksonville, Florida at the time of the accident, but he was working in Charleston, South Carolina for Defendant World Fiber Technologies when he was injured while installing fiberoptic cables. He testified he injured his back on the job and initially did not realize the extent of his injuries. The Claimant testified he realized his back injury was worse than expected and was sent home to Jacksonville to receive medical treatment about a month after the accident. The Claimant testified he was treated by Drs. Kleinhans and Sharf at Jacksonville Orthopaedics Institute and was initially sent to physical therapy. He testified the physical therapy did not improve his back and an MRI was eventually obtained. The Claimant testified he then underwent injections and a nerve test, but it was eventually recommended that he undergo surgery. The Claimant testified he underwent surgery on his back, performed by Dr. Sharf, and the surgery improved his range of motion, but he testified the surgery did not alleviate his pain. The Claimant testified he underwent three months of physical therapy following the surgery, but he stated the physical therapy only aggravated his condition.

The Claimant testified Dr. Sharf released him in September of 2011 and he has not seen Dr.

Sharf since. The Claimant testified his pain continues and he stated that it becomes worse if he remains seated or standing for long periods. He testified the pain is alleviated if he lies down in the fetal position, and he is required to lie in that position two or three times per day due to his pain. The Claimant testified he occasionally takes pain medications and he would like more treatment for his back if there is "something that would help me get better other than what I've had up till now..." The Claimant testified he underwent a functional capacity evaluation (FCE) and he feels that he had additional symptoms as a result of that test. The Claimant testified he does not believe he is able to return to his job installing fiberoptic cables, but he does believe he is capable of light duty work at this time. The Claimant testified he lost more than 50% of his ability in his spine due to the accident and he can no longer lean forward to grab anything.

On cross-examination, the Claimant testified he is thirty-nine (39) years old and has not tried to return to work.

The medical records of Jacksonville Orthopaedic Institute indicate the Claimant was seen by Dr. Robert J. Kleinhans on March 30, 2010 with complaints of constant low back pain radiating down the back of both legs and into both knees. Dr. Kleinhans obtained x-rays of the Claimant's lumbar spine, diagnosed the Claimant with acute lumbar strain, prescribed him Soma and Vicodin and sent the Claimant to physical therapy. The Claimant followed up with Dr. Kleinhans on April 22, 2010 with complaints of continued back pain which had not improved. Dr. Kleinhans diagnosed the Claimant with persistent low back pain with possible central disc herniation and ordered an MRI of the Claimant's low back. The Claimant underwent an MRI at Signet Diagnostic Imaging Services on April 28, 2010. The MRI revealed disc herniation at L5-S1 without nerve involvement, and on May 7, Dr. Kleinhans recommended the Claimant continue with physical therapy and referred the Claimant to a back specialist to evaluate the possibility of

surgery.

The Claimant was seen by Dr. Michael S. Scharf on June 2, 2010. Dr. Scharf noted the Claimant's MRI was consistent with a small, central subligamentous disc herniation at L4-5. Dr. Scharf noted the Claimant displayed submaximal effort in range of motion testing and opined there was "maybe a little bit of pain behavior response." Nonetheless, Dr. Scharf diagnosed the Claimant with central disc herniation and recommended he undergo epidural steroid injections. The Claimant underwent a series of injections which gave the Claimant only transient relief.

The Claimant underwent electrodiagnostic studies under Dr. Bruce A. Hartwig on October 21, 2010 which revealed a normal EMG of the bilateral lower extremities.

On November 1, 2010, Dr. Scharf recommended the Claimant undergo a discogram, which was "markedly positive at L4-5, L5-S1." Following the discogram reports, Dr. Scharf recommended the Claimant undergo a posterior fusion and posterior lumbar interbody fusion at L4-5 and L5-S1. The Claimant underwent a bilateral decompression and posterior lumbar interbody fusion on January 20, 2011 and Dr. Scharf noted the "procedure went well."

The Claimant was seen in follow-up on March 16, 2011 with complaints of a different kind of back pain than he had prior to the surgery. Dr. Scharf read x-rays as showing a good position of the hardware and noted the Claimant displayed "a lot of submaximal effort." Dr. Scharf prescribed physical therapy and Percocet. On May 25, 2011, Dr. Scharf noted x-rays to show early healing of the Claimant's fusion and released the Claimant to sedentary work at that time. Dr. Scharf referred the Claimant for an FCE on August 22, 2011 and noted the Claimant was close to MMI at that time.

The Claimant underwent an FCE on August 31, 2011 performed by Jennifer Hauser, a physical therapist. Miss Hauser opined the Claimant was capable of light work. It was also noted

by Ms. Hauser that the Claimant demonstrated some inconsistencies throughout the test. Therefore, the findings in her report represent the minimum at which he can function in an 8 hour per day basis.

Dr. Scharf saw the Claimant on September 19, 2011 after the Claimant had undergone the FCE and Dr. Scharf opined the Claimant could return to light work, released the Claimant, stated the Claimant was at MMI and assigned the Claimant a 12% permanent impairment. Dr. Scharf also noted the Claimant's range of motion in the lumbar spine was about 50% of normal.

A record such as was necessary for a decision was made of the proceeding and after careful consideration and study of all the evidence, the following findings of fact are accordingly made.

V. FINDINGS OF FACT

IT IS FOUND AS A FACT:

1. That Employee, Employer, and Carrier are subject to and bound by the terms and provisions of the South Carolina Workers' Compensation Act, as amended, with Norge L. Gonazalez Torres as Employee-Claimant and World Fiber Technologies, Inc. as Employer and The Standard Fire Insurance Company as Carrier, Defendants.
2. That Claimant was an employee of the above-named Employer on and prior to February 26, 2010, on which date he did sustain an injury to the back arising out of and in the course of his employment, and proper notice was given to Employer. This was an accepted claim, and Claimant has received appropriate medical benefits and is presently receiving temporary total compensation.
3. That the average weekly wage of Employee at the time of the above-described accident was \$390.23, making a compensation rate of \$260.17 applicable in this matter.
4. That Claimant reached maximum medical improvement on September 19, 2011 for

the injuries resulting from the February 26, 2010 accident and that there is no evidence in the record that any additional medical treatment would tend to lessen the period of Claimant's disability.

5. That Claimant has sustained 12% permanent partial disability to his back as a result of the accidental injury on February 26, 2010.

6. The Claimant underwent an MRI at Signet Diagnostic Imaging Services on April 28, 2010. The MRI revealed disc herniation at L5-S1.

7. On June 2, 2010, Dr. Michael S. Scharf diagnosed the Claimant with central disc herniation and recommended he undergo epidural steroid injections. The Claimant underwent a series of injections which gave the Claimant only transient relief.

8. The Claimant underwent electrodiagnostic studies under Dr. Bruce A. Hartwig on October 21, 2010 which revealed a normal EMG of the bilateral lower extremities.

9. On November 1, 2010, Dr. Scharf recommended the Claimant undergo a discogram, which was "markedly positive at L4-5, L5-S1." Following the discogram reports, Dr. Scharf recommended the Claimant undergo a posterior fusion and posterior lumbar interbody fusion at L4-5 and L5-S1.

10. The Claimant underwent a bilateral decompression and posterior lumbar interbody fusion on January 20, 2011, performed by Dr. Scharf.

11. The Claimant testified he underwent three months of physical therapy following the surgery, but he stated the physical therapy only aggravated his condition.

12. The Claimant was seen in follow-up on March 16, 2011 with complaints of a different kind of back pain than he had prior to the surgery. Dr. Scharf read x-rays as showing a good position of the hardware and noted the Claimant displayed "a lot of submaximal effort."

13. On May 25, 2011, Dr. Scharf noted x-rays to show early healing of the Claimant's fusion and released the Claimant to sedentary work at that time.

14. On August 22, 2011, Dr. Scharf referred the Claimant for a functional capacity evaluation (FCE).

15. The Claimant underwent an FCE on August 31, 2011, performed by Jennifer Hauser, M.P.T. Miss Hauser opined the Claimant was capable of light work.

16. Dr. Scharf saw the Claimant on September 19, 2011, after the Claimant had undergone the FCE, and Dr. Scharf opined the Claimant could return to light work, released the Claimant from his care, stated the Claimant was at MMI, and assigned the Claimant a 12% permanent impairment. Dr. Scharf also noted the Claimant's range of motion in the lumbar spine was about 50% of normal.

17. That Defendants are entitled to stop payment of temporary total disability compensation.

18. That Defendants are entitled to a credit for the overpayment of temporary total compensation since September 19, 2011 until the date of the hearing. This credit will be applied against the award for permanent partial disability ordered herein.

19. That Defendants are entitled to a credit for the overpayment of temporary total compensation from March 1, 2010 until September 19, 2011 in the amount \$43.85 per week, representing the difference between \$304.02 (amount of weekly TTD paid under the incorrect compensation rate) and \$260.17 (amount of weekly TTD under the correct compensation rate). This credit will be applied against the award for permanent partial disability ordered herein.

20. That Claimant has failed to prove that he is entitled to any further medical benefits, any award for serious disfigurement or any other compensable element under the law, other than

the award for disability as ordered herein.

21. The Claimant testified he is thirty-nine (39) years old and has not tried to return to work.

22. The Claimant testified he does not believe he is able to return to his job installing fiberoptic cables, but he does believe he is capable of light duty work at this time.

23. Defendants are to pay all causally related medical bills.

VI. CONCLUSIONS OF LAW

Accordingly, as provided in § 42-17-40, SC Code Ann. (1976), as amended, it is the determination of this Commission that:

1. Under § 42-1-130, Claimant was a covered employee at the time in question; and under § 42-1-140, Defendant/Employer was a covered employer under the Act.

2. Under § 42-1-160, Claimant did sustain an injury to his back by accident arising out of and in the course and scope of his employment on February 26, 2010.

3. Under §§ 42-9-10 and 42-1-120, Claimant was entitled to compensation for a period of temporary total disability until September 19, 2011, the date on which Claimant reached maximum medical improvement. Defendants are to stop payment of temporary total disability benefits to the Claimant.

4. Under § 42-9-30, Claimant has sustained 12% permanent partial disability to the back.

5. Under § 42-9-210, Defendants are entitled to a credit for the overpayment of temporary total compensation since September 19, 2011 until the present, to be applied against the award for permanent partial disability ordered herein.

6. Under § 42-9-210, Defendants are entitled to a credit for the overpayment of

temporary total compensation from March 1, 2010 until September 19, 2011 in the amount of \$43.85 per week, to be applied against the award for permanent partial disability ordered herein.

7. Under § 42-15-60, Claimant was entitled to, and Defendants are liable for, causally related medical, surgical, hospital and other authorized treatment until September 19, 2011, the date on which Claimant reached maximum medical improvement, but not thereafter, there being no evidence that any additional medical treatment would tend to lessen the period of his disability.

VII. ORDER/AWARD

IT IS HEREBY ORDERED that the Application of Employer/Carrier to stop payment of temporary total compensation is hereby granted, effective September 19, 2011, the date on which Claimant reached maximum medical improvement.

IT IS FURTHER ORDERED that as a result of Claimant's accidental injury occurring on February 26, 2010, he has sustained 12% permanent partial disability to the back, for which he is entitled to 36 weeks of compensation, at the compensation rate of \$260.17 per week. From this amount, the Defendants are entitled to a credit or offset for the overpayment of temporary total compensation in the total amount of \$10,500.46, which represents 23 weeks of overpayment (9/19/2011 – 2/27/2012) in the amount of \$304.02 per week and 80 weeks of overpayment (3/1/2010 – 9/19/2011) in the amount of \$43.85 per week.

IT IS FURTHER ORDERED that Defendants are to pay all causally related medical, surgical, hospital and other authorized medical treatment until September 19, 2011, the date on which Claimant reached maximum medical improvement.

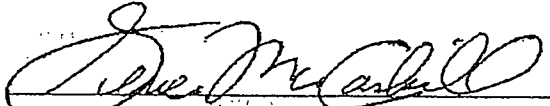
IT IS FURTHER ORDERED that Claimant reached maximum medical improvement on September 19, 2011, and as such Defendants are not liable for any additional medical, surgical, hospital or other medical treatment to Claimant after said date, until and unless further ordered by

this Commission.

No hearing costs are assessed in this instance.

IT IS SO ORDERED.

SOUTH CAROLINA WORKERS'
COMPENSATION COMMISSION



Commissioner Gene McCaskill

CERTIFICATE OF SERVICE

This is to certify the undersigned has this date served this order in the above entitled action upon all parties to this cause by sending an electronic copy hereof by electronic mail addressed to the attorney or attorneys for said parties or by depositing a copy hereof, postage paid, in the United States certified mail addressed to any unrepresented party.

April 23, 2012

By: Kellie Lindler, Administrative Assistant to Commissioner McCaskill

12/15

FULL COMMISSION ORDER
BEFORE THE SOUTH CAROLINA
WORKERS' COMPENSATION COMMISSION

WCC FILE NO. 1002408

Norge L. Gonazalez Torres,	)	
Employee,	)	
Claimant/	)	
	)	
vs.	)	
	)	
World Fiber Technologies, Inc.,	)	ORDER OF THE FULL COMMISSION
	)	
Employer,	)	
and	)	
	)	
The Standard Fire Insurance Company,	)	
	)	
c/o Travelers	)	
	)	
	)	
Carrier.	)	
Defendants/Appellants.	)	

STATEMENT OF THE CASE

This case was heard by Commissioner McCaskill in Columbia, South Carolina, on January 27, 2012.

This is an admitted injury by accident involving the Claimant's back. The Claimant reached maximum medical improvement (MMI) on September 19, 2011. At the single Commission hearing the Defendants sought a credit for overpayment of benefits from that date. Defendants sought a determination and award on the extent of the Claimant's permanent disability, if any.

Defendants objected to the compensation rate of \$304.02 and contended that the appropriate average weekly wage is \$327.00 with an applicable compensation rate of \$218.01. Defendants requested an adjustment of the compensation rate and a credit for overpayment of the incorrect compensation rate from March 1, 2010 until September 19, 2011, the date the Claimant allegedly reached MMI.

Defendants also objected to the Claimant testifying at the hearing because the Claimant did not submit a pre-hearing brief, and as such, the Claimant was not listed as a witness.

Lastly, Defendants objected to any award of further medical treatment or award of a second medical opinion for the Claimant's injuries.

It was the Claimant's position in this matter that he suffered permanent disability to his back in excess of the 12% impairment rating. The Claimant contended that \$304.02 is the correct compensation rate and he would be prejudiced by any award of credit for overpayment of the alleged incorrect compensation rate. The Claimant contended he would be prejudiced by not being allowed to testify at the hearing and asserted that there is no prejudice to Defendants if Claimant is to testify because Defendants expected the Claimant's testimony. Lastly, the Claimant submitted a medical bill to Defendants at the hearing and requested that the bill be paid in full.

Following the hearing, the undersigned Commissioner requested further information from the parties regarding the Claimant's appropriate average weekly wage and compensation rate. After hearing from both parties, the undersigned Commissioner found the correct average weekly wage to be \$390.23 with a corresponding compensation rate of \$260.17.

By Order dated April 23, 2012, Commissioner McCaskill granted the Application of Employer/Carrier to stop payment of temporary total compensation effective September 19, 2011, the date on which Claimant reached maximum medical improvement. The Commissioner further ordered that as a result of Claimant's accidental injury occurring on February 26, 2010, he sustained a 12% permanent partial disability to the back, for which he is entitled to 36 weeks of compensation, at the compensation rate of \$260.17 per week. From this amount, the Defendants were entitled to a credit or offset for the overpayment of temporary total compensation in the total amount of \$10,500.46, which represents 23 weeks of overpayment (9/19/2011 – 2/27/2012) in the amount of \$304.02 per week and 80 weeks of overpayment (3/1/2010 – 9/19/2011) in the amount of \$43.85 per week. It was further ordered that the Defendants are to pay all causally related medical, surgical, hospital and other authorized medical treatment until September 19, 2011, the

date on which Claimant reached maximum medical improvement. The Commissioner found that the Claimant reached maximum medical improvement on September 19, 2011, and as such Defendants were not liable for any additional medical, surgical, hospital or other medical treatment to Claimant after said date, until and unless further ordered by this Commission. There were not any costs assessed in this matter.

EVIDENCE OF THE CASE

The Claimant testified at the hearing in this matter, and his testimony allowed the Commissioner to observe the Claimant, to ask questions to the Claimant and to judge his credibility as a witness. The Claimant testified he lived in Jacksonville, Florida at the time of the accident, but he was working in Charleston, South Carolina for Defendant World Fiber Technologies when he was injured while installing fiberoptic cables. He testified he injured his back on the job and initially did not realize the extent of his injuries. The Claimant testified he realized his back injury was worse than expected and was sent home to Jacksonville to receive medical treatment about a month after the accident. The Claimant testified he was treated by Drs. Kleinhans and Sharf at Jacksonville Orthopaedics Institute and was initially sent to physical therapy. He testified the physical therapy did not improve his back and an MRI was eventually obtained. The Claimant testified he then underwent injections and a nerve test, but it was eventually recommended that he undergo surgery. The Claimant testified he underwent surgery on his back, performed by Dr. Sharf, and the surgery improved his range of motion, but he testified the surgery did not alleviate his pain. The Claimant testified he underwent three months of physical therapy following the surgery, but he stated the physical therapy only aggravated his condition.

The Claimant testified Dr. Sharf released him in September of 2011 and he has not seen Dr. Sharf since. The Claimant testified his pain continues and he stated that it becomes worse if he remains seated or standing for long periods. He testified the pain is alleviated if he lies down in the fetal position, and he is required to lie in that position two or three times per day due to his pain.

The Claimant testified he occasionally takes pain medications and he would like more treatment for his back if there is "something that would help me get better other than what I've had up till now..." The Claimant testified he underwent a functional capacity evaluation (FCE) and he feels that he had additional symptoms as a result of that test. The Claimant testified he does not believe he is able to return to his job installing fiberoptic cables, but he does believe he is capable of light duty work at this time. The Claimant testified he lost more than 50% of his ability in his spine due to the accident and he can no longer lean forward to grab anything.

On cross-examination, the Claimant testified he is thirty-nine (39) years old and has not tried to return to work.

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The Claimant was seen by Dr. Michael S. Scharf on June 2, 2010. Dr. Scharf noted the Claimant's MRI was consistent with a small, central subligamentous disc herniation at L4-5. Dr. Scharf noted the Claimant displayed submaximal effort in range of motion testing and opined there was "maybe a little bit of pain behavior response." Nonetheless, Dr. Scharf diagnosed the

Claimant with central disc herniation and recommended he undergo epidural steroid injections. The Claimant underwent a series of injections which gave the Claimant only transient relief.

The Claimant underwent electrodiagnostic studies under Dr. Bruce A. Hartwig on October 21, 2010 which revealed a normal EMG of the bilateral lower extremities.

On November 1, 2010, Dr. Scharf recommended the Claimant undergo a discogram, which was "markedly positive at L4-5, L5-S1." Following the discogram reports, Dr. Scharf recommended the Claimant undergo a posterior fusion and posterior lumbar interbody fusion at L4-5 and L5-S1. The Claimant underwent a bilateral decompression and posterior lumbar interbody fusion on January 20, 2011 and Dr. Scharf noted the "procedure went well."

The Claimant was seen in follow-up on March 16, 2011 with complaints of a different kind of back pain than he had prior to the surgery. Dr. Scharf read x-rays as showing a good position of the hardware and noted the Claimant displayed "a lot of submaximal effort." Dr. Scharf prescribed physical therapy and Percocet. On May 25, 2011, Dr. Scharf noted x-rays to show early healing of the Claimant's fusion and released the Claimant to sedentary work at that time. Dr. Scharf referred the Claimant for an FCE on August 22, 2011 and noted the Claimant was close to MMI at that time.

The Claimant underwent an FCE on August 31, 2011 performed by Jennifer Hauser, a physical therapist. Ms. Hauser opined the Claimant was capable of light work. It was also noted by Ms. Hauser that the Claimant demonstrated some inconsistencies throughout the test. Therefore, the findings in her report represent the minimum at which he can function in an 8 hour per day basis.

Dr. Scharf saw the Claimant on September 19, 2011 after the Claimant had undergone the FCE and Dr. Scharf opined the Claimant could return to light work, released the Claimant, stated the Claimant was at MMI and assigned the Claimant a 12% permanent impairment. Dr. Scharf also noted the Claimant's range of motion in the lumbar spine was about 50% of normal.

STANDARD OF REVIEW

The Full Commission is the ultimate finder of fact in a workers' compensation claim, and is not bound by the Single Commissioner's findings of fact or conclusions of law. The Full Commission is free to enter its own findings of fact and conclusions of law. The Full Commission is free to enter its own findings of fact and conclusions of law based on its *de novo* review of the evidence in the record. DeRoss v. American Red Cross 298 S.C. 490, 381 S.E.2d 728 (1989).

FINDINGS OF FACT

1. The preponderance of the evidence indicates that the Claimant was an employee of the above-named Employer on and prior to February 26, 2010, on which date he sustained an injury to his back arising out of and in the course of his employment, and proper notice was given to Employer. This was an accepted claim, and Claimant has received appropriate medical benefits and temporary total compensation.

2. The preponderance of the evidence indicates that the average weekly wage of Employee at the time of the above-described accident was \$390.23, making a compensation rate of \$260.17.

3. The preponderance of the evidence indicates that the Claimant reached maximum medical improvement on September 19, 2011 for the injuries resulting from the February 26, 2010 accident and that there is no evidence in the record that any additional medical treatment would tend to lessen the period of Claimant's disability.

4. The preponderance of the evidence supports the single Commissioner's Order that the Claimant sustained a 12% permanent partial disability to his back as a result of the accidental injury on February 26, 2010.

5. The Claimant underwent an MRI at Signet Diagnostic Imaging Services on April 28, 2010. The MRI revealed disc herniation at L5-S1.

6. On June 2, 2010, Dr. Michael S. Scharf diagnosed the Claimant with central disc herniation and recommended he undergo epidural steroid injections. The Claimant underwent a series of injections which gave the Claimant only transient relief.
7. The Claimant underwent electrodiagnostic studies under Dr. Bruce A. Hartwig on October 21, 2010 which revealed a normal EMG of the bilateral lower extremities.
8. On November 1, 2010, Dr. Scharf recommended the Claimant undergo a discogram, which was "markedly positive at L4-5, L5-S1." Following the discogram reports, Dr. Scharf recommended the Claimant undergo a posterior fusion and posterior lumbar interbody fusion at L4-5 and L5-S1.
9. The Claimant underwent a bilateral decompression and posterior lumbar interbody fusion on January 20, 2011, performed by Dr. Scharf.
10. The Claimant testified he underwent three months of physical therapy following the surgery, but he stated the physical therapy only aggravated his condition.
11. The Claimant was seen in follow-up on March 16, 2011 with complaints of a different kind of back pain than he had prior to the surgery. Dr. Scharf read x-rays as showing a good position of the hardware and noted the Claimant displayed "a lot of submaximal effort."
12. On May 25, 2011, Dr. Scharf noted x-rays to show early healing of the Claimant's fusion and released the Claimant to sedentary work at that time.
13. On August 22, 2011, Dr. Scharf referred the Claimant for a functional capacity evaluation (FCE).
14. The Claimant underwent an FCE on August 31, 2011, performed by Jennifer Hauser, M.P.T. Ms. Hauser opined the Claimant was capable of light work.
15. Dr. Scharf saw the Claimant on September 19, 2011, after the Claimant had undergone the FCE, and Dr. Scharf opined the Claimant could return to light work, released the Claimant from his care, stated the Claimant was at MMI, and assigned the Claimant a 12%

permanent impairment. Dr. Scharf also noted the Claimant's range of motion in the lumbar spine was about 50% of normal.

16. The preponderance of the evidence indicates that the Defendants are entitled to stop payment of temporary total disability compensation.

17. The preponderance of the evidence indicates that Defendants are entitled to a credit for the overpayment of temporary total compensation since September 19, 2011 until the date of the hearing. This credit is to be applied against the award for permanent partial disability ordered herein.

18. The preponderance of the evidence indicates that the Defendants are entitled to a credit for the overpayment of temporary total compensation from March 1, 2010 until September 19, 2011 in the amount \$43.85 per week, representing the difference between \$304.02 (amount of weekly TTD paid under the incorrect compensation rate) and \$260.17 (amount of weekly TTD under the correct compensation rate). This credit is to be applied against the award for permanent partial disability as ordered by Commissioner McCaskill.

19. The preponderance of the evidence indicates that the Claimant failed to prove that he is entitled to any further medical benefits, any award for serious disfigurement or any other compensable element under the law, other than the award for disability as ordered herein.

20. The Claimant testified he is thirty-nine (39) years old and has not tried to return to work.

21. The Claimant testified he does not believe he is able to return to his job installing fiberoptic cables, but he does believe he is capable of light duty work at this time.

22. Defendants are to pay all causally related medical bills

CONCLUSIONS OF LAW

Accordingly, as provided in § 42-17-40, SC Code Ann. (1976), as amended, it is the determination of this Commission that:

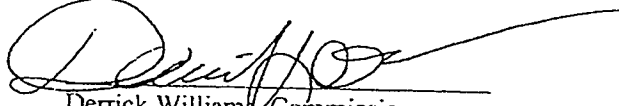
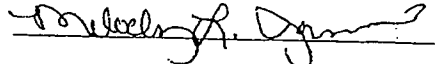
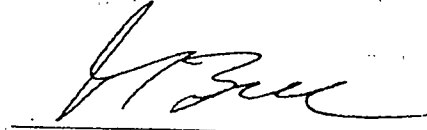
1. Under § 42-1-130, Claimant was a covered employee at the time in question; and under § 42-1-140, Defendant/Employer was a covered employer under the Act.
2. Under § 42-1-160, Claimant sustained an injury to his back by accident arising out of and in the course and scope of his employment on February 26, 2010.
3. Under §§ 42-9-10 and 42-1-120, Claimant was entitled to compensation for a period of temporary total disability until September 19, 2011, the date on which Claimant reached maximum medical improvement. Defendants are to stop payment of temporary total disability benefits to the Claimant.
4. Under § 42-9-30, Claimant has sustained 12% permanent partial disability to the back.
5. Under § 42-9-210, Defendants are entitled to a credit for the overpayment of temporary total compensation since September 19, 2011 until the present, to be applied against the award for permanent partial disability ordered herein.
6. Under § 42-9-210, Defendants are entitled to a credit for the overpayment of temporary total compensation from March 1, 2010 until September 19, 2011 in the amount of \$43.85 per week, to be applied against the award for permanent partial disability ordered herein.
7. Under § 42-15-60, Claimant was entitled to, and Defendants are liable for, causally related medical, surgical, hospital and other authorized treatment until September 19, 2011, the date on which Claimant reached maximum medical improvement, but not thereafter, there being no evidence that any additional medical treatment would tend to lessen the period of his disability.

ORDER/AWARD

IT IS HEREBY ORDERED that the Findings of Fact and Conclusions of Law from the single Commissioner's Decision and Order dated April 23, 2012 is hereby Fully Affirmed.

IT IS SO ORDERED.

SOUTH CAROLINA WORKERS'
COMPENSATION COMMISSION


Derrick Williams, Commissioner
Melody James, Commissioner
Scott Beck, Commissioner (Chair)

CERTIFICATE OF SERVICE

This is to certify the undersigned has this date served this order in the above entitled action upon all parties to this cause by sending an electronic copy hereof by electronic mail addressed to the attorney or attorneys for said parties or by depositing a copy hereof, postage paid, in the United States mail addressed to any unrepresented party.

By Valerie Deller on November 16, 2012

South Carolina Workers' Compensation Commission
P.O. Box 1715 - 1612 Marion Street
Columbia, South Carolina 29202-1715
(803) 737-5700

WCC File # 1002408
Carrier File # 026-CB-BHH9916-B
Carrier Code #
Employer FEIN 582354516

Norge Gonzalez-Torres 772-80-4216
Claimant's Name SSN
1706 Art Museum Dr Jacksonville FL 32207
Address City State Zip
(904) 470-9955 (770) 619-0118
Home Phone Work Phone

World Fiber Technologies, Inc.
Employer's Name
4070-9 McFarland Drive Alpharetta GA 30004
Address City State Zip
The Standard Fire Ins Company
Insurance Carrier
(770) 619-0118
Preparer's Name Phone #

A. Total Wages Paid

Date of Injury: 02/26/2010
month day year

1. Check Applicable Method
() Report of earnings of injured employee based on four completed quarters.
(X) Report of earnings of injured employee who did not complete four quarters based on actual time worked.
() Report of earnings of similar employee. Injured employee did not work sufficient time before alleged injury.
Hire Date: 07/22/2009
() Report of earnings of injured employee based on alternative method because Form 20 results in a compensation rate that is not fair and just. (Attach documentation to show how average weekly wage and compensation rate were calculated.)
2. List total wages paid as reported to Employment Security Commission on the Employer Quarterly Contribution and Wage Reports during the four quarters immediately preceding the quarter in which the injury occurred. Do not include the quarter during which the injury occurred.

Quarter	Ending Date	Total Wages Paid
1st	02/27/10	2,777.57
2nd	12/26/09	3,946.43
3rd	09/26/09	3,085.87
4th		

Total Paid 2. 9,809.87

3. List total value of other allowances of any character made in lieu of wages during four quarters above. 3. -----
4. Add lines 2 and 3. TOTAL WAGES PAID: 4. 9,809.87
5. List total number of weeks paid to employee during the four quarters immediately preceding the quarter in which the injury occurred. 5. 30

B. Average Weekly Wage

6. To calculate average weekly wage, divide total wages (line 4) by total weeks paid (line 5).
AVERAGE WEEKLY WAGE: 6. 327.00

C. Compensation Rate

7. The general rule for calculating the compensation rate is to multiply average weekly wage (line 6) by .6667. Estimate compensation rate by multiplying average weekly wage (line 6) by .6667. See part 8 below to determine the actual compensation rate. 7. 218.01
8. The compensation rate is as follows (choose one):
() When average weekly wage (line 6) is less than \$75.00, the compensation rate is the average weekly wage. Enter average weekly wage on line 8.
() When the estimated compensation rate (line 7) is less than \$75.00 and average weekly wage (line 6) is more than \$75.00, the compensation rate is \$75.00. Enter \$75.00 on line 8.
() When the estimated compensation rate (line 7) is more than the maximum compensation rate for the year in which the injury occurred, enter the maximum compensation rate for the year in which the injury occurred on line 8.
() Employee is within the exceptions listed in S.C. Code Ann. Section 42-7-65. List applicable exception here and enter appropriate compensation rate on line 8:
() The calculated compensation rate (line 7) applies. Enter amount from line 7 on line 8.

WEEKLY COMPENSATION RATE: 8. 218.01

Employee's representative shall prepare a Form 20 and serve per R.67-211 a copy on the claimant within thirty days of beginning temporary compensation. See R.67-1603 when no temporary compensation is paid. NOTE: Average weekly wage represents average gross pay before taxes and other deductions. WHEN THE CLAIMANT DOES NOT AGREE WITH THE COMPENSATION RATE ON LINE 8, HE OR SHE SHOULD CONTACT THE EMPLOYER'S REPRESENTATIVE TO TRY TO REACH AN AGREEMENT AS TO THE COMPENSATION RATE. IF NO AGREEMENT CAN BE REACHED, THE CLAIMANT SHOULD CONTACT THE CLAIMS DEPARTMENT AT (803) 737-5723.

WCC Form # 20
C24136 2/04

Rev. Date 3/97

20

STATEMENT OF EARNINGS
OF INJURED EMPLOYEE

South Carolina Workers' Compensation Commission
P.O. Box 1715 - 1612 Marion Street
Columbia, South Carolina 29202-1715
(803) 737-5700

Carrier File # 02-B-FHH9916-F
Carrier Code # 259
Employer FEIN 582354516

Norge Gonzalez-Torres
Claimant's Name SSN 772-80-4216

World Fiber Technologies, Inc.
Employer's Name

1706 Art Museum Dr Jacksonville FL 32207
Address City State Zip

4070 Nine McFarland Alpharetta GA
Address City State Zip

(904)470-9955
Home Phone #

The Standard Fire Ins Company
Insurance Carrier

Judy King
Work Phone #

(704)544-3649
Phone #

Judy King
Preparer's Name

Date of Injury: 02/26/2010
month day year

Date of Notice to Employer of Injury: _____
month day year

I. Payment of Temporary Compensation (choose A, B, or C) Check one: ☒ Initial Period ☐ Additional period ☐ Corrected compensation rate
A. Temporary Total at the compensation rate of \$ 304.02 per week. For this period of disability, disability began on 03/01/2010 and the date of first payment was 03/23/2010

B. Temporary Partial at the compensation rate of \$ _____ per week. Note: When the Temporary Partial compensation rate will vary, report the first payment here. Supplement throughout the period of Temporary Partial compensation by filing Form 15S with the Form 18, which shall be filed six months after the date of injury and each six months thereafter until the file is closed. For this period of disability, disability began on _____ and the date of first payment was _____

Calculation of Temporary Partial rate: Average weekly wage before injury \$ _____
- Current weekly wage - \$ _____
Difference in wages before injury and now \$ _____
x .6667 x .6667
Temporary Partial Compensation Rate \$ _____

C. Salary in lieu of (check one) ☐ temporary total ☐ temporary partial compensation in the amount of \$ _____ per week. For this period of disability, disability began on _____ and the date of first payment was _____

**THIS SECTION MAY BE USED ONLY WITHIN 150 DAYS AFTER NOTICE OF THE INJURY TO EMPLOYER.
ATTACH DOCUMENTATION AS TO THE REASON FOR THE TERMINATION.**

II. Termination of Temporary Compensation Temporary compensation payments were stopped on _____ for the following reason:

- ☐ Claimant has returned to work at least 15 days and no temporary partial compensation is due.
☐ Claimant agrees he/she is able to return to work and has signed a Form 17.
☐ Based on a good faith investigation, the claim is denied. Reason for denial: _____
☐ Claimant has been released to return to work without restrictions and employment has been offered.
☐ Claimant has been released to return to work at limited duty and employer has provided limited duty work consistent with the terms upon which the employee has been released.
☐ Claimant has refused medical treatment, examination, or evaluation. Note: Benefits must be resumed if claimant accepts the treatment, examination, or evaluation. Additional report must be filed if compensation is resumed.

I certify that this form has been served on the claimant per R.67-211.

Judy King
Signature of Claims Administrator

03/23/2010
Date

III. Notice to Injured Worker or Legal Representative when Temporary Compensation Has Been Stopped:

The employer's representative may stop benefits within 150 days of the date of notice of injury for the above reasons. However, if you believe that temporary compensation should not have been stopped, you may request a hearing by signing below and returning this form to the SCWCC Judicial Department at the address at the top of the form. A hearing will be held within 60 days of receipt of your request to determine if temporary compensation has been properly terminated.

MY SIGNATURE BELOW INDICATES THAT I DO NOT AGREE WITH THE TERMINATION OF TEMPORARY COMPENSATION. I REQUEST A HEARING TO DETERMINE WHETHER I AM ENTITLED TO FURTHER TEMPORARY COMPENSATION PAYMENTS.

Check one: Form 15(II) ☐ has ☐ has not been received.

Signature of claimant or legal representative

Date

Employer's representative must complete and file Form 15 with Claims Department within ten days after compensation begins or is terminated. Employer's representative must serve the Form 15 on the claimant when compensation begins per R.67-211. Employer's representative must prepare and serve Form 20 within thirty days of beginning compensation per R.67-1603. Employer's representative must serve per R.67-211 two copies of the Form 15 on claimant immediately on termination of compensation with documentation attached as to the reason for the termination. Injured worker may contest the termination of compensation by completing section III of the Form 15 and filing it with Judicial Department.

WCC FORM # 15 REV. DATE 3/97

15

TEMPORARY COMPENSATION REPORT

C24137 2/04

1 State of South Carolina
2 Before the
3 South Carolina Workers' Compensation Commission
4 WCC File No.: 1002408

5 Norge L. Gonzalez Torres,)
6 Employee,)
7 Claimant,)
8 vs.) Deposition of
9 World Fiber Technologies,) NORGE GONZALEZ TORRES
10 Incorporated,) December 2, 2011
11 Employer,) Via Teleconference
12 and)
13 The Standard Fire Insurance)
14 Company,)
15 Carrier,)
16 Defendants.)

COPY

17 Deposition on oral examination of
18 NORGE L. GONZALEZ TORRES, Via Teleconference,
19 reported by Cheryl A. Wiszowaty, Court Reporter
20 and Notary Public in and for the State of South
21 Carolina; said deposition taken pursuant to notice
22 of deposition and in accordance with the South
23 Carolina Rules of Civil Procedure, at the Law
24 Offices of Chappell, Smith & Arden, 1510 Calhoun
25 Street, Columbia, South Carolina, commencing on
Friday, December 2, 2011, at the hour of 2:39 p.m.

ABC REPORTING SERVICE (803) 532-5255

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APPEARANCES:

Representing the Employee/Claimant:

C. DANIEL VEGA, ESQUIRE
Chappell, Smith & Arden
1510 Calhoun Street
Post Office Box 12330 (29211)
Columbia, South Carolina 29201

Representing the Employer/Carrier:

S. LeANNE McCORMACK, ESQUIRE
Willson, Jones, Carter & Baxley, PA
4500 Fort Jackson Boulevard
Columbia, South Carolina 29209

Also Present:

William Aviles, Spanish Translator

1 CONTENTS

2 (Deposition of Norge L. Gonzalez Torres)

3

4 Page

5 Stipulations 4

6 Examination by Ms. McCormack 4

7 Certificate of Reporter 27

8

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11

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16 * * * * *

17 EXHIBIT INDEX

18

19 REPORTER'S NOTE: No exhibits were marked for

20 identification.

21

22

23

24

25

ABC REPORTING SERVICE (803) 532-5255

Lawyer's Notes

[illegible]

Compliments of ABC REPORTING

1 This deposition is taken in
2 accordance with the South Carolina Rules of Civil
3 Procedure.

4 It is agreed and stipulated by the
5 deponent and respective counsel that the reading
6 and signing of the deposition by the deponent is
7 expressly waived.

8 WHEREUPON:

9 WILLIAM AVILES, being duly sworn,
10 translated English to Spanish and Spanish to
11 English verbatim to the best of his ability:

12 MS. McCORMACK: And before we get
13 started, I just want to put on the record that the
14 claimant is actually in Florida and this
15 deposition is taking place by phone and the court
16 reporter and the interpreter are actually here in
17 Columbia with us and the claimant is in Florida.

18 The claimant's attorney, Danny Vega,
19 and I have discussed this, and we're just going to
20 waive any issues with that and move forward.

21 Is that correct, Danny?

22 MR. VEGA: No objections.

23 NORGE L. GONZALEZ TORRES, being duly
24 sworn and cautioned to speak the truth, the whole
25 truth and nothing but the truth, testified as

1 follows:

2 THE WITNESS: I do. All the truth,
3 only the truth, nothing but the truth.

4 EXAMINATION

5 BY MS. McCORMACK:

6 Q. Mr. Gonzalez, my name is LeAnne
7 McCormack, and I represent the employer and the
8 workers' compensation insurance carrier.

9 A. Yes.

10 Q. Have you ever had your deposition
11 taken before?

12 A. No.

13 Q. Do you understand that the testimony
14 that you're about to give is sworn testimony just
15 as if you were testifying at a hearing?

16 A. Yes.

17 Q. Are you under the influence of any
18 substance or medication that would influence your
19 ability to correctly answer my questions?

20 A. No. None.

21 Q. What is your full name?

22 A. Norge Lorenzo Gonzalez Torres.

23 Q. How old are you?

24 A. 39.

25 Q. What is your date of birth?

NORGE GONZALEZ TORRES 12-2-11

1 A. October 22, 1972.

2 Q. What is your address?

3 A. Could you please hold on a moment? I
4 don't know it off the top of my head. I have to
5 look it up on a piece of paper that I have.

6 Q. Sure.

7 A. One moment. Hold on a moment. My
8 address on this says: 1533, Apartment E, 61 Street
9 Avenue, West Palm Beach, Florida, 33415-6431.

10 Q. Who lives in the apartment with you?

11 A. Well, it's me, my two brothers and
12 the wife of my brother.

13 THE TRANSLATOR: The interpreter did
14 not understand his last statement, whether or not
15 he mentioned a child or not. Request
16 clarification or repetition.

17 MS. McCORMACK: Yes, please clarify
18 whether he has a child living there.

19 THE WITNESS: A boy and two girls.

20 BY MS. McCORMACK:

21 Q. And whose children are they?

22 A. They are my oldest brother's
23 children.

24 Q. Do you have any children?

25 A. No.

ABC REPORTING SERVICE (803) 532-5255

1 Q. How long have you been living in
2 Florida?

3 A. Ever since I arrived from Cuba I've
4 lived in Florida.

5 Q. Were you in South Carolina at the
6 time that you were injured?

7 A. Yes.

8 Q. So did you live in South Carolina for
9 a time period?

10 A. Yes. The time that I was working in
11 that place.

12 Q. So is it correct, the only time
13 you've lived in South Carolina is when you were
14 working for World Fiber?

15 A. Yes.

16 Q. Your accident was on February 26,
17 2010. Is that the correct date of accident?

18 A. Yes.

19 Q. How long did you live in South
20 Carolina before the date of the accident?

21 A. Well, we left for South Carolina in
22 October.

23 Q. October of 2009?

24 A. Yes.

25 Q. So from October 2009 until what point

1 did you leave South Carolina?

2 A. Well, I don't remember the exact date
3 of when I left South Carolina, but it was about a
4 month after the date of the accident. I remember
5 I spent about a month more there.

6 Q. Have you been in West Palm Beach,
7 Florida, the entire time since you left South
8 Carolina?

9 A. No. In Jacksonville.

10 Q. How long did you live in
11 Jacksonville?

12 A. Up until about a month and a half
13 ago.

14 Q. And is that when you moved to West
15 Palm Beach, Florida?

16 A. Yes.

17 Q. Are you married?

18 A. No.

19 Q. Have you ever been married?

20 A. Yes.

21 Q. Are you --

22 A. But not civilly. Just, what do they
23 call it, living together.

24 Q. Is she living with you now, though?

25 A. No. No. She lives in Cuba.

1 Q. Are you a U.S. citizen?

2 A. No.

3 Q. Have you worked anywhere since you
4 were injured in South Carolina on February 26,
5 2010?

6 A. No. I haven't been able to work
7 again.

8 Q. Have you applied for any jobs at all
9 since you were injured in South Carolina?

10 A. No. Because since I left South
11 Carolina, I've been under medical treatment up
12 until a month and a half ago when I last saw the
13 doctor.

14 Q. Do you plan on applying for any jobs?

15 A. Well, if I can apply for a job that
16 would allow me to work, then I would, but right
17 now I have a lot of pain that impedes me from
18 being able to move properly. I can't walk for a
19 long period of time or sit for a long period of
20 time. If I do, the pain continues to grow.

21 Q. Do you have a driver's license?

22 A. Yes.

23 Q. Is it a Florida driver's license?

24 A. Yes.

25 Q. Okay. Can you read off your number?

NORGE GONZALEZ TORRES 12-2-11

1 A. One moment. Hold on a moment.

2 Q. Thanks.

3 A. The number is 524632723820.

4 Q. Did you graduate from high school?

5 A. No. Well, what I did in Cuba would
6 be what would be here middle school.

7 Q. Okay. Why did you not finish school
8 in Cuba at the highest level that you could
9 attain?

10 A. Because the situation in Cuba is
11 financially very difficult, so we need to work,
12 and so I went to a school that was accelerated
13 courses and I took construction.

14 Q. Can you speak English at all?

15 A. Well, just a few words I can speak,
16 but whenever I'm spoken to, I don't understand.

17 Q. Can you read English?

18 A. No.

19 Q. Do you have any special job skills
20 other than in construction?

21 A. No. That's all I've ever done.

22 Q. Do you go back and forth to Cuba a
23 good bit?

24 A. No. Since I arrived, I've never gone
25 back.

ABC REPORTING SERVICE (803) 532-5255

1 Q. When did you arrive?

2 A. On March 26th of 2009.

3 Q. Can you use a computer?

4 A. A computer? No.

5 Q. Can you get on and off the Internet?

6 A. No.

7 Q. Is there a computer in your
8 apartment?

9 A. Yes, I do have a computer here but I
10 don't have Internet here at home.

11 Q. Are you able to use the Internet at a
12 computer no matter where the computer is?

13 A. No.

14 Q. Who does the computer belong to?

15 A. I didn't understand.

16 Q. Who owns the computer that's in your
17 apartment?

18 A. Me. Me.

19 Q. Why do you own a computer if you
20 can't use one?

21 A. Well, because when I was in
22 Jacksonville I had Internet there, and that's how
23 I could communicate, with my sister-in-law.

24 Q. So when I asked you if you knew how
25 to use the Internet earlier, was that a mistake.

1 Can you use the Internet?

2 A. No.

3 Q. Can you use the Internet or can you
4 not use the Internet?

5 A. No, I don't know how to use the
6 Internet.

7 Q. Well, how did you communicate with
8 your sister by Internet?

9 A. No. My sister-in-law was the one who
10 used the Internet, and she was the one who would
11 send messages to Cuba.

12 Q. Have you been your injured on any
13 other jobs while in the United States other than
14 with World Fiber?

15 A. No, I have never had any other
16 injuries. I've never had any other illnesses
17 either.

18 Q. What about while living and working
19 in Cuba, were you ever injured on any jobs while
20 living in Cuba?

21 A. No. Never.

22 Q. Do the people who live with you work?

23 A. Yes. My brother does work. The
24 other brother is not working right now.

25 Q. What about your sister-in-law, does

1 she work?

2 A. No. At this moment she can't work.

3 Q. Have you ever been involved in any
4 type of a lawsuit?

5 A. Never.

6 Q. Do you have a criminal record?

7 A. No.

8 Q. Have you ever done any work other
9 than construction?

10 A. No. In Cuba I've -- all my life I
11 have worked in construction, and in Cuba I did
12 some electrical, welding.

13 Q. Did you work for any other
14 construction company other than World Fiber while
15 living in the United States?

16 A. No.

17 Q. Please explain your job duties with
18 World Fiber.

19 A. Well, the work had the description of
20 laborer, so we had to do everything that was
21 required at the job.

22 Q. What was required physically at the
23 job?

24 A. We had to put all the signals on the
25 road for the job. We also had to organize all the

NORGE GONZALEZ TORRES 12-2-11

1 instruments and equipment for the job. We also
2 had to load and unload all of the equipment from
3 the truck, so anything that had to be moved during
4 that shift, we would move it, all of the crew.

5 Q. What would be the heaviest thing you
6 had to lift?

7 A. Well, I think the heaviest piece of
8 equipment that I would have to have lifted when I
9 was there was the piece of equipment that I got
10 injured with.

11 Q. And what was that?

12 A. It's a piece of equipment that's used
13 to roll up the fiber that goes onto the tube.

14 Q. Were you a bridge installer?

15 A. Yes.

16 Q. How many hours a day did you work?

17 A. Well, when we started out here in
18 West Palm Beach, we would work a 10-hour day, but
19 when we came over to South Carolina, the day would
20 be anywhere from eight hours to seven hours
21 depending on how the day worked out.

22 Q. When did you begin working for World
23 Fiber?

24 A. It was about in August. August of
25 2009. Somewhere around there.

ABC REPORTING SERVICE (803) 532-5255

1 Q. How much were you paid per hour?

2 A. 11. 11 every hour.

3 Q. Did you get overtime?

4 A. Very few times did we have overtime.

5 Q. If you worked overtime, did you get
6 time and a half?

7 A. No, because the time that I was
8 working in South Carolina we hardly reached 40
9 hours a week.

10 Q. How many days per week did you work?

11 A. Well, it was every day.

12 Q. You worked seven --

13 A. But we wouldn't work Saturdays or
14 Sundays.

15 Q. So you worked Monday through Friday;
16 is that correct?

17 A. Yes.

18 Q. How much did you gross each week?

19 A. It was 300, 300 something. When we
20 would work the 40 hours a week, we would get 400
21 and just a few dollars more. I don't remember the
22 exact amount.

23 Q. Would you all be paid every week or
24 every two weeks?

25 A. Weekly.

NORGE GONZALEZ TORRES 12-2-11

1 Q. I have an average weekly wage showing
2 \$327 per week. Does that sound correct to you?

3 A. Say again.

4 Q. I have wages from the employer which
5 show \$327 as your average weekly wage. Does that
6 sound correct to you?

7 A. No.

8 Q. Well, how much would your average
9 weekly wage be then if it's not 327?

10 A. Well, depending on -- we would work
11 how many hours we were able to work according to
12 how the week was, but if you take that \$40 -- 40
13 hours a week times \$11 an hour and plus they would
14 give us also an allowance to buy food, so whatever
15 that was.

16 Q. Well, tell me what the allowance they
17 would give you for food.

18 A. It was 101 to 102. Somewhere around
19 there.

20 Q. 101 to \$102 per week for food?

21 A. Yes. Yes.

22 Q. Would they add that to your check?

23 A. Yes. That would come together with
24 the check.

25 Q. Would it -- it would be combined in

ABC REPORTING SERVICE (803) 532-5255

1 the check for your work wages?

2 A. Yes. It was together with the weekly
3 wages.

4 Q. Was the allowance just for food or
5 was it for housing as well?

6 A. No. That was only for food.

7 Q. And that was included in the check
8 and not cash. I just want to make sure.

9 A. No. That was included with the
10 check.

11 Q. Did you all have a housing allowance?

12 A. No. They never did that. They would
13 always make the arrangements for the hotel, take
14 us there, give us the keys to the hotel, but they
15 never gave us any money for that. They always
16 made the arrangements for that.

17 Q. Did the employer pay for the hotel?

18 A. Yes, the employer did pay for the
19 hotels.

20 Q. Which hotel were you all staying in
21 when you were in South Carolina?

22 A. No, I don't remember the name of the
23 hotel.

24 Q. Was it more than one hotel?

25 A. I'm sorry?

1 Q. Was it more than one hotel?

2 A. No. It was only one hotel.

3 Q. And where was the hotel located in
4 South Carolina?

5 A. Well, it was located in Charleston.

6 Q. How many people were in a room?

7 A. Well, in one room in my case it was
8 two people. It was my brother and I because we
9 were there working together.

10 Q. All right. Tell me how you were
11 injured.

12 A. Well, when we started the workday, we
13 went to the work site and we parked at the edge of
14 the dock because we needed to get that piece of
15 equipment that I had told you about earlier that
16 rolls up the fiber at the work site off of the bed
17 of the truck, so one of us got onto the bed of the
18 truck and started to push that piece of equipment
19 to the edge of the bed so that when it got to the
20 tailgate three other people could receive it, but
21 since I was the only one that was ready to receive
22 it and the guy who was pushing it on the bed of
23 the truck didn't notice that, when he pushed the
24 piece of equipment, I was the only one who took
25 the brunt of that force.

1 Q. Did you hurt anything other than your
2 back in the accident?

3 A. No, none other.

4 Q. Have you ever had any problems with
5 your back before this work accident?

6 A. No never.

7 Q. Have you ever had any surgeries or
8 anything on any body parts before this accident?

9 A. Never.

10 Q. Okay. And the main doctor that's
11 been treating you has been Dr. Scarf; is that
12 correct?

13 A. Well, I've been seen by several
14 different doctors, so I don't remember their
15 names. The only one I can remember is the last
16 one I've seen whose name is something like
17 Michael Jack. Something like that.

18 Q. Okay. You had surgery on your back,
19 correct?

20 A. Yes.

21 Q. Did you improve with your back pain
22 following the surgery?

23 A. Well, the pain that I feel is
24 different but the pain continues.

25 Q. Is it better or is it worse?

1 A. Well, I think it's the same because
2 there is a lot of things that I can't do still.
3 For example, I can't walk for a long period of
4 time. I can't sit for a long period of time. At
5 night the pain wakes me up. It doesn't allow me
6 to sleep.

7 Q. Are you taking any medications right
8 now for your back?

9 A. Well, sometimes I take it but most of
10 the time I prefer to wait and deal with the pain
11 because it upsets my stomach. It doesn't let me
12 control my stomach well.

13 Q. Do you take prescription medications
14 or are these over-the-counter prescriptions?

15 A. Well, I do have some that the doctor
16 sent me, and so when I have a lot of pain I take
17 some of those.

18 Q. What are you taking?

19 A. Occasionally Oxycodone.

20 Q. Is that prescribed by the doctor?

21 A. Yes.

22 Q. Do you take anything over the
23 counter?

24 A. Well, I take a Bayer or a Tylenol but
25 that doesn't relieve the pain. When I have too

1 much pain and it's unbearable is when I take the
2 other medication.

3 Q. Do you have any refills on the
4 Oxycodone?

5 A. What do you mean "refill"?

6 Q. Can you go back and get more
7 Oxycodone when that runs out?

8 A. Well, I do have one prescription left
9 that the doctor gave me that I have not filled
10 yet.

11 Q. And would that be for Oxycodone?

12 A. Yes.

13 Q. Okay. Did you participate in a
14 functional capacity evaluation?

15 A. What?

16 Q. Did you participate in a functional
17 capacity evaluation where you were required to
18 lift and do certain things to see what your
19 abilities would be?

20 A. Yes.

21 Q. Did you give your full effort?

22 A. Well, I think I did more than what I
23 could have done.

24 Q. So do you think you overdid it in the
25 test?

1 A. Yes. In fact, I think it was either
2 15 to 20 days that I had pain afterwards because
3 of what I did there.

4 Q. Have you seen any other doctors for
5 your work-related injury to your back since being
6 released by the workers' comp doctor?

7 A. No, I haven't visited any other
8 doctor.

9 THE TRANSLATOR: Interpreter wishes
10 to add that the previous statement included, "I
11 could not walk."

12 MS. McCORMACK: Okay.

13 BY MS. McCORMACK:

14 Q. Have you had any accidents or
15 injuries since your work accident in South
16 Carolina?

17 A. No, none other.

18 Q. Do you have any income right now
19 other than your workers' comp checks?

20 A. No, none other.

21 Q. Have you applied for any kind of
22 disability benefits?

23 A. No, none.

24 Q. Did you ever return to work at all
25 after your work accident?

1 A. No. Ever since I was injured, I
2 couldn't return to work.

3 Q. Do you have any hobbies?

4 A. Hobbies? Well, I spend a lot of time
5 watching TV.

6 Q. What about before you had your work
7 accident, did you have any hobbies before that?

8 A. Well, I like to walk, to run, play
9 sports when I could. I had a normal life just
10 like anybody else. I had no problems in
11 performing any function.

12 Q. What sports did you like to play?

13 A. I like to run a lot, and I would
14 play -- I like to run a lot, and I would play
15 soccer. I played a lot of soccer in Cuba, but
16 since I left Cuba, I haven't played much of any
17 soccer, but I would go out and run or jog over
18 here.

19 Q. Have you been able to go running
20 since your work accident?

21 A. Well, if I can't walk right now, how
22 am I going to be able to run much less am I going
23 to be able to do that? Besides, the doctor told
24 me that, forget about running.

25 Q. So that was my question, is have you

1 run. That's all I need to know.

2 A. No, not again.

3 Q. Do you have any trouble driving?

4 A. A little bit. The seat gives me a
5 lot of pain in my back and it makes me very
6 uncomfortable.

7 Q. Do you have any type of a family
8 doctor at all in the United States?

9 A. No.

10 Q. Can you give me some more examples of
11 things that you feel like you're not able to do
12 that you used to be able to do before your work
13 accident?

14 A. For example, I can't bend down. If
15 anything falls on the floor, in order to get that
16 from the floor it requires a lot of effort on my
17 part. I feel extremely uncomfortable when doing
18 that. I have to brace myself and hold myself with
19 some kind of support, and then to get up from the
20 floor, it's another big effort.

21 Q. Since you're not working, what are
22 you doing all day?

23 A. Well, just imagine. I'm here at home
24 all day so I watch TV. I try to stand for a
25 while. If I feel very uncomfortable, I try to

1 maybe walk a bit, but then I have to sit down
2 because of the pain until the pain goes away, but
3 then that makes me more uncomfortable, so then I
4 then have to take a pill, and then I have to lay
5 down.

6 Q. Are you able to do any type of work
7 outside?

8 A. No.

9 Q. On a scale of one to ten, ten being
10 the very worst level of pain, what are you in with
11 your back when it's at its worst?

12 A. At the worst, an eight.

13 Q. What about at the best?

14 A. A four.

15 Q. What is it pretty consistently?

16 A. Regularly, a five or six.

17 Q. Do you feel like you're able to go
18 back to work?

19 A. Well, that's what I would want more
20 than anything right now, but if walking and
21 sitting gives me a great deal of pain, then
22 working would be unbearable.

23 Q. Have you tried to go back to work?

24 A. Well, the doctor never recommended
25 that I should go back to work and, personally, I

1 don't feel I'm in condition for that.

2 Q. If there was a job that you could do
3 within your restrictions, would you be willing to
4 try that job?

5 A. Well, it would depend on the type of
6 job.

7 Q. I understand that, but if there is a
8 job that you could do within your restrictions,
9 would you be willing to try it?

10 A. Well, I would try it out, but what
11 about when the pain starts up? Who is going to
12 give me a job when they know that my pain is going
13 to stop me from doing anything?

14 MS. McCORMACK: I don't have any
15 other questions. Please answer any your attorney
16 has for you.

17 MR. VEGA: No. We're done.

18 (The deposition concluded at
19 approximately 3:31 p.m.)

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1 CERTIFICATE OF REPORTER

2
3 I, Cheryl A. Wiszowaty, Court
4 Reporter and Notary Public for the State of South
5 Carolina at Large, do hereby certify:

6 That the foregoing deposition was
7 taken before me on the date and at the time and
8 location stated on Page 1 of this transcript; that
9 the deponent was duly sworn to testify to the
10 truth, the whole truth and nothing but the truth;
11 that the testimony of the deponent and all
12 objections made at the time of the examination
13 were recorded stenographically by me and were
14 thereafter transcribed; that the foregoing
15 deposition as typed is a true, accurate and
16 complete record of the testimony of the deponent
17 and of all objections made at the time of the
18 examination to the best of my ability.

19 I further certify that I am neither
20 related to nor counsel for any party to the cause
21 pending or interested in the events thereof.

22 Witness my hand, I have hereunto
23 affixed my official seal this 4th day of November,
24 2011, at Lexington County, South Carolina.
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Cheryl A. Wiszowaty, Court Reporter,
Notary Public
State of South Carolina at Large.
My Commission expires:
May 16, 2017

ABC REPORTING SERVICE (803) 532-5255

BEFORE THE
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

WCC FILE NO. 1002408

Norge Gonzalez-Torres,

Claimant,

vs.

World Fiber Technologies,
Inc., Employer,

and

Standard Life Insurance
Company Carrier,

Defendants.

TRANSCRIPT OF PROCEEDINGS

January 27, 2012

This hearing was held before Commissioner Gene McCaskill, reported by Kimberly T. Power, Court Reporter and Notary Public in and for the State of South Carolina; said proceedings were held at the South Carolina Workers' Compensation Commission, 1333 Main Street, Suite 500, Hearing Room B, Columbia, South Carolina, on Friday, January 27, 2012, commencing at the hour of 3:30 p.m.

Kimberly T. Power, Court Reporter
kimberlytpower@aol.com

APPEARANCES

ATTORNEYS FOR THE CLAIMANT

CHAPPELL, SMITH & ARDEN, P.A.
BY: C. DANIEL VEGA, ESQUIRE
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Columbia, South Carolina 29201

ATTORNEYS FOR THE DEFENDANTS

WILLSON, JONES, CARTER & BAXLEY, P.A..
BY: S. LEANNE MCCORMACK, ESQUIRE
4500 Fort Jackson Boulevard
Columbia, South Carolina 29209

ALSO PRESENT: WILMER AVILES, Interpreter

Kimberly T. Power, Court Reporter
kimberlytpower@aol.com

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Kimberly T. Power, Court Reporter
kimberlytpower@aol.com

1 THE COURT: Today's date is January 27, 2012.
2 This is the case of Norge Gonzalez-Torres, is the
3 claimant. The employer is World Fiber Technologies,
4 carrier is Standard Life Insurance Company. The claimant
5 is represented by Mr. Vega, and the defendant is
6 represented by Ms. McCormack. The date of the accident
7 was February 26, 2010. Any objections to jurisdiction,
8 venue, or any APA Submissions?

9 MS. MCCORMACK: No objections, Commissioner.

10 MR. VEGA: None from the claimant, Your Honor.

11 THE COURT: All right. Then the Commission
12 file becomes a part of the record with the exception of
13 self-serving declarations and unstipulated medical
14 reports. Ms. McCormack, it's a 21, so you are the moving
15 party.

16 MS. MCCORMACK: Yes, sir.

17 THE COURT: Let me hear from you, please,
18 ma'am.

19 MS. MCCORMACK: Yes, sir. Thank you. It is
20 the defendant's position that we are here today seeking
21 an order to stop payment of compensation. It is the
22 defendant's position that the claimant has reached MMI on
23 September 19, 2011. Defendants are requesting a credit
24 from the date of MMI which is September 17, 19 -- I mean,
25 2011 until today.

Kimberly T. Power, Court Reporter
kimberlytpower@aol.com

1 The claimant has a 12 percent impairment
2 rating to his back. We would ask the Commissioner to
3 make an award for permanent partial disability to the
4 back. We would also like to note that the defendants
5 have an objection to the comp rate that has been used so
6 far which has been \$304.02. The actual pay records
7 suggests an average weekly rage of \$327 with a
8 compensation rate of \$218.01.

9 We would ask the Commissioner to upward adjust
10 the average -- I mean, downward adjust that average
11 weekly wage and compensation rate based on the pay
12 records that I have produced. Defendants would request a
13 credit for overpayment of the compensation rate from
14 March 1, 2010 until today.

15 Defendants would also like to object to the
16 claimant testifying today. The basis of our objection is
17 that he's not listed as a witness on our brief. We will
18 defer to the Commissioner's ruling on that, though. And
19 we would also like to make special note of a couple of
20 APAs. Defendant's APA No. 1, Page 5; defendant's APA No.
21 1, Page 6; defendant's APA No. 1, Page 15; defendant's
22 APA No. 1, Page 18; and defendant's APA No. 4, Page 6.

23 We would just also like to object to the
24 Commissioner awarding any type of second opinion because
25 the first we've learned of the second opinion was today.

Kimberly T. Power, Court Reporter
kimberlytpower@aol.com

1 The authorized treating physician has placed him at MMI,
2 and we object to any additional treatment for this
3 claimant. Thank you, Commissioner.

4 THE COURT: Thank you. Mr. Vega.

5 MR. VEGA: Thank you, Your Honor. Just as
6 background reference, the Commissioner asks the claimant
7 if he spoke English. Commissioner, the claimant speaks
8 no English. He's actually a Cuban exile -- or not an
9 exile, but he fled Cuba and is here in the United States
10 as a refugee. He obtained employment with World Fiber
11 Technologies, did suffer an injury. It is an admitted
12 claim. The defendants did provide medical treatment and
13 Dr. Sharf did place him at maximum medical improvement on
14 September 19, 2011.

15 We would like to point out in the record on
16 Page 14 of the APAs that he did undergo a decompression
17 and fusion at the L4-5, L5-S1, and as such has a
18 two-level fusion to the spine. We believe that that
19 fusion continues to be symptomatic. We believe that the
20 claimant suffers disability in excess of the 12 percent
21 impairment rating. We would ask that the Commissioner
22 find that the claimant suffered disability in excess of
23 the 12 percent impairment rating.

24 We would point out with regards to the
25 overpayment noted on the Form 20 that the defendants

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1 filed a Form 15 in March of 2010, and on the Form 15 they
2 noted that the compensation rate was 304.02. We do have
3 an e-mail that was submitted by Ms. McCormack to the
4 Commissioner noting that they did not discover -- at
5 least bring this to our attention until November 30,
6 2011. And as such, the claimant has been prejudiced by
7 the overpayment and would be prejudiced by a finding that
8 he would have to pay that quantity back.

9 We would ask the Commissioner to allow the
10 compensation rate to remain 304. We believe that the
11 defendants do have the duty of due diligence, and I did
12 not exercise that duty of due diligence until November of
13 2011.

14 With regards to the claimant's testimony, we
15 would just say that the claimant would be prejudiced by
16 not being allowed to testify today. We would ask the
17 Commissioner to please allow claimant to testify. We do
18 not believe -- I think his testimony was expected by the
19 defendants, and there's no prejudice to them by having
20 the Commission hear his concerns.

21 And one other matter, Your Honor. There is a
22 medical bill that I gave to Ms. McCormack, and we just
23 ask that the medical bill be paid.

24 THE COURT: Anything further, Ms. McCormack?

25 MS. MCCORMACK: No, sir.

Kimberly T. Power, Court Reporter
kimberlytpower@aol.com

1 THE COURT: All right. Anything else,
2 Mr. Vega?

3 MR. VEGA: No, sir.

4 THE COURT: All right. I am going to overrule
5 your objection. I'm going to allow the claimant to
6 testify. Your other objections will be addressed in the
7 order.

8 MS. MCCORMACK: Thank you.

9 THE COURT: Thank you very much. All right.
10 Do you have any witnesses?

11 MS. MCCORMACK: No, sir. I will rely on my
12 pre-hearing brief and APA Submissions.

13 THE COURT: Very good.

14 MS. MCCORMACK: Just with reserving the right
15 to cross-examine.

16 THE COURT: Absolutely. Mr. Vega, are you
17 ready for me to swear in your witness?

18 MR. VEGA: Yes, sir.

19 THE COURT: First let me swear you in.

20 (WILMER AVILES, being duly sworn to tell the
21 whole truth and nothing but the truth, testified as
22 follows:)

23 THE COURT: Please state your name for the
24 record.

25 THE INTERPRETER: Wilmer, W-I-L-M-E-R, Aviles,

Kimberly T. Power, Court Reporter
kimberlytpower@aol.com

1 A-V-I-L-E-S.

2 (NORGE GONZALEZ TORRES, being duly sworn to
3 tell the whole truth and nothing but the truth, testified
4 as follows:)

5 THE COURT: Mr. Vega.

6 MR. VEGA: Thank you your Honor.

7 DIRECT EXAMINATION

8 BY MR. VEGA:

9 Q. Mr. Gonzalez, you worked for World Fiber
10 Technologies at one time?

11 A. Yes.

12 Q. And during that time did you suffer an injury
13 to your back?

14 A. Yes.

15 Q. As a result of your injury, did you notify
16 your employer and did your employer file a claim?

17 A. I'm sorry?

18 Q. When you suffered your injury, you told your
19 employer and they started your workers' comp for you?

20 A. Yes.

21 Q. And at the time of the injury you were in
22 Charleston; is that correct?

23 A. Yes.

24 Q. But you lived in Jacksonville; is that
25 correct?

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1 A. Yes.

2 Q. Now, as a result of your injury, did they
3 provide you medical treatment in Jacksonville?

4 A. Well, it was about a month after because I was
5 in Charleston during that time. And not realizing how
6 severe the injury was, I stayed there for that time. And
7 then they sent me back to Jacksonville and to get medical
8 attention in Jacksonville.

9 Q. Now, when they sent you to Jacksonville for
10 treatment, did you go see Dr. Kleinhans?

11 A. I don't remember the names of the different
12 doctors that I saw. The only one I know or can remember
13 his name is the surgeon who operated on me.

14 Q. Okay. You saw Dr. Sharf, and Dr. Sharf -- you
15 saw Dr. Kleinhans and Dr. Sharf and they're both at
16 Jacksonville Orthopedics Institute, correct?

17 A. Yes.

18 Q. Okay. And eventually Dr. Sharf, did he do a
19 surgery for your back?

20 A. Yes.

21 Q. Now, before the surgery, what type of
22 treatments were you getting?

23 A. Treatment, well, there was physical therapy.
24 But when I didn't improve, then they had an MRI done and
25 that's where they could see that I had injured my spine.

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1 And so the doctor then recommended injections and I had a
2 few of those, but I didn't improve. And shortly after,
3 they sent me to another place to do a nerve test and the
4 doctor said that the only way that I could find relief --

5 MS. MCCORMACK: Objection. Hearsay.

6 MR. VEGA: Your Honor, I believe that in order
7 to have clarity on the record, the interpreter should be
8 allowed to say what he was going to say. Then the
9 objection could be heard and --

10 MS. MCCORMACK: Then it's out there already.
11 I mean, he's heard -- he's heard it already.

12 MR. VEGA: Well, he's supposed to hear and
13 rule on the objection.

14 MS. MCCORMACK: He's about to testify to what
15 the doctor said and that's hearsay. You can't testify to
16 what a doctor said.

17 THE COURT: He just said the doctor said.

18 MS. MCCORMACK: So he doesn't have to hear it.

19 THE COURT: The doctor is not here for
20 Ms. McCormack to cross-examine.

21 MS. MCCORMACK: Thank you.

22 MR. VEGA: I'll instruct my client to avoid
23 that, Your Honor.

24 BY MR. VEGA:

25 Q. Mr. Gonzalez, when you testify, you cannot say

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kimberlytpower@aol.com

1 the words "the doctor said." If I ask you a question
2 with regards to treatment, you're allowed to say what the
3 doctor did for you, but not what the doctor told you in
4 private.

5 A. It's just that in the Spanish language,
6 there's a clarification -- it's just that in the Spanish
7 language when you're referring to another person, of
8 course you would have to say they said. It's not that
9 I'm trying to make up a story or anything.

10 Q. Okay. So the doctors -- you went to the
11 doctor several times, they did some therapies, then they
12 did the MRI and found your herniation, and then they did
13 injections, and then they recommended the surgery. Is
14 that the procedure?

15 A. Yes, sir, that's how it occurred. The
16 decision was mine.

17 MR. VEGA: And, Your Honor, the reason I
18 wanted to clarify that sequence is that the statements of
19 Dr. Kleinhan's and Dr. Sharf that Ms. McCormack pointed
20 out about pain behavior were prior to the MRIs and the
21 herniated disc being discovered and not subsequent to the
22 surgery.

23 BY MR. VEGA:

24 Q. Okay. So you underwent the surgery, and how
25 were you feeling after the surgery? What happened? What

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1 were you feeling?

2 A. Well, the pain really just changed. It didn't
3 go away.

4 Q. So how did it change? What were you feeling
5 before and what were you feeling after the surgery?

6 A. Well, after the surgery, well, I could move a
7 bit. But the pain has always persisted. It hasn't left.

8 Q. Okay. So surgery helped with motion in your
9 spine versus pain? Is that what you're saying?

10 A. Exactly.

11 Q. Okay. So since the date of the surgery, have
12 you had relief from pain completely?

13 A. I've never stopped feeling pain.

14 Q. Okay. So this pain that you're talking about,
15 could you describe it? What is it like?

16 A. Well, it's as if someone is hitting me and
17 it's almost as I can feel something pushing there
18 constantly.

19 Q. After the surgery, did you undergo physical
20 therapy?

21 A. Yes.

22 Q. How long were you able to go to therapy?

23 A. I went for three months.

24 Q. Did you have relief from the physical therapy?

25 A. No. In fact, when I would finish the therapy,

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1 I would finish with a lot more pain.

2 Q. So the therapy was, in your opinion, was
3 aggravating your condition?

4 A. Yes.

5 Q. Now, eventually Dr. Sharf released you from
6 his care; is that correct?

7 A. Yes.

8 Q. And you have not seen Dr. Sharf since
9 September of 2011?

10 A. No.

11 Q. Now, since then -- since Dr. Sharf stopped his
12 treatment, are you continuing to have symptoms?

13 A. Yes, the pain is the same.

14 Q. Do you have days where it's better or worse?

15 A. There are days where the pain is worse than
16 others, and the majority of the days it's almost the same
17 as any other day.

18 Q. So do you notice anything that causes your
19 pain to increase?

20 A. Yes.

21 Q. Like give us an example of things that may
22 cause you to have more pain.

23 A. Well, for example, seated for a long period of
24 time, I can't walk for a long period of time, and just
25 standing in one position for a long time also gives me

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kimberlytpower@aol.com

1 pain.

2 Q. How about when you have those symptoms like
3 that, what do you do to alleviate your pain?

4 A. Well, the thing that helps me the most is to
5 lie down in fetal position as the medics say.

6 Q. And do you do that -- are you talking about
7 going to bed at night or are you talking about during the
8 day you have to lie down sometimes?

9 A. During the day I have to do that. And also
10 when I go to bed at night, I can't sleep on my stomach.
11 I can't sleep on my back either.

12 Q. How often do you find yourself having to take
13 a break like that?

14 A. Two, three times a day.

15 Q. And do you lie down for a long period of time
16 or a short period of time?

17 A. Depends how I have the pain.

18 Q. Do you take any medications?

19 A. Sometimes I do.

20 Q. When you say sometimes, how often? What do
21 you mean? What do you take?

22 A. Well, when I say, you know, sometimes, it's
23 not always. It's whenever I have really, really strong
24 pain. If I don't have very strong pain, I don't take
25 any.

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1 Q. Okay. Now, in your opinion, is there -- do
2 you feel like you've completed all the treatment that
3 could help you or would you like to have some additional
4 treatment?

5 A. Well, if there were something that would help
6 me get better other than what I've had up till now, then
7 yes. But medical treatment is very expensive, and
8 there's no way that I could pay that.

9 Q. You had a functional capacity evaluation, do
10 you remember?

11 A. Yes.

12 Q. And do you remember what type of things they
13 made you do during that evaluation?

14 A. Yes.

15 Q. And what were those things and what kind of
16 symptoms were they producing?

17 A. Well, there was the one where I had to walk on
18 a treadmill. There was another one where I had to squat
19 down and change a wheel from different locations. There
20 was another one where I had to go up and down a ladder.
21 There was another one where I had to walk into different
22 positions that were already marked and also lifting and
23 moving a box with different weights.

24 Q. And while you were doing those activities, did
25 you have any symptoms?

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1 A. Yes, I had pain.

2 Q. And, in fact, you were in there during the
3 evaluation it looks like from 9:00 in the morning until
4 1:00 in the afternoon?

5 A. Approximately.

6 Q. So did you find it difficult to complete that
7 test?

8 A. Yes.

9 Q. And do you -- in your opinion or did you feel
10 that you had additional symptoms as a result of having to
11 do those things?

12 A. Yes. In fact, a lot more pain than I usually
13 feel. In fact, it was about 15 days that the pain
14 lasted.

15 Q. And did you express your concerns or your
16 symptoms to the evaluator?

17 A. To the therapist, I did, and she indicated
18 that if I wanted to have a --

19 MS. MCCORMACK: Objection to hearsay.

20 MR. VEGA: Yes. I mean, the only question was
21 whether he expressed his symptoms to him, and I think
22 he's answered that.

23 THE COURT: Let's move on.

24 BY MR. VEGA:

25 Q. Okay. In your opinion, are you able -- let me

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1 back up a little bit. You were installing fiberoptic
2 cables when you got hurt; is that correct?

3 A. Yes.

4 Q. And is that a heavy job that you did?

5 A. At some points during the job, you do have to
6 make force or -- or work hard.

7 Q. So you have to lift things and do a lot of
8 different type of hard work; is that correct?

9 A. Yes.

10 Q. Now, in your opinion, would you be able to
11 return to that job with the symptoms that you currently
12 have and your back condition?

13 A. No.

14 Q. In your opinion at this time would you be able
15 to do either a light, medium, or a heavy job only?

16 A. A light duty job. At this point I don't feel
17 able to be doing any heavy duty work.

18 Q. Now, if your back was 100 percent before this
19 accident, what would you say is your loss of use at this
20 point after the surgery and the treatment?

21 A. Well, I would say that I've lost more than
22 50 percent of my ability with my spinal column because
23 there are things I can't do. For example, I can't lean
24 forward to grab anything.

25 MR. VEGA: Nothing further at this time, Your

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1 Honor.

2 THE COURT: Ms. McCormack is now going to ask
3 you some questions. Please answer them.

4 MS. MCCORMACK: Commissioner, before I
5 cross-examine him, I just would like to make a reply to
6 what Mr. Vega asserted a few moments ago. In defendant's
7 APA No. 1, Page 15, which is after the claimant's
8 surgery, the authorizing treating physician noted
9 submaximal effort. After the claimant's surgery in APA
10 No. 1, Page 18, again it was noted that he was
11 self-limited. And the functional capacity exam, which is
12 APA No. 4, Page 26, states that he showed inconsistencies
13 and it was the minimum that he could function in an eight
14 hour day. So I just wanted to make some clarification
15 for the record.

16 CROSS-EXAMINATION

17 BY MS. MCCORMACK:

18 Q. You're only 39 years old, correct?

19 A. Yes.

20 Q. And you have not even tried to go back to
21 work, have you?

22 A. With the type of pain I have, I cannot return
23 to work like this. If it were a job where I could be
24 sitting and performing my work and can get up whenever I
25 feel in pain, sit back and do my work and they would

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1 accept that, then I would accept that type of job. But
2 in the condition I'm in right now, I can't perform that
3 type of work.

4 Q. But you don't even know if that type of job is
5 available because you haven't tried; isn't that correct?
6 Just answer the question.

7 A. Well, during this time, I've been under
8 medical treatment. And after the medical treatment was
9 over, now I'm in the process of this claim.

10 Q. But the question was you have not tried to go
11 back to work under what the doctor's restrictions are,
12 have you?

13 A. My employer has never called me to tell me to
14 come back to work.

15 Q. I didn't ask you about your employer. Again,
16 answer my question. I've asked you have you tried to go
17 back to work under the restrictions that your doctor has
18 given you; yes or no?

19 A. No, I have not. No.

20 Q. So you don't know if you can do it since you
21 haven't tried. You would agree with that, correct?

22 A. The problem is that I've always done heavy
23 duty work. I started doing heavy duty work when I was
24 17. I've never done anything different like light duty.

25 Q. But you haven't tried; yes or no?

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1 A. I haven't tried.

2 MS. MCCORMACK: I don't have any other
3 questions, Commissioner.

4 THE COURT: Anything further, Mr. Vega?

5 MR. VEGA: No, sir.

6 THE COURT: All right. You may step down.

7 Thank you. Anything further, Ms. McCormack?

8 MS. MCCORMACK: No, Commissioner.

9 THE COURT: Anything further, Mr. Vega?

10 MR. VEGA: No, sir.

11 THE COURT: All right. Then that concludes
12 this hearing.

13 (The hearing concluded at 4:06 p.m.)

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Kimberly T. Power, Court Reporter
kimberlytpower@aol.com

CERTIFICATE OF REPORTER

I, Kimberly T. Power, Court Reporter and Notary Public for the State of South Carolina at Large, do hereby certify:

That the foregoing transcript of proceedings was taken before me on the date and at the time and location stated on page 1 of this transcript; that the witness was duly sworn to testify to the truth, the whole truth, and nothing but the truth; that the testimony of the witness and all objections made at the time of the proceeding were recorded stenographically by me and were thereafter transcribed; that the foregoing transcript of proceedings as typed is a true, accurate and complete record of the testimony and of all objections made at the time to the best of my ability.

I further certify that I am neither related to nor counsel for any party to the cause pending or interested in the events thereof.

Witness my hand, I have hereunto affixed my official seal this 2nd day of April, 2012, at Richland County, South Carolina.



Kimberly T. Power Court Reporter
Notary Public, State of South Carolina
My Commission Expires: 07/22/2015

Kimberly T. Power, Court Reporter
kimberlytpower@aol.com



Claimant's Name: Norge L Gonazalez Torres

Employer's Name: World Fiber Technologies, Inc.

Address: 5304 Roberts Scott Road

Address: _____

City: Jacksonville State: FL Zip: 32207

City: _____ State: _____ Zip: _____

Home Phone: (904) 328-4465 Work Phone: _____

Carrier: The Standard Fire Insurance Company

Preparer's Name: S. LeAnne McCormack, Attorney for Defendants

Preparer's Phone #: (803) 227-2880

A claim for workers' compensation benefits is made based on the following grounds:

☒ Injury ☐ Illness ☐ Repetitive Trauma

1. Compensation Rate: \$ TBD 2. AWW: \$ TBD Date of Injury: February 26, 2010

3. Type of injury and body part(s): Back

4. Facts in controversy: To what extent is Claimant entitled to permanent partial disability benefits, if any, to his back? Whether the Carrier/Employer may stop payment of Claimant's temporary total disability benefits? Whether Employer/Carrier is entitled to a credit for overpayment of temporary total disability from the date of MMI?

5. Legal issues involved: § 42-15-60; § 42-9-30; Curriel vs. Environmental Management Services; and other applicable statutes, regulations, and case law.

6. Unusual aspects: Defendants reserve the right to and may move to either postpone or adjourn the scheduled hearing to exercise due process rights afforded by law to cross examine, respond to, and otherwise oppose evidence presented by the claimant.

7. Witnesses (designate if expert):* Employer Representative(s). See #6 above.

8. Exhibits: Claimant's Employment/Personnel File; Payroll Records; Deposition of Claimant

9. Medical evidence (indicate report pursuant to R.67-612; deposition or appearance): SEE APA SUBMISSION

10. Name, address, and specialty, if any, of the treating physician: Dr. Michael Scharf with Jacksonville Orthopaedic

11. Impairment rating(s); body part(s); physician and date of opinion: 12% impairment rating to the back by Dr. Scharf on September 19, 2011

12. I am amending my Form 50/51 in the following manner: N/A

I verify the contents of this form are accurate and true to the best of my knowledge.

Signature: _____

S. LeAnne McCormack, Willson Jones Carter & Baxley, P.A.

Email: simccormack@wjlaw.net

Date of hearing: December 8, 2011

Time needed for hearing: 30 minutes

On behalf of ☐ Claimant ☒ Employer

I certify that I have served this document pursuant to R.67-212 by delivering a copy to C. DANIEL VEGA, Esquire,
Name

P.O. Box 12330, Columbia, SC 29211; and The Honorable Andrea C. Roche, SC WCC, P.O. Box 1715, Columbia, SC 29202-1715

Address

on the 22nd day of November, 2011 by ☒ first class mail; ☐ personal service; ☐ certified mail.

Tessa W. Campbell
Tessa W. Campbell, Certifier

November 22, 2011
Date

File this form and proof of service on the opposing party according to R.67-611 and R.67-212. Do not send medical reports.

*Commissioners reserve the right to admit expert witnesses at hearings.

WCC Form # 58

Rev. 9/07

58

PRE-HEARING BRIEF

South Carolina Workers' Compensation Commission

P.O. Box 1715 • 1612 Marion Street
Columbia, South Carolina 29202-1715
(803) 737-5700

WCC File # 1002408

Carrier File # 026-CB-EHH916

Carrier Code #

Employer FEIN

Norge L. Gonzalez Torres

Claimant's Name

SSN

5304 Roberts Scott Road, Jacksonville, FL 32207

Address

City

State

Zip

(904) 328-4465

Home Phone

Work Phone

S. LeAnne McCormack

Preparer's Name

4500 Fort Jackson Boulevard, Columbia, SC 29209

Address

World Fiber Technologies, Inc.

Employer's Name

Address

City

State

Zip

The Standard Fire Insurance Company

Insurance Carrier

(803) 227-2880

Phone #

TO: SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION AND
C. DANIEL VEGA, ESQUIRE, ATTORNEY FOR CLAIMANT

YOU ARE HEREBY NOTIFIED THAT DEFENDANTS, pursuant to the provisions of the South Carolina Workers' Compensation Act and South Carolina Code Section 1-23-330, (1976, as amended), herewith submits the following medical reports as direct evidence on behalf of the defendants, to wit:

NAME OF PHYSICIAN/OTHER DATE OF REPORT PAGE

1. Jacksonville Orthopaedic Institute	March 30, 2010 – September 19, 2011	1 – 19
2. Signet Diagnostic Imaging Services	April 28, 2010	20 - 21
3. Bruce A. Hartwig, M.D., P.A.	October 21, 2010	22 – 25
4. Work Strategies	August 31, 2011	26 - 40

YOU ARE FURTHER HEREBY NOTIFIED that you have the right to cross-examination; and, should you desire to exercise said right, you are to forthwith schedule the depositions of any of the physicians, whose reports are submitted, for the purposes of cross-examination.

YOU ARE FURTHER NOTIFIED that the originals of the documents referred to herein, or photocopies received from said physicians/others, are being herewith forwarded to the South Carolina Workers' Compensation Commission, for insertion in the file of the South Carolina Workers' Compensation Commission and inclusion into the evidence on behalf of the employer-defendant.

YOU ARE FURTHER NOTIFIED that the following witnesses may be called on behalf of the defendants: See Pre-Hearing Brief.



S. LeAnne McCormack

Willson Jones Carter & Baxley, P.A.

4500 Fort Jackson Boulevard

Columbia, SC 29209

November 22, 2011

December 8, 2011

(hearing date)

JACKSONVILLE ORTHOPAEDIC INSTITUTE

5737 Barnhill Drive, Suite 102
Jacksonville, FL 32207
(904) 739-3319

GONZALEZ-TORRES, NORGE DOB: 10/22/1972 CHART# WK486193 SVC DATE: March 30, 2010

ROBERT J KLEINHANS MD

NEW PATIENT - INITIAL VISIT

CHIEF COMPLAINT: LOW BACK INJURY

HPI:

This is a 37-year-old male who is a construction worker. He was injured on 2/26/2010 at work when he was lifting some heavy equipment, which he was carrying with some other people. He states everyone else let go and left him holding it by himself and he strained back. The patient went to Primary Care who placed him on rest and gave him some pills. He states it is getting a little bit better, but is still having problems. The patient is complaining of pain in the low back area radiating down the back of both legs to both knees. He states the pain is constant. Denies any numbness or weakness in the legs.

PAST MEDICAL HISTORY:

Noncontributory.

PAST SURGICAL HISTORY:

Noncontributory.

SOCIAL HISTORY:

The patient denies the use of tobacco products and drinks alcoholic beverages on an occasional basis.

FAMILY HISTORY:

Negative for rheumatoid arthritis, cancer, HTN, diabetes or hemophilia.

MEDICATIONS:

Current medications include:

Hydrocodone
Ibuprofen
Carisoprodol

ALLERGIES:

No known drug allergies.

PHYSICAL EXAM:

General: This is a 37-year-old male who is alert and oriented x3 with normal affect. Normal sensation, DTR's, coordination and affect. Skin exam of all four extremities shows no rashes or ulcers. Musculoskeletal exam of all four extremities showed no crepitus or severe tenderness. Good ROM without pain.

On exam he has marked decreased range of motion of the low back. He can only flex to about 30 degrees secondary to pain. There is mild paraspinal spasm. SLR is negative. Sensory and motor exam in both legs are normal.

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5737 Barnhill Drive, Suite 102

Jacksonville, FL 32207

(904) 739-3319

GONZALEZ-TORRES, NORGE
2010

DOB: 10/22/1972

CHART# WK486193

SVC DATE: March 30,

ROBERT J KLEINHANS MD

X-RAYS/STUDIES:

X-ray five views of the lumbar spine taken today shows no fracture, dislocations or degenerative changes.

IMPRESSION:

1. ACUTE LUMBAR STRAIN

PLAN:

1. I gave him some SOMA 350 mg #60/0 and VICODIN 5 mg #40/0.
2. I am going to send him to physical therapy.
3. We discussed the various options including surgery.
4. Follow up in 3 weeks.

Robert J. Kleinhans MD

RJK/arf

JACKSONVILLE ORTHOPAEDIC INSTITUTE

5737 Barnhill Drive, Suite 102
Jacksonville, FL 32207
(904) 739-3319

GONZALEZ-TORRES, NORGE L DOB: 10/22/1972 CHART# WK486193 SVC DATE: April 22, 2010

ROBERT J KLEINHANS MD

-FOLLOW UP VISIT-

EIGHT IN A HALF WEEKS STATUS POST LOW BACK INJURY

The patient is here for follow up. He notes he is not improved and has constant low back pain especially with movement. The patient notes occasional radicular pain down to the right lateral thigh area.

PHYSICAL EXAM:

On exam active lumbar range of motion reveals 20 degrees of flexion and extension range of motion as well as 25 degrees of side bending bilaterally. There is 50% decrease in the backward bending quadrants with pain in all ranges of active range of motion for the right central low back.

Reflexes are 2+ bilateral, symmetrical and brisk for knee and ankle jerks with 5/5 lumbar myotomal strength. Right low back pain is elicited with seated resisted right hip flexion attempts. There is tenderness present in the right paracentral low back area.

IMPRESSION:

1. PERSISTENT LOW BACK PAIN WITH POSSIBLE CENTRAL DISC HERNIATION

PLAN/RECOMMENDATION:

1. I am going to send the patient for an MRI of the low back.
2. I would like to see the patient for follow up after MRI is completed.

Robert J. Kleinhans MD (Dictated by Kirk A. Laneve, PA-C)/arf

Electronically Signed by: Robert J. Kleinhans, MD on Wednesday, May 05, 2010 at 09:17 am

JACKSONVILLE ORTHOPAEDIC INSTITUTE

5737 Barnhill Drive, Suite 102
Jacksonville, FL 32207
(904) 739-3319

GONZALEZ-TORRES, NORGE L DOB: 10/22/1972 CHART# WK486193 SVC DATE: May 7, 2010

ROBERT J KLEINHANS MD

-FOLLOW UP VISIT-

LOW BACK PAIN

The patient is here for follow up and review of the MRI. Therapy seems to be helping some.

X-RAYS/STUDIES:

MRI reveals L5-S1 disc herniation without nerve involvement.

These findings were discussed with the patient.

PLAN/RECOMMENDATION:

1. He is to continue with therapy.
2. I think we need to refer him to a back specialist to evaluate whether this might need surgery or not.

RJK/arf

Electronically Signed by: Robert J. Kleinhans, MD on Thursday, May 13, 2010 at 11:54 am

JACKSONVILLE ORTHOPAEDIC INSTITUTE

1325 San Marco Boulevard, Suite 200
Jacksonville, FL 32207
(904) 346-3465

GONZALEZ TORRES, NORGE L DOB: 10/22/1972 CHART# W00492008 SVC DATE: June 2, 2010

MICHAEL S SCHARF MD

CHIEF COMPLAINT

This 37 year-old man comes in with complaints of pain in his low back since February 26, 2010. He does not speak English, he was here with an interpreter. At the time he was working on a bridge and lifting some equipment that got loose and he hyperextended his back. He started having pain, and that afternoon he went to the Emergency Room. He denies any prior history of back trouble. He states that occasionally the pain goes into his right leg, but his back is his main complaint. He has been treated with medication, which he takes as needed. He also saw Dr. Kleinhans who subsequently put him in physical therapy and did a MRI. After the MRI he was referred here. He states that the therapy did not help. He has not worked since February 26th.

MEDICAL HISTORY AND PAST MEDICAL HISTORY

Reviewed with patient and included in record for completeness.

MEDICATION

He takes no medication for any chronic medical conditions.

ALLERGIES

None.

SOCIAL HISTORY

He does not smoke.

REVIEW OF SYSTEMS

A 14-point review of systems is unremarkable.

PHYSICAL EXAMINATION

On examination, he moves around fairly easily. In the upright position, his spine is straight. Range of motion is nil due to submaximal effort. There is no palpable muscle spasm. In the sitting position, reflexes are symmetrical bilateral. In the supine position, straight leg raising reproduces low back pain at about 45 degrees when I bend his hips and knees. He also complains of back pain. There are no root tension signs.

X-RAY STUDIES

A MRI that he brought with him is consistent with a small, central subligamentous disc herniation at L4-5 which

JACKSONVILLE ORTHOPAEDIC INSTITUTE

1325 San Marco Boulevard, Suite 200
Jacksonville, FL 32207
(904) 346-3465

GONZALEZ TORRES, NORGE L DOB: 10/22/1972 CHART# W00492008 SVC DATE: June 2, 2010

MICHAEL S SCHARF MD

is probably new.

IMPRESSION

Central disc herniation.

DISPOSITION

His treatment to date has been appropriate. I feel that there is maybe a little bit of a pain behaviour response, but I also think he has a real problem. I am recommending epidural steroid injections. I discussed this with him. He will get those scheduled. His work status is unchanged.

Michael S. Scharf, M.D.

MSS/mlt

cc: Workman's Compensation

JACKSONVILLE ORTHOPAEDIC INSTITUTE

5737 Barnhill Drive, Suite 102
Jacksonville, FL 32207
(904) 739-3319

GONZALEZ-TORRES, NORGE L DOB: 10/22/1972 CHART# WK486193 SVC DATE: June 4, 2010

ROBERT J. KLEINHANS MD

-FOLLOW UP VISIT-

RIGHT L5, S1 DISC HERNIATION

The patient is here for follow up. He is complaining of increased pain in the right low back down the leg to the knee now. It is increased with walking and sit to stand. He notes the pain is getting worse. Denies any numbness or tingling.

PHYSICAL EXAM:

On exam active lumbar range of motion reveals 10 degrees of flexion and 20 degrees of extension. He has 20 degrees right side bending and a limitation of 50% of the right back bending quadrant before the advent of right low back and buttock pain.

There is a positive SLR with 5/5 lumbar myotomes throughout the right lower quarter. Pain is also elicited with seated active hip flexion range of motion. Reflexes are 2+ bilateral, symmetrical and brisk for knee and ankle jerks bilaterally.

REVIEW OF SYSTEMS:

He has seen Dr. Scharf who is recommending 3 epidurals.

IMPRESSION:

1. RIGHT L5, S1 DISC HERNIATION

PLAN/RECOMMENDATION:

1. He will check with Dr. Scharf and follow up with the epidurals.
2. Follow up with us on a prn basis.

Robert J. Kleinhans MD (Dictated by Kirk A. Laneve, PA-C)/arf

Electronically Signed by: Robert J. Kleinhans, MD on Thursday, June 10, 2010 at 11:22 am

JACKSONVILLE ORTHOPAEDIC INSTITUTE

Performed Outpatient - Baptist Medical Center

800 Prudential Drive

Jacksonville, Florida 32207

GONZALEZ TORRES, NORGE L
22, 2010

DOB: 10/22/1972

CHART# W00492008

SVC DATE: June

ROBERT G SAVARESE DO

CHIEF COMPLAINT:

Low back pain.

HISTORY OF PRESENT ILLNESS:

This is a 37-year-old gentleman, who injured himself on the job on 2/26/10. He does not speak english and he is here with an interpreter. He was working on a bridge, lifting some equipment that got lose and he hyperextended his back. He started having pain and that afternoon, he went to the ER. He denies any history of back trouble. He does have pain that goes into the right leg. He has tried anti-inflammatory medication, pain medications and he had an MRI, which shows a central disc at L4-5. Dr. Scharf ordered an epidural steroid injection.

PAST MEDICAL, FAMILY & SOCIAL HISTORY & REVIEW OF SYSTEMS:

Per the patient information sheet, reviewed and updated and there are no new findings of significance since the last evaluation.

PHYSICAL EXAMINATION:

He is alert and oriented times three. He is in no acute distress. He gets on and off the exam table without difficulty. Inspection of the lumbar spine is essentially normal. Upon palpation, he has tenderness throughout the lumbosacral paraspinals. Range of motion of the lumbar spine is very limited. Neurologic examination is grossly intact except he does have a mildly positive sit/slump maneuver and straight leg-raising on the right.

IMPRESSION:

Lumbar disc herniation central at L4-5 with right-sided radicular symptoms.

PLAN:

1. We will move forward with a right L4-5 interlaminar epidural steroid injection under fluoroscopic guidance. Please see separate dictated report for details.
2. The patient will return in one week for a repeat injection if need be.

RGS/als

cc: WC

cc: Michael S. Scharf, MD

JACKSONVILLE ORTHOPAEDIC INSTITUTE

1325 San Marco Boulevard, Suite 200
Jacksonville, FL 32207
(904) 346-3465

GONZALEZ TORRES, NORGE L DOB: 10/22/1972 CHART# W00492008 SVC DATE: June 30, 2010

MICHAEL S SCHARF MD

FOLLOW UP VISIT

He came in with his interpreter. He had one injection. He states that he got better for several days and then the pain started coming back. We will finish up the other two epidurals at L4-5.

He has been taking Tylenol for pain, which helps. He will return after the epidurals.

Michael S. Scharf, M.D.

MSS/mlt

cc: Workman's Compensation

JACKSONVILLE ORTHOPAEDIC INSTITUTE

1325 San Marco Boulevard, Suite 200
Jacksonville, FL 32207
(904) 346-3465

GONZALEZ TORRES, NORGE L DOB: 10/22/1972 CHART# W00492008 SVC DATE: August 16, 2010

MICHAEL S SCHARF MD

FOLLOW UP VISIT

He had his epidurals. He came in with an interpreter. He gets transient relief after the epidurals and the pain comes back. Most of the pain is in his low back.

On exam, he moves around fairly slowly. He does not demonstrate any abnormal pain behaviours. I think this man is genuine.

He does have significant degenerative change in L4-5 with an annular tear. There are also some degenerative changes in 5-1. I discussed surgery with him. He is amenable to have something done if it would help. I want to get a discogram. That should give us a lot of information.

MSS/mlt

cc: Workman's Compensation

JACKSONVILLE ORTHOPAEDIC INSTITUTE

1325 San Marco Boulevard, Suite 200
Jacksonville, FL 32207
(904) 346-3465

GONZALEZ TORRES, NORGE L DOB: 10/22/1972 CHART# W00492008 SVC DATE:
September 20, 2010

MICHAEL S SCHARF MD

FOLLOW UP VISIT

He came in with his interpreter. Apparently, Workman's Compensation sent him for second opinion with Dr. Rogozinski, which he saw on the 10th. According to the interpreter, Dr. Rogozinski agreed with doing a discogram. We will wait of his report and then proceed accordingly.

Michael S. Scharf, M.D.

MSS/mlt

cc: Workman's Compensation

JACKSONVILLE ORTHOPAEDIC INSTITUTE

1325 San Marco Boulevard, Suite 200
Jacksonville, FL 32207
(904) 346-3465

GONZALEZ TORRES, NORGE L DOB: 10/22/1972 CHART# W00492008 SVC DATE: November 1, 2010

MICHAEL S SCHARF MD

FOLLOW UP VISIT

He came in with his interpreter. I went over his electrical studies which were normal. We talked about doing a discogram and possible surgery. He asked some very insightful question about the surgery and I told him that this would require a fusion, but before we get into detail let us do the discogram first. He is in agreeance with that. I did not give him any medication for pain.

Michael S. Scharf, M.D.

MSS/mlt

cc: Workman's Compensation

JACKSONVILLE ORTHOPAEDIC INSTITUTE

1325 San Marco Boulevard, Suite 200
Jacksonville, FL 32207
(904) 346-3465

GONZALEZ TORRES, NORGE L. DOB: 10/22/1972 CHART# W00492008 SVC DATE: December 13, 2010

MICHAEL S SCHARF MD

FOLLOW UP VISIT

He came in with his interpreter. His discogram was markedly positive at L4-5, L5-S1. I had a long discussion with him through his interpreter about the next step. He wanted to get this fixed. I think he will do well with a posterior fusion and posterior lumbar interbody fusion. We will do this at 4-5, 5-1. I showed him the model. We will get him scheduled.

His work status is unchanged.

Michael S. Scharf, M.D.

MSS/mlt

cc: Workman's Compensation

JACKSONVILLE ORTHOPAEDIC INSTITUTE

Performed Inpatient - Baptist Medical Center

800 Prudential Drive

Jacksonville, Florida 32207

GONZALEZ TORRES, NORGE L DOB: 10/22/1972 CHART# W00492008 SVC DATE:
January 20, 2011

MICHAEL S SCHARF MD

SURGERY NOTE

He was taken to surgery today. I did a bilateral decompression at L4-5, L5-S1, a posterior lumbar interbody fusion using autologous bone plus stem cells. We used 11x22mm fusion cages. He also underwent bilateral lateral fusion at L4-5, L5-S1 with Denali and autologous bone plus stem cells. I did take a bone graft from the left posterior iliac crest. Dr. Grube assisted. The procedure went well.

Michael S. Scharf, M.D.

MSS/mlt

cc: Workman's Compensation

RECONSIDERATION

JACKSONVILLE ORTHOPAEDIC INSTITUTE

1325 San Marco Boulevard, Suite 200
Jacksonville, FL 32207
(904) 346-3465

GONZALEZ TORRES, NORGE L DOB: 10/22/1972 CHART# W00492008 SVC DATE: March 16, 2011

MICHAEL S SCHARF MD

FOLLOW UP VISIT

He is still having back pain, but states that it is different then the pain he had before. On exam today, his range of motion is markedly limited. There is a lot of submaximal effort. X-rays today show good position of his hardware.

I am starting him on physical therapy, which will include an H-Wave. He was given a prescription for Percocet.

He was seen with an interpreter. He will return in four weeks.

Michael S. Scharf, M.D.

MSS/mlt

cc: Workman's Compensation

JACKSONVILLE ORTHOPAEDIC INSTITUTE

1325 San Marco Boulevard, Suite 200
Jacksonville, FL 32207
(904) 346-3465

GONZALEZ TORRES, NORGE L DOB: 10/22/1972 CHART# W00492008 SVC DATE: May 25, 2011

MICHAEL S SCHARF MD

FOLLOW UP VISIT

He came in with his interpreter. He states that overall his pain is better and feels different then it did before surgery. He does not have the deep, sharp, shooting pain. He is still getting pain in the left buttock in the back of his leg. Straight leg raising does cause a pulling. His only medication has been Ibuprofen.

X-rays today show early healing in his fusion.

We will watch him for now. He will continue with his exercises. He will return in six weeks for A/P and lateral x-rays of his lumbar. He can engage in sedentary work.

Michael S. Scharf, M.D.

MSS/mt

cc: Workman's Compensation

JACKSONVILLE ORTHOPAEDIC INSTITUTE

1325 San Marco Boulevard, Suite 200
Jacksonville, FL 32207
(904) 346-3465

GONZALEZ TORRES, NORGE L DOB: 10/22/1972 CHART# W00492008 SVC DATE: July 11, 2011

MICHAEL S SCHARF MD

FOLLOW UP VISIT

He is still having a lot of pain, particularly when he forward flexes. He is able to do his exercises without too much difficulty. He is sort of maxed out on his physical therapy. He is doing his exercises at home. He states that his back hurts differently then it did before surgery and overall, he is somewhat better.

His work status is unchanged. I am still keeping him on sedentary work. He is now five months postoperative.

X-rays today show progressive healing of his fusion, but he is not completely fused. He will return in six weeks. He came in with his interpreter.

Michael S. Scharf, M.D.

MSS/mlt

cc: Workman's Compensation

JACKSONVILLE ORTHOPAEDIC INSTITUTE

1325 San Marco Boulevard, Suite 200
Jacksonville, FL 32207
(904) 346-3465

GONZALEZ TORRES, NORGE L DOB: 10/22/1972 CHART# W00492008 SVC DATE: August 22, 2011

MICHAEL S SCHARF MD

FOLLOW UP VISIT

He was seen with his interpreter. He is now seven months postoperative. He states that he is still having pain in his back, but it is a different pain than he had before. He states that he can not bend over because of the pain. He denies any leg pain. The only medication he is taking is over-the-counter, such as Advil and Tylenol which he takes as needed.

On exam he is very self limited. He will not bend at all. He states that he has pain on the left side of his back. Straight leg raising is unremarkable.

In reviewing his x-rays, including A/P and lateral of his lumbar spine, I feel that he is fused particularly in the lateral gutters.

He is getting close to maximum medical improvement. I am sending him for a functional capacity evaluation. He will return afterwards.

Michael S. Scharf, M.D.

MSS/mlt

cc: Workman's Compensation

JACKSONVILLE ORTHOPAEDIC INSTITUTE

1325 San Marco Boulevard, Suite 200

Jacksonville, FL 32207

(904) 346-3465

GONZALEZ TORRES, NORGE L DOB: 10/22/1972 CHART# W00492008 SVC DATE: September 19, 2011

MICHAEL S SCHARF MD

FOLLOW UP VISIT

He came in with his interpreter. I went over his FCE, which puts him in the light work category, although he did tell me that when he went home he could barely move because of the work that was required. The FCE seems to be fairly valid, although there were some inconsistencies.

I agree with the FCE that he can be engaged in light work. I am releasing him. He is at maximum medical improvement. He has a 12% permanent impairment. Range of motion of his lumbar spine is limited to about 50% of normal.

Michael S. Scharf, M.D.

MSS/mlt

cc: Workman's Compensation

SIGNET DIAGNOSTIC IMAGING SERVICES
4063 SALISBURY RD #100
JACKSONVILLE, FL 322166199
(904) 281-0133

ONE CALL MEDICA ONE CALL MEDICAL
PO BOX 614
PARSIPPANY, NJ 07054
DOS: 04/28/10

IN RE:	GONZALEZ TORRES, NORGE	F
Acct :	367781.0	DOB: 10/22/72
DOS# :	04/28/10	AUTH: OCM772804216
Location:	SALISBURY IMG CTR	Film N Fax Y Del N

MR OF THE LUMBAR SPINE WITHOUT CONTRAST:

HISTORY: Lifting injury. Low back pain and right hip pain.

TECHNIQUE: Sagittal and axial MR images were obtained of the lumbar spine in multiple imaging sequences on a 1.5 T-high field strength magnet.

FINDINGS: There is homogeneous marrow signal seen throughout the imaged portion of the lumbar spine without evidence for marrow edema or marrow replacement. The heights of the vertebral bodies are maintained. The conus has a normal appearance. There is no evidence of a mass lesion within the spinal canal.

L1-L2: There is no evidence of a herniated disc or nerve root encroachment. The neural foramina are patent bilaterally. The thecal sac, epidural fat and nerve roots are maintained. The facet joints are within normal limits.

L2-L3: There is no evidence of a herniated disc or nerve root encroachment. The neural foramina are patent bilaterally. The thecal sac, epidural fat and nerve roots are maintained. The facet joints are within normal limits.

L3-L4: There is no evidence of a herniated disc or nerve root encroachment. The neural foramina are patent bilaterally. The thecal sac, epidural fat and nerve roots are maintained. The facet joints are within normal limits.

L4-L5: There is mild disc space narrowing present with a small central subligamentous disc protrusion/herniation present. There is mild encroachment upon the thecal sac anteriorly. However, no gross compression upon the thecal sac or nerve root is seen.

SIGNET DIAGNOSTIC IMAGING SERVICES
4063 SALISBURY RD #100
JACKSONVILLE, FL 322166199
(904) 281-0133

MR OF THE LUMBAR SPINE WITHOUT CONTRAST:

IN RE: GONZALEZ TORRES, NORGE PAGE 2 OF 2
Acct : 367781.0

L4-L5 (continue): The neural foramina are widely patent bilaterally. There is mild disc desiccation demonstrated and the exact age of this herniation cannot be definitively determined on this study.

L5-S1: There is a small central disc protrusion/herniation present. Due to the increased amount of epidural fat anterior to the thecal sac at this level, no encroachment upon the thecal sac or nerve root is seen. There is again mild desiccation of the disc with the exact age of the herniation indeterminate. The thecal sac, epidural fat or facet joints are within normal limits.

IMPRESSION:

1. SMALL CENTRAL SUBLIGAMENOUS DISC HERNIATION AT L4-L5.
2. SMALL CENTRAL DISC HERNIATION AT L5-S1. BOTH OF THESE FINDINGS ARE MORE FULLY DESCRIBED ABOVE.

Thank you for allowing me to assist in the care of your patient.

HF/tr4/Dk
April 29, 2010

HARRIS FREED MD
BOARD CERTIFIED DIAGNOSTIC RADIOLOGIST
FELLOWSHIP-TRAINED MUSCULOSKELETAL
RADIOLOGIST

10/21/2010

Bruce A. Hartwig, M.D., P.A.

Neurology and Neurodiagnostics

Dillon Professional Building

1820 Barrs Street, Suite 752

Jacksonville Florida 32204

(904) 389-6226

Patient: Gonzalez Torres, Norge

DOB: 10/22/1972

Physician: Dr. Michael Scharf

ID#: OneCall772804216

SEX: Male

Ref. Phys:

Chief Complaint:

Patient is a 37 year old Male who presents with post traumatic low back strain 2-26-2010. Patient complains of persistent low back pain with spasms.

EMG

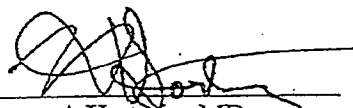
Side	Muscle	Nerve	Root	Ins Act	Fibs	Psw	Amp	Dur	Poly	Recrt	Int Pat	Comment
Left	AbdDigQuinti	LatPlantar	S1-2	Nml	Nml	Nml	Nml	Nml	0	Nml	Nml	
Left	MedGastroc	Tibial	S1-2	Nml	Nml	Nml	Nml	Nml	0	Nml	Nml	
Left	AntTibialis	Dp Br Peron	L4-5	Nml	Nml	Nml	Nml	Nml	0	Nml	Nml	
Left	VastusMed	Femoral	L2-4	Nml	Nml	Nml	Nml	Nml	0	Nml	Nml	
Right	AbdDigQuinti	LatPlantar	S1-2	Nml	Nml	Nml	Nml	Nml	0	Nml	Nml	
Right	MedGastroc	Tibial	S1-2	Nml	Nml	Nml	Nml	Nml	0	Nml	Nml	
Right	AntTibialis	Dp Br Peron	L4-5	Nml	Nml	Nml	Nml	Nml	0	Nml	Nml	
Right	VastusMed	Femoral	L2-4	Nml	Nml	Nml	Nml	Nml	0	Nml	Nml	

Summary and Findings:

Monopolar needle EMG was performed in selected bilateral lower extremities, innervated by L2-S2 nerve roots inclusive. No spontaneous activity was seen in any muscles tested in the form of fibrillations, positive sharp waves or fasciculations. Voluntary motor unit morphologies are otherwise normal.

Impression:

The above electrodiagnostic study reveals a normal EMG of the bilateral lower extremities.



Bruce A Hartwig, MD

p.02

9043887265

HP LASERJET FAX

09:30AM

10/22/10

22

10/21/2010

Bruce A. Hartwig, M.D., P.A.

Neurology and Neurodiagnostics

Dillon Professional Building

1820 Barrs Street, Suite 752

Jacksonville Florida 32204

(904) 389-6226

Patient: Gonzalez Torres, Norge

DOB: 10/22/1972

Physician: Dr. Michael Scharf

ID#: OneCall772804216

SEX: Male

Ref. Phys:

Chief Complaint:

Patient is a 37 year old Male who presents with post traumatic low back strain 2-26-2010. Patient complains of isolated low back pain without pain or weakness in lower extremities. He is 5'6" with feet temperatures of 32.3C.

Motor Nerves

Site	NR	Onset (ms)	Norm Onset (ms)	O-P Amp (mV)	Norm Amp (mV)	Neg Dur (ms)	Segment Name	Delta-O (ms)	Dist (cm)	Vel (m/s)	Norm Vel (m/s)
Right Peroneal (EDB)											
Ankle		3.44	<5.5	7.13	>2.5	4.77	B Fib-Ankle	8.20	40	48.78	>40.0
B Fib		11.64		6.31		5.31					
Right Tibial (AHB)											
Ankle		4.14	<6.8	7.15	>3.0	5.16	Knee-Ankle	8.91	46	51.63	>41.0
Knee		13.05		6.84		5.39					
Left Peroneal (EDB)											
Ankle		3.36	<5.5	5.14	>2.5	6.33	B Fib-Ankle	8.52	40	46.95	>40.0
B Fib		11.88		4.89		6.25					
Left Tibial (AHB)											
Ankle		4.38	<6.8	7.85	>3.0	4.92	Knee-Ankle	9.22	46	49.89	>41.0
Knee		13.59		7.37		4.84					

Sensory Nerves

Site	NR	Peak (ms)	Norm Peak (ms)	P-T Amp (μV)	Norm Amp (μV)	Segment Name	Delta-P (ms)	Dist (cm)	Vel (m/s)	Norm Vel (m/s)
Right Sural (Lat Mail)										
14 cm		2.94	<4.0	36.19	>75.0	14 cm-Lat Mail	2.94			
Left Sural (Lat Mail)										
14 cm		2.91	<4.0	40.06	>75.0	14 cm-Lat Mail	2.91			

FWave/HReflex

NR	Lat1 (ms)	Lat2 (ms)	Delta (ms)	Amp (μV)
Right Peroneal-F (EDB)				
	46.18	0.00	46.18	

23

p. 03

5927088265

HP LASERJET FAX

10/22/10 09:30AM

Patient: Gonzalez Torres, Norge

Test Date: 10/21/2010

p. 2

Right Tibial-F (AHB)

48.57 0.00 48.57

Left Peroneal-F (EDB)

46.82 0.00 46.82

Left Tibial-F (AHB)

47.93 0.00 47.93

Right Tibial H (Gastroc)

28.03 0.00 28.03

Left Tibial H (Gastroc)

28.98 0.00 28.98

Summary and Findings:

Motor nerve conduction studies revealed normal distal latencies and conduction velocities of bilateral tibial and peroneal nerves. Sensory nerve conduction studies revealed normal peak latencies and amplitudes for bilateral sural nerves. H-reflex studies were within the normal range. No significant side to side difference was noted.

Impression:

The above electrodiagnostic study reveals a normal nerve conduction study of the bilateral lower extremities.

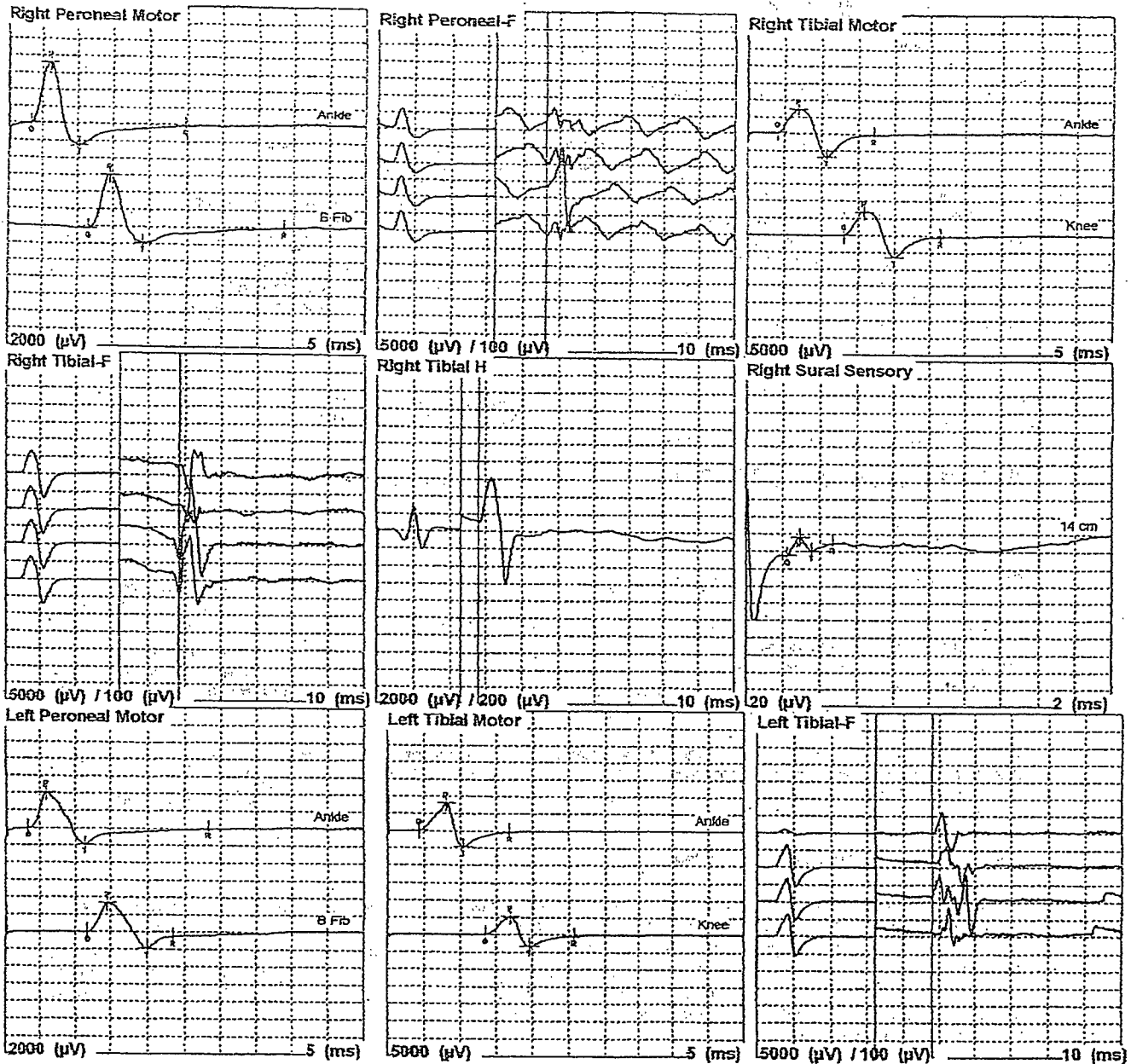


Bruce A Hartwig, MD

Patient: Gonzalez Torres, Norge

Test Date: 10/21/2010

p. 3



p.05

9043887265

HP LASERJET FAX

10/22/10 09:30AM

25

Sep. 6. 2011, 4:01PM

No. 5648 P. 3/17

FUNCTIONAL CAPACITY EVALUATION**Keeping America on the Job!**

Select Physical Therapy Westside-Jacksonville

FUNCTIONAL CAPACITY EVALUATION

NAME: Norge Gonzalez Torres
 EMPLOYER: World Fiber Technology
 DATE OF INJURY: February 28, 2010
 DATE OF EVALUATION: 8/31/11
 DATE OF REPORT: 8/31/11
 I.D. NO.: 670232460
 DIAGNOSIS: s/p fusion L4-S1

REFERRED BY: Dr. Michael Scharf
 PHYSICIAN: Dr. Michael Scharf
 INSURANCE CARRIER: Travelers
 INSURANCE REP.: Judy King
 INSURANCE I.D. NO.: EHH9916
 DATE OF BIRTH: October 22, 1972

VITAL SIGNS

HEIGHT: 69" WEIGHT: 210 lbs.
 RESTING HEART RATE: 99 bpm
 Starting Time: 9:12 AM Ending Time 1:36 PM

HAND DOMINANCE: RIGHT
 RESTING BLOOD PRESSURE: 152/82 mm/Hg

PURPOSE OF ASSESSMENT: Determine functional ability for own occupation.

CONCLUSION

The results of this evaluation indicate that Norge Gonzalez Torres is functioning in the LIGHT work classification and meets his positional job demands (based upon client report and written job description) with a full 8 hour work tolerance in the areas of sitting, standing, walking, stair climbing, ladder climbing, reaching at desk and overhead levels, balance, stooping, squatting, kneeling, crawling, handling, fingering, feeling, simple grasp, firm grasp and fine and gross manipulation. He did not meet his written job description in the areas of material handling per his written job description requirement of lifting and carrying 75 pounds as demonstrated by a maximal occasional lift of 20 pounds from floor to waist height and a frequent lift of 10 pounds.

During positional tolerance testing the client demonstrated constant sitting, simple and firm hand grasping; frequent, standing, walking, stair climbing, ladder climbing, balancing, horizontal and overhead reaching, stooping, fingering, handling, simple grasp, fine/gross manipulation, and firm grasping and occasional and kneeling and crouching.

Results of aerobic capacity are consistent with the Excellent work classification.

The client demonstrated some inconsistencies throughout the test. Therefore, the findings in this report represent the minimum in which he can function in an 8-hour per day basis. Inconsistencies in his performance included squatting: he was able to perform a full squat while lifting up to 20 pounds but couldn't ascend from a squat position without maximal assistance from bilateral upper extremities; gait: at times his gait was antalgic with a slower cadence and at times was within normal limits. At the end of the test, he was using bilateral upper extremity assistance on the stairs, yet when he left the clinic, he descended a curb without evidence of difficulty or wincing and without upper extremity assistance.

PHYSICAL DEMAND LEVEL: LIGHT (U.S. Department of Labor Standards)

Thank you for referring Norge Gonzalez Torres to Select Physical Therapy - Westside-Jacksonville. If you have any further questions regarding this evaluation, please do not hesitate to contact us.

Professionally,

Jennifer Hauser, MPT
 Physical Therapist

8/31/11

7033 Commonwealth Avenue, Suite 2 • Jacksonville • FL • 32220 • 904-928-1133 • 904-996-7001
 © SelectMark 2007

9326-10844

26

Sep. 6. 2011 4:01PM

No. 5648 P. 4/17

Functional Capacity Evaluation

Re: Norge Gonzalez Torres DOB: October 22, 1972

Insurance I.D. No.: EHH9916

cc: Dr. Michael Scharf file

Remainder of page intentionally left blank

Sep. 6. 2011 4:01PM

No. 5648 P. 5/17

Functional Capacity Evaluation

Re: Norge Gonzalez Torres DOB: October 22, 1972

Insurance I.D. No.: EHH9916

PHYSICAL ABILITIES ASSESSMENT (PAA)**LIGHT**

(U.S. Department of Labor Standards)

	Occasional (0 - 33%)	Frequent (33% - 66%)	Constant (66% - 100%)	Job Position	Comments
Material Handling :					
Lift - Floor to Waist	20 lbs.	10 lbs.	N/A lbs.	75 lbs per job description	Job Function Not Met
Lift - Waist to Shoulder	25 lbs.	10 lbs.	N/A lbs.	50 lbs per patient report	Job Function Not Met
Lift - Floor to Shoulder	20 lbs.	NT lbs.	N/A lbs.	50 lbs per patient report	Job Function Not Met
Carry - Bimanual	20 lbs.	NA lbs.	N/A lbs.	75 lbs per job description	Job Function Not Met
Push	48 lbs.	50/3 lbs. 0	N/A lbs.	75 lbs per job description	Job Function Not Met
Pull	62 lbs.	50/3 lbs. 0	N/A lbs.	75 lbs per job description	Job Function Not Met

Postional Tolerance:

	Frequency	Job Position	Comments
Sit	Constant	Rarely	Job Function Met
Stand	Frequent	Constant	Job Function Met
Walk	Frequent	Frequent	Job Function Met
Climb Stairs	Frequent	Occasional	Job Function Met
Climb Ladders	Frequent	Occasional	Not Tested
Reach Desk Level	Frequent	Frequent	Job Function Met
Reach Overhead	Frequent	Frequent	Job Function Met
Reach Floor Level	Occasional	Not Defined	See Comments
Balance	Frequent	Frequent	Job Function Met
Stoop	Frequent	Frequent	Job Function Met
Kneel	Occasional	Occasional	Job Function Met
Crouch	Occasional	Occasional	Job Function Met
Crawl	Occasional	Occasional	Job Function Met

Manipulative Ability:

	Frequency			
Object Handling	Right: Frequent	Left: Frequent	Frequent	Job Function Met
Fingering	Right: Frequent	Left: Frequent	Frequent	Job Function Met
Simple Hand Grasp	Right: Constant	Left: Constant	Constant	Job Function Met
Firm Hand Grasp	Right: Constant	Left: Constant	Frequent	Job Function Met
Fine/Gross Manipulation	Right: Frequent	Left: Frequent	Frequent	Job Function Met

Consistency Profile:

Maximal Voluntary Effort	Consistent	7 of 10 CV Scores < 20%; 1 of 2 Bell Shaped Curves
Pinch Strength Testing	Inconsistent	6 of 6 CV Scores < 20%
Isometric Push / Pull	Consistent	2 of 2 CV Scores < 15%
Dynamic Lift Test	Inconsistent	Expected Linear Heart Rate Increase
Waddell's Objective Signs	Consistent	Movement patterns consistent with objective findings

Comments:Evaluator: Jennifer Hauser, MPT
Physical Therapist

Date: 8/31/11

Evaluator Signature

Physician: Dr. Michael Scharf

Date:

Physician Signature

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W26-10345

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Sep. 6. 2011 4:01PM

No. 5648 P. 6/17

Functional Capacity Evaluation

Re: Norge Gonzalez Torres

DOB: October 22, 1972

Insurance I.D. No.: EHH9916

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Sep. 6. 2011 4:01PM

No. 5648 P. 7/17

Functional Capacity Evaluation

Re: Norge Gonzalez Torres DOB: October 22, 1972

Insurance I.D. No.: EHH9916

SUBJECTIVE HISTORY:

Norge Gonzalez Torres is a 38 year old male with the current diagnosis of s/p fusion L4-S1, onset February 26, 2010. The patient reports that the injury occurred when he was at work and he took some equipment down from a truck with 3 other people and he was getting ready to get the equipment. The workers didn't have full control of the equipment and when he went to catch it, it fell on him. He reports that he tried to hold it up to keep it from landing on his feet. Reports that he at first thought that it was a muscle strain and he continued to work. After it started raining, he had to stop working and by the end of the day he had no feeling in one leg and he had difficulty walking. When he was getting ready for bed that night, he felt a sharp pain in his back and couldn't stand up straight. He wound up going to the hospital that night. Present symptoms include: difficulty bending forward, Midline lumbar pain which is described as "so bad that I cannot do things" and is sharp in nature. The pain is intermittent, depending on activity.

Current medication includes: Tylenol and Advil which were last taken about two days ago.

Norge Gonzalez Torres reports the following relevant past medical history: no significant medical issues. In good overall health.

Previous testing and treatment for this injury/illness (as reported by patient) includes: L4-S1 fusion January 20, 2011. Physical Therapy for approximately 25 visits over approximately 6 weeks which helped right after surgery.

Norge Gonzalez Torres reported low pain at an intensity of 4 (0 = no pain; 1,2,3 = low; 4,5,6 = moderate; 7,8,9 = severe 10 = emergency pain). He reported that the pain ranges from 4 at best to 8 at its worst. He stated that prolonged walking >15-20 minutes, bending over to pick up an object, tying his shoes, and washing dishes aggravates his symptoms, and that lying down provides relief. Perceived abilities include: sitting 30 minutes, standing 30 minutes, walking 30 minutes, driving 30 minutes, and lifting 15-20 lbs.

The patient is independent with activities of daily living (ADL's) including: dressing, grooming, bathing, hygiene, cooking, laundry, household tasks and driving. He reports that he has some difficulty getting his shoes on, uses a chair to wash his feet and has difficulty doing any tasks bending forward such as making beds and washing dishes. He reports that he needs maximal assistance with yardwork as he is unable to push the lawnmower.

He describes a typical day as: waking up at approximately 7AM, he makes the bed and he sometimes goes out to get food for breakfast. He returns home and turns on the television. He sometimes has to wash dishes after breakfast. He then watches television until he gets up to make lunch, after lunch he goes back to bed. He reports that he rests on his side and he "surfs" the computer. He reports that by this time his back is bothering him so he has to take a rest. He used to babysit his nephew and sometimes play video games with him when he came home from school but his brother and nephew just moved so he no longer does that. He will occasionally clean or straighten up his car. He reports that he doesn't have very many friends in Jacksonville so he doesn't do much socializing. He usually has dinner cooked for him by his girlfriend and goes to bed early, by 8PM or 9PM. Norge Gonzalez Torres drove an automobile to the FCE appointment today.

Additional subjective information includes: (N/A)

VOCATIONAL/JOB HISTORY: Norge Gonzalez Torres is currently not working. He was employed as a Laborer at World Fiber Technology for approximately 7 months prior to his injury. He was required to lift up to 50 pounds by himself per patient report. He reports that he is required to stand constantly and works with a variety of power tools, many of which are above shoulder height. A job description was received and reviewed. Details of the job were given by the client as the job description only lists physical requirements of being able to lift and carry up to 75 pounds for short distances.

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Sep. 6. 2011 4:02PM

No. 5648 P. 8/17

Functional Capacity Evaluation

Re: Norge Gonzalez Torres DOB: October 22, 1972

Insurance I.D. No.: EHH9916

PHYSICAL DEMAND CATEGORY (U.S. Department of Labor, Dictionary of Occupational Titles)

Sedentary	Exerting up to 10 lbs. of force occasionally (Occasionally: activity or condition exists up to 1/3 of the time) and/or a negligible amount of force frequently (Frequently: activity or condition exists from 1/3 to 2/3 of the time) to lift, carry, push, pull or otherwise move objects, including human body.
Light	Exerting up to 20 lbs. force occasionally, and/or up to 10 lbs. force frequently, and/or a negligible amount of force constantly (Constantly: activity or condition exists 2/3 or more of the time) to move objects. Physical demand requirements are in excess of those for Sedentary Work.
Medium	Exerting 20 lbs. to 50 lbs. of force occasionally, and/or 10 lbs. to 25 lbs. of force frequently, and/or greater than negligible up to 10 lbs. of force constantly to move objects. Physical Demand requirements are in excess of those for Light Work.
Heavy	Exerting 50 lbs. to 100 lbs. of force occasionally, and/or 25 lbs. to 50 lbs. of force frequently, and/or 10 lbs. to 20 lbs. of force constantly to move objects. Physical Demand requirements are in excess of those for Medium Work.
Very Heavy	Exerting in excess of 100 lbs. of force occasionally, and/or in excess of 50 lbs. of force frequently, and/or in excess of 20 lbs. of force constantly to move objects. Physical Demand requirements are in excess of those for Heavy Work.

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Sep. 6. 2011 4:02PM

No. 5648 P. 9/17

Functional Capacity Evaluation

Re: Norge Gonzalez Torres DOB: October 22, 1972

Insurance I.D. No.: EHH9916

MUSCULOSKELETAL SCREENING SUMMARY

Gait: Within normal limits with slow cadence and decreased hip extension

Posture: Within normal limits with the exception of mild forward head and shoulders.

Soft Tissue: Within normal limits with the exception of bilateral mild paraspinal hypertonicity and left moderate piriformis hypertonicity.

Flexibility: Within normal limits with the exception of moderate hamstring tightness and bilateral mild hypertonicity of upper trapezius, levator scapula and scalenes.

Range of Motion: Refer to Active Range of Motion / Strength Measurements Form

Strength: Refer to Active Range of Motion / Strength Measurements Form

Neurological: Deep tendon reflexes = 2+ for Biceps, Triceps, Brachioradialis, Achilles and Patella.

Additional Testing: Waddell testing negative.

ENDURANCE / AEROBIC CAPACITYSub-Maximal Treadmill Test ☒ Completed Test ☐ Incomplete Test ☐ Not Tested

Classification: Excellent 54.29 ml/kg/min 6.2 METS

HR Increase: YES Respiration Increase: YES Blood Pressure: 140/96 mmHg

Comments: Mr. Norge Gonzales Torres was observed to ambulate at 2.4 mph and had a peak HR of 127 bpm during stage 2 of the treadmill test. Gait pattern remained non-antalgic throughout testing and he utilized bilateral handrails while on the treadmill. After the treadmill test was completed, Mr. Gonzales Torres continued to walk at a pace of 2.1 mph on the treadmill for a total walking time of 21 minutes. His ending HR was 115 bpm. Final Blood Pressure: 132/74 mmHg.

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Sep. 6. 2011 4:02PM

No. 5648 P. 10/17

Functional Capacity Evaluation

Re: Norge Gonzalez Torres DOB: October 22, 1972

Insurance I.D. No.: EHH9916

MATERIAL HANDLING**Waist to Shoulder Dynamic Lift Test**

Occasional Lift	Heart Rate	RPL	RFT	Frequent Lift	Heart Rate	RPL	RFT
25 lbs	131 bpm	9	Self Limit	10 lbs.	131 bpm	6	Self Limit
Start Heart Rate	99 bpm	HR Increase: Yes		Start Heart Rate:	122 bpm	HR Increase: Yes	
Comments:	Appropriate changes in posture, accessory muscle recruitment and changes in speed of movement were observed. Lifts were terminated due to reported increase in back pain for both occasional and frequent lifts. No evidence of compensation during lifts.						

Floor to Waist Dynamic Lift Test

Occasional Lift	Heart Rate	RPL	RFT	Frequent Lift	Heart Rate	RPL	RFT
20 lbs.	135 bpm	8	Self Limit	10 lbs.	146 bpm	8	Self Limit
Start Heart Rate:	106 bpm	HR Increase: Yes		Start Heart Rate:	122 bpm	HR Increase: Yes	
Comments:	Mr. Norge Gonzales Torres participated in floor to waist lifting. Appropriate changes in posture and accessory muscle recruitment were noted. Verbal cueing for proper maintenance of lumbar neutral was provided. He had a tendency to hold his breath during lifts and was cued to breathe normally. He was able to perform a full squat and ascend to standing while carrying 20 pounds without evidence of compensation.						

Floor to Shoulder Dynamic Lift Test

Occasional Lift	Heart Rate	RPL	RFT	Frequent Lift	Heart Rate	RPL	RFT
20 lbs.	141 bpm	8	Self Limit	NT lbs.	148 bpm	NA	Refused
Start Heart Rate	113 bpm	HR Increase: Yes		Start Heart Rate:	126 bpm	HR Increase: Yes	
Comments:	Norge Gonzales Torres participated in occasional lifting from floor to shoulder. This lift was terminated due to psychophysical reasons. He was able to perform a full squat to stand while carrying 20 pounds. He refused to attempt a frequent lift, reporting that his back was "too painful".						

Lift Capacity Performance: Inconsistent

Expected Linear Heart Rate Increase

Carry Testing

Occasional Carry	Heart Rate	RPL	RFT	Frequent Carry	Heart Rate	RPL	RFT
20 lbs. Bimanual	134 bpm	9	Self Limit	N/A lbs.	135 bpm	9	Self Limit
N/A lbs. Right	N/A bpm	N/A	N/A	N/A lbs.	N/A bpm	N/A	N/A
N/A lbs. Left	N/A bpm	N/A	N/A	N/A lbs.	N/A bpm	N/A	N/A
Start Heart Rate	114 bpm	HR Increase: Yes		Start Heart Rate:	122 bpm	HR Increase: Yes	
Comments:	30' Distance. Norge Gonzales Torres was given instruction and demonstration in proper carrying. He was able to lift and carry the above noted weights with good body mechanics and with normal visible signs of fatigue. Occasional lift was terminated due to reported pain and he refused to finish the frequent carry due to reported pain at the middle of his lumbar region.						

Push / Pull Testing

Occasional Push	Occasional Pull	Frequent Push/Pull	Heart Rate	RPL	RFT
48 lbs.	62 lbs.	50/30 lbs.	123 bpm	9	Self Limit
Peak Heart Rate: 112 bpm	Peak Heart Rate: 119 bpm	Start Heart Rate:	bpm	HR Increase:	
Comments:	The client pushed a BTE Hanoun strain gauge for occasional push pull testing and a sled was pushed for the frequent push for 20 feet. Frequent pushing and pulling were both terminated due to reported increased pain levels.				

Additional Testing

Occasional N/A	Heart Rate	RPL	RFT	Frequent N/A	Heart Rate	RPL	RFT
N/A lbs.	N/A bpm	N/A	N/A	N/A lbs.	N/A bpm	N/A	N/A
Start Heart Rate	N/A bpm	HR Increase: N/A		Start Heart Rate:	N/A bpm	HR Increase: N/A	
Comments:	N/A						

*RPL - Rate of Perceived Load

*RFT - Reason for Termination

Post Material Handling Blood Pressure: 144/86 mmHg

Sep. 6. 2011 4:02PM

No. 5648 P. 11/17

Functional Capacity Evaluation

Re: Jorge Gonzalez Torres DOB: October 22, 1972

Insurance I.D. No.: EHH9916

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No. 5648 P. 12/17

Functional Capacity Evaluation

Re: Norge Gonzalez Torres DOB: October 22, 1972

Insurance I.D. No.: EHH9916

POSITIONAL TOLERANCE:

	Frequency	Comments
Sitting	Constant	No deficit observed.
Standing	Frequent	No deficit observed.
Walking	Frequent	No deficit observed.
Stair Climbing	Frequent	Objective signs of fatigue observed. As the stair climbing sequence progressed, he demonstrated increased weight bearing on bilateral upper extremities on handrails for assistance and his cadence slowed considerably. HR 117-122 bpm.
Climb Ladders	Frequent	Objective signs of fatigue observed. Cadence slowed while ladder climbing and he started with a step through pattern of climbing and slowed to a step-to pattern. HR ranges 128-139 bpm.
Reach Desk Level	Frequent	No deficit observed. HR ranges 116-118 bpm.
Reach Overhead	Frequent	No deficit observed. HR ranges 107-122 bpm.
Reach Floor Level	Occasional	Elevated pain level. Self terminated due to pain with increased repetitions. HR ranges 125-132 bpm.
Balance	Frequent	No deficit observed.
Stoop	Frequent	Elevated pain level. HR ranges 119-134 bpm.
Kneel	Occasional	Pain behaviors observed. Started in high kneeling position and progressed to a position where he was sitting on his heels. HR ranges 116-124 bpm.
Crouch	Occasional	Attempted and unable to assume position. He was able to modify the position to a 1/2 kneel when he reported that he was unable to perform a full crouch due to pain. He refused to continue this activity due to reported pain. HR ranges 125-132 bpm.
Crawl	Occasional	Elevated pain level.

MANIPULATIVE ABILITY:

	Frequency	Comments
R Object Hand ling	Frequent	No deficit observed.
L Object Handling	Frequent	No deficit observed.
RFinger ing	Frequent	No deficit observed.
L Fingering	Frequent	No deficit observed.
RSimple Ha nd Grasp	Constant	No deficit observed.
L Simple Hand Grasp	Constant	No deficit observed.
RFirm Hand Grasp	Constant	No deficit observed.
L Firm Hand Grasp	Constant	No deficit observed.
RFine/Gro ss Manipulation	Frequent	No deficit observed.
L Fine/Gross Manipulation	Frequent	No deficit observed.

Additional Positional and Postural Tolerance Comments: Mr. Norge Gonzales Torres was observed to be inconsistent throughout the test. Inconsistencies in his performance included squatting: he was able to perform a full squat while lifting up to 20 pounds but couldn't ascend from a squat position without maximal assistance from bilateral upper extremities when prompted to perform a full squat; gait: at times his gait was antalgic with a slower cadence and at times was within normal limits. At the end of the test, he was using bilateral upper extremity assistance on the stairs.

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No. 5648 P. 13/17

Functional Capacity Evaluation

Re: Norgs Gonzalez Torres DOB: October 22, 1972

Insurance I.D. No.: EHH9916

yet when he left the clinic, he descended a curb without evidence of difficulty or wincing and without upper extremity assistance.

POST TEST VITAL SIGNS: Heart Rate: 119 bpm Blood Pressure: 138/90 mm/Hg

POST TEST PAIN LEVEL: 8/10

ADDITIONAL INFORMATION:

Sep. 6. 2011 4:02PM

No. 5648 P. 14/17

Functional Capacity Evaluation

Re: Norge Gonzalez Torres DOB: October 22, 1972

Insurance I.D. No.: EHH8916

PERFORMANCE CONSISTENCY**Maximal Voluntary Effort**

Grip Test	Grip Position														
	1			2			3			4			5		
Right Hand	50	30	41	40	45	55	67	62	61	55	47	55	55	35	40
Average	40.33			48.67			63.33			52.33			43.33		
Coefficient of Variation*	20%			13%			4%			7%			20%		
Left Hand	40	30	35	30	45	45	72	60	70	45	40	40	42	41	42
Average	35.00			40.33			67.33			41.67			41.67		
Coefficient of Variation*	12%			18%			8%			6%			1%		
7 of 10 Coefficient of Variation < 20% Consistent							1 of 2 Bell Shaped Curve Distributions								

HR(s): 99-108 Comments: The client reported no symptom increase with the above repetitive gripping task.

Pinch Strength Testing

Pinch Test	Tip Pinch			Palmar Pinch			Key Pinch		
Right Hand	13	15	12	19	21	23	22	23	28
Average	13.33			21.00			23.57		
Coefficient of Variation*	9%			8%			7%		
Left Hand	10	13	11	18	21	19	21	23	22
Average	11.33			19.33			22.00		
Coefficient of Variation*	11%			5%			4%		
6 of 8 Coefficient of Variation < 20% Inconsistent									

HR(s): 98-103 Comments: The client reported no symptom increase with the above repetitive pinch task.

Isometric Push / Pull

Test	Heart Rate	Trials (Pounds of Force)			Average	Standard Deviation	Coefficient of Variation*
		Trial 1	Trial 2	Trial 3			
Isometric Push	103-112	48.00	48.00	55.00	50.33	3.30	7%
Isometric Pull	109-119	62.00	61.00	61.00	61.33	0.47	1%
2 of 2 Coefficient of Variation < 15% Consistent							

Comments: The above Isometric testing was performed using a BTE Hanoun Strain Gauge for all activities. During the above isometric testing there were no voiced complaints of increased symptoms. Appropriate physiological response without any compensatory movements observed.

Sep. 6. 2011 4:02PM

No. 5648 P. 15/17

Functional Capacity EvaluationRe: Norge Gonzalez Torres
EHH9916

DOB: October 22, 1972

Insurance I.D. No.:

ACTIVE RANGE OF MOTION / STRENGTH

SPINE		NORM	AROM (Degrees)	☐ N/A
Cervical	Flexion	50°	20	
	Extension	60°	23	
	Right Lateral Flexion	45°	32	
	Left Lateral Flexion	45°	27	
	Right Rotation	80°	53	
	Left Rotation	80°	58	
Thoracic	Flexion	60°	11	
	Right Rotation	30°	5	
	Left Rotation	30°	10	
Lumbar	Flexion	60°	10	
	Extension	25°	4	
	Right Lateral Flexion	25°	5	
	Left Lateral Flexion	25°	3	
	Right SLR	80°	52	
	Left SLR	80°	52	

UPPER EXTREMITY		NORM	Right AROM	Left AROM	Right Strength	Left Strength	☐ N/A
Shoulder	Flexion	180°	WNL	WNL	5/5	5/5	
	Extension	50°	WNL	WNL	5/5	5/5	
	Abduction	180°	WNL	WNL	5/5	5/5	
	Adduction	40°	WNL	WNL	5/5	5/5	
	Internal Rotation	90°	WNL	WNL	5/5	5/5	
	External Rotation	90°	WNL	WNL	5/5	5/5	
Elbow	Flexion	140°	WNL	WNL	5/5	5/5	
	Extension	0°	WNL	WNL	5/5	5/5	
	Supination	80°	WNL	WNL	5/5	5/5	
	Pronation	80°	WNL	WNL	5/5	5/5	
Wrist	Flexion	80°	WNL	WNL	5/5	5/5	
	Extension	70°	WNL	WNL	5/5	5/5	
	Radial Deviation	20°	WNL	WNL	5/5	5/5	
	Ulnar Deviation	30°	WNL	WNL	5/5	5/5	

LOWER EXTREMITY		NORM	Right AROM	Left AROM	Right Strength	Left Strength	☐ N/A
Hip	Flexion	120°	85	78	4+/5	4/5	
	Extension	30°	12	10	4+/5	4+/5	
	Abduction	45°	18	21	4+/5	4+/5	
	Adduction	30°	8	8	5/5	5/5	
	Internal Rotation	45°	30	30	5/5	5/5	
	External Rotation	45°	36	47	5/5	5/5	
Knee	Flexion	135°	128	124	5/5	5/5	
	Extension	0°	0	0	5/5	5/5	
Ankle	Plantar Flexion	50°	WNL	WNL	5/5	5/5	
	Dorsiflexion	20°	WNL	WNL	5/5	5/5	
	Inversion	35°	WNL	WNL	5/5	5/5	
	Eversion	15°	WNL	WNL	5/5	5/5	

Normative Data - AMA Guides to the Evaluation of Permanent Impairment, 8th Edition
 - Normative Data - Rehabilitation of the Hand: Surgery and Therapy, 4th Edition
 - Normative Data - American Academy of Orthopedic Surgeons

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Sep. 6. 2011 4:03PM

No. 5648 P. 16/17

Functional Capacity EvaluationRe: Norge Gonzalez Torres
EHH9916

DOB: October 22, 1972

Insurance I.D. No.:

HAND		NORM*	Right AROM (Degrees)	Left AROM (Degrees)	Right Strength	Left Strength
Thumb	CMC Flexion	15°	WNL	WNL	5/5	5/5
	CMC Extension	20°	WNL	WNL	5/5	5/5
	CMC Abduction	70°	WNL	WNL	5/5	5/5
	MCP Flexion	50°	WNL	WNL	5/5	5/5
	MCP Extension	0°	WNL	WNL	5/5	5/5
	IP Flexion	90°	WNL	WNL	5/5	5/5
	IP Extension	0°	WNL	WNL	5/5	5/5
Index	MCP Flexion	90°	WNL	WNL	5/5	5/5
	MCP Extension	Up to 45°	WNL	WNL	5/5	5/5
	PIP Flexion	110°	WNL	WNL	5/5	5/5
	PIP Extension	0°	WNL	WNL	5/5	5/5
	DIP Flexion	60°	WNL	WNL	5/5	5/5
	DIP Extension	0°	WNL	WNL	5/5	5/5
Long	MCP Flexion	90°	WNL	WNL	5/5	5/5
	MCP Extension	Up to 45°	WNL	WNL	5/5	5/5
	PIP Flexion	110°	WNL	WNL	5/5	5/5
	PIP Extension	0°	WNL	WNL	5/5	5/5
	DIP Flexion	60°	WNL	WNL	5/5	5/5
	DIP Extension	0°	WNL	WNL	5/5	5/5
Ring	MCP Flexion	90°	WNL	WNL	5/5	5/5
	MCP Extension	Up to 45°	WNL	WNL	5/5	5/5
	PIP Flexion	110°	WNL	WNL	5/5	5/5
	PIP Extension	0°	WNL	WNL	5/5	5/5
	DIP Flexion	60°	WNL	WNL	5/5	5/5
	DIP Extension	0°	WNL	WNL	5/5	5/5
Small	MCP Flexion	90°	WNL	WNL	5/5	5/5
	MCP Extension	Up to 45°	WNL	WNL	5/5	5/5
	PIP Flexion	110°	WNL	WNL	5/5	5/5
	PIP Extension	0°	WNL	WNL	5/5	5/5
	DIP Flexion	60°	WNL	WNL	5/5	5/5
	DIP Extension	0°	WNL	WNL	5/5	5/5

Normative Data - American Academy of Orthopedic Surgeons, Rehabilitation of the Hand: Surgery and Therapy, 4th Edition

Hand Volume		Right		Left	
	Pretest		ml	Pretest	ml
	Post Test		ml	Post Test	ml
	Difference	+	ml	Difference	+

* Rehabilitation of the Hand: Surgery and Therapy, 4th Edition - Fluid volume changes are often 20 to 50 ml or more between one measurement and the next if swelling is present.

Circumference		Right		Left	
	Pretest		cm	Pretest	cm
	Post Test		cm	Post Test	cm
	Difference	+	cm	Difference	+
	Right (Pretest)		cm	Pretest	cm
	Right (Post Test)		cm	Post Test	cm
	Right Difference	+	cm	Difference	+
	Pretest		cm	Pretest	cm
	Post Test		cm	Post Test	cm
	Difference	+	cm	Difference	+

* Rehabilitation of the Hand: Surgery and Therapy, 4th Edition - Circumferential measurements of the hand and fingers or areas of swelling

Opposition		Right	Index - WNL	Long - WNL	Ring - WNL	Small - WNL
	Left		Index - WNL	Long - WNL	Ring - WNL	Small - WNL

* American Academy of Orthopedic Surgeons - Tip of thumb to base of tip of small digit.

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Sep. 6. 2011 4:03PM

No. 5648 P. 17/17

Functional Capacity Evaluation

Re: Norge Gonzalez Torres DOB: October 22, 1972
EHH9916

Insurance I.D. No.:

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Jacksonville, FL 32220
Phone: 904-928-1133
Fax: 904-996-7001

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-PR780-

WORLD FIBER TECHNOLOGIES, INC.
PAGE 1

PAYMENT HISTORY BY EMPLOYEE AND MONEY KEY
EMPLOYEES GONZAN THRU GONZAN
INCLUDES SECURED EMPLOYEES
Money Key: 100 FIELD REGULAR

DATE PROCESSED 04/05/10
TIME PROCESSED 16:38:51
INCLUDES ALL CHECKS

EMPL
NUMBER NAME

GONZAN NORGE LORENZO GONZALEZ-TORRES

AMOUNT	HOURS	CHECK DATE	CHECK NUMBER	*JOUR	NOS*	ACCTING DATE
440.00	40.00	8/07/09	006930	PC290	PE290	8/07/09
434.50	39.50	8/14/09	007055	PC291	PE291	8/14/09
440.00	40.00	8/21/09	007170	PC292	PE292	8/21/09
253.00	23.00	8/28/09	007287	PC293	PE293	8/28/09
368.50	33.50	9/04/09	007407	PC294	PE294	9/04/09
440.00	40.00	9/11/09	007528	PC295	PE295	9/11/09
440.00	40.00	9/18/09	007647	PC296	PE296	9/18/09
440.00	40.00	9/25/09	007763	PC297	PE297	9/25/09
440.00	40.00	10/02/09	007886	PC298	PE298	10/02/09
203.50	18.50	10/09/09	008009	PC299	PE299	10/09/09
440.00	40.00	10/16/09	008133	PC300	PE300	10/16/09
440.00	40.00	10/23/09	008257	PC301	PE301	10/23/09
220.00	20.00	10/30/09	008389	PC302	PE302	10/30/09
363.00	33.00	11/06/09	008519	PC303	PE303	11/06/09
330.00	30.00	11/13/09	008651	PC304	PE304	11/13/09
407.00	37.00	11/20/09	008783	PC305	PE305	11/20/09
440.00	40.00	11/27/09	008913	PC306	PE306	11/27/09
148.50	13.50	12/04/09	009038	PC307	PE307	12/04/09 11-22/11-28
374.00	34.00	12/11/09	009165	PC308	PE308	12/11/09 11-29/12-5
396.00	36.00	12/18/09	009292	PC309	PE309	12/18/09 12-6/12-12
385.00	35.00	12/24/09	009416	PC310	PE310	12/24/09 12-13/12-19
352.00	32.00	12/31/09	009540	PC311	PE311	12/31/09 12-20/12-26
352.00	32.00	1/15/10	009779	PC313	PE313	1/15/10 1-3/1-9
440.00	40.00	1/22/10	009906	PC314	PE314	1/22/10 1-10/1-16
434.50	39.50	1/29/10	010036	PC315	PE315	1/29/10 1-17/1-23
440.00	40.00	2/05/10	010168	PC316	PE316	2/05/10 1-24/1-30
396.00	36.00	2/12/10	010301	PC317	PE317	2/12/10 1-31/2-6
352.00	32.00	2/19/10	010435	PC318	PE318	2/19/10 2-7-2/14
264.00	24.00	2/26/10	010569	PC319	PE319	2/26/10 2-14/2-20
385.00	35.00	3/05/10	010699	PC320	PE320	3/05/10 2-21/2-27

EMPLOYEE TOTALS

11,258.50 1,023.50

FINAL TOTALS

11,258.50 1,023.50

Gross \$ 8417.75
thru -
Ad 12/31/09

21
WKS

-PR780-
WORLD FIBER TECHNOLOGIES, INC.
PAGE 1

PAYMENT HISTORY BY EMPLOYEE AND MONEY KEY
EMPLOYEES GONZAN THRU GONZAN
INCLUDES SECURED EMPLOYEES
Money Key: 101 FIELD-OVERTIME

DATE PROCESSED 04/05/10
TIME PROCESSED 16:37:37
INCLUDES ALL CHECKS

EMPL NUMBER	NAME	AMOUNT	HOURS	CHECK DATE	CHECK NUMBER	*JOUR	NOS*	ACCTING DATE
GONZAN NORGE LORENZO GONZALEZ-TORRES		16.50	1.00	8/21/09	007170	PC292	PE292	8/21/09
		49.50	3.00	10/16/09	008133	PC300	PE300	10/16/09
		156.75	9.50	11/27/09	008913	PC306	PE306	11/27/09
		~~82.50~~	~~3.00~~	1/22/10	009906	PC314	PE314	1/22/10
EMPLOYEE TOTALS		305.25	18.50					
FINAL TOTALS		305.25	18.50					

Data from healthy populations, when available and widely referenced, are incorporated into chapters of the *Guides*. In some organ or body systems, such as respiratory, certain measurements of lung function have been standardized for age and gender. In other body systems, such as the musculoskeletal, age and gender differences are not reflected in most of the values. While there may be age and gender differences anticipated for some musculoskeletal values, such as range of motion in the spine and extremities, this edition of the *Guides* mainly reflects average range of motion from healthy populations of mixed age and gender. The normal values presented in the musculoskeletal section are based on a review of studies measuring range of motion, as cited in the text. Evaluating physicians may use their clinical judgment, however, and comment on any significant age or gender effect for a particular individual. For instance, the "normal" preinjury range of motion for a gymnast with hypermobility may exceed the listed normal values.

If an individual had previous measurements of function that were below or above average population values, the physician may discuss that prior value and any subsequent loss for the individual, as well as compare it to the population normal. For example, a highly functioning athlete with documented, above-normal lung function, who has sustained an injury and now has decreased lung function that is nonetheless similar to population averages, has experienced a loss in his or her lung function and has sustained an impairment. Based only on a population comparison, the athlete would be given a 0% impairment rating. However, it would be more appropriate in this instance for the physician to assign an impairment rating based on the degree of change from the athlete's preinjury to postinjury state.

In evaluating impairment, the *Guides* considers both anatomic and functional loss. Some chapters place a greater emphasis on either anatomic or functional loss, depending upon common practice in that specialty. *Anatomic loss* refers to damage to the organ system or body structure, while *functional loss* refers to a change in function for the organ or body system. An example of an anatomic deviation is development of heart enlargement; functional loss includes a loss in ejection fraction or the ability of the heart to pump adequately. Anatomic loss receives greater emphasis in the musculoskeletal system, as in measurements such as range of motion. Functional considerations receive greater emphasis in the mental and behavioral section.

The impairment criteria outlined in the *Guides* provide a standardized method for physicians to use to determine medical impairment. The impairment criteria include diagnostic criteria, incorporating anatomic and functional measures. The impairment criteria were developed from scientific evidence as cited and from consensus of chapter authors or of medical specialty societies.

Impairment percentages or ratings developed by medical specialists are consensus-derived estimates that reflect the severity of the medical condition and the degree to which the impairment decreases an individual's ability to perform common activities of daily living (ADL), *excluding* work. Impairment ratings were designed to reflect functional limitations and not disability. The whole person impairment percentages listed in the *Guides* estimate the impact of the impairment on the individual's overall ability to perform activities of daily living, *excluding* work, as listed in Table 1-2.

Table 1-2. Activities of Daily Living Commonly Measured in Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) Scales ^{6,7}

Activity	Example
Self-care, personal hygiene	Urinating, defecating, brushing teeth, combing hair, bathing, dressing oneself, eating
Communication	Writing, typing, seeing, hearing, speaking
Physical activity	Standing, sitting, reclining, walking, climbing stairs
Sensory function	Hearing, seeing, tactile feeling, tasting, smelling
Nonspecialized hand activities	Grasping, lifting, tactile discrimination
Travel	Riding, driving, flying
Sexual function	Orgasm, ejaculation, lubrication, erection
Sleep	Restful, nocturnal sleep pattern

The medical judgment used to determine the original impairment percentages could not account for the diversity or complexity of work but could account for daily activities common to most people. Work is not included in the clinical judgment for impairment percentages for several reasons: (1) work involves many simple and complex activities; (2) work is highly individualized, making generalizations inaccurate; (3) impairment percentages are unchanged for stable conditions, but work and occupations change; and (4) impairments interact with such other factors as the worker's age, education, and prior work experience to determine the extent of work disability. For example, an individual who receives a 30% whole person impairment due to pericardial heart disease is considered from a clinical standpoint to have a 30% reduction in general functioning as represented by a decrease in the ability to perform activities of daily living. For individuals who work in sedentary jobs, there may be no decline in their work ability although their overall functioning is decreased. Thus, a 30% impairment rating does not correspond to a 30% reduction in work capability. Similarly, a manual laborer with this 30% impairment rating due to pericardial disease may be completely unable to do his or her regular job and, thus, may have a 100% work disability.

As a result, impairment ratings are not intended for use as direct determinants of work disability. When a physician is asked to evaluate work-related disability, it is appropriate for a physician knowledgeable about the work activities of the patient to discuss the specific activities the worker can and cannot do, given the permanent impairment.

Most impairment percentages in this fifth edition have been retained from the fourth edition because there are limited scientific data to support specific changes. It is recognized that there are limited data to support some of the previous impairment percentages as well. However, these ratings are currently accepted and should not be changed arbitrarily. In this edition, some percentages have been changed for greater scientific accuracy or to achieve consistency throughout the book.

A 0% whole person (WP) impairment rating is assigned to an individual with an impairment if the impairment has no significant organ or body system functional consequences and does not limit the performance of the common activities of daily living

indicated in Table 1-2. A 90% to 100% WP impairment indicates a very severe organ or body system impairment requiring the individual to be fully dependent on others for self-care, approaching death.

The activities of daily living, as originally developed for the *Guides* in the first and second editions,^{1,6} signify common activities currently represented in scales of Activities of Daily Living and Instrumental Activities of Daily Living.⁷ The *Guides* refers to common ADLs, as listed in Table 1-2. The ADLs listed in this table correspond to the activities that physicians should consider when establishing a permanent impairment rating. A physician can often assess a person's ability to perform ADLs based on knowledge of the patient's medical condition and clinical judgment. When the physician is estimating a permanent impairment rating, Table 1-2 can help to determine how significantly the impairment impacts these activities. Using the impairment criteria within a class and knowing the activities the individual can perform, the physician can estimate where the individual stands within that class.

There are many scales that measure ability to perform ADLs with greater degrees of accuracy. Many of these scales are concerned with more severe levels of disability, relevant to institutionalized patients and the elderly.⁷ During the 1970s, the ADL concept was extended to consider problems experienced by those living in the community, a field that has come to be termed Instrumental Activities of Daily Living (IADL).⁷ There is a continued effort to validate these scales; some of the more commonly utilized, validated IADL and ADL scales are listed in Table 1-3.⁷ Scales vary in their appropriateness for a given individual, based upon the level of impairment, body systems affected, and degree of accuracy required. Some scales are most appropriate for an active, working population; others are more suited to a chronically ill, disabled population. Since there is no agreed-upon scale for a working population and physicians who use the *Guides* may evaluate different populations of individuals (ie, healthy or chronically ill), a physician may choose the most appropriate of any of the validated scales for a more in-depth assessment of ADL, to obtain further information to supplement clinical judgment, or to gain assistance in determining where an individual stands within an impairment range.

5. If the individual does not have multilevel involvement or multiple recurrences/occasions and an injury occurred, determine the proper DRE category. Most ratings will fall into categories I, II, or III. A corticospinal tract injury is evaluated according to Section 15.7.
6. If the individual has been treated with surgery or another modality, evaluate the results, extent of improvement, and impact on the ability to perform activities of daily living. If residual symptoms or objective findings impact the ability to perform ADL despite treatment, the higher percentage in each range should be assigned. If an individual had a prior condition, was asymptomatic, and now—at MMI—has symptoms that impact the ability to perform activities of daily living, the higher rating within a range may also be used. If ratings are increased, explicit documentation of the reasons for the increase should be included in the report.
7. If more than one spine region is impaired, determine the impairment of the other region(s) with the DRE method. Combine the regional impairments using the Combined Values Chart (p. 604) to express the individual's total spine impairment.
8. From historical information and previously compiled medical data, determine if there was a preexisting impairment. Congenital, developmental, and other preexisting conditions may be differentiated from those attributable to the injury or illness by examining preinjury roentgenograms or by performing a bone scan after the onset of the condition.
9. If requested, apportion findings to the current or prior condition, following jurisdiction practices and assuming adequate information is available on the prior condition. In some instances, to apportion ratings, the percent impairment due to previous findings can simply be subtracted from the percent based on the current findings. Ideally, use the same method to compare the individual's prior and present conditions. If the ROM method has been used previously, it must be used again. If the previous evaluation was based on the DRE method and the individual now is evaluated with the ROM method, and prior ROM measurements do not exist to calculate a ROM impairment rating, the previous DRE percent can be subtracted from the ROM ratings. Because there are two methods and complete data may not exist on an earlier assessment, the apportionment calculation may be a less than ideal estimate.
10. For individuals with corticospinal tract involvement, refer to Table 15-6 for the appropriate impairment rating.

15.3 Diagnosis-Related Estimates Method

The DRE method has eight diagnosis-related categories for each of the three spinal regions. In assigning the individual to the correct DRE category, one of two approaches is used. The first is based on symptoms, signs, and appropriate diagnostic test results. The second is based on the presence of fractures and/or dislocations with or without clinical symptoms. If a fracture is present that places the individual into a DRE category, no other verification is required. The symptoms, signs other than fractures, and tests used to assist correct categorization of an individual are defined in Box 15-1.

Box 15-1 Definitions of Clinical Findings Used to Place an Individual in a DRE Category**Muscle Spasm**

Muscle spasm is a sudden, involuntary contraction of a muscle or group of muscles. Paravertebral muscle spasm is common after acute spinal injury but is rare in chronic back pain. It is occasionally visible as a contracted paraspinal muscle but is more often diagnosed by palpation (a hard muscle). To differentiate true muscle spasm from voluntary muscle contraction, the individual should not be able to relax the contractions. The spasm should be present standing as well as in the supine position and frequently causes a scoliosis. The physician can sometimes differentiate spasm from voluntary contraction by asking the individual to place all his or her weight first on one foot and then the other while the physician gently palpates the paraspinal muscles. With this maneuver, the individual normally relaxes the paraspinal muscles on the weight-bearing side. If the examiner witnesses this relaxation, it usually means that true muscle spasm is not present.

Muscle Guarding

Guarding is a contraction of muscle to minimize motion or agitation of the injured or diseased tissue. It is not true muscle spasm because the contraction can be relaxed. In the lumbar spine, the contraction frequently results in loss of the normal lumbar lordosis, and it may be associated with reproducible loss of spinal motion.

Asymmetry of Spinal Motion

Asymmetric motion of the spine in one of the three principal planes is sometimes caused by muscle spasm or guarding. That is, if an individual attempts to flex the spine, he or she is unable to do so moving symmetrically; rather, the head or trunk leans to one side. To qualify as true asymmetric motion, the finding must be reproducible and consistent and the examiner must be convinced that the individual is cooperative and giving full effort.

Nonverifiable Radicular Root Pain

Nonverifiable pain is pain that is in the distribution of a nerve root but has no identifiable origin; ie, there are no objective physical, imaging, or electromyographic findings. For dermatomal distributions, see Figures 15-1 and 15-2.

Reflexes

Reflexes may be normal, increased, reduced, or absent. For reflex abnormalities to be considered valid, the involved and normal limb(s) should show marked asymmetry between arms or legs on repeated testing. Once lost because of previous radiculopathy, a reflex rarely returns. Abnormal reflexes such as Babinski signs or clonus may be signs of corticospinal tract involvement.

Weakness and Loss of Sensation

To be valid, the sensory findings must be in a strict anatomic distribution, ie, follow dermatomal patterns (see Figures 15-1 and 15-2). Motor findings should also be consistent with the affected nerve structure(s). Significant, long-standing weakness is usually accompanied by atrophy.

Atrophy

Atrophy is measured with a tape measure at identical levels on both limbs. For reasons of reproducibility, the difference in circumference should be 2 cm or greater in the thigh and 1 cm or greater in the arm, forearm, or leg. The evaluator can address asymmetry due to extremity dominance in the report.

Radiculopathy

Radiculopathy for the purposes of the *Guides* is defined as significant alteration in the function of a nerve root or nerve roots and is usually caused by pressure on one or several nerve roots. The diagnosis requires a dermatomal distribution of pain, numbness, and/or paresthesias in a dermatomal distribution. A root tension sign is usually positive. The diagnosis of herniated disk must be substantiated by an appropriate finding on an imaging study. The presence of findings on an imaging study in and of itself does not make the diagnosis of radiculopathy. There must also be clinical evidence as described above.

Electrodiagnostic Verification of Radiculopathy

Unequivocal electrodiagnostic evidence of acute nerve root pathology includes the presence of multiple positive sharp waves or fibrillation potentials in muscles innervated by one nerve root. However, the quality of the person performing and interpreting the study is critical. Electromyography should

be performed only by a licensed physician qualified by reason of education, training, and experience in these procedures. Electromyography does not detect all compressive radiculopathies and cannot determine the cause of the nerve root pathology. On the other hand, electromyography can detect noncompressive radiculopathies, which are not identified by imaging studies.

Alteration of Motion Segment Integrity

Motion segment alteration can be either loss of motion segment integrity (increased translational or angular motion) or decreased motion secondary to developmental fusion, fracture healing, healed infection, or surgical arthrodesis. An attempt at arthrodesis may not necessarily result in a solid fusion but may significantly limit motion at a motion segment. Motion of the individual spine segments cannot be determined by a physical examination but is evaluated with flexion and

extension roentgenograms. The loss of motion segment integrity is defined in Section 15.1b.

Cauda Equina Syndrome

Cauda equina syndrome is manifested by bowel or bladder dysfunction, saddle anesthesia, and variable loss of motor and sensory function in the lower extremities. Individuals with cauda equina syndrome usually have loss of sphincter tone on rectal examination and diminished or absent bladder, bowel, and lower limb reflexes.

Urodynamic Tests

Cystometrograms are useful in individuals where a cauda equina syndrome is possible but not certain. A normal cystometrogram makes the presence of a nerve-related bladder dysfunction unlikely. Occasionally, more extensive urodynamic testing is necessary.

To use the DRE method, obtain an individual's history, examine the individual, review the results of appropriate diagnostic studies, and place the individual in the appropriate category. Although there are eight categories, almost all individuals will fall into one of the first three DRE categories. Altered motion segment integrity (ie, increased motion or loss of motion) qualifies the individual for category IV or V. A fracture and/or dislocation, with or without clinical symptoms, permits placement of the individual into a DRE category with no additional verification. If there are impairments in different spinal regions, rate each spinal region separately using the DRE method; then combine the ratings using the Combined Values Chart on page 604. As stated previously, fractures at more than one level in the same spinal region should be rated using the ROM method.

In most cases, using the definitions provided in Box 15-1, the physician can assign an individual to DRE category I, II, or III. An individual in category I has only subjective findings. In category II, the individual has objective findings but no radiculopathy or alteration of structural integrity, while in category III, radiculopathy with objective verification must be present. Since an individual is evaluated after having reached MMI, a previous history of objective findings may not define the current, ratable condition but is important in determining the course and whether

MMI has been reached. *The impairment rating is based on the condition once MMI is reached, not on prior symptoms or signs.*

If the individual had a radiculopathy caused by a herniated disk or lateral spinal stenosis that responded to conservative treatment and currently has no radicular symptoms or signs, he or she is placed in category II, since at MMI there is no radiculopathy. Category III is for individuals with a symptomatic radiculopathy, either after medical or surgical treatment, or for individuals who have a history of previous radiculopathy caused by disk herniation or lateral spinal stenosis but have improved or become asymptomatic following surgery.

The DRE method recommends that physicians document physiologic and structural impairments relating to injuries or diseases other than common developmental findings, such as (1) spondylolysis, found normally in 7% of adults; (2) spondylolisthesis, found in 3% of adults; (3) herniated disk without radiculopathy, found in approximately 30% of individuals by age 40 years; and (4) aging changes, present in 40% of adults after age 35 years and in almost all individuals after age 50.^{6,12} As previously noted, the presence of these abnormalities on imaging studies does not necessarily mean the individual has an impairment due to an injury.

In cases where the abnormalities discussed above are present on imaging studies and are known or assumed to have preexisted an injury being rated, physicians should acknowledge these antecedent conditions. If requested, physicians may need to assess whether the condition was previously symptomatic and whether any aggravation occurred as a result of the injury. Physicians should be aware of the statutory definition in the involved jurisdiction pertaining to *aggravation* to ensure their use of the term is consistent with their state's legal interpretation.

DRE categories are discussed in the following three sections.

15.4 DRE: Lumbar Spine

The lumbar spine DRE categories are summarized in Table 15-3. Apart from category I, each category includes a range to account for the resolution or continuation of symptoms and their impact on the ability to perform ADL.

Table 15-3. Criteria for Rating Impairment Due to Lumbar Spine Injury

DRE Lumbar Category I 0% Impairment of the Whole Person	DRE Lumbar Category II 5%-8% Impairment of the Whole Person	DRE Lumbar Category III 10%-13% Impairment of the Whole Person	DRE Lumbar Category IV 20%-23% Impairment of the Whole Person	DRE Lumbar Category V 25%-28% Impairment of the Whole Person
No significant clinical findings, no observed muscle guarding or spasm, no documentable neurologic impairment, no documented alteration in structural integrity, and no other indication of impairment related to injury or illness; no fractures	Clinical history and examination findings are compatible with a specific injury; findings may include significant muscle guarding or spasm observed at the time of the examination, asymmetric loss of range of motion, or nonverifiable radicular complaints, defined as complaints of radicular pain without objective findings; no alteration of the structural integrity and no significant radiculopathy <i>or</i> individual had a clinically significant radiculopathy and has an imaging study that demonstrates a herniated disk at the level and on the side that would be expected based on the previous radiculopathy, but no longer has the radiculopathy following conservative treatment <i>or</i> fractures: (1) less than 25% compression of one vertebral body; (2) posterior element fracture without dislocation (not developmental spondylolysis) that has healed without alteration of motion segment integrity; (3) a spinous or transverse process fracture with displacement without a vertebral body fracture, which does not disrupt the spinal canal	Significant signs of radiculopathy, such as dermatomal pain and/or in a dermatomal distribution, sensory loss, loss of relevant reflex(es), loss of muscle strength or measured unilateral atrophy above or below the knee compared to measurements on the contralateral side at the same location; impairment may be verified by electrodiagnostic findings <i>or</i> history of a herniated disk at the level and on the side that would be expected from objective clinical findings, associated with radiculopathy, or individuals who had surgery for radiculopathy but are now asymptomatic <i>or</i> fractures: (1) 25% to 50% compression of one vertebral body; (2) posterior element fracture with displacement disrupting the spinal canal; in both cases, the fracture has healed without alteration of structural integrity	Loss of motion segment integrity defined from flexion and extension radiographs as at least 4.5 mm of translation of one vertebra on another or angular motion greater than 15° at L1-2, L2-3, and L3-4, greater than 20° at L4-5, and greater than 25° at L5-S1 (Figure 15-3); may have complete or near complete loss of motion of a motion segment due to developmental fusion, or successful or unsuccessful attempt at surgical arthrodesis <i>or</i> fractures: (1) greater than 50% compression of one vertebral body without residual neurologic compromise	Meets the criteria of DRE lumbosacral categories III and IV; that is, both radiculopathy and alteration of motion segment integrity are present; significant lower extremity impairment is present as indicated by atrophy or loss of reflex(es), pain, and/or sensory changes within an anatomic distribution (dermatomal), or electromyographic findings as stated in lumbosacral category III and alteration of spine motion segment integrity as defined in lumbosacral category IV <i>or</i> fractures: (1) greater than 50% compression of one vertebral body with unilateral neurologic compromise

Example 15-18**78% Impairment Due to Burst Fracture With Cauda Equina Syndrome**

Subject: 54-year-old woman.

History: Fell from a ladder and sustained a burst fracture of L2 with a loss of height of 35%. In addition to numbness and weakness of both lower extremities, she was unable to empty her bladder and required catheterization. Following anterior decompression of the cauda equina and fusion from L1 to L3, the fractures healed, and she regained partial function in the muscles innervated by the L2 and lower nerve roots.

Current Symptoms: Persistent weakness of both lower extremities requiring the use of ankle-foot orthoses. Walks using two crutches. Requires intermittent catheterization of her bladder. She has occasional bowel incontinence.

Physical Exam: Mild tenderness to palpation at the fracture site. Neurologic examination reveals weakness of L2 to S1 innervated muscle and numbness and atrophy of both lower extremities. Decreased rectal tone. Knee and ankle reflexes are absent.

Clinical Studies: Repeat x-rays of the region: solid fusion from L1 to L3.

Diagnosis: Burst fracture L2 with cauda equina syndrome.

Impairment Rating: 78% impairment of the whole person.

Comment: Her lower extremity weakness and use of orthoses and crutches indicate a class 3, or 39%, WPI. The bladder impairment, requiring intermittent catheterization, indicates a class 4, or 50%, WPI. Her rectal tone is decreased, with occasional bowel incontinence, indicating a class 2 anorectal impairment of 20%. The burst fracture receives a DRE lumbar category III rating of 10%. Combining 50%, 39%, 20%, and 10% results in a combined whole person impairment of 78%.

15.8 Range-of-Motion Method

Although called the range-of-motion method, this evaluation method actually consists of three elements that need to be assessed: (1) the range of motion of the impaired spine region; (2) accompanying diagnoses (Table 15-7); and (3) any spinal nerve deficit, which is described in this chapter and in Chapter 13 (The Central and Peripheral Nervous System). Mobility, diagnoses, and nerve root deficits all provide important clinical information about function of an individual's spine.¹⁵⁻²¹ An impairment rating based on loss of motion is valid only if there is medical evidence of a documented injury or illness with a permanent anatomic and/or physiologic residual dysfunction. The whole person impairment rating is obtained by combining ratings from all three components, using the Combined Values Chart (p. 604).

All impairment estimates shown in the tables of this section are expressed as whole person impairments. Section 15.13 explains how to express a whole person spine impairment as a regional spine impairment. Tables 15-8 through 15-14 provide estimates for rating ankylosis and range of motion, while neurologic impairments are rated based on Tables 15-15 through 15-18. The data on standards and normal functioning described in this section are based on both medical studies and consensus judgments.^{15,18-27}

As previously stated (Section 15.2) the ROM method should be used only (1) if the DRE method is not applicable (no verifiable injury); (2) if, after obtaining the history and performing the examination, the physician cannot place the individual within a multilevel DRE category; (3) if multilevel involvement and/or alteration of motion segment integrity has occurred in the same spinal region; (4) if there is recurrent radiculopathy caused by a new (recurrent) disk herniation or a recurrent injury in the same spinal region; (5) if there are multiple episodes of other pathology producing alteration of motion segment integrity and/or radiculopathy; or (6) if statutorily mandated by the involved jurisdiction.

Concerns have been raised by users of the *Guides* regarding perceived age- and gender-related variations in the normal population, which may bias impairments in favor of males or older individuals, both of whom are perceived to be less flexible and therefore may be judged "impaired" even under normal circumstances. Since preparation of the fourth edition, some scientific evidence has accumulated and several relevant articles have been identified.²⁷⁻⁴⁵

Regarding gender, the scientific evidence is inconsistent. The majority of studies actually show a non-significant trend toward greater motion for male normal individuals in each age group. The only movement showing any statistically significant gender difference is cervical extension, and then only in younger women. This finding is inconsistent among various studies, however, and the difference disappears with advancing age.^{35,41}

There is a decrease in normal motion with advancing age, but the effect is not linear. Most studies examining a wide spectrum of age groups find greater alterations in mobility below 20 and above 60 years of age. Several studies suggest that lifestyle factors may influence flexibility far more than inherent factors, as the variability of overall motion between individuals increases with advancing years. However, the evidence is inconsistent, and the changes in normative data too small for the most relevant age groups 20 to 59, to warrant age adjustment in this edition of the *Guides*.

15.8a General ROM Method Measurement Principles

Impairment should be evaluated when the condition has stabilized after completion of all necessary medical, surgical, and rehabilitative treatment. This principle precludes rating an acute illness or injury. For example, if acute muscle spasm is present, this should be noted in the examiner's report; however, the mobility measurements would not be valid for estimating permanent impairment. Because the *Guides* only considers permanent impairment, rating should be deferred until after any acute exacerbation of the chronic condition has subsided, ie, when the individual is at MMI (see Chapter 1 and the Glossary).

Pain, fear of injury, disuse, or neuromuscular inhibition may limit mobility by diminishing the individual's effort, leading to inaccurately low and inconsistent measurements. *The physician should seek consistency when testing active motion, strength, and sensation. Tests with inconsistent results should be repeated. Results that remain inconsistent should be disregarded. When the physiologic measurements fail to match known pathology, they should be repeated and, if still inconsistent, disallowed until documented evidence is provided for the abnormalities noted on the physical examination.*

The reproducibility (precision) of an individual's performance is one (but not the sole) indicator of optimum effort. When measuring range of motion, the examiner should obtain at least three consecutive measurements and calculate the mean (average) of the three. Measurements should not change substantially with repeated efforts. If the average is less than 50°, three consecutive measurements must fall within 5° of the mean; if the average is greater than 50°, three consecutive measurements must fall within 10% of the mean. Motion testing may be repeated up to six times to obtain three consecutive measurements that meet these criteria. If after six measurements inconsistency persists, the spinal motions are considered invalid. The measurements and accompanying impairment estimates may then be disallowed, in part or in their entirety.

There are multiple potential sources of error in a quantitative physical examination.^{17,20,21} The greatest source of error that occurs is due to test administrator inexperience or lack of knowledge. The evaluator should also ensure adequate warm-up movements have been performed.¹⁶ When possible, the individual being evaluated should warm up prior to the ROM measurements: flexion and extension twice, left and right rotation twice, left and right lateral bending twice, and one additional flexion and extension. The warm-up movements do not need to be repeated before each subsequent test of motions of the same spinal region.

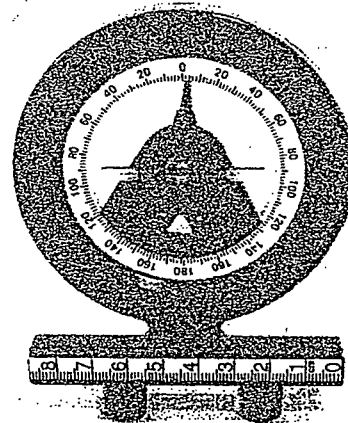
The physician also needs to ensure the anatomical landmarks are accurate, the body part is stabilized, the measurement device is properly stabilized on the spine, and appropriate instructions are provided to the individual.^{17,20,21} If these principles are followed, errors due to examination technique, the measurement device itself, or normal human variability will be minimized.

15.8b Principles of Inclination and Spine Motion Measurement

Since spinal motion is compound, it is essential to measure simultaneously motion of both the upper and lower extremes of the spine region being examined. Because the small joints of the spine do not lend themselves readily to two-arm goniometric measurements and measuring a spine segment's mobility is confounded by motion above and below the assessed points, an inclinometer is the preferred device for obtaining accurate, reproducible measurements in a simple, practical, and inexpensive way. The subcutaneous bony structures that mark the upper and lower ends of the three spine regions can be palpated readily.

Inclinometers, also called angle finders or level indicators, are small angle-measuring devices traditionally used by carpenters, mechanics, and tradespeople. Recently, physicians, therapists, and veterinarians have used them to measure angles and ranges of motion in humans and animals. Inclinometers work like a plumb line, operating on the principle of gravity, which is a constant. An inclinometer used by a physician should be marked off in 2° increments or less and in good operating condition (Figure 15-6). A mechanical inclinometer has a starting or 0° position indicated by a weighted needle or pendulum. A fluid level can cause errors in reading the meniscus. A fluid-filled inclinometer should allow rotation of its inclinometer face so any number on the face can be set as the initial position. Electronic inclinometers use gravity sensors to determine an angle from the vertical, and then perform internal calculations.²¹

Figure 15-6 Inclinometer



Features of a properly designed inclinometer for medical use include a dial large enough to allow easy reading of 2° increments but small enough to enable application on the spine and all joints of the body; features to enable repeated, accurate application and stabilization of the instrument on the body; and a dial that can both display the 0° gravity position and be set by the examiner to a 0° starting position when the body part cannot be placed in a 0° gravity or neutral position.

Box 15-2 offers a partial list of companies that produce or distribute inclinometers. The American Medical Association does not endorse or recommend any particular type or brand of inclinometer.

Box 15-2 Inclinometer Distributors

The following companies distribute inclinometers. To receive information about their products, *Guides* users should contact the company.

Acumar Technology
1314 SW 57th Ave
Portland, OR 97221
503 292-7137
www.acumar.com

ISOMED, Inc
975 SE Sandy Blvd
Portland, OR 97214
503 233-0051
503 233-5128 (fax)
www.isomedinc.com
isomedinc@heaven.com (e-mail)

McMaster Carr
600 County Line Rd
Elmhurst, IL 60126
630 834-9600
www.mcmaster.com

The Saunders Group, Inc
4250 Norex Dr
Chaska, MN 55318
612 944-1656; 800 654-8357 (toll-free)
www.thesaundersgroup.com

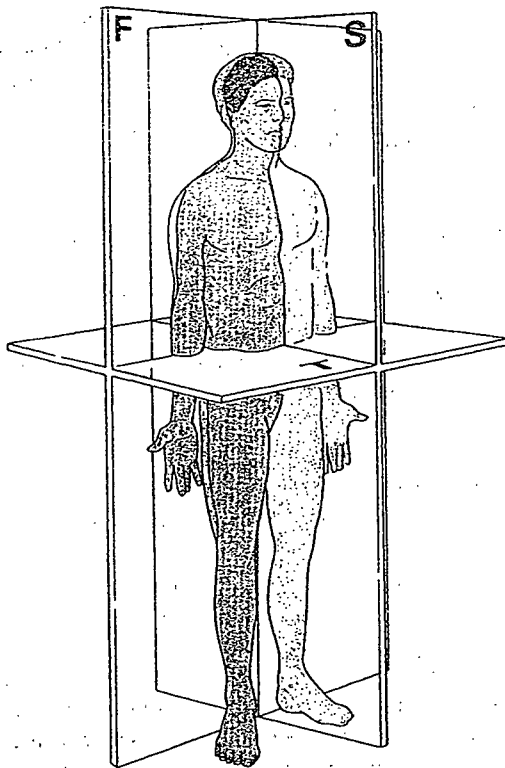
Techmaster
11855 SW Ridge Crest Dr
Beaverton, OR 97008
503 671-9317
503 671-0168 (fax)
techmaster@transport.com (e-mail)

The following principles, discussed in greater detail by Mayer,¹⁷ by Gerhardt et al,^{20,21} and in forthcoming AMA educational material, are important to follow to obtain accurate measurements.

Gravitational plane. An inclinometer works only in the vertical position because only that plane allows the pointer or sensor to move freely in response to gravity. An inclinometer will not operate properly if tilted or at all when horizontal. Therefore, the individual being examined must be in a position that permits motion of the part being tested in a vertical plane. For spinal measurements in the sagittal and frontal (coronal) planes the individual should be standing or sitting, with the spine vertical (Figure 15-7). Measurements in the transverse or axial plane must be made with the individual in the supine, prone, or flexed hip position.

Measure spinal ROM in three principal planes: sagittal (extension-flexion), frontal or coronal, and transverse or axial (rotation) (Figure 15-7). If a spinal region has two or more impaired motions, the ratings for each range of motion impairment are *added*. Impairments of two or more regions of the spine are *combined* using the Combined Values Chart (p. 604).

Stabilization. If the caudad (superior), or lower, part of a spine region can be stabilized so it does not move when the superior, or upper, part moves, a single mechanical inclinometer may be used, as with measuring cervical rotation (see Figure 15-17). However, two inclinometers are usually needed to measure most movements of the spine. Single electronic inclinometers use microprocessors to duplicate functions of mechanical inclinometers. Their use will not be described in detail here as information is available from the manufacturer. The user should ensure that the features described above are addressed.

Figure 15-7 Body Planes for Measuring Motion

S: sagittal plane, T: transverse plane, F: frontal or coronal plane.

Manual pressure during use. The inclinometer should be held so it remains firmly applied to the subcutaneous skeletal structure while the spine is moving through the entire range of motion. It must not deviate from the original position because of skin movement or uneven pressure on the skin overlying the bony landmark, which might occur with an obese individual. The inclinometer design is important to allow proper application and avoid slippage on subcutaneous bony prominences. Firm contact of two points of the instrument with the structure is essential, especially if a convex surface such as the sacrum or calvarium (top of the head) is involved.

Recording ROM Measurements

ROM measurements can be recorded on the summary sheets (Figures 15-10, 15-15, and 15-18).

15.8c Ankylosis and Motion With Ankylosis

Ankylosis is defined as the complete absence of joint motion and is expressed as a fixed position. In the spine, which has multiple motion segments in each region with vertebrae moving together and separately, complete absence of regional motion is rare. For spine impairment evaluation only, when an individual cannot reach the neutral (0°) position, the position or angle of restriction closest to neutral is considered the position of ankylosis or end-restricted movement.

If the individual has end-restricted movement, this value, taken as the ankylosis value, is used to determine impairment instead of the ROM. If the motion crosses the neutral position in any plane, the examiner should use the abnormal motion section of the appropriate table to determine the impairment for that plane.

In determining ankylosis impairments, the examiner should *add* the ankylosis impairments in several planes within a single region or *combine* the ankylosis impairments of two or more regions (Combined Values Chart, p. 604). If a spinal region has several range-of-motion impairments and an ankylosis impairment, the ROM impairments are added and the total is combined with the ankylosis impairment. Impairments of two or more regions are always combined (Combined Values Chart).

15.8d Estimating Whole Person Impairment Using the ROM Method

1. Determine whether the individual has reached MMI and the impairment is stable. If the condition is changing or likely to improve substantially with medical treatment, the impairment is not permanent and should not be rated. If it is permanent, proceed to step 2.
2. Select the impaired region: cervical, thoracic, or lumbar.
3. Use Table 15-7 to determine the percentage impairment for the part of the ROM diagnosis-based method. If there are two or more diagnoses within a spinal region, use that which is most significant. This percent will be combined with those for the impaired range(s) of motion and the whole person neurologic deficit (steps 7-9 below).

4. Measure the range of motion in the relevant sagittal, frontal (coronal), and transverse planes (Figure 15-7), and determine any angle of ankylosis or any restricted motion that is present.
5. Perform at least three measurements of each motion. Determine which measurements meet reproducibility criteria described under general measurement principles described in Section 15.8b. Calculate the average of each set of three measurements and determine whether the three measurements in each set fall within 5° or 10% of the mean, whichever is larger.
6. If the measurements do not meet the consistency requirements described in step 5, perform additional tests until the reproducibility criteria are satisfied, up to a maximum of six. If the test results remain inconsistent after six measurements, repeat the tests at a later date or disallow impairment related to that motion.
7. Use the maximum motion from a reproducible set of measurements to determine any impairment rating from the appropriate tables, based on the spinal region and type of movement. Refer to Section 15.8c, Ankylosis and Motion With Ankylosis, if there are several range-of-motion or ankylosis impairments in a region. For example, an individual who can flex the cervical spine from 30° to 60° but who lacks 30° of motion in reaching the neutral 0° position has restricted end motion and the same estimated impairment as if he or she had fixed ankylosis at 30° of cervical flexion. According to Table 15-12, the individual's impairment is 30% of the whole person. If there are impairments due to loss of motion in more than one plane in the same spinal region (extension, flexion, or rotation), the impairments are added to determine total impairment due to loss of motion in a spinal region.
8. Determine any impairments due to neurologic deficits, such as radiculopathy or spinal nerve injury. Refer to Table 15-15 for the procedure to evaluate the sensory deficit. Use Table 15-16 to determine the procedure for estimating loss of strength. Apply these tables to Table 15-17 (cervical and thoracic nerve roots) or Table 15-18 (lumbar and sacral nerve roots) as needed. Convert the neurologic impairments, initially calculated as upper or lower extremity, into a whole person impairment.
9. Combine the diagnosis-based (Table 15-7) and physical examination-based (mobility and neurologic) impairment percents using the Combined Values Chart (p. 604).
10. Repeat steps 1 through 9 for either of the other two spinal regions with significant involvement related to the primary diagnosis.
11. Combine the regional impairments into a single whole person impairment using the Combined Values Chart (p. 604).
12. Combine the whole person spine impairment with whole person ratings for any other organ system using the Combined Values Chart, if indicated.
13. Record the results of the evaluation on the Spine Impairment Summary form (see Table 15-20).

Instructions for Using Table 15-7

1. Use this table only when the ROM method is used.
2. Identify the most significant (impairing) diagnosis of the primarily involved region (lumbar, thoracic, or cervical).
3. The diagnosis-based impairment percent should be combined with range-of-motion impairment estimates and whole person impairment estimates involving sensation, weakness, and other conditions of the musculoskeletal, nervous, or other organ systems.
4. Combine the diagnosis-based, range-of-motion, and other whole person impairment estimates using the Spine Impairment Summary form (Table 15-20).
5. Repeat for other involved spine regions and combined regional impairments if those exist.

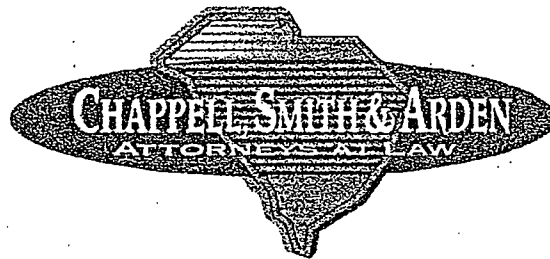
Table 15-7 Criteria for Rating Whole Person Impairment Percent Due to Specific Spine Disorders to Be Used as Part of the ROM Method*

Disorder	% Impairment of the Whole Person		
	Cervical	Thoracic	Lumbar
I. Fractures			
A. Compression of one vertebral body.			
0%-25%	4	2	5
26%-50%	6	3	7
> 50%	10	5	12
B. Fracture of posterior element (pedicle, lamina, articular process, transverse process).	4	2	5
Note: An impairment due to compression of a vertebra and one due to fracture of a posterior element are combined using the Combined Values Chart (p. 604). Fractures or compressions of several vertebrae are combined using the Combined Values Chart.			
C. Reduced dislocation of one vertebra.	5	3	6
If two or more vertebrae are dislocated and reduced, combine the estimates using the Combined Values Chart.			
An unreduced dislocation causes impairment until it is reduced; the physician should then evaluate the impairment on the basis of the individual's condition with the dislocation reduced.			
If no reduction is possible, the physician should evaluate the impairment on the basis of the range-of-motion and neurologic findings according to criteria in this chapter and Chapter 13, The Central and Peripheral Nervous System.			
II. Intervertebral disk or other soft-tissue lesion			
Diagnosis must be based on clinical symptoms and signs and imaging information.			
A. Unoperated on, with no residual signs or symptoms.	0	0	0
B. Unoperated on, with medically documented injury, pain, and rigidity* associated with none to minimal degenerative changes on structural tests.†	4	2	5
C. Unoperated on, stable, with medically documented injury, pain, and rigidity* associated with moderate to severe degenerative changes on structural tests;† includes herniated nucleus pulposus with or without radiculopathy.	6	3	7
D. Surgically treated disk lesion without residual signs or symptoms; includes disk injection.	7	4	8
E. Surgically treated disk lesion with residual, medically documented pain and rigidity.	9	5	10
F. Multiple levels, with or without operations and with or without residual signs or symptoms.	Add 1% per level		
G. Multiple operations with or without residual signs or symptoms	Add 2%		
1. Second operation	Add 1% per operation		
2. Third or subsequent operation			
III. Spondylolysis and spondylolisthesis, not operated on			
A. Spondylolysis or grade I (1%-25% slippage) or grade II (26%-50% slippage) spondylolisthesis, accompanied by medically documented injury that is stable, and medically documented pain and rigidity with or without muscle spasm.	6	3	7
B. Grade III (51%-75% slippage) or grade IV (76%-100% slippage) spondylolisthesis, accompanied by medically documented injury that is stable, and medically documented pain and rigidity with or without muscle spasm.	8	4	9
IV. Spinal stenosis, segmental instability, spondylolisthesis, fracture, or dislocation, operated on			
A. Single-level decompression without spinal fusion and without residual signs or symptoms	7	4	8
B. Single-level decompression without spinal fusion with residual signs or symptoms	9	5	10
C. Single-level spinal fusion with or without decompression without residual signs or symptoms	8	4	9
D. Single-level spinal fusion with or without decompression with residual signs and symptoms	10	5	12
E. Multiple levels, operated on, with residual, medically documented pain and rigidity.	Add 1% per level		
1. Second operation	Add 2%		
2. Third or subsequent operation	Add 1% per operation		

* The phrase "medically documented injury, pain, and rigidity" implies not only that an injury or illness has occurred but also that the condition is stable, as shown by the evaluator's history, examination, and other diagnostic data, and that a permanent impairment exists, which is at least partially due to the condition being evaluated.

† Structural tests include radiographs, myelograms with and without CT scan, CT scan and MRI with and without contrast, and diskogram with and without CT scan.

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William L. Smith, II
Mark T. Arden
W. Beau Busch
C. Daniel Vega
W. Hugh McAngus, Jr.*
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Of Counsel:
Solomon, Budman & Stricker

*Also licensed in North Carolina

February 17, 2012

Gene McCaskill, Commissioner
South Carolina Workers' Compensation Commission
PO Box 1715
Columbia, SC 29201

Re: Norge Gonzalez-Torres v. World Fiber Technologies
SCWCC No.: 1002408

Dear Hon. Comm. McCaskill:

In response to your question about the form 20 we contend the form 20 submitted by the defendants is incorrect. The form 20 calculation is not supposed to include the quarter in which the claimant was injured. In addition they are counting a week for checks that include one (1) hour pay, and three (3), nine-point five (9.5), and five hours (5) respectively - which only adds up to 18.5 hours.

The proper accounting would be 21 weeks, or one week for every full week worked beginning August 7, 2009 and ending December 31, 2009. This in my opinion is the most consistent with section 42-1-40 and avoids penalizing either party. The average weekly wage would then be \$390.23 and the compensation rate \$260.17.

Thank you for allowing this explanation.

I remain,

Very truly yours,

C. Daniel Vega
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CDV/DV

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THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM THE SOUTH CAROLINA WORKERS' COMPENSATION
COMMISSION

Case No.: 2012-213610

Norge L. Gonzalez-Torres.....Appellant,

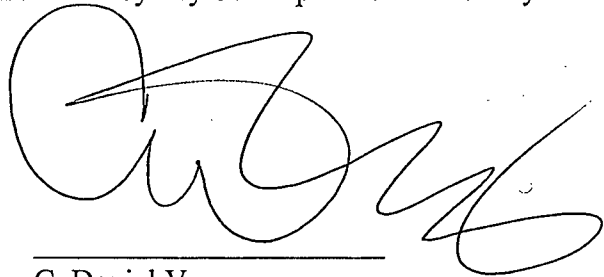
v.

World Fiber Technologies, Inc. and The Standard Fire Insurance Company, c/o
Travelers.....Respondent.

CERTIFICATE OF COUNSEL

The undersigned certifies that this Record on Appeal complies with Rule 210(g),
SCACR, and contains all material proposed to be included by any of the parties and not any other
material.

June 7, 2013



C. Daniel Vega
Chappell Smith & Arden, P.A.
Post Office Box 12330
Columbia, South Carolina 29211
(803)929-3600

Attorney for Appellant

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JUL 08 2013

SC Court of Appeals

The state of South Carolina
In the Court of Appeals

Appeal from the South Carolina
Workers Compensation Commission

W.C.C. No. 1002408

Norge Gonzalez-Torres,

Claimant/Appellant,

v.

World Fiber Technologies, Inc.,

Employer,

and

The Standard Fire Insurance Company,

Carrier,

Defendants/Respondents,

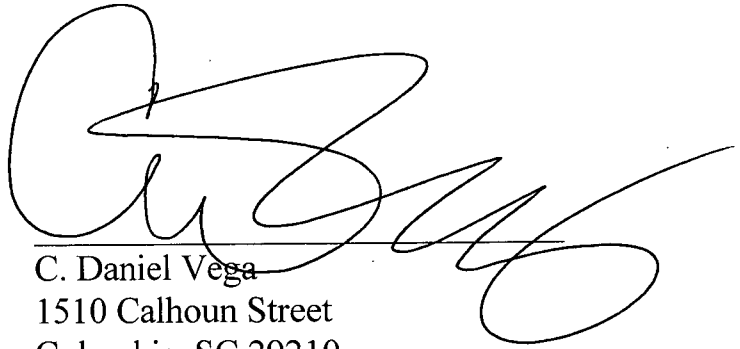
PROOF OF SERVICE

I certify that I have served the final Brief of Appellant, Reply Brief of Appellant and the Record on Appeal and including their corresponding Certificate of Counsel pursuant to Rule 211 on Defendants/Respondent by depositing a copy of it in the United States Mail, postage prepaid, on June 11, 2013, addressed to their attorneys of record, J. Gabriel Coggiola and LeAnne McCormick, 4500 Ft. Jackson Blvd., Columbia, SC 29209.

RECEIVED
JUN 11 2013

SC Court of Appeals

June 11, 2013

A large, stylized handwritten signature in black ink, likely belonging to C. Daniel Vega, positioned above the printed contact information.

C. Daniel Vega
1510 Calhoun Street
Columbia, SC 29210
803-929-3600
Attorney for Appellant

The state of South Carolina
In the Court of Appeals

Appeal from the South Carolina
Workers Compensation Commission

W.C.C. No. 1002408

Norge Gonzalez-Torres,

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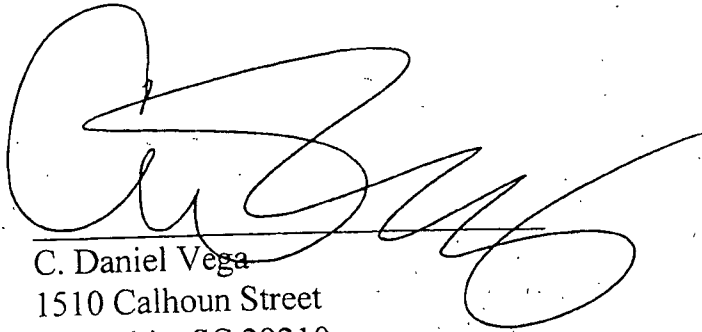
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