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SUPREME COURT OF APPEALS
OF WEST VIRGINIA

STATE OF WEST VIRGINIA
SUPREME COURT OF APPEALS

M.H.,
Claimant Below, Petitioner

vs.) **No. 21-0659** (BOR Appeal No. 2056520)
(Claim No. 2020012178)

Brooks Run South Mining,
Employer Below, Respondent

MEMORANDUM DECISION

Petitioner M.H. appeals the decision of the West Virginia Workers' Compensation Board of Review ("Board of Review").[1] Respondent Brooks Run South Mining filed a timely response.[2] The issues on appeal are medical benefits and an additional compensable condition. The claims administrator denied a request for bilateral transforaminal epidural steroid injections on May 18, 2020. On June 5, 2020, the claims administrator denied the addition of lumbar herniation disc to the claim. The claims administrator denied a request for the medication Neurontin on June 18, 2020. The Workers' Compensation Office of Judges ("Office of Judges") reversed the decisions in its February 25, 2021, Order, added lumbar herniated disc to the claim, and authorized the requested medical treatment. The Order was reversed by the Board of Review on July 29, 2021, and the claims administrator's May 18, 2020; June 5, 2020; and June 18, 2020, decisions were reinstated. Upon our review, we determine that oral argument is unnecessary and that a memorandum decision affirming the Board of Review's decision is appropriate. *See* W. Va. R. App. P. 21.

M. H., an electrician, completed an Employees' and Physicians' Report of Injury indicating that on November 8, 2019, he injured his head, shoulder, back, hip, and knee when he tripped and fell while carrying acetylene. The record indicates the claimant had preexisting low back issues. On March 20, 2014, Charles Hill, PA-C, treated M.H. for bilateral leg pain and joint tenderness in multiple sites and was diagnosed with compression arthralgia. On March 15, 2018, Mr. Hill noted that M.H. had lumbago. M.H. sought treatment from Mr. Hill on January 25, 2019, for numbness in his thighs and lower back pain. Mr. Hill diagnosed lumbago and peripheral

[1]We use initials where necessary to protect the identities of those involved in this case. *See* W. Va. R. App. P. 40(e).

[2]M.H. is represented by Lori J. Withrow, and Brooks Run South Mining is represented by Sean Harter.

neuropathy and referred M.H. to Barry Vaught, M.D., a neurologist. Dr. Vaught evaluated M.H. on March 5, 2019, and M.H. stated that his problems began about ten years prior but had worsened in the past six months. M.H. reported numbness from his mid-thoracic spine to his feet and severe abdominal numbness with painful dysesthesias. He also had leg weakness, difficulty controlling his bladder and bowels, and erectile dysfunction. After examination, Dr. Vaught diagnosed thoracic spondylosis with myelopathy. He noted a concern for a demyelinating disease but stated that the thoracic disc could be the cause of M.H.'s symptoms.

On March 19, 2019, a thoracic MRI showed a mild left T6-7 posterior disc osteophyte bulge, T7-9 minimal disc degeneration and broad based posterior disc osteophyte bulging, partially imaged severe degenerative changes with protrusion, and L5-S1 vertebral endplate sclerosis and spurs. M.H. underwent a lumbar MRI on April 9, 2019, which showed L5-S1 moderate disc space narrowing and desiccated signal change, medial right disc protrusion with mass effect on the thecal sac and right S1 nerve route sleeve, a probable discontiguous disc fragment, degenerative endplate changes, and an L4-5 mild disc bulge with mild desiccated disc signal changes.

M.H. returned to Dr. Vaught on April 15, 2019, and reported numbness, burning, dysesthesias, low back pain, lower extremity weakness, and fatigue off and on for at least ten years. His symptoms of numbness and aching from the chest down used to last twenty to twenty-five minutes but progressed to lasting the entire day and part of the night. M.H. had problems with bladder and bowel incontinence when sitting or lying down as well as erectile dysfunction, which had developed in the past six months. M.H. reported that he had difficulty at work and sometimes had to take breaks due to pain. Dr. Vaught diagnosed paresthesia of the skin, weakness, and visual disturbance. He opined that the etiology of M.H.'s symptoms was unclear and recommended further work-up.

On April 29, 2019, Dr. Vaught performed an EMG/NCS which showed polyneuropathy. A CT scan was performed on November 9, 2019, and revealed no acute osseous process in the lumbar spine; severe L5-S1 degenerative changes with disc space height loss and a posterior osteophyte complex; and severe bilateral foraminal narrowing. A chest and thoracic spine CT scan showed no evidence of intrathoracic injury or fracture. M.H. underwent a thoracic CT scan on November 11, 2019, which showed no fracture, subluxation, or significant arthritic changes. A lumbar CT scan revealed no fractures or subluxation, L5-S1 disc space narrowing with a herniated disc, and osteophytosis causing moderate bilateral neural foraminal compromise.

The claim at issue was held compensable for lower back and pelvic contusions on November 22, 2019. Right hip pain, thoracic spine pain, right shoulder pain, and acute pain due to trauma were denied as compensable conditions. On January 16, 2020, M.H. returned to Mr. Hill for treatment of the compensable injury and was diagnosed with L4-5 herniated disc, L5-S1 herniated disc, and lumbosacral radiculopathy. A consultation with John Orphanos, M.D., with West Virginia OrthoNeuro, was requested as soon as possible. On February 26, 2020, Mr. Hill requested a wheeled walker to assist M.H.'s mobility. On February 26, 2020, Family Healthcare Associates requested authorization of Tylenol with Codeine, diclofenac sodium, baclofen, and Neurontin for the treatment of lumbosacral radiculopathy, lumbosacral intervertebral disc

displacement, and severe pain in the low back and bilateral legs. M.H. underwent a lumbar MRI on March 9, 2020, which showed a right paracentral L5-S1 disc extrusion.

M.H. had a telemedicine visit with Dr. Orphanos on April 1, 2020. Dr. Orphanos reviewed M.H.'s MRI and assessed lumbar intervertebral disc disorders with radiculopathy and other lumbar spondylosis with radiculopathy. He diagnosed lumbar disc herniation with bilateral radiculopathy and recommended M.H. restart Neurontin. On May 12, 2020, M.H. reported continued bilateral pain in the legs radiating into the feet. Dr. Orphanos recommended bilateral L5 transforaminal epidural steroid injections and requested authorization for the treatment and follow-up with four weeks. The claims administrator rejected the treatment request on May 18, 2020. It stated that the epidural steroid injections appeared to be unrelated to a compensable diagnosis in the claim. Dr. Orphanos requested the addition of lumbar herniated disc to the claim on May 27, 2020. The claims administrator denied the request on June 5, 2020. On June 18, 2020, it denied authorization of the medication Neurontin.

In a June 19, 2020, letter, Mr. Hill stated that following his compensable injury, M.H. developed persistent symptoms of severe low back pain with radiculopathy. A CT scan taken a few days after the injury showed a herniated L5-S1 disc, which was confirmed by MRI. Mr. Hill asserted that a disc extrusion is inconsistent with disc degeneration but is consistent with an acute injury.

David Soulsby, M.D., performed an independent medical evaluation on July 14, 2020, in which he diagnosed herniated L5-S1 disc with complaints of bowel and bladder control loss. He opined that M.H. had not reached maximum medical improvement and recommended a second neurosurgical opinion as soon as possible due to M.H.'s severe symptoms. He also opined that M.H. was unable to return to work.

On September 16, 2020, Panayotis Ignatiadis, M.D., neurosurgeon, wrote a letter to Mr. Hill regarding his evaluation of M.H. Dr. Ignatiadis diagnosed knee pain, leg weakness, low back pain, lumbar disc herniation, and lumbar radiculopathy. He opined that M.H.'s L5-S1 herniated disc was the direct result of the compensable injury and further stated that the injury caused hyperextension injuries of the right hip and right knee. Dr. Ignatiadis recommended physical therapy and a right knee MRI and opined that the treatment was necessitated by the compensable injury.

In a September 25, 2020, independent medical evaluation addendum, Dr. Soulsby stated that he was provided additional information, including Dr. Vaught's preinjury EMG/NCS and updated MRIs. He stated that the new records show that M.H.'s severe pain, paresthesias, and bowel and bladder issues predated his compensable injury by many years and that M.H.'s disc abnormalities were present prior to the compensable injury. Dr. Soulsby opined that there was a reasonable medical probability that M.H.'s disc abnormalities were in no way the result of the compensable injury. He also opined that transforaminal epidural steroid injections were not necessary treatment for a compensable injury. He stated that the accepted compensable diagnoses were lower back and pelvis contusions and that such conditions were accurate. Dr. Soulsby asserted that Neurontin is not appropriate medication for a compensable condition in the claim. He

found that M.H. had reached maximum medical improvement for the compensable injury and that his continued symptoms were the result of his preexisting condition. He required no further treatment for a compensable condition. Dr. Soulsby noted that his July 14, 2020, recommendations were based on inaccurate information and incomplete records.

In its February 25, 2021, Order, the Office of Judges reversed the claims administrator's decisions denying a request for bilateral transforaminal epidural steroid injections, denying the addition of lumbar herniation disc to the claim, and denying authorization of the medication Neurontin. The Office of Judges added lumbar herniated disc to the claim and authorized the requested medical treatment. It found that though M.H. had low back symptoms prior to the compensable injury, an April 9, 2019, pre-injury MRI showed disc space narrowing at L5-S1 and bulging at L4-5 with was no disc herniation noted. Further, M.H. was seen by Mr. Hall and Dr. Vaught during that time and neither diagnosed a herniated disc. The Office of Judges determined that a CT scan taken on November 11, 2019, showed a herniated L5-S1 disc, which was confirmed by a March 9, 2020, MRI. Based on the imagining studies, Dr. Orphanos, diagnosed L4-5 and L5-S1 herniated discs and opined that they were the result of the compensable injury. His opinion was confirmed by Dr. Ignatiadis.

The Office of Judge noted that the only evidence in support of the employer's position is the addendum report completed by Dr. Soulsby. After reviewing the pre-injury MRI scans, he concluded that M.H.'s herniated disc conditions preexisted the compensable injury. The Office of Judges found that Dr. Soulsby's opinion was not consistent with a plain reading of the MRI studies or the remainder of the medical evidence. Therefore, the Office of Judges added lumbar herniated disc to the claim. Because the herniated disc was compensable, the Office of Judges also authorized the request for bilateral epidural steroid injections and the medication Neurontin.

On July 29, 2021, the Board of Review reversed the Office of Judges' order and reinstated the claims administrator's decisions denying a request for bilateral transforaminal epidural steroid injections, the addition of lumbar herniation disc to the claim, and authorization of the medication Neurontin. It found that M.H. reported bilateral leg pain, numbness, burning dysesthesias, low back pain, and lower extremity weakness prior to the compensable November 8, 2019, injury. On March 5, 2019, Dr. Vaught noted that M.H. reported paresthesias and numbness from his midthoracic region to his feet. The symptoms began ten years prior but had greatly worsened in the previous six months. Dr. Vaught diagnosed thoracic spondylosis with myelopathy and prescribed Neurontin. Dr. Vaught performed an EMG on April 29, 2019, and found mild polyneuropathy.

The Board of Review found that seven months prior to the compensable injury, an MRI was taken for a history of lumbar myelopathy and low back pain for the previous year, with radiation into the bilateral legs, as well as numbness and tingling. The MRI showed L5-S1 moderate disc space narrowing and desiccated signal change, a right L5-S1 paramedian disc protrusion with mass effect on the thecal sac and right S1 nerve root sleeve, a probable disc fragment at L5-S1, degenerative endplate signal changes, and L4-5 mild disc bulging. The Board of Review found that MRIs taken after the injury were not compared to the preinjury images. It noted that M.H. denied any prior low back injuries or issues when he was evaluated by Dr. Soulsby

and Dr. Ignatiadis. After being provided with preinjury records, Dr. Soulsby concluded that M.H.'s disc abnormalities preexisted the compensable injury, and the requested medical treatment was not necessary for a compensable condition. The Board of Review found no indication in the record that Drs. Orphanos or Ignatiadis were aware of M.H.'s preinjury lumbar issues or MRI. The Board of Review concluded that the reliable evidence of record shows that M.H. did not sustain a lumbar disc herniation as a result of the compensable injury. It therefore also determined that the requested medical treatment for such condition was not necessary or reasonable for the compensable injury.

This Court may not reweigh the evidentiary record, but must give deference to the findings, reasoning, and conclusions of the Board of Review, and when the Board's decision effectively represents a reversal of a prior order of either the Workers' Compensation Commission or the Office of Judges, we may reverse or modify that decision only if it is in clear violation of constitutional or statutory provisions, is clearly the result of erroneous conclusions of law, or is so clearly wrong based upon the evidentiary record that even when all inferences are resolved in favor of the Board's findings, reasoning, and conclusions, there is insufficient support to sustain the decision. *See* W. Va. Code § 23-5-15(c) & (e). We apply a de novo standard of review to questions of law. *See Justice v. W. Va. Off. of Ins. Comm'r*, 230 W. Va. 80, 83, 736 S.E.2d 80, 83 (2012).

The standard for the addition of a condition to a claim is the same as for compensability. For an injury to be compensable it must be a personal injury that was received in the course of employment, and it must have resulted from that employment. *See Barnett v. State Workmen's Comp. Comm'r*, 153 W. Va. 796, 172 S.E.2d 698 (1970).

After review, we agree with the reasoning and conclusions of the Board of Review. A preponderance of the evidence of record indicates that M.H. did not develop a herniated lumbar disc as a result of his compensable injury. Dr. Soulsby was the only evaluator of record to review M.H.'s preinjury MRI in comparison to the post-injury MRI, and he concluded that there were no new acute changes following the compensable injury. Further, it does not appear that Drs. Orphanos or Ignatiadis were aware of M.H.'s preexisting symptoms or lumbar MRI. The Board of Review was correct to reinstate the claims administrator's denial of the addition of lumbar herniated disc to the claim.

West Virginia Code § 23-4-3(a)(1) provides that the claims administrator must provide medically related and reasonably required sums for "healthcare services, rehabilitation services, durable medical and other goods, and other supplies[.]" The evidence clearly shows that the requests for bilateral epidural steroid injections and the medication Neurontin were aimed at treating M.H.'s lumbar disc issues, not the compensable injury.

Affirmed.

ISSUED: June 13, 2023

CONCURRED IN BY:

Chief Justice Elizabeth D. Walker
Justice Tim Armstead
Justice John A. Hutchison
Justice William R. Wooton
Justice C. Haley Bunn