**[Cite as *State ex rel. Kearns v. Indus. Comm.*, 2010-Ohio-1993.]**

IN THE COURT OF APPEALS OF OHIO

TENTH APPELLATE DISTRICT

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|---|---|---|
| State of Ohio ex rel. Mark Kearns, | : | |
| Relator, | : | |
| | | No. 09AP-591 |
| v. | : | |
| | | (REGULAR CALENDAR) |
| Industrial Commission of Ohio et al., | : | |
| Respondents. | : | |

D E C I S I O N

Rendered on May 6, 2010

*Agee, Clymer, Mitchell & Laret*, and *Robert M. Robinson*, for relator.

*Richard Cordray*, Attorney General, and *Stephen D. Plymale*, for respondent Industrial Commission of Ohio.

IN MANDAMUS

FRENCH, J.

**{¶1}** Relator, Mark Kearns, requests a writ of mandamus ordering respondent, Industrial Commission of Ohio, to vacate its order denying his motion for a scheduled-loss award under R.C. 4123.57(B) and to enter an order granting an award.

**{¶2}** This court referred this matter to a magistrate pursuant to Civ.R. 53(C) and Loc.R. 12(M) of the Tenth District Court of Appeals. The magistrate issued a decision, which includes findings of fact and conclusions of law and is appended to this

decision, recommending that this court deny the requested writ. No objections to that decision have been filed.

**{¶3}** Finding no error of law or other defect on the face of the magistrate's decision, this court adopts the magistrate's decision as our own, including the findings of fact and conclusions of law contained in it. In accordance with the magistrate's decision, the requested writ is denied.

*Writ of mandamus denied.*

TYACK, P.J., and BRYANT, J., concur.

# A P P E N D I X

IN THE COURT OF APPEALS OF OHIO

TENTH APPELLATE DISTRICT

| | | |
|---|---|---|
| State of Ohio ex rel. Mark Kearns, | : | |
| Relator, | : | |
| v. | : | No. 09AP-591 |
| Industrial Commission of Ohio and Michelle L. Ray, Accurate Sign & Lighting, | : | (REGULAR CALENDAR) |
| Respondents. | : | |

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M A G I S T R A T E ' S D E C I S I O N

Rendered on February 8, 2010

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*Agee, Clymer, Mitchell & Laret*, and *Robert M. Robinson*, for relator.

*Richard Cordray*, Attorney General, and *Stephen D. Plymale*, for respondent Industrial Commission of Ohio.

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IN MANDAMUS

**{¶4}** In this original action, relator, Mark Kearns, requests a writ of mandamus ordering respondent Industrial Commission of Ohio ("commission") to vacate its order denying his motion for an R.C. 4123.57(B) scheduled-loss award for an alleged loss of use of his legs, and to enter an order granting an award.

Findings of Fact:

**{¶5}** 1. On February 19, 1987, while employed as a shop supervisor for respondent Michelle L. Ray, dba Accurate Sign & Lighting, relator severely injured his lower back. The industrial claim (No. 87-27039) is allowed for "lumbosacral strain/sprain; dysthymia; herniated nucleus pulposus at L4-5[;] degenerative disc disease; post laminectomy syndrome/failed back syndrome[;] * * * spinal lumbar stenosis at L3-4."

**{¶6}** 2. On July 2, 2007, orthopedic specialist Ronald Lakatos, M.D., wrote:

> We will put in for a C-9 for a lumbar diskography. Will go L2-S1, at L2-L3, L3-L4, L4-L5 and L5-S1 with post diskography CT scan. I think this would be adequate to assess sources of his lumbar axial symptoms and then make a reasonable plan from there.
>
> The patient is in agreement with this plan. We discussed how the surgery is performed along with the risks and complications. He is familiar with this, has had one from Dr. Poppmany [sic] many years ago at Grant Hospital.

**{¶7}** 3. On July 6, 2007, Dr. Lakatos completed a C-9 requesting authorization for a discogram and a CT scan following the discogram. The C-9 was initially denied by "University CompCare Case Manager," Jill Todaro, R.N.

**{¶8}** 4. On August 21, 2007, Dr. Lakatos wrote to Todaro:

> The cryptic denial provided states that the proposed treatment is not medically appropriate, not recommended per [Official Disability Guidelines].
>
> Unfortunately, this minimal amount of information is not even enough to even comment on, but the main issues in regards to Mr. Kearns still stand. First off, the patient still continues to have low back pain, since the time of his injury in the late 1980s, despite the surgery successfully performed by Dr. Papp with what appears to be potentially a successful arthrodesis at L4-5. The patient does have disk degenera-

> tion, continued low back pain and findings that suggest other possible sources of his lumbar symptoms. If L4-5 is fused, then it is unlikely that it is causing any symptoms in the lumbar spine and it would be most likely from an adjacent structure.
>
> The purpose of the lumbar diskography test is to help indentify the possible sources of the patient's symptoms, that is[,] the low back pain. It is not intended to provide any information in regards to stenosis or radiculopathy, and in Mr. Kearns['] case, this information that we would obtain from this test would help guide us in deciding any additional treatment options that may be appropriate for his condition. Therefore, based on the findings from the MRI and the CT scans, Mr. Kearns does meet appropriate criteria for the lumbar for the requested procedure, that is[,] lumbar diskography at L2 to S1, not including the fused L4-5 level, to help diagnose the source of his lumbar symptoms, and utilizing L2-3 as a potential control disk, as is standard protocol for lumbar diskography.

**{¶9}** 5. On September 19, 2007, Nicholas Ahn, M.D., performed an alternative dispute resolution ("ADR") review. Dr. Ahn wrote:

> Opinion: Lumbar discography is not considered an appropriate test, as per the Official Disability Guidelines. The test is to determine whether or not an individual with disc degeneration has symptoms that are symptomatic and lean to a particular disc. It is used to determine whether or not fusion at a particular level would lead to benefit.
>
> However, as per the Official Disability Guidelines, fusion for discogenic changes or discogenic disease/degenerative disc disease is not considered reasonable or appropriate because the results are often predictable. In addition, the results of discography have not been found to correlate with overall clinical results from fusion. Thus, discography is not considered reasonable or appropriate, and is not recommended under any circumstances, as per the Official Disability Guidelines.
>
> Thus, the C9 dated 07/06/07 should be denied requesting discogram L2-3, L3-4 and L5-S1 and a CT scan after the discogram. Once again, as per the Official Disability

> Guidelines, it is not considered reasonable or appropriate for any of the allowed conditions in the claim.

**{¶10}** 6. By letter dated September 24, 2007 from "University Hospitals CompCare," Dr. Lakatos was informed, by an ADR nurse of Dr. Ahn's decision:

> Appeal information and previously submitted documentation has been reviewed in accordance with the Alternate Dispute Resolution procedure. A consultant in an appropriate specialty has UPHELD THE INITIAL DENIAL for the reason(s) explained in the attached report, which references standard guidelines.
>
> Pursuant to Ohio Administrative Code 4123-6-16(A)[,] the injured worker, employer or provider may appeal this decision IN WRITING WITHIN 7 CALENDAR DAYS of receipt of this notification. * * *

(Emphases sic.)

**{¶11}** 7. On October 1, 2007, Dr. Lakatos wrote to the ADR nurse:

> This letter is in regards to yours dated 9/24/07 regarding Mr. Kearns and the denial for requested discography, including response to the statements from Dr. Ahn.
>
> As listed in your response, this is Dr. Ahn's opinion. I agree with Dr. Ahn relative to his second statement of the opinion stating that discography ["]is to determine whether or not an individual with disc degeneration has symptoms that are symptomatic and lean to a particular disc["], a reasonable summarization. I disagree with Dr. Ahn's next statement, as most spine physicians would, that the discography results are just applicable to treatment with fusion surgery of the spine, as a [sic] many additional treatment considerations can be made based on the test results.
>
> The entire second paragraph in Dr. Ahn's opinion is just that, with obvious bias which is exemplified by a general informative article written about him at the appointment of his current job. In reviewing the spine literature, results concerning discography and spinal fusion can vary, but there is sufficient evidence in the literature supporting proper applied treatment to discogenic pain diagnosed with a properly performed discography test. It is important to point out that

> the lumbar discography is a provocative diagnostic test, not a treatment, and does not necessarily lead to arthrodesis procedures as suggested in Dr. Ahn's opinion. In other words, lumbar discography can help indentify where the patient's lumbar axial symptoms are coming from and that information can be utilized to determine what are the most appropriate treatment measures.
>
> In the way that I practice spine care, I engage all conservative measures possible to avoid arthrodesis type surgeries, and spine arthrodesis is limited to those patients that are deemed appropriate, after all reasonable conservative measures are exhausted, and only in select patients that meet appropriate criteria. Spine arthrodesis in certain patients can be of benefit, but this is in a limited subset of patients and the majority of the patients with low back pain are usually referred for conservative management, including those diagnosed with discogenic pain on discography, to include physical therapy, appropriate injections, and IDET if appropriate.
>
> In Mr. Kearns['] case, our goal here is to try to identify what levels are causing his pain and then determine what the best treatments are[,] and not necessarily an arthrodesis, as indicated by Dr. Ahn's opinion. This diagnostic test is most certainly within reasonable guidelines for determining the source and nature of Mr. Kearns' symptoms and is appropriate, relative to the patient's continued chronic low back pain and spine care history.

**{¶12}** 8. On November 24, 2008, at relator's request, he was examined by Nancy Renneker, M.D., who is board certified in physical medicine and rehabilitation. Dr. Renneker wrote:

> HISTORY:
>
> * * * Mr. Kearns reports that he recently was referred to Ohio State University Spine Center i.e. to Dr. Severyn, due to ongoing low back and bilateral leg complaints, including bilateral feet numbness and weakness about left lower leg. Mark Kearns reports that Dr. Severyn told him that there was a 50/50 chance that he would benefit from an additional low back surgery; however, Dr. Severyn stated that Mr. Kearns would need to undergo a lumbar discogram prior to any

surgical intervention. Mark Kearns reports that the BWC has denied this test. Mark Kearns reports that over time he is progressively getting worse in that for the past 1 ½ years he has needed to use a motorized scooter for all outside the home ambulation. Mark Kearns reports that in his home he uses a cane or cart to maneuver from one room to the other and Mark Kearns reports that he has his furniture situated so that he is able to hold onto the backs of furniture to maneuver within his home. * * *

Mark Kearns reports that his home is ramped to be accessible for his motorized scooter and Mr. Kearns reports that he needs assist from his son in getting out of bed, going down the stairs to the 1st level of his home with Mark Kearns reporting that there are no bedrooms on the first level of his home. Mark Kearns reports that once he is on the 1st level of his home that he does not return to the 2nd level i.e. go upstairs, until he is ready to retire to bed for the night. Mark Kearns reports that there are bathroom facilities on both floors. Mark Kearns reports that unless his son is home that he will stay upstairs in his home for the entire day and Mr. Kearns reports that he has a small college refrigerator upstairs. Mark Kearns reports that he lives with his wife and son; however, Mr. Kearns reports that his wife is unable to assist him with going up or down stairs due to the amount of help that he needs to perform this task. Mark Kearns reports that his wife must assist him with getting on and off of the toilet, getting on and off of a shower bench and Mr. Kearns reports that he has had additional grab bars/safety bars added to his shower and toilet area of his bathroom. Mark Kearns needs assist from his wife with lower extremity bathing, as well as with lower extremity dressing i.e. from his waist down. * * *

* * *

PRESENT COMPLAINTS:

Mark V. Kearns complains of: (1) non-constant but with all weight bearing, right lateral hip-right greater trochanter pain and Mark Kearns reports radiation of this right hip pain down right anterior thigh to right knee, constant stiffness about right hip and right hip weakness. Mark Kearns reports that he has difficulty, at times, lying on his right side for sleep due to an increase in right hip-right greater trochanter pain with this activity[.]

> (2) constant bilateral low back pain, constant low back stiffness, constant bilateral pain/paresthesia into bilateral buttock region and Mr. Kearns['] complains of bilateral lateral shin pain, "patches" of numbness throughout bilateral feet, left lower leg weakness with Mr. Kearns reporting that he drags his left foot with gait and Mr. Kearns also complains of nocturnal, left greater than right, leg tremors with Mr. Kearns reporting that he will wake from his sleep with his left, right or both legs "shaking". * * * Mark Kearns states that initially after his two low back surgeries that he did well i.e. Mark Kearns reports that he was able to walk using a cane only until 2004 with Mr. Kearns reporting that he had no additional injury; however, by 2004 he needed to not only use a cane, but hold onto furniture or a cart which he has both upstairs and downstairs in his home for gait. * * *
>
> EXAMINATION:
>
> * * * Mark V. Kearns use[d] a motorized scooter at [the] time of this evaluation and Mark Kearns is able to maneuver this scooter in through doorways, as well as maneuver in small surfaces due to a 0 turn radius on his scooter. Mark Kearns reports that prior to obtaining a scooter that he had a manual wheelchair with Mr. Kearns reporting that he then had to rely on another person to push his chair. With help, Mark Kearns was able to stand and hold onto the exam table and a chair for this examination. * * * Of note, Mark Kearns was unable to stand without the assistance of a family member or without holding onto the exam table or other furniture in the examination room and Mark Kearns was unable to walk without assistance from 2 persons during this examination. Of note, Mark Kearns needed assist from one with getting on and off of his motorized scooter.
>
> OPINION:
>
> Based on medical records, my exam of this date and in my medical opinion, Mark V. Kearns, who is status post L4-5 interbody fusion with instrumentation with instrumentation later removed and with residual bilateral lower extremity radiculopathy, including numbness in both feet and weakness in bilateral ankles and left EHL to the extent in which he is unable to stand for any amount of time, nor is he able to walk, with Mark Kearns needing to use a motorized scooter for a mobility devise and as such, it is my medical opinion that Mark V. Kearns is entitled to an award of functional loss

> of use of his bilateral lower extremities due to residual impairments related to his work injury of 2-19-87 (Claim no. 87-27039).

**{¶13}** 9. On December 8, 2008, citing Dr. Renneker's November 24, 2008 report, relator moved for R.C. 4123.57(B) scheduled-loss compensation for the alleged loss of use of his legs.

**{¶14}** 10. Relator's motion prompted the Ohio Bureau of Workers' Compensation ("bureau") to have relator examined by H. Thomas Reynolds, M.D., on February 16, 2009. Dr. Reynolds reported:

> * * * In early 1992, he underwent a L4-L5 fusion by Dr. Papp and then the third follow up with Dr. Papp, an MRI showed that the screws were coming out of place and he had a bulge above the area of fusion. In 1994, the screws, pins and plates were taken out. He was awarded permanent and total impairment in 1998 and he is also receiving SSI benefits. He was told he had degenerative disk disease. Since 2000, he has been seeing Dr. Severyn at the OSU Spine Center for pain management and he has had a pain pump since March of 2005 with Dilaudid, using fentanyl patches and morphine. His medication list is extensive[.] * * * His wife was along with him and provided most of the history. He has had several epidural steroid trials by Dr. Severyn in July of 2007. He was referred then to Dr. Lakatos, the associate of Dr. Severyn's [sic] who is a back surgeon and said that there was cloudiness in his tailbone and bone spurs of the coccyx and recommended a discogram at the level above the fusion, but this has been denied 3 times. He was given a 60% to 65% chance of being able to go up and down steps by himself and he thought this was as good [as] being able to flip a coin. He has been told without the discogram, there is nothing else to do, and he is on maximum medications. Every 4 months, he gets some of the nerve block in his back at Dr. Seveyn's [sic] office that helps him for about 3 months and then he tightens back up again. Dr. Severyn manages the pain medications. * * * He falls at home, especially if things are put in his way. He ambulates primarily with a scooter that BWC has approved and paid for. * * * He is looking at getting a stair lift to help him up and down the steps. He needs a wheelchair ramp for the back. * * * He

goes to aquatic therapy once a week at Kenny Road for 45 minutes and then gets a 30 minute soft tissue massage and uses Theraband at home for exercises. * * * If he stands he has increasing sharp low back discomfort that goes up his back and down both hips and legs. He can stand for 5 or 10 minutes at most. Both legs bother him about the same. He can only get up and down the steps once a day and his 24-year-old son has moved in to help with that. He gets a nagging ache in the upper back clear down to his feet and his legs get weak. * * *

On physical examination today, he was evaluated in the presence of his wife. He ambulated to and from the exam room in a scooter that he was independently operating. He was able to get up and down off the table and in and out of a chair, with assistance of his wife holding on. He uses a cane in the right hand also. At home, they both report he uses a cane and holds on to furniture or someone that is with him. Plantar responses are flexor in nature and no ankle clonus or spasticity is seen. There is trace reflexes at the knees at most with facilitation and 1+ ankle reflex bilaterally routinely. Light touch sensation is decreased in both lower limbs in general, more so on the left than the right, especially proximally. He has no proprioceptive sensation in the left first toe and decreased light touch, more in the left lateral calf and thigh. This is all objective. He has intact position and proprioceptive sensations in both first toes and right 5th digit in the foot. He is able to wiggle his toes. Manual muscle testing in both feet at least a good strength level, estimated today. He has a stated height of 5 feet 7.5 inches tall and a stated weight of 207 pounds. Straight leg raising sitting lacked about 70 degrees in the extension with hamstring tightness and complaints of back pain. There are well-healed vertical scars about the low back midline and he has his pain pump on the right lower abdomen, anteriorly and inferiorly. There is minimal range of motion of the low back, mostly done at the hips with about forward flexion of about 15 degrees with flattening of the lumbar spine, as one would expect with a fusion; lateral flexion to the left was to neutral and to the right was maybe 5 degrees with extension, lacking maybe a few degrees even getting to neutral. He stands a little forward flexed at the hips and back. Circumferential measurements about the calves, 5 inches below the infrapatellar border on the left was 36.5 cm and right 36 cm in a right-handed individual.

> * * *
>
> The examination/evaluation today was to provide additional medical information towards the injured worker filing an application for loss of use of the lower extremities. It is my opinion, based on today's evaluation that the claimant has not lost use of his lower limbs for ability to transfer, some ambulation and maneuverability. He is able to help support his weight with a cane and with help. He can stand for 5 to 10 minutes, he reports, before the pain becomes too bad. He does have ability to transfer using both legs. In my opinion, the allowed injury has not resulted in total, permanent loss of use to such a degree that the affected body part is useless, for all practical purposes, and the lower limbs are capable of performing most of the functions for which he commonly performs although resulting in a lack of distance in this claim. However, the length of time he could perform these activities are severely limited. He has ability to wiggle his toes and has at least good strength in both feet; he has intact light touch, although decreased in both lower limbs, left more than the right and has intact reflexes at both ankles and knees.

**{¶15}** 11. On March 17, 2009, Dr. Renneker completed a medical questionnaire that was presumably prepared by relator's counsel. Dr. Renneker marked the "Yes" response to each of the following six questions:

> 1. I have reviewed the medical report completed by Dr. Reynolds.
>
> 2. Based upon my review of the medical reports, as well as my personal knowledge of Mr. Kearns, I believe that he retains only minimal use of his legs.
>
> 3. As a result of the allowed conditions in his Workers' Compensation claim, Mr. Kearns is unable to walk, run, jump, climb ladders, climb stairs, hop on one leg independent of the other, hop on both legs together. Claimant is unable to kick a ball, use his feet and legs in an industrial setting to operate machinery, press pedals or other industrial functions.
>
> 4. Claimant is unable to ambulate normally without an assistive devise.

> 5. Claimant currently uses a motorized scooter to compensate for his inability to ambulate due to the allowed conditions in the claim.
>
> 6. As a result of the above opinions, I believe that Mr. Kearns has lost the use of his leg[s] for all practical purposes.

**{¶16}** 12. Following a March 17, 2009 hearing, a district hearing officer ("DHO") issued an order denying relator's December 8, 2008 motion:

> Based on the 02/16/2009 report of H. Reynolds, M.D., this District Hearing Officer finds the request for an award for "bilateral loss of use of lower extremities["] is not medically supported. Medically, Dr. Reynolds document[ed] some retained practical, limited use of the lower extremities.
>
> Therefore, the request for an award for "bilateral loss of use of lower extremities" is denied.

**{¶17}** 13. Relator administratively appealed the DHO's order of March 17, 2009.

**{¶18}** 14. Following an April 16, 2009 hearing, a staff hearing officer ("SHO") issued an order affirming the DHO's order. The SHO's order explains:

> After reviewing all of the evidence pertaining to the issue, considering the testimony of Injured Worker and arguments of counsel, it is the order of the Staff Hearing Officer that the Injured Worker's C-86 motion, filed 12/09/2008, is denied.
>
> It is the finding of the Staff Hearing Officer that the Injured Worker has not loss [sic] the use of his legs bilaterally for all practical purposes. The Staff Hearing Officer notes that the Injured Worker has the ability to walk for short periods and stand[.]
>
> The Staff Hearing Officer relies upon the medical report of Dr. Reynolds who note[s] that [sic] Injured Worker['s] use of his legs. See report dated 02/16/2009.
>
> The Staff Hearing Officer also notes that Dr. Kearns [sic] has requested a discogram to help the Injured Worker control his pain. The Injured Worker['s] pain is limiting his ability to stand and walk [f]or longer periods. The Injured Worker also filed an appeal of the denial by the managed care

> organization. See medical records of Dr. Kearns [sic] dating from September 2008 forward.
>
> File referred to the Bureau of Workers' Compensation to process the Injured Worker's appeal of the denial of the discogram.

**{¶19}** 15. On May 15, 2009, another SHO mailed an order refusing relator's appeal from the SHO's order of April 16, 2009.

**{¶20}** 16. On June 17, 2009, relator, Mark Kearns, filed this mandamus action.

Conclusions of Law:

**{¶21}** Several issues are presented: (1) whether the commission used an incorrect legal standard in determining that relator has not lost the use of his legs or, alternatively, whether the commission incorrectly applied the correct legal standard; (2) whether the commission abused its discretion when addressing the discogram; and (3) whether the commission's order violates *State ex rel. Noll v. Indus. Comm.* (1991), 57 Ohio St.3d 203.

**{¶22}** The magistrate finds: (1) the commission did not use an incorrect legal standard nor did it incorrectly apply the correct legal standard; (2) the commission did not abuse its discretion when addressing the discogram; and (3) the commission's order does not violate *Noll*.

**{¶23}** Accordingly, it is the magistrate's decision that this court deny relator's request for a writ of mandamus, as more fully explained below.

**{¶24}** Turning to the first issue, in *State ex rel. Alcoa Bldg. Products v. Indus. Comm.*, 102 Ohio St.3d 341, 2004-Ohio-3166, ¶10, the court succinctly set forth the historical development of scheduled awards for loss of use under R.C. 4123.57(B). The *Alcoa* court states:

> Scheduled awards pursuant to R.C. 4123.57(B) compensate for the "loss" of a body member and were originally confined to amputations, with the obvious exceptions of hearing and sight. In the 1970's, two cases—*State ex rel. Gassmann v. Indus. Comm.* (1975), 41 Ohio St.2d 64, 70 O.O.2d 157, 322 N.E.2d 660, and *State ex rel. Walker v. Indus. Comm.* (1979), 58 Ohio St.2d 402,12 O.O.3d 347, 390 N.E.2d 1190—construed "loss," as similarly used in R.C. 4123.58, to include loss of use without severance. *Gassmann* and *Walker* both involved paraplegics. In sustaining each of their scheduled loss awards, we reasoned that "[f]or all practical purposes, relator has lost his legs to the same effect and extent as if they had been amputated or otherwise physically removed." *Gassmann*, 41 Ohio St.2d at 67, 70 O.O.2d 157, 322 N.E.2d 660; *Walker*, 58 Ohio St.2d at 403-404, 12 O.O.3d 347, 390 N.E.2d 1190.

**{¶25}** In *Alcoa*, the claimant sustained a left arm amputation just below the elbow. Continuing hypersensitivity at the amputation site prevented the claimant from ever wearing a prosthesis. Consequently, the claimant moved for a scheduled-loss award for loss of use of his left arm.

**{¶26}** Alcoa established through a videotape that the claimant could use his remaining left arm to push open a car door and to tuck paper under the arm. Nevertheless, the commission granted the claimant an award for the loss of use of his left arm.

**{¶27}** This court denied Alcoa's complaint for a writ of mandamus and Alcoa appealed as of right to the Supreme Court of Ohio.

**{¶28}** Affirming this court's judgment and upholding the commission's award, the *Alcoa* court explained, at ¶10-15:

> * * * Alcoa urges the most literal interpretation of this rationale and argues that because claimant's arm possesses some residual utility, the standard has not been met. The court of appeals, on the other hand, focused on the opening four words, "for all practical purposes." Using this inter-

pretation, the court of appeals found that some evidence supported the commission's award and upheld it. For the reasons to follow, we affirm that judgment.

Alcoa's interpretation is unworkable because it is impossible to satisfy. *Walker* and *Gassmann* are unequivocal in their desire to extend scheduled loss benefits beyond amputation, yet under Alcoa's interpretation, neither of those claimants would have prevailed. As the court of appeals observed, the ability to use lifeless legs as a lap upon which to rest a book is a function unavailable to one who has had both legs removed, and under an absolute equivalency standard would preclude an award. And this will always be the case in a nonseverance situation. If nothing else, the presence of an otherwise useless limb still acts as a counterweight—and hence an aid to balance—that an amputee lacks. Alcoa's interpretation would foreclose benefits to the claimant who can raise a mangled arm sufficiently to gesture or point. It would preclude an award to someone with the hand strength to hold a pack of cards or a can of soda, and it would bar—as here—scheduled loss compensation to one with a limb segment of sufficient length to push a car door or tuck a newspaper. Surely, this could not have been the intent of the General Assembly in promulgating R.C. 4123.57(B) or of *Gassmann* and *Walker.*

Pennsylvania defines "loss of use" much as the court of appeals did in the present case, and the observations of its judiciary assist use here. In that state, a scheduled loss award requires the claimant to demonstrate either that the specific bodily member was amputated or that the claimant suffered the permanent loss of use of the injured bodily member for all practical intents and purposes. Discussing that standard, one court has written:

"Generally, the 'all practical intents and purpose' test requires a more crippling injury than the 'industrial use' test in order to bring the case under section 306(c), supra. However, it is not necessary that the injured member of the claimant be of absolutely no use in order for him to have lost the use of it for all practical intents and purposes." *Curran v. Walter E. Knipe & Sons, Inc.* (1958), 185 Pa.Super. 540, 547, 138 A.2d 251.

This approach is preferable to Alcoa's absolute equivalency standard. Having so concluded, we further find that some

> evidence indeed supports the commission's decision. Again, Dr. Perkins stated:
>
> "It is my belief that given the claimant's residual hyper-sensitivity, pain, and tenderness about his left distal forearm, that he is unable to use his left upper limb at all and he should be awarded for the loss of use of the entire left upper limb given his symptoms. He has been given in the past loss of use of the hand, but really he is unable to use a prosthesis since he has had the amputation, so virtually he is without the use of his left upper limb * * *."

**{¶29}** Relying upon *Alcoa*, this court, in *State ex rel. Richardson v. Indus. Comm.*, 10th Dist. No. 04AP-724, 2005-Ohio-2388, ¶7, explained the standard that *Alcoa* clarified:

> * * * [W]hen a claimant seeks a scheduled loss award, the proper inquiry is whether, taking into account both medical findings and real functional capacity, the body part for which the scheduled loss award is sought is, for all practical purposes, unusable to the same extent as if it had been amputated or otherwise physically removed. * * *

**{¶30}** Here, in the report upon which the commission exclusively relied, Dr. Reynolds opined: "[T]he allowed injury has not resulted in total, permanent loss of use to such a degree that the affected body part is useless for all practical purposes."

**{¶31}** Here, while relator states in his brief that the commission "used the wrong standard," his actual argument is that the commission incorrectly applied the *Alcoa* standard. (Relator's brief, at 13.)

**{¶32}** In any event, the magistrate finds that Dr. Reynolds' report does not indicate that Dr. Reynolds used the "absolute equivalency" standard that the *Alcoa* court rejected.

**{¶33}** Thus, the question remains as to whether it can be successfully argued that the commission, in relying upon Dr. Reynolds' report, incorrectly applied the *Alcoa*

standard. The magistrate finds that the commission did not misapply the *Alcoa* standard.

**{¶34}** In addressing this issue, it is helpful to review this court's decision in *Richardson*. In that case, John Richardson applied for R.C. 4123.57(B) scheduled-loss compensation for an alleged total loss of use of his left foot. Following the commission's denial of his application, Richardson filed a mandamus action in this court.

**{¶35}** In denying Richardson's application, the commission relied upon the medical reports of Drs. Gibson and Wilkey.

**{¶36}** In his September 17, 2003 report, Dr. Gibson stated:

> He does ambulate and get about with the use of a foot drop brace, and to this extent, the left ankle and foot are functional. Clearly, it could not be compared to an amputation or total loss of function of the left foot. The very fact that ambulation is possible, and certain ankle motions (as plantar flexion) are intact, would not allow for the conclusion that there is total and permanent loss of use of the left foot.

Id. at ¶16.

**{¶37}** In his October 14, 2003 report, Dr. Wilkey stated:

> Observation. This patient uses a cane for ambulation. There is a significant limp. An AFO was presented that has considerable wear consistent with prolonged use. * * *

Id. at ¶17.

**{¶38}** In *Richardson*, this court denied the writ of mandamus, explaining:

> In his report, Dr. Gibson explicitly indicated that the question posed to him was whether the allowed conditions have resulted in a total, permanent loss of use of the left foot as if amputated. He equated weight-bearing capability with the absence of a total and permanent loss of use. He took into account the lack of flexion in the foot, as well as the pain, numbness and weakness present. However, he noted that with a foot drop brace relator can ambulate. Based upon this

> capability, Dr. Gibson opined that the foot is functional and "could not be compared to an amputation or total loss of function of the left foot." The findings in the Wilkey and Gibson reports do not render relator's situation similar to that in *Alcoa*, where the claimant's partially amputated arm lacked functional capacity because it could be used for little other than petting a dog or pushing open a car door. This case is also not akin to [*State ex rel. Walker v. Indus. Comm.* (1979), 58 Ohio St.2d 402], in which the claimant's paralyzed legs could not be used except as a resting place for reading material or a plate of food.
>
> Relator argues that his affidavit, in which he describes the constant pain he experiences in his left foot, demonstrates that the Wilkey and Gibson reports are fatally flawed because they do not take into account relator's chronic pain. But relator's pain need not be considered by these experts or the commission, even under *Schultz* [citation omitted in original] and [*State ex rel. Timmerman Truss, Inc. v. Indus. Comm.*, 102 Ohio St.3d 244, 2004-Ohio-2589], if the same does not affect his *functional capacity*. No expert, including relator's examining physician, Dr. Siegal, reported that relator's pain is so intense and uncontrollable that it renders his foot unable to bear weight, resulting in an inability to walk. Here, the reports of Drs. Wilkey and Gibson establish that relator *can walk*, albeit with the help of a brace. Thus, the com-mission did not abuse its discretion in finding that relator has not sustained a total loss of its use. The court cannot imagine a more paramount use for a foot than the activity of walking.

Id. at ¶9-10. (Emphases sic.)

**{¶39}** Here, while relator's ability to ambulate is less than Richardson's ability, it is nevertheless clear that relator retains significant ambulation ability with the assistance of someone such as his wife or son or by holding onto the furniture at his house.

**{¶40}** When Dr. Reynolds opined that relator had not lost the use of his lower limbs, he focused on his observation that relator retains "ability to transfer, some ambulation and maneuverability."

**{¶41}** Dr. Reynolds further noted: "He is able to help support his weight with a cane and with help. He can stand for 5 to 10 minutes, he reports, before the pain becomes too bad. He does have ability to transfer using both legs." Clearly, relator's legs retain weight-bearing capacity albeit with assistance. That factor compares with the weight-bearing capability of Richardson.

**{¶42}** Also, the ability to transfer is significant. Apparently, Dr. Reynolds' repeated reference to "ability to transfer" indicates that, by using his legs, relator can maneuver his body with assistance from his scooter to the examination table or, at home, he can maneuver himself around his house by holding onto the furniture.

**{¶43}** In the magistrate's view, Dr. Reynolds identified significant residual capabilities upon which he could properly opine that relator has not lost the use of his legs under the *Alcoa* standard.

**{¶44}** Accordingly, based upon the above analysis, the magistrate concludes that the commission did not use an incorrect legal standard nor did it incorrectly apply the correct legal standard in determining that relator has not sustained the loss of use of his legs.

**{¶45}** Turning to the second issue, it is well-settled law that R.C. 4123.57(B) requires that the loss of use be permanent. *State of Ohio ex rel. Welker v. Indus. Comm.*, 91 Ohio St.3d 98, 99, 2001-Ohio-292; *State ex rel. Carter v. Indus. Comm.*, 10th Dist. No. 09AP-30, 2009-Ohio-5547, ¶54.

**{¶46}** In his August 21, 2007 letter to Todaro, again, Dr. Lakatos wrote:

> The purpose of the lumbar diskography test is to help indentify the possible sources of the patient's symptoms, that is[,] the low back pain. It is not intended to provide any information in regards to stenosis or radiculopathy, and in

> Mr. Kearns['] case, this information that we would obtain from this test would help guide us in deciding any additional treatment options that may be appropriate for his condition.
> * * *
>
> In his October 1, 2007 letter to the ADR nurse, again, Dr. Lakatos states:
>
> * * * It is important to point out that the lumbar discography is a provocative diagnostic test, not a treatment, and does not necessarily lead to arthrodesis procedures as suggested in Dr. Ahn's opinion. In other words, lumbar discography can help indentify where the patient's lumbar axial symptoms are coming from and that information can be utilized to determine what are the most appropriate treatment measures.
>
> * * *
>
> In Mr. Kearns['] case, our goal here is to try to identify what levels are causing his pain and then determine what the best treatments are[,] and not necessarily an arthrodesis, as indicated by Dr. Ahn's opinion. This diagnostic test is most certainly within reasonable guidelines for determining the source and nature of Mr. Kearns' symptoms and is appropriate, relative to the patient's continued chronic low back pain and spine care history.

**{¶47}** Contrary to relator's assertion here, based upon Dr. Lakatos' August 21 and October 1, 2007 letters, the SHO could appropriately state that Dr. Lakatos "has requested a discogram to help [relator] control his pain." That the discogram itself is not a treatment for the control of pain does not render the SHO's statement incorrect or inappropriate. Obviously, the discogram results can lead to the right treatment for pain control.

**{¶48}** Moreover, the SHO appropriately stated that relator's "pain is limiting his ability to stand and walk [for] longer periods." This statement is obviously supported by Dr. Reynolds' report wherein he stated: "If he stands he has increasing sharp low back

discomfort that goes up his back and down both hips and legs. He can stand for 5 or 10 minutes at most. Both legs bother him about the same."

**{¶49}** Clearly, the SHO's order indicates that administrative approval of the discogram could result in an improvement in relator's ability to ambulate. Without directly so stating, the SHO's order indicates a concern that relator's condition, as assessed by Dr. Reynolds, may not be permanent if the discogram were approved.

**{¶50}** However, that a discogram might lead to pain control and improvement of relator's condition is not the primary basis for denial of a scheduled-loss award. The SHO's order states reliance upon Dr. Reynolds' report which, independently of the discogram issue, supports the commission's decision.

**{¶51}** In short, based upon the above analysis, it is clear that the SHO's comments regarding the discogram and pain control do not, in any way, detract from the commission's reliance upon Dr. Reynolds' report which provides the some evidence supporting the commission's decision.

**{¶52}** Turning to the third issue, the syllabus of *Noll* states: "In any order of the Industrial Commission granting or denying benefits to a claimant, the commission must specifically state what evidence has been relied upon, and briefly explain the reasoning for its decision."

**{¶53}** As relator points out, the SHO's order of April 16, 2009 contains grammatical, punctuational and other errors.

**{¶54}** For example, a period is missing after the word "stand" at the end of the second sentence of the second paragraph of the order, as quoted above. According to relator, the missing period suggests that the SHO failed to complete his thought or to

finish the sentence. The magistrate disagrees. If a period is inserted after the word "stand," we have a complete sentence that makes perfect sense.

**{¶55}** Another example of error is found in the fourth paragraph of the SHO's order as quoted, where Dr. Lakatos is twice referred to as Dr. Kearns. The mistake is obvious and does not significantly detract from the message or intelligibility of the paragraph.

**{¶56}** The last sentence of the fourth paragraph mistakenly refers to the medical records as dating from "September 2008 forward." As earlier noted, the relevant medical records from Dr. Lakatos are dated July 2, July 6, August 21 and October 1, 2007. Again, the error is obvious from the record as stipulated by the parties.

**{¶57}** The following unedited sentence appears in the fourth paragraph: "The Staff Hearing Officer relies upon the medical report of Dr. Reynolds who note that Injured Worker use of his legs."

**{¶58}** According to relator, the above-quoted sentence incorrectly indicates that Dr. Reynolds indicates that relator has the ability to walk for short periods and stand unassisted. The magistrate disagrees that the sentence must be read in the manner suggested by relator.

**{¶59}** According to relator, the above-described errors in the SHO's order prevent this court from performing a meaningful review of the commission's decision. Again, the magistrate disagrees.

**{¶60}** While this type of order is obviously not a model to be followed, the errors do not prevent this court from performing a meaningful review. Thus, the order does not violate *Noll*.

**{¶61}** Accordingly, for all the above reasons, it is the magistrate's decision that this court deny relator's request for a writ of mandamus.

/s/ Kenneth W. Macke
KENNETH W. MACKE
MAGISTRATE

**NOTICE TO THE PARTIES**

Civ.R. 53(D)(3)(a)(iii) provides that a party shall not assign as error on appeal the court's adoption of any factual finding or legal conclusion, whether or not specifically designated as a finding of fact or conclusion of law under Civ.R. 53(D)(3)(a)(ii), unless the party timely and specifically objects to that factual finding or legal conclusion as required by Civ.R. 53(D)(3)(b).