[Cite as *State ex rel. Hoffman v. Indus. Comm.*, 2013-Ohio-673.]

IN THE COURT OF APPEALS OF OHIO

TENTH APPELLATE DISTRICT

State of Ohio ex rel. Michael Hoffman,	:	
Relator,	:	No. 12AP-456
v.	:	(REGULAR CALENDAR)
Industrial Commission of Ohio and Home Depot USA Inc.,	:	
Respondents.	:	

D E C I S I O N

Rendered on February 26, 2013

Scully & Delaney, and *Timothy J. Delaney*, for relator.

Michael DeWine, Attorney General, and *Justine S. Casselle*, for respondent Industrial Commission of Ohio.

Dinsmore & Shohl, LLP, *Michael L. Squillace*, *and Christen S. Hignett*, for respondent Home Depot USA Inc.

IN MANDAMUS
ON OBJECTIONS TO THE MAGISTRATE'S DECISION

BROWN, J.

{¶ 1} Relator, Michael Hoffman ("claimant"), has filed this original action requesting that this court issue a writ of mandamus ordering respondent, Industrial Commission of Ohio ("commission"), to vacate its order that denied temporary total disability ("TTD") compensation and to enter an order granting said compensation.

{¶ 2} This matter was referred to a court-appointed magistrate pursuant to Civ.R. 53(C) and Loc.R. 13(M) of the Tenth District Court of Appeals. The magistrate issued the appended decision, including findings of fact and conclusions of law, and recommended

that this court deny claimant's request for a writ of mandamus. Claimant has filed objections to the magistrate's decision.

{¶ 3} Claimant first argues that the magistrate's finding of fact in paragraph36 was in error. In paragraph 36, the magistrate found that Dr. Lisa Kurtz's August 9, 2011 report listed the allowed conditions in relator's claim but failed to list the newly allowed conditions of generalized and focal seizure activity and migraine headaches. Claimant argues that the magistrate's finding assumes Dr. Kurtz examined claimant on the additionally allowed conditions of generalized and focal seizure activity and migraine headaches and merely failed to list them. Claimant argues that it is probable that Dr. Kurtz examined him for only the four allowed conditions Dr. Kurtz actually cited.

{¶ 4} We disagree. A review of Dr. Kurtz's August 9, 2011 report reveals that Dr. Kurtz performed an in-depth review of claimant's relevant medical records, and she referenced claimant's seizures and headaches multiple times throughout her thorough report. Dr. Kurtz devoted the review of symptoms section of her report entirely to discussing claimant's headaches and seizures, and she repeatedly references his headaches and seizures in her discussion section. In the physical examination section of the report, Dr. Kurtz reviewed claimant's speech patterns, tics, and tremors. Therefore, it is clear that Dr. Kurtz examined claimant for the allowed conditions of generalized and focal seizure activity and migraine headaches for purposes of her August 9, 2011 report.

{¶ 5} Similarly, claimant argues that the magistrate erred in her finding of fact in paragraph 38. In paragraph 38, the magistrate stated that because Dr. Kurtz failed to consider all of the allowed conditions, the doctor completed a September 9, 2011 addendum to discuss whether or not relator had reached maximum medical improvement ("MMI") for the newly allowed conditions of focal seizure activity and migraine headaches. Claimant contends that no one knows what "generated" that addendum, and there is no explanation in the addendum as to how relator reached MMI on the newly allowed conditions. With regard to why the addendum was "generated," it appears clear that Dr. Kurtz completed the addendum for the sole purpose of adding her opinion regarding the allowed conditions of focal seizure activity and migraine headaches. Furthermore, although relator also argues that the September 9, 2011 report does not explain how he reached MMI, our standard of review is whether the report constituted

"some evidence" to support the commission's conclusion. *See State ex rel. Fiber-Lite Corp. v. Indus. Comm.*, 36 Ohio St.3d 202 (1988), syllabus. In this case, Dr. Kurtz's reports satisfy that requirement. To go further and assess the credibility of the evidence would place this court in the impermissible role of a "super commission." *State ex rel. Burley v. Coil Packing, Inc.*, 31 Ohio St.3d 18, 20 (1987). Therefore, these arguments are without merit.

{¶ 6} Claimant next argues that the magistrate erred when she concluded that Dr. Kurtz's September 9, 2011 addendum report constituted some evidence upon which the commission could base its decision that relator had reached MMI on January 11, 2010. Claimant asserts that the addendum does not resurrect or reference the examination findings of the August 9, 2011 report. Claimant also contends that the addendum does not describe how the seizure activity and migraine headaches reached a state of permanency on January 11, 2010. Claimant points to Dr. William J. Novak's June 7, 2010 report that indicates claimant's seizure activity had improved with the use of anti-epileptic medication, which would contradict Dr. Kurtz's September 9, 2011 addendum finding of MMI on January 11, 2010.

{¶ 7} We disagree with claimant's contentions. Dr. Kurtz's September 9, 2011 addendum report does, in fact, reference the original examination. The addendum report indicates that the date of examination was August 9, 2011, thereby implicitly incorporating those examination findings from the original report. Also, as we stated with regard to claimant's earlier argument in the same vein, the commission could rely upon Dr. Kurtz's opinion in her addendum even though the addendum did not explain how claimant had reached MMI on the two newly allowed conditions. The addendum provided "some evidence" upon which the commission could rely. Furthermore, although claimant contends Dr. Novak's June 7, 2010 report contradicts Dr. Kurtz's September 9, 2011 addendum finding of MMI, under the some evidence review, "the presence of contrary evidence is immaterial, so long as the 'some evidence' standard has been met." *State ex rel. Am. Standard, Inc. v. Boehler*, 99 Ohio St.3d 39, 2003-Ohio-2457, ¶ 29. "The 'some evidence' standard reflects the established principle that the [administrative body] is in the best position to determine the weight and credibility of the evidence and disputed facts." *State ex rel. Woolum v. Indus. Comm.*, 10th Dist. No. 02AP-780, 2003-Ohio-3336,

¶ 4, citing *State ex rel. Pavis v. Gen. Motors Corp., B.O.C. Group*, 65 Ohio St.3d 30, 33 (1992). Thus, Dr. Novak's contradictory assessment that claimant has not reached MMI does not eliminate Dr. Kurtz's report as some evidence in support of the commission's determination. Therefore, Dr. Kurtz's addendum report constitutes some evidence supporting the commission's decision. For these reasons, we overrule claimant's objections.

{¶ 8} After an examination of the magistrate's decision, an independent review of the record, pursuant to Civ.R. 53, and due consideration of claimant's objections, we overrule the objections and adopt the magistrate's findings of fact and conclusions of law. Claimant's writ of mandamus is denied.

Objections overruled;
writ of mandamus denied.

TYACK and McCORMAC, JJ, concur.

McCORMAC, J., retired of the Tenth Appellate District, assigned to active duty under authority of the Ohio Constitution, Article IV, Section 6(C).

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[Cite as *State ex rel. Hoffman v. Indus. Comm.*, 2013-Ohio-673.]

APPENDIX

IN THE COURT OF APPEALS OF OHIO

TENTH APPELLATE DISTRICT

State of Ohio ex rel. Michael Hoffman,	:	
	:	
Relator,	:	No. 12AP-456
v.	:	(REGULAR CALENDAR)
Industrial Commission of Ohio and Home Depot USA Inc.,	:	
Respondents.	:	

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

Rendered on November 16, 2012

Scully & Delaney, and *Timothy J. Delaney*, for relator.

Michael DeWine, Attorney General, and *Justine S. Casselle*, for respondent Industrial Commission of Ohio.

Dinsmore & Shohl, LLP, M*ichael L. Squillace and Christen S. Hignett*, for respondent Home Depot USA Inc.

IN MANDAMUS

{¶ 9} Relator, Michael Hoffman, has filed this original action requesting that this court issue a writ of mandamus ordering respondent Industrial Commission of Ohio ("commission") to vacate its order which denied relator's request for temporary total disability ("TTD") compensation and ordering the commission to find that he is entitled to that compensation.

Findings of Fact:

{¶ 10} 1. On June 29, 2007, while working for respondent Home Depot USA, Inc. ("Home Depot"), relator had some type of seizure which caused him to loose consciousness and fall. As he fell, relator struck his head on a countertop.

{¶ 11} 2. Relator was taken to Akron City Hospital and was admitted for the following reason:

> The patient is a 26-year-old gentleman seizure with fall, subsequent subarachnoid hemorrhage with progression to bifrontal intraparenchymal hemorrhage, nonoperative. The patient evaluated as trauma consult for findings of intracranial hemorrhage. The patient with complaints of preceding nosebleed and headache, nausea and vomiting.

{¶ 12} 3. Relator remained in the hospital until he was discharged on July 7, 2007.

{¶ 13} 4. At the time he was discharged, the hospital records note the following:

> **IMPRESSION:**
>
> 1. Fall.
> 2. Seizure.
> 3. Subarachnoid hemorrhage.
> 4. Bifrontal intraparenchymal hemorrhage.
> 5. Nondisplaced left occipitoparietal skull fracture.
> 6. Hypertension.
> 7. Blurry vision.
> 8. Subconjunctival hemorrhage.
> 9. Hyponatremia[1], resolved.

{¶ 14} 5. Following his discharge from the hospital, relator continued to suffer from persistent headaches and occasional seizures.

{¶ 15} 6. On June 24, 2009, relator filed a First Report of Injury, Occupational Disease or Death form ("FROI-1"). In support, relator submitted the records from Akron City Hospital.

{¶ 16} 7. Relator presented at Barberton Hospital on June 25, 2009, complaining of the following:

> This is a 28-year-old male comes in to the Emergency Department after having a seizure tonight. He is a known

[1] "A decreased concentration of sodium in the blood." *Taber's Cyclopedic Medical Dictionary* 1053 (20th Ed.2005).

> seizure patient for the past two to three years after traumatic brain injury. His last grand mal seizure was about a year ago. He has had several smaller seizures, which he has not presented to the hospital with. He is on Dilantin 300 mg a day, but it was decreased about two months ago from 600 to 300 mg and on further questioning, he states that he might not have taken it today and he misses some doses from tiem to time. He states he feels much better now. He has also had a headache over the past three days, but he has these headaches ever since he has had a traumatic brain injury. This is not a new headache, not different headache. He actually states since he has had this seizure his headache his much improved at this time. No decrease, double or blurry vision. No neck pain. No fevers. No chills. No recent illnesses. His girlfriend that is here with him states his behavior is normal and appropriate. I did review the squad notes at this time. He appeared to be postictal at that time.

{¶ 17} When he was discharged, relator's dosage of Dilantin, a seizure medication, was increased.

{¶ 18} 8. A file review was conducted by Rafael M. Ramirez, M.D. In his November 30, 2009 report, Dr. Ramirez provided a detailed history of relator's symptomatology since the date of his injury and identified the medical records which he reviewed. Ultimately, Dr. Ramirez concluded as follows:

> Based on the history of trauma, it must be concluded that the skull fracture, the s[u]barachnoid and intracerebral hemorrhage and the resulting [e]ncephalomalacia (brain softening) in the frontal areas of the brain, is the direct result of the industrial injury of 6/29/07. I would therefore concur with Dr. Nair's opinion that these conditions should be included in this injured worker's claim allowance, for the reasons previously exposed.
>
> It is my opinion that this claimant had a pre-existing condition that contributed to the industrial injury of 6/29/07 in the form of hyponatremia (low sodium level). He suffered a first time seizure. The records do not indicate that this claimant had any previous history of such condition. However, at the time of admission to the emergency room the sodium level was 127 (normal 133-145). The Admission Note also indicates that this claimant had been placed on "water pills" for high blood pressure 7 days prior to the seizure. Water pills or diuretics can cause a drop in the level of sodium, as well as other electrolytes. Hyponatremia is a

> known cause of seizure activity and when severe enough can even cause coma.
>
> It is my opinion that this seizure, therefore, was due to metabolic changes (low sodium level) and not related to any abnormal brain discharges, such as epilepsy or other type of seizure disorder, hence, his two negative EEG's.

{¶ 19} 9. Home Depot contested the claim allowance and the matter was heard before a district hearing officer ("DHO") on January 11, 2010. Following the hearing, the DHO determined that relator's claim should be allowed for the following conditions:

> Subarachnoid hemorrhage, intracerebral hemorrhage, s[k]ull fracture, and encephalomalacia.

{¶ 20} The DHO order was based on the November 30, 2009 report of Dr. Ramirez.

{¶ 21} 10. After his claim was allowed, relator filed a C-9 requesting a consultation with a headache clinic, consultation to psychiatry, an EEG, and a brain MRI.

{¶ 22} 11. In response, Dr. Ramirez authored an addendum dated March 11, 2010. In that addendum, Dr. Ramirez discussed relator's treatment from Drs. Novak and Silveira:

> Mr. Hoffman was evaluated at the Cleveland Clinic Epilepsy Center by Dr. Silveira on 2/4/10. The consultation was requested by Dr. William Novak Jr. for an opinion regarding seizures. The consultation note included the sequence of events following the initial convulsion at his place of employment. Mr. Hoffman had been initially treated with Dilantin, an anti-convulsant medication, which later was switched to Keppra. His last seizure, according to the consultant, was on 1/16/10. At that point the dose of Keppra was increased from 500 mg. b.i.d. to 1500 mg. b.i.d. A previous seizure described by his wife occurred in June 2009 while watching television. This was apparently a generalized seizure and he was unresponsive for about 5 minutes, followed by confusion and tendency to sleep for 2 days. The seizure on 1/16/10 caused him to fall down, hitting the door and was also generalized with tongue biting. Afterwards he became aggressive and refused treatment. The typical duration of the seizure was 5 to 10 minutes with a frequency of once every 6 months. The longest seizure free interval was 8 months. There was a history of status epilepticus lasting up to 10 minutes and the postictal symptoms included

> confusion and aggressive behavior. The review of systems includes headaches located on the back of the head; type, pressure. He had been tried on various medications, including Neurontin and Topamax, without affect. The headaches were described as almost constant and with a severity of 8 over 10. There was also a history of depression, but without suicidal ideation. On examination Dr. Silveira reported him to be fully conscious and alert and the only neurological deficit was the presence of a quadratic visual field defect on the left side. The gait was described as showing mild difficulty on the left, without further description and difficulty with tandem walking.
>
> Dr. Silveira's impression included focal epilepsy (likely left frontal). Etiology: head trauma. Seizure classification: Seizure Type A, with tonic and generalized tonic-clonic seizure. The treatment plan included an increase of Keppra to 1500 mg. b.i.d.; prolonged 2-hour EEG. Brain MRI without contrast - extra-temporal lobe epilepsy protocol, blood work, psychiatric consultation for depression and consultation with headache clinic.

{¶ 23} Dr. Ramirez opined that a consultation at a headache clinic, the psychiatric consultation, and the requested EEG were indicated; however, Dr. Ramirez indicated that the requested MRI was not necessary.

{¶ 24} 12. Thereafter, Dr. Ramirez authored a second addendum dated May 17, 2010. The purpose of this addendum was to address relator's request for a pain management consultation and urine drug screen. In opining that the requested services were not indicated, Dr. Ramirez explained:

> Additional documentation included an office note from Dr. Laszio, dated 3/1/10 regarding an office visit. The reason for the visit included headache and hypertension. The information regarding the headache indicates that it is of moderate severity and of a 3-year duration, described by Mr. Hoffman as a pressure. Dr. Laszio also indicated the headache developed, "due to recent head trauma in June 29, 2007". They are aggravated by bright lights and stress, with no relieving factors. Associated symptoms include blurring of vision, dizziness, nausea, performance changes, personality changes and vomiting. In the pertinent negatives he includes head trauma, which is contradictory.

> The note lists the medications Mr. Hoffman was taking, which included Keppra (anticonvulsant), Vicodin for headache and Diovan (anti-hypertensive). The clinical assessment included headache, chronic. Refills were provided for Vicodin and a plan to refer Mr. Hoffman to pain management.
>
> **DISCUSSION AND OPINION:**
>
> I had previously provided an addendum on this individual on 3/11/10. The purpose of that addendum was related to a C-9 dated 2/04/10, requesting authorization for consult with headache clinic, with Dr. Banford, in addition to other services. This time the request is for pain management consult. Mr. Hoffman suffers primarily from headaches, and the management of this condition is ordinarily through a headache clinic, which is a facility usually available in the Neurology Department of a university hospital. There is no information regarding the requested consultation at a headache clinic with Dr. Bandford or whether this actually took place. Intractable headaches are not ordinarily within the domain of pain management consultants.
>
> Reviewing Dr. Laszio's record it becomes apparent that no neurological examination was performed on Mr. Hoffman, except to indicate that he was alert and oriented. On the other hand, there was no reference made to the reason why the urine drug screen was requested.
>
> It is my conclusion that the requested services of pain management consultation and the urine drug screen are not indicated for the treatment of the allowed conditions in this claim.

{¶ 25} 13. On May 29, 2010, relator presented at Akron General Hospital complaining of a headache. Hospital records from that date describe relator's complaints as follows:

> This patient is a 29 Yr old male who presents with a chief complaint of headache. * * * The onset time was 2 month(s) ago. The symptoms came on gradually. The pain is unchanged since onset. * * * The severity of the pain is (was) moderate. The current headache is like previous headaches. * * * The symptoms developed following trauma. Has known [traumatic brain injury] and chronic [headache].

{¶ 26} The hospital records from that day also indicate that relator had a prescription for an MRI; however, he presented to the ER so that his insurance company would pay the bill since the Ohio Bureau of Workers' Compensation ("BWC") was arguing that this was a normal post traumatic headache.

{¶ 27} 14. Following a seizure, relator again presented at Akron General Hospital on July 25, 2010. According to the hospital records, relator indicated that he believed he had a seizure earlier in the day. Relator further indicated that he sees Dr. Novak, that he had been compliant with his medications, and that he currently had a headache which was typical for him following a seizure.

{¶ 28} 15. On August 30, 2010, relator treated with Tony Lababidi, D.O., at the Comprehensive Pain Management Specialists. Relator's chief complaint was head pain which he had been experiencing for three years. Dr. Lababidi provided the following assessment and prescribed Opana ER 10 mg twice a day, and relator was to follow up in one month:

> Patient presents with the complaint of head pain with associated seizures that started after the patient suffered a work related injury where he had a fractured skull with intracranial bleed[.]

{¶ 29} 16. Relator followed up with Dr. Lababidi on September 27, 2010. According to the report prepared by Dr. Lababidi, relator indicated that there were no changes in his symptoms at this time. Dr. Lababidi increased relator's prescription of Opana ER to 15 mg and relator was told to follow up in one month.

{¶ 30} 17. Relator was seen again by Dr. Lababidi on October 25, 2010. According to the report of the same day, relator indicated that he would like to increase his pain medication, that his "pain level is better than previous but he is still at a 5[,] would like to be at a 3." Dr. Lababidi continued relator on Opana 15 mg two times a day and provided him with Opana 5 mg to be taken on an empty stomach as needed for pain every six hours. Relator was to follow up in one month.

{¶ 31} 18. Relator saw Dr. Lababidi again on November 22, 2010. At the time, relator indicated that he had suffered from headaches for three years since the date of his injury and that the present pain regimen was working well but that, in relator's opinion,

the relief did not last the full 12 hours. Dr. Lababidi made no changes in relator's treatment.

{¶ 32} 19. On December 1, 2010, relator filed a C-86 motion seeking to have his claim additionally allowed for the following conditions:

> Generalized and focal seizure activity[;] migraine type headaches[.]

{¶ 33} 20. An independent medical evaluation was completed by Bienvenido D. Ortega, M.D., a neurologist. In his January 17, 2011 report, Dr. Ortega opined:

> In my medical opinion, within a reasonable degree of medical probability, the generalized and focal seizures and migraine type headaches are recognizable conditions and not merely symptoms.

{¶ 34} 21. Relator's motion was heard before a DHO on January 27, 2011. Based on the report of Dr. Ortega, the DHO determined that relator's claim should be additionally allowed for generalized and focal seizure activity and migraine headaches.

{¶ 35} 22. No appeal was taken from the DHO order.

{¶ 36} 23. On June 27, 2011, relator filed a motion requesting that TTD compensation be paid beginning January 11, 2010. Relator's motion was supported by numerous medical records detailing both the treatment and difficulties encountered relating to his reoccurring headaches and seizures.

{¶ 37} 24. In response, Home Depot had relator examined by Lisa Kurtz, M.D. In her August 9, 2011 report, Dr. Kurtz listed the allowed conditions in relator's claim; however, she failed to list the newly allowed conditions of generalized and focal seizure activity and migraine headaches. In her report, Dr. Kurtz identified and discussed the medical records which she reviewed. With regard to relator's current symptoms and treatment, Dr. Kurtz noted the following:

> Mr. Hoffman reports he has poor long-term memory and reports since his injury he is "not as sharp." He states that simple tasks are "difficult" and he is unable to do more than one thing at a time, and it is hard for him to multi-task and if a task requires multiple steps, he cannot think to the second step. He also admits his "confidence is low" and "everything is slower." He reports his biggest complaint is headaches and states they are "like a balloon in his head blowing up," and there is "nothing I can do," when he gets the headaches. He

feels pressure with the headaches. He does lie in a dark room in the quiet and puts an ice pack on his neck and reports the headaches "can get unbearable." Mr. Hoffman reports with his seizure he can "drop like a sack of potatoes" and he has no associated aura with the seizure. He reports he has "no smell" since the injury and "fifty percent" of his taste is affected and he "uses a lot of seasonings." He states since he was started on Opana the headaches have improved and the overall number of headaches has been reduced. He states that his Opana was increased a few months ago, and he now takes 30 mg twice daily. Mr. Hoffman reports he "gets wobbly," associated with dizziness when he is "moving up and down" and he states he has frequent falls. He recalls falling down four to five steps approximately a year ago when he was ascending the carpeted stairs and fell down. Mr. Hoffman states he cannot remember anything "three months before or after" (his injury), and following the injury he reports he "didn't know who or where I was for a year." Mr. Hoffman reports after his injury he had a "regular seizure" approximately one month after his injury and he has two seizure types, generalized tonic clonic seizures and petit mal seizures. He reports his generalized tonic clonic seizures occur every six months, on average, and the petit mal seizures are "clustered together" and occur three to four times a month on average. He reports the petit mal seizures occur when he is "around a lot of people" or there is a lot of activity going on and with the petit mal seizures he describes it as he "looks drunk, tired, and sleepy and (he) doesn't remember it." Mr. Hoffman reports with his current seizure medicines his seizures are shorter in duration and not as severe. Mr. Hoffman reports his triggers for seizures include multi-tasking, "confusion," or if he is around a lot of people or if he is in the heat. Mr. Hoffman also reports if he has "no structure" he "gets lost."

MEDICATIONS

Mr. Hoffman takes Keppra 1500 mg twice daily, Tegretol ER 200 mg twice daily, Lyrica 160 mg three times daily, of which these medictions were started approximately one year ago, Neurontin 300 mg three tablets at bedtime, which was started approximately one year ago, Azor 10/40 mg one tab daily, and Opana 30 mg twice daily, which was increased a few months ago.

{¶ 38} Thereafter, Dr. Kurtz provided her findings upon examination and concluded that relator's allowed conditions had reached maximum medical improvement ("MMI") as of January 11, 2010.

{¶ 39} 25. Because she had failed to consider all of the allowed conditions, Dr. Kurtz completed an addendum on September 9, 2011 to discuss whether or not relator had reached MMI for the newly allowed conditions of generalized and focal seizure activity and migraine headaches. Dr. Kurtz concluded that he had, stating:

> It is my medical opinion, stated with a high degree of certainty, that Mr. Hoffman has reached maximum medical improvement regarding the allowed conditions in this claim, which include subarachnoid hemorrhage, intracerebral hemorrhage, skull fracture, encephalomalacia, generalized and focal seizure activity, and migraine headaches, in this Workers' Compensation claim, which is now more than four years old.
>
> * * *
>
> It is my medical opinion, stated with a high degree of certainty, that Mr. Hoffman did in fact reach maximum medical improvement as of 01/11/2010, based on the allowed conditions in this claim.
>
> * * *
>
> It is my medical opinion, stated with a high degree of certainty, that Mr. Hoffman does not require further medical treatment for the allowed conditions in this claim, which include subarachnoid hemorrhage, intracerebral hemorrhage, skull fracture, encephalomalacia, generalized and focal seizure activity, and migraine headaches. All of these allowed conditions have reached maximum medical improvement and no further medical treatment is necessary or required for the management of these allowed conditions, all of which have reached maximum medical improvement. Therefore, no further medical treatment is medically reasonable or necessary for the allowed conditions in this Workers' Compensation claim.

{¶ 40} 26. Relator's motion was heard before a DHO on September 9, 2011 and was denied. The DHO's order denying relator's request for TTD compensation was based on the reports of Dr. Kurtz.

{¶ 41} 27. Relator's appeal from the DHO's order was heard before a staff hearing officer ("SHO") on October 19, 2011. The SHO affirmed the prior DHO order and denied the request for TTD compensation based on the September 9, 2011 addendum report of Dr. Kurtz.

{¶ 42} 28. Relator's further appeal was refused by order of the commission mailed November 9, 2011.

{¶ 43} 29. Thereafter, relator filed the instant mandamus action in this court.

Conclusions of Law:

{¶ 44} In this mandamus action, relator asserts that the commission abused its discretion by relying on the September 9, 2011 addendum report of Dr. Kurtz to deny his request for TTD compensation. Not only does relator assert that the reports of Dr. Kurtz do not constitute some evidence upon which the commission could properly rely, relator also contends that the commission failed to explain the reason for denying him TTD compensation in light of his evidence from four different medical providers documenting the treatment for seizures and headaches as well as his disability from work.

{¶ 45} Because the magistrate finds that the addendum report of Dr. Kurtz does constitute some evidence upon which the commission could rely to find that all of relator's allowed conditions, including generalized and focal seizure activity and migraine headaches, had reached MMI and because the commission's explanation is adequate, the magistrate would deny relator's request for a writ of mandamus.

{¶ 46} In order for this court to issue a writ of mandamus as a remedy from a determination of the commission, relator must show a clear legal right to the relief sought and that the commission has a clear legal duty to provide such relief. *State ex rel. Pressley v. Indus. Comm.*, 11 Ohio St.2d 141 (1967). A clear legal right to a writ of mandamus exists where the relator shows that the commission abused its discretion by entering an order which is not supported by any evidence in the record. *State ex rel. Elliott v. Indus. Comm.*, 26 Ohio St.3d 76 (1986). On the other hand, where the record contains some evidence to support the commission's findings, there has been no abuse of discretion and mandamus is not appropriate. *State ex rel. Lewis v. Diamond Foundry Co.*, 29 Ohio St.3d 56 (1987). Furthermore, questions of credibility and the weight to be

given evidence are clearly within the discretion of the commission as fact finder. *State ex rel. Teece v. Indus. Comm.*, 68 Ohio St.2d 165 (1981).

{¶ 47} TTD compensation awarded pursuant to R.C. 4123.56 has been defined as compensation for wages lost where a claimant's injury prevents a return to the former position of employment. Upon that predicate, TTD compensation shall be paid to a claimant until one of four things occurs: (1) claimant has returned to work; (2) claimant's treating physician has made a written statement that claimant is able to return to the former position of employment; (3) when work within the physical capabilities of claimant is made available by the employer or another employer; or (4) claimant has reached MMI. See R.C. 4123.56(A); *State ex rel. Ramirez v. Indus. Comm.*, 69 Ohio St.2d 630 (1982).

{¶ 48} Relator contends that the commission abused its discretion by finding that all the allowed conditions in his claim had reached MMI. Ohio Adm.Code 4123-3-32(A)(1) defines maximum medical improvement as:

> "Maximum medical improvement" is a treatment plateau (static or well-stabilized) at which no fundamental functional or physiological change can be expected within reasonable medical probability in spite of continuing medical or rehabilitative procedures. An injured worker may need supportive treatment to maintain this level of function.

{¶ 49} Relator sustained his injury in 2007 and, as the stipulation of evidence indicates, relator began receiving treatment immediately thereafter. Beginning in 2009, the medical records are replete with references to both seizures and headaches. As indicated in the June 25, 2009 emergency report, relator indicated that he had been having both seizures and headaches ever since the date of injury. Further, relator had been treating for those conditions. As evidenced by the June 7, 2010 report from relator's treating physician, William J. Novak, Jr., M.D., it appears likely that relator will continue to suffer from headaches and seizures indefinitely. Specifically, Dr. Novak indicated as follows in his report:

> The headaches he now complains of are of a migranous nature and likely secondary to a post-concussive syndrome (PCS). PCS can occur in 30-80% of head injuries and is diagnosed when symptoms resulting from concussion or head injury last greater than 90 days from time of the injury.

> Symptoms can include headache, cognitive dysfunction, and mood changes. There is no treatment for PCS, but rather treatment is aimed at specific symptoms – in the case of Mr. Hoffman, his headaches. While his current treatment is focused on alleviating his headaches, the prognosis for complete resolution of headaches is uncertain.
>
> Mr. Hoffman's seizures (epilepsy) are also likely secondary to the known head injury with intracerebral hemorrhage, as there was no history of seizures prior to this event. Often, in the case of head injury, seizures chronically recur. The patient has had an EEG performed with photic stimulation and hyperventilation on 1/19/10 and per the interpreting physician: "this is an essentially normal EEG. There is no clearcut evidence of a lateralized abnormality or epileptogenic activity." However, it needs to be noted that a normal EEG does not rule out epilepsy. There may have been no seizure activity during the relatively short time the test was given. A normal EEG does not exclude the diagnosis of epilepsy - the diagnosis also depends on the clinical history. In the case of Mr. Hoffman, his clinical history is strongly suggestive of generalized tonic-clonic seizure activity, which has resulted in multiple emergency department visits and the need for anti-epileptic medications. It should also be noted that Mr. Hoffman's seizure activity has improved with the use of anti-epileptic medications.

{¶ 50} As part of his argument, relator points out that four separate doctors have treated him for skull fracture, intracranial bleed, seizures and migraine headaches – specifically, Dr. Novak, Peter T. Laszlo, M.D., Dr. Lababidi, and Diosely Silveria, M.D. Relator contends that his continuing treatment by these physicians is evidence that he has not reached MMI.

{¶ 51} As noted previously, relator has suffered from headaches and seizures since the date of his injury. Relator has seen several different physicians for his problems and those physicians continue to work with him to help him manage both the headaches and the seizures. However, the fact remains that relator has been treating for these conditions for four years in spite of the fact that his claim was not additionally allowed for the seizure disorder or the headaches until 2011. It is understood that continuing treatment may be necessary even for conditions that have reached MMI. Ohio Adm.Code 4123-3-32(A)(1).

Further, the medical evidence establishes that relator's seizures and headaches are not likely to resolve; instead, they are chronic conditions.

{¶ 52} The magistrate finds this court's decision in *State ex rel. Ramsey v. Frisch Fairborn, Inc.*, 10th Dist. No. 08AP-995, 2009-Ohio-4485 is instructive. In that case, Olabee Ramsey sustained a work-related injury and her workers' compensation claim was originally allowed for:

> Lumbar subluxation; dislocation lumbar vertebrae; dislocated sacrum; sprain sacrum; dysthymic disorder; pain disorder; adjustment disorder with anxiety; herniated disc at L5-S1; bulging disc at L4-L5.

Id. at ¶ 12.

{¶ 53} Ramsey received TTD compensation until a June 3, 2005 hearing before a DHO who concluded that her allowed conditions had reached MMI.

{¶ 54} Thereafter, Ramsey filed a motion asking that her claim be allowed for additional conditions and, in a DHO order dated November 30, 2005, a DHO additionally allowed Ramsey's claim for "facet joint arthritis." *Id*. at ¶ 15.

{¶ 55} In an order mailed May 2, 2008, the BWC granted Ramsey's motion and additionally allowed her claim for "bilateral lumbar L5-S1 radiculopathy." *Id*. at ¶ 16.

{¶ 56} Shortly there after, Ramsey filed a motion seeking TTD compensation based solely on the newly allowed conditions. Ultimately, that request was denied by an SHO who found that Ramsey had been receiving treatment for the newly allowed conditions for a number of years. Specifically, the SHO stated:

> According to *Donald Rice v. I.C.* (5021098), 10th Ct.App., No. 97APD06-842, an additional allowance of a new condition is not in-and-of-itself proof of new circumstances to warrant further temporary total compensation, there must be showing of a real change in the physical condition and/or treatment.
>
> According to the 04/07/2005 report from Dr. Lawson, the injured worker last worked on 11/22/2002. The injured worker was found to have reached maximum medical improvement by District Hearing Order of 06/03/2005, based on the 04/07/2005 report from Dr. Lawson.
>
> The claim was additionally allowed for "LUMBAR FACET JOINT ARTHRITIS" by District Hearing Order of

> 11/30/2005. However, Dr. Lawson clearly notes that treatment for the facet arthritis had already been done before the time of his examination. No request for any new and different type of treatment for facet arthritis since 04/07/2005 is found in file.
>
> The claim was additionally allowed for "L5-S1 RADICULOPATHY" by Bureau of Workers' Compensation order of 05/02/2008. However, as noted by Dr. Williams in his review of 06/29/2008, the additionally allowed L5-S1 radiculopathy has been ongoing and treated for years. He also notes that all of the treatment now being requested has all been tried in the past. This is consistent with the fact the radiculopathy stems from the L5-S1 disc herniation that was previously treated and found to have reached maximum medical improvement. The treatment now being requested was also all tried before Dr. Lawson's examination according to his report. Nothing has changed other than the formal recognition of the previously treated conditions.
>
> The medical evidence noted above does not indicate new and changed circumstances but instead a gradual worsening of the allowed conditions. Based on this history and evidence, Dr. Williams' opinion that no new and changed circumstances have been demonstrated is found persuasive and the requested temporary total compensation is denied.

Id. at ¶ 22.

{¶ 57} Ramsey filed a mandamus action in this court; however, this court adopted the magistrate's decision and denied the request for a writ of mandamus.

{¶ 58} The present case differs from the *Ramsey* case in that relator did not have a previous period of TTD compensation paid which was ultimately terminated based on a finding that his allowed conditions had reached MMI. However, relator's case is similar to the *Ramsey* case in that both relator and Ramsey were receiving treatment for conditions which, at the time the treatment began, were not allowed. It would be years before those conditions were allowed and the request for TTD compensation based on those allowed conditions was made. From a legal standpoint, the outcome is the same. The commission can rely on a medical report which contains an opinion as to the permanency of conditions prior to the date of the examination provided that the physician review the medical records concerning treatment. Here, Dr. Kurtz examined relator and

reviewed the medical records discussing relator's treatment and symptomatology from the date of injury forward. Based on Dr. Kurtz's examination of relator and her review of those records, Dr. Kurtz concluded that relator had been receiving treatment for the newly allowed conditions long before relator asked that those conditions be allowed. The magistrate does not find this to be an abuse of discretion.

{¶ 59} Relator also argues that Dr. Kurtz's second report dated September 9, 2011 does not constitute some evidence upon which the commission could rely because Dr. Kurtz provided no supporting facts on how she determined that relator had reached MMI as of January 11, 2010. In relator's opinion, the addendum report must stand alone and not as an addition to her earlier report.

{¶ 60} The commission specifically cited Dr. Kurtz's September 9, 2011 addendum report which was prepared for one purpose and one purpose only: In her August 9, 2011 report, Dr. Kurtz did not consider the fact that relator's claim had been additionally allowed for generalized and focal seizure activity and migraine headaches. In that ten-page report, Dr. Kurtz identified the medical records which she reviewed and discussed those records prior to noting her own physical findings upon examination. Thereafter, Dr. Kurtz opined that relator's allowed conditions (without considering the generalized and focal seizure activity and migraine headaches) had reached MMI. Because she had failed to consider the additional conditions, Dr. Kurtz was asked to provided an opinion as to whether or not those two conditions had also reached MMI. In her September 9, 2011 addendum report, Dr. Kurtz opined that relator's newly allowed conditions had reached MMI.

{¶ 61} Relator contends that the September 9, 2011 report does not cite the basis for Dr. Kurtz's report; however, an addendum cannot, in reality, be considered without considering the original report. The word "addendum" is defined as "1: a thing added: ADDITION 2: a supplement to a book." *Webster's Ninth New Collegiate Dictionary* 55 (9th Ed.1987.) In the first report, Dr. Kurtz specifically discussed relator's seizures and headaches. She addressed them historically and noted the different treatment which relator had received, including the most recent medications, Keppra and Opana. In her addendum, Dr. Kurtz listed all the allowed conditions and opined that they had reached MMI. The magistrate finds that Dr. Kurtz's September 9, 2011 report does constitute

some evidence and that her failure to report all the information contained in her August 9, 2011 report does not serve to remove it from evidentiary consideration. To argue that her addendum report is not supported, is simply inaccurate. That report constitutes some evidence upon which the commission relied.

{¶ 62} Based on the foregoing, it is this magistrate's decision that this court should deny relator's request for a writ of mandamus.

/S/ MAGISTRATE
STEPHANIE BISCA BROOKS

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).