

# **BEST DOCTOREVER , M.D.**

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Anymonth 1, 2018

Best Attorneyrepresentativeever  
555 Main Street  
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RE: Any Client

Dear Mr. Attorneyrepresentativeever,

I reviewed Mr. Client's medical records from May 2013 to the present, and a copy of the Social Security Administration's (SSA's) Listing of Impairments, Section 1.04, Disorders of the Spine. I believe Mr. Client meets Section 1.04B since May 2013.

I serve as the chief of the Spine Division in the Department of Orthopedic Surgery and a professor of orthopedic neurological surgery at the University of Colorado, School of Medicine. My areas of clinical expertise include spine deformities, degenerative spine disorders, arachnoiditis, spine tumors, and disc arthroplasty. I have been a surgeon for 31 years. I have performed about 900 spine surgeries.

Mr. Client he has a herniated nucleus pulposus, arachnoiditis, spinal stenosis, and degenerative disk disease. Objective test results demonstrate that Mr. Client has nerve root compromise and compression. Mr. Client suffered a May 2013 spinal injury at the L3-4 that required a July 2014 fusion to address it. Because of continuing problems, his physician in November 2015 obtained an EMG which demonstrated chronic denervation and chronic L5 radiculopathy. He had an objective finding of radiculopathy on an EMG test because Mr. Client had a nerve root compression and compromise as the result of scar tissue, inflammation or another type of injury to his L5 nerve root. Nerve root compression and compromise is the only cause of chronic L5 radiculopathy. If there is no nerve root compression and compromise, there can be no chronic radiculopathy. Radiculopathy means that a patient's nerve is being compromised and compressed to the point where the patient gets neurological symptoms in the distribution of that nerve as did Mr. Client. Mr. Client's nerve root compromise and compression is evidenced by EMG, SEP, and MRI testing, and has existed since at least May 2013. Mr. Client's pain, paresthesia, and numbness falls within the L-5 nerve root distribution.

Mr. Client's chronic denervation and radiculopathy demonstrated on his November 2015 EMG more than one year after his surgery would have become permanent by that time. The L5 nerve damage found on the June 2013 EMG was caused by his injury that required the July 2014 lumbar fusion. I believe the buildup of scar tissue, or arachnoiditis, resulted from the fusion. Because findings on subsequent MRIs are unclear regarding the presence of scar tissue, I cannot say with certainty, but I believe his nerve root compromise and compression shown on his November 2015 EMG was, on a more probable than not basis, to a reasonable degree of medical certainty, at least partly the result of scar tissue. Scar tissue is typically the main cause of a failed spinal surgery, as I believe is the case with Mr. Client.

A September 2016 lumbar MRI showed an annular tear, adhesions, and scar tissue resulting in bulging of the disk and subsequent compromise and compression of the L5 nerve root which more probably than not developed as a result of the L3-4 fusion. An annular tear means that the tough outer covering of the disc had been permanently breached and was bulging or leaking disc material which MRIs show compromised and compressed his L5 nerve root bilaterally at the lateral recess in several places. Mr. Client's August 2017 MRI shows adhesions, and scar tissue, a L4-5 disc bulge compromising and compressing the L5 nerve root. Mr. Client's September 2017 lower extremity SEP demonstrated abnormalities at the L2 and L5 regions and radiculopathy which, as I have explained, demonstrates compression and compromise. Mr. Client's December 2017 lower extremity EMG demonstrated polyneuropathy, and probable mild L5 radiculopathy.

Mr. Client's medical providers commonly refer to encroachment of the nerve root. There is no meaningful distinction between, on the one hand, encroachment of the nerve root and, on the other hand, nerve root compromise and compression. The dictionary definition of encroachment is to advance beyond the usual or proper limits. It is commonly accepted in the field of orthopedic surgery that a finding of encroachment on the nerve root necessarily means that something is present in the same space as the nerve root which should not be there and is thereby compromising and compressing the nerve. Something cannot occupy the same space as a nerve root without compressing and compromising it.

The doctor who reviewed Mr. Client's file on behalf of the Social Security Administration (SSA) wrote, "The claimant usually presented with normal reflexes, normal strength, and only some atrophy." The doctor also wrote, "While the claimant did have loss of motion of the spine as well as occasional sensory deficits and occasional positive straight leg raising, the claimant did not have persistent evidence of sensory deficits or abnormal straight leg raising." These opinions are not inconsistent with nerve root compromise or compression. Mr. Client's medical providers note the absence of muscle weakness, atrophy and abnormal reflexes. However, the lack of these three findings is in no way indicative of whether a nerve root is being compressed and certainly irrelevant as to whether the patient is experiencing severe pain. Mr. Client's MRI, EMG and SEP testing clearly establish he has nerve root compromise and compression.

The doctor who reviewed Mr. Client's file on behalf of the SSA also wrote the claimant's lumbar x-rays and 2015 CT exam were largely normal. However, x-rays cannot show whether a patient has nerve compromise or compression. An x-ray only shows the bone, the space where the disc is, and if there is any hardware placement. Mr. Client's August 2015, February 2016, and May 2017 x-rays are irrelevant to assess whether he has nerve root compromise and compression. The 2015 lumbar CT scan does not detract from my opinion that he has nerve root compromise and compression. The CT scan showed mild to moderate foraminal stenosis. A CT scan is not as good at evaluating Mr. Client's condition as an MRI because it is not as accurate or reliable in assessing whether a patient has nerve root compromise, compression, or nerve damage.

In March 2018, Mr. Client underwent a lumbar MRI showing a stable fusion and hardware, mild canal narrowing, mild foraminal narrowing, a possible transfer lesion, and L2-3 and L4-5 disc bulges. You asked me if this MRI showing a stable fusion and hardware and only mild foramina narrowing detract from the opinion that Mr. Client has nerve root impingement. Absolutely not. The findings you reference on those MRI's have nothing to do with whether Mr. Client had nerve root compromise or compression. Although they show that he has L2-3 and 4-5 disc bulges and deterioration as a result of the abnormal stresses placed on the discs above and

below the his L3-4 fusion, the radiologist did assess whether there was scar tissue, or arachnoiditis, that compromised or compressed the nerve root. However, it is my view that this March 2018 MRI does show continued arachnoiditis and a compressed nerve root.

It is my opinion Mr. Client meets Listing 1.04B since May 2013. Arachnoiditis refers to the buildup of scar tissue around the nerve root. Scar tissue is the main cause of a failed spinal surgery, as is the case with Mr. Client. His 2016 and 2017 MRIs show adhesions and scar tissue. He has nerve root clumping of the thecal sac which would have developed within about six months of his 2014 lumbar fusion. It is my opinion, on a more probable than not basis, that Mr. Client has arachnoiditis which is a permanent condition. Mr. Client's November 2015 EMG shows radiculopathy of the L5 nerve root. His 2018 MRI does show arachnoiditis and a L4-5 disc protrusion that's encroaching on the L5 nerve root. In other words, it's compromising and compressing the L5 nerve root. And then in January of 2018, he has an absent patella tendon reflex which is the result of damage to the L4 nerve root. The L4 nerve root was affected as a result of his L3-4 fusion. And also in 2018, Mr. Client frequently told his doctor that he'd had bad burning pain for three years. Burning pain is a classic sign of nerve pressure. Mr. Client's SEP and EMG testing establish that he continued to have chronic nerve root denervation.

Sincerely,

The Best Doctorever, M.D.