

**FINAL AWARD ALLOWING COMPENSATION**  
(Affirming Award and Decision of Administrative Law Judge)

Injury No.: 03-080102

Employee: Stanley Chubb

Employer: Robinson Construction Company

Insurer: St. Paul Fire & Marine Insurance Company

The above-entitled workers' compensation case is submitted to the Labor and Industrial Relations Commission (Commission) for review as provided by § 287.480 RSMo. Having reviewed the evidence and considered the whole record, the Commission finds that the award of the administrative law judge is supported by competent and substantial evidence and was made in accordance with the Missouri Workers' Compensation Law. Pursuant to § 286.090 RSMo, the Commission affirms the award and decision of the administrative law judge dated March 25, 2011. The award and decision of Chief Administrative Law Judge Lawrence C. Kasten, issued March 25, 2011, is attached and incorporated by this reference.

The Commission further approves and affirms the administrative law judge's allowance of attorney's fee herein as being fair and reasonable.

Any past due compensation shall bear interest as provided by law.

Given at Jefferson City, State of Missouri, this 16<sup>th</sup> day of February 2012.

LABOR AND INDUSTRIAL RELATIONS COMMISSION

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William F. Ringer, Chairman

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James Avery, Member

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SEPARATE OPINION FILED  
Curtis E. Chick, Jr., Member

Attest:

\_\_\_\_\_  
Secretary

Employee: Stanley Chubb

**CONCURRING IN PART AND DISSENTING IN PART**

I have reviewed and considered all of the competent and substantial evidence on the whole record. Based on my review of the evidence as well as my consideration of the relevant provisions of the Missouri Workers' Compensation Law, I believe the decision of the administrative law judge should be reversed.

I agree with the administrative law judge that the August 7, 2003, work accident either caused a new injury and/or aggravated a pre-existing condition in the employee's lumbar spine which caused the employee's low back to become more symptomatic. I agree that the accident was a substantial factor in causing employee's low back injury and resulting medical condition and that employee's low back condition is medically causally related to the August 7, 2003, work accident. But, contrary to the conclusions of the majority and the administrative law judge, I do not believe any employer could reasonably be expected to hire employee in his current physical condition.

**Permanent Total Disability**

The administrative law judge explicitly stated he relied upon the opinions of Dr. Kennedy, Dr. Park, and Ms. Abram in reaching his conclusion that employee was not permanently and totally disabled.

Dr. Kennedy offered a series of ambiguous opinions. Within the series, Dr. Kennedy's opinion that employee suffered no permanent disability is sandwiched between two separate declarations that Dr. Kennedy is not sure what physical restrictions are appropriate for employee.

- On February 10, 2004, Dr. Kennedy said he was unable to draw any firm conclusion about employee's functioning capacity. Nonetheless, Dr. Kennedy issued his recommendation of "activity as tolerated" and his imposition of no specific work restrictions. Dr. Kennedy's opinions regarding employee's abilities and restrictions are based upon an inadequate foundation.
- On March 26, 2004, Dr. Kennedy opined that employee suffered no permanent disability as a result of the August 7, 2003, work injury.
- On February 22, 2005, Dr. Kennedy reiterated that it was difficult to determine what restrictions to place on employee.

Apparently, since Dr. Kennedy did not know what physical restrictions were appropriate, he imposed none. Then, while he still did not know what restrictions were appropriate, Dr. Kennedy opined that employee suffered no permanent disability from his work injury. I cannot understand how a medical expert can be certain a worker suffered no permanent disability when the expert does not know if the injury left the worker with physical restrictions. I do not find Dr. Kennedy's opinions credible. Naturally, then, I find not credible the myriad opinions that are founded upon Dr. Kennedy's imposition of no physical restrictions.

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Dr. Park did not offer an opinion on employee's ability to compete in the open labor market. In September 2004, Dr. Park thought employee may be able to perform some clerical type work with a 10-pound lifting restriction. But Dr. Park thought employee needed more treatment at that time, so he was not offering an opinion on employee's permanent disability.

Ms. Abram did not consider the role employee's narcotic use would play in employee's pursuit of employment. Because employee relies heavily on narcotics to relieve his severe pain symptoms, Ms. Abram's opinion regarding employee's ability to compete in the open labor market is of no value.

I find credible the opinion of vocational expert, Susan Shea. Ms. Shea identified eight factors that she believes render employee unable to compete in the open labor market. Ms. Shea took into account employee's need to take narcotic pain medications to relieve his severe pain symptoms and the effect narcotics have on employee's ability to compete for employment.

Based upon the foregoing, I conclude employee is permanently and totally disabled.

### **Work Injury Rendered Employee Permanently and Totally Disabled**

The administrative law judge found credible Dr. Volarich's opinions regarding medical causation. But he discredited Dr. Volarich's opinion regarding permanent total disability based upon his belief that Dr. Volarich gave contradictory opinions regarding permanent total disability.

Dr. Volarich's opinions regarding permanent total disability contradict themselves. Dr. Volarich stated that the employee had a pre-existing low back condition that was a hindrance or obstacle in performing his job duties prior to August 7, 2003. He stated that as a result of the August 7, 2003 accident the employee sustained a 35% permanent partial disability of the body as a whole referable to his low back. At that point, he did not say that the employee was permanently totally disabled from the last accident alone but did state that the combination of those two disabilities created a substantially greater disability than the total of each injury. Dr. Volarich then contradicted himself and stated that if the vocational assessment could not find a suitable job, then the employee was permanently and totally disabled as a direct result of the August 7, 2003 accident alone. He did not say it was from the combination of the pre-existing low back condition and the back condition from August 7, 2003. These contradictions affect the credibility of Dr. Volarich's on the issue of permanent total disability. I find that the opinion of Dr. Volarich on this issue is not persuasive.

Award p. 22.

Dr. Volarich gave only one opinion regarding permanent total disability. Dr. Volarich believes that if a vocational assessment were to reveal that there is no job for which

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employee is suited, employee was rendered permanently and totally disabled by the limitations and problems caused by the work injury.

Dr. Volarich also believes that employee's preexisting permanent partial disabilities combine with the permanent partial disabilities from the primary injury in a synergistic manner such that employee's overall permanent partial disability is greater than the simple sum of the disabilities. But that opinion is not an opinion regarding permanent total disability.

The determination of whether a worker is permanently and totally disabled is not solely a medical question. An injured worker is permanently and totally disabled if he can no longer compete in the open labor market. The test is whether an employer would be reasonably expected to hire the worker in his current condition. If a worker is determined to be permanently and totally disabled, the next issue for determination is whether the work injury rendered the worker unable to compete for employment. If it did, there is no need to consider if the work injury also synergistically combines with preexisting conditions.

Dr. Volarich's opinions are not inconsistent. I find credible Dr. Volarich's opinions regarding permanent total disability. I have concluded that employee is permanently and totally disabled. Dr. Volarich opined that if employee is permanently and totally disabled it is due to the work injury. Based upon the foregoing, I conclude that employee was rendered permanently and totally disabled by the work injury, considered in isolation.

### **Conclusion**

I would modify the award of the administrative law judge. I would award permanent total disability benefits from employer/insurer to employee. I respectfully dissent from the portion of the majority's decision awarding only permanent partial disability to employee.

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Curtis E. Chick, Jr., Member

ISSUED BY DIVISION OF WORKERS' COMPENSATION

**FINAL AWARD**

Employee: Stanley Chubb Injury No. 03-080102  
Dependents: N/A  
Employer: Robinson Construction  
Additional Party: N/A  
Insurer: St. Paul Fire and Marine  
Appearances: Dan Rau, Attorney for the Employee  
Robert Frayne, Attorney for Employer/Insurer  
Hearing Date: December 22, 2010 Checked by: LCK/rf

**SUMMARY OF FINDINGS**

1. Are any benefits awarded herein? Yes.
2. Was the injury or occupational disease compensable under Chapter 287? Yes.
3. Was there an accident or incident of occupational disease under the Law? Yes.
4. Date of accident or onset of occupational disease? On or about August 7, 2003.
5. State location where accident occurred or occupational disease contracted: Perry County, Missouri.
6. Was above employee in employ of above employer at time of alleged accident or occupational disease? Yes.
7. Did employer receive proper notice? Yes.
8. Did accident or occupational disease arise out of and in the course of the employment? Yes.
9. Was claim for compensation filed within time required by law? Yes.
10. Was employer insured by above insurer? Yes.

11. Describe work employee was doing and how accident happened or occupational disease contracted: The employee injured his low back while lifting.
12. Did accident or occupational disease cause death? No.
13. Parts of body injured by accident or occupational disease: Body as a whole referable to the low back.
14. Nature and extent of any permanent disability: 15% permanent partial disability of the body as a whole referable to the low back.
15. Compensation paid to date for temporary total disability: \$15,562.59.
16. Value necessary medical aid paid to date by employer-insurer: \$23,328.29
17. Value necessary medical aid not furnished by employer-insurer: \$2,482.68
18. Employee's average weekly wage: \$828.94
19. Weekly compensation rate: \$552.63 for TTD and PTD. \$347.05 for PPD.
20. Method wages computation: By agreement.
21. Amount of compensation payable:
  - \$2,482.68 for previously incurred medical.
  - \$20,823.00 for permanent partial disability.
  - \$440.84 to be paid to the Missouri Department of Social Services
22. Second Injury Fund liability: N/A
23. Future requirements awarded: None.

Said payments shall be payable as provided in the findings of fact and rulings of law, and shall be subject to modification and review as provided by law.

The Compensation awarded to the claimant shall be subject to a lien in the amount of 25% of all payments hereunder in favor of the following attorney for necessary legal services rendered to the claimant: Dan Rau.

## **FINDINGS OF FACT AND RULINGS OF LAW**

On December 22, 2010, the employee, Stanley Chubb, appeared in person and with his attorney, Dan Rau, for a hearing for a final award. The employer was represented at the hearing by its attorney, Robert Frayne. At the time of the hearing, the parties agreed on certain undisputed facts and identified the issues that were in dispute. These undisputed facts and issues, together with the findings of fact and rulings of law, are set forth below as follows:

### **UNDISPUTED FACTS**

1. Robison Construction Company was operating under and subject to the provisions of the Missouri Workers' Compensation Act, and liability was fully insured by St. Paul Fire and Marine.
2. On August 7, 2003 Stanley Chubb was an employee of Robinson Construction Company and was working under the Workers' Compensation Act.
3. On or about August 7, 2003 the employee sustained an accident arising out of and in the course of his employment.
4. The employer had notice of the employee's accident.
5. The employee's claim was filed within the time allowed by law.
6. The average weekly wage was \$828.94. The rate of compensation for temporary total disability and permanent total disability is \$552.63 per week. The rate of compensation for permanent partial disability is \$347.05.
7. The employer-insurer paid \$23,328.29 in medical aid.
8. The employer-insurer paid \$15,562.59 in temporary disability.
9. There were 28 1/7 weeks of compensation paid beginning on August 8, 2003 and continuing through February 21, 2004.

### **ISSUES**

1. Medical causation.
2. Claim for previously incurred medical.
3. Claim for additional or future medical aid.
4. Nature and extent of permanent disability.
5. Direct medical fee dispute.
6. Medicaid lien.

### **EXHIBITS**

The following exhibits were offered and admitted into evidence:

#### Employee's Exhibits

- A. Medical bills and records.
- B. The deposition, report and CV of Dr. Volarich.
- C. The deposition, report and CV of Susan Shea.

- D. Medicaid lien.
- E. List of activities from the employee.
- F. Missouri Department of Conservation hunting license.

Employer-Insurer's Exhibits

- 1. MidAmerica report/FCE.
- 2. Medical records of Dr. Woods.
- 3. Medical records of Dr. Kennedy.
- 4. Deposition and report of Dr. Kitchens including his CV.
- 5. Report and Deposition of Donna Abram with her CV.

Judicial notice of the contents of the Division's file was taken.

**WITNESSES:** Stanley Chubb, the employee, Jeremy Rogers and Penny Dooley for the employee.

**BRIEFS:** The employee and the employer filed their briefs on January 21, 2011.

**FINDINGS OF FACT:**

The employee is 43 years old and was born in 1966. At the hearing he was walking with a cane. The last day he worked was on August 7, 2003. On the day of the hearing he was on a Duragesic Patch, Lorcet 10/650, Valium, and Norvaz. He graduated from Greenville High School in 1985. Prior to August 7, 2003, he did commercial construction work. In the past he has worked in a saw mill; mowed grass commercially; and on his own performed residential construction, mainly odd jobs. While working at Robinson Construction he was a concrete finisher and a journeyman carpenter which was heavy manual labor. He worked for Robinson for a total of 7 years. He has not done any office or clerical work, or light duty. His jobs have all been heavy manual work.

The employee testified that prior to August 7, 2003, he had a little arthritis in his back which bothered him but not to the extent he could not work. He had back pain and problems with sleeping and saw Dr. Woods for those conditions. Dr. Woods prescribed pain medication and something for sleeping. He would usually take one or two pain pills a day, and occasionally would take three. He took Valium one time a day. Since December 4, 2002, he has never stopped taking pain medications for his low back. He testified that the location of the pain in the back was in the middle up to his shoulder blade. He did not have any numbness or pain in his right leg associated with back complaints. Prior to August 7, 2003, the back complaints did not affect his work, he did not miss days, he was not on light duty, and was not sent home early. Most of the time he worked about 50 hours a week and never turned down overtime due to his back. His back did not affect working around his house.

Jeremy Rogers testified on behalf of the employee. He is 44 years old, and has known the employee about all of his life. In August of 2003, he worked for Robinson as a general foreman

but the employee was not in his crew at that time. He and the employee occasionally rode to work together. When he was the employee's foreman he did not put him on light duty, cut hours, miss time from work or send him home early due to back problems. He last worked for Robinson about three years ago to become self employed. He sees the employee on a social basis. He was not aware that prior to August 7, 2003 the employee was taking medication for his back.

### 2002

On December 4 the employee saw Dr. Woods for chronic back pain. The employee was taking Lorcet 7.5/650 and Xanax to help him sleep at night. Dr. Woods prescribed Lorcet 7.5/650 and 10 mg. of Valium.

### 2003

On February 6 the employee saw Dr. Woods for back pain. The employee had to take his medicine more frequently than prescribed and occasionally took it four times a day. Dr. Woods increased the dose of Lorcet to 10/650 but noted that he would not fill it early. The employee had lumbar tenderness. Dr. Wood diagnosed degenerative disc disease and continued Valium.

The employee saw Dr. Woods on April 3 for back pain and degenerative disc disease. The employee was tender over the lumbar spine and was assessed with degenerative joint disease. He was taking Lorcet 10/650 and Valium. On June 3, the employee saw Dr. Woods for back pain. The employee had tenderness over the lumbar spine. Dr. Woods diagnosed back pain and degenerative disc disease. The employee was on Vicodin and Valium.

The employee saw Dr. Woods on August 4 for back pain, insomnia, and degenerative disc disease. He was tender over the lumbar spine. Dr. Woods diagnosed degenerative joint disease and prescribed Lorcet 10/650 for pain and Valium for insomnia.

The employee testified that on August 7, 2003, as he was lifting a heavy sawhorse, he felt a pull in his low back. It then got worse, and he told his boss. The employer sent him to a doctor in Cape Girardeau. The pain was across the back and down into right hip. Later it went down his leg toward his knee.

On August 7, the employee saw Dr. DeFelice for intense low back pain. He was moving one hundred pound steel saw horses out of a truck and felt a give in his back. The employee stated that he never had any back injuries in the past and denied any trauma. The low back pain did not shoot down his leg. He had a negative straight leg raising test. X-rays showed minor spondylosis at L5. Dr. DeFelice diagnosed a lumbosacral strain and put the employee on restrictive duty of no lifting greater than ten pounds with no twisting, bending, squatting or lifting above the shoulders. Dr. DeFelice prescribed Vioxx and Skelaxin.

On August 7, the employee saw Dr. Woods and noted that he injured his back at work while lifting. The employee was tender over the lumbar spine and his straight leg raising was

positive at 30 degrees on the right. Dr. Woods diagnosed back pain and sciatica, and noted it was somewhat suspicious for disc disease. He agreed with light duty of no lifting over 10 pounds. Dr. Woods prescribed Percocet, Decadron and a Prednisone Dose Pack. Dr. Woods stated that if the employee did not improve he should get a CT scan.

The employee testified that due to severe pain he was taken by ambulance to the emergency room.

On August 8, 2003 the employee was transported by ambulance to Southeast Missouri Hospital for 10 out of 10 low back pain that radiated down his right leg and up to his neck resulting from lifting a heavy object at work on August 7. The emergency room records noted that yesterday at work he picked up a very heavy object and started to have immediate pain in the right side of his lower back with pain in his right lower extremity. His straight leg raise test produced only a minimal amount of pain to the low back down the right buttock and into the upper thigh. Dr. Swafford stated that the employee was very adamant about getting an MRI, and most likely he had a disc protrusion with spinal nerve root impingement. An outpatient MRI was ordered.

The August 11 MRI showed a mild annular bulge which flattened the ventral thecal sac without producing significant stenosis at L3-4. At L4-5 there was a right disc bulge which flattened the ventral thecal sac and narrowed the right neural foramina. A saggital image demonstrated a central annular tear. The left neural foramen was mildly narrowed. At L5-S1 there was a minimal right lateral bulge which touched the exiting right L5 nerve root in the lateral foramen without displacing it.

On August 12, Dr. Wood noted that the employee had back pain and sciatica with pain radiating down the legs, right greater than left. Dr. Woods noted the employee was unable to do straight leg raising due to pain in the lower extremities particularly in the right. Dr. Woods prescribed Percocet.

The employee saw Nurse Practitioner Inman on August 13 with 9 or 10 out of 10 pain. On physical exam, there was positive right knee raises and point tenderness in the right lower lumbar spine. The MRI showed a bulging disc at L5-S1 that stenosed on the right nerve root causing pain to go down the right leg. Nurse Inman referred the employee to a neurosurgeon.

On August 18, Dr. Woods stated that the employee had degenerative disc disease at L4-5 which was more pronounced at L5-S1 which was putting pressure on the right lateral nerve root which is probably contributing to his sciatica. Dr. Woods agreed the employee should get a surgical consultation due to the discomfort, and prescribed Percocet.

The employee saw Dr. Raskas, an orthopedic surgeon on August 22 and September 5, 2003. On September 15, the employee saw Dr. Moore due to a referral from Dr. Raskas for L5 radiculopathy. Dr. Moore diagnosed right lumbar radiculopathy and performed a lumbar epidural steroid injection.

The employee had physical therapy from September 24 through October 13 of 2003. On October 1, the employee saw Dr. Woods with continued back pain that radiated down the leg with spasms and increased difficulty sleeping. Dr. Woods prescribed Vicodin 10/650 and Valium.

On October 5 the employee was taken to Southeast Missouri Hospital emergency room via ambulance. The employee had begun physical therapy and the pain was intolerable. His back and right lower extremity pain dropped him to the floor. Over the past several weeks he had had some right lower extremity numbness and tingling. Both the ambulance and hospital had given Morphine. Dr. McIntosh discussed the case with Dr. Raskas. Decadron and Percocet were prescribed. The diagnosis was exacerbation of back pain with right sciatica.

On October 7, Dr. Moore diagnosed lumbar radiculopathy and prescribed Percocet 10/325. On October 10, Dr. Raskas noted that the employee had severe back pain radiating to his right leg with a bit of give-away strength. The employee was walking with a cane and was very reluctant to put weight on the right side. Dr. Raskas diagnosed discogenic pain. Dr. Raskas had a long discussion with the employee about pain medication usage and was the employee was only to use pain medication from him. Dr. Raskas ordered a CT myelogram.

The myelogram and post-myelogram CT scan was performed on October 13. The myelogram showed degenerative changes in the L4-5 disc space with no significant extradural effacement and no compression deformities. The impression was very mild effacement suggestive of the S1 nerve roots. The CT scan showed a diffusely bulging disc at L5-S1 which may extend into the foramen slightly greater on the right. There was no definite effacement of the exiting L5 nerve roots and no effacement of the descending S1 nerve roots. The impression was diffusely bulging disc at L5-S1. A plain x-ray showed degenerative changes about the L4-5 disc space.

On October 31, the employee had pain with straight leg raising with weakness in his legs. Dr. Woods prescribed Vicodin 10/650 and Valium. On November 5 the employee saw Dr. Woods and was concerned about the insurer not getting him to see a physician in a timely fashion. He wanted a second opinion for his back. Dr. Woods referred him to Dr. Park for further evaluation.

The employee returned to see Dr. Raskas on November 3, 2003. Dr. Raskas noted the employee continued to have terrible back pain that radiated into his leg, and was very inactive. The employee was not sleeping through the night and took pain medication to help him sleep. Dr. Raskas tried to explain the condition to the employee and that it did not seem to really penetrate but the employee did not believe him. Dr. Raskas stated that the employee had a back condition that is sometimes very similar to age-related changes in the back that appeared on the MRI but are not always the cause of pain. The employee thought that the doctor in Cape told him that the problem with his back needed to be fixed and that Dr. Raskas' trying conservative measures has been delaying his treatment. Dr. Raskas recommended a discography but the employee did not want to go through such a test. Dr. Raskas was not comfortable proceeding

with any further intervention without a discography. The employee wanted a second opinion which Dr. Raskas agreed with.

The employee testified that Dr. Raskas wanted to do a discogram prior to having surgery, and he wanted a second surgical opinion. He saw Dr. Park because Dr. Raskas mentioned surgery not because he wanted to do a discogram. The employee was never offered a discogram, and never refused a discogram.

The employee saw Dr. Park, a neurosurgeon on December 4, 2003 for back and right leg pain. The employee reported that he had no previous history of back trouble. On August 7, 2003 he had a lifting injury and developed back and right leg pain. Dr. Park reviewed the lumbar MRI and stated it showed a L3-4 and L4-5 right-sided, high intensity zone into the foramen possibly suggesting foraminal annular tear. At the L4-5 level the foraminal disc protrusion abuts the L4 nerve root. Dr. Park stated the employee had a probable annular tear at L3-4 and L4-5 which may be the source of his right-sided back pain. Dr. Park thought the employee needed a discogram to confirm the pain generator. Dr. Park stated that the plan by Dr. Raskas was reasonable and appropriate.

The employee saw Dr. Kennedy, a neurosurgeon on December 9. Dr. Kennedy noted the employee was walking with a cane. Motor examination showed normal tone and bulk with no atrophy. Sensory examination was grossly normal in all dermatomes. The reflexes were 1+ and symmetric. Straight leg raising was negative for clear cut sciatic type signs. Dr. Kennedy reviewed the October 2003 myelogram which demonstrated a disc bulge at L5-S1 but no clear cut evidence of nerve root impingement. Dr. Kennedy was not sure what to make of the employee's symptoms. The employee described symptoms compatible with sciatica but he did not see any signs of nerve root tension on exam or any clear cut evidence of nerve root impingement on the myelogram. Dr. Kennedy did not have a problem in principal with the recommendation of a discogram by Dr. Raskas but based on the current examination was not sure that it would pinpoint the pain source. Dr. Kennedy recommended an EMG to localize the level of nerve root involvement. On December 29, Dr. Woods continued to prescribe Vicodin and Valium.

#### 2004

The employee saw Dr. Woods on January 8 with back pain radiating down his right leg. Dr. Woods stated that the employee was in severe pain and probably needed surgical treatment. He had been evaluated and has been told that surgery was a consideration. Dr. Woods prescribed Neurontin.

On January 12 Dr. Phillips performed a nerve conduction study. The employee had a cane. The lower extremity muscle testing was limited by report of pain but atrophy was not noted. Dr. Phillips noted that the values fell within the range of normal and the study was not impressive for active lumbar radiculopathy. Dr. Phillips noted a lumbar myelogram demonstrated a disc bulge at L5-S1 with very mild effacement suggestive of S1 nerve roots but that was insufficient to be reflected in the electro diagnostic studies.

On January 15, 2004 Dr. Kennedy stated that the nerve study did not show any evidence of ongoing active radiculopathy and he did not see anything on the myelogram that suggested ongoing nerve root compression. He ordered a Functional Capacity Evaluation to determine restrictions.

On January 19, Dr. Woods saw the employee for degenerative joint disease with muscle spasms. The employee was on Lorcet 10/650 and Valium.

The Functional Capacity Evaluation was performed at MidAmerica Rehab on January 22. Robert Sherrill, the physical therapist noted that movement patterns were exaggerated and inconsistent throughout the examination. The validity analysis showed invalid results in six of eight categories. All functional activities were self-limited due to the report of pain. The employee demonstrated over guarding and exaggerated response to subjective reports of increased pain. It was the therapist's opinion that the employee provided unacceptable and invalid effort during testing. It was not felt that the employee's limitations and ability documented in the report represented the individual's true level of function. Secondary to symptom magnification behavior and over guarding, it was the opinion of therapist that the function displayed was not a valid representation of the employee's true functional abilities, and the true level of function must be left to conjecture. The therapist could not document objective proof that he can perform his prior job or recommend any specific limitation with accuracy. The Waddell signs were positive in six out of seven categories; and that if three or more categories were positive than the findings are clinically significant for non-organic low back pain.

On February 10, Dr. Kennedy reviewed the Functional Capacity Evaluation. Based on the evaluation, Dr. Kennedy was not able to determine what the employee's level of functioning really was; and was not able to draw a firm conclusion as to what the patient's real functional capacity was. Dr. Kennedy stated the employee should be able to perform activity as tolerated and he would not place any specific restrictions as a result of the work injury. He placed the employee at maximum medical improvement.

In a patient message from Dr. Kennedy's office on February 19, it was noted the employee was aware of the FCE result and the dictation from Dr. Kennedy. The employee wanted to have a discogram and was told that he could follow up with workers' compensation or its attorney for the next step but from their standpoint, he was at maximum medical improvement. The employee requested Percocet 10/325. It was explained that they could not prescribe something that strong but could prescribe something less strong one time until he sees a treating doctor. The employee declined anything but Percocet.

On February 19, the employee saw Dr. Woods with right-sided leg pain and back pain, and was prescribed Valium and Lorcet. On February 23, the employee saw Dr. Woods and requested a prescription for Percocet. Dr. Woods noted that he already a prescription for Vicodin 10/650 and a prescription for Valium. Dr. Woods would not give the employee a prescription for a third narcotic which made the employee quite agitated. Dr. Woods was concerned that the employee was starting to have drug seeking behavior.

On February 27, 2004 the employee saw Dr. Moore. The employee was in a wheelchair and stated that the September of 2003 epidural steroid injection had no results. Dr. Moore diagnosed lumbar radiculopathy and stated there was nothing at that point he could do to definitely help the employee with his problem.

On March 3, the employee requested a letter from Dr. Woods that stated his difficulties in performing activities. Dr. Woods' Nurse Practitioner wrote a note that the employee had documented degenerative disc disease which has caused problems with performing activities of daily living.

The employee went to the emergency room at Southeast Missouri Hospital for severe low back pain on March 6. The employee felt incapacitated by pain and was only able to handle the pain with Percocet which he had run out of. The employee stated he was getting 80 Percocet at a time which the emergency room doctor was uncomfortable prescribing. The emergency room doctor noted that it was important that the employee had continuity of care and not episodic care for his back discomfort. The emergency room doctor gave the employee sixteen Percocet and was to follow up with Dr. Woods.

On March 8, Dr. Woods stated that the employee needed additional studies to determine if the disc protrusions in his lumbar spine are causing any nerve impingement or require any surgical intervention. The employee went to Advanced Family Care and saw Dr. Campbell on March 8 who prescribed 60 Percocet. On March 18, Dr. Campbell prescribed 60 additional Percocet.

On March 26 Dr. Kennedy stated that the employee had no permanency regarding the work related injury of August 7, 2003.

On April 2 Dr. Campbell assessed back pain. On April 15, the employee told Dr. Campbell that without medication his pain level was 9 out of 10 and with pain medicine it was a 4-5 out of 10.

On April 20, Dr. Campbell wrote a report which noted that he diagnosed back pain and muscle spasms in the lumbar area presumed to be discogenic in origin. The prognosis was poor for medical management alone and poor for his return to his usual and customary type work. Dr. Campbell noted that he had been providing high-level medical pain management; and recommended an aggressive interventional approach to correct the underlying pathology. If a surgeon did not feel that is possible, Dr. Campbell suggested other aggressive efforts to control the pain without the dependence on narcotic pain medication. On April 30, Dr. Campbell noted the employee appeared to be in extreme distress and used a cane for assistance in walking. Dr. Campbell prescribed additional Percocet and suggested that the employee's wife stay home to give appropriate care to the employee who needed assistance as well as their young children.

On May 14, Dr. Campbell noted that the employee appeared to be in severe pain and he was attempting to refer him to a neurosurgeon. At the end of May, Dr. Campbell assessed chronic back pain presumed to be traumatic disc disease in etiology, and prescribed Percocet.

Dr. Campbell prescribed pain medication in June and July. The employee saw Dr. Woods in April, May, June and July of 2004. He continued to prescribe Vicodin 10/650 and Valium. Dr. Campbell continued to treat the employee with Percocet in August and September.

The employee went to the emergency room on August 2, 2004. Dr. Meece diagnosed chronic low back pain with evidence of disc disease and radiculopathy. He noted that the employee had been there a total of three times for the same complaint, and would be concerned if the employee started making regular visits to the emergency room for pain shots.

On September 2, Dr. Park stated it was his opinion that the employee's current symptoms are in substantial part caused by the injury of August 7, 2003. Dr. Park's recommendation included a discogram and possible surgery. It was Dr. Park's opinion that the employee can participate to some degree at work perhaps with a ten pound lifting restriction and mostly clerical type of activity.

The employee saw Dr. Woods in August, September, October and November of 2004, and was prescribed Vicodin, Valium, and Flexeril. The employee continued to be treated by Advanced Family Care with Percocet and Oxycontin in October, November, and December of 2004.

On December 15, Advanced Family Care would no longer provide medical services to the employee. On December 16, the employee was transported to Southeast Missouri Hospital via ambulance. The employee wanted pain medication refills. The employee noted that Dr. Woods and Advanced Pain Clinic had been prescribing pain medication but they had cut him off. The employee requested prescriptions for Oxycontin, Hydrocodone and Oxycodone; and was insistent that he receive prescriptions for those substances. The emergency room doctor told him that he would treat him but would not prescribe controlled substances. The employee was not interested in anything else. The emergency room doctor's impression was chronic pain syndrome and possible drug seeking behavior.

## 2005

The employee started going to Med Stop One in January and saw Dr. Cova.

The employee returned to see Dr. Kennedy on February 22. On exam, it was noted that range of motion was slightly reduced in all planes and the employee told him that he was able to bend only minimally in any direction. Straight leg raising was negative for sciatic signs with either leg at about 60 degrees. There was scattered sensory loss involving the entire right leg in a non-anatomic distribution. Dr. Kennedy stated that the employee's symptoms remained unchanged. It was his opinion that there was no further treatment that would likely benefit him since he has been through an extensive program of non-operative treatment. Dr. Kennedy did not think discography would offer reliable diagnostic information. Based on the subjective symptoms he thought the employee was at maximum medical improvement; and it was difficult to determine what restrictions to place on him due to his non-physiologic/neurologic examination.

The employee saw Dr. Cova in February and March of 2005. In March the employee started seeing Dr. Samuel who ordered an MRI. The March 29 MRI showed at L3-4 a modest diffuse annular disc bulge which did not cause significant narrowing of the spinal canal. At L4-5 there was a broad based disc bulge which impressed the ventral thecal sac. There was modest disc intrusion into the foramen on the right. At L5-S1 there was a broad based disc bulge which abutted the ventral thecal sac but did not cause significant narrowing of the spinal canal. There was modest disc extension into the foramen bilaterally. The radiologist stated the current exam demonstrated that the vertebra and disc to be essentially stable in appearance when compared to the employee's prior examination. There was a modest disc intrusion into the foramina at L5-S1 bilaterally and at L4-5 on the right with little appreciable interval change.

The employee continued to see Dr. Samuel who prescribed Lorcet and Valium in April, May, and June. Dr. Samuel referred the employee to Dr. Litofsky, a neurosurgeon at University Hospital and Clinics in Columbia. The employee testified that he went to Dr. Litofsky on his own in June of 2005.

Dr. Litofsky noted that the MRI showed mild discogenic changes with no evidence of nerve root compression. He diagnosed lumbar radiculopathy with no neurologic compressive lesion with possible neuritic pain. Surgical intervention was not indicated. Dr. Litofsky recommended the anti-neuritic pain medications Elavil or Neurontin. If the medical interventions were not successful, the employee may be a candidate for behavioral modifications and coping strategy. Dr. Litofsky noted that the employee did not require neurosurgical intervention and it would not likely lead to improvement in his pain.

The employee testified that he continued to see a family doctor and was treated with medication and injections. In July of 2005, Dr. Samuel prescribed Elavil, Neurontin, Lorcet and Valium.

#### 2007-2010

The employee continued to see Dr. Samuel on a monthly basis in 2007. It was noted on July 25 that the employee's house had burned yesterday morning and he had lost his medication. He has been in severe pain. Dr. Samuel prescribed Valium, a Duragesic patch, Lorcet, and a Depo Medrol Dose Pack. The employee continued to see Dr. Samuel on a monthly basis the rest of 2007 and on a monthly basis in 2008, 2009, and 2010. He continued to receive Valium, Lorcet, Duragesic patches and occasionally other types of medication for his back. On May 7, 2010 Dr. Samuel collected a sample for Quest Diagnostics which showed that the Hydrocodone, Hydromorphone results were high along with the Oxazepam and Nordiazepam. On November 18, 2010, the employee was prescribed Valium, Lorcet 10/650, and a Duragesic patch.

#### Opinions

On November 10, 2009, the employee saw Dr. Kitchens, a neurosurgeon. His deposition was taken on April 27, 2010. It was Dr. Kitchens' opinion that the report of severe pain in his low back and down into his right hip and right leg was circumferential and was not in a radicular

manner. The employee had signs of symptom magnification as noted by severe pain with simple touching of his lower back and inconsistencies in body posture from sitting to standing and performing range of motion of the lumbar spine. The employee had a history of chronic lower back pain prior to the work incident. His subsequent workup did not reveal nerve root impingement or signs or symptoms of lumbar radiculopathy and he does not have signs or symptoms of a lumbar radiculopathy on his current examination. It was Dr. Kitchens' opinion that the employee sustained a muscular strain from the work incident and did not sustain a disc herniation, nerve root impingement or radiculopathy. He had a history of chronic narcotic and chronic lower back pain prior to the work incident. His chronic narcotic use has persisted and indicates narcotic dependency. It was Dr. Kitchens' opinion that the employee would not benefit from additional treatment including surgery or treatment of chronic narcotic medication. It was Dr. Kitchens' opinion that the employee has a permanent partial disability of 2% related to a muscular strain from his August 7, 2003 work incident. It was his opinion that the work incident of August 7, 2003 was not the substantial factor in the cause of the current lower back pain; and his current back pain is degenerative in nature and pre-existed his work incident. It was his opinion that the employee can work without restrictions as noted by Dr. Kennedy and that the employee is at maximum medical improvement with regard to the August 7, 2003 work incident.

Dr. Volarich saw the employee on January 19, 2009. His deposition was taken on December 10, 2010. During his examination, Dr. Volarich noted the motor exam was difficult to assess due to breakaway involving the upper and lower extremities. With regard to reflexes, the extensor hallucis longus strength was diffuse to assess because of breakaway bilaterally. With regard to his lumbar musculoskeletal exam, multiple trigger points were identified and 5 out of 5 Waddell signs were positive.

The employee had a history of low back pain and was treated by Dr. Woods for chronic back pain and degenerative disc disease from L4 to S1 with prescribed medication prior to August 7, 2003. The employee was taking Lorcet a narcotic pain medicine and Valium as a muscle relaxer; and had been on those types of medicines since December of 2002. The employee stated that in order to work prior to August 7, 2003 he had to take medications such as Valium and Lorcet for his low back but he did not have radicular symptoms. Dr. Volarich diagnosed pre-existing lumbar pain syndrome.

Dr. Volarich stated the employee had prior difficulties because he was requiring medication including narcotics and muscle relaxants but the injury of August 7, 2003 significantly worsened his whole pain syndrome, his need for medications, and his inability to get back to work. With regard to August 7, 2003 accident and injury, Dr. Volarich diagnosed disc bulging at L4-5 and L5-S1 with intermittent right leg radicular symptoms and severe lumbar myofascial pain syndrome. It was Dr. Volarich's opinion that the August 7, 2003 work accident was the substantial contributing factor as well as the prevailing or primary factor causing the disc bulging at L4-5 and L5-S1 with intermittent right leg radicular symptoms that required extensive conservative management. Dr. Volarich stated the MRI scan showed disc bulging at L4-5 and L5-S1 without nerve root impingement. Dr. Kennedy performed a myelogram which showed a bulge at L5-S1 but no nerve root impingement. It did not show any surgical pathology and no

disc herniation. The employee developed severe pain syndrome which required extensive pain management.

With regard to the pre-existing low back condition, it was Dr. Volarich's opinion that the employee had a 15% permanent partial disability of the body as a whole rated at the lumbosacral spine due to his chronic lumbar syndrome/degenerative disc disease at L4 through S1. The rating accounts for back pain syndrome and loss motion as well as the need to take narcotic pain medications on a daily basis prior to August 7, 2003. It was his opinion that the pre-existing problem was a hindrance or obstacle in performing his job duties prior to August 7, 2003.

It was Dr. Volarich's opinion that as a direct result of the August 7, 2003 accident and injury, the employee sustained a 35% permanent partial disability of the body as a whole rated at the lumbosacral spine due to the disc bulges at L4-5 and L5-S1 to the right causing intermittent right leg paresthesias and radicular symptoms. The rating accounts for the injury's contribution to a severe myofascial back pain syndrome as well as lost motion in the low back. Dr. Volarich stated the disability existed as a result of his pain behavior but he deferred to psychiatric evaluation for that assessment.

It was Dr. Volarich's opinion that the combination of his disabilities created a substantially greater disability than the simple sum or total of each separate injury and illness and a loading factor should be added.

Dr. Volarich recommended the employee undergo vocational evaluation and assessment to determine how he might best return to the open labor market in the Southeast Missouri region. Dr. Volarich noted the employee was 42 years old (a younger individual), has an education limited to graduation from high school, has worked as a laborer/carpenter his entire work career, and has been unable to get back to work since August 7, 2003. If vocational assessment was able to identify a suitable job, Dr. Volarich had no objection with his attempting to return to work based on the limitations set forth below. If the vocational assessment was unable to identify a suitable job, it was Dr. Volarich's opinion that the employee is permanently and totally disabled as a direct result of the work related injuries of August 7, 2003 standing alone.

It was Dr. Volarich's opinion that the employee had reached maximum medical improvement but would require ongoing indefinite pain management. Dr. Volarich stated to maintain his current state, he would require ongoing care for his pain syndrome including, but not limited to narcotic and non-narcotic medications, muscle relaxants, physical therapy and other similar treatment for symptomatic pain relief. Dr. Volarich stated that the narcotics are physically and psychologically addicting. Patients typically become dependent on Valium due to the relaxation effect; but they are usually not addictive. Since the employee has been on those types of medications since 2002, there was a definite dependence on them. The employee required treatment at a pain clinic due to his severe myofascial lumbar pain syndrome. The epidural steroid injections, nerve root blocks, trigger point injections, TENS units and other similar treatments would all help his pain syndrome. Dr. Volarich noted that surgery was not indicated. Dr. Volarich doesn't typically prescribe narcotic types of medications long term, and there are different options to help limit the use of narcotics by alternative type treatments in pain

management. Dr. Volarich believed that a referral to a pain clinic would be necessary to cure him and aid in the employee's work related injury.

Dr. Volarich stated that the employee was able to perform most activities for self care and may be able to perform some work activities on a limited basis with the restrictions set forth below. With regard to work and other activities referable to the spine, the employee was advised to avoid all bending, twisting, lifting, pushing, pulling, carrying, climbing and other similar tasks. He should not handle any weight greater than ten to fifteen pounds and limit those tasks to an occasional basis. He should avoid remaining in a fixed position for anymore than about twenty minutes at a time including both standing and sitting. He should change positions frequently to maximize comfort and rest when needed including resting in a recumbent fashion.

The employee met with Susan Shea on September 15, 2009. Her deposition was taken on December 3, 2010. Ms. Shea stated since the employee is a high school graduate, his level of education would not represent a hindrance to obtaining work or being re-trained for work. Since the employee worked in a highly skilled work, a transferrable skills analysis was performed to see if any jobs were indicated that would come close to accommodating his needs. The employee's lifting restrictions placed him in the sedentary category of work. The analysis was unable to indicate any jobs that were directly transferrable or generally transferrable from the employee's past work that would come close to meeting his restrictions and his pain, depression, use of narcotics and the need to change positions every 20 minutes.

In her summary, Ms. Shea stated the employee is 43 years old, is a high school graduate and has worked in highly skilled, very physically demanding work for most of his vocational career. His back injury resulted in severe pain and loss of function to the degree that he was not able to return to work in any capacity. It was Ms. Shea's opinion that the employee is unemployable in the regular workforce of the national labor market. The factors adding to the opinion include a reported pain factor that precludes all work, the medication usage including narcotic medications which have been unable to reduce his pain to a degree that would allow for work. Jobs as performed by the employee are often restricted by use of a narcotic medication, the employee has restrictions both from a physician and from his own perspective that do not allow for any work within the national labor force, a transferrable skills analysis was unable to indicate jobs that he could perform despite the restrictions being reduced when applied to the analysis, the employee's tolerance for fixed positions would not allow for the full range of sedentary or light work and would not allow for re-training. His medical history and restrictions provide a disincentive to the typical employer such that it is highly unlikely that the employee would even be considered as a candidate for hire by any typical employer. He can no longer lift more than fifteen pounds nor can he remain in a fixed position for more than twenty minutes. He is in constant pain despite medications and injections. He uses a cane to ambulate and appears to be in pain. It would be highly unlikely that any typical employer would consider hiring such an individual. It was Ms. Shea's opinion that the employee is unable to compete successfully in the open labor market.

Ms. Shea was asked if Dr. Kennedy's opinions were accurate that the employee could work without restrictions as of February 10, 2004, than was it her opinion that the employee

would be employable. Dr. Woods initially saw the employee in December of 2002 for chronic back pain and prescribed Lorcet, Xanax, and Valium. Some of the side effects of that medication are drowsiness. The employee was working in a full duty capacity without restrictions prior to August 7, 2003 even while taking the pain medication.

The employee saw Donna Abram for a vocational evaluation on August 13, 2010. Her deposition was taken on October 25, 2010. It was Ms. Abram's opinion that the employee appears to be able to access employment that exists in the open labor market and would have sufficient options available to him to make a job search. It was Ms. Abram's opinion that the employee is employable in the open labor market. With regard to placeability, Ms. Abram noted the employee is currently 43 years old and looks slightly younger. The employee is considered to be a younger worker in the labor market since he is under the age of 50. He would not be considered to be hindered by his age when looking for a new job in the open labor market. The employee was only 37 when the incident occurred. He was appropriately dressed and had good communication skills. Ms. Abram noted that the employee lead a much more sedentary life style than the doctors' restrictions would require. Dr. Kennedy and Dr. Kitchens indicated the employee could return to work with no limitations. Using those opinions, the employee could have returned to work in 2004 with no loss of access to employment for any reason. Dr. Park and Dr. Volarich gave specific restrictions and using their restrictions, Ms. Abram's evaluation identified a number of appropriate positions the employee could perform in 2004 and continues to be able to perform these types of job classifications today when analyzing the non-physical components associated with the matter. It was Ms. Abram's analysis that the employee remained clearly employable.

Ms. Abram stated whether the employee would be able to successfully obtain and maintain a new job is not as clear. None of the doctors indicated the employee was not able to work. Ms. Abram indicated a number of job classifications that the employee was suited for but there are a number of vocational barriers that existed which can prevent him from being considered for a current job opening. She noted that the employee has been out for over six years from work, and that the longer a person is out of the workforce the harder it will be for them to successfully return.

It was Ms. Abram's opinion that the employee would still be employable in the open labor market at this time. Based on his assessment, functional level and his verbal statements it was doubtful that the employee would be able to obtain and sustain a new job. However, if she looked at the employee's release to return to work in 2004, using Dr. Park's assessment, it was her conclusion that would have been significantly different. The employee would have had the ability to locate suitable work and be able to locate a new job with a new employer. If she considered the facts that were present in 2004, knowing that no significant treatment had taken place since then, the employee was both employable and placeable in the open labor market.

When asked her opinion as to the employee's employability in the open labor market, it was Ms. Abram's opinion that the employee has a work history, the education, the skills, the aptitude and the potential to do jobs that exist in the open labor market that fall within the doctors' limitations as given to her which means the employee has met the definition of

employability from a vocational perspective. It is her opinion that the employee is employable. With regard to place ability, currently he has been out of the workforce for a considerable length of time, he is on medication, and has poor pain control from what he indicated to her. His age is a bonus because he is considered a younger worker in the labor market and doesn't quite look his age. During the interview, his pain level did increase and his ability to concentrate seemed to wane which could be a problem. As of today, there are serious concerns about whether or not he would be able to compete and obtain a position because of the type of labor market there is. It was Ms. Abram's opinion that if he had attempted to return to work in 2004 when Dr. Kennedy first released him, it was going to be a totally different situation. The labor market was different, he was younger, and he wouldn't have had the gap in employment. It was her opinion that he would have been clearly employable and placeable in the open labor market at that point as of the date of maximum medical improvement in 2004 but presently, the employee has some barriers that he has to overcome before he is placeable in the open labor market, and be able to obtain and maintain a job.

The employee testified that on a typical day, he gets his boys up and off to school, takes his medicines, and then lies down. He will then get up and try to do as much as he can but it is not a lot. It hurts him to stand for more than 15-20 minutes at a time. He can only walk about 100 feet or so then has to stop due to his right leg. He cannot sit and stand very long due to low back pain and right leg pain. Prior to the accident he could walk for miles, stand all day, and sit for as long as wanted. The most he can sleep is about three hours and then he wakes up due to low back pain. He prepared Exhibit E which is a list of 95 activities that he can no longer do. In addition to the list, he can no longer run with his sons, cannot drive anywhere far, cannot take his sons hunting, and cannot play ball with his sons or coach their team. He cannot sit for a prolonged period without moving but could sit for an hour or so if he had to. Since August 7, 2003, he has not worked, has not looked for work or applied for jobs because there is not a job where he can sit, stand or lie down when he needs to. Prior to August 7, 2003, the medication he was taking took away his pain. Now he is always in pain even with taking medication. He continues to take some of the same medication that he was taking prior to August 7, 2003 including Valium, Xanax, and Lorcet but is taking more now. He is now on a Duragesic Patch, is taking Valium three times a day as opposed to once a day, and is taking twice as much Lorcet. The additional Lorcet and Valium affect his ability to work. The main thing that prevents him from working is pain but he would not feel safe working around machines with his medication intakes.

The employee testified that he has a valid driver license but has handicap plates which he got through Dr. Samuels. He has a special permanent hunting license which is shown in Employee's Exhibit F which allows him to hunt from a stationary vehicle. It was issued on November 1, 2006 and filled out by Dr. Samuels. He has gone deer hunting three times since the injury. In 2009, he killed a deer after hunting for an hour with his brother. His brother lifted and dressed the deer. He has gone fishing twice at his brother-in-law's pond. He only had to walk 10-15 feet to a dock where he got into a boat with a trolling motor and fished for about 35-40 minutes.

Penny Dooley testified on behalf of the employee. She is the employee's sister and since August 7, 2003 has performed consumer directed services which are basically home health for family members. She works for her brother through Pyramid and provides home health services including personal care, housekeeping, transportation and meals. For the first several years, she was not paid but helped him out since he was no longer able to care of himself and take care of his two boys. She did not know there were services that would pay her for her services. The employee was screened for those services and has to be re-evaluated periodically.

The employee testified that since being released by Dr. Kennedy on February 21, 2004, he never asked for or received permission to see any of the health care providers that he saw. The treatment since then has basically been medications.

## **RULINGS OF LAW:**

### ***Issue 1. Medical causation***

The employer-insurer is disputing that the employee's injury was medically causally related to the accident.

Prior to August 7, 2003, the employee had chronic low back tenderness and pain and was treated by Dr. Woods for degenerative disc and joint disease. When he started seeing Dr. Woods in December of 2002 the employee was already taking Lorcet 7.5/650 and Xanax. Dr. Woods prescribed Lorcet 7.5/650 and 10 mg of Valium. The employee saw Dr. Woods in February, April and June of 2003. The Lorcet dose was increased to 10/650 and the Valium was continued. On August 4, 2003, just four days prior to the accident, the employee saw Dr. Woods for back pain, insomnia, and degenerative disc disease. Dr. Woods prescribed Lorcet 10/650 for pain and Valium for insomnia.

Under Missouri law, the employer can be held responsible for accidents that aggravate pre-existing conditions prior to the date of the accident. See Indelictio v. Missouri Baptist Hospital, 690 S.W.2d 183 (Mo. App. 1983). The worsening of a pre-existing condition is a change in pathology needed to show a compensable injury. See Windsor v. Lee Johnson Const. Co., 950 S.W. 2d 504,509 (Mo. App. 1997). The aggravation of a pre-existing symptomatic condition is compensable. See Rector v. City of Springfield, 820 S.W.2d 639 (Mo. App. 1991) and Parker v. Mueller Pipeline, 807 S.W. 2d 518 (Mo. App. 1991). In Kelly v. Banta and Stude Construction Company, Inc., 1 S.W.3d 43 (Mo. App. 1999), the Court of Appeals held that the employer-insurer was liable for hip replacements based on a finding that the employee's work activity aggravated the employee's pre-existing osteoarthritis.

It is sufficient that causation be supported only by reasonable probability. See Davis v. Brezner, 380 S.W.2d 523 (Mo. App. 1964) and Downing v. Willamette Industries, Inc., 895 S.W.2d 658 (Mo. App. 1995). The Court of Appeals in Bloss v. Plastic Enterprises, 32 S.W.3d 666 (Mo. App. 2000), held that if work is a substantial factor in the cause of the injury, it can be compensable even if the injuries were triggered or precipitated by the work. The Court of Appeals in Cahall v. Cahall, 963 S.W.2d 368 (Mo. App. 1998), held that a work-related accident

can be both a triggering event and a substantial factor. There is no bright line test or minimum percentage defining a substantial factor. A causative factor may be substantial even if it is not the primary or most significant factor. The Court held that one-third of a cause is sufficient to be a substantial factor.

Prior to August 7, 2003, the employee had a pre-existing condition in his lumbar spine but did not have any problems with his right lower extremity. On August 7, 2003, as the employee lifted a heavy sawhorse, he felt a pull in his low back and developed pain across his back, down into his right hip and leg.

Dr. Woods diagnosed degenerative disc disease at L4-5 and L5-S1 which was putting pressure on the right lateral nerve and was probably contributing to his sciatica. Dr. Moore diagnosed right lumbar radiculopathy. Dr. McIntosh diagnosed an exacerbation of back pain with right sciatica, and Dr. Raskas diagnosed discogenic pain. Dr. Litofsky stated that the MRI showed mild discogenic changes with no evidence of nerve root compression. He diagnosed lumbar radiculopathy with no compressive lesion and possible neuritic pain

Dr. Park stated that the MRI showed a L3-4 and L4-5 right-sided high intensity zone possibly suggesting annular tears; and at L4-5 a disc protrusion that abutted the L4 nerve root. Dr. Park stated the employee had a probable annular tear at L3-4 and L4-5 on the right which may be the source of his back pain. It was his opinion that the employee's current symptoms were in substantial part caused by the injury of August 7, 2003.

Dr. Kennedy stated that the October 2003 myelogram showed a L5-S1 disc bulge but no evidence of nerve root impingement. The employee described symptoms compatible with sciatica but Dr. Kennedy did not see any signs of nerve root tension on exam or clear cut evidence of nerve root impingement on the myelogram. Dr. Kennedy stated that the employee had no permanency regarding the work related injury of August 7, 2003.

It was Dr. Kitchens' opinion that the workup and examination did not reveal nerve root impingement or lumbar radiculopathy; that the employee sustained a muscular strain from the work accident but did not sustain a disc herniation, nerve root impingement or radiculopathy. It was his opinion that the August 7, 2003 accident was not the substantial factor in the cause of the current low back pain; and his current back pain is degenerative in nature and pre-existed the work accident.

Dr. Volarich stated that the employee had a history of chronic low back pain with degenerative disc disease from L4 to S1 prior to August 7, 2003. It was his opinion that the accident of August 7, 2003, significantly worsened his pain syndrome. He diagnosed bulging discs at L4-5 and L5-S1 with intermittent right leg radicular symptoms and severe lumbar myofascial pain syndrome. It was Dr. Volarich's opinion that the August 7, 2003 work accident was the substantial contributing factor as well as the prevailing or primary factor causing the disc bulges at L4-5 and L5-S1 with intermittent right leg radicular symptoms that required extensive conservative management.

Based on a review of all the evidence, I find that the opinions of Dr. Volarich and Dr. Park are more credible than the opinions of Dr. Kitchens and Dr. Kennedy on the issue of medical causation.

Based on a review of the evidence and the opinions of the physicians, I find that the August 7, 2003 work accident either caused a new injury and/or aggravated a pre-existing condition in the employee's lumbar spine which caused the employee's low back to become more symptomatic. I find that the accident was a substantial factor in causing the low back injury and resulting medical condition. I find that the employee's low back condition was medically causally related to the August 7, 2003 work accident.

***Issue 4. Nature and extent of permanent disability.***

The employee has alleged that he is permanently and totally disabled. Section 287.020.7 RSMo. provides as follows:

The term "total disability" as used in this chapter shall mean the inability to return to any employment and not merely mean inability to return to the employment in which the employee was engaged at the time of the accident.

The phrase "the inability to return to any employment" has been interpreted as the inability of the employee to perform the usual duties of the employment under consideration, in the manner that such duties are customarily performed by the average person engaged in such employment. Kowalski v M-G Metals and Sales, Inc., 631 S.W.2d 919, 922(Mo.App.1992). The test for permanent total disability is whether, given the employee's situation and condition, he or she is competent to compete in the open labor market. Reiner v Treasurer of the State of Missouri, 837 S.W.2d 363, 367(Mo.App.1992). Total disability means the "inability to return to any reasonable or normal employment". Brown v Treasurer of the State of Missouri, 795 S.W.2d 479, 483(Mo.App.1990). The key is whether any employer in the usual course of business would be reasonably expected to hire the employee in that person's physical condition, reasonably expecting the employee to perform the work for which he or she is hired. Reiner at 365. See also Thornton v Haas Bakery, 858 S.W.2d 831, 834 (Mo.App.1993).

I find that there is not sufficient evidence to find that the employee is permanently and totally disabled. There are a number of factors that affect the employee's claim for permanent total disability.

Alleged Severity of Symptoms

There were several health care providers that questioned the severity of the employee's symptoms. Robert Sherrill, the physical therapist who performed the functional capacity evaluation, noted that the employee's movement patterns were exaggerated and inconsistent throughout the examination; the validity analysis showed invalid results in six of eight categories; and the employee demonstrated over guarding and exaggerated response to subjective reports of increased pain. He stated that the employee provided unacceptable and invalid effort

during testing. He further noted that Waddell signs were positive in six out of seven categories which are clinically significant. Secondary to symptom magnification behavior and over guarding, it was the opinion of the therapist that the function displayed was not a valid representation of the employee's true functional abilities.

Dr. Kennedy stated it was difficult to determine what restrictions to place on the employee due to the non-physiologic/neurologic examination. Dr. Kitchens stated that the employee had signs of symptom magnification as noted by severe pain with simple touching of his lower back and inconsistencies in body posture from sitting to standing and performing range of motion of the lumbar spine. Even Dr. Volarich, the employee's rating physician, noted that the motor examination was difficult to assess due to breakaway involving the upper and lower extremities; the extensor hallucis longus strength was diffuse to assess because of breakaway bilaterally; and five out of five Waddell signs were positive.

These observations substantially affect the employee's claim for permanent total disability.

#### Usage of Narcotic Medication

There was concern from various health care providers that the employee was taking more narcotics than prescribed and had drug seeking behavior. Even prior to August 7, 2003, Dr. Woods noted that the employee was taking Lorcet more often than prescribed and told the employee he would not fill the prescription early. In October of 2003, Dr. Raskas noted that he had a long discussion with the employee about pain medication usage and told the employee that he was only to use pain medication from him. That same month, the employee went back to Dr. Woods who prescribed Vicodin 10/650 and Valium. On February 19, 2004, the employee contacted Dr. Kennedy's office and requested Percocet 10/325. When told that Dr. Kennedy would only prescribe something less strong, the employee declined anything but Percocet. Four days later on February 23, the employee requested a prescription for Percocet from Dr. Woods who noted that he already had prescriptions for Vicodin 10/650 and Valium. Dr. Woods would not give the employee a prescription for a third narcotic which made the employee quite agitated. Dr. Woods was concerned that the employee had drug seeking behavior.

In March of 2004, the employee went to the emergency room and told the physician that he was incapacitated by low back pain and was only able to handle it with Percocet which he had run out of. The employee stated that he had been getting 80 Percocet at a time. The emergency room doctor prescribed sixteen Percocet and told the employee to follow up with Dr. Woods. In August of 2004, Dr. Meece noted that the employee had been to the emergency room three times and would be concerned if the employee started making regular visits to the emergency room for pain. On December 15, 2004, Advanced Family Care would no longer provide medical services to the employee. The next day the employee was transported by ambulance to the emergency room where he requested pain medication refills noting that Dr. Woods and Advanced Pain Clinic had stopped prescribing pain medication. The employee was insistent that he receive prescriptions for Oxycontin, Hydrocodone and Oxycodone. The emergency room doctor refused to prescribe them. The employee was not interested in anything else. The emergency room

doctor's impression was possible drug seeking behavior. In May of 2010, Dr. Samuel collected a blood sample that showed high results for Hydrocodone, Hydromorphone, Oxazepam and Nordiazepam.

Dr. Kitchens noted that the employee had chronic narcotic use prior to the work related incident which persisted and indicated narcotic dependency. Dr. Volarich noted that narcotics are physically and psychologically addicting. Patients typically become dependent on Valium due to the relaxation effect; but they are usually not addictive. Since the employee has been on those types of medications since 2002, there was a definite dependence on them.

These concerns bring into question the alleged severity of the employee's symptoms and substantially affect his claim for permanent total disability.

#### Dr. Volarich's Opinions are Contradictory

Dr. Volarich noted that prior to August 7, 2003 the employee had a history of low back pain and was treated with medications by Dr. Woods for chronic back pain. Dr. Woods prescribed Lorcet a narcotic pain medicine and Valium as a muscle relaxer or a similar combination. He noted that the employee had been on those medications since December of 2002. Dr. Volarich noted that the employee told him that in order to work prior to August 7, 2003, he had to take Valium and Lorcet for his low back. It was Dr. Volarich's opinion that the employee had a pre-existing 15% permanent partial disability of the body as a whole at the lumbosacral spine due to his chronic lumbar syndrome, loss of motion and the need to take daily narcotic pain medications. It was his opinion that the pre-existing problem was a hindrance or obstacle in performing his job duties prior to August 7, 2003.

It was Dr. Volarich's opinion that as a direct result of the August 7, 2003 accident and injury, the employee sustained a 35% permanent partial disability of the body as a whole at the lumbosacral spine due to the disc bulges at L4-5 and L5-S1 causing intermittent right leg paresthesias and radicular symptoms. Dr Volarich stated that it was his opinion that the combination of his disabilities created a substantially greater disability than the simple sum or total of each separate injury and a loading factor should be added. He stated that the employee was able to perform most activities for self care and may be able to perform some work activities on a limited basis with restrictions.

With regard to work and other activities referable to the spine, the employee was advised to avoid all bending, twisting, lifting, pushing, pulling, carrying, climbing and other similar tasks. He was advised not to handle weight greater than fifteen pounds and limit that to an occasional basis. He should avoid remaining in a fixed position for any more than twenty minutes at a time and should change positions frequently. He should rest when needed including resting in a recumbent fashion.

Dr. Volarich then recommended the employee undergo vocational evaluation and assessment to determine how he might best return to the open labor market. If vocational assessment was able to identify a suitable job, Dr. Volarich had no objection with the employee

attempting to return to work with limitations. If the vocational assessment was unable to identify a suitable job, it was Dr. Volarich's opinion that the employee is permanently and totally disabled as a direct result of the work related injuries of August 7, 2003 standing alone.

Dr. Volarich's opinions regarding permanent total disability contradict themselves. Dr. Volarich stated that the employee had a pre-existing low back condition that was a hindrance or obstacle in performing his job duties prior to August 7, 2003. He stated that as a result of the August 7, 2003 accident the employee sustained a 35% permanent partial disability of the body as a whole referable to his low back. At that point, he did not say that the employee was permanently totally disabled from the last accident alone but did state that the combination of those two disabilities created a substantially greater disability than the total of each injury. Dr. Volarich then contradicted himself and stated that if the vocational assessment could not find a suitable job, then the employee was permanently and totally disabled as a direct result of the August 7, 2003 accident alone. He did not say it was from the combination of the pre-existing low back condition and the back condition from August 7, 2003. These contradictions affect the credibility of Dr. Volarich's on the issue of permanent total disability. I find that the opinion of Dr. Volarich on this issue is not persuasive.

#### Other Permanent Total Disability Opinions

Ms. Shea stated the employee is 43 years old, is a high school graduate and has worked in highly skilled, very physically demanding work for most of his vocational career. The back injury resulted in severe pain and loss of function to the degree that the employee was not able to return to work in any capacity. It was Ms. Shea's opinion that the employee is unemployable in the regular workforce of the national labor market. The factors for this opinion include a reported pain factor that precludes all work and the medication usage including narcotic medications which have been unable to reduce his pain to a degree that would allow for work. Jobs are often restricted by use of a narcotic medication; the employee has restrictions both from a physician and from his own perspective that do not allow for any work within the national labor force; a transferrable skills analysis was unable to indicate jobs that he could perform despite the restrictions being reduced when applied to the analysis; and, the employee's tolerance for fixed positions would not allow for the full range of sedentary or light work and would not allow for re-training. His medical history and restrictions provide a disincentive to the typical employer such that it is highly unlikely that the employee would even be considered as a candidate for hire by any typical employer. He can no longer lift more than fifteen pounds nor can he remain in a fixed position for more than twenty minutes. He is in constant pain despite medications and injections. He uses a cane to ambulate and appears to be in pain. It would be highly unlikely that any typical employer would consider hiring such an individual. It was Ms. Shea's opinion that the employee is unable to compete successfully in the open labor market.

Dr. Campbell stated that the prognosis was poor for the employee's return to his usual and customary work. It was Dr. Park's opinion that the employee can participate to some degree at work perhaps with a ten pound lifting restriction and mostly clerical type of activity.

Dr. Kennedy stated the employee should be able to perform activity as tolerated and he would not place any specific restrictions as a result of the work injury. It was his opinion that the employee had no permanency regarding the work related injury of August 7, 2003.

It was Dr. Kitchens' opinion that the employee has a permanent partial disability of 2% related to a muscular strain from his August 7, 2003 work incident, and that the employee can work without restrictions.

Ms. Abram stated that Dr. Park and Dr. Volarich gave specific restrictions and using their restrictions, she identified a number of appropriate positions the employee could perform in 2004 and continues to be able to perform. It was her opinion that the employee was employable in the open labor market. With regard to placeability, the employee has been out of the workforce for a considerable length of time, he is on medication, and has poor pain control from what he indicated. When Ms. Abram saw the employee, there were concerns whether the employee would be able to compete and obtain a position due to the current labor market. Ms. Abram noted the employee was only 37 years old when the accident occurred, was currently 43 years old and looks slightly younger. Since he is under the age of 50, he is considered a younger worker in the labor market. The employee had good communication skills. Ms. Abram noted that the employee led a much more sedentary life style than the doctors' restrictions would require. Dr. Kennedy and Dr. Kitchens indicated the employee could return to work with no limitations. Using those opinions, the employee could have returned to work in 2004 with no loss of access to employment for any reason. It was Ms. Abram's opinion that in 2004, when Dr. Kennedy first released him, he was clearly employable and placeable in the open labor market. The employee would have had the ability to locate suitable work and be able to locate a new job with a new employer. It was Ms. Abram's opinion that the employee has a work history, the education, the skills, the aptitude and the potential to do jobs that exist in the open labor market that fall within the doctors' limitations and in her opinion the employee is employable in the open labor market.

Based on a review of the evidence, I find that the opinions of Dr. Park, Dr. Kennedy, Dr. Kitchens and Ms. Abram are persuasive and more credible than the opinions of Dr. Volarich and Ms. Shea.

Based on the evidence, I find that the employee has failed to satisfy his burden of proof on his claimed permanent total disability for the August 7, 2003 accident. Although the employee's injuries will likely preclude the employee from doing heavy manual labor, the evidence does not support a finding that the employee is unemployable in the open labor market. I find that the employee is not permanently and totally disabled. The employee's request for an award of permanent total disability against the employer-insurer for the August 7, 2003 accident is denied.

However, the evidence clearly supports a finding that the employee has sustained permanent partial disability to his body as a whole referable to his low back. Based on the evidence, I find that as a direct result of the August 7, 2003 accident the employee sustained a 15% permanent partial disability of the body as a whole referable to his low back. The employer-

insurer is ordered to pay the employee 60 weeks of compensation at the rate of \$347.05 per week for a total award of permanent partial disability of \$20,823.00.

***Issue 3. Claim for additional or future medical aid***

The employee must establish through competent medical evidence that the medical care requested, “flows from the accident” before the employer-insurer is responsible. See Crowell v. Hawkins, 68 S.W.3d 432 (Mo. App. 2001), Landers v. Chrysler Corporation, 963 S.W.2d 275 (Mo. App. 1997); Modlin v. Sunmark, Inc., 699 S.W.2d 5, 7 (Mo. App. 1995); and Sifferman v. Sears, Roebuck and Company, 906 S.W.2d 823 (Mo. App. 1995). Where future medical benefits are to be awarded the medical care must of necessity flow from the accident, via evidence of a medical causal relationship between the injury from the condition and the compensable injury before the employer-insurer is to be held responsible. See Mickey v. City Wide Maintenance, 996 S.W. 2d 144 (Mo. App. 1999). The employee has the burden of proof to show that any future medical care flows from the compensable work accident. There must be sufficient medical evidence showing that the employee needs future treatment for his compensable work related low back condition that “flows” from the accident and not from his pre-existing low back condition.

The employee’s burden of proof is complicated by and made more difficult by the fact that the employee has been taking prescription medication including narcotic pain medication due to chronic low back pain at least since December of 2002, approximately 8 months prior to the accident.

In Bowyers v. Hiland Dairy Company, 132 S.W.3d (Mo. App. 2004) the Court held that when an injured employee is taking medications for a pre-existing condition, just the fact that a work injury would require the same medication including the type and extent does not mean that the treatment becomes compensable. The Court gave an example that if medication is being taken for a pre-existing condition, the claim for prescription cost for increased dosages or for stronger medication caused by a work injury may be compensable even if it benefits the pre-existing condition. The treatment must be due to the work injury and not the pre-existing condition.

The employee testified that he continues to use some of the same medication that he was taking prior to August 7, 2003 including Valium, Xanax, and Lorcet but is taking more of them now. He testified that he is using a Duragesic Patch.

It was Dr. Volarich’s opinion that the employee would require ongoing care for his pain syndrome including, but not limited to narcotic and non-narcotic medications, muscle relaxants, physical therapy and other similar treatment for symptomatic pain relief. He stated that epidural steroid injections, nerve root blocks, trigger point injections, TENS units and other similar treatments would all help his pain syndrome. Dr. Volarich believed that a referral to a pain clinic would be necessary to cure and aid in the employee’s work related injury.

I find that Dr. Volarich’s opinion does not meet the required burden of proof of sufficient

competent medical evidence. Dr. Volarich did not separate out what medical care including medication was required due to the work related accident compared to what was needed due to the pre-existing chronic low back pain. I find that his opinion did not provide the proper basis to show that the employee needs future treatment for his compensable work related low back condition that “flows” from the accident and not from his pre-existing low back condition.

In February of 2004, Dr. Kennedy placed the employee at maximum medical improvement. In February of 2005, it was Dr. Kennedy’s opinion that the employee continued to be at maximum medical improvement and no further treatment would likely benefit him.

Dr. Kitchens stated that the employee had a history of chronic narcotic use for chronic low back pain prior to the work incident. It was Dr. Kitchens’ opinion that the employee would not benefit from additional treatment including treatment with chronic narcotic medication, and that the employee was at maximum medical improvement with regard to the August 7, 2003 work incident.

Based on a review of the evidence, I find that the opinions of Dr. Kennedy and Dr. Kitchens are more credible than the opinion of Dr. Volarich regarding future medical treatment.

I find that there is not sufficient medical evidence that any future medical treatment is a result of and flows from the compensable work accident. I find that the employee failed to satisfy his burden of proof that any future medical treatment flows from the work accident and there is a medical causal relationship between the injury from the condition and the compensable injury. The employee’s claim for future medical aid is denied.

***Issue 2. Claim for previously incurred medical and Issue 6. Medicaid lien***

The employee is claiming \$12,196.27 in previously incurred medical aid. He is claiming 7,042.00 for medical bills contained in the medical bill summary that are still unpaid and what he paid out of pocket. These are contained in Exhibit A. He is also claiming an additional \$5,154.27 in medical bills that had been paid by the Missouri Department of Social Services and which are contained in their lien which is Exhibit D.

The employer-insurer is disputing those bills with regard to the authorization, reasonableness, necessity and medical causal relationship.

The medical bills are:

Southeast Missouri Hospital	\$1,841.30
Occupational Medical Services	\$169.00
Anesthesia Associates of Cape	\$812.00
Cape Radiology Group	\$405.00
Dr. Park	\$115.00
Advanced Family Care	\$1,248.00
Dr. Samuel	\$199.00

Healing Arts Pharmacy	\$2.00
Walgreens Pharmacy	\$1,159.56
Advance Pharmacy	\$413.53
David's Pharmacy	\$445.20
Twin City Pharmacy	\$65.41
Broadway Pharmacy	\$12.00
Kneibert Clinic	\$17.50
Central Pharmacy	\$4.50
Puxico Drugs	\$14.00
Wood's Medical Clinic	\$119.00

The employer sent the employee to Occupational Medical Services on August 7 and August 13, 2003. The bill from Cape Radiology is for services on August 7, 2003 which were for x-rays ordered by Occupational Medical Services and for reading of the August 11, 2003 MRI which was authorized by and paid by the employer-insurer. The bill from Anesthesia Associates is for dates of service on September 15 and October 7 of 2003, and February 27, 2004 for treatment with Dr. Moore who was referred by Dr. Raskas, an authorized treating physician. There are bills from Southeast Missouri Hospital in the amount of \$713.12 for the epidural steroid injection performed by Dr. Moore on September 15, and in the amounts of \$94.75 and \$106.75 for the follow up visits with Dr. Moore at the pain clinic. The \$2.00 bill from Healing Arts is for a prescription from Dr. Moore. From Advance Pharmacy there is a \$4.00 bill for a prescription from Dr. DeFelice and a \$176.06 bill for a prescription from Dr. Raskas. I find that all of these medical bills for these services are authorized, reasonable, necessary and medically causally related to the August 7, 2003 accident, and total \$2,482.68.

With regard to the issue of authorization, Section 287.140 RSMo gives the employer the right to select the treating physician. The statute also gives the employee the option of selecting his own physician at his own expense. See Anderson v. Parrish, 472 S.W. 2d 452 (Mo. App. 1971).

When the employee saw Dr. Park on December 4, 2003, the employer-insurer had been providing treatment with Dr. Raskas. He last saw the employee on November 3, 2003. The employer-insurer set up an appointment with Dr. Kennedy for December 9, 2003. I find that the medical treatment by Dr. Park was unauthorized and the employee exercised his right under the statute to have treatment on his own through Dr. Park. I find that the employer-insurer is not liable for Dr. Park's bill in the amount of \$115.00.

The employee testified that since being released by Dr. Kennedy on February 21, 2004, he never asked for or received permission to see any of the health care providers that he saw. The treatment since then has basically been medications.

The remaining bills of Southeast Missouri Hospital are for emergency room visits on March 6, August 2, and December 16 of 2004. The bills for Advanced Family Care are for services beginning on March 8, 2004. The employee started seeing Dr. Samuel on March 24, 2005. Most of the remaining bills are for charges incurred after February 21, 2004. I find that

since being released by Dr. Kennedy, the employee did not request additional treatment and that any medical bills for treatment after February 21, 2004 are not authorized and the employer-insurer are not liable for those medical bills.

Based on my reasoning set forth in my ruling in Issue 3 with regard to future medical treatment, I am also denying the remaining bills from Southeast Missouri Hospital, Advanced Family Care, Wood's Medical Clinic and the various pharmacies on the issue of medical causation. I find that there was insufficient medical evidence that the medical treatment for these medical bills was medically causally related to the August 7, 2003 accident.

I therefore find that the employer-insurer is responsible for and is directed to pay the employee the sum of \$2,482.68 for the following previously incurred medical bills contained in Exhibit A:

Occupational Medical Services	\$169.00
Anesthesia Associates	\$812.00
Cape Radiology Group	\$405.00
Southeast Missouri Hospital	\$914.62
Healing Arts Pharmacy	\$2.00
Advance Pharmacy	\$180.06

The Missouri Department of Social Services filed a lien in the amount of \$5,154.27. Section 287.266 RSMo, provides that the State shall have a lien for the payment of medical benefits, if those payments were made for a compensable injury, occupational disease or disability.

Employee Exhibit D contains a summary of medical treatment paid for by the Department of Social Services. The medical services that were paid are:

<u>Beginning Date of Service</u>	<u>Provider Name</u>
3/29/2005	Southeast Missouri Hospital
6/13/2005	University of Missouri
6/13/2005	Dr. Litofsky
1/10/2005	MedStop One
8/07/2003	Dr. Woods
8/25/2003	Medical Arts Pharmacy
1/20/2005	Broadway Prescription
2/24/2006	Kneibert Clinic
10/31/2003	Twin City Pharmacy
3/17/2004	David's Pharmacy
8/13/2003	Advance Pharmacy
9/14/2004	Walgreens
12/17/2004	Central Pharmacy
2/27/2004	Healing Arts Pharmacy

3/29/2005  
8/08/2003

Cape Radiology  
Stoddard County Ambulance

I find that the \$130.78 paid by the Department of Social Services to Advance Pharmacy for prescription medicines prescribed by Dr. DeFelice with a date of service of August 14 and August 21, 2003; and the \$62.06 paid to Healing Arts Pharmacy for prescription medication prescribed by Dr. Moore was for authorized treatment by the employer-insurer, and was medically causally related to the August 7, 2003 accident. I further find that the \$248.00 paid to Stoddard County Ambulance District for services on August 8, 2003 was medically causally related to the August 7, 2003 accident. I therefore order that the employer-insurer pay to and reimburse the Missouri Department of Social Services the sum of \$440.84.

As set forth in Issue 3, I find that for the remainder of the medical treatment that was paid by the Department of Social Services, there was no sufficient medical evidence to show that it was medically causally related to the work related accident of August 7, 2003. Therefore I find said medical treatment was not incurred for treatment for an injury under Chapter 287 RSMo. Therefore, neither the employer nor the employee is responsible to pay the remainder of the lien of the Department of Medical Services.

***Issue 5. Direct medical fee dispute filed by Southeast Missouri Hospital***

Southeast Missouri Hospital filed an Application for Direct Payment with the Division on September 16, 2005 with the amount being requested of \$466.63. An amended Application for Direct Payment was filed on December 17, 2010 which raised the amount requested to \$1,841.30. Under Section 287.140.13(6) RSMo, a health care provider whose services have been authorized in advance by the employer or insurer may give notice to the division of a claim for services provided for a work related injury that is covered by this chapter.

The Applications filed by Southeast Missouri Hospital left blank the name and title of the person giving authorization for the services and the date authorization was given. Although notified of the hearing, Southeast Missouri Hospital failed to appear. There was no evidence that the treatment was authorized in advance by the employer or insurer. I find that Southeast Missouri Hospital did not meet its burden of proof that its services were authorized in advance and the Application for Direct Payment is denied.

**ATTORNEY'S FEE**

Dan Rau, attorney at law, is allowed a fee of 25% of all sums awarded under the provisions of this award for necessary legal services rendered to the employee. The amount of this attorney's fee shall constitute a lien on the compensation awarded herein.

**INTEREST**

Interest on all sums awarded hereunder shall be paid as provided by law.

Employee: Stanley Chubb

Injury No. 03-080102

Date: \_\_\_\_\_

Made by:

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Lawrence C. Kasten  
*Chief Administrative Law Judge*  
*Division of Workers' Compensation*

A true copy: Attest:

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Naomi Person  
*Division of Workers' Compensation*