

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

Injury No.: 99-164772

Employee: Gary Cole
Employer: Schreiter Concrete Company
Insurer: Employers Mutual Casualty Company
Additional Party: Treasurer of Missouri as Custodian
of Second Injury Fund

The above-entitled workers' compensation case is submitted to the Labor and Industrial Relations Commission (Commission) for review as provided by section 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 section 286.090 RSMo, the Commission affirms the award and decision of the administrative law judge dated December 14, 2010, and awards no compensation in the above-captioned case.

The award and decision of Administrative Law Judge Edwin J. Kohner, issued December 14, 2010, is attached and incorporated by this reference.

Given at Jefferson City, State of Missouri, this 17th day of August 2011.

LABOR AND INDUSTRIAL RELATIONS COMMISSION

NOT SITTING

William F. Ringer, Chairman

Alice A. Bartlett, Member

Curtis E. Chick, Jr., Member

Attest:

Secretary

AWARD

Employee:	Gary Cole	Injury No.:	99-164772
Dependents:	N/A		Before the
Employer:	Schreiter Concrete Company		Division of Workers'
Additional Party:	Second Injury Fund		Compensation
Insurer:	Employers Mutual Casualty Company		Department of Labor and Industrial
Hearing Date:	September 21, 2010		Relations of Missouri
			Jefferson City, Missouri
		Checked by:	EJK/ch

FINDINGS OF FACT AND RULINGS OF LAW

1. Are any benefits awarded herein? No
2. Was the injury or occupational disease compensable under Chapter 287? No
3. Was there an accident or incident of occupational disease under the Law? Yes
4. Date of accident or onset of occupational disease: August 2, 1999
5. State location where accident occurred or occupational disease was contracted: Warren 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 occurred or occupational disease contracted:
The employee was on the plant roof, shoveling sand from the roof into a bucket on a front-end loader, lost his footing on the sand, and fell off the roof.
12. Did accident or occupational disease cause death? No Date of death? N/A
13. Part(s) of body injured by accident or occupational disease: Alleged neck and right knee
14. Nature and extent of any permanent disability: None from the accident
15. Compensation paid to-date for temporary disability: None
16. Value necessary medical aid paid to date by employer/insurer: None

Employee: Gary Cole

Injury No.: 99-164772

17. Value necessary medical aid not furnished by employer/insurer? None

18. Employee's average weekly wages: \$480.00

19. Weekly compensation rate: \$320.00/\$303.01

20. Method wages computation: By agreement

COMPENSATION PAYABLE

21. Amount of compensation payable:

None

22. Second Injury Fund liability: No

TOTAL:

None

23. Future requirements awarded: None

Said payments to begin immediately and to be payable and 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: Mark R. Bahn, Esq.

FINDINGS OF FACT and RULINGS OF LAW:

Employee:	Gary Cole	Injury No.:	99-164772
Dependents:	N/A		Before the
Employer:	Schreiter Concrete Company		Division of Workers'
			Compensation
Additional Party:	Second Injury Fund		Department of Labor and Industrial
			Relations of Missouri
			Jefferson City, Missouri
Insurer:	Employers Mutual Casualty Company		Checked by: EJK/ch

This workers' compensation case raises several issues arising out of an alleged work related injury in which the claimant claimed that he suffered torn right knee cartilage and a crushed vertebra in his neck on August 2, 1999, when he fell off a roof while shoveling sand off the employer's building. The issues for determination are (1) Medical causation, (2) Liability for past medical expenses, (3) Future medical care, (4) Temporary disability, (5) Permanent disability, and (6) Second Injury Fund liability.

At the hearing, the claimant testified in person and offered the report of injury, the claim and amended claim for compensation, records from the Missouri Division of Workers' Compensation, depositions of Dr. Polinsky, Dr. Berkin, and Vickie Tucker, medical bills from Missouri Baptist Medical Center and Dr. Polinsky, and voluminous medical records. The employer offered a deposition of Marvin Mishkin, M.D., a medical report from Sherwyn Wayne, M.D., and medical records, and a lien letter from Missouri Healthnet. The Second Injury Fund offered a deposition of the claimant.

All objections not previously sustained are overruled as waived. Jurisdiction in the forum is authorized under Sections 287.110, 287.450, and 287.460, RSMo 2000, because the accident was alleged to have occurred in Missouri. Any markings on the exhibits were present when offered into evidence.

The primary issue for resolution in this case is whether the August 2, 1999, accident at work was a substantial factor in causing the claimant's cervical and right knee conditions, and need for cervical spine and right knee surgery. The evidence compels an award for the defense, because the evidence submitted by the claimant does not support an award of workers' compensation benefits. The claimant's testimony was impeached by the defense, because it conflicted with numerous prior statements found in many medical records from a variety of medical providers and in the claimant's deposition. In addition, the forensic medical evidence submitted by the claimant was not credible, because those medical experts had no information about the claimant's preexisting conditions that were well documented by medical providers that rendered medical services to the claimant before the accident. The evidence as a whole supports a finding that the claimant has a long history of degenerative osteoarthritis, but is not sufficient to establish whether, or to what extent, the accident at work was a substantial factor causing or aggravating that condition.

SUMMARY OF FACTS

Before the Accident

The claimant began working for this employer on March 17, 1999, as a concrete mixer and truck driver. He drove and maintained a truck. See claimant deposition, pages 13-14. At job sites, the claimant was responsible for keeping rock and sand bins filled, running a lift, and putting the rock in the right bins. The claimant performed heavy lifting including lifting steel bars and rods and bags of lime. See claimant deposition, page 15. Immediately before working for this employer, the claimant was in prison for 18 months for drug possession with intent to distribute. Before incarceration, the claimant drove a truck over the road for various employers. See claimant deposition, pages 18-19. The claimant had no neck pain before August 1, 1999, and never injured his neck before August 2, 1999. See claimant deposition, pages 41-42. Before the August 1999 occurrence, the claimant suffered injuries to his low back and left shoulder.

At the hearing, the claimant testified that he had no complaints regarding the right knee or treatment for his right knee before August 1, 1999. In his deposition, however, the claimant testified that he had right knee problems before August 1999. There was a disc floating around in his right knee. The claimant had fluid drained from the knee. See claimant deposition, pages 50-51. On July 9, 1999, the claimant went to Dr. Merenda, an orthopedic surgeon, and reported injuries to his "back, right knee, left shoulder, left hand, right foot" from work related injuries on "11-13-86/5-23- or 24-99". See Exhibit 2. The claimant stated that his back pain began bothering him in 1994. See Exhibit 2. The Patient Medical History Form asked the claimant to state the percentage of pain he had in his extremities, and the claimant reported that he had 80-90% pain in his left arm, 60-70% pain in both legs, 40-50% pain in his neck, and 100% pain in his back. See Exhibit Q. Most all physical activity worsened the pain. The claimant described his pain as pins and needles in the left buttock, left leg, lower back, numbness and tingling in the left hand, left shoulder and arm. The claimant signed the Patient Medical History Form. See Exhibit Q.

Dr. Merenda examined the claimant on July 12, 1999, and the claimant related that he had increasing back pain for the past five months, with what sounded like a 1986 work-related injury. He had experienced intermittent back pain ever since. The claimant suffered from chronic intermittent low back pain, and bilateral leg pain, left greater than right. See Exhibit 2. Dr. Merenda performed a physical exam. Straight leg raising was negative. The claimant had normal motor strength and reflexes and a negative straight leg raising test. Dr. Merenda ordered an MRI and opined that the claimant did not require surgery. See Exhibit 2.

A July 21, 1999 lumbar spine MRI showed degenerative disc disease, greatest at L4-5 and L3-4. The claimant had desiccation of the discs at L3-4 and L4-5. There was a mild diffuse bulge at L3-4, without stenosis. The claimant had a mild posterior disc protrusion at L4-5, which did not produce significant nerve root impingement. There was mild facet arthropathy bilaterally at L5-S1. See Exhibit 2.

The Accident and Subsequent Medical Care

The claimant testified that his injury occurred between August 1, 1999, and August 3, 1999, but could not recall the exact date of the accident. When he was injured, the claimant was

on the plant roof, shoveling sand from the roof into a bucket on a front-end loader. The claimant lost his footing on the sand and fell off the roof. The claimant estimated that he fell ten to fifteen feet, hit his chest on a rubber tire on the front-end loader, and fell onto his back on concrete. While the claimant had no pain at the time he fell, he believed he was unconscious for “a second” but got up a few minutes later. He could not recall having any pain or symptoms at that time in any part of his body. See claimant deposition, pages 26-27.

The claimant testified that he returned to work and did not seek medical treatment on the day of the accident. See claimant deposition, pages 17, 18, 26, 27. He continued to work for 1½ to 2½ weeks. As the claimant continued to work, he testified that he slowly began to experience symptoms in his low back, right arm, and both knees. See claimant’s deposition, pages 26-28.

The claimant went to the Emergency Room at Doctors Hospital on August 3, 1999, reported that he “fell off roof at work - 1 month ago”, and had bilateral knee pain. The registration notes state that the claimant reported a chronic back pain, and now had knee pain radiating to his feet. See Exhibit L. The claimant was diagnosed with chronic back pain and left knee pain. No swelling was noted in either knee. See Exhibit L. However, no physician found that the claimant had right knee pathology. The records disclose no diagnostic studies, including x-rays, of the claimant’s right knee or any complaints of cervical spine or neck pain. See Exhibit L.

On October 4, 1999, the claimant went to Dr. Imboden, an osteopathic physician specializing in family practice, and reported right knee pain. The right knee clicked and had decreased range of motion in the knee. Dr. Imboden diagnosed right knee pain due to trauma and ordered an MRI. See Exhibit I. An October 6, 1999, right knee MRI demonstrated a high signal intensity in the medial meniscus that did not extend into the articular surface, but the significance of this finding was unknown. See Exhibit I.

On October 22, 1999, the claimant returned to Doctors Hospital with continuous right knee pain for 3½ months now at the level of a 5 on a 1/10 scale. See Exhibit K. The claimant related that he was originally injured at work, three to four months before that date. The claimant made no complaints pertaining to, and sought no treatment for, his cervical spine. See Exhibit K. The claimant returned to work on October 23, 1999, with restrictions of standing and walking as tolerated, but he was not to climb ladders. The diagnosis was right knee pain – torn cartilage. A notation in the report indicated, “Patient doesn’t want this under workman’s comp”. See Exhibit K. On October 25, 1999, Dr. Imboden diagnosed a torn meniscus of the right knee and referred the claimant to Dr. Rummel, an orthopedic surgeon. See Exhibit I.

The claimant testified that he missed a significant amount of work after the August 1999 accident, but he also testified that the wage statement pertaining to his employment was most likely correct reflecting that the claimant missed very little work between August 1, 1999 and his termination of employment in October 1999. The employer’s agent testified that the claimant worked 40+ hours every week, including overtime, after August 4, 1999. See Tucker deposition, pages 36-37. The employer terminated the claimant’s employment on October 27, 1999, for not showing up to work when he was supposed to. See Tucker deposition, pages 16, 37.

On October 29, 1999, the claimant went to Dr. Rummel, and reported that he fell from a roof twelve feet onto his legs while at work four months earlier. The claimant complained of right knee pain and swelling. He reported that he continued to work as a truck driver. He reported that two days before the appointment, he had increasing right knee pain. The claimant related that he had been off work "off and on". Right knee x-rays revealed arthritic changes in the tibial eminences. A right knee MRI showed a high signal intensity in the area of the medial meniscus. Dr. Rummel injected the claimant's right knee. See Exhibit J. On October 29, 1999, Dr. Rummel completed a Report to Employer diagnosing right knee pain – medial meniscus tear and a treatment with a cortisone injection. The claimant's estimated return to work date was November 1, 1999. See Exhibit J. When the claimant returned to Dr. Rummel on November 19, 1999, he continued to have persistent right knee pain at the medial joint line. Dr. Rummel suspected a torn medial meniscus. See Exhibit J.

On December 6, 1999, Dr. Rummel performed a removal of loose body, chondroplasty of the medial femoral compartment, and chondroplasty of the patellofemoral joint of the right knee. When the claimant returned to Dr. Rummel on December 13, 1999, he was favoring his right knee. Dr. Rummel recommended an aggressive therapy program. See Exhibit J. During Dr. Rummel's January 3, 2000, exam, the claimant related that his right leg popped. The claimant had a little crepitus, which was consistent with the arthritic change he had in his patellofemoral joint. The claimant's right knee was not totally stable. However, the claimant had healed nicely. He reported numbness in the lateral aspect of the leg, which had occurred since surgery. This numbness was over multiple dermatomes, from L1 down to L5. Dr. Rummel ordered an EMG of claimant's lower extremities. See Exhibit J.

On February 16, 2000, the claimant consulted Dr. Buckles, an osteopathic physician specializing in internal medicine, complaining of neck, right arm, and right knee pain. Dr. Buckles diagnosed radiculopathy in the right arm, a questionable herniated disc in the cervical spine, and knee pain. He ordered an MRI. See Exhibit 2(i). On February 19, 2000, the claimant underwent a cervical spine MRI which revealed broad-based bulges, most pronounced at the C5-6 level, with associated spurring and mild to moderate neural foraminal encroachment. Minimal borderline neural foraminal encroachment was suggested at C4-5 on the right and at the C6 level bilaterally. There was no evidence of fracture or subluxation. There was borderline spinal stenosis at C5-6. See Exhibit 2(i).

On February 27, 2000, the claimant went back to Doctors Hospital and was admitted to Dr. Buckles' service for a herniated disc and right arm radiculopathy. Dr. Buckles asked Dr. Orell, an orthopedic surgeon, to perform an orthopedic consultation of claimant's neck and right arm pain. See Exhibit 2(c).

Dr. Orell examined the claimant on February 28, 2000, and the claimant reported neck and occasional right arm pain, since a fall that occurred in October or November 1999. See Exhibit 3. The claimant complained of pain to the neck area with decreased range of motion and muscle spasm. He had pain along the C6 dermatome, down the right upper extremity. The claimant had good sensation and active range of motion with the right upper extremity. The claimant reported a history of right knee pain. He complained of pain with range of motion testing in the right knee. See Exhibit 3. Dr. Orell diagnosed cervical radiculopathy, right arm, along the C6 dermatome; history of bulging disc at the C5-6 level, with mild degenerative joint

disease and mild stenosis per 2-19-00 MRI scan. He recommended physical therapy for the claimant's neck and right arm pain, a nerve root injection, and a consultation with Dr. Vellinga, an osteopathic physician specializing in pain management. See Exhibit 3.

On March 1, 2000, Dr. Vellinga evaluated the claimant's neck and right arm pain. The claimant related that he injured himself on the job two months earlier in a lifting incident. He also reported a fall that caused the claimant's pain. He described the pain as a dull ache, with numbness radiating from the neck into the arm and fingers. See Exhibit 2(f). Dr. Vellinga performed a physical examination and found that the claimant had limitation of active range of motion of the cervical spine in all directions. He had subjective paresthesias of the right C6-7 dermatomal distribution in the upper extremity. A cervical spine compression test was positive with upper extremity radicular exacerbation of pain and paresthesias. Dr. Vellinga diagnosed cervicgia secondary to extensive degenerative arthritis and bulging discs, right upper extremity radiculitis secondary to the cervicgia, and myofascial pain. He performed a cervical epidural steroid injection. See Exhibit 2(f). The claimant returned to Dr. Vellinga on March 9, 2000, and reported little to no relief of cervical pain following injection therapy. See Exhibit 2(f).

On July 31, 2000, Dr. Orell examined the claimant for neck and right arm complaints. The claimant reported that on August 1, 1999, he fell off a roof, and slid down a front loader, injuring his neck. While the claimant received treatment from a pain management physician, he could not get comfortable in regard to the cervical radiculopathy in his right arm. The claimant reported numbness and tingling, as well as weakness in his right hand. He dropped items easily. The claimant had complaints of right knee pain, with occasional swelling and evidence of synovitis. The right knee gave way easily. Dr. Orell diagnosed a herniated disc at C5-6, and right arm radiculopathy. He prescribed Vioxx and a Medrol Dose Pack. See Exhibit 3.

On August 15, 2000, Dr. Polinsky, a neurosurgeon, examined the claimant for neck and right arm pain. The claimant related that in mid-August 1999, he fell off a roof, falling 15 feet onto the tire of a vehicle, and striking his anterior chest wall. The claimant had the wind knocked out of him, and an onset of neck pain. Shortly afterwards, the claimant began noticing pain radiating into the right shoulder, right upper arm, radial forearm, and the radial aspect of his hand. Medication provided no significant relief. The claimant reported joint pain, muscle weakness, and cramping in the arm and low back. See Exhibit P. The claimant moved about slowly, with an antalgic gait, some of which was due to arm symptoms, and some due to low back pain. Dr. Polinsky's review of a February 19, 2000, cervical spine MRI revealed a visible spur and disc herniation to the right of C5-6 that significantly narrowed the C6 foramen. At C4-5 and C6-7, there was spurring that slightly narrowed the C5 and C7 foramina, respectively. See Exhibit P. Dr. Polinsky found that the claimant had a probable C6 radiculopathy, secondary to a C5-6 disc herniation and mild neurological deficit. He ordered a myelogram. See Exhibit P.

Cervical spine x-rays taken on August 22, 2000, demonstrated degenerative disc disease from C4 through C7, with disc space narrowing predominating at C5-6. There was osteophyte formation predominantly about the C5-6 disc space. An August 22, 2000, cervical myelogram showed a large root sleeve abnormality of the C6 root sleeve on the right side, compatible with a disc herniation. An August 22, 2000, cervical spine CT scan showed a large disc herniation lateralizing to the right within the canal, which extended to the foramen on the right at C5-6, with nonfilling of the right C6 root sleeve. Mild spinal stenosis was present at C5-6. See Exhibit P.

On August 31, 2000, the claimant was admitted to Missouri Baptist Medical Center, and Dr. Polinsky performed a C5-6 anterior cervical discectomy, a C5-6 allgraft bone fusion, and C5-6 anterior cervical plating. Dr. Polinsky's pre- and post-operative diagnosis was right C5-6 disc herniation. The claimant was discharged from Missouri Baptist Medical Center on September 1, 2000, with a discharge diagnosis of right C5-6 disc herniation. See Exhibit P.

The claimant followed up with Dr. Polinsky on November 1, 2000, and reported neck discomfort but complete resolution of arm symptoms. The claimant had not been wearing his collar continuously, and had been repeatedly moving his neck. On exam, the claimant had full strength and sensation in his extremities. The claimant's gait was normal. Review of cervical spine x-rays showed that there might be some collapse of the disc space and early non-union. The claimant was to wear a hard collar for the next six weeks. The claimant was to remain off any activities that involved lifting, bending, and twisting. See Exhibit P. The claimant returned to Dr. Polinsky on January 12, 2001, and reported that he had been wearing his hard cervical collar intermittently. The claimant denied any difficulties with neck or arm pain. On exam, the claimant had full strength and sensation throughout his upper extremities. Dr. Polinsky's review of cervical spine films showed a stable appearance, compared to prior films. There appeared to be a healing of the bone graft across the C5-6 disc space. While the claimant presented Dr. Polinsky with a Social Security disability application, the doctor responded that his anterior cervical discectomy had not totally disabled him. See Exhibit P.

As of February 28, 2001, the claimant was doing very well in regard to his cervical spine. He had minimal neck pain. On exam, the claimant had normal strength in the upper and lower extremities. Review of cervical spine x-rays revealed stable position of the plate and screws. There appeared to be some bone healing across the disc space. See Exhibit P. The claimant had done very well in regard to his cervical disc disease. The claimant was at maximum medical improvement from the standpoint of his cervical spine. See Exhibit P.

On November 19, 2003, Dr. Orell examined the claimant and took a medical history of bilateral knee pain for the past two years, left worse than his right. The claimant had problems walking, and used a cane. He had catching and giving way of the right knee, with swelling and joint line pain. The claimant had a history of degenerative joint disease and a bulging disc, as shown on earlier lumbar spine x-rays and a CT scan. A right knee x-ray showed moderate degenerative joint disease with varus deformity. Dr. Orell injected the claimant's right knee with cortisone. See Exhibit 3.

On January 7, 2004, the claimant reported right knee pain with locking, popping, and edema to Dr. Orell. He had severe sharp pain in both knees. On exam, the claimant had some synovitis. Dr. Orell gave the claimant a Medrol Dose Pack for his sciatic symptoms. See Exhibit 3. When the claimant returned to Dr. Orell on May, 13, 2004, he reported bilateral knee pain, edema, popping, catching, and giving way, decreased bilateral knee range of motion and difficulty walking. See Exhibit 3.

The claimant returned to Dr. Orell on March 28, 2006, reporting bilateral knee pain, worse on the right, with popping, catching, giving way and edema. The claimant used a cane to walk and felt unsteady on his feet. X-rays of the left and right knees showed moderate

degenerative joint disease of the right knee with varus deformity, and mild degenerative joint disease of the left knee. The claimant's right knee had patellofemoral arthralgia with crepitus, joint line pain, positive McMurray testing, and synovitis. The claimant had internal derangement of the right knee. The claimant complained of myositis of the right leg. Dr. Orell recommended right knee diagnostic arthroscopy. See Exhibit 3.

On April 6, 2006, Dr. Orell performed a right knee diagnostic arthroscopy, including a partial medial and lateral meniscectomies, chondroplasty of the patellofemoral articulation, medial and lateral femoral condyle, and medial and lateral tibial plateaus, and a partial synovectomy. Dr. Orell's preoperative diagnosis was internal derangement, right knee. His post-operative diagnoses were: torn posterior horn medial meniscus, right knee; torn lateral meniscus, right knee; grade II-III chondromalacia affecting the patellofemoral articulation, medial and lateral femoral condyles, and medial and lateral tibial plateaus, right knee; and reactive synovitis, right knee. See Exhibit 3.

When the claimant returned to Dr. Orell on April 10, 2006, he had no pain or popping of the right knee. The claimant had no effusion and good neurovascular status. The claimant was to wean himself off crutches. On April 20, 2006, the claimant's right knee sutures were removed. The claimant had no sign of infection in the right knee. The claimant did not follow up with Dr. Orell following April 20, 2006, for treatment of his right knee. See Exhibit 3. On July 12, 2006, Dr. Orell wrote to the claimant after he failed to appear for a follow-up exam on May 31, 2006, and informed the claimant that when a patient was non-compliant with the treatment plan, he could not assess proper healing following surgery. Dr. Orell informed him that he would not be responsible for the final orthopedic outcome if the claimant chose not to return for a recheck examination. See Exhibit 3.

On August 26, 2008, Dr. Jones performed a pre-operative exam of the claimant at Truman VA Medical Center. The claimant reported bilateral leg numbness and weakness during the last week. X-rays showed no acute findings. See Exhibit 4(a). On the same date, Dr. Parkins performed a total right knee arthroplasty at Truman VA Medical Center with a pre- and post-operative diagnosis of right knee osteoarthritis. See Exhibit 4(a). On September 18, 2008, the claimant visited the emergency department at Truman VA Center for persistent right knee pain. The claimant could not do physical therapy, because his pain was not controlled. The claimant had no swelling, redness, or drainage in his right knee. Since the claimant was on chronic pain medication, he had been warned preoperatively that his pain might be difficult to control post-operatively. X-rays revealed that the hardware was stable. See Exhibit 4(a).

On October 3, 2008, Dr. Sahaya examined the claimant for a neurological consultation at the Truman VA Center. Following right knee replacement, the claimant reported numbness, pain, and weakness in his bilateral lower extremities, more on the right. The claimant related a single episode of weakness and numbness of the whole lower extremity one night on waking, which lasted for thirty minutes and gradually resolved. See Exhibit 4(a). Dr. Sahaya diagnosed radiculopathic symptoms in the bilateral lower extremities, and chronic symptoms in the upper extremities. See Exhibit 4(a). An October 20, 2008, a right knee x-ray showed status post right knee total arthroplasty. No evidence of hardware failure. See Exhibit 4(a). On November 25, 2008, Dr. Toombs examined the claimant for low back pain. The claimant reported chronic low back pain, osteoarthritis involving the knees, and degenerative joint disease of the right knee. Dr.

Toombs' diagnosed low back pain – degenerative disc disease with radicular features; and right knee pain – status post total knee replacement. See Exhibit 4(a). A November 25, 2000, EMG nerve conduction study was normal. See Exhibit 4(a).

On May 1, 2009, Dr. Dholakia examined the claimant for bilateral lower extremity radiculopathy pain. The claimant complained of pain around the right knee joint, and pain and burning in his calves and feet, along with numbness in the back of both legs. Dr. Dholakia diagnosed radiculopathic pain in both legs. See Exhibit 4(a).

Current Medical Condition

The only conditions that the claimant attributes to the August 2, 1999, accident are those in his right knee and cervical spine according to the claim for compensation. The claimant has undergone a total knee replacement of both the right and left knees at the VA Hospital and now walks with the use of a cane. Use of a cane is necessary, in part because of the claimant's knees, and in part because of his lumbar spine condition. The last medical treatment the claimant received for his cervical spine was that provided by Dr. Polinsky.

The claimant is able to drive and has no restrictions on his license. While the claimant can drive 50-75 miles at a time, driving causes lower back pain. See claimant deposition, pages 54-56. On a typical day, claimant gets up early, goes to bed early, and does not do much during the day. Prior to the 8-1-99 injury, claimant had no difficulty doing dishes, mopping, mowing grass, or taking out the trash. At present, the claimant performs few chores. Sometimes he takes out the trash. He does some grocery shopping. While he can take care of himself, his wife helps him put on his pants and shoes, because he has difficulty bending his knees and back. See claimant deposition, pages 54-55. The claimant has swelling and pain in his right knee. The right knee gives out on him. The claimant takes Naproxen and Percocet for knee pain, but testified that nothing alleviates the pain in the claimant's right knee. See claimant deposition, pages 33-35.

The claimant has ongoing constant neck pain, and neck stiffness makes it difficult for the claimant to turn his head. Medication does not alleviate the claimant's neck complaints. See claimant deposition, pages 35-36.

The claimant limits his lifting to five pounds and can lift a gallon of milk and a 12-pack of soda. Before the August 1999 accident, the claimant could lift over 100 pounds, but as of January 2000, he was only able to lift 50-60 pounds. See claimant deposition, pages 36-37. In addition, the claimant has difficulty climbing up and down stairs but had no difficulty with stairs before August 1999. The claimant had no difficulty walking before August 1999 but can now walk only 30-40 feet without difficulty. After walking a greater distance, the claimant's knees buckle on him. (Dep.37-38). Sitting is also difficult for the claimant. After sitting approximately 30-45 minutes, the claimant's lower back and right buttock become numb. The claimant had no difficulty with sitting before August 1999. See claimant deposition, pages 37-38.

In 2005, the claimant underwent a year of in-patient alcohol and substance abuse treatment at Ozark Correctional Center as a result of pleading guilty to a charge of possession of

a controlled substance (methamphetamines) with intent to deliver, distribute, and/or manufacture. See claimant deposition, pages 68-69.

After being terminated by this employer, the claimant did not attempt to return to work in any capacity. He has not sought employment, looked for a job, worked out of his home, or performed volunteer work on a regular basis. No physician informed claimant that he could not or should not seek employment. See claimant deposition, pages 25-26, 56-57. The claimant was involved in a motor vehicle accident on November 19, 2007, and suffered multiple rib fractures and a fractured left collarbone. The claimant testified that he did not injure his neck, low back, or either knee during the 2007 accident. See claimant deposition, pages 62-65.

Forensic Expert Opinion Evidence

Dr. Berkin

Dr. Berkin, an osteopathic physician specializing in family practice, examined the claimant on February 8, 2002. See Dr. Berkin deposition, pages 5-6, 14; Dep. Exhibit 1. The claimant reported pain and swelling in his right knee, and instability of the knee. The claimant experienced pain when kneeling and squatting. His knee pain was aggravated by lifting. The claimant also reported neck pain. See Dr. Berkin deposition, page 9; Dep. Exhibit 1. The claimant reported that he had prior injuries to his low back and left shoulder. Dr. Berkin's physical examination revealed that the claimant had limitations in cervical range of motion. Both upper extremities had normal muscle tone without swelling or atrophy. The claimant walked with a limp. Examination of the right knee revealed no swelling, joint effusion, or right knee joint instability. Range of motion of the right knee was reduced. See Dr. Berkin deposition, page 10, Dep. Exhibit 1. Dr. Berkin opined that the claimant suffered a right knee strain with the presence of a loose body of the right knee. The claimant was status post arthroscopy of the right knee to remove the loose body and a chondroplasty of the medial femoral compartment and the patellofemoral joint. See Dr. Berkin deposition, page 11; Dep. Exhibit 1.

Dr. Berkin opined that the claimant injured his right knee in August 1999, when he fell from a roof. See Dr. Berkin deposition, pages 11-12; Dep. Exhibit 1. Dr. Berkin opined that the August 1999, accident was a substantial factor causing the strain to the claimant's right knee, necessitating surgery for removal of a loose body and a chondroplasty. Dr. Berkin made no findings in regard to the claimant's neck and was not sure that the claimant's neck condition was directly related to the August 1999 accident. See Dr. Berkin deposition, page 12. Dr. Berkin did not have enough information from the medical records to find that Dr. Polinsky's cervical surgery was related to the claimant's 1999 fall. See Dr. Berkin deposition, page 20.

Dr. Berkin opined that the claimant sustained a 35% permanent partial disability to his right knee. See Dr. Berkin deposition, page 13; Dep. Exhibit 1. Dr. Berkin recommended the use of non-steroidal anti-inflammatory medication, participation in a home exercise program and avoid repetitive kneeling, stooping, squatting, and climbing. He opined that the claimant should avoid rapid movements and pivoting of his right leg, and should be cautious when climbing ladders and walking on uneven surfaces. See Dr. Berkin deposition, Dep. Exhibit 1.

Dr. Berkin also opined that the claimant suffered a pre-existing 25% permanent partial disability of the lumbar spine and a pre-existing 35% permanent partial disability the left shoulder. He opined that the disabilities involving the claimant's preexisting low back and left shoulder disabilities combined with his right knee disability from the August 1999 accident and created an overall disability that exceeded the sum of claimant's individual disabilities. See Dr. Berkin deposition, page 13; Dep. Exhibit 1. Dr. Berkin opined that the claimant had reached a steady state in regard to his right knee condition, did not require additional surgical treatment for his right knee, but might need a right knee replacement at some time in the future. See Dr. Berkin deposition, pages 23-24.

Dr. Polinsky

Dr. Polinsky, a board-certified neurosurgeon, examined the claimant on August 15, 2000, and found normal reflexes and no weakness on examination. His gait was antalgic. The claimant reported numbness and tingling going into his right arm. See Dr. Polinsky deposition, pages 7-9. The claimant opined that some of this was due to his arm condition and some was due to the low back pain. See Dr. Polinsky deposition, page 9. Dr. Polinsky reviewed a cervical spine MRI revealing a spur and possible disc herniation to the right side at C5-6 that narrowed the channel for the C6 nerve. He also found bulging of the C5-6 disc to the left and spurring at C4-5 and C6-7. See Dr. Polinsky deposition, pages 9-10. Dr. Polinsky opined that the claimant suffered from a right C6 radiculopathy resulting from a C5-6 disc herniation. See Dr. Polinsky deposition, pages 10-11. A cervical myelogram also revealed spurring and a disc herniation on the right at C5-6. On August 31, 2000, Dr. Polinsky performed a C5-6 anterior cervical discectomy with an allograft bone fusion and anterior cervical plating. See Exhibit P. Dr. Polinsky followed claimant post-operatively and opined that the treatment and surgery he performed was fair and reasonable under the circumstances. See Dr. Polinsky deposition, pages 13-14.

As of November 1, 2000, the claimant had neck discomfort, but complete resolution of his right arm symptoms. See Exhibit P. The claimant had not been wearing his collar continuously and had been repeatedly moving his neck. See Dr. Polinsky deposition, page 15, Exhibit P. The claimant had normal cervical strength and sensation. See Exhibit P. Cervical spine x-rays revealed possible collapse at the C5-6 disc space and a possible early non-union of the bone graft. Dr. Polinsky recommended that the claimant remain off activities that involved lifting, bending or twisting. See Dr. Polinsky deposition, pages 15-16.

When the claimant returned to Dr. Polinsky on January 12, 2001, he had been wearing his hard collar intermittently. The claimant denied any difficulties with neck or arm pain. On exam, the claimant had normal cervical strength and sensation. A cervical spine x-ray showed a stable appearance of the bone graft. There appeared to be some healing of the bone graft across the disc space at that time. See Dr. Polinsky deposition, pages 16-17. The claimant described right knee pain. While the claimant had undergone right knee surgery in December 1999, Dr. Polinsky did not have any record of right knee pain prior to that date. See Dr. Polinsky deposition, pages 17-18.

On February 28, 2001, the claimant had minimal neck pain, normal strength in his upper and lower extremities, and reflexes and sensation were normal. See Dr. Polinsky deposition,

pages 18-19. Cervical spine x-rays revealed stable position of the plate and screws. There appeared to be with bone healing across the disc space. Dr. Polinsky reviewed a March 1998 lumbar spine myelogram and CT scan revealing degenerative changes, but no spinal canal stenosis, disc herniation, or pinched nerve problems. See Dr. Polinsky deposition, page 19. As of February 28, 2001, Dr. Polinsky found that the claimant had reached maximum medical improvement with regard to his cervical spine. See Dr. Polinsky deposition, pages 19-20.

Dr. Polinsky opined that the claimant's cervical disc herniation resulted from the August 1999 accident assuming that the claimant's pain began immediately after the accident and that the claimant has no prior neck conditions. See Dr. Polinsky deposition, pages 11-13, 24. Dr. Polinsky had not reviewed Dr. Merenda's records and had not reviewed all of the medical records regarding the claimant's neck condition. See Dr. Polinsky deposition, pages 33-42, 56. Dr. Polinsky's medical bills exhibited write-downs of charges generated by Medicare and insurance companies, and Dr. Polinsky was contractually obligated to accept the amount paid by the insurer. See Dr. Polinsky deposition, pages 21-22.

Dr. Wayne

Dr. Wayne, a board-certified orthopedic surgeon, examined the claimant twice. The first examination was on April 14, 2000, and the claimant reported right knee and cervical spine pain. Dr. Wayne found that the claimant had superficial tenderness to the neck, which appeared exaggerated and inappropriate. The claimant refused to move his neck in any direction, stating that it was too painful. There was no atrophy or reflex abnormality in the upper extremities. The claimant reported the entire right half of his neck, shoulder, and right arm to be numb to sensory pinwheel testing. Dr. Wayne opined that this was a non-organic response that did not fit an accepted anatomical dermatome distribution. See Exhibit 2. On exam of the right knee, the claimant had tenderness of the right medial femoral condyle and a slight reduction in range of motion with no evidence of joint effusion. All ligaments were intact. See Exhibit 2. Right knee x-rays revealed no evidence of joint space narrowing, malalignment, or a previous fracture. Based on the history of symptom onset, Dr. Wayne did not relate any of the claimant's cervical complaints to his alleged work injury. He opined that the claimant's cervical complaints were subjective, without objective evidence of pathology, and with non-organic inconsistencies. See Exhibit 2. The claimant was 5 months status post right knee arthroscopy performed for complaints and possibly some sort of pathology, which might or might not relate to the August 1, 1999 work injury. Dr. Wayne could not say whether the claimant could work at that time or whether he was at MMI. See Exhibit 2.

Dr. Wayne issued a second report on May 24, 2000, after reviewing the claimant's medical records. Upon review of those records, Dr. Wayne considered claimant's cervical complaints to be incidental. He recommended that the claimant follow up in regard to those complaints with his personal physician. Dr. Wayne opined that if the claimant had sustained a significant knee injury, he would have sought immediate attention, and there would be additional, contemporaneous medical records regarding such treatment. While the August 3, 1999, ER report revealed a history of chronic back pain, along with pain in the knees radiating to the feet, there was no indication of primary knee pathology or any diagnostic studies, including x-rays, performed on claimant's knees. See Exhibit 2.

Dr. Wayne examined the claimant again on May 18, 2004, after the claimant's anterior cervical fusion. The claimant continued to experience limited cervical motion with weakness of grip in the right arm. The claimant had resolution of his right arm pain. In November 2003, the claimant underwent left knee arthroscopy. However, the claimant had no improvement following that procedure and recently had aspiration of joint fluid. The claimant had minimal right knee discomfort, but did not report swelling, locking, giving way, or weakness of the knee. See Exhibit 2. Dr. Wayne found no palpable tenderness in the cervical back area. The claimant had 75% of cervical motion. He complained of discomfort with shoulder movement, which he described as residual from shoulder surgery several years prior. There was no evidence of atrophy about the shoulder girdle area, upper arm, forearm, or intrinsic muscle areas of the hands. Reflexes were symmetrical throughout the upper extremities. There was no sign of a sensory deficit. See Exhibit 2. Cervical spine x-rays revealed a C5-6 anterior cervical fusion, which was healed. Degenerative changes were noted at C6-7, with mild disc space narrowing and very mild bilateral foraminal narrowing. See Exhibit 2.

With regard to the claimant's lower back, Dr. Wayne opined that the history and medical records indicated chronic, pre-existing degenerative disc and joint disease, compatible with symptoms of lower back pain radiating into both lower extremities. Dr. Wayne found that the claimant's cervical complaints related to the presence of multi-level advanced degenerative disc and joint disease, as identified on a February 2000 MRI scan and surgically fused in December 2000, at the C5-6 level. Current radiologic studies showed an excellent fusion at that level. He opined that the claimant had a good physical outcome from surgery. He opined that his "residual cervical symptoms would relate to the presence of diffuse disease elsewhere in his cervical spine, above and below the fusion level." See Exhibit 2. Dr. Wayne found that the claimant did not require any additional diagnostic or therapeutic measures. See Exhibit 2. With regard to causation, Dr. Wayne concluded that there was no indication that the claimant injured his cervical spine, or demonstrated any cervical pathology, directly attributable to the August 1999 work incident. Dr. Wayne opined that the February 19, 2000, MRI revealed no acute fracture or disc herniation in the cervical spine. See Exhibit 2.

After reviewing the claimant's medical records, Dr. Wayne concluded that the medical history showed no pathology, directly resulting from the August 1, 1999, accident. Specifically, there was no finding of hemarthrosis or internal derangement secondary to a meniscus or ligamentous disruption. Dr. Wayne found findings consistent with chronic degenerative joint disease and associated loose bodies. See Exhibit 2. An exam of both knees revealed satisfactory alignment. No effusion was present on the right. There was no patellofemoral crepitation or sign of increased heat about either knee. No tenderness was noted with palpation on the right. Ligaments were normal. See Exhibit 2.

In the presence of this form of disease, Dr. Wayne opined that the claimant could be expected to have right knee discomfort in the future. He related the condition to progressive degenerative joint disease of the knee. He opined that there was no evidence of a substantial aggravation of pre-existing disease in the claimant's cervical, lumbar or knee areas as a result of his August 1999 injury. Rather, the claimant's current findings related to progression of pre-existing degenerative disease. He opined that additional knee surgery was not indicated. However, conservative measures, including exercises and use of anti-inflammatory medication, were appropriate. See Exhibit 2.

Dr. Wayne opined that the claimant was probably unable to perform any kind of work, other than sedentary or light-duty work, because of the extent of his multi-system diseases, the most notable of which involved his lungs. See Exhibit 2. Dr. Wayne opined that there was no objective evidence of any permanent partial disability involving claimant's cervical spine or right knee, which was the direct result of the August 1, 1999, accident. See Exhibit 2.

Dr. Mishkin

Dr. Mishkin, another board-certified orthopedic surgeon, examined the claimant on May 10, 2010. See Dr. Mishkin deposition, pages 3-5. The claimant reported low back pain and bilateral knee pain. He had undergone a left total knee replacement 4-5 weeks before. The claimant had a previous total knee replacement of his right knee. The claimant had decreased motion in the neck and was unable to rotate to the left or right because of stiffness and pain. The claimant reported several episodes of paralysis. About six months before, the claimant suddenly found he could not move his right arm. This incident lasted for an hour and a half. The claimant had an episode where he could not move anything below his waist for 1½ hours. The claimant had a sling on his left upper extremity for a left clavicle fracture. See Dr. Mishkin deposition, Dep.Ex.2.

The claimant walked with a limp. On examination of the neck, the claimant had no pain, tenderness, or swelling. There was no evidence of pain or discomfort with palpation of the neck. See Dr. Mishkin deposition, Dep.Ex.2. Sensation was intact throughout both upper extremities. There was no muscle weakness. Motor strength testing throughout the lower extremities was normal. Sensation was intact in both lower extremities. See Dr. Mishkin deposition, Dep.Ex.2. Cervical spine x-rays revealed a fusion at C5-6, which was solid. There was a moderate osteophyte on the anterior/inferior portion of C5. Bilateral knee x-rays showed evidence of total joint replacement, in good position and alignment. See Dr. Mishkin deposition, Dep.Ex.2.

After examining the claimant and reviewing the medical records, Dr. Mishkin diagnosed status post fracture of left clavicle, requiring open reduction and internal fixation; status post fracture of left shoulder related to a fall in the past, with residual stiffness; status post anterior cervical discectomy at C5-6 with excellent result; pre-existing degenerative disc disease of the lumbar spine, primarily at L4-5; and history of surgical treatment for right knee arthroscopic surgery, left knee arthroscopic surgery, and total knee replacements for both the left and right knees. See Dr. Mishkin deposition, pages 10-11.

Dr. Mishkin could not determine within a reasonable degree of medical certainty whether the claimant's cervical condition was related to or caused by the August 1999 incident. Dr. Mishkin reasoned that the claimant voiced no complaints about his neck during the 6 months following the August 1999 accident. See Dr. Mishkin deposition, pages 10-11. Dr. Mishkin also reasoned that Dr. Merenda's July 9, 1999, report stated that the claimant had previous complaints of back and neck pain beginning in 1984 and that a February 19, 2000, cervical spine MRI report indicated broad-based bulges, with spurring in the cervical spine. Dr. Mishkin also observed that the radiologist found that the claimant had degenerative discs, which were bulging but did not find that the claimant had a herniated disc as of February 2000. See Dr. Mishkin deposition, pages 24-25. Instead, Dr. Mishkin opined that the claimant had degenerative disc disease in his

neck long before the August 1999 accident. See Dr. Mishkin deposition, pages 26, 27. While the claimant had subjective complaints of neck pain, there was no reference in the medical documentation regarding claimant's neck until 2000. See Dr. Mishkin deposition, pages 26, 27, 34, 35, 38.

In addition, Dr. Mishkin opined that the claimant had pre-existing degenerative arthritis in both knees. At the time of surgery on the claimant's right knee on December 6, 1999, the operating surgeon found osteoarthritis and a degenerative loose body. While the MRI originally showed the possibility of a torn meniscus, no torn meniscus was found during the December 6, 1999, surgery. See Dr. Mishkin deposition, page 11; Dep. Exhibit 2. Dr. Mishkin opined that as the osteoarthritic process in the claimant's right knee progressed, there was softening of the cartilage and little flakes of cartilage tore away. The loss of cartilage caused inflammatory changes of the lining of the knee. He testified that the flaking off and tearing of cartilage caused loose bodies in the knee and that loose bodies were flakes of cartilage and fragments of bone that had actually worked loose, or had become dislodged, and were floating around within the knee joint. See Dr. Mishkin deposition, pages 11-12. Dr. Mishkin opined that the osteoarthritis and degenerative loose body found in the claimant's right knee pre-existed the August 1999 accident and had been present for many years before the accident. See Dr. Mishkin deposition, pages 12-13; Dep. Exhibit 2. Dr. Mishkin found that Dr. Rummel's December 6, 1999, surgery, finding diagnoses of degenerative arthritis of the right knee, a loose body, and plica, was not related to or caused by the August 1999 accident. Plica was the thickening of the lining of the knee joint. It was a physiological response to stress on the knee, not the result of an injury or fall. See Dr. Mishkin deposition, page 13, 15, 16; Dep. Exhibit 2. Dr. Mishkin opined that the claimant's right knee condition and surgical procedures related to pre-existing degenerative changes that were unrelated to the 1999 accident. See Dr. Mishkin deposition, pages 16-17.

Dr. Mishkin opined that the claimant sustained a 10% permanent partial disability to his cervical spine and that the disability was not related to the August 1999 accident. See Dr. Mishkin deposition, page 30; Dep. Exhibit 2. Dr. Mishkin opined that the claimant had a 20% permanent partial disability of the right knee and a 20% permanent partial disability of the left knee, related to a history of multiple operative procedures and total knee replacements. Dr. Mishkin opined that the disability in the claimant's knees were unrelated to and not caused by the August 1999 accident. See Dr. Mishkin deposition, pages 30-31; Dep. Ex. 2. He opined that the claimant's right knee condition was not related to or a result of the August 1999 accident. See Dr. Mishkin deposition, Dep. Exhibit 2. Dr. Mishkin opined that the August 1999 accident did not render claimant permanently and totally disabled. He opined that the claimant had disability relating to pre-existing conditions in his left shoulder, back, neck, and knees. He opined that as of May 20, 2010, the claimant's disability totaled 30-40% of the body as a whole. See Dr. Mishkin deposition, page 31; Dep. Exhibit 2.

MEDICAL CAUSATION

“The claimant in a workers' compensation case has the burden to prove all essential elements of her claim, including a causal connection between the injury and the job.” Royal v. Advantica Rest. Group, Inc., 194 S.W.3d 371, 376 (Mo.App.W.D.2006) (citations and quotations omitted). “Determinations with regard to causation and work relatedness are questions of fact to be ruled upon by the Commission.” Id. (citing Bloss v. Plastic Enters., 32 S.W.3d 666, 671

(Mo.App.W.D.2000)). Under the statute, “[a]n injury is clearly work related if work was a substantial factor in the cause of the resulting medical condition or disability.” § 287.020.2. On the other hand, “[a]n injury is not compensable merely because work was a triggering or precipitating factor.” *Id.* “Awards for injuries ‘triggered’ or ‘precipitated’ by work are nonetheless proper *if* the claimant shows the work is a ‘substantial factor’ in the cause of the injury.” “Thus, in determining whether a given injury is compensable, a ‘work related accident can be both a triggering event and a substantial factor.’ Royal, 194 S.W.3d at 376 (quoting Bloss, 32 S.W.3d at 671).

“[T]he question of causation is one for medical testimony, without which a finding for claimant would be based upon mere conjecture and speculation and not on substantial evidence.” Elliot v. Kansas City, Mo., Sch. Dist., 71 S.W.3d 652, 658 (Mo.App. W.D. 2002). Accordingly, where expert medical testimony is presented, “logic and common sense,” or an ALJ’s personal views of what is “unnatural,” cannot provide a sufficient basis to decide the causation question, at least where the ALJ fails to account for the relevant medical testimony. Cf. Wright v. Sports Associated, Inc., 887 S.W.2d 596, 600 (Mo. banc 1994) (“The commission may not substitute an administrative law judge’s opinion on the question of medical causation of a herniated disc for the uncontradicted testimony of a qualified medical expert.”). Van Winkle v. Lewellens Professional Cleaning, Inc., 358 S.W.3d 889, 897, 898 (Mo.App. W.D. 2008).

For an injury to be compensable, the evidence must establish a causal connection between the accident and the injury. Silman v. William Montgomery & Associates, 891 S.W.2d 173, 175 (Mo.App. E.D. 1995). The testimony of a claimant or other lay witness can constitute substantial evidence of the nature, cause, and extent of disability when the facts fall within the realm of lay understanding. *Id.* Medical causation, not within the common knowledge or experience, must be established by scientific or medical evidence showing the cause and effect relationship between the complained of condition and the asserted cause. McGrath v. Satellite Sprinkler Systems, 877 S.W.2d 704, 708 (Mo.App. E.D. 1994). Where the condition presented is a sophisticated injury that requires surgical intervention or other highly scientific technique for diagnosis, and particularly where there is a serious question of preexisting disability and its extent, the proof of causation is not within the realm of lay understanding nor -- in the absence of expert opinion -- is the finding of causation within the competency of the administrative tribunal. Silman, supra at 175, 176. This requires claimant’s medical expert to establish the probability claimant’s injuries were caused by the work accident. McGrath, supra. The ultimate importance of the expert testimony is to be determined from the testimony as a whole and less than direct statements of reasonable medical certainty will be sufficient. *Id.*

Right Knee

The claimant alleged in his claim for compensation that he injured his right knee in the August 1999 accident at work. However, the claimant had knee pain in July 1999, and Dr. Rummel performed a removal of loose body, chondroplasty of the medial femoral compartment, and chondroplasty of the patellofemoral joint of the right knee on December 6, 1999.

The claimant’s right knee pain persisted and the claimant had numerous additional surgical procedures. On April 6, 2006, Dr. Orell performed a right knee diagnostic arthroscopy, including a partial medial and lateral meniscectomies, chondroplasty of the patellofemoral

articulation, medial and lateral femoral condyle, and medial and lateral tibial plateaus, and a partial synovectomy. Dr. Orell's preoperative diagnosis was internal derangement, right knee. His post-operative diagnoses were: torn posterior horn medial meniscus, right knee; torn lateral meniscus, right knee; grade II-III chondromalacia affecting the patellofemoral articulation, medial and lateral femoral condyles, and medial and lateral tibial plateaus, right knee; and reactive synovitis, right knee. See Exhibit 3.

On August 26, 2008, Dr. Jones performed a pre-operative exam of the claimant at Truman VA Medical Center. The claimant reported bilateral leg numbness and weakness during the last week. X-rays showed no acute findings. See Exhibit 4(a). On the same date, the claimant underwent a total right knee arthroplasty at Truman VA Medical Center, performed by Dr. Parkins. Dr. Parkins' pre- and post-operative diagnoses were right knee osteoarthritis. See Exhibit 4(a). On September 18, 2008, the claimant visited the emergency department at Truman VA Center for persistent right knee pain. The claimant could not do physical therapy, because his pain was not controlled. The claimant had no swelling, redness, or drainage in his right knee. Since the claimant was on chronic pain medication, he had been warned preoperatively that his pain might be difficult to control post-operatively. On x-rays, the hardware was stable. See Exhibit 4(a). On October 3, 2008, Dr. Sahaya examined the claimant for a neurological consultation at the Truman VA Center. Following right knee replacement, the claimant reported numbness, pain, and weakness in his bilateral lower extremities, more on the right. The claimant had weakness of the right knee. The claimant related a single episode of weakness and numbness of the whole lower extremity one night on waking, which lasted for thirty minutes and gradually resolved. See Exhibit 4(a). Dr. Sahaya diagnosed radiculopathic symptoms in the bilateral lower extremities, and chronic symptoms in the upper extremities. See Exhibit 4(a). An October 20, 2008, right knee x-ray showed status post right knee total arthroplasty. No evidence of hardware failure. See Exhibit 4(a).

The claimant offered expert medical opinion evidence at the hearing. The first expert, Dr. Polinsky provided medical care for the claimant's neck condition beginning in August 2000 but did not treat the claimant's knee or provide any expert medical opinion linking the claimant's right knee condition to the August 1999 accident.

The claimant's second medical expert, Dr. Berkin examined the claimant on February 8, 2002, and the claimant reported pain and swelling in his right knee and right knee instability when kneeling and squatting. See Dr. Berkin deposition, page 9. Dr. Berkin opined that the claimant suffered a right knee strain with the presence of a loose body in the right knee and diagnosed status post right knee arthroscopy to remove the loose body and chondroplasty of the medial femoral compartment and the patellofemoral joint. See Dr. Berkin deposition, page 11. Dr. Berkin opined that the claimant injured his right knee in August 1999, when he fell from a roof. See Dr. Berkin deposition, pages 11-12. Dr. Berkin opined that the August 1999 accident was a substantial factor causing a right knee strain, necessitating surgery for removal of a loose body and a chondroplasty. See Dr. Berkin deposition, page 12.

Dr. Berkin's causation opinion was based upon the history the claimant provided and premised on an assumption that was not supported by the medical records. The claimant reported no prior pain and/or treatment for his right knee. See Dr. Berkin deposition, page 18. Dr. Berkin reviewed no medical records showing that the claimant had been treated for his right

knee. At the time of his evaluation, Dr. Berkin was unaware of whether the claimant had any prior medical care for his right knee. See Dr. Berkin deposition, pages 18-19. On July 9, 1999, the claimant filled out a Patient Medical History Form stating that he had 60-70% pain in both legs. See Exhibit 2(l). Dr. Berkin did not have an opportunity to review Dr. Merenda's records regarding his July 12, 1999, examination revealing that the claimant suffered from bilateral leg pain. See Exhibit 2(l). Dr. Berkin assumed that the loose body in the claimant's right knee and the need for Dr. Rummel's chondroplasty resulted from the August 1999 accident, based on his belief that the claimant did not have any significant right knee pain necessitating active treatment before August 1999.

Accordingly, Dr. Berkin did not have a substantial basis in fact for his causation opinion in regard to the claimant's right knee condition and the necessity of right knee surgery and his medical opinion cannot support a finding that the August 1999 accident was a substantial factor in causing the claimant's right knee condition and need for surgery. In addition, Dr. Berkin's finding that the claimant sustained a 35% permanent partial disability of the right lower extremity at the level of the knee was based on the assumption that the claimant had no pre-existing permanent partial disability to that knee from any other cause. See Dr. Berkin deposition, page 18. However, Dr. Berkin premised his conclusion on an assumption the claimant had no preexisting condition in his right knee, because Dr. Berkin reviewed no medical records showing that the claimant was being treated for his right knee before the accident and the claimant did not report any prior pain and/or treatment for his right knee to Dr. Berkin. See Dr. Berkin deposition, pages 18-19.

The claimant's right knee pain manifested before the accident and continued to deteriorate throughout the following decade suggesting a progressive degenerative deterioration in both knees. Dr. Wayne and Dr. Mishkin examined the claimant on various dates and reviewed the claimant's medical records and diagnostic tests and opined that the claimant suffered from chronic degenerative joint disease, associated loose bodies, and osteoarthritis. Their findings are more consistent with the overall medical findings of the treating physicians over the long range of medical treatment. In addition, they had an opportunity to review the vast majority of the claimant's medical records, and their medical findings bear more credibility than those of the other experts who did not have that opportunity.

Neck

The claimant alleged in his claim for compensation that he injured his neck as a result of the August 1999 accident, and he testified that he suffered neck pain immediately following the accident. He presented that medical history to Dr. Polinsky with no other medical history, such as medical records, and Dr. Polinsky opined that the claimant's August 1999 accident at work was a substantial factor causing his herniated disc in his neck. The defense presented medical opinion evidence from Dr. Wayne and Dr. Mishkin who opined that the claimant's cervical condition was pre-existing and degenerative in nature, and did not result from the August 1999 accident at work.

The claimant's testimony in this case does not constitute competent or substantial evidence on the cause of his cervical condition, because it is inconsistent with and contradicted

by a vast volume of medical records from his treating medical providers that contradict the claimant's testimony regarding the onset of neck pain and preexisting neck pain.

On August 2, 1999, after falling, the claimant returned to work and continued to work for the remainder of his shift. The claimant testified that he experienced no pain at the time of his fall. Specifically, the claimant did not recall having any pain in any part of his body and did not seek medical treatment on the day of the accident. See claimant deposition 26-28. On August 3, 1999, the claimant went to the Doctors Hospital emergency room. He testified that he complained of neck pain. The August 3, 1999, Doctors Hospital records reflect that the claimant reported that he "fell off roof at work- 1 month ago" and had a chronic back problem and bilateral knee pain. The medical records do not reflect that the claimant voiced any complaints regarding his cervical spine or sought treatment for, or undergo any diagnostic studies, regarding his cervical spine. See Exhibit L.

On October 4, 1999, the claimant consulted Dr. Imboden complaining of right knee pain but did not voice any cervical spine complaints, or seek treatment regarding his cervical spine. See Exhibit I. On October 22, 1999, the claimant returned to the Doctors Hospital emergency room and cited a chief complaint of right knee pain. The claimant related that he had right knee complaints for 3½ months but did not voice any complaints in regard to his cervical spine or seek any treatment related to his cervical spine. See Exhibit K. When the claimant returned to Dr. Imboden on October 25, 1999, he voiced no complaints in regard to his cervical spine but complained solely about right knee pain. Dr. Imboden referred the claimant to Dr. Rummel. See Exhibit I.

The claimant testified that he complained about neck pain to Dr. Rummel, but Dr. Rummel's records do not corroborate the claimant's testimony. On October 29, 1999, the claimant reported that he fell from a roof while at work four months earlier and complained of right knee pain and swelling. According to the medical records, the claimant voiced no complaints regarding his cervical spine. See Exhibit J. Dr. Rummel performed surgery on the claimant's right knee on December 6, 1999. See Exhibit J. Dr. Rummel's medical records disclose no complaints regarding his cervical spine following surgery. See Exhibit J.

The first mention of cervical complaints in the medical records occurred on February 16, 2000, when the claimant consulted Dr. Buckles and complained of right knee pain, neck pain, and right arm pain. Dr. Buckles diagnosed radiculopathy of the right arm and a questionable herniated disc in the cervical spine. He ordered an MRI. See Exhibit 2(i). A February 19, 2000, cervical spine MRI revealed broad-based disc bulges, most pronounced at the C5-6 level, with associated spurring and mild to moderate neural foraminal encroachment. Minimal borderline neural foraminal encroachment was suggested at C4-5 on the right and bilaterally at C6. There was no evidence of fracture or subluxation. See Exhibit 2(i).

The claimant was admitted to Doctors Hospital on February 27, 2000, under Dr. Buckles' service for neck pain and right arm radiculopathy. See Exhibit 2(c). At the hospital, the claimant reported his medical history and condition to various medical providers. When Dr. Orell examined him on February 28, 2000, the claimant related that he had neck pain and occasional right arm pain, since a fall that occurred in October or November 1999. See Exhibit 3. When Dr. Vellinga evaluated the claimant on March 1, 2000, his chief complaints were neck and right

arm pain. The claimant related that he injured himself on the job approximately two months ago. However, the claimant was vague in describing his injuries to Dr. Vellinga. The claimant related the injury to a lifting incident rather than a fall off a roof as alleged in the claim for compensation. See Exhibit 2(f).

While the claimant alleged that he injured his cervical spine during his August 1999 fall off a roof, the medical records contemporaneous with, and shortly after that incident, contain no history of cervical complaints from the claimant, or any documentation that the claimant sought treatment for his cervical spine or underwent any diagnostic studies in regard to his cervical spine for six months after the August 1999 accident. The medical records show that the first mention of any cervical spine pain after the August 1999 accident was on February 16, 2000, when the claimant consulted Dr. Buckles, more than six months after the accident. See Exhibit 2(i). The medical records contradict the claimant's testimony that he complained about neck pain to his care providers shortly after the accident occurred.

If the claimant had injured his cervical spine as a result of the August 1999 accident, it would be reasonable to expect the claimant to make cervical complaints to his care providers, and to seek treatment for those complaints. The absence of a contemporaneous history of cervical spine complaints in the medical records of the treating medical providers within six months after the August 1999 accident refutes the claimant's testimony that he suffered cervical spine complaints from the August 1999 accident. Given the conflict between the claimant's testimony that he suffered cervical spine complaints shortly after the August 1999 accident, and continuing thereafter, and the unsworn accounts regarding the nature of the claimant's complaints contained in the medical records, the claimant's testimony is lacking in credibility.

In addition, the claimant testified that he had no neck problems before the August 1999 accident. However, the claimant consulted Dr. Merenda on July 9, 1999, and reported that he had 40-50% pain in his neck. See Exhibit 2(l). Thus, the claimant's testimony that he had no prior cervical complaints was contradicted by the medical records from another treating physician. This also tends to reduce the credibility of the claimant's testimony.

The claimant also submitted expert medical opinion evidence from two medical experts. The first medical expert, Dr. Berkin, examined the claimant on February 8, 2002, and made no findings regarding the claimant's cervical spine. He testified that he was unsure whether the claimant's neck condition was directly related to the August 1999 accident. See Dr. Berkin Deposition, page 12. At the time, the claimant had already undergone cervical surgery, but Dr. Berkin did not have enough information from the medical records to find that the surgery was related to the August 1999 fall. See Dr. Berkin Deposition, page 20. Dr. Berkin's testimony does not support a finding that the August 1999 accident was a substantial factor causing the claimant's cervical spine condition or the need for an anterior cervical fusion.

Dr. Polinsky's testimony does not support a finding that the August 1999 accident was a substantial factor in bringing about the claimant's cervical condition or the need for an anterior cervical fusion, because his opinion was premised upon an assumption that the claimant developed neck pain immediately after the accident, an assumption not supported by the medical records in evidence. Dr. Polinsky testified that so long as the claimant's cervical neck pain began immediately after the August 1999 accident and the claimant had no pre-existing neck pain, he

would find that the August 1999 accident caused claimant's cervical disc herniation and condition. See Dr. Polinsky deposition, pages 13, 14, 24.

However, Dr. Polinsky did not treat the claimant until August 2000 and did not review any medical records, other than the diagnostic studies the claimant provided. Dr. Polinsky relied on the history the claimant provided. See Dr. Polinsky deposition, page 22. The history the claimant provided was that almost immediately after falling, he had an onset of neck pain, and thereafter noted radiating pain into his right shoulder, upper arm, and forearm. See Dr. Polinsky deposition, pages 23-25. Dr. Polinsky had not reviewed Dr. Merenda's records. Thus, he was unaware of the Patient Medical History Form the claimant filled out for Dr. Merenda on July 9, 1999, stating that the claimant had pain in 40-50% of his neck. See Dr. Polinsky deposition, pages 26, 28-30. Dr. Merenda's records do not support Dr. Polinsky's assumption that the claimant had no neck pain prior to the August 1999 accident. The medical records contemporaneous with the claimant's fall do not support Dr. Polinsky's assumption that the claimant's cervical pain began immediately after that incident. The medical records from the huge volume of medical providers that provided medical care for the claimant for the first six months after the August 1999 accident are devoid of any complaints of neck or shoulder pain. Therefore, Dr. Polinsky's findings lack substantial credibility on the issue of causation.

The defense offered expert medical opinions from Dr. Wayne and Dr. Mishkin, who examined the claimant at various times, reviewed the claimant's medical records and diagnostic studies, and concluded that the claimant did not sustain an acute injury to his cervical spine as a result of the August 1999 accident. They opined that the condition was degenerative in nature.

Based on the weight of the credible evidence, the claimant's August 1999 accident at work was not a substantial factor causing the claimant's cervical spine injury or his surgical requirement.

CONCLUSION

The weight of the credible evidence compels a finding that the claimant's extensive disability is a progressive degenerative condition, and that the 1999 accident at work was not a substantial factor causing that condition. These conditions are not simple conditions that are easily determined by ignoring credible expert medical opinion evidence. While the claimant submitted forensic medical opinion evidence from Dr. Berkin and Dr. Polinsky, the experts lacked knowledge about the claimant's preexisting conditions revealed in medical records one month before the accident. In addition, the claimant's poor recollection about when those conditions manifest as health conditions reduced his credibility in determining whether those conditions manifested immediately after the accident or resulted from a preexisting condition or subsequent occurrence. The claimant's testimony, deposition testimony, and medical records submitted as evidence were inconsistent and contradictory without explanation. As a result, the claimant failed to submit a prima facie case to support a conclusion that the 1999 accident at work was a substantial factor causing the claimant's neck and knee conditions. The defense submitted its own expert medical opinion evidence from qualified medical experts that had a better knowledge of the claimant's entire medical history and provided credible forensic medical opinions that the claimant's medical condition resulted from the claimant's progressive degenerative disease that is consistent with the medical records that document the medical

history. They credibly opined that the 1999 accident at work was not a substantial factor causing the claimant's knee and neck conditions.

For these reasons the claimant's claim for compensation is denied, and the employer, its insurer, and the Second Injury Fund bear no liability for the claimant's progressive degenerative medical condition, expenses of medical care to treat them, or for disability benefits.

Made by: /s/ EDWIN J. KOHNER
EDWIN J. KOHNER
Administrative Law Judge
Division of Workers' Compensation

This award is dated and attested to this 14th day of December, 2010.

/s/ NAOMI L. PEARSON
Naomi L. Pearson
Division of Workers' Compensation