Issued by THE LABOR AND INDUSTRIAL RELATIONS COMMISSION

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

Injury No.: 99-146294

Employee: John Dedear

Employer: Proffer Transportation, Inc.
d/b/a Proffer Produce Company

Insurer: Missouri Employers Mutual Insurance

Additional Party: Treasurer of Missouri as Custodian
of Second Injury Fund (Dismissed)

Date of Accident: October 21, 1999

Place and County of Accident: California

The above-entitled workers' compensation case is submitted to the Labor and Industrial Relations Commission (Commission) for review as provided by § 287.480 RSMo. Pursuant to § 286.090 RSMo, the Commission affirms the award and decision of the administrative law judge dated May 16, 2006.

Employee raises one point in his Application for Review, which point does not challenge the administrative law judge's findings of fact or conclusions of law. As a result, we may determine this matter without reviewing the record developed at hearing.

Specifically, employee alleges, in part:

> The Final Award is erroneous in that the Administrative Law Judge failed to prorate the lump sum of $30,502.80 over the employee's life expectancy pursuant to § 287.250.9 RSMo. Claimant did not request such a proration at trial as he was seeking permanent total disability.

Section 287.250.9 RSMo, reads:

> The parties, *by agreement* and with approval of an administrative law judge, legal advisor or the commission, may enter into a *compromise lump sum settlement* in either permanent total or permanent partial disability cases which prorates the lump sum settlement over the life expectancy of the injured worker. When such an agreement has been approved, neither the weekly compensation rate paid throughout the case nor the maximum statutory weekly rate applicable to the injury shall apply. No compensation rate shall exceed the maximum statutory weekly rate as of the date of the injury. Instead, the prorated rate set forth in the approved settlement documents shall control and become the rate for that case. This section shall be retroactive in effect.
> (Emphasis added).

By its terms, § 287.250.9 authorizes proration only of claims resolved by an agreement of the parties in the form of a compromise lump sum settlement approved by an administrative law judge or this Commission. Section 287.250.9 is inapplicable to this case. The administrative law judge heard the above-referenced claim in a contested hearing and issued an award of compensation. A cardinal principle of all administrative law cases is that an administrative tribunal is a creature of statute and exercises only that authority invested by legislative enactment. *Farmer v. Barlow Truck Lines*, 979 S.W.2d 169, 170 (Mo. banc 1998). The administrative law judge did not err by failing to prorate the award of permanent partial disability in this matter.

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

fair and reasonable.

The award and decision of Chief Administrative Law Judge Jack H. Knowlan, Jr., issued May 16, 2006, is attached and incorporated by this reference.

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

Given at Jefferson City, State of Missouri, this ____30th____ day of August 2006.

LABOR AND INDUSTRIAL RELATIONS COMMISSION

_____NOT SITTING_____
William F. Ringer, Chairman

_____
Alice A. Bartlett, Member

_____
John J. Hickey, Member

Attest:

_____
Secretary

ISSUED BY DIVISION OF WORKERS' COMPENSATION

FINAL AWARD

Employee: John Dedear Injury No. 99-146294

Dependents: N/A

Employer: Proffer Transportation, Inc. d/b/a Proffer Produce Company

Additional Party: Second Injury Fund (Claim dismissed prior to hearing)

Insurer: Missouri Employers Mutual Insurance

Hearing Date: April 10, 2006 Checked by: JK/kh

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? October 21, 1999
5. State location where accident occurred or occupational disease contracted: California (contract of employment

and principle place of business occurred in St. Francois 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 when he fell while loading his tractor-trailer with produce.

12. Did accident or occupational disease cause death? No

13. Parts of body injured by accident or occupational disease: Low back

14. Nature and extent of any permanent disability: 30% of the body as a whole

15. Compensation paid to date for temporary total disability: None

16. Value necessary medical aid paid to date by employer-insurer: None

17. Value necessary medical aid not furnished by employer-insurer: Undetermined

18. Employee's average weekly wage: $381.29

19. Weekly compensation rate: $254.19

20. Method wages computation: By agreement

21. Amount of compensation payable:

    Permanent partial disability: $254.19 per week for 120 weeks ($30,502.80)

22. Second Injury Fund liability: Claim dismissed by employee prior to hearing

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: Robert Miller and Brown & Crouppen (see findings).

The compensation awarded to claimant is also subject to a medical lien and child support liens (see findings).

FINDINGS OF FACT AND RULINGS OF LAW

On April 10, 2006, the employee, John Dedear, appeared in person and by his attorney, Mr. Robert Miller, for a

hearing for a final award. The employer-insurer was represented at the hearing by its attorney, Mr. Patrick McHugh. 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. On or about October 21, 1999, Proffer Transportation, Inc., doing business as Proffer Produce Company was a covered employer operating under and subject to the provisions of the Missouri Workers' Compensation Act, and its liability was fully insured by Missouri Employers Mutual Insurance.
2. On or about October 21, 1999, John Dedear was an employee of Proffer Transportation, Inc. and was working under the provisions of the Missouri Workers' Compensation Act.
3. The employer had notice of the employee's accident.
4. The employee's claim for compensation was filed within the time allowed by law.
5. The employee's average weekly wage was $381.29 and his rate of compensation for temporary total disability, permanent total disability and permanent partial disability is $254.19.
6. No medical aid was furnished by the employer-insurer.
7. No temporary total disability benefits were paid by the employer-insurer.
8. The employee is making no claim for additional medical aid, either past or future.

ISSUES:

1. Accident
2. Medical causation
3. Nature and extent of disability
4. Medicaid lien
5. Child support lien
6. Attorney's lien

EXHIBITS:

The following exhibits were offered and admitted into evidence:

Employee's Exhibits

A. Medical records of St. Anthony Medical Center dated October 25, 1999
B. Medical records of Mineral Area Regional Medical Center from November 9, 1999 through September 23, 2002
C. Medical records of Dr. David B. Robson
D. Medical records of Dr. Rustico Ramos
E. Medical records of Parkland Health Center
F. Medical records of Missouri Baptist Medical Center
G. Medical records of Veterans Administration Hospital
H. Medical records of Dr. David M. Peeples
I. Deposition of Dr. David B. Robson
J. Deposition of Ms. Donna Kisslinger-Abrahm
K-1. Phone records of Proffer Transportation, Inc.
K-2. John Dedear log book
K-3. New Star bill of lading
K-4. Proffer Transportation, Inc. wage statement
K-5. John Dedear fuel card printout
K-7. John Dedear physical examination dated January 28, 1999
K-20. Bruce's Am-Best Truck Stop invoice 615048
L. Map of Southern California
M. Copies from Southwestern Bell telephone book
N. Drawing of trailer
O. Calendar
P. Attorney's lien from Brown & Crouppen
Q. Social Security cards

Employer-Insurer's Exhibits

1. Report of Injury
2. November 15, 1999 Claim for Compensation
3. July 9, 2003 amended Claim for Compensation
4. Deposition of Dr. Daniel Kitchens
5. Driver's application for employment
6. Certified copies of records from Division of Workers' Compensation
7. Social Security card
8. Deposition of John Dedear taken January 6, 2000
9. Deposition of John Dedear taken October 26, 2005
10. Termination Form

FINDINGS OF FACT:

At the time of his accident, John Dedear (hereinafter referred to as "Employee") was employed as a truck driver by Proffer Transportation, Inc., d/b/a Proffer Produce Company (hereinafter referred to as "Proffer" or "Employer").

On October 21, 1999, the employee was loading produce into his trailer at a location near Bakersfield, California when he slipped and fell landing on his buttocks. The height of the employee's fall is not clear. In his original deposition, the employee testified that his foot slipped as he was stepping from the pallet onto the floor, and he fell backwards onto his buttocks (Employer-insurer's exhibit 8, page 55). The medical records, however, indicate the employee told several healthcare providers that the fell 13 feet onto his sacrum (Employee's exhibits E, B, G and H). At the time of the hearing, the employee did not specify how far he fell, but during his cross examination the employee agreed that he was inside the trailer and his fall could not have been 13 feet because the trailer was only 9 feet high. This example is one of several instances in which the employee exaggerated, embellished or distorted the facts during the course of his medical treatment.

After the employee slipped and fell onto his buttocks, the employee "laughed it off", and did not have any symptoms other than his "butt was sore and wet" (Employer-insurer's exhibit 8, page 55). During his return trip from California to Missouri, the employee testified that he started experiencing stiffness and pain in his low back, and numbness in his right leg. Both the employee and his wife, Marion, testified that they reported his fall in several telephone conversations with Mr. Chuck Skiles. Mr. Skiles was the dispatcher for Proffer who had brokered the employee's load. Mr. Skiles was no longer working for Proffer at the time of the hearing, and emphatically denied that either the employee or his wife had ever reported a fall or injury during these telephone conversations. Mr. Skiles indicated that he did not become aware that the employee was hurt until almost two weeks later, after the employee had been to the hospital.

After returning to Missouri and delivering his load, the employee went to the emergency room at St. Anthony's Medical Center on October 25, 1999. The employee gave a history of falling in his trailer four days ago, and was complaining of low back and right leg pain. The emergency room physician diagnosed low back pain with sciatica, and gave the employee Demerol, Vistaril, Valium and a prescription for Percocet. The doctor gave the employee an "off work slip" for 5 days, and the nurse noted the employee's condition was "good" at the time he was discharged (Employee's exhibit A).

After an unsuccessful attempt to return to work, the employee sought additional treatment at Mineral Area Regional Medical Center on November 9, 1999. Based on a CT scan, the employee was diagnosed as having a central and lateral disc herniation at L4-5 and a small paracentral disc herniation at L5-S1. The emergency room physician prescribed additional medication and recommended the employee see an orthopedic surgeon (Employee's exhibit B).

The employee was subsequently referred by his attorney to Dr. David Robson, who is an orthopedic surgeon in St. Louis. Dr. Robson initially examined the employee on November 16, 1999. Dr. Robson reviewed the CT scan and diagnosed the employee as having a herniated nucleus pulposus at the L4-5 level on right side. Dr. Robson recommended a lumbar epidural steroid injection and physical therapy, and concluded the employee was unable

to work (Employee's exhibit C).

In a follow up visit on November 30, 1999, Dr. Robson was under the impression that he had been authorized to treat the employee and scheduled the employee's epidural steroid injection. In a letter to the employee's attorney dated December 14, 1999, Dr. Robson noted the employee had failed to improve after the epidural steroid injection, and suggested the employee would require a laminectomy and fusion, pending approval from the insurance company.

After a February 2, 2000 visit, Dr. Robson contacted the employee's attorney and was informed that the workers' compensation carrier had denied coverage, and the employee's first attorney was no longer representing the employee. Since the employee did not have health insurance, Dr. Robson recommended the employee seek treatment at the JFK Clinic at St. John's Mercy Medical Center (Employee's exhibit C).

After a gap in treatment, the employee went to the Parkland Health Center on August 14, 2000, and sought treatment with Dr. Rustico Ramos. Based on a telephone call Dr. Ramos received from Dr. Day at the ER Clinic at PHC-South, Dr. Ramos noted that the employee and his wife had been making frequent visits to the ER requesting narcotic pain medication. Dr. Ramos was concerned about possible "drug seeking behavior" (Employee's exhibit D).

Notwithstanding this concern, Dr. Ramos gave the employee a limited prescription for Lorcet and Naprosyn, and scheduled an MRI. Based on the employee's statement that he had been in the Marine Corps 1969 to 1972, Dr. Ramos requested an application from the VA Hospital so the employee could apply for covered medical care (Employee's exhibit D).

The statement to Dr. Ramos that he was in the Marine Corps from 1969 to 1972 is another example of the employee's tendency to exaggerate, embellish or distort the facts in an apparent attempt to garner attention or sympathy. In a VA medical psychological evaluation on May 2, 2001, the employee stated that he was in the Marine Corps from 1968 to 1972 where he served two years in Vietnam as a helicopter gunner (Employee's exhibit G). He gave a similar history to Donna Abraham during a vocational evaluation (Employee's exhibit J, page 9). The employer-insurer's attorney notes the employee was born on November 17, 1954, and would have been 13 or 14 years old in 1968. At the time of his first deposition, the employee testified that he was in the army in the 70's but was medically discharged during the boot camp at Fort Knox, Kentucky because of a problem with his heart (Employer-insurer's exhibit 8, page 11 and 12). At the time of the hearing, the employee denied that the was in the army or in Fort Knox, Kentucky, but stated that he was in the Marine Corps for boot camp, and was subsequently discharged for medical reasons related to his heart.

The MRI ordered by Dr. Ramos indicated the employee had "desiccated discs at L4-5 and L5-S1" with "focal centralized herniation of the nucleus pulposus at the L4-5 extending laterally to the right". The radiologist also felt the employee had a herniated disc on the right side at the L5-S1 level (Employee's exhibit E).

Based on this finding, Dr. Ramos tried unsuccessfully to get the employee treated, first by Dr. Robson and then at the Barnes Neurosurgery Clinic. Dr. Ramos' office then arranged for the employee to receive treatment at the VA Hospital in St. Louis (Employee's exhibit D).

The employee was first seen at the VA Hospital on August 23, 2000. At the time of this evaluation, the employee complained of no feeling in his right legs since June of 2000 with numbness and tingling in his left leg for 1 ½ months. The employee reported that he had no movement in his right leg, but still had movement in his left leg. The employee also reported bowel incontinence (Employee's exhibit G).

After additional testing, the employee was scheduled for surgery by Dr. David C. Crafts on October 23, 2000. The operative note indicates Dr. Crafts performed a right L5-S1 hemilaminectomy and discectomy. Under the heading "problems", Dr. Crafts noted that before the surgery the employee demonstrated no movement of the right lower extremity, "but unless urged, would extend knee or flex hip only by hand". Dr. Crafts added that this "could not be explained on basis of nerve root compression at right L5-S1" (October 23 record in Employee's exhibit G). Dr. Crafts further commented that the pre-op cervical and thoracic spine MRI were negative, and the MRI of the lumbar spine showed only the right paracentral disc protrusion "with fairly large canal, so rather little evidence of

root compression" (October 23, 2000 record in Employee's exhibit G).

The employee's testimony at the hearing about the reason for his surgery was not consistent with the medical records. The employee testified that the diagnostic testing showed he had a shattered disc with a piece of bone cutting into his spinal cord like a saw, and he had to have emergency surgery in an effort to avoid paralysis. The medical records indicate the employee had a herniated disc at the L4-5 and L5-S1 levels, but there is no evidence of any fractured vertebrae or other bone fragments pressing on the spinal cord at a level that would explain the employee's complaints of total loss of feeling and use of his right leg.

The employee's testimony at the hearing also gave the impression that prior to the surgery he was not walking normally and had foot drop in his right leg, but was able to walk on crutches and was not using a wheelchair. After the surgery by Dr. Crafts, the employee testified that he could not feel his right leg at all, was no longer able to walk and had to use a wheelchair issued by the VA. The employee also indicated that after the surgery that he was no longer able to control his bowels or urine, and was forced to use diapers. The VA records, however, confirm that the employee was in his own wheelchair at the time of his initial visit on August 23, 2000, and by September 6, 2000 reported that he had been using a wheelchair for the last month. The employee was also reporting bowel incontinence by August 23, 2000 and was prescribed diapers after reporting urine incontinence on September 6, 2000 (Employee's exhibit G). These problems all developed prior to his October 23, 2000 surgery.

After the surgery by Dr. Crafts, the VA records contain numerous entries that raise serious questions regarding the employee's alleged paraplegic condition. A few of these entries are summarized as follows:

- On November 12, 2000, the employee advised Dr. Tan that he was unable to move his right leg after the surgery. Dr. Tan noted, however, that it was interesting that "on abduction and adduction of the hip against resistance both of the employee's lower extremities demonstrated equal power (4 out of 5)". Dr. Tan concluded, "I remain uncertain regarding the pathophysiology of patients seemingly profound deficits, and wonder if conversion disorder ought to be considered" (November 17, 2000 record, Employee's exhibit G).
- On December 21, 2000, the employee was requesting additional medication for low back pain and radiculopathy, and was examined by Dr. Qubaiah and Dr. Ko. The doctors' notes indicate the employee continued to have pain after the surgery and was taking Morphine. The doctors noted the employee had four positive Wadell's signs that "stand against any serious disc disease. He had the paralysis in his right leg for more than a year now which was investigated in the past by MRI's of the whole spine which did not give an explanation". The doctor then added "objective neurological exam show, including reflexes, Babiniski, clonus testing were normal. The right lower extremity doesn't show any atrophy or spaticity" (December 21, 2000 record, Employee's exhibit G).
- On December 24, 2000, Dr. Crafts had a post operation visit with the employee. The employee complained of pain in the low back that ran down both thighs to his knees, right greater than left. The employee complained of complete weakness in his right lower extremity "which has been present all along, and is not explained by a ruptured disc at L5-S1, or any know pathology (Pre-op had MRI of entire spine)". Dr. Crafts noted the employee revealed "only a trace of movement of RLE, …, despite urging. There is NO atrophy despite at least three months virtual paralysis". Dr. Crafts impression was "physical cause of paralysis of RLE has not been found yet. Plan CT of head to rule out structural cause there; otherwise difficult to account for near total lack of motor, sensory function with essentially normal reflexes, no atrophy. Consider conversion reaction, malingering" (December 24, 2000 record, Employee's exhibit G). Dr. Crafts suggested physical therapy, a possible EMG and a psychiatric evaluation.
- On January 15, 2001, Dr. Balsalobre performed a nerve conduction study to evaluate for a possible peripheral neuropathy. Dr. Balsalobre's impression was "this is an abnormal electrophysiological study with evidence of peripheral neuropathy in the lower extremities of a mild nature. These findings provide no clue to etiology" (January 15, 2001 record, Employee's exhibit G).
- On January 16, 2001, the employee was evaluated for an electric wheelchair. Dr. Swanson concluded the employee did not meet the criteria for an electric wheelchair, and stated, "note absence of lower extremity atrophy on evaluation. Unclear what the etiology of his dysfunction is at this time" (January 16, 2001 record, Employee's exhibit G).
- On January 30, 2001, the employee had a physical therapy evaluation. The physical therapist noted the employee was "in no noted distress during subjective evaluation, observed to frequently shift positioning in wheelchair without difficulty, no noted muscle wasting/atrophy in (R) LE". The physical therapist assessment was as follows:

  > While it appears that patient is experiencing some pain syndrome – he also exhibits multiple signs of non-organic pain syndrome. Multiple positive tests for Wadell's signs, overreaction to light touch, sudden changes in ability to make a muscle contraction from one day until the next, conflicting accounts of

history of condition, etc. Patient also talking a lot about workers' comp. and/or pain meds with whatever question he was asked. Difficult to keep patient on question asked of him. All of these conditions make patient a poor candidate for positive results from any type of physical therapy at this time. Patient discharged from physical therapy…with no physical therapy follow up recommended at this time (January 30, 2001 record, Employee's exhibit G).

- On May 21, 2001, Dr. Crafts re-examined the employee. The employee complained of low back pain with pain in the left lower extremity to the mid-calf level. The employee also continued to deny any movement in his right lower extremity. Dr. Crafts found the employee still did not have atrophy in the right leg, and commented that if he had not moved his leg for several months there should be atrophy. He also commented the employee had a positive Hoover test. For the Hoover test the employee was put in a supine position and was told to raise each leg with the doctor's hand under the opposite heel. For the right leg, the employee could not raise the leg, but put no downward pressure on the left heel. Dr. Crafts interpreted this to indicate "no effort". For the left leg, the employee did exert mild downward pressure with the right heel, which Dr. Crafts indicated contradicts the employee's statement that he cannot move the right leg. Based on the lack of atrophy, the positive Hoover test and a normal knee jerk reflex in both knees, Dr. Crafts concluded, "I see no explanation for his right lower extremity paralysis other than conversion reaction or malingering (May 11, 2001 record, Employee's exhibit G).
- On October 4, 2002, the employee was seen by Dr. Heather Garrett at the Primary Care Walk in Clinic for the VA Hospital in St. Louis. The employee reported that his wheelchair had turned over 6 days earlier as he was going down a ramp, and he felt a loud pop. The employee had received a prescription for Tylenol 4 at the ER, but had run out and was requesting additional medication. Dr. Garrett reviewed the employee's medical history and noted the concerns regarding malingering or conversion disorder, and the possibility of drug seeking behavior. Dr. Garrett stated, "patient has no wasting of lower extremities or contractures as would be expected with true paralysis. Note also that soles of shoes were worn and filled with fresh dirt and gravel". Dr. Garrett also noted the employee had no bruising or pain on his right side where he claimed he fell. Dr. Garrett concluded, "it is my opinion that patient is malingering and drug seeking" (May 18, 2004 record on page 117 and page 118 of progress notes, Employee's exhibit G).

In addition to the VA Hospital records indicating the employee may not be suffering from total paralysis of his right lower extremity, the medical records also indicate the employee may have been addicted to narcotic pain medication, and that addiction may have accounted for some of the employee's complaints and repeated requests for pain medication. The medical records from Mineral Area Regional Medical Center, Dr. Ramos, Parkland Health Center and the VA Hospital all contain multiple entries in which the employee appeared and requested medication based on some occurrence or aggravating incident.

On April 18, 2000, the employee went to the ER at Mineral Area Regional Medical Center and reported feeling a pop in his low back while using crutches. The employee received a prescription for Lorcet. The employee also received additional prescriptions at Mineral Area Regional Medical Center on June 16, 2000, when he reported falling in the shower; on February 4, 2001 when he fell over in his wheelchair; and on September 23, 2002 when he heard a pop with increased low back pain while lifting himself. The record from this visit indicates the employee gave a history of being "paralyzed from the waste down" since 1999 after falling 13 feet and "shattering the first five vertebrae" (Employee's exhibit B).

The medical records of Dr. Ramos confirm that the employee was receiving prescriptions for Lorcet, Oxycontin, MS Contin, and Morphine for several months before Dr. Ramos became aware that the employee was also getting similar prescriptions from several area emergency rooms and the VA Hospital. On October 2, 2000, the employee complained of bilateral shoulder pain from pushing his wheelchair, and said that he "hurts all over and only Lorcet will help". On November 15, 2000, the employee convinced Dr. Ramos to refill his prescriptions for MS Contin and Oxycontin even though the employee was still being treated at the VA Hospital. On December 15, 2000, the employee reported that he had turned over his wheelchair while going down a ramp, and received a prescription for MS Contin and Oxycontin. This was the first of three incidents in which the employee reported to different healthcare providers that his wheelchair had turned over while using a ramp. On January 15, 2001, Dr. Ramos refilled the employee's MS Contin and Oxycontin, but advised the employee that he would not give the employee any more refills or narcotic medications.

On January 29, 2001, Dr. Ramos' records indicate that he had a long telephone conversation with Dr. Babu, who is the director of the pain clinic at the VA Hospital. Both Dr. Ramos' records and the VA Hospital records indicate the employee had been untruthful with the doctors in order to obtain narcotic pain medication. The employee had misrepresented the results of post surgical MRIs and CT scans, the EMG test and had been using the same stories of new accidents or loss of medication at both Dr. Ramos' office and the VA Hospital (Employee's exhibit

D). Dr. Ramos reported:

> Dr. Babu is concerned about a conversion disorder, but they have ruled out everything organic. There is significant drug seeking behavior here. On their end, they will not give him any additional narcotics, as he must follow up with his primary care physician (Employee's exhibit D).

Dr. Ramos further stated "there is a real illness and he is entitled to good healthcare, however, since he has not been straight forward, forthcoming or truthful about his medical condition with his doctors, we will proceed with the above". In an addendum Dr. Ramos noted that the employee saw Dr. Babu the same day and told Dr. Babu that he had only seen Dr. Ramos one time when "indeed we have seen about one or twice a month since August of 2000. He will now be receiving no narcotics from any location at the VA. He must receive all of his follow up care from our office" (Employee's exhibit D).

The medical records of Dr. Ramos indicate the employee made additional attempts to get narcotic pain medication from the VA on February 6, 2001, and from Dr. Ramos on March 16, 2001. Both the VA Hospital and Dr. Ramos denied the employee's request, but Dr. Ramos offered the employee a detox program at Mineral Area Regional Medical Center. The employee declined the offer by stating "no, I guess I will continue to live with the pain".

This pattern of drug seeking behavior is also reflected in multiple visits to Parkland Health Center in Farmington and the VA Hospital clinic. The employee received prescriptions from Parkland Health Center in Farmington on November 1, 2000; January 3, 2001; February 7, 2001; February 11, 2001 and February 24, 2001. Dr. Babu's VA Hospital record of January 29, 2001 contains the "flip side" of his conversation with Dr. Ramos. The records confirm the employee had been dishonest with the physicians at the VA Hospital, and was manipulating the system to obtain excess amounts of narcotic pain medication (January 29, 2001 medical record, Employee's exhibit G).

To support his claim that he is permanently and totally disabled as a result of his accident, the employee offered the deposition of Dr. David B. Robson, a medical report from Dr. David M. Peeples and a deposition of vocational rehabilitation consultant, Donna Kisslinger-Abram.

Dr. Robson's deposition was taken June 24, 2004. After Dr. Robson's initial evaluation of the employee on November 16, 1999 and his subsequent referral to the VA Hospital, Dr. Robson was asked to examine the employee again on June 24, 2003. The employee's complaints at that time were that he could not ambulate with both legs, he could no sustain an erection, was incontinent of bowel and bladder and wore a diaper (Employee's exhibit I, page 11).

Dr. Robson diagnosed the employee as being status post lumbar laminectomy with nothing functioning below the L1 level, and recommended a CT myelogram. The CT myelogram was done on July 23, 2003. Dr. Robson reviewed the films and concluded the employee had degenerative changes at L4-5 and L5-S1, but no surgical lesions. Dr. Robson felt the employee needed to accept his situation, but suggested a neurological referral (Employee's exhibit I, page 12 and 13).

At the request of the employees attorney, Dr. Robson then reviewed additional records and the employee's deposition and prepared a medical report dated February 24, 2004 (Plaintiff's exhibit 2 attached to Employee's exhibit I). Based on this report, and after assuming additional facts suggested by the employee's attorney, Dr. Robson testified that as a result of the employee's October 21, 1999 accident, the employee sustained a herniated disc at the L4-5 level lateralizing to the right (Employee's exhibit I page 14). On the issue of disability, Dr. Robson felt the employee was basically functioning as a paraplegic at the L1 level, and concluded the employee was permanently and totally disabled (Employee's exhibit I, page 15).

During cross examination, Dr. Robson refused to comment on whether Dr. Crafts was reputable (Employee's exhibit I page 21), but it was clear from reading his deposition that Dr. Robson was attributing the employee's apparent paralysis to the surgery performed at the VA Hospital. Dr. Robson, however, was relying on the employee's history that his inability to ambulate and his bowel and bladder incontinence all started after the surgery. A thorough review of the VA records, however, establish the employee's problems moving his right leg, using a wheelchair, and maintaining incontinence had all developed prior to his surgery (Employee's exhibit G).

Although Dr. Robson was never questioned about those records, the employer-insurer's attorney did ask Dr. Robson if he had any concerns about whether the employee's paralysis was legitimate. Dr. Robson's answer was "no", but he admitted there was nothing in the CT myelogram to explain why the employee had paralysis (Employee's exhibit I, page 23 and 24).

During additional cross-examination, Dr. Robson was questioned about whether there was anything in his physical examination to explain the paralysis. Dr. Robson explained that he could obtain no motor function of the employee's lower extremities, which would correlate with a lesion at the L1 level because hip flexors are controlled by the L2 nerves. Dr. Robson agreed, however, that there was no evidence of any lesions at that level (Employee's exhibit I, page 24).

The employee also offered a medical record of Dr. David M. Peeples who is a neurologist in St. Louis, Missouri. Dr. Peeples examined the employee on January 5, 2004. Dr. Peeples took a brief history from the employee and performed a limited examination, but he did not have any of the employee's medical records or diagnostic studies to review. Dr. Peeples "Impression" was "By history traumatic Cauda Equine syndrome with lower extremity paralysis". It should be noted that the history provided by the employee to Dr. Peeples was that he had fallen 13 feet and landed directly on his back, and the employee advised Dr. Peeples that he had been paralyzed since before the surgery (Employee's exhibit H).

The deposition of Donna Kisslinger-Abram was taken on June 30, 2004. Ms. Abram is a certified vocational rehabilitation consultant with Concentra (Employee's exhibit J, page 5). Ms. Abram evaluated the employee on May 17, 2004, and also reviewed medical records from Dr. Robson, Dr. Peeples and the VA Hospital (Employee's exhibit J, page 7). Based on her evaluation of the employee, Ms. Abrahm concluded:

> I don't believe that he would be able to locate employment. Whether or not he could sustain employment is something that I did not analyze, because I don't think that he would be able to find a position that would meet his abilities, skills, and physical capabilities at this time period. I just don't believe they exist in his labor market. (Employee's exhibit J, page 17)

During cross-examination, Ms. Abrahm agreed that if the employee is not wheelchair dependent and is able to ambulate, that might change her vocational assessment (Employee's exhibit J, page 24). Ms. Abrahm also admitted that she was not aware of the concerns regarding the employee's drug seeking behavior, and admitted that if that were true it could influence the employee's motivation to return to work (Employee's exhibit J, page 27 and 28).

The employer-insurer relied on the report and deposition of Dr. Daniel L. Kitchens, who is a neurosurgeon with Cardinal Neurology and Spine, Inc. in St. Louis, Missouri. Dr. Kitchens examined the employee on August 23, 2005, and prepared a report that was admitted as deposition exhibit 2, attached to employer-insurer's exhibit 4. Based on his physical examination of the employee and his review of the medical records, Dr. Kitchens concluded that there is no anatomical explanation for the loss of sensation that the employee is reporting (Employer-insurer's exhibit 4, page 16). Dr. Kitchens indicated the most significant physical finding was the lack of any decubitis ulcers. He noted "patients that are paralyzed always have decubitis ulcers, pressure sores in their buttocks and their sacrum from the weight of the body being confined to a bed or being confined in a wheelchair". Dr. Kitchens noted the employee did not have any ulcers nor had he received any treatment for ulcers (Employer-insurer's exhibit 4, page 13 and 25).
As part of his examination, Dr. Kitchens gave the employee a test known as the Babinski sign. If a patient has a spinal cord injury, Dr. Kitchens explained that they always have a positive Babinski sign. The Babinski sign is performed by gently touching the bottom of the foot. If the big toe comes up or withdraws, that would be an abnormal Babinski test that would indicate a spinal cord lesion or spinal damage. Dr. Kitchens indicated the employee had a negative Babinski sign, with no evidence of a spinal cord injury (Employee's exhibit 4, page 17).

Dr. Kitchens also testified that his review of the medical records did not support the employee's claim of paralysis. Dr. Kitchens referred to the records of Dr. Robson, the CT scans and MRIs and the EMGs and nerve conduction studies, and testified that none of these records supported a finding of paralysis (Employer-insurer's exhibit 4, page 19-21).

Dr. Kitchens emphasized that “there was no evidence of a traumatic injury or fracture of the spine. There was no abnormality in the region of the conus or the cauda equina at the lumbar levels” (Employer-insurer’s exhibit 4, page 21). Dr. Kitchens explained that the spinal cord ends in the lower thoracic level of the back, and below that level the spinal cord becomes nerve roots that travel down the spinal cord and exit at certain levels in the spine. This area is called the conus because it is shaped like a cone. As the spinal cord tapers down, and then branches out into the individual nerve roots, it is called cauda equina. Cauda equina means “horsetail”, and this name was used because the nerve roots have the appearance of a horsetail. Dr. Kitchens then emphasized that “for a patient to be paralyzed at the thoracic level, have loss of all motor and sensory deficits from the waist down, for instance, there would have to be an abnormality or lesion in the lower thoracic spinal cord or the conus or cauda equine. He did not have lesions in any of those areas” (Employer-insurer’s exhibit 4, page 22).

When questioned about his opinion regarding the employee’s diagnosis, Dr. Kitchens concluded that the employee suffered a musculoskeletal strain as a result of his October 21, 1999 accident. Dr. Kitchens testified, however, that the employee “did not sustain an injury to his spinal cord on that date because he had no fracture or subluxation or lesion to his upper or lower thoracic spine or upper lumbar spine that would account for subsequent development of his paralysis” (Employer-insurer’s exhibit 4, page 24).

Dr. Kitchens did not believe the employee had suffered any disability as a result of his fall (Employer-insurer’s exhibit 4, page 26), but agreed the employee has “functional paralysis”. He explained this conclusion by indicating that when he uses the term functional he is referring to “acting like he has paralysis”. Although the employee is acting like he has paralysis, there is no true anatomic correlation or basis for his paralysis” (Employer-insurer’s exhibit 4, page 27).

At the conclusion of the hearing, the employee requested an award for permanent total disability, or in the alternative, permanent partial disability. Both attorneys requested leave to file a brief on the disputed issues. The employee’s brief was faxed to the Division on April 21, 2006, and the employer-insurer’s brief was received by the Division on April 24, 2006.

RULINGS OF LAW:

Issue 1. Accident, Issue 2. Medical Causation and Issue 3. Nature and Extent of Disability

Notwithstanding the employee’s pattern of exaggerating, embellishing or distorting the facts, the evidence still supports a finding that the employee slipped and fell on his buttocks while loading his trailer on October 21, 1999. The employee’s wife witnessed the fall, and the employee gave an accurate history of his accident to an emergency room physician four days later. The inconsistencies raised by the employer-insurer regarding the number of pallets, the exact location of the accident and other details indicate the employee is a poor historian, but do not refute the employee’s evidence that he did slip and fall while loading his trailer. The fact that the employee may or may not have reported his accident during the trip back from California is relevant, but does not defeat the employee’s claim since he reported it to the hospital four days later and his employer admitted that they learned of the accident within two weeks after the date of the fall.

The fact that the employee later began to exaggerate the height of his fall and the severity of his injuries is likely the result of some pre-existing personality disorder. Neither party, however, offered any psychological or psychiatric evidence to explain the employee’s tendency, as the old saying goes, to “lie when the truth would have helped him”. The medical records are replete with examples of the employee misrepresenting things such as his military service when there was very little to be gained, and there was a very high probability that his lies would be discovered (i.e. telling the doctors at the VA Hospital that he had served two tours of duty in Vietnam).

Unfortunately, this personality flaw of not being truthful led the employee down a dangerous path of drug seeking behavior. Although there is no medical evidence to support a conclusion that the employee was addicted to narcotics, the medical records establish that the employee was fabricating accidents, overstating his symptoms and lying to his treating physicians to obtain narcotic pain medication from several area hospitals and physicians.

The employee's pattern of not being truthful and engaging in drug seeking behavior has had a negative impact on the employee's credibility with both the healthcare professionals and the administrative law judge. The doctors were not sure if the employee was complaining because he was really having low back pain or because he wanted more narcotics. This uncertainty also carried over to the employee's complaints of paralysis. It is not clear whether the employee was using a wheelchair because he could not use his legs or because he wanted to convince the physicians to prescribe additional medication.

The employee's credibility was also adversely affected by the lack of any anatomical basis or medical explanation regarding his paralysis. Although the employee testified that he cannot move his legs, and has not been out of wheelchair since his surgery, all the doctors agree there is no medical or physical evidence to explain this result. The employee's disc pathology was at the L4-5 and L5-S1 levels, yet the type of paralysis described by the employee could only be caused by an injury or trauma to the thoracic or upper lumbar spine. While this might be explained by a psychosomatic disorder or conversion reaction (i.e. it's all in his head), the issue is further complicated by the contradictory absence of certain physical findings. The employee testified that he cannot move his legs (especially his right leg), and has been in a wheelchair continuously since October 23, 2000, yet several doctors noted he has no atrophy in his legs. As noted by Dr. Kitchens, the employee has never had a problem with ulcers, and those ulcers are always associated with patients that are wheelchair bound. To add "fuel to the fire", the employee failed the Babinski sign and the Hoover test. One VA doctor also noted that the employee had worn soles on his shoes, and his shoes contained "fresh" gravel and dirt. This evidence led Dr. Crafts and other VA physicians to conclude that the employee might be guilty of "malingering" as opposed to a conversion disorder or some other unexplained physical cause.

In the end, the administrative law judge was left with the responsibility of making a difficult choice from three options. The first was to totally ignore the employee's habit of being untruthful and the lack of supporting medical evidence, and find that the employee is paralyzed, and that his paralysis was medically causally related to his accident. The second option, on the opposite end of the continuum, was to totally deny the employee's claim on the basis that his credibility was damaged to the point where none of his evidence was believable. The final option, and the one selected, was to find that the employee did have a work related accident that caused disc herniations at the L4-5 and L5-S1 levels, but the employee failed to satisfy his burden of proof on the issues of paralysis and permanent total disability.

I therefore find that on or about October 21, 1999, the employee had an accident that arose out of and in the course of his employment with Proffer. I further find that the employee's accident was a substantial factor in causing a herniated or protruding disc at the L4-5 and L5-S1 levels. The medical evidence, however, does not support a finding that the employee is suffering from paralysis as a result of his accident. Although the employee may be totally disabled due to congestive heart failure, diabetes, or other reasons, the evidence does not support a finding that his October 21, 1999 accident was a substantial factor in causing the employee to be permanently and totally disabled.

Although the employee's claim for permanent total disability has been denied, the evidence does support a finding that the employee has sustained permanent partial disability as a result of his accident. There is no evidence of any significant pre-existing back problems, and both the hospital records and the testimony of Dr. Robson indicate the employee had right-sided disc herniations at the L4-5 and L5-S1 levels. There is no explanation, however, for the fact that Dr. Robson recommended surgery at the L4-5 level and Dr. Crafts performed surgery L5-S1 level. While Dr. Kitchens' opinions regarding the employee's paralysis were credible, his conclusion that the employee did not initially have any disc herniations was contrary to all of the other diagnostic studies and the opinions of the other physicians, and was not credible.

Based on this evidence, I find that, as a direct result of his October 21, 1999 accident, the employee sustained a two level herniated disc, and has a 30% permanent partial disability of his body as a whole. The employer-insurer is therefore directed to pay to the employee the sum of $254.19 per week for 120 weeks for a total award of permanent partial disability equal to $30,502.80.

Issue 4. Medicaid Lien

The amount of compensation awarded herein is subject to a Department of Social Services, Division of Medical Services Medicaid lien. The most recent notice indicates the amount of the lien is equal to $2,190.82. For the current balance of the Medicaid lien, the parties should contact the Third Party Liability Unit at (573) 751-2005.

Issue 5. Child Support Lien

The amount of compensation awarded herein is subject to multiple child support liens filed by the Director of the Family Support Division of the Department of Social Services. According to the lien notices, the parties should contact the Financial Resolutions Section, Family Support Division, P O Box 22747, Jefferson City, Missouri 65102-2277 (Telephone number 573-526-5446) for current arrearage information before sending payment. Based on the lien notices filed, it appears the child support liens will exceed 50% of the disposable lump sum, after payment of attorney's fees and costs and the Medicaid Lien. The Circuit Court identifying numbers for the liens filed are CV-1926115 DR and CV1934288 DR, with IV-D Case Numbers 60133168 and 20387049.

Issue 6. Attorney's Lien

Robert Miller and Brown and Crouppen are allowed a combined attorney's fee of 25% of all sums awarded under the provisions of this award for necessary legal services rendered to the employee. The total attorney's fee awarded is therefore equal to 25% of $30,502.80 or $7,625.70. Of this total, $2,027.50 shall be payable to Brown & Crouppen and $5,598.20 shall be payable to Robert Miller. Brown and Crouppen shall also be entitled to $165.39 for litigation costs for a total payment for attorney's fees and expenses of $2,192.89. Mr. Robert Miller shall also be entitled to reimbursement for reasonable costs and expenses related to the prosecution of the employee's claim. The total amount of attorney's fees and expenses shall constitute a lien on the compensation awarded herein.

INTEREST:

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

Employee: John Dedear Injury No.: 99-146294

Date: _____ Made by:

_____
Jack H. Knowlan, Jr.
Chief Administrative Law Judge
Division of Workers' Compensation

A true copy: Attest:

_____
Ms. Patricia "Pat" Secrest
Director