

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

Injury No.: 02-110459

Employee: Eddie Edwards

Employer: U. S. Nursing

Insurer: Safety National Casualty

Date of Accident: October 16, 2002

Place and County of Accident: St. Louis County, Missouri

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 Act. Pursuant to section 286.090 RSMo, the Commission affirms the award and decision of the administrative law judge dated April 21, 2006, and awards no compensation in the above-captioned case.

The award and decision of Administrative Law Judge Grant C. Gorman, issued April 21, 2006, is attached and incorporated by this reference.

Given at Jefferson City, State of Missouri, this 3rd day of November 2006.

LABOR AND INDUSTRIAL RELATIONS COMMISSION

William F. Ringer, Chairman

Alice A. Bartlett, Member

John J. Hickey, Member

Attest:

Secretary

AWARD

Employee: Eddie Edwards

Injury No.: 02-110459

Dependents: N/A
Employer: U.S. Nursing
Additional Party: None
Insurer: Safety National Casualty
Hearing Date: January 12 and 18, 2006

Before the
**Division of Workers'
Compensation**
Department of Labor and Industrial
Relations of Missouri
Jefferson City, Missouri

Checked by: GCG

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? Yes
3. Was there an accident or incident of occupational disease under the Law? Yes
4. Date of accident or onset of occupational disease: 10/16/02
5. State location where accident occurred or occupational disease was contracted: St. Louis County
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: While treating a patient, employee was kicked in the shoulder.
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: Left Shoulder, Back
14. Nature and extent of any permanent disability: None
15. Compensation paid to-date for temporary disability: \$108,336.73
16. Value necessary medical aid paid to date by employer/insurer: \$128,694.57

Employee: Eddie Edwards Injury No.: 02-110459

17. Value necessary medical aid not furnished by employer/insurer? None.
18. Employee's average weekly wages: Above the statutory maximum.
19. Weekly compensation rate: 649.32/340.12
20. Method wages computation: Statutory Calculation

COMPENSATION PAYABLE

21. Amount of compensation payable: \$0
- Unpaid medical expenses: \$0
- 0 weeks of temporary total disability (or temporary partial disability)

0 weeks of permanent partial disability from Employer

0 weeks of disfigurement from Employer

22. Second Injury Fund liability: No

TOTAL: \$0

23. Future requirements awarded: None

FINDINGS OF FACT and RULINGS OF LAW:

Employee:	Eddie Edwards	Injury No.:	02-110459
Dependents:	N/A	Before the	Division of Workers'
Employer:	U.S. Nursing	Compensation	
Additional Party:	None	Department of Labor and Industrial	
		Relations of Missouri	
		Jefferson City, Missouri	
Insurer:	Safety National Casualty	Checked by:	GCG

INTRODUCTION

The above referenced case was heard by the undersigned Administrative Law Judge beginning on January 12, 2006, and concluded on January 18, 2006. The record was left open for Claimant to submit certain medical bills from St. Mary's Health Center until February 7, 2006. Claimant was present in person and represented by David Tarlow. Martin Klug represented Employer U.S. Nursing and its insurer Safety National Casualty.

The parties stipulate that: On October 16, 2002, Claimant sustained an accidental injury arising out of and in the course of employment. Claimant was an employee of Employer. Venue is proper in the City of St. Louis. Employer received proper notice. Claim was filed within the time prescribed by law. Claimant's average weekly wage was above the statutory maximum resulting in a rate of \$649.32 for total disability benefits and 340.12 for permanent partial disability benefits. Employer has paid temporary total disability benefits (TTD) in the amount of \$108,336.73 representing 166 and 6/7ths weeks. Employer has paid 128,694.57 in medical benefits.

The issues in dispute are: Medical causation of certain injuries. Nature and extent of employer liability. Whether

employer is liable for past medical care. Whether Claimant is entitled to future medical care. Whether Attorney Theodore Pashos is entitled to enforce his attorney fee lien.

SUMMARY OF THE EVIDENCE

I. Live Testimony.

Claimant is a 49-year-old male who was working for Employer as a critical care nurse. Claimant is right hand dominant. Claimant was a nurse for 19 years. He began working for Employer in April 2002. The incident that is the subject of this case happened on October 16, 2002. Claimant testified that on that date, he treating the burns of a large Downs Syndrome patient. The patient was in 4-point restraints, and when Claimant had removed one of the leg restraints to treat the area under the restraint, the patient kicked him in the shoulder, causing Claimant to strike his back against the wall. Claimant's testimony was that he was struck with such force that his feet came up off the floor, and that after striking the wall, he then slumped to the floor.

Claimant returned to work to complete that shift after about an hour break. Claimant saw a doctor within 24 hours. He testified that at the time of the incident he had pain in the back of his head, his left elbow and shoulder, and his buttocks. Claimant's initial treatment was with an occupational doctor at St. John's Hospital.

Claimant testified that Dr. Doerr was the first treating physician. Dr. Doerr took x-rays and performed other diagnostic tests. Claimant stated that Dr. Doerr told him that he could not do much for Claimant and referred him to Dr. Schoedinger. Dr. Schoedinger ordered mylogram and discogram tests on Claimant. Claimant's impression was that these tests revealed protrusions and bulges at the L3, L4, and L5 vertebrae and that Dr. Schoedinger wanted to perform surgery, but the insurance company denied coverage for the procedure, hence there was no operation performed.

Dr. Schmidt then treated Claimant. Claimant's understanding of Dr. Schmidt's diagnosis was that he had Reflex Sympathetic Dystrophy (RSD), Myofascial Pain Syndrome, and Cauda Equina. Claimant testified that he had previously had RSD in conjunction with Carpal Tunnel Syndrome (CTS) in 2000 or 2001, but that it had not bothered him since the surgery to repair the CTS, approximately two years prior to this incident.

Subsequent to Dr. Schmidt, Dr. Strege treated Claimant. Dr. Strege treated Claimant with therapy and pain injections. It is Claimant's understanding that Dr. Strege rated him at 25% disability in the shoulder and 30% disability for the RSD. According to Dr. Strege, Claimant was at Maximum Medical Improvement (MMI). Since Dr. Schmidt could not give him any more pain injections, he then went to his personal physician, Dr. Abbott. Dr. Abbott took over his pain control and treatment.

Claimant was admitted to St. Mary's Hospital in August 2003 for pain and subsequently ended up in a "narcotic coma." He has visited the emergency on other occasions for pain. Claimant testified pain is a daily problem, that he takes medication for the pain, and that he did not have to take pain medication for at least one year prior to this incident.

Claimant testified that he had been treating with the above referenced physicians for about two years when he began seeing Dr. Irvin for depression. He had not worked during those two years. Before treating with Dr. Irvin, he had never been treated by a psychiatrist. Dr. Irvin suggested Claimant get a job. Claimant testified that he did in fact try teaching, but there was too much "running around," and that the pain in his back was a "problem." Claimant also testified that he was still taking narcotics for pain, and this also affected his ability to teach. Dr. Irvin also referred Claimant to Dr. Schwabo for behavior modification.

Claimant testified that he was prescribed the drug Seroquil as part of his treatment. He testified that the use of Seroquil resulted in his breasts enlarging. The swelling was painful and therefore he underwent a "bilateral mastectomy." As a result of this operation, his chest is disfigured from the scars, he can't take his shirt off in public, and that this has all made his depression worse.

Claimant testified that he had treated for back pain one time prior to this injury. His treatment was not on a regular basis and he took over the counter medications.

Claimant testified that his current problems are: Pain in his lower back, RSD, Capsulitis in shoulder, Major Depression, Post-Traumatic Stress Disorder, and bowel and bladder dysfunction that requires him to wear a diaper when in public. Claimant walks with a cane and has a wheelchair, but doesn't use the wheelchair often. One time he tried not to use the cane, but "paid for it" the next day.

He testified that his day-to-day activities include playing with his dog and sometimes attending local medical seminars that are sponsored by his attorney, Mr. Tarlow. Claimant feels he needs continued treatment for pain with Dr. Abbott and for Depression with Dr. Irvin. He further testified he also currently suffers from Radiculopathy and Sciatica.

During cross-examination, Claimant testified he does not recall a Worker's Compensation settlement from 1997 in which he received a PPD settlement of 5% for the Lumbar Spine and 7.5% for the left elbow. (Employer's Exhibit 3). He

does remember a Workers' Compensation claim form Nebraska in 2001 for Carpal Tunnel Syndrome (CTS), in which he received a PPD settlement of 20% of the left upper extremity. (Employers Exhibit 4). Claimant also concedes that he did not tell Dr. Abbott or Dr. Cohen that he had RSD prior to this accident.

He further testified that he has had two injuries since the work injury of October 16, 2002. An August 2003 occurrence at St. Mary's Hospital, which resulted in Claimant being in a narcotic coma. Claimant testified that his injuries were "all mental," but have physical manifestations. He was initially more depressed, but he has returned to his normal level. He testified that he first began psychiatric treatment after this incident.

Claimant testified that he was an automobile accident in 2004. He went to the hospital 1 hour after accident and received a pain shot. He testified that his back problems increased after this accident, but his back condition has returned to where it was prior to this accident.

Geraldine Breite testified on behalf of Claimant. Breite is a Life Care Planner and a Legal Nurse Consultant. Breite testified that as a Nurse Life Care Planner she evaluates long-term medical issues in response to injury or illness and addresses the medical needs of the patient. Breite prepared a voluminous report of her findings marked as Claimant's Exhibit S. Counsel for Claimant initially moved for the admission of Exhibit S, however, Counsel for Employer objected. Claimant then withdrew his request at that time, and never renewed his request that Exhibit S be received in evidence. Breite did testify at length to the contents of the Exhibit, to the extent that she was permitted to do so as limited by objections.

Breite testified under cross-examination that she had not reviewed any medical records of Claimant prior to October 16, 2002. She also testified that causation was not important to her evaluation and that she does not form an opinion as to causation.

Attorney Theodore Pashos testified regarding his lien for legal services rendered. He submitted a document that was received into evidence as Court's Exhibit I that summarized the work done on Claimant's case. He testified that he billed \$150.00 per hour, and that was a similar rate to other attorney's in the area. He testified that he spent 1.5 hours researching a possible claim against one of Claimant's co-workers arising from the same incident. The lien amount Mr. Pashos claims is \$3123.76, which represents \$3,078.00 in fees and \$45.76 for advanced expenses.

II. Medical Testimony.

Dr. David Abbott testified by deposition taken January 5, 2006. Dr. Abbott diagnosed claimant as having: RSD, back pain, myofascial pain, Cauda Equina Syndrome, Adhesive Capsulitis of left shoulder, and degenerative joint disease. Dr. Abbott rated Claimant's disability at 75%, predominately for the back injury, but also including the other conditions that he diagnosed.

Under cross-examination, Dr. Abbott testified that Claimant treated with him on October 29, 2002 and did not mention the work accident, nor did he make any complaints of back or arm pain. He further testified that the first time Claimant told him about the work injury was February 24, 2003. Claimant began treating with Dr. Abbott for back pain in 1997. Dr. Abbott could not conclude that the work injury was the cause of Claimant's back pain, although he noticed an escalation of back pain in Claimant since 2002.

Dr. Abbott testified that Claimant did not inform him that he had been diagnosed with RSD prior to October 2002, and the fact that he had would change his opinion regarding the causation of RSD. A diagnosis of Cauda Equina was not made until around September of 2005, and there were no findings that would support a diagnosis of Cauda Equina prior to that. His psychiatric treatment for panic attacks began prior to 2002, and his more recent problems of panic attacks sleep problems and other psychiatric problems did not begin until after the August 2003 incident at St. Mary's Hospital.

Dr. Raymond Cohen testified by deposition on January 9, 2006. Dr. Cohen had previously conducted two medical evaluations of Claimant on September 29, 2003 and April 20, 2004. Dr. Cohen diagnosed Claimant with RSD of the left upper extremity and lumbar myofascial pain disorder in his first evaluation of Claimant. In the second evaluation, he added diagnoses for chronic pain syndrome and depression secondary to the original diagnoses. Dr. Cohen testified that in the second evaluation he had opined that these diagnoses were a direct result of the injuries sustained on October 16, 2002. He further opined that all the treatment received by Claimant was medically necessary and it was reasonable, and that Claimant was temporarily totally disabled from the date of the injury up through the date of the report.

Dr. Cohen rated Claimant's permanent disability of the lumbar spine at 30% of the whole body, and left upper extremity at 45% of the shoulder. For the degree of disability regarding depression, Dr. Cohen stated he would defer to mental health professionals.

During cross-examination Dr. Cohen testified that his diagnosis of depression was based on Claimant's report that he was depressed. He further testified that he was not given any history of prior injuries or treatment; and the only history he was given about the Claimant's back injuries was that he had treated one time twenty years ago and that those problems had resolved. Dr. Cohen had never been provided with records of Dr. Abbott regarding back injuries or treatment.

Dr. William Irvin, Jr. testified by deposition on April 5, 2005 and April 14, 2005. The deposition of April 5 was a discovery deposition taken by counsel for Employer. The April 14 deposition was for the purpose of testimony taken on behalf of Claimant. Dr. Irvin testified that the first time he saw Claimant was December 17, 2003, and that he had been treating Claimant about once a month for 17 months.

Dr. Irvin opined that the Claimant was 100% disabled and is not able to seek or obtain gainful employment. Dr. Irvin's opinion seemed to be that Claimant's current psychiatric condition was related to the October 16, 2002 work incident. In his deposition of April 14, Dr. Irvin stated that Claimant's psychiatric illness "can be traced back to the original events." Dr. Irvin stated that Claimant gets "panicky" when around patients. This relates to his anxiety as opposed to depression.

Dr. Irvin testified in both depositions that his diagnosis is dependent on the history given by Claimant. Dr. Irvin was not provided any treatment records of Claimant, and he totally relied upon the credibility and accuracy of what Claimant told him. Dr. Irvin testified that Claimant did not inform him of any prior treatment for anxiety. Dr. Irvin also agreed that he sent Claimant to Dr. Schwabo for therapy, and that Dr. Schwabo's records state that Claimant's condition began when he was hospitalized. Claimant did not start treatment with Dr. Irvin until after he was hospitalized in August 2003.

Dr. Gregg Bassett testified by deposition December 15, 2005. Dr. Bassett saw Claimant on two occasions. Dr. Bassett performed a psychiatric independent medical examination (IME) of Claimant. The exam included two separate psychological tests administered by Dr. Richard Wetzel of Washington University School of Medicine. Dr. Bassett prepared a 53-page report with an appendix. Dr. Bassett diagnosed Claimant with: somatoform disorder, factitious disorder, malingering, depressive disorder and anxiety disorder. He specifically mentions that each of these, with the exception of the depressive disorder, were pre-existing. Dr. Bassett testified that he would still agree with the findings in his report. In his report he opined that Claimant was 41.25 to 61.25% disabled due to the psychiatric disorder. Dr. Bassett testified that giving Claimant the benefit of the doubt, 50% of that disability was attributed to the work injury. He also testified that realistically, he didn't think Claimant could work. Further, he felt that when Claimant was observed by him, he appeared to be physically more impaired than when he was not aware he was being observed. Claimant would not execute a release for Dr. Bassett to receive all of his previous treatment records from Dr. Abbott.

Dr. Russell Cantrell testified by deposition on December 8, 2005. Dr. Cantrell had performed two IME's on Claimant, August 12, 2003 and November 7, 2005. Dr. Cantrell testified that Claimant does not require any further treatment to cure and relieve the effects of the October 16, 2002 work injury. Dr. Cantrell testified that he does not feel that Claimant has any permanent partial disability as a result of the October 16, 2002 work injury. After reviewing the record, Dr. Cantrell could not find any objective medical evidence to support Claimant's complaints. Dr. Cantrell testified that he is not a psychiatrist and that a psychiatrist is in a better position to diagnose and treat depression.

Other medical evidence was introduced in the form of medical records as exhibits. The exhibits introduced are as follows:

Claimant's Exhibits:

- A. Records from Unity Health
- B. Records from Pain Management Services
- C. Records from Dr. David Strege
- D. Records from Dr. David Abbott
- E. Records from Dr. William Irvin, Jr.
- F. Records from Dr. Anthony Guarino
- G. Records from SSM Health Care – Excluded on objection by Employer,
- H. Records from SSM Health Care – Excluded on objection by Employer,
- I. Records of prescriptions from Walgreens
- J. This exhibit was withdrawn
- K. Report of Dr. Gregg Bassett.
- L. Interpretive Report - MCMI-III test
- M. Interpretive Report – MMPI-2 test
- N. Interpretive report of Dr. Richard D. Wetzel
- O. Deposition transcript of Dr. David Abbott
- P. Deposition transcript of Dr. Gregg Bassett
- Q. Deposition transcript of Dr. Raymond Cohen
- R. Deposition transcript of Dr. William Irvin, Jr.
- S. Life Care Plan prepared by Geraldine Breite – There was no formal motion made for this exhibit to be received as evidence, and therefore it was not received into evidence.

Employer's Exhibits:

1. Deposition transcript of Dr. Russell Cantrell
2. Deposition transcript of Dr. Gregg Bassett
3. Certified copies of Division of Workers' Compensation file for Injury Number 97-028743
4. Settlement Records of Nebraska Workers' Compensation Court

5. Notice of Lien for Delinquent Child Support
6. Records of Dr. Bruce Schlafly
7. Records of Dr. David B. Robson
8. Records of Dr. Phillip G. George
9. Records of Dr. Dale E. Doerr
10. Tax records of Claimant for the year 2004

There was an additional exhibit marked as Court's Exhibit I, which is an itemized bill for services rendered by attorney Theodore Pashos.

This Administrative Law Judge left evidence open until February 7, 2006 for Claimant to submit medical bills from a hospitalization at St. Mary's Hospital in late December 2005 and January 2006 as an exhibit for consideration of admission as part of the evidentiary record. Claimant, through counsel, submitted 17 bills from June 12, 2004 to February 1, 2006, which was after the hearing dates of this case. In light of the fact that this exhibit is far beyond the scope of the parameters set forth for submission of additional medical bills, this exhibit is not admitted into evidence.

FINDINGS OF FACT AND RULINGS OF LAW

Based on the substantial and competent evidence, including Claimant's testimony, my personal observations of Claimant, deposition testimony, the medical records, and all the other evidence of record, I find as follows:

Based on his actions and testimony in the hearing, as well as his conduct and candor with physicians, Claimant is not a credible witness. During the hearing on this matter, Claimant constantly winced as if in unbearable pain, changed position often with exaggerated grimaces and groans, and on several occasions tinkered with his TENS unit as if he couldn't get pain relief. These constant and acute symptoms some three years after the work incident are alleged to be the result of an injury that he did not even bother to report to his personal physician, much less complain of any discomfort, only 13 days after the incident.

During direct examination, Claimant could not remember if he was hospitalized in August of 2003 or 2004 and seemed to ponder this until prompted by his own attorney that the time he was alleged to be in a narcotic coma was in 2003. Then, under cross-examination, when asked about the same incident at St. Mary's Hospital in August 2003, Claimant, without hesitation, recalled the exact date of August 14, 2003 and stated he knew it because it was close to his birthday. Claimant also testified that he could not remember the settlement of his Workers' Compensation claim in 1999 for Injury Number 97-028743 (Employers Exhibit #3), in which he received over eleven thousand dollars. The stipulation he could not remember signing also included permanent partial disability to his back and left arm, the very parts of the body he is alleged to have injured in the present case.

Claimant, who is a critical care nurse, is certainly in a position to understand the importance of an accurate medical history in diagnosis and treatment. Yet he repeatedly left out important parts of his medical history when being evaluated and treated. It seems to be more than mere coincidence that the facts omitted were most often facts that were detrimental to Claimant's case.

Regarding his alleged psychiatric injury, he failed to inform his treating physician Dr. Irvin, that he had been treated for anxiety prior to the October 16, 2002 work injury. (Exhibit R, Deposition of Dr. Irvin, p. 80, ln. 9). In his testimony, Dr. Irvin stated that he totally relied on the credibility and accuracy of the history provided and that his opinions on causation are dependant upon the accuracy of the history. (Exhibit R p.79, ln. 4-12). Dr. Irvin also acknowledged that Claimant reported that the onset of depression was August 2003 (Exhibit R p.32, ln.20), nine months after the work incident. However, August 2003 is the same month as his alleged coma incident at St. Mary's Hospital, which Claimant testified had caused mental injuries with physical manifestations. Dr. Schwabo apparently also attributed Claimants psychiatric injuries to the event at St. Mary's, as that was she stated was the cause in her letters to Claimant's attorney. (Exhibit R, beginning p.82, ln.14).

Claimant also refused to execute authorizations for Dr. Bassett to procure his entire medical history, for Dr. Bassett to use in his evaluation of Claimant. Dr. Bassett also noted that Claimant seemed to exaggerate his pain and impairment, and he appeared to be physically more impaired then when he was not aware he was being observed. (Exhibit P, Deposition of Dr. Bassett, beginning on p.20, ln.4).

Regarding his alleged physical injuries, Claimant engaged in similar behavior. He did not inform his treating physician, Dr. Abbott, that he had RSD prior to October 2002. In fact, under cross-examination, Dr. Abbott stated that if Claimant had RSD prior to 2002, it would seem to say the RSD is not related to the work injury. (Exhibit O, Deposition of Dr. Abbott, p.46 beginning ln.9).

Claimant again concealed the history of his two prior work related injuries and his long history of treatment for back pain from Dr. Cohen during his evaluation for a disability rating. Although he had a prior Workers' Compensation settlement from Nebraska in 2002 for 20% of the left upper extremity (Employer's Exhibit 4), and a Workers' Compensation

settlement from Missouri in 1999 for 5% of the BAW at the lumbar spine and 7.5% of the left elbow (Employer's Exhibit 3), he gave Dr. Cohen a history that included no prior arm injuries and that he had only treated one time about 20 years ago for his back. (Exhibit Q, Deposition of Dr. Cohen, pp. 24-31). Claimant also failed to disclose that he had been treating with Dr. Abbott since 1997 for chronic back pain. Dr. Cohen testified that he relied on the history given. (Exhibit Q, p.35, ln.23-25).

The Division is charged with the responsibility of passing upon the credibility of witnesses. It may disbelieve testimony of a witness even though no contradictory or impeaching information is introduced. *Lawson v. Emerson Electric Co.*, 833 S.W.2d 467, 470 (Mo.App. S.D. 1992); *Page v. Green*, 686 S.W.2d 528, 530 (Mo.App., S.D. 1985).

The inconsistencies in his testimony, his demeanor at hearing, and the omission of clearly relevant history to physicians, coupled with Dr. Bassett's diagnosis that Claimant is a somatoform and malingerer, render Claimant's testimony completely unreliable. His complete lack of candor to physicians has rendered, by their own admissions, their opinions as to causation and extent of disability, to be unreliable. If causation and extent of disability remain unproven, opinions regarding liability for past medical bills and future medical treatment become mere speculation. The only physician provided with an accurate factual and medical history, Dr. Russell Cantrell, testified that Claimant has no permanent disabilities, that he is at maximum medical improvement, and that he needs no future medical treatment as a result of the October 16, 2002 work injury.

The party claiming benefits under The Workers' Compensation Law for the State of Missouri bears the burden of proving all material elements of his or her claim. *Duncan v. Springfield R-12 School District*, 897 S.W.2d 108, 114 (Mo. App. S.D. 1995), *citing Meilves v. Morris*, 442 S.W.2d 335, 339 (Mo. 1968); *Brufat v. Mister Guy, Inc.* 933 S.W.2d 829, 835 (Mo. App. W.D. 1996); and *Decker v. Square D Co.* 974 S.W.2d 667, 670 (Mo. App. W.D. 1998). It is axiomatic that the employee bears the burden of proving all elements of his claim for compensation, including whether his injury arose out of and in the course of his employment. *Duncan v. Springfield R-12 School District*, 897 S.W.2d 108, 114 (Mo.App. 1995). Proof of causation cannot be made based on surmise or speculation. *Griggs v. A.B. Chance Co.*, 503 S.W.2d 697 (Mo.App. 1973).

Claimant has failed to meet his burden of proof of establishing a causal connection between the events of October 16, 2002 and his alleged injuries, that Employer owes for past medical treatment, that he suffers any permanent disability from this incident, and that he is entitled to an award of future medical benefits. As no benefits are awarded, the issue of whether Attorney Theodore Pashos is entitled to enforce an attorney's lien is moot.

CONCLUSION

Claimant was kicked in the shoulder by a patient on October 16, 2002 while he was an employee for Employer. Employer has paid temporary total disability benefits in the amount of \$108,336.73 and medical benefits in the amount of \$128,694.57. Claimant has failed to prove with competent and substantial evidence entitlement to any further benefits.

Date: _____

Made by: _____

Grant C. Gorman
Administrative Law Judge
Division of Workers' Compensation

A true copy: Attest:

Patricia "Pat" Secret
Director
Division of Workers' Compensation