

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

Injury No. 05-135562

Employee: Robby Gower

Employer: Technical Plastics

Insurer: Fidelity & Guaranty Insurance Co.

The above-entitled workers' compensation case is submitted to the Labor and Industrial Relations Commission (Commission) for review as provided by § 287.480 RSMo. Having reviewed the evidence and considered the whole record, the Commission finds that the award of the administrative law judge is supported by competent and substantial evidence and was made in accordance with the Missouri Workers' Compensation Law. Pursuant to § 286.090 RSMo, the Commission affirms the award and decision of the administrative law judge dated May 19, 2014, and awards no compensation in the above-captioned case.

The award and decision of Administrative Law Judge Maureen Tilley, issued May 19, 2014, is attached and incorporated by this reference.

Given at Jefferson City, State of Missouri, this 23rd day of October 2014.

LABOR AND INDUSTRIAL RELATIONS COMMISSION

John J. Larsen, Jr., Chairman

James G. Avery, Jr., Member

Curtis E. Chick, Jr., Member

Attest:

Secretary

ISSUED BY DIVISION OF WORKERS' COMPENSATION

FINAL AWARD

Employee: Robby Gower

Injury No. 05-135562

Dependents: N/A

Employer: Technical Plastics

Additional Party: N/A

Insurer: Fidelity & Guaranty Ins. Co.

Hearing Date: February 19, 2014

Checked by: MT/rmm

SUMMARY OF FINDINGS

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? No.
4. Date of alleged accident or onset of alleged occupational disease? December 1, 2005.
5. State location where alleged accident occurred or alleged occupational disease contracted: Butler 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? See findings.
8. Did alleged accident or alleged occupational disease arise out of and in the course of the employment? No.
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: Employee testified that he was pushing a 1,500-pound Gaylord (a large container) when he slipped and fell to the ground. He stated he injured his back from this incident.
12. Did accident or occupational disease cause death? No.
13. Parts of body alleged to be injured by accident or occupational disease: Lumbar spine.
14. Nature and extent of any permanent disability: None.
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: See findings.
18. Employee's average weekly wage: \$429.29.
19. Weekly compensation rate: \$286.19.
20. Method wages computation: By agreement.
21. Amount of compensation payable: None.
22. Second Injury Fund liability: None.
23. Future requirements awarded: See findings.

FINDINGS OF FACT AND RULINGS OF LAW

On February 19, 2014, the employee, Robby Gower, appeared in person and with his attorney, Ronald Little, for a hearing for a final award. The employer was represented at the hearing by its attorney, Shelly Wilson. 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. **Covered Employer:** Employer was operating under and subject to the provisions of the Missouri Workers Compensation Act and liability was fully insured by Fidelity & Guaranty Insurance Co.
2. **Covered Employee:** On or about December 1, 2005, Robby L. Gower was an Employee of Technical Plastics and was working under the Workers' Compensation Act.
3. **Statute of Limitations:** Employee's claim was filed within the time allowed by law.
4. **Average Weekly Wage and Rate:** Employee's average weekly wage was \$429.29 resulting in a weekly compensation rate for all purposes of \$286.19.
5. **Medical Aid furnished by Employer/Insurer:** None.
6. **Temporary Disability paid by Employer/Insurer:** None.

ISSUES:

1. **Accident:** Did Employee sustain an accident arising out of and in the course of his employment on or about December 1, 2005?
2. **Notice:** Did Employer have notice of Employee's accident?
3. **Medical Causation:** Was Employee's injury medically causally related to his work accident?
4. **Previously Incurred Medical Aid:** Is Employee entitled to be reimbursed for the expense of his previously incurred medical aid in the total amount of \$201,894.80? Employer/Insurer dispute the authorization, reasonableness, necessity and causal relationship of this previously incurred medical a
5. **Mileage under Section 287.140 RSMo.:** Is Employee entitled to be reimbursed for his medical miles traveled in the total amount of \$301.39?

6. **Future Medical Aid:** Is Employee entitled to an award of future medical aid?
7. **TTD:** Is Employee entitled to temporary total disability benefits for the period December 23, 2005 - December 29, 2007 (105.29 weeks) for a total of \$30,131.71?
8. **Permanent Disability:** What is the nature and extent of Employee's disability?

EXHIBITS:

Employee's Exhibits: The following exhibits were admitted into evidence, without objection, on behalf of Employee:

- Exhibit A - 10/09/2012 IME Report from Dr. Thomas Musich (offered under Section 287.210.7 RSMo).
- Exhibit B - Missouri Department of Corrections - Medical Records: 2/22/90 to 4/26/05.
- Exhibit C - Haven Hills Medical Clinic - Medical Records: 10/31/05.
- Exhibit D - Dr. Kimberly Schisler - Medical Records and Bills: 12/7/05 to 7/12/06.
- Exhibit E - Poplar Bluff Regional Medical Center - Medical Records and Bills: 12/28/05 to 10/19/11.
- Exhibit F - Bluff Radiology Group/Cape Radiology Group - Medical Records and Bills: 12/29/05 to 1/7/08.
- Exhibit G - Dr. Kee Park - Medical Records and Bills: 12/29/05 to 3/16/06.
- Exhibit H - St. Francis Medical Center - Medical Records and Bills: 12/29/05 to 1/2/06.
- Exhibit I - St. Francis Home Medical Equipment - Medical Records and Bills: 1/2/06 to 10/26/06.
- Exhibit J - Kneibert Clinic/Dr. W.H. Elliot - Medical Records and Bills: 10/31/06 to 9/5/08.
- Exhibit K - Advanced Healthcare /Dr. Davis - Medical Records and Bills: 5/5/06 to 12/11/06.
- Exhibit L - Tinsley Medical Clinic - Medical Records: 12/12/07.
- Exhibit M - Cape Anesthesia Group - Medical Bills: 12/30/05.
- Exhibit N - Letassy Pharmacy - Medical Bills: 3/13/06 to 4/12/06.
- Exhibit O - East Side Discount Pharmacy - Medical Bills: 5/5/06 to 3/30/11.
- Exhibit P - Key Drugs - Medical Bills: 4/8/06 to 12/11/07.
- Exhibit Q - Kneibert Clinic Pharmacy - Medical Bills: 1/2/08 to 9/30/08.
- Exhibit R - Unpaid Temporary Total Disability (chart).
- Exhibit S - Unpaid Mileage (chart).
- Exhibit T - Wage Statement.
- Exhibit U - Attorney Contract.

Employer/Insurer Exhibits: The following exhibit was admitted into evidence, without objection, on behalf of Employer/Insurer:

- Exhibit 1 - Deposition of David Lange, M.D. w/medical report and CV.

FINDINGS OF FACT:

Employee's Trial Testimony

Employee testified that he is 45 years old. He attended high school through the 10th grade and obtained his GED in 1988. Employee stated that he attended vocational school for hydraulics through the Missouri Department of Corrections. He also attended vocational school to obtain his CDL, which he obtained approximately 5 months ago. Employee testified that he was in the Coast Guard for one year, but was ultimately discharged due to his inability to adapt to life on a boat.

On direct examination, Employee testified that he was incarcerated from May 1998 through April, 2005 for distribution, delivery, and manufacture of a controlled substance. He also testified to serving 1½ years in prison in approximately 1990 or 1991 for auto theft. Further, Employee testified on direct examination that he has been incarcerated twice since December 2005. In late 2006 or early 2007, he was incarcerated for 30 to 40 days for parole violations. Employee was again incarcerated for 14 months in 2009 for parole violations due to noncompliance with his conditions of parole.

On cross examination, Employee testified that he was incarcerated in 1988 or 1989 for stealing. He admitted serving three years at that time. He further testified that he was incarcerated in the early 1990's for driving without a license.

Employee testified that he began working for Employer in May 2005. He denied any physical limitations at the time.

Employee testified that he experienced prior complaints with his back, including soreness and stiffness. He testified on direct examination that these complaints began in 2000 or 2001, when he was jumped in prison. He stated that, following that altercation, he experienced stiffness and soreness in his back, but never experienced any complaints of radiating pain. Employee testified that he did not receive medical treatment following the altercation. After the altercation, he would occasionally seek medical treatment in prison for complaints of stiffness and soreness in his back. He estimated that he sought treatment in prison for back complaints 5 to 10 times. He stated that he would be provided with Motrin and anti-inflammatory medication and that he would receive a "lay in" so that he could rest. He stated that his back always responded positively to this treatment.

On direct examination, Employee denied any problems with his back prior to his prison altercation. However, on cross examination, Employee testified that he had a back injury in 1994. He stated that he was helping his father build a house when he was struck in the back by a two-by-four. He admitted to wearing a brace for two to three months. He claimed to be unable to recall whether he saw a physician for this injury.

Employee testified on direct examination that he began working for Employer through a temporary service called Pro Staff, and then was hired directly by Employer. Employee testified

he last worked on December 23, 2005. Employee described his work as heavy pushing and pulling, with heavy lifting. He claimed he was able to perform this work, including lifting up to 75 pounds, alone. He indicated that he never asked for help due to back complaints.

Employee testified that, in late September 2005 or early October 2005, he sought treatment with Dr. Varma due to stiffness in his back. He also complained of soreness in his back at that time. He was provided with pain medication and his symptoms resolved. He indicated that he never followed up with Dr. Varma.

Employee testified that he was injured at work on December 1, 2005. He described pushing a 1,500 pound Gaylord (a large container) when he slipped and fell to the ground. Employee speculated that he slipped in oil leaking from a machine. Employee testified he experienced immediate pain in his left hip, low back, and left leg. He indicated that none of his co-workers saw him fall. He testified that both of his supervisors asked him why he was limping and he advised them of his work injury, but that he finished his shift.

Employee further testified that, the day following his alleged injury, his pain complaints continued and he asked for a substitute to perform his job. At that point, he testified he was put in a lighter position by Employer.

Employee testified that he made an appointment to see Dr. Schisler the following week. Employee selected Dr. Schisler on his own. He stated that Dr. Schisler was not selected for him by Employer. He explained the delay in seeking treatment by stating that he thought he was experiencing his "usual symptoms" and did not know that he had injured himself "that badly." On direct examination, Employee testified that he advised Dr. Schisler about his fall at work as well as the fight in prison. Employee indicated Dr. Schisler recommended an MRI of the lumbar spine, which was performed a few days later. Employee stated that he had never before undergone an MRI for his low back complaints.

On direct examination, Employee testified that, after his MRI, he was referred to Dr. Park, who saw him on December 29, 2005. Dr. Park recommended immediate surgical treatment. This was scheduled for the following morning. Employee described continued treatment with Dr. Park for three months.

Employee testified that he had lost his health insurance through his employer and therefore could not attend the physical therapy ordered by Dr. Park. Employee testified Dr. Park refused to treat him any longer after he lost his health insurance. He last saw Dr. Park in March 2006. He stated that, at that time, he was still using a walker because he had not yet recovered. Employee estimated that it took him two years to recover fully from his back surgery.

After Employee ceased treating with Dr. Park, he returned to Dr. Schisler to receive prescriptions. Employee then sought treatment with Dr. Davis, who also wrote prescriptions. Employee testified that, while treating with Dr. Davis, he tested positive for cocaine. As a result, Dr. Davis refused to treatment the Employee any longer. Employee then began a course of

medical care with Dr. Elliot. According to Employee, Dr. Elliot insisted on performing random drug tests, which Employee stated were all negative.

Employee was asked if he advised Dr. Musich and Dr. Lange of his prior low back complaints and treatment. There is no mention of any low back complaints or treatment predating December 2005 in the history given by Employee to either Dr. Musich or Dr. Lange. Despite this, Employee testified that he discussed prior low back complaints and treatment with each of these physicians.

Employee testified his current complaints include numbness and throbbing in his back, left leg, and left hip. He testified that his surgery with Dr. Park did improve his pain complaints. Employee testified that, prior to December 2005, he never before experienced complaints of weakness or numbness in his left leg or left foot drop.

Regarding the treatment Employee received in relation to his alleged accident and injury, Employee testified he never asked Employer to provide him with medical treatment. He never advised Employer that he planned to seek treatment with Dr. Schisler. Employee indicated he may have told his employer about his plan to receive treatment from Dr. Park, but he was uncertain.

Employee testified that he returned to work, full-time, in 2009 or 2010. He worked at a saw mill for 10 months, but was eventually let go because of absenteeism due to alleged back pain. He then worked at his cousin's saw mill for about a year until the mill was sold. He last worked in 2013 and has not worked full time due to an inability to find a job.

Currently, Employee testified that a typical day usually involves him hanging around the house. Some days, he claims that he is unable to get up. He performs some jobs. He is currently residing with a friend and babysits the friend's daughter in exchange for a place to live. He reported no steady income and stated that, on occasion, he is homeless.

Employee indicated that he is unable to bend or lift much over 5 to 10 pounds. Prolonged standing, sitting, and lying down are painful. He reports difficulty sleeping. He lays down for a significant period of time on a daily basis.

On cross-examination, Employee stated that he has never sought treatment at the Emergency Room for his current low back complaints. He stated that he cannot afford to treat in the Emergency Room.

Employee testified that he is not currently taking any pain medication. He stated that he does not take over the counter medication or prescription medication. Employee admitted to stealing pain pills from his friends whenever he has the opportunity to do so. He testified he sneaks into their bathrooms and steals prescription medication from their medicine cabinets. Aside from those pills that he steals from his "friends," Employee testified he does not take any other medication.

Employee stated that he applied for disability benefits in 2006, but was not able to pursue them due to his incarceration.

Employee's Treatment Records

As stated above, Employee was incarcerated several times and received treatment relating to his back throughout his numerous incarcerations. According to Medical Records from Missouri Department of Corrections, Employee received treatment to his back on August 20, 2001. Employee slipped getting down from his bunk and hurt his back. Further it was noted Employee had a prior back injury when he broke his back in 1994.

Two days later, Employee returned to the doctor complaining of severe back pain, requesting a "lay in" for no work. Employee was diagnosed with a back sprain and given a "lay in" for no work for three days.

On October 27, 2003, Employee complained of low back pain. He was provided medication and placed on activity restrictions. On October 29, 2003, Employee completed a "Medical Services Request" indicating he had back pain that was caused when he was hit across the lower back with a 60-pound truck tire.

Employee complained of back pain again on December 10, 2003. He reported he "pulled a muscle in his lower back" one day prior while throwing tires. Employee had difficulty bending over and was assessed with a back strain. X-rays of his lumbar and thoracic spine were taken on December 11, 2003. The thoracic X-ray did not reveal specific findings of fractures, spondylolisthesis, or significant degenerative changes. However, the lumbar X-ray revealed disk space narrowing at L5-S1 with subtle retrolisthesis.

On September 30, 2004, Employee reported that he twisted his knee and back at work and was feeling sharp pains in his back. Employee followed-up for his back pain on October 3, 2004, October 4, 2004, and October 5, 2004. Employee reported that he was carrying a chainsaw, when he stepped on loose rocks and stumbled. In trying to keep his balance, he strained his mid and lower back. He had decreased range of motion in thoracic and lumbar spine with paraspinal spasm at T10-L3.

Employee was seen back for his back complaints on October 14, 2004. He was given medication and placed on activity restrictions. On October 18, 2004, Employee was given a "lay in" for no work. He returned for further evaluation on October 21, 2004, complaining of persistent back pain after a fall while on a work crew. His "lay in" was renewed until November 30, 2004.

On October 28, 2004, Employee was still complaining of back pain. X-rays of his lumbar spine were performed, which were normal. On December 2, 2004, Employee again complained of back pain. He was assessed with impaired physical mobility.

On October 31, 2005, Employee presented at Haven Hills Medical Clinic complaining of low back pain. At that time, he was currently taking Hydrocodone.

Employee's alleged accident allegedly occurred on December 1, 2005.

On December 7, 2005, Employee presented to Dr. Schisler complaining of back and left hip pain. Pursuant to Dr. Schisler's report, Employee provided a history of being beaten while incarcerated. The records further indicated Employee was to have surgery due to the injuries he sustained during the attack, but was released from prison. Dr. Schisler diagnosed Employee with low back pain. Of note, there is nothing in Dr. Schisler's report which indicated Employee had a work injury or sustained an accident on December 1, 2005.

An MRI of Employee's lumbar spine was performed on December 20, 2005. A history of left leg weakness, low back pain and left hip pain was provided. The MRI revealed a large herniated disc at L4-5 posteriorly and to the left of midline compressing the left nerve root with inferior migration of the herniated disc.

On December 28, 2005, Employee presented to the Emergency Department at Poplar Bluff Regional Medical Center. The December 28, 2005 report documents the injury occurred at Employee's home. The records state that "earlier tonight he fell and reinjured his back." Additionally, it was noted that Employee was taking Hydrocodone and Ibuprofen. There was no mention of a work accident or injury. He was diagnosed with low back pain and referred to Dr. Park.

Dr. Park saw Employee on December 29, 2005. Dr. Park noted Employee was a "previously healthy" male, who reported slipping on oil at work on December 1, 2005, and felt a sharp pain down his back going into his hip and leg. It is important to note, this is the first indication Employee allegedly sustained an injury while at work. Further it is important to note, Dr. Park makes no reference to Employee's complaints while being incarcerated or his December 28, 2005 fall at home.

Dr. Park indicated Employee's December 20, 2005 MRI revealed an L4-5 broad disc herniation with severe canal stenosis and migrational fragment inferiorly and L5-S1 disc degeneration and collapse. He noted this caused L5 nerve root compression with foot drop. Dr. Park offered Employee surgical intervention the next day.

On December 30, 2005, Employee presented to St. Francis Medical Center for a pre-operative history and physical report and surgical intervention. The pre-operative report indicated Employee had a past medical and surgical history of "hemorrhoidectomy" and "only other medical history is of back pain from the back injury when he fell at work on December 1, 2005." The pre-operative report fails to mention Employee indicated he had a fall at home on December 28, 2005, that he sustained injuries from an attack when he was incarcerated, or that he received previous treatment to his back while incarcerated or prior to the alleged accident.

On that date, Dr. Park performed a L4-5 and L5-S1 bilateral laminotomy and microdiscectomy with microdissection; L4-5, L5-S1 posterior lumbar interbody fusion and placement of Tetris PEEK interbody spacers; L4-5 and L5-S1 posterolateral intertransverse fusion and posterior segmental fixation using Global system; Right iliac crest bone graft harvest through separate fascial incision, morselization of local bone for bone grafting; intraoperative fluoroscopy 3 hours; and lumbar puncture for injection of narcotics. Employee was discharged on January 2, 2006. He received a “wheeled walker” from St. Francis Home Medical Equipment on January 2, 2006.

Employee returned to Poplar Bluff Regional Medical Center on January 4, 2006, complaining of low back pain. Pursuant to the medical report, Employee was brought in by a friend because Employee was taking too much medication. It was noted that since the previous Tuesday, Employee took 23 Percocets and 17 Valium.

Employee followed-up with Dr. Park on January 25, 2006. Dr. Park noted Employee’s back and left hip pain had improved. He scheduled a follow-up in two months and refilled Employee’s prescription for Lorcet 10/650. On February 16, 2006, Employee called in for a refill on his medication and Dr. Park reduced the prescription from Lorcet 10/650 to Lorcet 7.5.

On February 23, 2006, Employee called in to Dr. Park’s office complaining of increased back pain and a bulge on his back. Employee was scheduled for an evaluation and provided refills of his prescriptions for Valium and Lorcet.

Employee returned for a follow-up with Dr. Park on March 8, 2006. Dr. Park noted Employee was doing reasonably well, but that he had complaints of numbness and weakness of his right hand. Dr. Park ordered a cervical MRI.

On March 13, 2006, Employee returned to Dr. Schisler. Dr. Schisler noted Employee was doing fairly well post-operatively, but that he needed prescription refills for pain and sleeplessness. Additionally, she noted Employee complained of right hand numbness and pain to his right neck. She ordered an MRI and EMG of Employee’s right upper extremity.

Employee followed-up with Dr. Park on March 16, 2006. Dr. Park noted Employee underwent a cervical spine MRI which was normal and there was no evidence of C8 nerve root compression.

On May 5, 2006, Employee presented to Dr. Davis at Advanced Healthcare complaining of low back pain. Employee returned to Dr. Schisler on May 12, 2006. Dr. Schisler indicated Employee was doing “ok”, but still had low back pain and neck pain. On June 5, 2006, Employee returned to Dr. Davis. Dr. Davis assessed Clamant with depression/anxiety, chronic low back pain and genital warts. Dr. Davis prescribed Employee Celexa, Lorcet, and continued Employee’s other medications. Further, Dr. Davis advised Employee to stay active and to increase his exercise and activities.

Employee returned to Dr. Davis on July 6, 2006. It was noted that Employee's back pain was unbearable at times and Dr. Davis recommended Employee undergo an MRI of his lumbar spine. Dr. Davis continued Employee's current medication and told him to diet, exercise and increase his water intake. The lumbar MRI was performed on July 10, 2006. It revealed postoperative changes at L4-5 and L5-S1, mild stenosis of spinal canal at L3-4, and degenerative disc disease of L3-4 disc. On July 13, 2006, Employee followed-up with Dr. Davis.

On August 10, 2006, Employee returned to Dr. Davis. Dr. Davis indicated Employee suffered from chronic low back pain, depression and anxiety. Employee's current medications were continued in addition to adding Methadone. Employee was instructed to monitor his diet closely and to stay active. On September 12, 2006, Dr. Davis noted Employee was doing "ok" and was able to function. On October 10, 2006, Employee was complaining of weight loss, no appetite, and side effects from his medication. His prescriptions were continued and he was given a Duragesic patch.

On October 31, 2006, Employee presented to Kneibert Clinic complaining of low back pain. It was noted that Employee's medications for his low back pain included Ultram, Naprosyn, Neurontin, and Celexa. Employee was instructed to follow-up in two weeks.

Employee visited Dr. Davis on November 7, 2006, for his back pain. It was noted that Employee was having "break through pain" before his next Duragesic patch was applied.

Employee last visited Dr. Davis on December 11, 2006. At that visit, Employee admitted to using alcohol, cocaine, and cigarettes. Dr. Davis diagnosed Employee with chronic low back pain, alcohol abuse, cocaine abuse, tobacco abuse, depression and anxiety. Interestingly, as indicated on all prior records from Dr. Davis, Employee denied smoking and drinking alcohol. Employee was obviously being untruthful to Dr. Davis about his tobacco, alcohol and cocaine use. In addition to admitting he used cocaine, Employee tested positive for cocaine on December 11, 2006.

On August 7, 2007, Employee presented at Poplar Bluff Regional Medical Center complaining of low back pain. He indicated he was changing a light bulb and fell off the first rung of a ladder. He was medicated with Dilaudid and Phenergan, diagnosed with acute low back pain and discharged.

Employee returned to Poplar Bluff Regional Medical Center on December 11, 2007, complaining of low back pain which started one day previously. He was diagnosed with chronic low back pain and fractured coccyx. Employee was medicated with Meperidine, Phenergan, and Toradol and received prescriptions for Vicodin and Motrin. On December 12, 2007, Employee presented at Tinsley Medical Clinic indicating he fell out of a truck on December 10, 2007, and needed pain medication. Employee was prescribed Celestone 6, Toradol, Medrol, Flexaril, Ibuprofen and Hydrocodone. Later that day, the pharmacist called to indicate his prescriptions for Ibuprofen and Hydrocodone were denied because he filled the same medications at Key Drugs the previous day.

On January 2, 2008, Employee presented to Kneibert Clinic complaining of back pain. Employee was prescribed Lorcet, Flexaril, and Lorcet Plus. He returned to Kneibert Clinic on January 7, 2008, for an evaluation with Dr. Elliot. X-rays were taken of his left hip which revealed normal alignment and a probable small cyst. Additionally, X-rays of his lumbar spine revealed postoperative changes at L3-S1. Employee was provided prescriptions for Percocet, Tizanidine, Neurontin and Naprosyn. Employee continued to receive care from Dr. Elliot through September of 2008.

On April 5, 2008, Employee reported his complaints of back pain had improved. On May 5, 2008, Employee indicated he was "better than ever." Employee complained of a flare up in his back and left hip pain on June 3, 2008. It was noted Employee had seen Dr. Soeter, who may have recommended an epidural injection. Employee last treated with Dr. Elliot on September 5, 2008.

On March 25, 2010, Employee presented at Poplar Bluff Regional Medical Center complaining of nausea and vomiting associated with headaches and back pain. He was diagnosed with atypical chest pain, elevated blood pressure and cervical radiculopathy.

On March 30, 2011, Employee presented at Poplar Bluff Regional Medical Center complaining of a left foot injury. Employee was diagnosed with a crush injury left foot, acute fracture of distal phalanx left great toe, and extensor tendon injury of left great toe.

On October 19, 2011, Employee presented at Poplar Bluff Regional Medical Center complaining of an injury to his left knee as a result of a direct blow. He was diagnosed with a ligamentous injury and abrasion of his left knee.

IME Report from Dr. Musich

Dr. Musich evaluated Employee for the purposes of an IME on October 9, 2013, upon the request of Employee's Counsel. Dr. Musich indicated Employee sustained acute low back trauma on December 1, 2005, while working for Employer.

Interestingly, Dr. Musich notes that Employee reported "sore muscles" in his low back while incarcerated in order to "skip work" and that Employee never noted persistent low back pain. Dr. Musich indicated Employee's treatment began when he was "referred" to Dr. Schisler following his December 1, 2005 work injury.

It is significant to note, Dr. Musich did not comment on Employee's medical records from Missouri Department of Corrections, which document numerous visits to the infirmary for his low back pain. Additionally, Dr. Musich did not comment or address the Haven Hills Medical Clinic October 31, 2005 medical record, which indicated Employee was complaining of low back pain. Moreover, Dr. Musich was not aware that Employee sought treatment with Dr. Varma, in late September 2005 or early October 2005, due to stiffness in his back.

In his report, Dr. Musich continually references to medical reports documenting a history of “work related trauma”. However, Dr. Musich failed to address Dr. Schisler’s December 7, 2005 record which identifies a significant back injury resulting from being beaten while incarcerated, nor does he address the December 28, 2005 Poplar Bluff Regional Medical Center report which documents Employee’s injury occurred when he fell in his home.

Dr. Musich goes on to described the treatment Employee received from Dr. Park.

Ultimately, Dr. Musich opined Employee suffered acute work related trauma adversely affecting his lumbosacral spine on December 1, 2005. He goes on to indicate that trauma was the prevailing factor in the development of acute and incapacitating low back pain and left lower extremity radiculopathy, which necessitated Employee’s medical treatment. Dr. Musich opined Employee sustained 50% permanent partial disability of the person as a whole due to Employee’s December 1, 2005 accident. He further indicated Employee did not have any disability prior to December 2005.

Deposition and IME Report from Dr. Lange

Dr. Lange evaluated Employee upon the request of Employer’s counsel on February 26, 2013. Dr. Lange’s report notes that Employee alleges he sustained an accident on December 1, 2005, when he slipped and fell. However, during the evaluation, Dr. Lange asked Employee if he had ever previously injured his back, to which Employee replied, “no...other than pulled muscles.”

However, Dr. Lange’s report documents an extensive history of back complaints and problems, dating back to 2001. Dr. Lange noted at least ten different reports that Employee hurt his back while he was incarcerated. Additionally, throughout the treatment Employee received while he was incarcerated, Dr. Lange noted he continually complained of persistent back pain, and on several occasions, pain radiating down legs and peripheral numbness.

Dr. Lange indicated Employee had a history of back pain going back to 2001, and as late as December 2004. He specifically noted that on December 7, 2004, Employee had back and left hip pain with left lower extremity weakness and “give away with leg.”

Dr. Lange diagnosed Employee with status post lumbar surgery for an L4-5 herniation with left lower extremity weakness; status post L5-S1 surgery for preoperative degenerative changes, not likely symptomatic prior to surgery, history of left lower extremity foot drop, now better, but with mild subjective residual dorsiflexion weakness; and by history a postoperative ulnar neuropathy, presumably related to intraoperative positioning.

However, Dr. Lange opined that it would be impossible to suggest that Employee’s work-related accident was the substantial reason for Employee’s complaints. Dr. Lange further stated Employee has 25% permanent partial disability relating to his diagnosis, but that the permanency is not attributable to Employee’s December 1, 2005 accident.

RULINGS OF LAW:

Issue 1. Accident

Employee has alleged that a work accident occurred on December 1, 2005.

On December 7, 2005, Employee presented to Dr. Schisler complaining of back and left hip pain. Employee provided a history of being beaten while incarcerated. The records further indicated Employee was to have surgery due to the injuries he sustained during the attack, but was released from prison. There is nothing in Dr. Schisler's report which indicated Employee had a work injury or sustained an accident on December 1, 2005.

Further, an MRI of Employee's lumbar spine was performed on December 20, 2005.

On December 28, 2005, Employee presented to the Emergency Department at Poplar Bluff Regional Medical Center. The December 28, 2005 report documents the injury occurred in his home. The records state that "earlier tonight he fell and reinjured his back."

Dr. Park saw Employee on December 29, 2005. Dr. Park noted Employee was a "previously healthy" male, who reported slipping on oil at work on December 1, 2005, and felt a sharp pain down his back going into his hip and leg. This is the first indication Employee allegedly sustained an injury while at work. Further it is important to note, Dr. Park makes no reference to Employee's complaints while being incarcerated or his December 28, 2005 fall.

Based on all of the evidence presented, including the medical records, I find Employee's testimony regarding the alleged work accident on December 1, 2005, was not credible. Therefore, I find that Employee did not meet his burden of proof that a work accident occurred on December 1, 2005, that was arising out of and in the course of his employment. Based on this finding, Employee's claim for compensation is denied. Furthermore, based on this ruling, the other issues are moot and shall not be ruled upon.

Employee: Robby Gower

Injury No. 05-135562

Made by:

Maureen Tilley
Administrative Law Judge
Division of Workers' Compensation