

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

Injury No.: 02-128697

Employee: Bennie Johnston
Employer: Arch Johnston Paving & Quarry
Insurer: Missouri Employers Mutual Insurance
Additional Party: Treasurer of Missouri as Custodian
of Second Injury Fund

This workers' compensation case is submitted to the Labor and Industrial Relations Commission (Commission) for review as provided by § 287.480 RSMo. We have reviewed the evidence, read the parties' briefs, heard the parties' arguments, and considered the whole record. Pursuant to § 286.090 RSMo, we modify the award and decision of the administrative law judge. We adopt the findings, conclusions, decision, and award of the administrative law judge to the extent that they are not inconsistent with the findings, conclusions, decision, and modifications set forth below.

Preliminaries

The parties asked the administrative law judge to resolve the following issues: (1) medical causation; (2) past medical in the amount of \$14,734.13; (3) future medical aid; (4) additional temporary total disability; (5) permanent total disability against the Second Injury Fund or employer; (6) permanent partial disability against the Second Injury Fund and/or employer; and (7) whether there was an overpayment of temporary total and temporary partial disability in the amount of \$1,157.47.

The administrative law judge rendered the following findings and conclusions: (1) employee's work was a substantial factor in causing employee to suffer a lumbar sprain, but the work was not a substantial factor in causing myofascial pain syndrome or any psychiatric injury; (2) employee's request for additional medical aid is denied; (3) employer is ordered to pay any unpaid bills from Dr. Klinginsmith as outlined in Exhibit U for dates of service from November 27, 2002, through February 14, 2003; (4) employer is not responsible for the payment of any other medical expenses outlined by the employee in Exhibit U; (5) employee's request for payment of any medical expenses associated with psychiatric conditions is denied; (6) employee's request for temporary total disability benefits after February 14, 2003, is denied; (7) employee's reporting of his complaints is not credible in light of inconsistencies between employee's complaints and the medical records; (8) the opinions of Dr. Tate and Mr. England are more credible than the opinions of Dr. Volarich and Mr. Dolan on the issue of permanent total disability; (9) employee did not prove that he was unemployable in the open labor market; (10) employee sustained a 10% permanent partial disability of the body as a whole referable to the lumbar spine from the November 27, 2002, work accident; (11) the Second Injury Fund does not have any liability for permanent partial disability because employee's primary injury did not meet the statutory threshold; and (12) employer is entitled to a credit for overpayment of benefits in the amount of \$1,157.47.

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Employee filed a timely Application for Review with the Commission alleging the administrative law judge erred in finding employee is not entitled to permanent total disability benefits, past medical benefits, future medical benefits, and temporary total disability.

We note that, after employee filed his Application for Review on March 7, 2013, the administrative law judge issued an Amended Final Award in this matter on March 8, 2013. The Amended Final Award issued March 8, 2013, is void, because the administrative law judge was prohibited under § 287.610.6 RSMo from acting after the filing of a timely Application for Review in this matter. *Farmer v. Barlow Truck Lines*, 979 S.W.2d 169, 170 (Mo. 1998). Consequently, we have disregarded the Amended Final Award issued March 8, 2013, and confined our review to the administrative law judge's award issued February 28, 2013.

On August 12, 2013, the Commission received employee's Motion To Strike Treasurer's Response To Appellant's Reply Brief (Motion). Employee argues that the Commission should strike the Second Injury Fund's Response to Appellant's Reply Brief because our rules do not specifically provide that a respondent may file a brief in response to an appellant's reply brief.

We note that employee's twenty-five page Application for Review contains an exhaustive recitation of facts and argument, and for all practical purposes, amounts to an additional "brief" by the employee. Taken together with employee's other filings, the Commission now has over sixty-five pages setting forth employee's position in this matter. Given these circumstances, and because this is a factually complex case involving numerous disputed issues, we see no reason to strike any portion of the Second Injury Fund's responsive filings. Employee's Motion is hereby denied.

Findings of Fact

The administrative law judge's award sets forth the stipulations of the parties and the administrative law judge's findings of fact as to the issues disputed at the hearing. We adopt and incorporate those findings to the extent that they are not inconsistent with the modifications set forth in our award. Consequently, we make only those findings of fact pertinent to our modifications herein.

Medical causation

Although the administrative law judge explicitly found Dr. Tate more credible than Dr. Volarich, she also found, contrary to the testimony of Dr. Tate, that claimant sustained permanent partial disability as a result of the primary injury. We agree with the administrative law judge's ultimate finding that claimant sustained 10% permanent partial disability as a result of the primary injury. In doing so, however, we must conclude that the opinion of Dr. Volarich is more credible than that of Dr. Tate as to the issues of causation and permanent partial disability.

Specifically, we find persuasive Dr. Volarich's opinion that employee's work for employer was a substantial factor causing him to sustain the resulting medical condition of a lumbar strain and permanent partial disability.

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Permanent total disability

The administrative law judge found that employee is not permanently and totally disabled, based on a finding that employee's testimony regarding his complaints lacks credibility, and a finding that Dr. Tate and Mr. England provided the more credible opinions regarding the issue of permanent total disability. Although the record certainly provides ample support for that result, we disagree for the following reasons.

Employee suffers from well-documented cognitive limitations and psychiatric difficulties. Employee attended special education courses in school until he entered the labor market after the fifth or sixth grade. Employee's testimony at the hearing reveals that he has a poor memory; employee was unable to recite his own Social Security number. Both psychiatric experts who testified agreed that employee suffers from an anxiety disorder, although the doctors disagree whether it was preexisting. We find particularly persuasive the testimony from Dr. Harbit that, although the primary injury did not cause employee's anxiety condition, the primary injury has certainly become the *focus* of employee's anxiety, to the extent that he now attributes all of his problems to that event. We interpret this as an opinion from Dr. Harbit that there is a synergistic interaction between employee's preexisting psychiatric disability and the effects of the primary injury.

Employee's denial of preexisting complaints and attribution of all of his problems to the primary injury thus appears to be a byproduct of cognitive and psychiatric difficulties, rather than any conscious attempt to mislead. Seen in this light, employee's poor memory and inconsistent testimony lend support to the opinions from both Drs. Harbit and Stillings that employee's cognitive and psychiatric problems significantly impact his employability. We note that Dr. Harbit went so far as to express her belief that employee is permanently and totally disabled on the basis of his preexisting conditions and lifelong cognitive limitations alone.

In light of the fact employee was working up to 60 hours per week performing heavy-duty work for employer at the time of the primary injury, and because "a test for probable future employment cannot change the fact of past employment" *Lturno v. Carnahan*, 640 S.W.2d 470, 473 (Mo. App. 1982), we do not find persuasive Dr. Harbit's suggestion that employee was permanently and totally disabled *before* the primary injury. We do, however, find persuasive her opinion that employee suffered from preexisting borderline intellectual functioning and an anxiety disorder at the time of the primary injury, and that these diagnoses amounted to permanent disabling conditions that significantly impacted his employability. We also accept Dr. Harbit's opinions that employee did not suffer any additional psychiatric disability due to the primary injury, that employer has no liability for future psychiatric care, and that there is a synergistic effect between employee's preexisting psychiatric disability and the effects of the primary injury.

Mr. Dolan opined that employee is permanently and totally disabled owing to a combination of his preexisting cognitive and psychiatric problems and the effects of the primary injury. Mr. Dolan pointed to decades of experience in working with individuals with low IQs, and explained that individuals with very low intellectual functioning are dependent upon their physicality to get through the world. A physical injury is thus far more devastating to such an individual, as they've lost their sole asset in terms of employability. Turning to the

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opinions from Mr. England, we note that he opined that if the fact-finder accepts the opinions from Drs. Volarich and from Dr. Stillings (who, like Dr. Harbit, opined that employee suffers from considerable preexisting psychiatric disability) employee is permanently and totally disabled owing to a combination of his preexisting conditions with the effects of the primary injury. In this respect, Mr. England's testimony does not strike us as significantly inconsistent with that of Mr. Dolan.

In light of our findings with respect to employee's preexisting psychiatric and cognitive disabilities, we deem Mr. Dolan's ultimate opinions regarding permanent total disability to be the most persuasive on this record. Accordingly, we adopt Mr. Dolan's opinion that employee is permanently and totally disabled owing to a combination of his preexisting disabling conditions and the effects of the primary injury. We find that employee reached maximum medical improvement from the effects of the primary injury on February 14, 2003.

Conclusions of Law

Medical causation

Section 287.020.2 RSMo sets forth the standard for medical causation applicable to this claim and provides, in relevant part, as follows:

An injury is compensable if it is clearly work related. An injury is clearly work related if work was a substantial factor in the cause of the resulting medical condition or disability.

We have modified the credibility findings of the administrative law judge and found that Dr. Volarich is more credible than Dr. Tate on the issue of medical causation. We conclude that work was a substantial factor in causing employee to suffer the resulting medical condition of a lumbar strain, as well as permanent partial disability to the extent of 10% of the body as a whole referable to the lumbar spine.

Unpaid and authorized past medical expenses

The administrative law judge ordered employer to pay all authorized and unpaid medical expenses relating to treatment from Dr. Klinginsmith, but also concluded that employer is not liable for any of the other medical expenses reflected in employee's Exhibit U. See *Award*, page 26. We agree with this result, although we note that the administrative law judge applied the "substantial factor" test for medical causation in her analysis under § 287.140 RSMo. The courts have made clear that the appropriate test under § 287.140 is whether the disputed treatments were reasonably required to cure and relieve the effects of the work injury. *Tillotson v. St. Joseph Med. Ctr.*, 347 S.W.3d 511, 518 (Mo. App. 2011). We wish to make clear that we have applied the appropriate test in our analysis, and that we decline to award additional past medical expenses to employee because he has failed to persuade us that his self-directed medical treatments after February 14, 2003, were reasonably required to cure and relieve the effects of his lumbar strain injury.

We note that employee argues, in his brief, that the administrative law judge's award failed to include the costs of an MRI ordered by Dr. Klinginsmith. Employee fails to explain how the administrative law judge's award works that effect, and also fails to provide a citation to the record where the disputed bill and treatment records may be found.

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To the extent that such a clarification appears to be necessary, we specifically conclude that employer is liable for all authorized and unpaid medical expenses incurred through February 14, 2003. This, of course, includes the aforementioned bill from Health South Diagnostic Center in the amount of \$1,100.00 for an MRI ordered by Dr. Klinginsmith on January 22, 2003.

Second Injury Fund liability

Section 287.220 RSMo creates the Second Injury Fund and provides when and what compensation shall be paid in "all cases of permanent disability where there has been previous disability." As a preliminary matter, the employee must demonstrate "a preexisting permanent partial disability whether from compensable injury or otherwise, of such seriousness as to constitute a hindrance or obstacle to employment or to obtaining reemployment if the employee becomes unemployed..." *Id.* The Missouri courts have articulated the following test for determining whether a preexisting disability constitutes a "hindrance or obstacle to employment":

[T]he proper focus of the inquiry is not on the extent to which the condition has caused difficulty in the past; it is on the potential that the condition may combine with a work-related injury in the future so as to cause a greater degree of disability than would have resulted in the absence of the condition.

Knisley v. Charleswood Corp., 211 S.W.3d 629, 637 (Mo. App. 2007)(citation omitted).

We have found that employee suffered from preexisting permanent partially disabling psychiatric and cognitive conditions at the time he sustained the primary injury. We are convinced these conditions were serious enough to constitute hindrances or obstacles to employment. This is because we are convinced employee's preexisting psychiatric and cognitive conditions had the potential to combine with a future work injury to result in worse disability than would have resulted in the absence of the conditions. See *Wuebbeling v. West County Drywall*, 898 S.W.2d 615, 620 (Mo. App. 1995).

Having found that employee suffered from preexisting permanent partially disabling conditions that amounted to hindrances or obstacles to employment, we turn to the question whether the Second Injury Fund is liable for permanent total disability benefits. In order to prove entitlement to such an award, employee must establish that: (1) he suffered a permanent partial disability as a result of the last compensable injury; and (2) that disability has combined with a prior permanent partial disability to result in total permanent disability. *ABB Power T & D Co. v. Kempker*, 236 S.W.3d 43, 50 (Mo. App. 2007). Section 287.220.1 requires us to first determine the compensation liability of the employer for the last injury, considered alone. If employee is permanently and totally disabled due to the last injury considered in isolation, the employer, not the Second Injury Fund, is responsible for the entire amount of compensation. "Pre-existing disabilities are irrelevant until the employer's liability for the last injury is determined." *Landman v. Ice Cream Specialties, Inc.*, 107 S.W.3d 240, 248 (Mo. 2003).

We have adopted the administrative law judge's finding that employee sustained permanent partial disability as a result of the primary injury, and adopted the expert opinion

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from Mr. Dolan that employee's permanent total disability results from a combination of his preexisting psychiatric and cognitive disability with the effects of the primary injury. We find that employee is not permanently and totally disabled as a result of the last injury considered in isolation.

We conclude employee is permanently and totally disabled owing to a combination of his preexisting disabling conditions with the effects of the primary injury. The Second Injury Fund is liable for permanent total disability benefits.

Conclusion

We modify the award of the administrative law judge as to the issues of permanent total disability and Second Injury Fund liability.

The Second Injury Fund is liable for weekly permanent total disability benefits beginning February 14, 2003, at the differential rate of \$65.65 for 40 weeks. Thereafter, the Second Injury Fund shall pay weekly permanent total disability benefits at the stipulated rate of \$405.77. The weekly payments shall continue thereafter for employee's lifetime, or until modified by law.

The award and decision of Administrative Law Judge Maureen Tilley, issued February 28, 2013, is attached hereto and incorporated herein to the extent not inconsistent with this decision and award.

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

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

Given at Jefferson City, State of Missouri, this 1st day of November 2013.

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: Bennie Johnston

Injury No. 02-128697

Dependents: N/A

Employer: Arch Johnston Paving & Quarry

Additional Party: Second Injury Fund

Insurer: Missouri Employers Mutual Insurance

Hearing Date: November 29, 2012

Checked by: MT/rmm

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: November 27, 2002.
5. State location where accident occurred or occupational disease was contracted: Jefferson County, Missouri.
6. Was above employee in employ of above employer at time of alleged accident or occupational disease? Yes.
7. Did employer receive proper notice? Yes.
8. Did accident or occupational disease arise out of and in the course of the employment? Yes.
9. Was claim for compensation filed within time required by Law? Yes.
10. Was employer insured by above insurer? Yes.
11. Describe work employee was doing and how accident occurred or occupational disease contracted: The employee was involved in a motor vehicle accident.

12. Did accident or occupational disease cause death? No.
13. Part(s) of body injured by accident or occupational disease: The parties stipulate that the employee injured his low back in the accident. All other claimed parts of the body injured are in dispute. This includes Employee's alleged psychiatric injury and Employee's alleged myofascial pain syndrome.
14. Nature and extent of any permanent disability: See findings.
15. Compensation paid to-date for temporary disability: \$5,147.64.
16. Value necessary medical aid paid to date by employer/insurer? The employer/insurer paid \$6,356.72 in medical expenses.
17. Value necessary medical aid not furnished by employer/insurer? See findings.
18. Employee's average weekly wages: \$608.66.
19. Weekly compensation rate: The rate for temporary total disability benefits is \$405.77. The employee is at the maximum rate of \$340.12 for permanent partial disability benefits.
20. Method wages computation: By stipulation.
21. Amount of compensation payable:
 - Unpaid medical expenses: None.
 - Weeks of temporary total disability (or temporary partial disability): None.
 - Weeks of permanent partial disability from Employer: The employee is entitled to a payment of 10% of the body as a whole or 40 weeks of permanent partial disability.
 - Permanent total disability benefits: None.
22. Second Injury Fund liability: None.
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: Dean Christianson.

FINDINGS OF FACT AND RULINGS OF LAW

On November 29, 2012, the employee, Bennie Johnston, appeared in person and with his attorney, Dean Christianson, for a hearing on final award. The employer was represented at the hearing by its attorney, Kenneth Voigt. The Second Injury Fund was represented by Attorney Kevin Nelson. At the time of the hearing, the parties agreed on certain undisputed facts and have identified the issues in dispute. These undisputed issues, together with the Findings of Fact and Rulings of Law are set forth below as follows:

UNDISPUTED FACTS:

1. Covered Employer: The employer, Arch Johnston Paving & Quarry, Inc. was operating under and subject to the provisions of the Missouri Workers' Compensation Act and liability was fully insured by Missouri Employers Mutual.
2. Covered Employee: On or about the date of the alleged accident, the employee was an employee of Arch Johnston Paving Quarry, Inc. and was working under the Missouri Workers' Compensation Act.
3. Accident: On or about November 27, 2002, the employee sustained an accident arising out of and in the course of his employment.
4. Notice: The employer had notice of employee's accident.
5. The Claim for Compensation was filed within the statute of limitations.
6. Average weekly wage and rate: The parties have stipulated that the average weekly wage is \$608.66. The parties have stipulated to the rate for temporary total and permanent total disability benefits of \$405.77 with a corresponding maximum rate for permanent partial disability of \$340.12.
7. The parties stipulate that the employer/insurer have paid medical aid totaling \$6,356.72.
8. The parties stipulate that the employer/insurer has paid temporary total disability benefits for the period of December 7, 2002 through December 16, 2002, in the amount of \$726.20. The employer/insurer has paid temporary partial disability benefits for the period of December 17, 2002 through January 13, 2003, in the amount of \$1,444.02. The employer/insurer has paid temporary total disability benefits for the period of January 15, 2003 through February 24, 2003, in the amount of \$2,977.42.
9. The parties stipulated that the employer/insurer has paid the medical bills of Charles Klinginsmith, M.D. for the period of November 30, 2002 through February 7, 2003. The employee and employer/insurer stipulate to a hold harmless agreement for the bills of Dr. Klinginsmith for the time period of November 30, 2002 through February 7, 2003 as the

employer/insurer assert that they have paid for the bills from Dr. Klinginsmith for this time period.

ISSUES:

1. Medical causation: Is the employee's injury of November 27, 2002, the substantial factor in the development of the employee's ongoing: a. Low Back Condition and b. Psychiatric Condition?
2. Previously incurred medical: The employee is claiming that he is entitled to reimbursement for previously incurred medical expenses as outlined in Exhibit U. The amount claimed is \$14,734.13. The employer/insurer is disputing this claim based on authorization, reasonableness, necessity and causal relationship.
3. Future medical aid: The employee is also claiming that the employee is entitled to future medical care.
4. Temporary total disability benefits: The employee is claiming that he is entitled to temporary total disability benefits after February 14, 2003.
5. Permanent total disability benefits: The employee is claiming that he is entitled to permanent total disability benefits against the Second Injury Fund or the employer/insurer.
6. Permanent partial disability: The employee is claiming that he is entitled to permanent partial disability benefits against either the employer/insurer or the Second Injury Fund.
7. Is the employer/insurer is claiming that they are entitled to a credit for overpayment of TTD and TPD in the amount of \$1,157.47.

EXHIBITS

The following exhibits were offered and admitted into evidence:

Employee's Exhibits:

- A. Deposition of Dr. Volarich.
- B. Deposition of Dr. Stillings.
- C. Deposition of Stephen Dolan.
- D. Medical records of Abercrombie Family Medicine.
- E. Medical records of Dr. Anderson.
- F. Medical records of Jefferson Regional Medical Center.
- G. Medical records of Dr. Enger.
- H. Medical records of Dr. McGarry.

- I. Medical records or ProRehab.
- J. Medical records of Dr. Krewet.
- K. Medical records of Vista Imaging of Jefferson County.
- L. Medical records of Open MRI of Jefferson County.
- M. Medical records of Dr. Klinginsmith.
- N. Medical records of Occupational Medicine Specialty Center.
- O. Medical records of HealthSouth.
- P. Medical records of Microsurgery and Brain Research Institute.
- Q. Medical records of Twin City Wellness.
- R. Medical records of JMH Rehab.
- S. Certified records of the Division of Workers' Compensation.
- T. Certified records of Festus Middle School.
- U. Medical bills and summary prepared by employee's attorney.

Employer-Insurer's Exhibits:

- 1. Deposition transcript of Sandra Tate, M.D. taken on January 13, 2010.
- 2. Deposition transcript of James England taken on August 9, 2012.
- 3. Deposition transcript of Melissa Harbit, M.D. taken on August 15, 2012.
- 4. Report of Open MRI of Jefferson County - lumbar spine - dated January 8, 2003.
- 5. Report of Open MRI of Jefferson County - thoracic spine - dated January 8, 2003.
- 6. Radiology report of HealthSouth Diagnostic Center - MRI of the lumbar spine - dated January 23, 2003.
- 7. Radiology report of the whole body scan completed on February 13, 2003.
- 8. Radiology report of Open MRI of Jefferson County dated June 24, 2003.
- 9. X-ray of the lumbar spine at Jefferson Memorial Hospital dated November 27, 2002.
- 10. Reports of Paul Young, M.D. dated April 21, 2003 and April 22, 2003.
- 11. Radiology report of St. Anthony's Medical Center dated April 22, 2003.
- 12. Report of Charles Weatherington, M.D. dated February 13, 2007.
- 13. EMG/NCV report of John McGarry, M.D. dated August 31, 2007.
- 14. Records of Manzoor Tariq, M.D. dated October 5, 1999 through September 14, 2001
- 15. Records of Charles Klinginsmith, D.C. dated November 7, 2000 through November 25, 2001.

The Second Injury Fund did not offer any exhibits into evidence.

FINDINGS OF FACT:

EMPLOYEE TESTIMONY

Bennie Johnston, hereafter referred to as "Employee", currently resides at 208 South Lincoln, Desloge, Missouri. He was born on September 5, 1954. He could not recall his weight, height, or Social Security Number.

Employee brought with him 14 separate medications which he uses for conditions involving diabetes, high cholesterol, depression, acid reflux, pain, sinus infections and sleep disorder.

Employee testified that on the date of injury, he was driving a dump truck. He was turning into the quarry on Highway 21 when another driver struck his dump truck on his driver's side door. He immediately felt pain in his lower back.

Employee testified that he was seen at Jefferson Memorial Hospital with symptoms of pain in his lower back. X-rays were taken and "packs" were placed on his back. The employee acknowledged problems with his back before the accident, but stated that following the November 27, 2002 accident was much worse.

The employee testified that he can no longer lift bags of rock. After February 24, 2003, he was unable to continue working. He could not do any of the lifting required at his position.

His employer sent him to Dr. Klinginsmith. He was also sent by the insurance company to Dr. Tate and Dr. Krewet.

Employee testified to receipt of treatment on his own with Dr. Paul Young and Dr. Anderson. He also saw his family physician, Dr. Abercrombie.

In connection with his mental condition, Employee was seen at the Jefferson Regional Health Center.

Most recently, he has been treated by Dr. Phan, a spinal specialist. He has also received treatment with Dr. Abercrombie, his family care physician.

Mr. Johnston could not recall any treatment for his heart condition. He did not remember any treatment with a cardiologist, Dr. Tariq.

The employee suffers from flashbacks and is scared when he thinks about the events of the November 27, 2002 accident. In terms of his back pain, he reported throbbing into his feet and pain that "never quits."

Employee has difficulty sitting, standing, or walking for periods of time. He lies down on his side which relieves his back symptoms. If he sits for longer than 10 minutes, he has pain that travels through his groin.

In terms of his daily activities, Employee does not do any work around the home. His sister cooks. He is unable to vacuum and does not work in the yard. He has a loss of bowel and bladder control. He is only able to sleep three to four hours at most. He is able to dress himself.

Employee testified that he no longer plays sports or has any hobbies and does not hunt or perform archery given his ongoing complaints.

On questioning from the employer/insurer, Employee could not recall his earlier deposition testimony completed on March 21, 2005. He did not recall any of the details of his treatment following his injury.

When asked to provide details as to his treatment with Dr. Klinginsmith, Employee testified that he was having a difficult time remembering the course of his medical treatment with Dr. Klinginsmith before his work injury of November 27, 2002. In addition to his inability to recall treatment with Dr. Klinginsmith before November 27, 2002, Employee also testified that he was unable to recall treatment immediately after his injury with Dr. Klinginsmith. He could not recall any of the diagnostic tests that were done involving his low back. He could not recall the results of any diagnostic tests that were performed. He did not know whether Dr. Young performed diagnostic studies for his low back. He did, however, acknowledge on direct examination that he treated on his own with Dr. Young. The employee could not recall whether he received any treatment for his low back in the years of 2008, 2009, 2010 or 2011.

The employee was asked the specifics regarding his treatment with Dr. Klinginsmith beginning on March 27, 2002, exactly eight months before the work injury. Employee testified that he could not recall his prior complaints, treatment, symptoms, or diagnoses in the eight months leading up to his November 7, 2002 work injury.

Employee was then asked about his educational history and the records from Festus Middle School. Employee guessed that he completed the 6th grade. He took special education classes. He acknowledged that once he completed the 6th grade, he started to work for his dad's brother, his uncle, in 1971.

Mr. Johnston stated that he worked on and off for his uncle until 1978 at which time he started full time work for his uncle which continued from 1978 up through his injury date of November 27, 2002.

Employee was unable to remember any treatment details concerning his prior heart condition. He was also unable to remember any doctors diagnosing depression or stress which predate his November 27, 2002 work injury. Employee had a difficult time putting forth answers to questions posed by the employer/insurer.

On questioning from the Second Injury Fund, Employee testified prior to his injury that he was working up to 60 hours a week. While he treated with Dr. Klinginsmith before his injury, this did not prevent him from working. He denied any problems walking, sitting, or standing before his accident. Employee also testified that he did not have any difficulty with urination or bladder control before his work injury.

DEPOSITION TESTIMONY OF DR. SANDRA TATE

Dr. Tate initially evaluated Employee on February 10, 2003 (Exhibit 1, Page 6). At that time, Employee reported that he was driving a dump truck, pulled into the parking lot, and was impacted by a four-door mid-size car. The driver side door of the dump truck was damaged (Exhibit 1, Page 7).

During her initial evaluation of Employee, Mr. Johnston reported pre-existing difficulties with his low back (Exhibit 1, Page 7). Specifically, Employee reported back pain that started without a specific injury of May of 2002. Employee sought chiropractic care from Dr. Klinginsmith three to four times per week which had been ongoing ever since May of 2002 (Exhibit 1, Page 7). Dr. Tate testified that Employee's reporting of severe burning in his legs with weakness and numbness on October 21, 2002 was consistent with Mr. Johnston's reporting of a prior back condition leading up to November 27, 2002 (Exhibit 1, Page 8).

Dr. Tate reviewed a prior MRI taken of the Employee's lumbar spine on June 24, 2002 (Exhibit 1, Page 9). This MRI showed mild degenerative changes at L4-L5 and L5-S1 (Exhibit 1, Page 9).

In connection with her initial assessment, Dr. Tate noticed the way Employee walked into the office and walked out of the office (Exhibit 1, Page 10). When he walked into the office, the employee flexed at about 40 degrees. But as he walked out of the office, he was more extended and only flexed about 20 degrees. Once he made it to the hallway, he was standing nearly straight (Exhibit 1, Page 10).

Dr. Tate noted during her examination that Employee presented with multiple non-anatomic findings (Exhibit 1, Page 11-12).

In addition to her physical examination, Dr. Tate reviewed MRI films of the lumbar spine completed after the injury (Exhibit 1, Page 13). The MRI's were completed on January 8, 2003 and January 23, 2003 (Exhibit 1, Page 13). Dr. Tate noted that the MRI film of January 8, 2003 showed a degenerative disc change at L5-S1 (Exhibit 1, Page 13). The degenerative disc change at L5-S1 was consistent with the MRI findings completed before the injury on June 24, 2002 (Exhibit 1, Page 13).

In connection with the January 23, 2003 MRI, the findings were similar (Exhibit 1, Page 13). The January 23, 2003 MRI also showed degenerative changes at L5-S1 (Exhibit 1, Page 13). The MRI findings of January 23, 2003 were consistent with the MRI taken of Employee before the injury on June 24, 2002 (Exhibit 1, Page 13).

Dr. Tate testified that Employee had high subjective complaints of low back pain with symptom magnification (Exhibit 1, Page 14). She referenced Employee's inconsistencies when walking in and out of the examining room, his inconsistent testing on range of motion, and his positive Waddell symptom magnification signs (Exhibit 1, Page 14-15).

Despite the negative MRI findings of January 8, 2003 and January 23, 2003, as well as the physical exam which failed to show any evidence of injury, Dr. Tate nonetheless ordered a bone scan (Exhibit 1, Page 15).

The bone scan was completed on February 13, 2003. The bone scan did not show evidence of fracture or abnormalities in the spine (Exhibit 1, Page 16).

As of February 14, 2003, Dr. Tate noted that Employee was at maximum medical improvement (Exhibit 1, Page 17). Dr. Tate opined that Employee could work full duty without restriction (Exhibit 1, Page 17).

As of February 14, 2003, Employee did not need any further medical care (Exhibit 1, Page 17). Dr. Tate stated that Employee had no permanent partial disability (Exhibit 1, Page 17).

Dr. Tate evaluated the Employee again on October 13, 2009 (Exhibit 1, Page 20). At that time, Dr. Tate reviewed Employee's treatment records following her initial assessment in February, 2003. Dr. Tate conducted an evaluation of Employee on October 13, 2009 (Exhibit 1, Page 21). During the evaluation, Employee failed all Waddell's tests (Exhibit 1, Page 23). Dr. Tate explained that there were five Waddell's tests that she performed and Employee's responses were positive for symptom magnification on all five (Exhibit 1, Page 23).

Employee had verbally reported that he was unable to move his back or lower extremities from February, 2003 through October, 2009 (Exhibit 1, Page 24). Dr. Tate stated that one would expect some sort of atrophy or muscle wasting if Employee was unable to move his back or lower extremities and had the degree of disability reported during his exam (Exhibit 1, Page 24).

During her physical exam on October 13, 2009, Dr. Tate found no evidence of any atrophy or muscle wasting (Exhibit 1, Page 24). Dr. Tate noted that the patient had been using his extremities to a reasonable extent as there was no atrophy (Exhibit 1, Page 24).

Dr. Tate testified that Employee's gait and coordination was inconsistent (Exhibit 1, Page 25). At times, Employee walked with a limp and other times he did not (Exhibit 1, Page 25). At times, Employee would limp with decreased weight bearing on his right leg while at other times he would limp with decreased weight bearing on his left leg (Exhibit 1, Page 25).

Dr. Tate noted inconsistencies throughout Employee's testing on range of motion, tenderness, and his ability to walk (Exhibit 1, Page 26).

Following her second evaluation of October 13, 2009 in connection with her review of additional medical records, Dr. Tate noted that the Employee had subjective complaints of back pain with no objective findings (Exhibit 1, Page 27).

In addition to her physical exam and review of medical records, Dr. Tate also reviewed the results of a myelogram CT completed on January 9, 2007 (Exhibit 1, Page 26). The myelogram results completed on that day revealed only degenerative disc changes (Exhibit 1, Page 26).

Following her review of the diagnostic studies, medical records, and her second evaluation of the employee on October 13, 2009, Dr. Tate testified within a reasonable degree of medical certainty that Employee was not in need of any further medical care (Exhibit 1, Page 28). Dr. Tate further testified that Employee had 0% permanent partial disability with respect to the lumbar spine relative to the November 27, 2002 injury (Exhibit 1, Page 28).

DEPOSITION TESTIMONY OF DR. MELISSA HARBIT

Dr. Harbit evaluated Employee on May 17, 2012 (Exhibit 3 Page 7). In connection with her evaluation, Dr. Harbit reviewed deposition transcripts from Dr. Tate, Dr. Enger, Dr. Abercrombie, Dr. Stillings, Dr. Volarich, and Mr. Dolan (Exhibit 3 Page 7). She also reviewed deposition transcripts taken of Employee on March 21, 2005 and November 14, 2011 (Exhibit 3 Page 7). Further, she reviewed medical records as well as the transcripts and educational records from the Festus Middle School (Exhibit 3 Page 7).

Dr. Harbit noted that her psychiatric evaluation of Employee lasted approximately 2 1/2 hours (Exhibit 3 Page 7). In connection with her 2 1/2 hour assessment of Mr. Johnston, Dr. Harbit also reviewed four to five inches of medical records (Exhibit 3 Page 12).

Dr. Harbit provided a diagnosis of anxiety disorder, personality disorder, and cognitive limitations whether it be mental retardation or borderline intellectual functioning (Exhibit 3 Page 13).

In connection with Employee's anxiety disorder, Dr. Harbit noted that the employee treated for anxiety dating back to 1999. He had been diagnosed with depression and anxiety by Dr. Tariq on November 5, 1999 (Exhibit 3 Page 16). In her opinion, Employee's anxiety disorder pre-existed the work injury (Exhibit 3 Page 17-18).

Based upon her evaluation of the employee, Dr. Harbit noted that the work injury of November 27, 2002, was not a substantial factor in the need for any further psychiatric treatment, including medication or psychotherapy (Exhibit 3 Page 20).

Dr. Harbit was asked the following:

Q: "Is the work injury of November 27, 2002 a substantial factor in the need for any psychiatric treatment?"

A: "No."

Q: "Is the work injury of November 27, 2002 a substantial factor in any psychiatric disability Mr. Johnston has?"

A: "No." (Exhibit 3 Page 20).

DEPOSITION TESTIMONY OF JAMES ENGLAND, JR.

Mr. England is a vocational rehabilitation counselor (Exhibit 2 Page 4). He evaluated Employee on March 19, 2012 (Exhibit 2 Page 6). In connection with his evaluation, Mr. England reviewed the Employee's medical records and interviewed Employee concerning his family and social background, educational background, vocational history, functional restrictions, and limitations (Exhibit 2 Page 8).

In assessing Employee's educational background, Mr. England testified that Employee's education was limited (Exhibit 2 Page 10). He had completed the 6th grade in a special education program at Festus Middle School in Jefferson County (Exhibit 2 Page 10). Employee did not have a GED (Exhibit 2, Page 10).

Mr. England reviewed the Wide Range Achievement Test administered by Mr. Dolan (Exhibit 2 Page 11). On this testing, Employee scored at the first grade, first month level as far as word recognition (Exhibit 2 Page 11). He comprehended sentences at a kindergarten level and his math level was at a second grade, seventh month level (Exhibit 2 Page 11).

In reviewing additional intelligence tests, Mr. England noted that Employee's results showed that he was mildly mentally retarded (Exhibit 2 Page 11).

In applying Employee's intelligence level to his employability before the work accident of November 27, 2002, Mr. England testified:

"It always limited his options. It's always limited him to work that was, in fact, non verbal and could be learned through watching somebody else do it and where he didn't have to do paperwork or he didn't have to handle math and things that like." (Exhibit 2 Page 14).

Mr. England reviewed medical records outlining the Employee's ability to work (Exhibit 2 Page 14-15). First, he reviewed the medical records of Dr. Frank Krewet (Exhibit 2 Page 15). Dr. Krewet noted in February of 2003, that the Employee could work without restriction (Exhibit 2 Page 15). He also reviewed records from Dr. Young and McGarry, both of whom indicated that Employee had no need for restrictions (Exhibit 2 Page 15).

Finally, Mr. England reviewed the report of Dr. Volarich (Exhibit 2 Page 16). Assuming the restrictions of Dr. Volarich, Employee would be restricted to a more sedentary level of exertion (Exhibit 2 Page 16).

Mr. England also reviewed the restrictions outlined by Dr. Stillings (Exhibit 2 Page 17).

Based upon his review of the medical records, deposition transcripts, his meeting with Employee, and the testing he performed, Mr. England testified that Employee had many obstacles to employment before his work injury of October 27, 2002 (Exhibit 2 Page 18). Primarily, Employee had significant academic and intellectual limitations which limited his employability (Exhibit 2 Page 18). He also had pre-existing problems with his back and was missing time from work up to his November 27, 2002 injury (Exhibit 2 Page 19).

Mr. England reviewed records from Employee's treating chiropractor, Dr. Klinginsmith. The records in the three to four months before the work injury document Employee's complaints of severe pain and burning in his legs (Exhibit 2 Page 19). Mr. England noted that the Employee had complaints of low back pain and difficulty working two days before the primary injury (Exhibit 2 Page 19-20).

Taking into consideration the medical opinions of Dr. Tate, Dr. Krewet, Dr. Young, and Dr. McGarry, Mr. England testified that the Employee would have been capable of returning to work that he had done before from a physical standpoint (Exhibit 2, Page 20).

If Mr. England took into consideration the restrictions of Dr. Volarich coupled with the restrictions outlined by Dr. Stillings, Employee would not be capable of working (Exhibit 2 Page 21). His opinion was based on the assumption and qualification that the restrictions outlined by Dr. Volarich (who evaluated the employee on one occasion) and Dr. Stillings (who evaluated the employee on one occasion) were found to be credible (Exhibit 2 Page 21).

Mr. England testified that Employee's overall disability was due to a combination of his pre-existing factors and disability coupled with his primary injury (Exhibit 2 Page 21).

In addressing Employee's pre-existing conditions, Mr. England noted that Employee had been prescribed Xanax in 2000 (Exhibit 2 Page 53). Also, in July of 2002, the employee had throbbing, numbness, and pain in both legs (Exhibit 2 Page 53). In October of 2002, the employee left work early to go to the doctor's office because of severe burning in his back (Exhibit 2 Page 55). Also, Employee reported there was no relief from his pain in any position on October 21, 2002 (Exhibit 2 Page 55). Two days before the primary injury, Employee reported severe pain (Exhibit 2 Page 55).

Mr. England testified that in addition to these records, Employee also reported urination problems in July of 2002 (Exhibit 2 Page 56). On October 30, 2002, Employee reported burning pain worse during urination (Exhibit 2 Page 56). Employee's urination and bowel problems progressively got worse in October, 2002 (Exhibit 2 Page 57).

EMPLOYEE TREATMENT RECORDS

Following the November 27, 2002 accident, Employee was seen at Open MRI of Jefferson County on January 8, 2003. An MRI of the lumbar spine was read as completely normal (Exhibit 4).

Employee also underwent an MRI of the thoracic spine on January 8, 2003. The radiologist found the MRI of the thoracic spine to be normal (Exhibit 5).

Two weeks later, Employee underwent a follow-up MRI of the lumbar spine completed at HealthSouth Diagnostic Center. The MRI was read to be negative for any disc herniation stenosis (Exhibit 6). There was no change as compared to the prior study completed on January 8, 2003 (Exhibit 6).

Approximately two weeks after his second MRI, Employee underwent a bone scan. The radiologist completing the bone scan on February 13, 2003, found no evidence of fracture or abnormality of the lumbar spine (Exhibit 7).

As referenced in the deposition of Dr. Tate, Employee underwent an MRI on June 24, 2002, approximately five months before his work injury. The MRI of June 24, 2002 showed degenerative disc disease at L4-L5 and L5-S1 (Exhibit 8).

On the date of his injury, November 27, 2002, Employee underwent x-rays of the lumbar spine at Jefferson Regional Medical Center. No fractures were seen and Employee was noted to have minimal osteoarthritis at L5-S1 (Exhibit 9).

Employee testified on direct examination that he sought treatment on his own at the office of Dr. Paul Young. Employee was seen by Dr. Young on April 21, 2003, four months after his work injury (Exhibit 10). Dr. Young reviewed the MRI films taken in January of 2003 (Exhibit 10). Dr. Young commented that the films showed mild degenerative changes. Dr. Young ordered a lumbar myelogram and post CT scan (Exhibit 10).

In a follow-up note dated April 22, 2003, Dr. Young reviewed the results of the lumbar myelogram and post CT scan. The films showed only mild degenerative changes (Exhibit 10).

After seeking treatment on his own with Dr. Young in 2003, Employee returned to the office of Dr. Paul Young four years later in 2007, but was seen by his partner, Dr. Charles Wetherington (Exhibit 12). Dr. Wetherington evaluated Employee on February 15, 2007 (Exhibit 12). Dr. Wetherington of the St. Louis Neurosurgical Specialists indicated Employee's exam showed exaggerated responses (Exhibit 12). The patient did not cooperate with volitional control during the exam (Exhibit 12). Additionally, while the patient reported diminished sensation during the exam, his complaints did not follow any dermatomal pattern (Exhibit 12).

Dr. Wetherington reviewed the MRI of the lumbar spine as well as the myelogram which showed only generalized degenerative changes (Exhibit 12).

Employee also sought medical treatment on his own at the office of Dr. John McGarry. Dr. McGarry ordered an EMG/nerve conduction study of the lower extremities to evaluate for lumbar radiculopathy (Exhibit 13). On August 13, 2007, the nerve conduction study was completely normal without any evidence of neuropathy (Exhibit 13). Employee did not participate in the EMG study (Exhibit 13).

In connection with his prior medical condition, the employee was seen by Dr. Tariq on October 5, 1999. At that time, Employee complained of left sided chest pain radiating into his left arm. He stated that he had similar pains for the prior month, sometimes on exertion (Exhibit 14).

Employee also reported that he had chest pain:

“Sometimes on condition of severe emotional distress (patient is going through a divorce lately). The employee was admitted to the hospital for chest pain to rule out a myocardial infarction.” (Exhibit 14).

Employee was admitted to Jefferson Memorial Hospital on October 5, 1999. The admission report indicated that he was going through the divorce process which was “kind of getting hard on him”... (Exhibit 14). Employee also reported that his pain in the chest and left arm became significant enough that he almost passed out and could not breathe for several seconds (Exhibit 14).

On November 5, 1999, Dr. Tariq diagnosed angina as well as depression (Exhibit 14). He prescribed Xanax for the employee’s anxiety and noted that he was to follow-up for further care. In March of 2000, Employee repeated periods of stress secondary to going through a divorce. He was diagnosed with hypertension and hyperlipidemia. He was prescribed medication for those conditions and was prescribed Xanax (Exhibit 14).

MEDICAL RECORDS OF CHARLES KLINGINSMITH, M.D.

Employee submitted as Exhibit 15, certified records of Dr. Charles Klinginsmith for dates of service November 7, 2001 through November 25, 2002 (Exhibit 15). The records document treatment received by Employee leading up to two days before the work injury (Exhibit 15).

Beginning on April 8, 2002, Employee reported stiffness and soreness in his back with an inability to stand on concrete (Exhibit 15). In a follow-up note dated April 12, 2002, Employee reported too much heavy lifting with pain at a 7 to 8 in his back (Exhibit 15). The employee received medical treatment throughout April, 2002 (Exhibit 15).

On May 11, 2002, Employee reported ongoing pain in his back with spasms and discomfort in his legs (Exhibit 15). By June 7, 2002, Employee reported not only pain in his low back, but numbness in both legs (Exhibit 15). Employee reported that his legs felt as though they were giving out on him (Exhibit 15). As of June 17, 2002, Dr. Klinginsmith noted that Employee may take off work for two weeks and should have an MRI done (Exhibit 15). As noted above, the employee underwent an MRI on June 24, 2002 (Exhibit 15).

On July 17, 2002, Employee reported that his pain had gotten worse (Exhibit 15). He had pain with throbbing and numbness in his legs with no new injury or illness (Exhibit 15). Employee reported that no treatment or medication has been helping his severe pain (Exhibit 15).

Beginning on July 31, 2002, the employee reported urination problems (Exhibit 15). In the note of July 31, 2002, Employee stated:

“Tells me just today of urination problems, goes in pants, and not known it and then have urge and not able to do.” (Exhibit 15)

Employee continued his treatment with Dr. Klinginsmith and on August 19, 2002 reported back pain with prolonged standing and stooping too much (Exhibit 15). Sitting also aggravated his complaints (Exhibit 15).

On September 25, 2002, Dr. Klinginsmith commented that Employee’s condition had improved since he was not lifting and prying rocks at work (Exhibit 15). However, on October 4, 2002, Employee reported that he had significant pain in his back and the Aleve that he was taking on his own was barely taking the edge off his low back pain (Exhibit 15).

On October 21, 2002, the Employee reported that he left work early due to severe pain (Exhibit 15). The employee reported no relief in any position or any time of day (Exhibit 15). He also stated that his legs feel weak and he reported numbness in both legs (Exhibit 15).

Exactly, two weeks before the work injury of November 27, 2002, the Employee was seen on November 13, 2002 (Exhibit 15). He reported pain after lifting on a Saturday (Exhibit 15). He had numbness in his legs (Exhibit 15). He felt as though he could not control his legs and reported that his pain was a 9 out of 10 (Exhibit 15). He could not find any relief for his pain in any position or any time of the day (Exhibit 15).

The final note before the work injury is dated November 25, 2002, two days before the work accident (Exhibit 15). At that time, Employee reported continued severe pain but was still working (Exhibit 15).

DEPOSITION TESTIMONY OF DR. DAVID VOLARICH

Employee presented the deposition of Dr. David Volarich. His deposition was taken on November 18, 2011.

Dr. Volarich evaluated Employee at the request of his attorney on one occasion, August 2, 2011 (Exhibit A, Page 6).

In connection with his review of the medical records, Dr. Volarich reviewed multiple diagnostic tests (Exhibit A, Page 14). First, he reviewed the June 24, 2002 MRI which pre-dated the work injury (Exhibit A, Page 14). According to Dr. Volarich, the MRI showed degenerative disc disease at L5-S1 and to a lesser degree, degenerative disc disease at L4-L5 (Exhibit A, Page 14). Dr. Volarich did not see any disc protrusion, nerve root encroachment, or spinal stenosis in the MRI of June 24, 2002 (Exhibit A, Page 14). Thereafter, Dr. Volarich reviewed another MRI done six or seven months later on January 8, 2003, that did not show any change from the pre-injury MRI of June 24, 2002 (Exhibit A, Page 15).

Dr. Volarich noted during his evaluation of Employee that he presented multiple positive Waddell's signs (Exhibit A, Page 16). Dr. Volarich explained the patient's perception of pain and his physical problems did not correlate to objective findings (Exhibit A, Page 16). In explaining the Waddell's tests, Dr. Volarich stated that Employee had a positive Waddell's sign involving axial loading (Exhibit A, Page 17). In explaining this positive Waddell's test, Dr. Volarich noted"

"When examining the patient and they're standing upright, you push down on the top of the patient's head. If they have a neck problem, you expect -- this is called Spurlings we typically talk about. You expect something to go to the arm or shoulder girdle. When you push on the top of the head and they complain of low back pain, that's abnormal axial loading. It shouldn't happen. You should not get low back when you push on somebody's head." (Exhibit A, Page 17)

In coming to a diagnosis, Dr. Volarich stated that with reference to the November 27, 2002 accident, his diagnosis was whole body myofascial pain syndrome (Exhibit A, Page 18).

Dr. Volarich testified:

"I found no evidence of spinal cord or nerve root impingement based upon multiple diagnostic studies that were performed or from my physical exam." (Exhibit A, Page 18)

Dr. Volarich testified that the accident of November 27, 2002, was the substantial contributing factor in causing a lumbar strain injury which turned into myofascial pain syndrome that required conservative treatment (Exhibit A, Page 20).

In connection with the employee's pre-existing conditions, Dr. Volarich diagnosed prior chronic lumbar syndrome, hypertension, and mild coronary disease (Exhibit A, Page 20).

In connection with his assessment of permanent partial disability, Dr. Volarich indicated that the employee had a 25% permanent partial disability of the body as a whole rated at the lumbar spine due to the lumbar strain injury and aggravation of mild degenerative disc disease at L5-S1 and to a lesser degree, L4-L5 (Exhibit A, Page 22).

In connection with the employee's ability to sustain gainful activity, Dr. Volarich noted that Employee was permanently and totally disabled as a result of the work injury of November 27, 2002 in combination with his pre-existing medical conditions including significant psychiatric disorders (Exhibit A, Page 26). Dr. Volarich noted that Employee was 57 years old, had an education limited to the sixth grade and never earned at GED (Exhibit A, Page 26).

Dr. Volarich reviewed the Employee's x-rays completed on the date of injury - November 27, 2002 (Exhibit A, Page 28). He agreed that the changes seen on the x-ray pre-dated the work injury (Exhibit A, Page 28). He also reviewed the MRI of the lumbar spine on January 8, 2003,

noting that it showed mild degenerative changes but no nerve root impingement or surgical pathology (Exhibit A, Page 29-30).

In his review of the prior medical records, Dr. Volarich noted that the prior medical reports from Dr. Klinginsmith documented degenerative changes at L4-L5 and L5-S1 (Exhibit A, Page 32).

In connection with his examination of the Employee, Dr. Volarich noted that there were multiple non-anatomic findings on motor exam (Exhibit A, Page 34-35). He found the employee to report non-anatomic tenderness (Exhibit A, Page 36). He also stated that there were no objective findings of any atrophy (Exhibit A, Page 38). In essence, Dr. Volarich found that there was no nerve root impingement or damage to the joints causing the muscles above or below the joint to be smaller because of a loss of function (Exhibit A, Page 38). There was no nerve root impingement that caused atrophy or loss of function of the muscle from the spinal cord (Exhibit A, Page 38).

In addressing Mr. Johnson's accuracy in the reporting of his complaints, Dr. Volarich noted that while the employee attributed all of his problems from sitting, standing, walking, lifting, and carrying to his work injury, the medical records show otherwise (Exhibit A, Page 46-47).

DEPOSITION TESTIMONY OF DR. WAYNE STILLINGS

Employee presented the deposition of Dr. Wayne Stillings. His deposition was taken on December 12, 2011.

Dr. Stillings evaluated Employee on one occasion, August 10, 2011 (Exhibit B, Page 5). The evaluation took place at the request of employee's attorney in connection with the Missouri Workers' Compensation claim (Exhibit B, Page 6).

In connection with his evaluation, Dr. Stillings took a history from Employee (Exhibit B, Page 8). The employee noted that Employee's ex-wife was extremely emotionally and physically abusive of his son (Exhibit B, Page 8). Additionally, Employee's ex-wife, who he divorced in 1999 or 2000, was abusive of Employee, making threats to kill both he and his son and then commit suicide (Exhibit B, Page 8). Dr. Stillings noted that Employee had five years of significant marital trauma (Exhibit B, Page 8).

Dr. Stillings diagnosed a generalized anxiety disorder, depressive disorder, and post-traumatic stress disorder. In connection with post-traumatic stress disorder, Employee testified that the employee's ex-wife was an alcoholic, emotionally, and physically abusive (Exhibit B, Page 13-14). In explaining this diagnosis, Dr. Stillings repeated that Employee's ex-wife abused their son and made threats to kill both of them (Exhibit B, Page 14). This condition pre-existed the November 27, 2002 work injury (Exhibit B, Page 14).

Additionally, Employee had a mood disorder due to a general medical condition and also had a learning disability with an impoverished IQ which was pre-existing the work injury (Exhibit B, Page 13).

Dr. Stillings noted that Employee clearly had pre-existing emotional and cognitive problems (Exhibit B, Page 13). Dr. Stillings testified that Employee suffered a learning disorder, low intellectual function, and personality disorder which pre-existed the November 27, 2002 work injury (Exhibit B, Page 14). He commented that Employee's mood disorder, anxiety disorder, and pain disorder were caused by the injury (Exhibit B, Page 14). Dr. Stillings testified that a combination of Employee's pre-existing learning disability, personality disorder, and low intellectual functioning coupled with the mood disorder and anxiety disorder rendered Employee permanently and totally disabled from a psychiatric standpoint (Exhibit B, Page 14-15).

Dr. Stillings rated Employee's pre-existing psychiatric disability at 15% for the pre-existing post-traumatic stress disorder (Exhibit B, Page 15). He rated the pre-existing low IQ and learning disability at 15% of the body as a whole. He also rated the pre-existing personality disorder at 5% of the body as a whole (Exhibit B, Page 15). Overall, the pre-existing disability was 35% of the body as a whole.

With respect to the work injury, Dr. Stillings rated 20% for a mood disorder, 10% for anxiety disorder, and 15% for a pain disorder for a total of 45% of the body as a whole (Exhibit B, Page 15).

DEPOSITION TESTIMONY OF STEPHEN DOLAN

The deposition of Stephen Dolan was taken on behalf of the employee on December 16, 2011. Mr. Dolan evaluated Employee on one occasion at the request of his attorney (Exhibit C, Page 7). The evaluation was to be used in connection with the Workers' Compensation claim (Exhibit C, Page 7). The evaluation took place on August 8, 2011 (Exhibit C, Exhibit 2).

In connection with his vocational assessment, Mr. Dolan took a history from Employee, asked about his complaints as well as his vocational history (Exhibit C, Page 15-17). Mr. Dolan also conducted education testing (Exhibit C, Page 18). Specifically, he administered the Wide Range Achievement Test 4 WRAT (Exhibit C, Page 18). Employee's scored at the second grade, seventh month level (Exhibit C, Page 18). Mr. Dolan also administered the Slosson Intelligent Test, a type of IQ test (Exhibit C, Page 18). Employee scored a 68 which is in the mildly, mentally retarded range (Exhibit C, Page 18). Mr. Dolan noted that Employee can't read, can't write, and can only do the simplest forms of math (Exhibit C, Page 19).

Mr. Dolan noted that given Employee's level of intelligence, he was never able to perform anything other than physical jobs because he did not have the cognition to read, write, or do anything other than very simply math (Exhibit C, Page 19-20). Additionally, Employee needed a job where he was able to go home frequently and call home frequently without any warning because he had serious issues between his then wife and son which pre-existed the work injury (Exhibit C, Page 19-20).

Mr. Dolan indicated that Employee is not employable in the open labor market (Exhibit C, Page 20-21).

In assessing Employee's employability, Mr. Dolan admitted that he utilized work restrictions given by Dr. Stillings and by Dr. Volarich, each of whom evaluated Employee on only a one-time basis (Exhibit C, Page 26).

In connection with Employee's pre-existing low IQ, Mr. Dolan testified that Employee was being accommodated by his uncle who employed him at Arch Johnston Paving Quarry (Exhibit C, Page 32). Mr. Dolan explained that in the years before the work injury, his uncle accommodated him because of his personal family problems (Exhibit C, Page 32). Later, Employee was accommodated throughout the entire employment with his uncle because he needed more instruction and more supervision than most people would have needed (Exhibit C, Page 32). Employee's inability to do any type of work that involved mental work, spelling, reading, or math clearly pre-existed the November 27, 2002 work injury (Exhibit C, Page 33). Mr. Dolan testified that it is a combination of Employee's pre-existing mental and physical problems before November 27, 2002, in combination with the effects of the November 27, 2002 injury, that combined to make Employee unemployable in the open labor market (Exhibit C, Page 34).

MEDICAL TREATMENT RECORDS SUBMITTED BY EMPLOYEE

Employee submitted as Exhibit I, records from ProRehab which pre-date the work injury. The records document treatment from July 2, 2002 through July 15, 2002.

In the July, 2002 report of ProRehab, Employee stated that he felt pain in his low back beginning in March of 2002 (Exhibit I). He reported stiffness in his low back, weakness in both legs, numbness from the cheeks of his buttocks down to his calves of his legs bilaterally, and difficulty lifting his feet up when ascending stairs (Exhibit I).

Employee reported that his pain was aggravated with lifting for greater than 30 minutes, sitting in a truck, or sitting for an extended period of time (Exhibit I).

Further, Employee reported bowel and bladder disturbances as his frequency of urination increased and he has voided uncontrollably a few times (Exhibit I). The therapist completing the July 2, 2002 report indicated that Employee presented signs and symptoms consistent with a lumbosacral strain, but also presented several non-organic symptoms and a 2/5 positive Waddell's Test (Exhibit I).

In completing the lumbar spine assessment dated July 2, 2002, the therapist noted that Employee's low back pain interfered with Employee's ability to sleep (Exhibit I). Employee was sleeping only two to three hours per evening on July 2, 2002 (Exhibit I). In fact, the Employee's pain limited his work, activities of daily living, and mobility (Exhibit I - July 2, 2002 report).

In connection with the employee's treatment following the work injury, Employee presented records from the Microsurgery & Brain Research Institute, P.C. as Exhibit P. The records included a report from Dr. Charles Wetherington dated February 21, 2007 (Exhibit P). Therein,

Dr. Wetherington reviewed MRI as well as myelogram of the lumbar spine which revealed no cord compression. There was no thecal sac compression (Exhibit P).

After his release by Dr. Tate in March of 2003, Employee testified that he treated on his own at the office of Dr. Paul Young. Dr. Young evaluated Employee on April 21, 2003. At that time, Dr. Young reviewed the patient's lumbar MRI scan which showed mild degenerative changes (Exhibit P). Dr. Young ordered a lumbar myelogram with post CT scan. He reviewed the scan on April 22, 2003. The myelogram and post-CT scan showed mild degenerative changes. His final diagnosis was degenerative lumbar disc disease (Exhibit P).

EDUCATION RECORDS

Employee submitted copies of the educational records from Festus Middle School as Exhibit T.

The records document attendance at the elementary school from 1965 through 1968 (Exhibit T). Remarks indicate that the employee was involved in special education (Exhibit T).

Records from the junior high indicate that the Employee failed or received an incomplete in his four classes from 1968 through 1969 (Exhibit T).

The achievement test records note that in January, 1969, Employee completed the Iowa Basic Test while in junior high school. The results placed him at a third grade level and finished in the 1% (Exhibit T).

RULINGS OF LAW:

Issue 1. Medical causation, Issue 2. Previously incurred medical, Issue 3. Future medical aid

Employee is claiming that his work-related injury of November 27, 2002, is the substantial factor in the development of ongoing low back. He is seeking additional medical aid for these complaints.

Employee was seen following his work injury of November 27, 2002, at the office of Dr. Klinginsmith. He ordered an MRI of the lumbar spine which was completed on January 8, 2003. The MRI showed only degenerative changes at L5-S1. This MRI was consistent with an MRI completed before the work injury on June 24, 2002.

Employee underwent another MRI of the lumbar spine on January 23, 2003. This MRI showed only degenerative changes at L5-S1. This film was also consistent with the MRI of January 8, 2003 and the pre-injury MRI of June 24, 2002.

Dr. Tate noted during her deposition that Employee presented with multiple non-anatomic findings. During her evaluation, she highlighted the employee's inconsistencies while walking in and out of the examining room. While walking into the examining room, Employee was bent

over and his back was flexed at 40 degrees. As he walked out of the office, he stood up straighter and his back was flexed at about 20 degrees. Once he made it out of the examining room into the hallway, Employee walked out of the office standing nearly straight.

Dr. Tate ordered a bone scan. The bone scan completed on February 13, 2003 showed no evidence of any abnormality of the lumbar spine.

Employee was placed at maximum medical improvement as of February 14, 2003. Dr. Tate noted that Employee could work full duty without restriction. She did not find any permanent partial disability.

Thereafter, Employee was seen by Frank Krewet, M.D. Dr. Krewet stated in his March 11, 2003 report that Employee had to walk in a bent-over position. Employee could not straighten his back (Exhibit J). This finding by Dr. Krewet was consistent with the manner in which the employee walked into Dr. Tate's office on February 10, 2003, but was inconsistent with the way he walked out of the Dr. Tate's office and into the hallway.

Dr. Krewet noted that Employee was capable of working per the recommendations of Dr. Tate.

Employee sought treatment on his own with a neurosurgeon, Dr. Paul Young. Employee was seen by Dr. Young on April 21, 2003. Dr. Young reviewed the MRI films taken on January 8, 2003 and January 23, 2003. He commented that the films showed only mild degenerative changes. Dr. Young ordered a lumbar myelogram and post CT scan to assess any nerve root compression.

Employee was, thereafter, seen on April 22, 2003. Dr. Young reviewed the results of the lumbar myelogram and post CT scan done on that date. The films showed only mild degenerative changes.

There is no evidence of medical treatment for Employee's low back at the office of Dr. Young from April, 2003 through February, 2007 when Employee was seen by Dr. Young's partner, Dr. Wetherington. The employee saw Dr. Wetherington on his own. Employee's exam, around four years later, showed symptom magnification. Employee did not cooperate with volitional control during the exam. His complaints did not follow any dermatomal pattern. Dr. Wetherington performed additional diagnostic studies which showed only degenerative changes. There was no change in the 2007 diagnostic studies as compared to those completed in 2003.

Employee also sought medical treatment on his own from Dr. McGarry. Dr. McGarry ordered a nerve conduction study which was completely normal and showed no evidence of neuropathy.

Employee had a pre-injury MRI on June 24, 2002, approximately five months before his work injury. The MRI of June 24, 2002 showed degenerative disc disease at L4-L5 and L5-S1.

Thereafter, Employee underwent a series of diagnostic tests all of which were negative the injury findings as seen on the MRI of June 24, 2002. These diagnostic studies showed the following:

1. November 27, 2002 x-ray of lumbar spine at Jefferson Regional Medical Center - minimal osteoarthritis at L5-S1.
2. January 8, 2003 MRI of the lumbar spine – normal.
3. January 8, 2003 MRI of the thoracic spine- normal.
4. January 23, 2003 MRI of the lumbar spine - negative for disc herniation or stenosis. No changes compared to the prior study of January 8, 2003.
5. February 13, 2003 bone scan - no evidence of fracture or abnormality of the lumbar spine.
6. April 22, 2003 lumbar myelogram and post CT scan - degenerative changes.
7. January 9, 2007 lumbar myelogram and CT - degenerative disc disease.
8. August 13, 2007 nerve conduction study of the lower extremities - normal without any evidence of neuropathy.

Dr. Tate testified that as of February 14, 2003, Employee was at maximum medical improvement. She opined that he was able to work full duty without restriction. He did not need any further medical care and had no permanent partial disability.

The findings of Dr. Tate on February 14, 2003, are consistent with the above-mentioned diagnostic tests which were completed both before and after her initial evaluation.

Dr. Tate evaluated Employee a second time on October 13, 2009. During the second evaluation, Dr. Tate found no objective evidence on exam of injury. She found no evidence of atrophy or muscle wasting and stated that the employee had been using his lower extremities. She further noted that Employee limped inconsistently throughout the exam, with an exhibited limp on the right side while other times limping on the left leg.

Dr. Tate noted that all of Employee's medical records from her last evaluation on February 14, 2003 through her second evaluation of October 13, 2009, confirmed her opinion that the employee had subjective complaints of back pain with no objective findings. Her opinions were supported by all of Employee's diagnostic studies.

Dr. Volarich noted during his evaluation of Employee that he presented multiple positive Waddell's signs (Exhibit A, Page 16). Dr. Volarich explained the patient's perception of pain and his physical problems did not correlate to objective findings (Exhibit A, Page 16). In explaining the Waddell's tests, Dr. Volarich stated that Employee had a positive Waddell's sign involving axial loading (Exhibit A, Page 17). In explaining this positive Waddell's test, Dr. Volarich noted"

“When examining the patient and they’re standing upright, you push down on the top of the patient’s head. If they have a neck problem, you expect -- this is called Spurlings we typically talk about. You expect something to go to the arm or shoulder girdle. When you push on the top of the head and they complain of low back pain, that’s abnormal axial loading. It shouldn’t happen. You should not get low back when you push on somebody’s head.” (Exhibit A, Page 17)

In coming to a diagnosis, Dr. Volarich stated that with reference to the November 27, 2002 accident, his diagnosis was whole body myofascial pain syndrome (Exhibit A, Page 18).

Dr. Volarich testified:

“I found no evidence of spinal cord or nerve root impingement based upon multiple diagnostic studies that were performed or from my physical exam.” (Exhibit A, Page 18)

Dr. Volarich testified that the accident of November 27, 2002, was the substantial contributing factor in causing a lumbar strain injury which turned into myofascial pain syndrome that required conservative treatment (Exhibit A, Page 20).

Based upon the evidence presented including the multiple negative diagnostic testing, I find the opinions of Dr. Tate to be more credible than the opinions of Dr. Volarich on the issues of medical causation, past medical bills incurred, and the need for further treatment as it relates to the employee’s low back condition. The employee sustained a low back strain on November 27, 2002.

I find that Employee’s work accident on November 27, 2002, was the substantial factor in causing the Employee’s lumbar strain. I find that lumbar strain was medically causally related to his accident on November 27, 2002. However, I find that Employee did not meet his burden of proof that the accident on November 27, 2002, was the substantial factor in causing myofascial pain syndrome. Furthermore, Employee did not meet his burden of proof that myofascial pain syndrome was medically causally related to his accident on November 27, 2002.

Employee received authorized medical care for that low back strain and was at maximum medical improvement for the work-related back strain as of February 14, 2003. Therefore, I find that any additional medical treatment was not authorized or causally related to Employee’s work accident on November 27, 2002.

Employee is claiming that his work-related injury of November 27, 2002 is a substantial factor in the development of a psychiatric condition.

The medical records submitted by the parties do not demonstrate any treatment by a psychiatrist or psychologist. Employee was seen at Jefferson Regional Medical Center on March 20, 2008, complaining of chest pain and disorientation (Exhibit F). The neurologic consultation from

Jefferson Memorial Hospital indicates that the Employee was found to be confused when he presented to the emergency room. An EEG was completed (Exhibit F).

Employee was also seen for a psychiatric assessment while at the hospital. Employee reported by way of personal history that he was married for 20 years; however, his wife became an alcoholic and they were divorced (Exhibit F).

“The patient states that his wife died of cancer in January, 2008, after being diagnosed to have cancer of the lungs for six months. She died in January, 2008. Ever since then, the stressors and concerns have increased.” (Exhibit F).

The medical records reflect Employee’s first consultation with a psychiatrist in March of 2008, three months after the death of his ex-wife. Employee did not treat with a psychiatrist in the five plus years between the injury date of November 27, 2002 and his admission to Jefferson Memorial Hospital on March 20, 2008.

In connection with the Workers’ Compensation Claim, Employee was seen on August 10, 2011, by Dr. Wayne Stillings. The evaluation took place well over eight years after the injury (Exhibit B).

Employee reported a pre-existing history of marital difficulties to Dr. Stillings (Exhibit B - Report of Dr. Stillings, Page 4). Therein, Employee stated that his marriage ended in divorce due to traumatic circumstances involving his wife’s alcoholism (Exhibit B). Employee’s ex-wife emotionally abused Employee and emotionally and physically abused their son (Exhibit B - Report of Dr. Stillings, Page 4). The ex-wife’s abusive behavior prior to the work injury included:

“One attempt to kill their son, a threat to kill Mr. Johnston and their son, an attempt to stab their son in the face with a pencil and punching their son in the face. Mr. Johnston would stay out late with their son to protect him, coming home after his wife had passed out in an alcoholic stupor. He developed symptoms of PTSD, including disturbing, intrusive, recurrent recollections of the marital trauma, nightmares, flashbacks, and symbolic triggering of the marital trauma, avoidance symptoms, and hyper arousal symptoms.” (Exhibit B - Report of Dr. Stillings, Page 4).

Dr. Stillings further noted in connection with Employee’s pre-existing psychiatric health:

“The five years of significant marital trauma took its toll on the mental health of Mr. Johnston and created an adverse affect on his occupational functional capacity. For example, he was tardy from work because he would leave the house at 3:30 a.m. instead of 5:30 a.m. to get away from his wife. He would drive to work and sometimes sleep in his truck past his start time and often a cousin awakened him. Furthermore, he would leave work early to pick up his son from school so his wife did not, to protect his son from the boy’s mother. His wife threatened to kill their son and Mr. Johnston and then commit suicide with a gun. On one occasion, his wife threw a radio into the bathtub

while his son was bathing, but Mr. Johnston was able to rescue him. On another occasion, she attempted to stab their son in the face with a pencil. The extensive marital trauma reduced Mr. Johnston's pace and persistence in the workplace... His sleep deprivation adversely affected his work performance. During those five years, he would pass on most overtime work to care for and protect his son. His employer, who was his uncle, was aware of his serious marital issues and was supportive and understanding." (Exhibit B - Dr. Stillings' Report, Pages 4-5)

Dr. Stillings noted that Employee did not receive treatment at the office of a psychiatrist or psychologist (Exhibit B, Employee's Exhibit 2). Employee did report that his family physician prescribed Xanax in March, 2008.

Dr. Stillings noted that Employee clearly had pre-existing emotional and cognitive problems (Exhibit B, Page 13). Dr. Stillings testified that Employee suffered a learning disorder, low intellectual function, and personality disorder which pre-existed the November 27, 2002 work injury (Exhibit B, Page 14). He commented that Employee's mood disorder, anxiety disorder, and pain disorder were caused by the injury (Exhibit B, Page 14). Dr. Stillings testified that a combination of Employee's pre-existing learning disability, personality disorder, and low intellectual functioning coupled with the mood disorder and anxiety disorder rendered Employee permanently and totally disabled from a psychiatric standpoint (Exhibit B, Page 14-15).

Dr. Stillings rated Employee's pre-existing psychiatric disability at 15% for the pre-existing post-traumatic stress disorder (Exhibit B, Page 15). He rated the pre-existing low IQ and learning disability at 15% of the body as a whole. He also rated the pre-existing personality disorder at 5% of the body as a whole (Exhibit B, Page 15). Overall, the pre-existing disability was 35% of the body as a whole.

With respect to the work injury, Dr. Stillings rated 20% for a mood disorder, 10% for anxiety disorder, and 15% for a pain disorder for a total of 45% of the body as a whole (Exhibit B, Page 15).

Both the Employer and Employee submitted medical record from Dr. Tariq which pre-dated the work injury. On October 5, 1999, Employee reported severe emotional stress as he was going through a divorce. He was prescribed Xanax (Exhibit 14). He had a follow-up visit with Dr. Tariq dated March 8, 2000, reflects Employee's report of stress secondary to going through a divorce. Xanax was prescribed.

Employee was seen at the request of the employer/insurer by Dr. Melissa Harbit. Dr. Harbit noted that the work injury of November 27, 2002, was not a substantial factor in any psychiatric disability Employee had (Exhibit 3, Page 20). She stated that the work injury of November 27, 2002, was not a substantial factor in the need for any psychiatric treatment (Exhibit 3, Page 20).

Dr. Harbit provided a diagnosis of borderline intellectual functioning which Employee has had his entire life (Exhibit 3). Dr. Harbit also diagnosed Employee with a pre-existing anxiety disorder (Exhibit 3, Dr. Harbit Report, Page 17). Dr. Harbit noted that the work-related injury

did not lead to a need for any additional treatment or any disability (Exhibit 3, Dr. Harbit Report, Page 17). Dr. Harbit noted that Employee was disabled prior to the work injury given his life-long cognitive limitations in addition to his pre-existing conditions (Exhibit 3, Dr. Harbit Report, Page 17).

In explaining the pre-existing cognitive limitations, Dr. Harbit reviewed Employee's educational records as well as the testing done by Mr. Dolan both of which showed an IQ in the borderline intellectual functioning range (Exhibit 3, Dr. Harbit Report, Page 15).

Based on all the evidence presented, I find the opinions of Dr. Harbit to be more credible than that of Dr. Stillings on the issue of medical causation in connection with the employee's psychiatric condition. I find that Employee's work injury on November 27, 2002, was not a substantial factor in causing Employee's psychiatric condition. Furthermore, I find that Employee did not meet his burden of proof that his psychiatric condition was medically causally related to his accident on November 27, 2002.

Based on all of the evidence presented, I find that the employee was at maximum medical improvement, could work full duty without restriction, and needed no further medical care as of February 14, 2003.

Given this finding, Employee's request for additional medical aid is hereby denied.

Furthermore, given this finding, Employee's injury of November 27, 2002, was not a substantial factor in the need for any treatment received by the employee after February 14, 2003. Therefore, Employee's request for payment of medical expenses incurred in the amount of \$14,734.13 is hereby denied.

To the extent that the medical bills of Dr. Klinginsmith are unpaid, the employer/insurer are hereby ordered to pay the bills from Dr. Charles Klinginsmith as outlined in Exhibit U for dates of service November 27, 2002 through February 14, 2003.

The employer/insurer are not responsible for the payment of any other medical expenses outlined by the employee in Exhibit U.

Based on the finding that the accident of November 27, 2002, is not a substantial factor in the employee's psychiatric condition, Employee's request for payment of any medical expenses associated with the psychiatric condition is hereby denied.

Finally, based on the ruling that the work injury of November 27, 2002, is not a substantial factor in the employee's psychiatric condition, the Employee's request for any further medical care for his psychiatric condition is hereby denied.

Issue 4. Temporary total disability

Dr. Harbit was found to be more credible than Dr. Stillings on the issue of medical causation regarding Employee's psychiatric condition. Employee did not meet his burden of proof on the issue of his psychiatric condition and medical causation was denied.

Dr. Tate was found to be more credible than Dr. Volarich on the issue of medical causation regarding Employee's low back. Dr. Tate testified that Employee was at maximum medical improvement as of February 14, 2003. Dr. Tate found Employee capable of returning to full duty work without restriction as of that date.

Based on all of the evidence presented, Employee's request for TTD benefits after February 14, 2003 is hereby denied.

Issue 5. Permanent total disability, Issue 6. Permanent partial disability

The medical records of Dr. Tate demonstrate symptom magnification and exaggeration of complaints during her examinations of Employee in February of 2003 and in October, 2009. Employee failed all the Waddell's tests and demonstrated symptom magnification during the October 13, 2009 examination. Employee's symptoms are not supported by any findings on physical exam by Dr. Tate. Moreover, Employee's complaints and symptoms are not supported by any diagnostic findings.

Employee sought treatment on his own at the office of Dr. Wetherington in February, 2007. Dr. Wetherington of the St. Louis Neurosurgical Specialists found that Employee's exam showed exaggerated responses. Employee did not cooperate with volitional control during his exam and his complaints during the evaluation were not supported by any objective findings on exam.

Employee was seen by Dr. Volarich for the purposes of a rating assessment on August 2, 2011. During his evaluation, Dr. Volarich noted that there were multiple non-anatomic findings on exam. Employee reported non-anatomic tenderness. There were no objective findings of atrophy. Dr. Volarich found no evidence of any nerve root impingement or damage to the joints causing the muscles above or below the joints to be smaller because of any reported loss of function. There was no nerve root impingement that caused any atrophy or loss of function in the muscles in the spinal cord.

Dr. Volarich noted that during Employee's exam, he also failed multiple Waddell's tests which signify symptom magnification.

Dr. Volarich's diagnosis of the primary injury was that of a lumbar strain and aggravation of mild degenerative disc disease at L5-S1 and to a lesser degree, L4-L5.

Importantly, Dr. Volarich noted that he performed ten Waddell's tests to assess symptom magnification. In connection with his lumbar exam, Dr. Volarich noted that all ten of the tests for symptom magnification were positive.

Dr. Volarich conceded in his testimony that he needed to rely upon the accuracy and veracity of Employee in reporting his complaints when coming to his opinions with respect to the extent of disability. He further stated that he needed to rely on the accuracy and veracity of Employee in reporting his symptoms and complaints when coming to his opinions with respect to his permanent restrictions and employability.

The deposition testimony of both the employer's expert, Dr. Tate, and Employee's expert, Dr. Volarich, demonstrate symptom magnification on the part of the employee. While Employee has reported an inability to return to the workforce, his self-reported complaints and self-reported limitations are not supported by the medical evidence.

Moreover, the Employee's credibility is in question in connection with his testimony at trial. Employee consistently testified that he was able to perform all physical activities leading up to his injury of November 27, 2002. He testified repeatedly to no problems with any physical activity he needed to perform in the years and months leading up to his work injury of November 27, 2002.

Both Employee and Employer have submitted the prior records of Dr. Klinginsmith. Those records document significant complaints on the part of the employee throughout 2002 leading up to November 27, 2002. The records of Dr. Klinginsmith demonstrate Employee's report of pain in his low back, numbness in his legs, and difficulty with bowel and bladder function in the months leading up to November 27, 2002. In fact, the records demonstrate that the employee was seen on November 25, 2002, two days before his work injury, complaining of severe low back pain.

The records of Dr. Klinginsmith document significant complaints on the part of Employee leading up to November 27, 2002. These medical records are directly contrary to Employee's testimony given at the time trial.

Additionally, the vocational testimony of Mr. England does not support a finding of permanent total disability benefits.

The employer presented the deposition of vocational expert, Jim England. His testimony was taken on August 9, 2012. Mr. England reviewed the employee's medical records, deposition transcripts, and conducted a vocational interview of Employee.

Mr. England testified that taking into consideration the medical opinions of the treating physicians - Dr. Tate, Dr. Krewet, Dr. Young, and Dr. McGarry, the Employee was capable of returning to essentially of the work that he had done before his injury from a physical standpoint.

If he considered only the restrictions found by Dr. Stillings and Dr. Volarich, Mr. England testified that the combination of psychiatric, learning problems, and physical problems, Mr. Johnston would be excluded from all employment (Exhibit 2, Page 21). He explained that this opinion is based in part on whether or not the restrictions found by Dr. Volarich and Dr. Stillings are found to be credible.

Mr. England testified that Employee was not permanently totally disabled based upon the medical opinions of Dr. Tate, Dr. Krewet, Dr. McGarry, and Dr. Young.

The medical evidence of Dr. Tate is supported by all of the diagnostic studies, the records of Dr. Krewet, the records of Dr. McGarry, and the records of Dr. Young.

Mr. Dolan, a vocational expert for the Employee, testified that it is a combination of Employee's pre-existing mental and physical problems before November 27, 2002, in combination with the effects of the November 27, 2002 injury that combined to make Employee unemployable in the open labor market (Exhibit C, Page 34).

Based on all of the evidence presented I find that the opinions of Dr. Tate and Mr. England are more credible than the opinions of Dr. Volarich and Mr. Dolan on the issue of permanent total disability.

Further, I do not find the Employee's reporting of his complaints to be credible in light of the inconsistencies between his complaints and the medical records which document both pre-existing medical conditions as well as symptom magnification on the employee's part.

RSMo Section 287.020.6 defines total disability as the inability to return to any employment and not merely inability to return to the employment in which the employee was engaged at the time of the accident.

Based on all of the evidence presented, I find that Employee did not prove that he was unemployable in the open labor market. Therefore, Employee's claim against Employer/insurer and the Second Injury Fund regarding permanent total disability is denied.

Dr. Tate found the employee's MRI and myelograms to reveal only degenerative changes. In both of her examinations, she noted symptom magnification. She testified that the employee had a 0% permanent partial disability to the lumbar spine.

Dr. Volarich testified that the accident of November 27, 2002, was a substantial factor in causing a lumbar strain injury that required conservative treatment.

Based on all of the evidence presented, I find that Employee sustained 10% permanent partial disability of the body as whole referable to the lumbar spine from the November 27, 2002 work accident. The Employee's rate for permanent partial disability is \$340.12. Therefore, the employer/insurer is directed to pay Employee \$13,604.80.

The Employee's primary injury did not meet the statutory threshold for liability of the Second Injury Fund. Therefore, the Second Injury Fund does not have any liability regarding permanent partial disability.

Issue 7. The Employer/insurer claims that there is an overpayment of TTD and TPD in the amount of \$1,157.47

At the hearing, Employee stipulated to a pre-injury average weekly wage of \$608.66. This translates to a compensation rate for temporary total disability benefits of \$405.77.

Employee also stipulated that Employer/Insurer paid temporary total disability benefits at an incorrect rate of \$508.34 for the period of December 7, 2002 through December 16, 2002. Temporary partial disability benefits were paid based upon an incorrect average weekly wage of \$762.50 for the period of December 17, 2002 through January 13, 2003.

Finally, temporary total disability benefits were, thereafter, paid from January 15, 2003 through February 24, 2003 at an incorrect compensation rate of \$508.34.

Taking into consideration the stipulated temporary total disability rate of \$405.77 and based upon the payments made for both temporary total and temporary partial disability for the period of December 7, 2002 through February 24, 2003, Employer is entitled to a credit for overpayment of benefits made during the afore-mentioned period of time of \$1,157.47.

ATTORNEY'S FEE:

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

INTEREST:

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

Made by:

Maureen Tilley
Administrative Law Judge
Division of Workers' Compensation