

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

Injury No.: 99-140949

Employee: David Kindel
Employer: St. John's Regional Medical Center
Insurer: Preferred Physician Insurance
Additional Party: Treasurer of Missouri as Custodian of Second Injury Fund
Date of Accident: September 14, 1999
Place and County of Accident: Joplin, Missouri

The above-entitled workers' compensation case is submitted to the Labor and Industrial Relations Commission (Commission) for review as provided by section 287.480 RSMo. Having reviewed the evidence and considered the whole record, the Commission finds that the award of the administrative law judge, as modified herein, is supported by competent and substantial evidence and was made in accordance with the Missouri Workers' Compensation Act. Pursuant to section 286.090 RSMo, the Commission affirms the award and decision of the administrative law judge dated February 21, 2006, except to the extent modified herein.

The administrative law judge awarded future medical treatment as indicated in the life-care plan by Dr. Terry Winkler. We do not so limit the award. Employee is awarded future medical care as needed to cure and relieve him of the effects of the injury pursuant to the provisions of the Workers' Compensation Act.

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

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

The award and decision of Administrative Law Judge Karen Wells Fisher, issued February 21, 2006, is attached and incorporated by this reference, except to the extent modified herein.

Given at Jefferson City, State of Missouri, this 29th day of September 2006.

LABOR AND INDUSTRIAL RELATIONS COMMISSION

William F. Ringer, Chairman

Alice A. Bartlett, Member

Attest: _____
John J. Hickey, Member

Secretary

AWARD

Employee: David Kindel
Dependents: N/A
Employer: St. John's Regional Medical Center
Additional Party: Second Injury Fund
Insurer: Preferred Physician Insurance

Injury No. 99-140949

Before the
**DIVISION OF WORKERS'
COMPENSATION**
Department of Labor and Industrial
Relations of Missouri
Jefferson City, Missouri

FINDINGS OF FACT AND RULINGS OF LAW

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: September 14, 1999
5. State location where accident occurred or occupational disease was contracted: JOPLIN, MO
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: LIFTING AND CARRYING 50-70 POUND BOXES
12. Did accident or occupational disease cause death? NO
13. Part(s) of body injured by accident or occupational disease: BACK AND BODY AS A WHOLE
14. Nature and extent of any permanent disability: PERMANENT TOTAL DISABILITY
15. Compensation paid to-date for temporary disability: NONE
16. Value necessary medical aid paid to date by employer/insurer? \$89,522.36
17. Value necessary medical aid not furnished by employer/insurer? \$6,501.52
18. Employee's average weekly wages:
19. Weekly compensation rate: \$578.48 / \$303.01 / \$578.48
20. Method wages computation: AGREED

COMPENSATION PAYABLE

21. Amount of compensation payable:
 - Unpaid medical expenses: \$6,501.52
 - weeks of temporary total disability (or temporary partial disability)
 - weeks of permanent partial disability from Employer
 - weeks of disfigurement from Employer

22. Second Injury Fund liability: NONE

TOTAL:

23. Future requirements awarded: PERMANENT TOTAL DISABILITY

Said payments to begin September 15, 1999 and to be payable and be subject to modification and review as provided by law.

The compensation awarded to the claimant shall be subject to a lien in the amount of 25% of all payments hereunder in favor of the following attorney for necessary legal services rendered to the claimant:

FINDINGS OF FACT and RULINGS OF LAW:

Employee: Kindel, David Injury No: 99-140949

Dependents: N/A

Employer: St. John's Regional Medical Center

Additional Party: Second Injury Fund

Insurer: Preferred Physician Insurance

Checked by:

Before the
**DIVISION OF WORKERS'
COMPENSATION**
Department of Labor and Industrial
Relations of Missouri
Jefferson City, Missouri

AWARD ON HEARING

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The above-referenced workers' compensation claim was heard before the undersigned Associate Administrative Law Judge on August 18, 2005. The employee appeared personally and through his attorney, Matthew Webster. The employer and insurer appeared through their attorney, John Dolence. The custodian of the Second Injury Fund appeared through its attorney, Karen Johnson, Assistant Attorney General.

ISSUES

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The parties have stipulated that the compensation rate in this case is \$578.48 per week for temporary total disability benefits, \$303.01 for permanent partial disability benefits, and \$578.48 per week for permanent total disability benefits. The parties further agreed that no temporary total disability had been paid to the date of the hearing and that the employer has provided medical treatment to the employee having paid \$89,522.36 in medical expenses. The parties agreed that the following issues are to be determined as a result of the hearing.

1. Whether the events of September 14, 1999, and September 15, 1999, caused the injuries and disabilities for which benefits are now being claimed.
2. Whether the employer and insurer are obligated to pay for certain past medical care and expenses in the amount of \$6,501.52.
3. Whether the claimant has sustained injuries that will require future medical care in order to cure and relieve the claimant of the effects of the injuries.
4. Whether the claimant sustained any permanent disability as a consequence of the alleged accident and, if so, the nature and extent of the disability.
5. Whether the Second Injury Fund is liable for payment of permanent total disability compensation or enhancement of permanent partial disability compensation.

EVIDENCE PRESENTED

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The claimant testified at the hearing in support of his claim. The deposition testimony of Dr. Behm, Dr. Winegarner, Dr. Mace, Dr. Lennard, Dr. Pinkerton, Dr. Hopkins, Dr. Koprivica, Dr. Halfaker, and Mr. Eldred were also offered. The testimony in pertinent part is as follows.

Mr. Kindel testified that he was born January 18, 1953, and was 52 years old on the date of the hearing. He testified that he had graduated high school and had earned a B.S. in nursing and a Masters in Business Management. He testified that he rode bulls bareback for a few years while touring in a rodeo. He also served in the military from 1971 to 1979. During this time he served in the Army in combat arms and as a light and heavy weapons specialist. He did a second stint in the army and worked as an oral specialist. He testified that he served later in the Air Force. He went to flight nursing school and was in charge of the emergency room and critical care at the base. He left the Air Force in 1987.

He worked as a Director of Nursing at Sisters of Mercy Hospital in Independence, Kansas and was then recruited to Liberal, Kansas at Southwest Medical Center and was ultimately promoted to president and CEO. He testified he was then recruited to St. John's Hospital in Joplin as a Sr. Vice President and CEO.

Mr. Kindel testified that he did have injuries prior to September of 1999. He testified that as a result of bull riding he had suffered a broken nose and sinuses, he had several dislocations, broken ribs, a fractured foot, ankle and legs, and a broken neck. He testified that he stopped riding after the broken neck. He indicated these injuries left no ongoing symptoms or required ongoing treatment.

He testified that while in the military he had to maintain a certain level of physical fitness. He hurt himself while lifting weights in 1986. This involved a ruptured disc in his neck and he initially had trouble moving his right side. A decompression and fusion was performed and Mr. Kindel testified that he recovered full mobility although he had a dead spot in his right forearm and did experience a slight loss of grip strength.

After he got out of the Air Force and was working at Southwest Medical Center in the emergency room, he, in September of 1992, experienced a bulging disc at L3-4. In 1994 he had surgery through Kansas workers' compensation. He testified that he was released from further care from this injury with a 50-pound weight restriction. He testified that he did experience some problems with overuse, but otherwise he had no problems as a result of that injury.

In 1997 Mr. Kindel did have surgery to his knee. He had a bucket-handle tear of the medial meniscus, this was also covered by workers' compensation in Kansas. Subsequent to that surgery he testified that he had no problems with the left knee. In September of 1999 Mr. Kindel testified he did not have radicular pain and no severe pain in his low back. He also testified he had sought no treatment or medication for his back prior to September of 1999. He hunted deer, pheasant, and turkey. He raised and trained quarter horses. He fished, rode ATVs, played basketball, and had no problem performing these activities.

Mr. Kindel testified that on September 14, 1999, he was employed by St. John's hospital in Joplin. The hospital had an employee picnic scheduled on a Saturday. On Friday Mr. Kindel testified that he went to the kitchen to help get ready for the picnic. He moved boxes of ground beef weighing 50 to 75 pounds and made hamburger patties. On Saturday he lifted the boxes of patties onto a trailer and also lifted bags of charcoal. He also cooked hamburgers from 10:00 a.m. to 4:00 p.m. on that day. On Friday the floor in the kitchen where he was moving the boxes of meat was very slick. He testified that he did not fall, but had tensed his body to carry the boxes of meat in order not to slip. He did note that his back was sore on Friday and he still noticed the soreness on Saturday morning. He testified that he was very sore on Sunday, and Monday he started experiencing pain down into his leg. He did report it to his employer and noted that the back continued to get worse.

He indicated that he first saw Dr. Behm in October of 1999. She recommended treatment with heating pads and over-the-counter medications. When he saw Dr. Behm, he indicated that his low back was really hurting, and hurting into his leg, and that his arms and neck were very sore. He testified that he was starting to experience bowel and bladder problems and erectile dysfunction. He testified that an MRI was performed and his understanding was that there was a bulge hitting the L5 nerve root and there was an L3-4 bulge. He continued treating with Dr. Behm.

He saw Dr. Winegarner November 12, 1999, and indicated low back pain and leg pain in both legs, the right greater than the left. He

indicated bladder problems, leg fatigue, an inability to control flatulence, fecal staining, and that he was walking stooped.

Mr. Kindel testified that initially he had pain in the right leg only, but within a week or 10 days the left leg started to hurt also. He testified that these problems still persist. He has been on medication for physical pain since he first saw Dr. Behm. He is now also on medication for psychological symptoms. He was taking medications from December 1999 to March of 1999.

The employee does contend that he has psychological problems from this injury. He saw Dr. Saba as a referral from Dr. Pinkerton. He saw Dr. Hopkins, who performed surgery, but this surgery was not successful. Mr. Kindel testified that he continues to return to the symptoms he experienced as stated in November of 1999. Mr. Kindel testified that he continued to work until December of 2002. The medications he was on caused memory loss. He would forget meetings and conversations and he would have to close his office door and lay on the floor in order to get through the day. He has not worked since that time.

He testified that currently he has muscle spasms in his back and legs. His legs feel tired and weak. He is getting carpal tunnel symptoms from using canes to walk. He cannot control his bladder and he has pain when he sits, stands, or walks and he does experience erectile dysfunction. Mr. Kindel also testified that he can occasionally walk his circle drive. He is unable to sit still. He does lay down throughout the day. He has difficulty with memory and concentration due to his medication and he is suffering from depression.

Under cross-examination Mr. Kindel also testified that he does have diabetes and prior to the injury experienced unstable angina since 1990, high blood pressure, Barrett's esophagus and epidermal nevus (lesions on the skin). He did have a prior knee surgery, low back surgery, prior neck surgery, and T-12 compression fracture. He recalled no back problems prior to 1999 and he did indicate that he had ridden horses once or twice since the events in September of 1999. Mr. Kindel testified that he had in fact told Dr. Pinkerton about having had prior difficulties with bowel and bladder control and erectile dysfunction, but that the current symptoms are different than the prior ones.

Under cross-examination by the Second Injury Fund Mr. Kindel testified that for two years prior to 1999 he had not missed work due to a physical reason, that he had no limit on sitting or standing during that time, and he had had no problems with urinary or bowel incontinence for three to four years prior to that time. He indicated that the preexisting problems had not been a hindrance to his employment.

The claimant also submitted the deposition testimony of various doctors. The following is a summary of this evidence.

LAURIE L. BEHM, M.D.

Dr. Behm testified that she was a specialist in physical medicine and rehabilitation concentrating on patients in back pain and neck pain. She testified that she first saw Mr. Kindel for treatment on October 19, 1999. His initial complaints at that appointment were right arm tingling, forearm numbness and right buttock pain for the last two or three weeks. He did indicate to her that he had had leg and arm weakness in the past. She testified that his history was that he attributed the onset of the current symptoms to events at a hospital picnic where he had done a lot of activities including leaning over the grill and cooking on the grill and probably picking up boxes of hamburger. Dr. Behm indicated she had ordered an MRI and that a follow-up appointment occurred on October 21, 1999.

Dr. Behm's interpretation of the MRI was that there was essentially negative C-spine and lumbar with a possible slight bulge hitting the L5 root. She testified that that would be the L4-5 disc level. Dr. Behm testified that she had recommended no prolonged car riding as it was unsupported sitting and could aggravate his back symptoms or exacerbate any pathological findings that might be in his lower back. Dr. Behm testified that after the MRI they tried conservative treatment with physical therapy and some medication and had an epidural steroid.

One week later on the 28th there had been some improvement and he was doing better. Her impression at that time was L5 radiculopathy from an L5 nerve root irritation. Dr. Behm also testified that at the October 28th appointment she first noticed the piriformis syndrome which is buttock pain after physical exam.

She then testified that on November 11, 1999, she saw Mr. Kindel again at which time he had a new complaint of left foot pain. Dr. Behm also indicated that the buttock pain had completely resolved. He also indicated at that appointment that 10 days prior he was beginning to have increasing problems with bowel and bladder. This symptom was new to her but Dr. Behm testified that she believed he had not

indicated it to her before because he was embarrassed of those problems. Dr. Behm indicated that it was her impression that there wasn't a big mass pushing on the canal or a big herniation. There wasn't a narrowing significant enough to have caused the bowel and bladder problems. As a result she ordered a myelogram of the thoracic spine and had Mr. Kindel see a neurologist. This referral was also made as a result of the bilateral leg pain because the slight bulge noted at the L4-5 was to the right which would not necessarily correlate with left leg pain. Therefore, she was concerned about a systemic problem. She also ordered physical therapy which was unsuccessful in that Mr. Kindel was unable to make the appointments.

Dr. Behm testified that there was a note from November 29th indicating that Mr. Kindel had an exacerbation of pain from an extended car ride. However, in her testimony she was unable to determine from that point forward how much of his back pain symptoms were from an aggravation of riding in the car versus what he had previously had because of the hamburger grilling.

Dr. Behm testified that by the May 18th appointment piriformis injections had been performed and she defined piriformis syndrome as being a situation where the nerve runs through the bellies of the muscle and then it spasms out and you get radicular pain. She testified that Mr. Kindel returned again to see her August 2nd but mentioned that she had hospitalized him a couple of times prior to that at which time she did a procedure for piriformis injection. He was in the hospital July 31st for the piriformis injection. Dr. Behm testified that two days later he was back in her office with an exacerbation from an incident where he was sitting and got up suddenly and had a sudden onset of severe back pain. She admitted him to the hospital as a way to help him handle the pain through administering IV drugs regarding any neurological problems. The reason for her recommendation of a facet injection at this time was that the complaints were more of back pain rather than piriformis. He was discharged on August 3rd directly to Dr. Kistler's office. When asked if the facet disease that she had noted on August 3, 2000, and in October of 1999 predated Mr. Kindel's complaints of what happened in September of 1999, Dr. Behm indicated that "on the facet pain, he didn't have a big back component so that you would think that there would be a presenting problem with the back, but it could be also leg pain, so it's kind of hard to say. And then the facet pain can radiate to the piriformis area, so they're all kind of right in that area. But he had facet disease on the first MRI."

Dr. Behm again saw Mr. Kindel on September 8th on which date he was doing much better. She indicated that the waxing and waning of symptoms is consistent with patients who have a lot of wear and tear on their back. Dr. Behm testified that in her mind non-specific low back pain was really a function of him compensating in so many ways and he had so many different things going on, "like the piriformis we fixed that and then something else, his facet would be a problem and we'd fix it. We could isolate the pain source you know, and we'd fix it, but something else would flare up and that's the chronic state of it. That's from the wear and tear. So you have a bad disc, it goes bad and you put more stress on the facet, the facet goes bad then you alter your gait you know and then you have other pelvic mechanics that go wrong and so then you're just shooting at different ideologies of the pain when they occur and that's what made him so difficult." Dr. Behm indicated that she believed the piriformis spasming was from his gait abnormality which was caused from the weakness in his foot. Her opinion was that the weakness in the foot had been there from the first day she saw him.

She testified that on February 1, 2001, she discussed with Mr. Kindel an intradiscal electrothermal procedure (IDET). Dr. Behm felt that some of his pain was from the disc as well as the facet and as well as the piriformis and thought possibly the IDET would help control his pain and keep him at work. She believed the disc was the L4-5 level.

On his April 23rd office visit Dr. Behm noted that she believed he had a long chronic condition with disc degeneration chronic in nature and that Mr. Kindel understood and agreed with that assessment. With that diagnosis she would anticipate his condition to worsen over time. Dr. Behm testified that her definition of chronic referenced being present for more than six months, therefore, when she described his condition as chronic in 2001 it could mean that it started in September of 1999. She also testified that a temporal relationship as far as onset of symptoms to a specific event can help a physician determine a source of a problem. She agreed that if someone is not having any symptoms then something happens to them and then symptoms start, if you don't have any other information than that it helps determine whether or not that event was the cause of the symptomology.

When questioned regarding Mr. Kindel's symptoms from Dr. Winegarner's records because they were very detailed regarding his symptoms, Dr. Behm agreed that not only had Mr. Kindel seen Dr. Winegarner a couple of months after the event but that also he had seen Dr. Winegarner prior to the extended car ride that he had taken and was having all the symptoms that were listed in those notes prior to the eight-hour car ride. She also testified that it was her opinion that the piriformis syndrome was a result of Mr. Kindel's altered gait and that she in fact saw him limping. She testified that some days he would be good and then some days he would be bad, but it was a general downward trend.

Dr. Behm testified that in her opinion Mr. Kindel may have developed a chronic pain syndrome from the September 1999 injury which may have led to other altered mechanics and so forth, but she did not believe the bowel, bladder, and incontinence were caused by that injury.

Dr. Behm also feels that from a chronic pain perspective it would benefit Mr. Kindel if he were not on pain medication although he is to a point where he relies on it to do some type functioning. However, she would look at a spinal stimulator or some other way of monitoring or managing his pain.

J. CHARLES MACE, M.D.

Dr. Mace testified that he is a board certified neurosurgeon in Springfield, Missouri and saw Mr. Kindel as referred by Dr. Behm. He saw him on one occasion, June 7, 2000. Mr. Kindel's main complaints at the time of this appointment were back pain, pain into the right hip, pain into the anterior aspect of his right leg to the foot and big toe, and increased urinary frequency. Dr. Mace indicated that there was no surgical lesion on his imaging and explained that if there is a nerve that is pushed on or pinched by something that is may be causing the symptoms this may appear in a myelogram or MRI. He, however, could not see anything on the myelogram images that explained the symptoms Mr. Kindel was having so there was nothing he could offer to help his symptoms. Dr. Mace indicated that he did not have benefit of records prior to November of 1999, but that based upon the information he had and according to what he reviewed it was his opinion that the development of symptoms was causally related to Mr. Kindel's injury in September of 1999.

TED LENNARD, M.D.

Dr. Lennard testified by deposition that he saw Mr. Kindel in February 21, 2001, to evaluate his current status and make any recommendations. This was an independent medical examination. Mr. Kindel, at that time, described having general pain in his back, hip, buttock and thigh region. Dr. Lennard had the reports of Dr. Behm, Dr. Winegarner, Dr. Mace and Dr. Royal available for his review. Dr. Lennard indicated that Mr. Kindel may have L5 radiculopathy which is usually caused by a compressed disc in the back, usually the L4-5 disc. Dr. Lennard also felt that the examination was more consistent with the S1 vertebra based on his atrophy and his loss of sensation. He also indicated that Mr. Kindel did have complaints of urinary urgency. His impression of Mr. Kindel was that of lumbar diskogenic pain with underlying radiculopathy. Dr. Lennard ultimately concluded that Mr. Kindel's current complaints appear directly related to his work accident in September of 1999. He testified that he based his conclusion upon his Mr. Kindel's history and his review of the previous treating physician. Dr. Lennard also testified that he felt that unless there was some unusual event that occurred while he was standing (up from the chair) he would not consider that to be a new injury nor would he consider riding in a car, even if he had increased pain, to be a new injury. Dr. Lennard further testified that it was still his opinion that he believed the September 1999 event at work was what caused Mr. Kindel's severe pain symptom. He felt the September 1999 event is what necessitates the treatment that he was recommending in his report.

MARK C. PINKERTON, M.D.

Dr. Pinkerton testified that he is an anesthesiologist interventional pain physician. He has been at the St. John's Pain Management Clinic since 2000. He testified that he first saw Mr. Kindel on June 19, 2001. Since that time and at least through 2004 he continued to see Mr. Kindel approximately once a month. Dr. Pinkerton first diagnosed a possible new herniated L5-S1 disc on his first visit and radiculitis at S1. The neurological findings that caused him to identify the S1 radiculitis was an absent right ankle jerk. He had a positive straight leg raise sign, but that could be S1 or L5 classically that can cause sciatica. The S1 is the enervation of the bottom heel or can be a crossover between L5 of S1. He also was able to review a June 27, 2001MRI which he had recommended. He testified that in July of 2001 he performed a discography, which is an injection of a contrast material into the disc to see if he can reproduce pain. The findings were significant pain upon injection at L4-5 with a normal appearing disc and minimal pain right leg upon L5-S1 disc injection. Dr. Pinkerton felt based upon the discogram that he did not really have anything more to offer Mr. Kindel from a pain management perspective and he wanted to get another opinion from a spine surgeon. He also performed a selective nerve root block at L5-S1 following the discogram. His thinking was that if he had pain on injection of L4-5, maybe he had a little bit of an annular tear and it was leaking out on the L5 root and causing pain and so his approach was to just go ahead and see if he couldn't get some relief. He did have a little bit of right leg pain after the L5-S1 injection, so he had enough information there that he felt like if he did his L5 root he might give Mr. Kindel some really good relief. Dr. Pinkerton then testified that after that nerve block and a couple of other treatments he concluded in October 2001 that Mr. Kindel was at maximum medical

improvement from the pain management perspective, but he also kept it open for epidural injections, spinal cord stimulator implant, or intrathecal drug infusion system because at that point it looked like he was responding well to the therapy. Also, Dr. Pinkerton believed that Mr. Kindel had aggravated his preexisting condition of post-lumbar laminectomy syndrome. By December Dr. Pinkerton diagnosed Mr. Kindel along with the L5 irritation as having a lumbar facet arthralgia. This diagnosis occurred because in October he did another selective nerve root block on L5 and it did nothing. He explained that from a holistic point of view if you have L5 root irritation it is certainly possible to get referred pain into that area over the facet, so his attention was initially was at the L5 root. When that attention did not help or did not help as well as he would have liked, he moved on to that facet generator. He had a positive extension sign in August of 2001 to indicate facet arthralgia which would, of course, have surfaced after the L5 root block as the primary generator. If you take care of one then the other one shows up, so that is what he was talking about. So he explained this is how it is possible to mask an L4 facet arthralgia with an L5 root irritation.

In January of 2002 Dr. Pinkerton performed a radio frequency thermoneurolysis at L4-5 and L5-S1 rhizolysis using radio frequency lesioning. He testified that this was a process of using a radio frequency cannula about the size of a pin, but it is placed right on the nerve and is basically fried so that it would denervate the facet anticipating resolution of the facet arthralgia.

Dr. Pinkerton felt that it was very significant that Mr. Kindel was clearly not a magnifier of pain based upon his exams, and that from a pain management perspective this was critical to look at this psychological aspect. Dr. Pinkerton indicated in his testimony that in his practice he does see non-classical responses to nerve root injuries. In other words, even though the injury is at one specific area, it does not enervate just like you would expect. He also agreed in his testimony that medicine is not an exact science, and for example, in Mr. Kindel's case, he has a normal looking 4-5 disc on an MRI, CAT scan, or myelogram and yet a positive discogram from that area which could suggest that there is still a problem at that area. He also testified that there is a definite temporal relationship between the time of the onset of Mr. Kindel's problems and the injury at work in September of 1999 and that they could be definitely related to the disc that they were talking about at L4-5.

He further testified that the symptoms that he treated Mr. Kindel for and that he continues to treat Mr. Kindel for are as a result of that September of 1999 accident at work. He also recommended future treatment. He thinks he needs an MRI to evaluate the low back with and without contrast and that it has been recommended that he have fusion by more than one physician, both Dr. Hopkins and the Texas Back Institute. He would definitely join in the recommendation to send Mr. Kindel to the Texas Back Institute. He would also recommend ongoing medication and ongoing physical monitoring and any lab work that is necessary. He finally testified that he believes that Mr. Kindel is totally disabled.

WILLIAM O. HOPKINS, M.D.

Dr. Hopkins testified that he is a board certified orthopedic surgeon in Overland Park, Kansas and that he saw and treated Mr. Kindel having first seen him on February 21, 2002. Dr. Hopkins testified that at the first appointment Mr. Kindel described his pain as severe and from his initial exam and review of the MRI films, his opinion as to the source of that pain was lumbar radiculopathy, but he thought that he had multiple level disease and it would be difficult for him to point to a single level as causative of all the symptoms. At that time Dr. Hopkins recommend a procedure called nucleoplasty also known as percutaneous disc decompression. It is the use of a radio frequency devise centrally inside the disc. He felt it had some degree of potential for improving some of Mr. Kindel's symptoms. This is a procedure that is used in instances primarily in people who are significant risks for a major operation, people who have diabetes, heart disease, neuropathies, or other conditions that would make one apprehensive about doing a major operation on them. It has the potential of relieving both the radicular pain and the lower back pain. He also testified that he performed a discogram on the 22nd of February to determine the levels where Mr. Kindel might need the nucleoplasty. The discogram had a positive finding at the L5-S1 level. The pain radiated down the right leg to the great toe. Normally at L5-S1 we would expect radiation of pain to the outside of the foot, not to the inside of the foot. So he demonstrated a pattern of pain one level higher. The doctor testified he presumed that is because of his prior procedure and the effect of scar tissue in the spine. The doctor then performed the nucleoplasty at the L5-S1 level and L3-4 level. Mr. Kindel apparently had some temporary improvement from this procedure.

Dr. Hopkins testified that on April 29th when he saw him, however, Mr. Kindel was still symptomatic with substantial back, buttock, and leg pain, numbness and weakness but symptomatically he felt that he was somewhat better. It was Dr. Hopkins's opinion that by September of 2002 Mr. Kindel was permanent and stationary in regards to his functional impairment. Dr. Hopkins initially indicated that Mr. Kindel would be capable of sedentary work and gave a 52% whole person disability rating. He did not address the issue of causation and later

indicated by an addendum letter written November of 2002 that he believed Mr. Kindel was completely disabled for any and all work activities even though he had not seen him since his last report of September 3, 2002. His recollection was that Mr. Kindel, in September of 2002, had desired to continue working and that would have been the reason why he gave a different opinion in November than in September. Dr. Hopkins agreed that Mr. Kindel had L5-S1 herniation and L3-4 central protrusion as well as a piriformis syndrome which he feels is a radicular symptom and that he had facet disease, disc disease, intractable pain syndrome, facet arthralgia syndrome, refractory spondylosis, failed back syndrome, cauda equina syndrome, and L5 radiculopathy, and also sexual dysfunction. Dr. Hopkins indicated that the things Mr. Kindel told him of and that he found on his physical exam were commensurate with the abnormalities that he saw on his diagnostic studies.

Dr. Hopkins stated that when Mr. Kindel had an episode of bending over in the shower and had an immediate return of symptoms, he presumed was that Mr. Kindel was still symptomatic, but that minor episode just reaccentuated all of his symptoms. Dr. Hopkins, in his deposition testimony, did indicate that his understanding was that Mr. Kindel did not suffer from severe leg pain prior to September of 1999, that he did not have foot drop before September of 1999, that he did not have a history of urinary urgency or loss of bladder function prior to September of 1999, that he did not have a history of erectile dysfunction prior to September of 1999, nor a history of undergarment soiling prior to September of 1999, he did not have severe bilateral radiating pain into his lower extremities prior to September of 1999 and did not have severe ambulatory problems involving an inability to get around without using canes and walkers prior to September of 1999. He testified that it was his opinion, based not only on the objective testing that he had reviewed, but also on the history provided to him from Mr. Kindel including all of the above symptomology that those things were caused by the September of 1999 work injury.

Additionally, his recommendation that Mr. Kindel be evaluated by the Texas Back Institute is also necessitated by his work injury of September 1999 as well as the need for ongoing medication and a spinal cord stimulator. Dr. Hopkins last saw Mr. Kindel in July of 2003 at which time he was having severe difficulty getting around and was walking with two canes and even prior to that Dr. Hopkins had prescribed him a walker and he believed that was also necessitated by the September of 1999 injury. He also gave an opinion that a scooter would be a preferable method of gait assistance and that would be his recommendation and that would also be necessitated by his work injury.

P. BRENT KOPRIVICA, M.D.

Dr. Koprivica testified in deposition that he is a medical doctor board certified in occupational medicine and emergency medicine. Dr. Koprivica examined Mr. Kindel for an independent medical examination on June 16, 2003. At the time of that exam Mr. Kindel complained of severe postural limitation and said those postural limitations are what led him to leave work at St. John's Medical Center in Joplin. He said he could sit less than one hour and during that time would be squirming and changing positions. He could stand less than 15 minutes. He could walk less than one block and relied on a cane. He could not go up and down stairs because of the severity of the pain that he experienced. He was relying on the cane so much that his hands were going numb and he was having to alternate between hands in using the cane because of that numbness. He had urinary and fecal incontinence.

It was Dr. Koprivica's understanding that following the 1994 surgery that Mr. Kindel had little or no pain on an ongoing basis. He felt that Mr. Kindel was appropriate under Waddell's criteria for symptom magnification (not a symptom magnifier) and performed a physical examination, but did not do formal motion testing in his head, neck, or low back area in that he felt it would cause him to hurt more to see how far he could bend even though the doctor knew it wouldn't be normal. He concluded that the work activity he was doing associated with the picnic in September of 1999 resulted in an annular injury sustained at L3-4 and L5-S1.

It was also his understanding that following the September 1999 lifting event Mr. Kindel suffered from low back pain with low back spasms, urinary urgency and increased urinary frequency, erectile softness, right greater than left extremity pain and numbness radiating to the great toe, he was slow and stooped in his ambulation because of pain and had fatigue in his legs. He had difficulty controlling flatulence and had some fecal staining. He had difficulty sleeping because of pain. The doctor testified it was his opinion that the work injury of September 14, 1999, was the cause of these symptoms.

Dr. Koprivica gave a formal diagnosis of annular injury at L3-4 and L5-S1 with the development of symptomatic diskogenic pain at those levels for which he had undergone percutaneous decompressions at L3-4 and L5-S1 with a failed back syndrome. He further indicated the failed back syndrome was caused by the work injury of September 14, 1999.

Dr. Koprivica also recommended future medical treatment. He recommended that Mr. Kindel be considered for spinal cord stimulation, possible surgical intervention and to see a psychologist or psychiatrist to deal with his response to the injury. He felt that all of these recommendations would be necessitated by the injuries he sustained associated with the September 14, 1999, work injury. He further felt that Mr. Kindel would likely need gait assistance as time went on in the form of some type of mechanical device like a scooter, and that he due to the severity of his problem he would like need a caretaker in the future.

Dr. Koprivica testified that he assigned a 25% permanent partial disability to the body as a whole as related to Mr. Kindel's prior neck injury and surgery that he had had in the 1980's. He assigned a 20% body as a whole rating as a result of Mr. Kindel's prior hemilaminectomy at L4-5. Dr. Koprivica assigned, at the time of his June 16, 2003, report, a permanent partial disability rating of 50% of the body as a whole as a result of the September 1999 injury.

He additionally indicated restrictions as a result of that injury which included being restricted to sedentary physical demand level of activity or less, that allowed occasional lifting or carrying up to 10 pounds. He felt his gait limitations were so severe that he should be given access to a wheelchair or an electric scooter to assist him and he would need to use a cane due to the limited standing and walking activities that he could do. He also felt that he needed the flexibility of being able to sit whenever necessary and sitting should be limited to less than one-hour intervals. He could not squat, crawl, kneel, or do any type of climbing. He restricted him from bending at the waist, pushing, pulling, or twisting except on rare occasions, and he should avoid sustained or awkward positions of his low back. He also noted that the chronic narcotics he used would impact him from an employability standpoint in terms of being able to concentrate or be precise about work, and that there would be negative impact from the urinary and fecal incontinence that he was experiencing. He testified those restrictions were necessitated as a result of the September 1999 injury.

Dr. Koprivica testified that at the time of his June 16th report he felt that as a result of the combination of his prior injuries and the September work-related injury that Mr. Kindel was totally disabled. However, after he had completed his June 16, 2003, report he was provided some additional medical records and was asked to review those and make an addendum report. Upon doing so Dr. Koprivica reevaluated Mr. Kindel's situation and had a new opinion regarding the effect of his primary work injury of September 1999 on his ability to access the open labor market. He concluded that if he looked at the last injury in isolation and the restrictions that he was having to adhere to as a result of that injury, he would be totally disabled based on that in isolation. He also had an opportunity to review a life care plan prepared by Dr. Winkler. He testified that the recommendations in Dr. Winkler's life care plan were reasonable and necessitated by the September 1999 work injury.

Under cross-examination Dr. Koprivica testified that he agreed that there were significant degenerative changes in the spine after looking at an MRI scan report from October 20, 1999. Dr. Koprivica testified that his conclusion that there was an annular tear as a result of the September 1999 injury was based on the findings of the MRI and the onset of the symptoms that he had not complained of before. Dr. Koprivica was asked a question about the incident of Mr. Kindel sitting up from the chair and experiencing pain and then being hospitalized August 2, 2004, and about Mr. Kindel's indication that he was going down a step and stepped down hard and noted pain. Dr. Koprivica testified that unless there was something unusual that would suggest there was a new structural change that it is just a manifestation of the same process because he expects a person who has a permanent injury to continue to have symptoms when they try to do things. He testified he does not necessarily equate symptoms with a new injury. He clarified that if it is something that results from a temporary increase in pain that their overall clinical course does not permanently change after a few days or having some similar types of complaints, then he does not consider it to be permanent. When asked if one can have an increase in pain symptoms that are a permanent disability because of the increased symptoms without a change of structure, he clarified

A. The way that I interpret things is I don't believe there can be any permanent increase in symptoms without a change in structure. So if you give me as part of that equation that they have a permanent change or they have new symptoms that are permanent in nature or an increase of symptoms that are permanent in nature, by definition, there is a structural change.

You may not be able with the level of sophistication of diagnostic studies to prove what that is because as we know, MRI scans are not conclusive. Oftentimes, you do an MRI scan and when they do surgery they find pathology that the MRI scan didn't find.

By the way I am operating, by definition, if there is a permanent change in terms of symptoms, new symptoms

that are ongoing or an increase in symptoms, that implies there has been a permanent structure change. I consider that to result in disability.

Now, there may have or may not have been something that precedes it that put them at risk for that structure change, and oftentimes, there is. But if there is no structure change, then you don't have a permanent change in symptoms.

Dr. Koprivica also described how his opinion was that there was an aggravation and acceleration of Mr. Kindel's degenerative process because of the September 1999 event. He testified that whenever you cause injury at the annular level and you injure the disc producing aggravation to the degenerative disc, the ability of the disc complex to absorb force is compromised, and when that occurs there are increased stresses that are placed on the other structures of the spine. The ligaments that support the facet joints, those are put under increased strain due to the inability of the disc to absorb force in a normal fashion. It is a progressive failure of those structures that leads to the degeneration.

DALE HALFAKER, Ph.D.

Dr. Halfaker testified that he was a licensed psychologist. Dr. Halfaker indicated that he had reviewed medical records relating to the claimant. He had also performed testing on the claimant in addition to his interview of Mr. Kindel. Dr. Halfaker also testified that he had made certain diagnosis regarding the claimant's condition. Dr. Halfaker testified to his knowledge and from what he had seen in the sources, the medical records that were provided, Mr. Kindel's history to him, as well as the results of his own testing that he did not believe there was any significant preexisting kind of psychological problem. There was nothing that would significantly impact his ability to function in the areas of his life that were important to him, so there really was not any indication of any significant or disabling psychological disability or impairment prior to the incident of September 1999.

Dr. Halfaker also testified that he had made certain diagnoses regarding the claimant's condition utilizing the diagnostic manual DSM4. On Axis I Dr. Halfaker diagnosed Mr. Kindel with what's called a pain disorder associated with both psychological factors and a general medical condition chronic. The other portion of that was a major depressive disorder single episode severe but without psychotic features. He described this as meaning when someone experiences a chronic pain disorder there are a number of rather predictable responses that come into play like depression, anxiety, frustration, anger, hopelessness, despair. Then if a person is struggling with negative emotions due to a pain disorder, those emotions begin to influence the expression of that pain and can magnify it. Dr. Halfaker defined a major depressive disorder as a clinical entity within the DSM4 so it is not normal everyday mood variation that all of us experience when you have a bad day. It represents a departure from that in which the depression is present for at least two weeks and is of significant severity to warrant the diagnosis. In a single episode it means this is the first time that the person has had depression of this nature or this severity. Dr. Halfaker goes further to say that in his viewpoint as a psychologist what he sees is an individual who has been diagnosed as having the kind of injury that results in pain. Although he cannot make a medical determination as to causation of those injuries, he feels that from the psychological perspective the pain is what results in his loss of function and that loss of function and disability results in the emotional response of the depression, the anxiety, the anger, the frustration so that basically the injury of September 14, 1999, is the cause for the diagnosis. He went further to say that he believed Mr. Kindel could benefit from some kind of psychological intervention. He was currently receiving medications for his psychological problems and he would expect that that would probably continue on a permanent basis or at least for the foreseeable future. He would also suggest that some psychological counseling as well would help him deal with his pain. Those treatments would be necessitated by the work injury. Dr. Halfaker went on to indicate that Mr. Kindel has suffered a permanent partial disability on a psychological basis between 20 to 25 percent of the body as a whole. Dr. Halfaker then testified that Mr. Kindel's global score on the DMS4 was a score of 50, indicating that with a score within the 51 to 59 range, we're looking at serious problems. "So definitely with his rating of 50 we are looking at someone who has got some pretty serious psychological and emotional problems."

PHILLIP ELDRED

Mr. Eldred testified through deposition and stated that he was a certified rehabilitation counselor. He met with Mr. Kindel on March 3, 2005. Mr. Eldred conducted an interview of Mr. Kindel and then conducted vocational testing. In preparation for that interview and testing Mr. Eldred reviewed the medical records, reports and depositions listed in Exhibit 2 as attached to the deposition. He also indicated that he relied on those records, reports, and depositions in formulating the opinions contained in his report dated April 9, 2005. Indetermining whether Mr. Kindel was employable in the open labor market Mr. Eldred considered that he is a 52-year-old white male who suffered injuries

on September 14, 1999, while employed at St. John's Regional Medical Center in Joplin, that he is now unable to return to any of his past employment due to his pain and the medical restrictions assigned by his physicians, and that he has been trying to adjust to living with constant pain and physical restrictions. He also considered that he will continue to need ongoing medications and therapy. Mr. Eldred concluded that while Mr. Kindel did have physical limitations before September of 1999 his limitations did not prevent him from being competitively employed and that his current physical restrictions now prevent him from performing any competitive employment according to Dr. Hopkins, Dr. Pinkerton, and Dr. Koprivica. Mr. Eldred considered Mr. Kindel's cognitive and emotional disabilities in assessing his potential for returning to gainful employment. He relied on Dr. Halfaker's opinion, who indicated that Mr. Kindel had serious psychological and emotional problem. He finally concluded that Mr. Kindel was working at a job that he was physically able to perform and due to his injury in September of 1999 his opportunity for work became no longer available to him and that he now has lost his ability to perform gainful employment. It was his opinion that Mr. Kindel is neither employable nor placeable in the open labor market and that he is permanently and totally disabled when it comes to gainful employment due to the injury in September of 1999 in isolation.

In deposition Mr. Eldred testified that the doctors had limited Mr. Kindel to sedentary and less than sedentary work. He defines sedentary work as work that is mainly sitting, exerting up to 10 pounds of force occasionally and/or a negligible amount of force frequently to lift, carry, push, or otherwise move objects including the human body. Sedentary work involves sitting most of the time, but may involve walking or standing for brief periods of time. He then indicated that less than sedentary work is not specifically defined, and indicated that when we are talking about less than sedentary we are talking about someone who is not employable. He then went on to indicate that the restrictions given by Dr. Hopkins, Dr. Pinkerton, and Dr. Parmet. Dr. Hopkins and Dr. Pinkerton were less than sedentary and Dr. Parmet's were sedentary work level based on a 2002 time frame, but that Dr. Parmet also mentioned that that may not be true at this time. He also indicated that the restrictions by Frank Eitemiller at St. John's, who performed a functional capacity examination, would have indicated less than sedentary. Additionally, Dr. Koprivica's restrictions would fall within a less than sedentary work level. Mr. Eldred also testified that even applying the sedentary work level according to the restrictions given by Dr. Parmet, his opinion was that Mr. Kindel would still be unemployable as he considered several things including his ability to perform work tasks, his age, education, work experience, vocational skills and aptitudes, any transferable skills from his previous jobs to a new job, and his training potential or if he has the ability to perform unskilled job which don't require training. He concluded that he did not have any transferable skills to sedentary occupations based upon the physical limitations that he now has. Therefore, he is not employable at a sedentary work level and at a less than sedentary work level that in and of itself shows he is not employable.

DANA M. WINEGARNER, M.D.

Dr. Winegarner testified that he is a physician having been residency trained in neurology and has been practicing as an adult neurologist since completing that course of training in 1996. He testified that Mr. Kindel was referred to him for the first time on November 12, 1999, by Laurie Behm, a physiatrist in the Neuroscience and Rehab Institute in Joplin. Dr. Behm felt that Mr. Kindel would benefit from seeing an neurologist to rule out neurological causes for his pain syndrome and also wanted to employ Dr. Winegarner's expertise in injecting botulism toxin into a particular muscle that is difficult to inject into to find if that would help him.

Dr. Winegarner indicated that Mr. Kindel presented a history of two days of heavy lifting in September of 1999 resulting in low back spasms and pain. He had pain in other locations, but specifically was talking about low back spasms and noted that they began at the time of the heavy lifting. He indicated at that appointment urinary urgency and increased frequency a couple of weeks after the incident. He also indicated bilateral leg pain with the right being worse than the left.

Dr. Winegarner testified that the nerve root itself could not be seen on the MRI. What could be seen was that there was a protrusion into the foramen where the nerve root exists. One could speculate that the protrusion which he believed was a disc from previous surgery was possibly a disc or some other soft tissue since it occupied a space normally occupied by the nerve root that there might be compression there, but without actually seeing it he could not say. He agreed that it is accurate to say that what is seen on the MRI does not necessarily correlate to any clinical picture. The MRI only provides another piece of evidence which may or may not be germane to the patient's complaint. In this case it appeared that possibly there was something that could be germane. He also indicated that the reason to do a CT myelogram is to find out if the MRI, the myelogram, and all the other pieces of evidence all point towards the same culprit. In Mr. Kindel's case the myelogram did not seem to point to any specific nerve root impingement. In Mr. Kindel's case the myelogram showed no compression at the L5 root level.

Dr. Winegarner testified that he next saw Mr. Kindel on March 23, 2000. Mr. Kindel indicated at that time that he had the same pains,

but the pain was worse. Dr. Winegarner indicates that he again saw Mr. Kindel on August 16, 2000. He notes that while he had not seen him in the office for a visit (since March) he did on occasion have opportunity to see Mr. Kindel at the hospital in the administrative area and would have occasion to observe him from time to time at a distance and at no time did he observe him to be acting or performing in a different way than he did in the office. "If he was wincing, limping, leaning against a wall, or grimacing in the office, I saw him also doing this when he didn't know when I was observing him in the hospital."

The August 16th exam was the first follow up after Mr. Kindel's August hospitalization. Dr. Winegarner indicates that they were dealing with a patient who had untreatable pain without a firm diagnosis. So he had to incorporate all the data available to him to try and discover what to do for him. Dr. Winegarner indicated in his testimony that when his report indicated he had worked up everything conceivable he meant that there is virtually an endless array of testing that can be done on a given patient to work up diffuse non-specific pain syndromes, but that it fast becomes prohibitive, and the law of diminishing returns had already set in in this case. Dr. Winegarner indicated, however, that Mr. Kindel did have the injury to the nerve root which seemed to fit historically and by MRI and by EMG as a neurological source for his pain symptom. He indicated that injury to that nerve root can have an effect on pain causing pain in that nerve's distribution. One could also construe low back pain to be associated with that, the patient did have a right-foot drop which was mild, but would effect his gait and the gait disturbance caused by the neurological problem could engender low back and low extremity pain to some extent. His right hammer toe low extremity atrophy on the right from the Brown-Sequard lesion could also cause gait instability resulting in some musculoskeletal pain. He indicated that all of those things would be neurologic and would contribute to a pain syndrome but whether it completely explained his pain, that was the question still. The hammer toe right leg atrophy and Brown-Sequard lesion had occurred prior in 1986.

Also the claimant offered for admission the following exhibits:

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| Exhibit A | Dr. Halfaker, psychologist, deposition |
| Exhibit B | Dr. Koprivica deposition |
| Exhibit C | Mr. Phillip Eldred, vocational counselor, deposition |
| Exhibit D | Dr. Terry Winkler, Life Care Plan |
| Exhibit E | Southwest Medical records |
| Exhibit F | Dr. Makdisi report |
| Exhibit G | Wesley Medical Center records |
| Exhibit H | Southwest Medical Center records |
| Exhibit I | Dr. Jeffery Cone records |
| Exhibit J | Dr. Anne Christopher records |
| Exhibit K | Four-State Surgery Center records |
| Exhibit L | Midwest Orthopedic records |
| Exhibit M | Shawnee Mission Medical Center records |
| Exhibit N | Dr. Brian Murphy report |
| Exhibit O | Dr. James Orlando records |
| Exhibit P | Dr. Jack Rhoades records |
| Exhibit Q | Bills |
| Exhibit R | St. John's Medical Center records |
| Exhibit S | Report of Injury |
| Exhibit T | Dr. Mark Pinkerton deposition |
| Exhibit U | Dr. Charles Mace deposition |
| Exhibit V | Springfield Neurological Clinic records |
| Exhibit W | Dr. Ted Lennard deposition |
| Exhibit X | Springfield Physical Medicine records |
| Exhibit Y | Dr. William Hopkins deposition |
| Exhibit Z | Dr. William Hopkins records |
| Exhibit AA | Dr. Laurie Behm deposition |
| Exhibit BB | Dr. Laurie Behm records |
| Exhibit CC | Claim for Compensation |

Employer/insurer presented the deposition testimonies of Dr. Allen J. Parmet and Dr. Marjorie Eskay-Auerbach, a summary of which follows.

The employer and insurer presented one witness at the hearing, Becky Knapp, Employee Health Coordinator from St. John's and the deposition testimony of Dr. Winegarner, Dr. Parmet, and Dr. Esday-Auerbach. This testimony in is in pertinent part as follows: These exhibits were received and admitted into evidence.

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| Exhibit 1 | Answer to Claim for Compensation |
| Exhibit 2 | Dr. Dana Winegarner deposition |
| Exhibit 3 | Dr. Allen Parmet deposition |
| Exhibit 4 | Video - Dr. Eskay-Auerbach deposition |
| Exhibit 5 | Dr. Dana Winegarner records |
| Exhibit 6 | Dr. Marjorie Eskay-Auerbach deposition |
| Exhibit 7 | Not offered |
| Exhibit 8 | Not offered |
| Exhibit 9 | Claimant questionnaire |
| Exhibit 10 | Claimant questionnaire supplement |

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ALLEN J. PARMENT, M.D.

Dr. Parmet reviewed the medical records and conducted a physical examination as a part of forming his opinions regarding Mr. Kindel's condition. Dr. Parmet testified that having reviewed the medical reports and in particular the imaging studies of 1999 into 2002 that there was some sequence change in that time. It was his opinion that those changes were not a direct result of any of events that happened in September of 1999. He felt they were more or less degenerative changes over time where life and gravity keep winning the battle with his back. Dr. Parmet feels that Dr. Hopkin's rating for Mr. Kindel's preexisting disabilities was far too low considering the significance of those problems and the physical findings that were there, and noted that he had other significant health problems that at least would have affected his employability in certain occupations.

When asked regarding Mr. Kindel's sexual dysfunction and incontinence, Dr. Parmet indicated that those would be highly unusual to see in somebody who had only a back problem, even a major disc herniation, unless they were having a condition called cauda equina syndrome where all of the nerves of the lower spine are being compressed simultaneously. He testified that you don't see that with a herniated disc at L5 or L2-3 because the nerves that control the bowel and bladder are down at the S1, S2 level. He indicated that the sexual dysfunction is separate because it is not controlled by the cord. He indicated that there are objective tests that can be performed to determine whether or not someone has sexual dysfunction and that these tests had not been performed. He also indicated that it is common after Brown-Sequard to have problems with bowel and bladder control because that has taken out half of the muscles. Brown-Sequard being the hemiparesis half of the body. Dr. Parmet indicated that even after recovery from Brown-Sequard the bowel problem can progress slightly due to the fact that as we age we tend to have a general loss and weakening of some of these functions.

He also testified that he did not have the information to tell that the back strain and pain he developed in September of 1999 was still the cause of all his symptoms that he had indicated at the exam on August 6, 2002.

MARJORIE ESKAY-AUERBACH, M.D., J.D.

Dr. Eskay-Auerbach testified that she was an orthopedic surgeon with fellowship training in spine surgery practicing currently in Tucson, Arizona. She no longer performed surgeries but was now doing patient care of workers' compensation related injuries, medical/legal consultations, independent medical exams, and record reviews. She indicated she was retained by both plaintiffs and defendants. Dr. Eskay-Auerbach was asked to review the records in this case and what events played a role with respect to Mr. Kindel's complaints. She did not personally examine Mr. Kindel as a part of her review. Her opinion was that with respect to causation issues examining the patient several years later is of no benefit.

The doctor testified that it was her opinion that although the incident in September of 1999 might have triggered low back pain that there was no new injury to Mr. Kindel's low back that was identified as a cause of his new symptoms. The basis for her opinion was that there really was not any identifiable lesion or new anatomic finding that could account for his complaints. It was her opinion that his symptoms actually were almost identical to those described by Dr. Cone in 1993 involving both legs, the bowel and bladder dysfunction, and the loss of ability to have an erection, so his symptoms are very similar to those earlier.

It was also her opinion that there had been intervening events that would exacerbate his symptoms, namely, an event where he was in the car for eight hours, and then an episode where he had difficulty getting up from a chair, and an episode where he bent over in the shower, and then also when he walked off a curb and had increased low back pain associated with that. Her opinion was that unless there was some particular pathology that showed up on an imaging study you really cannot differentiate between the cause of the symptoms in that case. She testified that in this gentlemen the leg symptoms changed and were not consistent and he had had that previous history of a cervical spine injury which left him with some changes and his previous surgery, so it would be very difficult to identify or to discriminate between those cumulative events. She indicated that Mr. Kindel did have an increase in symptoms after each of those events.

She also testified that she disagreed with Dr. Koprivica's finding that there was an annular tear as a result of the September 1999 incident because an annular tear by itself is not a specific finding that can be related to a specific event. Additionally, she disagreed with Dr. Koprivica's finding of cauda equina syndrome. She stated that typically cauda equina syndrome involves multiple nerve roots in both lower extremities. The patient had saddle numbness or numbness in the saddle area, the perineal area, loss of rectal sphincter tone with the one rectal exam that was noted in the medical records showed that he has good rectal tone. Her opinion was that usually urodynamic studies are done to rule out a neurogenic bladder and those studies were not done, so he certainly does not have a cauda equina syndrome by the standard definition. He appears to have some components that might be consistent with, but not the whole complex. She finally testified that she can only say that Mr. Kindel became symptomatic following the injury in September of 1999 but was not able to identify a specific injury that occurred on that date.

On cross-examination Dr. Eskay-Auerbach agreed that after the car ride for which Mr. Kindel suffered increased symptoms that they were the same symptoms that he had had prior.

The Second Injury Fund called no witnesses. The following Second Injury Fund exhibit was received and admitted into evidence:

1A Second Injury Fund Answer to Claim for Compensation

FINDINGS OF FACT

At the time of trial Mr. Kindel was 52 years old and lived in rural Carthage, Missouri. He graduated from high school in 1971 and served on active duty in the United States Army from July of 1971 until March of 1979. He was trained in combat arms and then later was in recruiting for the Army. During his military service he served in Viet Nam. He also served overseas in Panama, Japan, and Korea. Mr. Kindel had suffered no disability during his time in the military. He then attended Ft. Hayes State University where he received his bachelor of science in nursing in 1982. He served in the Army Reserves from 1979 through 1982 and suffered no disability during that time. He then reenlisted in the United States Air Force and was on active duty from 1983 until November of 1987. He did receive his masters of business administration from Webster College in 1985.

While in the Air Force Mr. Kindel had an accident doing weight lifting which resulted in an injury to his neck. He ended up having an anterior cervical discectomy and fusion at C5, C6. As a result Mr. Kindel chose to leave the military. He was given permanent restrictions of no lifting more than 50 pounds. He was also advised to avoid running or jumping activities. He began working for Mercy Health Systems in hospitals in Independence, Kansas from 1987 until 1990 as an assistant administrator and vice president of patient care. He suffered no injuries during that employment. He then worked for Southwest Medical Center in Liberal, Kansas from 1990 until 1998 as chief operating officer and later chief executive officer. While at Southwest Medical Center he did have a work-related low back injury which resulted in a right-sided L4-5 disc herniation. He underwent a right L4-5 hemi-laminectomy, discectomy, and foraminotomy. He received a 20% whole person partial impairment settlement through Kansas workers' compensation and was restricted to lifting of no more than 25 to 50 pounds maximum.

He also had a history of heart disease which included a coronary angioplasty in April of 1996. Mr. Kindel had a history of multiple traumas while doing rodeo activities during his youth. These included fractured ribs, fracture of C4-5 that was treated in a closed fashion, dislocation of both shoulders, a fracture of his right hand, fracture of his right tibia and fibula, and fracture of his right foot. These injuries recovered without ongoing limitation in his work activities.

In September 1998 Mr. Kindel began work at St. John's Regional Medical Center in Joplin. His last day of work there was December 13, 2002. He was told at that time that the problems associated with his disabling conditions were such that he was not a candidate to maintain employment. Mr. Kindel is currently receiving social security disability. While employed at St. John's Medical Center in Joplin, Mr. Kindel was injured on September 14, 1999, in an incident that occurred when he was helping out with a company sponsored picnic. The picnic was scheduled on Saturday and on Friday Mr. Kindel was helping in the kitchen. The kitchen personnel complained that the floor was slick and Mr. Kindel was helping carry 50- to 75-pound boxes of hamburger for the picnic. The next day Mr. Kindel helped grill hamburgers and cooked from 9:30 in the morning to 4:30 in the afternoon. Following this he began having persistent and progressive difficulties with his back and lower extremities.

He reported the injury to his employer and was sent to Dr. Murphy, who referred him to Dr. Behm. Mr. Kindel first saw Dr. Behm on October 19, 1999. Dr. Behm treated Mr. Kindel conservatively and referred him to various other doctors in order to try to determine the source of his pain complaints. She also recommended an MRI scan of the cervical and lumbar spine as he was having pain from his neck into his right arm as well as low back and leg pain. She recommended an MRI scan of the cervical spine and lumbar spine because in addition to his low back he was also having pain going from his neck into his right arm.

He then saw Dr. Winegarner at the referral of Dr. Behm who performed botox injections. Dr. Winegarner noted that there were problems with urinary and fecal incontinence. He also noted that the new complaints in terms of low back and right leg were related to the work injury. Mr. Kindel was then referred to Dr. Mace who felt there was a right L5 radiculopathy and that his symptoms were work related but did not recommend surgical intervention. Dr. Royal evaluated Mr. Kindel on September 2, 2000. Dr. Royal performed radio frequency ablation of the L3, L4, L4-L5 and L5, S1 facet joints bilaterally. However, Mr. Kindel sustained no relief of symptoms with these intervention.

In an independent medical exam performed on February 21, 2001, by Dr. Lennard indicated that Mr. Kindel's injury and complaints were work related. Mr. Kindel began receiving medical care and treatment for chronic pain management with Dr. Pinkerton. He continued on medication with Dr. Pinkerton and went through selective nerve blocks as well as a diskogram. Despite the ongoing chronic pain management Mr. Kindel continued to have progressive problems. Dr. Pinkerton referred him to Dr. Hopkins and was seen on February 21, 2002. Dr. Hopkins performed percutaneous central disc decompressions at L3, L4 and L5, S1 on February 22, 2002. Mr. Kindel had improvement for approximately one week but this was temporary and eventually the symptoms returned. Dr. Hopkins had recorded that Mr. Kindel was having recurrent and progressive disabling pain and recorded on June 13, 2002, that he had merely bent forward at the waist in the shower and had severe pain. Dr. Hopkins suggested that spinal cord stimulation was a consideration. He felt that if that failed then an anterior/posterior fusion would be appropriate.

At this point in time Mr. Kindel was paying for his own chronic pain management. He was unable to afford invasive procedures due to the expense. He was paying for his own medications and there were a number of medications including methadone. He was wearing a right knee brace, back brace, and using a TENS unit, nevertheless, he was having overwhelming pain. As a result of the pain he was having thoughts of suicide although he was very adamant that he would not act on them.

Mr. Kindel's current complaints are that he is in constant pain with muscle spasms in his back and legs. His legs feel tired and weak. He is getting carpal tunnel symptoms from using the canes to walk. He cannot control his bladder. He has pain when he sits, stands, or walks. He has erectile dysfunction. He is unable to sit still. He has to lay down throughout the day. He has difficulty with memory and concentration due to medication and as a result of all of the above he is suffering from severe depression.

CONCLUSIONS

The party claiming benefits under The Workers' Compensation Law for the State of Missouri bears the burden of proving all material elements of his or her claim. *Duncan v. Springfield R-12 School District*, 897 S.W.2d 108, 114 (Mo.App. S.D. 1995), *citing*

Meilves v. Morris, 442 S.W.2d 335, 339 (Mo. 1968); *Bruffat v. Mister Guy, Inc.* 933 S.W.2d 829, 835 (Mo.App. W.D. 1996); and *Decker v. Square D Co.* 974 S.W.2d 667, 670 (Mo.App. W.D. 1998). Where several events, only one being compensable, contribute to the alleged disability, it is the claimant's burden to prove the nature and extent of disability attributable to the job-related injury.

Yet, the claimant need not establish the elements of the case on the basis of absolute certainty. It is sufficient if the claimant shows them to be a reasonable probability. "Probable", for the purpose of determining whether a worker's compensation claimant has shown the elements of a case by reasonable probability, means founded on reason and experience, which inclines the mind to believe but leaves room for doubt. See, *Cook v. St. Mary's Hospital*, 939 S.W.2d 934 (Mo.App., W.D. 1997); *White v. Henderson Implement Co.*, 879 S.W.2d 575,577 (Mo.App., W.D. 1994); and *Downing v. Williamette Industries, Inc.*, 895 S.W.2d 650 (Mo.App., W.D. 1995). All doubts must be resolved in favor of the employee and in favor of coverage. *Johnson v. City of Kirksville*, 855 S.W.2d 396, 398 (Mo.App. W.D. 1993).

In the present case I find that the claimant, David Kindel, sustained an occupational accident arising out of and in the course of his employment on September 14, 1999. As a consequence of this accident he suffered an injury to his back and body as a whole resulting in a chronic pain syndrome which then resulted in him suffering from severe depression. Further, as a consequence of this work-related injury I find that the claimant is permanently and totally disabled and is unemployable in the work force.

There is no doubt in this case that the claimant had significant preexisting injuries, but none of which were an obstacle to his employment. He was currently employed and fully functioning at the time of the injury on September 14, 1999, and it is clear from the medical evidence in this case that as a result of his physical disabilities resulting from this accident and as a result of the psychological impact of the pain syndrome on this individual that he is permanently and totally disabled as a result of this injury in isolation.

Claimant has clearly met his burden of proof in this case in that six of the doctors who examined this claimant including the treating physicians as well as those who performed independent medical evaluations concluded that the symptoms from which he complained were a result of the event on September 14, 1999. Dr. Laurie Behm indicated that the claimant's pain syndrome, although not the bowel and bladder problems, were caused or substantially contributed to be caused by the September of 1999 accident. Dr. Pinkerton indicated that the injury of 1999 aggravated a preexisting condition and was an exacerbating event. Dr. Lennard indicated that the claimant's current complaints were directly work related. Dr. Mace indicated that Mr. Kindel's symptoms were related to his work injury. Dr. Hopkins indicated that claimant's symptoms and injury were related to the work injury. Dr. Koprivica indicated that the work activity associated with the picnic resulted in the annual injury at L3-4 and L5, S1 and resulted in a failed back syndrome. Additionally, Dr. Halfaker indicated that the September of 1999 injury was the direct and proximate cause of his chronic pain disorder and major depressive disorder.

Dr. Koprivica, Dr. Pinkerton, and Dr. Hopkins all concluded that the claimant was totally disabled as a result of these injuries. Dr. Halfaker indicated that he had a 20 to 25% body as a whole disability as a result of the psychological component. Mr. Eldred concluded that as a result a of his permanent total disability as indicated by the doctors and as a result of considering other factors related to the claimant and the testing he had performed that he was unemployable in the work force.

Additionally, the report of Dr. Halfaker indicated that the psychological difficulties he was experiencing in the form of severe depression were also a result of this injury alone. In looking at these opinions in combination, it is clear that the claimant has without question met his burden of proof. Therefore, I order the employer/insurer to pay to the claimant effective as of December 13, 2002, the sum of \$578.48 per week. In addition I order the employer/insurer to pay past medical expenses in the amount of \$6501.52. I also order the employer/insurer to provide future medical treatment as indicated in the life-care plan by Dr. Terry Winkler. I would also order that the future medical treatment be monitored by Dr. Mark Pinkerton.

An attorney's fee of 25% of the benefits ordered to be paid is hereby approved on behalf of Matthew B. Webster and shall be a lien against the proceeds until paid.

Date: _____02/21/06_____

Made by: /s/ Karen Fisher
Karen Wells Fisher
Administrative Law Judge
Division of Workers' Compensation

A true copy: Attest:

/s / Pat Secret
Patricia "Pat" Secret
Director
Division of Workers' Compensation