Issued by THE LABOR AND INDUSTRIAL RELATIONS COMMISSION

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

Injury No.: 08-022088

Employee: Anton Kloepfer

Employer: John Bender, Inc.

Insurer: Sea Bright Insurance Company

The above-entitled workers' compensation case is submitted to the Labor and Industrial Relations Commission (Commission) for review as provided by section 287.480 RSMo. Having reviewed the evidence and considered the whole record, the Commission finds that the award of the administrative law judge is supported by competent and substantial evidence and was made in accordance with the Missouri Workers' Compensation Law. Pursuant to section 286.090 RSMo, the Commission affirms the award and decision of the administrative law judge dated December 18, 2009, and awards no compensation in the above-captioned case.

The award and decision of Administrative Law Judge John K. Ottenad, issued December 18, 2009, is attached and incorporated by this reference.

Given at Jefferson City, State of Missouri, this 21st day of July 2010.

LABOR AND INDUSTRIAL RELATIONS COMMISSION

William F. Ringer, Chairman

Alice A. Bartlett, Member

DISSENTING OPINION FILED
John J. Hickey, Member

Attest:

Secretary

DISSENTING OPINION

I have reviewed and considered all of the competent and substantial evidence on the whole record. Based on my review of the evidence as well as my consideration of the relevant provisions of the Missouri Worker's Compensation Law, I believe the decision of the administrative law judge (ALJ) should be reversed and employee should be awarded past medical expenses, past temporary total disability benefits, future medical care, and permanent partial disability benefits.

The findings of fact and stipulations of the parties were accurately recounted in the award of the ALJ and I adopt the same to the extent they are not inconsistent with this dissent.

The ALJ and the majority found that employee failed to meet his burden of proof to show that he sustained an accident in the course and scope of his employment, or that his neck and left arm complaints are medically causally related to any alleged accident.

As the ALJ correctly stated in his award, this injury took place in 2008, therefore, this case falls under the purview of the post-2005 amendments to Missouri Workers' Compensation Law. The statutory sections relevant to this case are listed below.

Section 287.120.1 RSMo (2005) provides, in pertinent part:

> Every employer subject to the provisions of this chapter shall be liable, irrespective of negligence, to furnish compensation under the provisions of this chapter for personal injury or death of the employee by accident arising out of and in the course of the employee's employment….

Section 287.020.2 RSMo (2005) defines accident as:

> an unexpected traumatic event or unusual strain identifiable by time and place of occurrence and producing at the time objective symptoms of an injury caused by a specific event during a single work shift. An injury is not compensable because work was a triggering or precipitating factor.

Lastly, section 287.020.3(1) RSMo (2005) provides, in pertinent part:

> An injury by accident is compensable only if the accident was the prevailing factor in causing both the resulting medical condition and disability. 'The prevailing factor' is defined to be the primary factor, in relation to any other factor, causing both the resulting medical condition and disability.

The ALJ largely based his conclusion that employee failed to meet his burden of proof on a finding that employee did not provide credible testimony. The ALJ reasoned that he did not find employee's testimony credible because, after reviewing the entire record, he discovered differences and discrepancies in employee's testimony and statements, ranging from differences in the date of injury, to different descriptions of the injury, to different explanations of the effect the injury had on his ability to work, to different descriptions of his complaints and their onset.

After having reviewed the entire record myself, I find these alleged "differences and discrepancies" to be either nonexistent or irrelevant. In any event, I do not find that the ALJ's conclusion with regard to employee's credibility is supported by the substantial weight of the evidence.

Date of Accident

With regard to the date of the accident, it is clear from the record that employee consistently stated that the accident occurred on February 18, 2008. The ALJ misconstrued various statements and medical records in arriving at the conclusion that employee contradicted himself on said issue.

The ALJ notes that when employee was seen by Dr. Weis on February 25, 2008, he wrote down "2/23/08" in response to "Date of Injury/Date Symptoms First Appeared" on the medical history form completed upon arriving at Dr. Weis' office. The ALJ took issue with the fact that employee did not specifically reference the February 18, 2008, incident involving his neck. However, as employee argued in his brief, the ALJ failed to give proper consideration to the circumstances surrounding employee's completion of this form.

Employee completed this form prior to being seen by Dr. Weis. This is vital because it was not until after employee was examined by Dr. Weis that he first came to learn that the burning pain in his left bicep was being caused by a disc problem in his neck. Therefore, employee's responses on the aforementioned form must be viewed in the proper light. At the time employee completed said form, employee was seeking treatment for severe burning in his left arm and bicep. Employee understood that this symptom "First Appeared" on Saturday, February 23, 2008. This was a symptom that was different and much more severe than anything he had felt during the week. Further, this was a symptom which employee understood was related to his shoulder and arm as evidenced by the fact that he identified his "shoulder" as the body part for which he was seeking treatment. Therefore, I do not find there is any true discrepancy regarding the date of accident to employee's neck because employee's answers on the form were clearly in reference to his shoulder and arm, not his neck. When employee completed the form he did not correctly assess the medical causation because he had not been seen by Dr. Weis yet and did not know that his neck injury was the actual cause of his bicep pain. Accordingly, employee was stating what he believed he may have done to his shoulder or arm to result in the severe arm and bicep pain, thinking that he perhaps pulled a tendon or muscle. To that end, employee believed that his arm was hurting from carrying tools up and down stairs and lifting drywall.

The second date discrepancy that the ALJ noted involved St. John's Corporate health records. Employee was seen at St. John's on February 28, 2008. The records indicate that the date of injury was reported as being February 10 or 11, 2008. This was obviously a mistake in either the recording of the date by St. John's or by employee getting his Mondays mixed up. In any case, this "discrepancy" is irrelevant because at this point the Report of Injury had already been made and correctly stated that the date of the ceiling drywall incident involving his neck was Monday, February 18, 2008. In fact, the very same medical record from St. John's which contains this mistaken

February 10 or 11 reference even identifies the "DOI/DOA" as "2/18/2008." In addition, even if there was some confusion about the date, it was certainly clarified at the time of the March 7, 2008, recorded statement in which employee confirmed that the date of accident involving his neck was February 18, 2008. Further, employee testified that he is certain this is the correct date, and his wife testified and substantiated the same based on her knowledge that it was the Monday of the week that they attended a certain dinner function.

Given all the evidence which consistently identifies the date of accident to employee's neck as February 18, 2008, I find that the ALJ's use of the above-listed records for the purpose of discounting employee's credibility is unwarranted. I find that the accident occurred on February 18, 2008, and that this conclusion is supported by the sufficient weight of the evidence.

Description of Accident

In finding that employee was not credible, the ALJ also found discrepancies in employee's description of how the injury occurred. While there may be slight discrepancies in employee's description of the accident, to say that said discrepancies discount employee's credibility is preposterous.

Employee testified that he was installing ceiling drywall with a co-worker and was on a ladder and stretch board while working with a 10-12 foot piece of drywall which weighed about 100 pounds. Employee described having his end up with his hands above his head and his neck in a tilted position. The co-worker was flexing/pushing the sheet up and down and moving it around a lot in order to get his end between a soffit and the ceiling. Employee testified that the coworker thrusted very hard on the last attempt, resulting in pressure on employee's end, which caused his neck to be wrenched. Similarly, the Report of Injury indicates that employee was hanging ceiling drywall and felt pain in his neck when the partner flipped drywall.

The next history is in the St. John's records in which employee states that he was working with another gentleman installing ceiling drywall, and was putting it up when the other man kind of rolled it and his neck was jerked to the left. Also, in employee's March 7, 2008, recorded statement he indicated that he was on a ladder and stretch board and wrenched his neck putting up ceiling drywall when his partner rolled or flipped the sheet. In Dr. Chabot's report dated April 21, 2008, it is noted that employee strained his neck while moving sheets of drywall. Lastly, Dr. Robson's record dated May 1, 2008, noted that employee was hanging drywall and working overhead when the drywall gave way and he strained his neck.

Despite the aforementioned consistent descriptions of the accident, the ALJ decided to rely heavily on the previously discussed description employee gave to Dr. Weis in finding employee not credible. As stated earlier, the description employee wrote on the initial form was filled out prior to employee seeing Dr. Weis and, therefore, employee did not know at that time that his bicep and shoulder pain was medically caused by his neck injury. It is only logical for a layperson that had pain in their bicep to try to think back about how they had used that arm and assume, in employee's situation, that

"carrying in tools up and down flights of stairs" and "lifting drywall" is what caused said pain. The average person would not make the connection between severe bicep pain and a neck injury.

Effect of Accident on Ability to Work

In finding that employee was not credible, the ALJ also found that employee's statements concerning the effect the accident had on his ability to work were contradictory. Once again, I find that the ALJ misunderstood the context in which employee's statements were made and, therefore, incorrectly assessed employee's credibility.

The ALJ cited employee's recorded statement wherein employee stated that after the February 18, 2008, accident, "there was no problem working." The ALJ found that this statement was "flatly contradictory" to employee's testimony that for the remainder of the week he was only able to continue working with small pieces of drywall.

The ALJ does not have a basis to conclude that these two statements are "flatly contradictory." It is too much of a stretch to conclude that employee's statement that "there was no problem working" meant that he could fully perform all aspects of his job. It is more logical, considering the whole record, to conclude that when employee made said statement he meant that he was able to complete smaller tasks and that employer had smaller tasks available for him to work on. Therefore, the two statements are not contradictory and the ALJ's conclusion that they are is nonsensical.

Description of Complaints and Onset

Lastly, to support his finding that employee was not credible, the ALJ determined there were discrepancies in the description of employee's complaints and their onset. I disagree with the ALJ.

The ALJ stated that there are no neck complaints contained in the records from employee's February 25, 2008, visit with Dr. Weis. This is not completely true. Employee's medical history form makes reference to "lateral side neck" pain/symptoms. In response, Dr. Weis ordered a cervical x-ray. The emphasis of employee's visit was on his bicep because that was where the pain was at the time of the visit. Employee did not deny having neck pain; therefore, the ALJ's finding that there was a contradiction is once again unsupported by the record.

The ALJ also stated that the St. John's records reflect that employee reported that the aching in his neck improved over a couple of days, reasoning that this was inconsistent with his testimony at the hearing that his neck did not really improve during the week. At the hearing, employee was actually asked whether his "neck improved much?" Employee answered "no," meaning that his neck did not improve "much." This is different than saying that his neck did not improve at all.

Finally, the ALJ noted that employee stated in his March 7, 2008, recorded statement that the left side of his lower neck was the only part injured at the time of the accident. The ALJ found that this contradicted employee's reporting to Dr. Robson that he strained his neck and developed severe left arm pain. This finding by the ALJ is

illogical. The natural meaning of the word "developed" is to unfold gradually. Thus, employee stating that the only part of his body injured on February 18, 2008, is not contradictory to him reporting to Dr. Robson that he strained his neck and developed severe left arm pain.

Medical Causation

In addition to finding employee was not credible, the ALJ also found Dr. Chabot's causation opinions to be more credible than Dr. Robson's. I find that the ALJ failed to consider all of Dr. Robson's records and, consequently, incorrectly discredited his opinions.

The ALJ found that Dr. Chabot's opinions were more credible than Dr. Robson's because of a significant difference in the information available to them in forming their opinions. The ALJ stated that Dr. Robson had "none" of the prior treatment records available to him at the time he rendered his opinion. First of all, neither doctor had the records of Dr. Weis, so the ALJ must be referring to the records from St. John's. Secondly, Dr. Robson did have at the time of his opinion the March 1, 2008, MRI report and film which had been ordered and performed as part of the treatment through St. John's.

The ALJ also discredited Dr. Robson's opinion by stating that the five (5) day delay in employee's severe arm symptoms was outside the 72-hour inflammatory response period opined by Dr. Robson. Dr. Robson did not testify to some hard and fast 72-hour response period. He simply testified that the response could take "72 hours or so" to progress. The ALJ improperly limited his opinion by applying a strict 72-hour cap.

Finally, the ALJ failed to consider vital evidence established by Dr. Robson regarding the acute nature of employee's cervical herniations. Specifically, Dr. Robson reviewed a post myelogram CT which showed an extrusion at C5-6 and protrusions at other levels. Dr. Robson explained that an extrusion is consistent with extruded disc fragments, which is consistent with an acute herniation. Dr. Robson was able to determine that although both the C5-6 and C6-7 levels had degenerative changes, they had herniated discs as an acute finding. Further, Dr. Robson found that the February 18, 2008, accident was the prevailing factor in causing employee's cervical condition.

For the foregoing reasons, I find that the ALJ incorrectly weighed the evidence as a whole. Further I find that employee's February 18, 2008, accident was the prevailing factor in causing his cervical neck condition. Employee should be awarded past medical expenses, past temporary total disability benefits, future medical care, and permanent partial disability benefits. I would reverse the award of the administrative law judge and award employee the same.

For the foregoing reasons, I respectfully dissent from the decision of the majority of the Commission.

_____
John J. Hickey, Member

AWARD

Employee: Anton Kloepfer

Injury No.: 08-022088

Dependents: N/A

Employer: John Bender, Inc.

Additional Party: N/A

Insurer: Sea Bright Insurance Company

Hearing Date: August 11, 2009

Checked by: JKO

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? No
2. Was the injury or occupational disease compensable under Chapter 287? No
3. Was there an accident or incident of occupational disease under the Law? No
4. Date of accident or onset of occupational disease: (allegedly) February 18, 2008
5. State location where accident occurred or occupational disease was contracted: St. Louis City
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? No
9. Was claim for compensation filed within time required by Law? Yes
10. Was employer insured by above insurer? Yes
11. Describe work employee was doing and how accident occurred or occupational disease contracted: Claimant was employed as a drywall carpenter for Employer and allegedly developed neck and left arm complaints after hanging a drywall ceiling with a co-worker.
12. Did accident or occupational disease cause death? No Date of death? N/A
13. Part(s) of body injured by accident or occupational disease: (allegedly) Body as a Whole—Cervical Spine
14. Nature and extent of any permanent disability: N/A
15. Compensation paid to-date for temporary disability: $0.00
16. Value necessary medical aid paid to date by employer/insurer? $0.00

Employee: Anton Kloepfer Injury No.: 08-022088

17. Value necessary medical aid not furnished by employer/insurer? N/A

18. Employee's average weekly wages: N/A

19. Weekly compensation rate: N/A for TTD/ N/A for PPD

20. Method wages computation: N/A

COMPENSATION PAYABLE

21. Amount of compensation payable: None

$0.00

22. Second Injury Fund liability: N/A

TOTAL: **$0.00**

23. Future requirements awarded: None

Said payments to begin immediately 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: Mark Panzeri.

FINDINGS OF FACT and RULINGS OF LAW:

Employee: Anton Kloepfer

Injury No.: 08-022088

Dependents: N/A

Employer: John Bender, Inc.

Additional Party: N/A

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

Insurer: Sea Bright Insurance Company

Checked by: JKO

On August 11, 2009, the employee, Anton Kloepfer (Claimant), appeared in person and by his attorney, Mr. Mark Panzeri, for a hearing for a temporary or partial award on his claim against the employer, John Bender, Inc., and its insurer, Sea Bright Insurance Company. The employer, John Bender, Inc., and its insurer, Sea Bright Insurance Company, were represented at the hearing by their attorney, Ms. Jennifer Yates Weller. At the time of the hearing, the parties agreed on certain stipulated facts and identified the issues in dispute. These stipulations and the disputed issues, together with the findings of fact and rulings of law, are set forth below as follows:

STIPULATIONS:

1) Claimant was an employee of John Bender, Inc. (Employer).

2) Venue is proper in the City of St. Louis.

3) Employer received proper notice.

4) The Claim was filed within the time prescribed by the law.

5) Employer has not paid any benefits to date.

ISSUES:

1) Was there an accident and/or occupational disease under the statute?

2) Did the accident and/or occupational disease arise out of and in the course of employment?

3) Are Claimant's injuries and continuing complaints, as well as any resultant disability, medically causally connected to his alleged accident and/or occupational disease at work?

4) What is the appropriate date of injury under the statute?

5) What are Claimant's appropriate average weekly wage and rates of compensation for temporary total disability and permanent partial disability?

6) Is Claimant entitled to payment for past medical expenses in an amount to be determined?

7) Is Claimant entitled to future medical treatment?

8) Is Claimant entitled to the payment of temporary total disability benefits for a period of time to be determined?

EXHIBITS:

The following exhibits were admitted into evidence:

Employee Exhibits:

A. Certified copy of Report of Injury
B. Transcribed recorded statement of Claimant taken March 7, 2008
C. Certified medical treatment records of Dr. Terry Weis
D. Certified medical treatment records of St. John's Mercy Corporate Health
E. Certified medical treatment records of St. Louis Spine Care Alliance
F. Certified medical treatment records of Spine Care, Inc.
G. Certified medical treatment records of Millennium Pain Management, L.L.C.
H. Certified medical treatment records of Dr. Brett Taylor
I. Certified records of the Carpenters' Health and Welfare Trust Fund
J. Certified medical bills of the St. Louis Spine Care Alliance
K. Certified medical bills of Dr. David Kennedy
L. Certified medical bills of St. Louis Spine & Orthopedic Surgery
M. Certified medical bills of Spine Care, Inc.
N. Certified medical bills of Professional Imaging
O. Certified medical bills of South County Anesthesia
P. Certified medical bills of Dr. Brett Taylor
Q. Certified medical bills of TDI
R. Deposition of Dr. David Robson, with attachments, dated March 19, 2009

Employer/Insurer Exhibits:

1. Deposition of Dr. Michael Chabot, with attachments, dated July 29, 2009
2. Original Claim for Compensation filed in Injury Number 08-022088
3. Amended Claim for Compensation filed in Injury Number 08-022088
4. Claimant's Wage Statement from Employer

Notes: *1) Exhibits R and 1 were admitted with objections contained in the depositions. Unless otherwise specifically noted below, the objections are overruled and the exhibits are fully admitted into evidence in this case.*

2) Some of the records submitted at hearing contain handwritten remarks or other marks on the Exhibits. All of these marks were on these records at the time they were admitted into evidence and no other marks have been added since their admission on August 11, 2009.

FINDINGS OF FACT:

Based on a comprehensive review of the evidence, including Claimant's testimony, the testimony of Claimant's wife, the medical records and bills, the medical opinions and testimony, and the other documentation, as well as my personal observations of Claimant and his wife at hearing, I find:

1) **Claimant** is a 50-year-old, currently unemployed individual, who testified that he has worked in construction since 1979. Claimant testified that he had worked as a drywall carpenter for approximately 2 years for John Bender, Inc. (Employer). He worked approximately 40 hours per week for Employer and was paid $27.50 per hour.

2) Claimant testified that prior to the alleged accident that is the subject of this case, he had no prior claim, no accident, no pain, no problems, no treatment, no missed work, or no missed work activities because of any neck or left arm issues.

3) Claimant's **Wage Statement from Employer** (Exhibit 4) documents the hours Claimant worked and the pay he received for that work for the week of his alleged injury and for 14 weeks prior to the alleged injury. In reviewing the wage statement, I find that he did work 40 hours during the week of his alleged injury, the pay period ending February 23, 2008. For the 13 weeks preceding the alleged date of injury, the wage statement shows the following:

Week No.	Period ending	Hours worked	Pay received
1	2/16/08	37	$1,017.50
2	2/9/08	24	$660.00
3	2/2/08	22	$605.00
4	1/26/08	30	$825.00
5	1/19/08	8	$220.00
6	1/12/08	28	$770.00

7	1/5/08	Nothing reported	Nothing reported
8	12/29/07	Nothing reported	Nothing reported
9	12/22/07	8	$220.00
10	12/15/07	40	$1,100.00
11	12/08/07	32	$880.00
12	12/1/07	40	$1,100.00
13	11/24/07	23	$632.50

4) Claimant testified that on Monday, February 18, 2008, he was working off of St. Louis Avenue on a two-family flat rehab job installing a drywall ceiling. He was working on this job with a co-worker, Sean Graves. He testified that they were on ladders approximately 4-5 feet off the ground installing the drywall ceiling. The drywall they were using was 10-12 feet long, 5/8 inch drywall, which he estimated weighed approximately 100 pounds per sheet. Claimant testified that his partner was trying to push the drywall into place, with 8 to 10 thrusts to get it past a soffit, when he felt pain in his neck. He described that his neck was tilted some to the side while doing this installation, so he felt a lot of pressure in the back of his neck. Claimant testified that after this occurred, he told Sean he did not feel good. Claimant continued working on the job, but he only did small drywall for the rest of the day.

5) Claimant testified that he told his wife about the incident. He worked the rest of the week and performed all tasks expected of him on his job, except he only did small drywall pieces. He testified that his neck pain did not go away and did not improve. He noted that his left arm was also getting progressively weaker. Claimant admitted that he did not seek treatment because he thought it would get better if he just made it to the weekend and rested.

6) Claimant testified that on Saturday night, February 23, 2008, he laid down to sleep and got a burning pain in his left arm by his elbow. He said that he had to sleep in a lounge chair because he could not lay down in bed. Therefore, on Monday, February 25, 2008, Claimant testified that he sought treatment on his own at Northland Orthopedics with Dr. Weis. Claimant testified that he marked on the forms it was a work-related condition, but they told him they could not see him if it was work-related, so he scratched off the “Yes” and marked “No” so that he could be seen that day because of the pain he was having. Claimant testified that most of the pain was in his shoulder and arm at that time, and he told the doctor it occurred during the week.

7) Claimant testified that Monday morning before going to his doctor appointment, he called Employer to tell them that he would not be into work. He spoke to Lawrence Fry, the Safety Manager, who asked Claimant to come into work to do a report on this the next day. After filling out the report, Employer sent Claimant to Dr. Godar at St. John’s. Claimant testified that he did not know why their records contained different dates for his injury. He had an MRI done and then was sent to Dr. Chabot for further evaluation. Claimant testified that he waited 5 weeks for the Dr. Chabot appointment, and then the doctor was only in the room with him for approximately 5 minutes. Claimant testified that he was working light duty during this time. Later, after the Dr. Chabot appointment, Claimant was told that it was all degenerative, and they would

not treat him because it was degenerative disc disease. He was also told that he could be working full duty.

8) The medical treatment records from **Dr. Terry Weis** (Exhibit C) document Claimant's first medical treatment following his alleged neck injury at work. On the medical history sheet Claimant filled out at the doctor's office on February 25, 2008, Claimant wrote that he was being seen for left shoulder complaints. On the line entitled, "DATE OF INJURY/DATE SYMPTOMS FIRST APPEARED," Claimant wrote "2/23/08." On the line asking if he was on the job when this injury occurred, Claimant apparently first wrote "yes" and the crossed it out and wrote "no." When asked to describe how the injury occurred or the problems started, Claimant wrote, "I believe carrying in tools up & down the flights of stairs all week. Then lifting 5/8 D.W. all week." Claimant also filled out a pain diagram showing that he was having stabbing pain across his low back, and stabbing pain in the left shoulder and upper arm. There was nothing marked in the cervical region. Dr. Weis took X-rays of the left shoulder and cervical spine and prescribed some medications for Claimant.

9) The **Report of Injury** (Exhibit A) filed by Employer with the Division of Workers' Compensation indicates that Claimant alleged he was injured on February 18, 2008 at 10:00 A.M. when he was hanging a ceiling and felt pain in his neck when his partner flipped the drywall. The report notes that Claimant was employed by Employer as a full-time Hanger since 2006 making $27.50 per hour. The parts of body affected are listed as Claimant's neck and left shoulder. The report indicates that Employer was notified on February 26, 2008, and Claimant was sent to Dr. Godar for initial medical treatment.

10) The medical treatment records from **St. John's Mercy Corporate Health** (Exhibit D) document the treatment Claimant received at that facility when Employer sent him there after he reported the alleged accident. In the first report dated February 28, 2008, Claimant reported that on February 10 or 11, 2008, he was putting up a ceiling with another worker, and the co-worker rolled the sheet to the left, jerking his neck and causing immediate discomfort. However, at the top of the report, the date of injury is listed as February 18, 2008. He reported that the neck was aching and uncomfortable, but improved over a couple of days until the weekend when he noticed it became acutely worse with pain radiating down the left arm. Dr. Godar assessed a cervical strain pattern with the potential for disc involvement because of the pain and radiating symptoms. She ordered an MRI and placed him on light duty office work.

11) The **MRI of the cervical spine** (Exhibit D) taken on March 1, 2008 revealed multilevel degenerative changes with a question of a congenital anomaly of the left inferior cerebellum. There were references to disc protrusion, facet degeneration, bilateral neural foraminal narrowing, and canal stenois at a number of levels in the cervical spine. When Claimant was seen back at St. John's Mercy Corporate Health on March 3, 2008, he reported that his pain level had decreased. Claimant was told that the MRI showed multiple degenerative changes from C3 down through C7. The changes were characterized as "essentially preexisting conditions." Claimant was

kept on medication and light duty work, and referred to a physiatrist for further evaluation. As of March 13, 2008, Claimant had still not been seen by the specialist, and was reporting increased discomfort and weakness in the left arm. Dr. Godar reiterated his need for further evaluation and continued his light duty work restriction and pain medications.

12) On March 7, 2008, Insurer took a **Recorded Statement from Claimant** (Exhibit B) concerning the alleged accident that is the subject of this case. Claimant provided a consistent work history and details regarding his rate of pay and the job he was performing at the time of the alleged injury. However, Claimant described that he was injured on February 18, 2008, when his co-worker rolled his sheet of drywall as they were lifting it to put in a ceiling, and he wrenched his neck. Claimant described the process a couple of times in the statement whereby the two workers are lifting a sheet of drywall from the floor, then set it up on their feet, then basically hoist it from their feet up overhead to get it flat and in place for the ceiling by rolling it. He noted that when he wrenched his neck, he injured the left side of his lower neck. That was the only body part involved at the time. He described that he had some neck pain, but not too bad, and then on Saturday night he developed a stabbing pain in his left arm that prevented him from sleeping, and also developed some pain in the lower back. Claimant mentioned that even though it really did not hurt too bad, he told his normal partner, Sev Savage, the next day that he wrenched his neck at work. However, the first time he sought medical care, and the first time he told a supervisor about his problem was on Monday, February 25, 2008. Claimant noted that during this week between his alleged injury and his reporting it to a supervisor, he continued working his regular job for Employer. He said specifically, "there was no problem working." After seeing Dr. Weis, Claimant asked Lawrence Fry for light duty work so he could keep working, and Lawrence apparently told Claimant that he could only get light duty if this was a work injury and he went through workman's compensation.

13) Claimant filed his first **Claim for Compensation** (Exhibit 2) in this matter on May 7, 2008. It was assigned Injury Number 08-022088. In this Claim, Claimant alleged a date of accident or occupational disease of February 18, 2008, and a time of injury of 9:30 P.M. He further alleged injury to his neck, back and person as a whole from working with drywall, when he was holding one end of the drywall over his head, and a co-worker caused the load to shift, thereby resulting in injury.

14) Then, sometime later, Claimant filed an **Amended Claim for Compensation** (Exhibit 3) in this matter modifying the time of the accident to 9:30 A.M., and also modifying the description of how the injury occurred. On this amended Claim, in addition to describing the same accident as was contained on the original Claim, Claimant alleged, "Or in the alternative, Claimant has suffered an occupational disease as defined under Section 287.067 in working as a journeyman draywall [SIC] person for over 20 years causing a degenerative disc disease & such occupation was the prevailing factor in causing both his medical condition (DDD) & the disability in which he suffers."

15) Claimant was examined by **Dr. Michael Chabot** (Exhibit 1) at Employer's request on April 21, 2008. Claimant provided a history of straining his neck at work on February 18, 2008, while he was moving sheets of drywall. Claimant explained that the complaints were not severe enough to seek treatment and he continued working during the week until Saturday when he began experiencing terrible radiating pain into the left upper extremity. Dr. Chabot reviewed some of the prior medical records, including the MRI, and performed a physical examination of Claimant. Dr. Chabot diagnosed cervical radiculopathy, cervical disc degeneration, cervical spinal stenosis, and a questionable disc protrusion at C5-6. Based on the diagnostic studies showing advanced degenerative changes in the cervical spine, worse at C5-6 and C6-7, as well as myelomalacia at C6-7, which is associated with long-standing cord irritation or compression secondary to stenosis, and based on Claimant not having severe enough symptoms after any specific accident at work to require treatment, Dr. Chabot opined that there was insufficient documentation to indicate that any alleged injury at work was the prevailing factor in Claimant's cervical condition or need for treatment. He was unable to find a clear injury that was significant or substantial enough to produce these symptoms in the neck, especially in light of the advanced degeneration in the cervical spine. He opined that Claimant's condition was "associated with chronic degenerative disease and is most likely associated with genetic factors and not his work duties."

16) Claimant testified that he next saw Dr. Robson on his own. Dr. Robson told him that he had herniated discs. Dr. Robson ordered more testing, including a CT scan, MRI and myelogram, and then recommended surgery. Claimant had his first neck surgery performed by Drs. Robson and Kennedy on May 29, 2008, when they performed a fusion with plates at two levels in the neck. Claimant testified that he had the same excruciating pain after the surgery that he had been experiencing before the surgery. He was doing physical therapy, but he had only minimal lifting power, and he was taking pain medications. Claimant testified that because of his complaints, he tried pain management with Dr. Granberg. He said it helped for a couple of weeks, but eventually, he was told that his lower fusion was not taking, and Dr. Robson wanted to perform another surgery.

17) The medical treatment records of the **St. Louis Spine Care Alliance and Dr. David Robson** (Exhibit E) begin with Claimant's first visit there on May 1, 2008. Claimant reported that he was working overhead when the drywall gave way and he strained his neck and developed severe left arm pain. Claimant reported that he tried to make it through the week but the severe pain in his neck and left arm persisted all week. Claimant continued to report a high degree of pain in the neck and left arm when he was seen by Dr. Robson. He was continuing to work as a carpenter at the time of that examination. Dr. Robson reviewed the MRI and found a herniated disc at C6-7 on the left side and to a lesser extent at C5-6. Dr. Robson opined that the work accident on February 18, 2008, while hanging drywall, was the prevailing factor in causing the symptoms Claimant was having. He recommended some further testing and then surgery to treat Claimant's cervical complaints.

18) Claimant had the post myelogram CT scan on May 5, 2008 (Exhibit E). It showed degenerative changes at C4-5, C5-6 and C6-7, as well as a right central disc protrusion at C6-7, a left subarticular and foraminal disc extrusion at C5-6, and a central disc protrusion at C4-5. When Dr. Robson next examined Claimant on May 6, 2008, he noted the degenerative changes, but felt that the herniated disc represented an acute finding. He again recommended surgery, and opined that the need for surgery related to the injury at work on February 18, 2008.

19) On May 23, 2008, **Dr. Michael Chabot** (Exhibit 1) authored a supplemental report after reviewing the most recent records from Dr. Robson, and the cervical myelogram and post-myelogram CT scan. He noted that none of these additional tests and records changed any of his initial opinions described in his first report. Dr. Chabot confirmed his opinion that Claimant's long-standing degenerative disease in the cervical spine was most likely the reason for the development of the disc protrusion at C5-6 and the noted disc changes at C6-7. With no documentation of a significant work injury requiring medical treatment within 24-48 hours, with the development of more significant symptoms at home on the weekend and not at work, and with the advanced degeneration found in the neck, Dr. Chabot did not believe work was the prevailing factor in his symptomology, but instead the prevailing factor was the significant underlying degeneration.

20) **Dr. David Robson and Dr. David Kennedy** (Exhibit E) performed Claimant's neck surgery on May 29, 2008 at the St. Louis Spine and Orthopedic Surgery Center. They performed a partial corpectomy and microdiscectomy at C5-6 and C6-7, along with a fusion and plating from C5-C7. Specifically, upon surgical intervention, they found the extruded herniated disc at C5-6 on the left and cervical spondylosis with disc space collapse at C6-7. In follow-up examinations with Dr. Robson in the months after his surgery, Claimant was reporting improvement from his presurgical symptoms, but still some left arm pain and weakness that seemed to be gradually improving with time. Claimant attended a course of physical therapy at **SpineCare, Inc.** (Exhibit F) from July 25, 2008 through September 11, 2008. By September 9, 2008, Claimant was still complaining of neck and left arm radiating pain. His motor, sensory and deep tendon reflex testing in the upper extremities was normal except for some mild left biceps weakness. Dr. Robson recommended an EMG and CT scan to further evaluate his condition. The EMG performed on September 10, 2008 was normal except for some irritation at the left biceps, but the CT scan showed that the C6-7 level was incompletely fused at that point, and there was a bulging disc at C4-5 above the fusion. By October 30, 2008, Dr. Robson suggested a left C5 selective nerve root block because of his left arm weakness, and pain in the neck and left arm.

21) Medical treatment records from **Millennium Pain Management, LLC** (Exhibit G) show that on November 11, 2008, Claimant presented with complaints of nerve pain in the left biceps, back and neck. He reported that the pain first came on "explosively" when he was installing a drywall ceiling. **Dr. Steven Granberg** performed a fluoroscopically guided transforaminal cervical epidural steroid injection at the left C5 nerve root on that date.

22) On November 20, 2008, Dr. Robson reported that the nerve root block did nothing to relieve any of his symptoms. Claimant was also complaining of low back problems which had been plaguing him for several months, but which were less severe than the cervical complaints. He recommended another CT scan of the cervical spine and an MRI of the lumbar spine. By December 4, 2008, because of Claimant's continued neck pain and radiating pain into the left arm, Dr. Robson suggested the possible need for more surgery to stabilize the neck.

23) Claimant sought a second opinion from **Dr. Brett Taylor** (Exhibit H) before agreeing to more neck surgery. Dr. Taylor examined Claimant on December 10, 2008. In Dr. Taylor's notes there are references to neck, low back, and left arm complaints, as well as right arm complaints for the first time in the medical records. Dr. Taylor found that Claimant had failed neck syndrome, with very severe pathology, including evidence of myelomalacia on the MRI and myeloradiculopathy. He believed Claimant had a nonunion at C6-7. He recommended injections, upper extremity EMGs, a discogram with post discogram CT and MRI, as well as an updated cervical myelogram. Following the testing, Dr. Taylor provided a surgical recommendation that was a bit different than Dr. Robson's recommendation, but he nonetheless agreed that Claimant had a nonunion at C6-7. Although Claimant had one more cervical epidural steroid injection at C6-7 with Dr. Granberg (Exhibit G) on January 15, 2009, he eventually returned to Dr. Robson for further care.

24) Claimant returned to **Dr. David Robson** (Exhibit E) on February 3, 2009 with continued complaints in the neck and left arm, and also with minimal right arm symptoms. Drs. Robson and Kennedy performed their second surgery on Claimant's neck on February 17, 2009. Essentially, they performed a posterior foraminotomy at C6-7 and fixation with lateral mass screws to treat the pseudoarthrosis at C6-7. Following surgery, Claimant had some complications with esophagitis for which he was hospitalized for five days. Otherwise, as he continued to follow up with Dr. Robson, he noted some improvement, but still some fatigue in the left arm. By June 10, 2009, Dr. Robson noted some neck pain and some weakness in the left arm. He found Claimant had myelomalacia in the cervical spinal cord, but he believed Claimant was making slow and steady progress. He opined that Claimant could not return to his work as a carpenter on a permanent basis, and he would likely have a permanent 10-pound weight–lifting restriction. He continued his medications and recommended follow-up in 6 months.

25) Claimant testified that he was unable to work between these two surgeries because of the pain, weakness and high doses of pain medications he was taking. When he followed up with Dr. Robson after the second surgery, Dr. Robson eventually put a 10-pound weight-lifting restriction on him. Claimant has another follow-up appointment with Dr. Robson in 5 months, but he noted that he may want to see the doctor sooner because of his continued nerve pain.

26) Currently, Claimant testified that he is taking Oxycodone, Symbalta, Lexium and Neurontin for his pain complaints associated with this alleged injury.

27) Claimant testified that he wants to get back to work, but he does not think that he can do physical work anymore because of his neck. He said that he could not do construction work while he is on pain medications. He noted that he has been studying to become a home inspector. He is doing an on-line course to study for it, because he took the test once and did not pass it. He admitted that he has not applied for any other jobs.

28) Claimant testified that his medical bills have been paid by the Carpenters' Union, not by him. He advised them of the work accident and signed a reimbursement agreement. He noted that they currently have a claim for $53,107.74 for the medical bills they have paid so far. Claimant also received a weekly disability payment through the Union for 6 months (June 2008 through November 2008) of $240-$280 per week. He signed a reimbursement agreement for this benefit as well. Their claim for reimbursement for the disability payments is approximately $6,464.50.

29) Claimant placed into evidence numerous certified medical bills from **St. Louis Spine Care Alliance** (Exhibit J), **Dr. David Kennedy** (Exhibit K), **St. Louis Spine and Orthopedic Surgery Center** (Exhibit L), **SpineCare, Inc.** (Exhibit M), **Professional Imaging** (Exhibit N), **South County Anesthesia** (Exhibit O), **Dr. Brett Taylor** (Exhibit P), and **TDI** (Exhibit Q) for treatment described above and related to the alleged accident that is the subject of this case.

30) Claimant also placed into evidence the certified records of the **Carpenters' Health and Welfare Trust Fund** (Exhibit I) showing the payments they made in connection with the medical treatment related to the alleged injury that is the subject of this case. These records document that out of total bills submitted of $133,219.74, they paid $53,107.74 in connection with the medical treatment described above with these various providers for Claimant's cervical condition. It further indicates that there was a member responsibility for these bills of $6,942.20. Finally, these records document that Claimant received weekly benefits from the Carpenters' Health and Welfare Fund totaling $6,464.50 from May 27, 2008 through November 12, 2008.

31) Claimant testified that he has had no other income during this period of time. He has three children at home and has been living off of his savings. He noted that he applied for Social Security Disability and he is waiting for a hearing.

32) On cross-examination, Claimant confirmed that he was claiming a specific injury on February 18, 2008. Although there was some indication in the medical records that his left arm pain started on Saturday, and although his deposition testimony from December 30, 2008 indicated that his left arm complaints started on Saturday, Claimant testified that that was not correct. He further confirmed that the nerve pain in the left arm started on Saturday, but he had weakness in both arms during that whole week starting at the time of the alleged accident. There was also some question about weakness in his right arm after the alleged accident, but he said that was never evaluated because most of the weakness was in his left arm. Regarding his ability to work during the week following the alleged accident, Claimant testified in his deposition on December 30, 2008 that he resumed full duties during that week,

and made a similar statement in his recorded statement, but testified at trial that he was not able to resume full duties because of the weakness in his arms.

33) Claimant's wife, **Sandi Kloepfer**, testified that she had no knowledge of her husband having any prior neck or left arm complaints. She testified that her husband told her about the injury and complained about neck pain. She provided a history of the injury consistent with her husband's history. She said that she gave Claimant ibuprofen because of his neck pain. She knows the injury occurred on February 18th, because they attended a progressive dinner on the 23rd and he was miserable during the dinner. She testified that her husband called her from Dr. Weis' office saying that they would not see him, and she told him to stay there and be seen because of the problems he was having. She noted that he was not able to do much with his left arm before or after the surgeries, but it's now both his arms where he is having problems. She confirmed that Claimant has not worked at all since the first neck surgery.

34) The deposition of **Dr. David Robson** (Exhibit R) was taken by Claimant on March 19, 2009 to make his opinions in this case admissible at trial. Dr. Robson is board certified in orthopedic surgery, and has performed hundreds of neck surgeries. He examined and treated Claimant in connection with this alleged injury as described in more detail above, including performing two neck surgeries on Claimant. Dr. Robson testified consistent with his opinions described above. Specifically, he felt that the incident Claimant described as occurring on February 18, 2008, when he was hanging drywall, tried to right it, and felt neck and left arm radiating pain, was the prevailing factor in the development of his neck and left arm pain and need for treatment. When asked about the week delay in obtaining any treatment, Dr. Robson responded that it would be typical to have an injury, and then the inflammation would cause increased symptoms over the next several days, perhaps 72 hours for the inflammatory response to really kick in and cause complaints. Dr. Robson further explained that he believed the herniated discs were an acute finding consistent with a traumatic event because the one level was extruded. He explained that a degenerative herniated disc would be more like a bone spur or a bulge, while an extruded disc which has left the disc area is more consistent with an acute finding. He believed that extrusion further supported his conclusion that this was a specific injury suffered at work as opposed to the ordinary progression of degenerative findings. He also casually connected the herniated discs to Claimant's alleged injury at work on February 18, 2008. He opined Claimant was unable to work following the first surgery, and continued to be unable to work, especially as a carpenter, up through the time of his deposition. He did not believe Claimant had yet reached maximum medical improvement. He also opined that all of the treatment and surgery was necessary to cure and relieve Claimant of the effects of his injury.

35) On cross-examination, Dr. Robson agreed that Claimant had a number of degenerative findings in his cervical spine as identified on the MRI of March 1, 2008, including the myelomalacia (softening of the spinal cord), neuroforaminal narrowing, disc bulging, endplate spurring, canal stenosis, and facet degeneration. Dr. Robson agreed that the narrowing of the foramen and the canal stenosis could cause the irritation of the nerves exiting the spine or the spinal cord itself, resulting in radiculopathy complaints

(arm pain and numbness). Dr. Robson agreed that the alleged February 18, 2008 accident did not cause the underlying degenerative disc changes, but rather it caused, in his opinion, the symptomology that gave rise to the need for treatment, and it also caused the herniated disc. He specifically did not believe that herniated discs could result from just the progression of degenerative changes. He believed they were always the result of some type of trauma, just sometimes not memorable trauma to a patient. He agreed that the C5-6 and C6-7 levels are the most common levels at which degenerative changes occur in the cervical spine. He also admitted that it was Claimant who requested the medical causation opinion from Dr. Robson at the time of the first examination. According to Dr. Robson, Claimant was "frustrated and was insistent that he hurt himself at work and wanted to comment on that."

36) The deposition of **Dr. Michael Chabot** (Exhibit 1) was taken by Employer on July 29, 2009 to make his opinions in this case admissible at trial. Dr. Chabot is board certified in orthopedic surgery, with a specialty in orthopedic spine surgery. He examined Claimant on one occasion at the request of Employer and provided no treatment. Dr. Chabot testified consistent with his opinions described above. In characterizing the findings on his physical examination of Claimant, Dr. Chabot indicated they were "pretty soft findings." He explained that if someone was in a lot of pain, he would expect significantly reduced range of motion, guarding and spasm, but he found none of those things. Although there was some change to the left biceps reflex, Dr. Chabot found intact sensation and normal muscle strength. He testified that he found no evidence of an acute injury on the cervical X-rays, just degenerative changes. On the MRI, he testified that he again found degenerative changes at a number of levels, including disc spur complex, where the disc bulges out as the spur develops off the vertebrae. He also explained how the myelomalacia is a chronic compression of the cord that usually takes a long time to develop and is classically associated with spinal stenosis. He agreed that it is possible to come from a significant injury such as a direct fall on the head with fracture of the spine, but Claimant did not report any such injury in this case, and he did not believe the injury Claimant reported could have caused the myelomalacia. He further opined that the left-sided disc protrusion at C5-6 was caused by degeneration. He testified that the positive finding on Claimant's examination, the left biceps reflex changes, generally does not develop acutely, but rather is associated with more chronic changes. He explained that it is common for individuals with advanced degenerative changes to become symptomatic once the condition reaches a critical level, even absent a specific injury, and even just being at home not doing any particular activity. Dr. Chabot opined that the disc pathology in the cervical spine was all of a degenerative nature, and the surgical procedures were performed to try to deal with the degenerative disease in the neck.

37) On cross-examination, Dr. Chabot agreed that Claimant had disc protrusions, also known as herniations, at C4-5, C5-6 and C6-7. He also agreed that disc herniations or extrusions could be typical of acute findings, but he also believed they could be associated with chronic changes. He testified that a disc herniation could be a manifestation of the progression of disc degeneration. Dr. Chabot further explained that his opinion in this case was based on both the lack of documentation of a specific

acute injury on a specific date, as well as no indication that acute left arm symptoms developed within 24 or even 72 hours of the alleged injury.

RULINGS OF LAW:

Based on a comprehensive review of the evidence, including Claimant's testimony, the testimony of Claimant's wife, the medical records and bills, the medical opinions and testimony, and the other documentation, as well as my personal observations of Claimant and his wife at hearing, and based on the applicable laws of the State of Missouri, I find the following:

The first three issues can be addressed at the same time since they are inter-related in this case.

Issue 1: Was there an accident and/or occupational disease under the statute?

Issue 2: Did the accident and/or occupational disease arise out of and in the course of employment?

Issue 3: Are Claimant's injuries and continuing complaints, as well as any resultant disability, medically causally connected to his alleged accident and/or occupational disease at work?

Claimant alleges in the alternative that he either sustained an accident or an occupational disease causing injury to his neck on or around February 18, 2008. However, I find that Claimant has provided absolutely no evidence to support an occupational disease theory for this claim. Only two doctors, Drs. Robson and Chabot, provided opinions on this injury and the medical causation of it. Neither of them testified that Claimant's neck complaints and need for treatment and surgery came from an occupational disease. Dr. Chabot opined that the cervical complaints were related to the progression of Claimant's overall degenerative spine disease with his alleged injury not being the prevailing factor in the development of the condition and his complaints. Dr. Robson related Claimant's complaints to a specific injury at work on February 18, 2008. In the absence of any medical evidence in the record to causally relate Claimant's cervical condition to an occupational disease at work for Employer, that part of the Claim fails for lack of proof.

Considering the date of the alleged injury, it is important to note that the new statutory provisions are in effect including, **Mo. Rev. Stat. § 287.800 (2005),** which mandates that the Court "shall construe the provisions of this chapter strictly" and that "the division of workers' compensation shall weigh the evidence impartially without giving the benefit of the doubt to any party when weighing evidence and resolving factual conflicts." Additionally, **Mo. Rev. Stat. § 287.808 (2005)** establishes the burden of proof that must be met to maintain a claim under this chapter. That section states, "In asserting any claim or defense based on a factual proposition,

the party asserting such claim or defense must establish that such proposition is more likely to be true than not true."

Under **Mo. Rev. Stat. § 287.120.1 (2005)**, every employer subject to the Workers' Compensation Act shall furnish compensation for the personal injury of the employee by accident arising out of and in the course of employee's employment. Pursuant to **Mo. Rev. Stat. § 287.020.2 (2005)**, "The word 'accident' as used in this chapter shall mean an unexpected traumatic event or unusual strain identifiable by time and place of occurrence and producing at the time objective symptoms of an injury caused by a specific event during a single work shift. An injury is not compensable because work was a triggering or precipitating factor." Pursuant to **Mo. Rev. Stat. § 287.020.3(1) (2005)**, "An injury by accident is compensable only if the accident was the prevailing factor in causing both the resulting medical condition and disability. 'The prevailing factor' is defined to be the primary factor, in relation to any other factor, causing both the resulting medical condition and disability."

Claimant bears the burden of proof on all essential elements of his Workers' Compensation case. ***Fischer v. Archdiocese of St. Louis-Cardinal Ritter Institute***, 793 S.W.2d 195 (Mo.App. E.D. 1990) *overruled on other grounds by Hampton v. Big Boy Steel Erection*, 121 S.W.3d 220 (Mo. 2003). The fact finder is charged with passing on the credibility of all witnesses and may disbelieve testimony absent contradictory evidence. ***Id***. at 199.

Considering the competent and substantial evidence listed above, I find that Claimant has failed to meet his burden of proving that an accident occurred which arose out of and in the course of employment for Employer, and which was medically causally connected to it.

In order for Claimant to prevail in this matter, first, he would have had to provide credible testimony explaining the circumstances surrounding the alleged accident and the effect the alleged accident had on his cervical condition. In order to make a finding on Claimant's credibility, I had to consider not only his testimony at trial, but also his prior deposition testimony as covered on cross-examination, his recorded statement, and his statements to the medical providers in the various medical records in evidence. In comparing these various sources, there were a number of differences and discrepancies that I discovered, ranging from differences in the date of injury, to different descriptions of the injury, to different explanations of the effect the injury had on his ability to work, to different descriptions of his complaints and their onset.

With regard to the different dates of injury described in the records, Claimant testified at trial that he was injured on a specific date, February 18, 2008. When he presented at Dr. Weis' office on February 25, 2008, Claimant wrote on the medical history sheet that the date of injury or the date the symptoms first appeared was February 23, 2008. He explained at trial that he wrote this date because that was the date the symptoms really intensified. Then the St. John's Mercy Corporate Health records from February 28, 2008 contain a description of the injury having occurred on February 10 or 11, 2008. However, at the top of the report, they contain a date of accident of February 18, 2008. Claimant testified that he did not know why those February 10 or 11 dates were contained in the report. However, even if I believed Claimant's explanations and could get past the discrepancies in the date of the injury, there are then discrepancies in the description of the injury.

With regard to the different descriptions in the record of how the injury occurred, Claimant testified at trial that his partner was trying to push the drywall into place, with 8 to 10 thrusts to get it past a soffit, when he felt pain in his neck. He described that his neck was tilted some to the side while doing this installation, so he felt a lot of pressure in the back of his neck. When he appeared at Dr. Weis' office on February 25, 2008, Claimant wrote on the medical history sheet that he was injured from, "I believe carrying in tools up & down the flights of stairs all week. Then lifting 5/8 D.W. all week." In the Report of Injury on February 26, 2008, Claimant reported he was hanging a ceiling and felt pain in his neck when his partner flipped the drywall. At St. John's Mercy Corporate Health on February 28, 2008, Claimant reported that he was injured when he was putting up a ceiling with another worker, and the co-worker rolled the sheet to the left, jerking his neck and causing immediate discomfort. In his recorded statement taken on March 7, 2008, Claimant described that he was injured when his co-worker rolled his sheet of drywall as they were lifting it to put in a ceiling, and he wrenched his neck. Claimant described the process a couple of times in the statement whereby the two workers are lifting a sheet of drywall from the floor, then set it up on their feet, then basically hoist it from their feet up overhead to get it flat and in place for the ceiling by rolling it. Then with Dr. David Robson on May 1, 2008, Claimant reported that he was working overhead when the drywall gave way and he strained his neck and developed severe left arm pain.

Although it seems to me from the various descriptions of the accident that rolling the drywall and holding it overhead while his co-worker thrusts it into place are two very separate and distinct activities, even if I were to assume that those descriptions were close enough to merit a finding in Claimant's favor on accident, there is simply no way to credibly explain the history of injury Claimant provided to Dr. Weis. Dr. Weis is the very first medical professional Claimant saw after the alleged injury that allegedly occurred only one week earlier, and Claimant gives him no history of a specific accident on February 18, 2008 with holding drywall overhead, or even rolling drywall. Claimant writes that he believed his complaints were coming from carrying tools up and down stairs and lifting drywall all week. Given that this was the first doctor he saw only one week after the alleged injury, the description of how the injury occurred should have been the freshest in his mind at this point, but yet, this is the history of injury that is the most divergent from any of the subsequent histories of injury that he provided to any of the other treating physicians or to his employer or at trial. Quite simply, with the vast difference in the histories of injury that he has provided in this case, I cannot justify a finding in favor of Claimant on the issue of accident, because I do not find him credible in this regard.

However, even if I were to get past the discrepancies on the date of injury and the description of the injury as enumerated above, then there are the different explanations of the effect the alleged injury had on his ability to work for the week after the alleged accident. There is no question that despite the alleged injury, Claimant worked a full 40-hour week following the alleged accident. At trial, Claimant testified that while we worked, he did not do certain aspects of full-duty work during that week. He testified that as a result of his neck pain and arm weakness, he only worked with small pieces of drywall for the rest of that week. However, in his recorded statement given on March 7, 2008, he said that during that week following the alleged injury he continued working his regular job for Employer. He said specifically, "there was no problem working." These statements are flatly contradictory and go to the heart of the issue of whether he was having problems during this week after the alleged injury or if instead the real problems with the neck and arm started at home on Saturday, when he tried to sleep but could not

because of the pain. This discrepancy caused further damage to Claimant's overall credibility and caused me to further question the veracity of the testimony he offered in this case.

Finally, even if I were to get past the discrepancies on the date of injury, the description of the injury as enumerated above and the effect the injury had on his ability to work during the following week, then there are the different descriptions of his complaints and their onset, which have an even more detrimental effect on Claimant's credibility. At trial, Claimant testified that he felt pain in his neck pain immediately at the time of the alleged accident and it did not go away and did not improve during that next week. He noted that his left arm was also getting progressively weaker during that week. On cross-examination at trial, Claimant testified that although his deposition testimony from December 30, 2008 indicated that his left arm complaints started on Saturday, that was not correct. He further confirmed that the nerve pain in the left arm started on Saturday, but he had weakness in both arms during that whole week starting at the time of the alleged accident.

However, the medical records contain different histories of the onset of his complaints and what body parts were involved. In the first medical treatment record from Dr. Weis, Claimant wrote on the medical history sheet on February 25, 2008 that on February 23, 2008 he began to suffer from pain in the left shoulder. He filled out a pain diagram that showed complaints in the left shoulder/upper arm and low back, but no complaints in the neck or right shoulder. Claimant tried to explain at trial that it was the nerve pain in the left arm he was reporting, and that he had complaints in the neck, but there are certainly no such complaints noted in Claimant's hand-written history to the doctor. Then, when Claimant sees the doctor at St. John's Mercy Corporate Health on February 28, 2008, he reported that the neck was aching and uncomfortable, but improved over a couple of days until the weekend when he noticed it became acutely worse with pain radiating down the left arm. There is no mention of the right arm. When his recorded statement is taken on March 7, 2008, Claimant noted that when he wrenched his neck, he injured the left side of his lower neck. That was the only body part involved at the time, according to Claimant's statement. Claimant provided a history to Dr. Chabot similar to what is reported to St. John's Mercy Corporate Health, but then when he saw Dr. Robson, Claimant reported that he strained his neck and developed severe left arm pain. Claimant reported that he tried to make it through the week but the severe pain in his neck and left arm persisted all week. It should also be noted that the first mention of right arm pain or problems in the records, despite Claimant's trial testimony to the contrary, was on December 10, 2008 in Dr. Taylor's records.

Given all of these various inconsistencies that go to the very heart of Claimant's case, I find Claimant was not a credible witness, and he failed to provide competent, credible testimony on his own behalf. Therefore, Claimant has failed to prove that he sustained an accident which occurred in the course and scope of his employment for Employer.

Having reviewed and considered all of the evidence in the record, I find that the credible evidence leads me to conclude that Claimant developed severe left arm complaints while at home over the weekend of February 23, 2008, as a result of the natural progression of his advanced degenerative spine disease in the neck. Although he may have been symptom free prior to this onset of complaints, I find that the degenerative disc disease was significant based on the extent of the degeneration, the multiple levels involved, and the myelomalacia, a chronic compression

of the cord, that usually takes a long time to develop and is classically associated with spinal stenosis. I find that Claimant was unsure if he had done something to hurt himself at work. He thought he may have hurt his shoulder lifting tools or drywall but he did not know for sure. When Dr. Weis told him that he needed to be on light duty, and he asked Lawrence Fry about light duty work, Claimant learned that he would need to have had a work injury to qualify for light duty with this Employer. It was at that point that he first reported this as a work injury and began to remember a lifting incident with drywall on February 18, 2008. However, even after remembering a drywall incident, there was still confusion as to whether he was lifting it, rolling it or holding it while his partner thrust it into place. Given these findings, as well as my prior finding that Claimant was not credible, I find that even if there was some kind of minor incident while working with drywall, it was not the prevailing factor in the development of Claimant's cervical condition or his current symptomology or need for treatment.

I further find that Claimant has failed to meet his burden of showing that his cervical condition and his continuing complaints, as well as any resultant disability, are medically causally connected to this alleged accident at work. I reach this additional conclusion by specifically finding that Dr. Chabot's testimony and medical opinions in this case are more competent, credible and reliable than the contrary opinions of Dr. Robson.

In evaluating the credibility of these physicians, I am mindful of the fact that in considering their qualifications and level of expertise, both of them are qualified physicians who regularly surgically treat individuals with cervical conditions similar to the one with which Claimant presents. However, the main difference I find in the basis of their opinions is the information they had available to them when they formulated those medical causation opinions. Dr. Chabot had some of the prior medical treatment records available to him as well as a history from Claimant that his complaints were not severe enough to seek treatment and he continued working during the week until Saturday when he began experiencing terrible radiating pain into the left upper extremity. Whereas, Dr. Robson had none of the prior treatment records available to review and he had a history from Claimant of the development of neck and severe left arm pain at the time of the alleged accident, as well as Claimant's report that he tried to make it through the week but the severe pain in his neck and left arm persisted all week. Because Dr. Robson based his medical causation opinion on the incomplete and inconsistent history from Claimant, I find that his opinion is, thus, fatally flawed, and cannot be used as a basis to support a medical causation finding in this case.

Admittedly, in the deposition, Claimant tried to bolster Dr. Robson's opinion by having him agree that it would be typical to have an injury, and then the inflammation would cause increased symptoms over the next several days, perhaps 72 hours for the inflammatory response to really kick in and cause complaints. Therefore, in his opinion, the week delay in obtaining treatment was not unusual. In fact, even Dr. Chabot agreed that arm symptoms could begin within 24 to 72 hours of an injury to allow a finding that the injury caused the complaints. However, we do not have a 72-hour delay in the significant symptoms occurring, but rather a 5-day delay. This 5-day delay is even outside the 72 hours Dr. Robson thought would be possible, but Dr. Robson was not really aware that there was a 5-day delay, because he had received the history from Claimant that the complaints started immediately after the injury, and he had no information or other records to show him anything different from that history given by Claimant.

Given that my findings on the first three issues are dispositive of this case, the remaining issues are moot and will not be ruled on in this award. Further, even though this was tried as a temporary hearing, because the finding on those issues results in a denial of all benefits in this matter, I am making this a final award, rather than a temporary or partial award, to allow the parties, if they wish, to have an immediate appeal to the Labor and Industrial Relations Commission. Since I have denied the case, there is nothing that can be gained by keeping this as a temporary or partial award. The Claim is denied and the final award in this matter is hereby issued.

CONCLUSION:

Claimant has failed to meet his burden of proof to show that he sustained an accident in the course and scope of his employment, or that his neck and left arm complaints are medically causally related to any alleged accident. He failed to meet his burden of proof by failing to provide credible testimony on his own behalf. Given that my findings on the first three issues are dispositive of this case, the remaining issues are moot and will not be ruled on in this award. Since I have denied the case, there is nothing that can be gained by keeping this as a temporary or partial award. Therefore, the Claim is denied and the final award in this matter is hereby issued.

Date: _____ Made by: _____

JOHN K. OTTENAD
Administrative Law Judge
Division of Workers' Compensation

A true copy: Attest:

_____
Naomi Pearson
Division of Workers' Compensation