

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

Injury No.: 05-123810

Employee: Linda S. McLeary
Dependent: Johnny G. McLeary
Employer: Arvin Meritor
Insurer: Self-Insured
Additional Party: Treasurer of Missouri as Custodian
of Second Injury Fund

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

Findings of Fact

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

Preexisting permanent partial disability

The Second Injury Fund and employee stipulated that, at the time employee sustained the compensable work injury, she suffered from a 12.5% permanent partially disabling condition of the body as a whole referable to a preexisting diagnosis of cancer that involved surgery and development of a chronic pain condition. The Second Injury Fund and employee also stipulated that an award against the Second Injury Fund for permanent partial disability benefits would be properly calculated using a 12.5% "load" or synergy factor.

Employee's evaluating expert, Dr. Musich, opined that employee's preexisting disabilities combine with the effects of the primary injury in such a way as to result in greater disability than the simple arithmetic sum of the disabilities; we find this opinion to be persuasive.

The primary injury

The administrative law judge found that employee lacks credibility and credited employer's medical experts, Drs. Cantrell and Kitchens, over employee's expert Dr. Musich, as to the issue of medical causation. We disagree with this analysis for the following reasons.

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We find that employee is generally credible. While she is not a completely reliable historian (a circumstance perhaps affected by employee's longstanding issues with depression) employee's testimony is generally consistent with and supported by the medical records. We do not share the administrative law judge's concern that employee's primary care physician, Dr. Boardman, did not consistently note her back and neck complaints; a thorough review of this physician's records reveals that for any given visit, his notes focus solely on the primary concern that brought employee into his office, which was usually follow-up for diabetes. Further, contrary to the findings of the administrative law judge, many of Dr. Boardman's records do indicate back and/or neck pain, e.g., the treatment records for March 13, April 13, May 23, June 6, and September 25, 2006, as well as for February 27 and March 26, 2007. We do not regard Dr. Boardman's occasional silence as to the neck and back when he was seeing employee for high blood pressure or diabetes to cast any material doubt on employee's testimony regarding the severity of her work injury.

Nor do we view the surveillance footage provided by employer to have any impact on employee's credible testimony provided at the hearing. The surveillance video that we reviewed bears little resemblance to the description provided in the administrative law judge's award. The videos depict employee engaged in innocuous activities such as walking or sitting in a car and demonstrate very little physical activity and certainly no prolonged physical activity. The videos also depict employee walking stiffly or holding her back. Especially when we consider that employer did not provide any foundational testimony that would allow us to further evaluate this evidence in light of factors such as when and for how long investigators followed employee or how many hours of raw footage were distilled to produce the videos entered into evidence, we do not find employee's testimony regarding her symptoms or limitations to be materially contradicted or refuted by the surveillance footage.

Turning to the expert testimony, we note that Dr. Kitchens opined that employee's accident, wherein a large industrial plastic bin crashed into her entire left side with enough force to knock her into an adjacent bin, caused employee to suffer only a mild strain of the thoracic spine with a 2% permanent partial disability of the body as a whole. In minimizing employee's injuries, Dr. Kitchens relied on the erroneous assertion that employee was struck only in the "left flank," as well as the purported absence of any complaints indicative of cervical radiculopathy in the contemporaneous medical treatment records. Dr. Kitchens appears to have overlooked (or simply ignored) the following records: the December 1, 2005, emergency room record from Missouri Southern Healthcare indicating complaints of a "pins and needles" sensation in the left leg and arm on the date of injury; the January 16, 2006, record from Healthsouth indicating complaints of numbness and tingling in the left arm and leg; the January 18, 2006, record from Healthsouth, indicating complaints of numbness and tingling in the left arm and leg; the May 23, 2006, record from Dr. Boardman, indicating tingling and numbness in the arm; and the May 30, 2006, record from Dr. Boardman, indicating arm and hand numbness and hand weakness.

Clearly, Dr. Kitchens's testimony is predicated on demonstrably false impressions or assumptions regarding the nature of the trauma employee sustained and the symptoms

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she manifested in the immediate aftermath of the 2005 injury. As a result, Dr. Kitchens is not credible.

On March 7, 2006, Dr. Cantrell provided his opinion that employee suffered only mild strains affecting the cervical and lumbar spine and a strain and abrasion to her left shoulder as a result of the December 2005 accident. Dr. Cantrell provided his opinions without the benefit of a May 30, 2006, cervical MRI. Consequently, we give little weight to his report.

In light of the foregoing considerations, we are more persuaded by Dr. Musich's testimony that, as a result of the work injury, employee suffered acute strain syndromes referable to the cervical and lumbar spine with multilevel cervical disc pathology, as well as symptomatic lumbar spondylosis and left lower extremity radiculopathy over the left L5 dermatome. We are not convinced, however, by Dr. Musich's testimony that employee is permanently and totally disabled as a result of the primary injury. Given employee's post-injury return to full-duty work, subsequent August 2007 event which Dr. Musich agreed worsened employee's symptoms, and multiple surgeries which (as discussed immediately below) we are not convinced were reasonably required as a result of the work injury, we find Dr. Musich's opinion lacking persuasive force on the issue of permanent total disability. Rather, we find that employee suffered a 50% permanent partial disability of the body as a whole referable to her cervical and lumbar spine injuries as a result of the accident on December 1, 2005.

Whether employee had a need for additional treatment flowing from the work injury

Employee claims \$277,836.66 in past medical expenses incurred after employer stopped authorizing medical treatment for her neck and back injuries in April 2006. To make her case that employer is liable for these considerable expenses, employee relies solely on the opinion of Dr. Musich, who opined that employee's injury "necessitated several cervical surgeries." *Transcript*, page 200. Given employee's preexisting degenerative conditions referable to the cervical spine, her successful post-injury return to full-duty work in March 2006, and the subsequent August 2007 event that worsened employee's symptoms, we would expect employee's evaluating expert to provide some explanation as to why cervical spine surgery in October 2007 was reasonably required to cure and relieve the effects of the December 2005 work injury.

It appears that employee's symptoms referable to her neck injury may have waxed and waned over time, but in his report, Dr. Musich did not address this issue, and in fact provided no explanation whatsoever for his opinion regarding past medical expenses. Nor was Dr. Musich asked to do so at his deposition. Potentially helpful would have been testimony addressing how additional treatment including cervical spine surgery was reasonably required despite employee's successful return to full-duty work (including overtime) for over a year, and why a need for surgery should be seen to flow from the work injury in light of the various other factors potentially affecting the condition of employee's cervical spine as of October 2007. In the absence of any such testimony, we are left to speculate as to how Dr. Musich would have answered these pivotal questions.

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In her brief, employee also advances the records from her treating surgeon, Dr. Park, as evidence supporting a finding that her need for cervical spine surgery flows from the work injury. Dr. Park's treatment record merely recites that (1) employee had a work injury, (2) employee has a disc herniation at C4-5, and (3) this "correlates with her symptoms." *Transcript*, page 1083. We disagree that this amounts to an opinion regarding whether employee's need for surgery in October 2007 flows from the December 2005 work injury, but even if it did, we do not find it particularly persuasive, as it is conclusory and lacking any pertinent explanation or rationale.

The Missouri courts have consistently held that we need not adopt each of an expert's opinions, and may reject "any part" of an expert opinion that we do not find persuasive. See, e.g., *Massey v. Missouri Butcher & Cafe Supply*, 890 S.W.2d 761, 763 (Mo. App. 1995); *Massengill v. Ozark Action, Inc.*, 762 S.W.2d 850, 851 (Mo. App. 1989). In the absence of any explanation or rationale addressing the concerns identified above, we find Dr. Musich's testimony regarding employee's need for additional medical care after April 5, 2006, to be lacking in persuasive force. Further, we find that by offering only the nonspecific and generalized testimony of Dr. Musich, employee has failed to meet her burden of proof with regard to the question whether, after April 5, 2006, she had a need for additional medical treatment that flowed from the work injury. Accordingly, we find that as of April 5, 2006, employee did not have a need for additional medical treatment flowing from the work injury. For similar reasons, we do not find persuasive Dr. Musich's testimony that employee may have a need for future medical treatment as a result of the work injury.

The above discussion is dispositive with regard to the issues whether employee is entitled to temporary total disability benefits in connection with her surgeries, or reimbursement for her mileage related to disputed treatments after April 5, 2006. We note, however, that employee presented evidence that employer failed to reimburse her for mileage incurred in travelling to a December 23, 2005, authorized treatment with Bluff Radiology Group. Employer failed to present any evidence to contradict or rebut employee's evidence with respect to this issue. We find employee's evidence persuasive. We find that employee drove 85.92 miles for the December 23, 2005, authorized treatment with Bluff Radiology Group. Referring to the bills from Bluff Radiology Group, we find that this medical provider is located in Poplar Bluff, Missouri. The parties stipulated that, at the time of the accident, employee was working for employer in Stoddard County, Missouri. We take administrative notice of the fact that Poplar Bluff, Missouri, is not located within Stoddard County, Missouri.

Conclusions of Law

Medical causation

Section 287.020.3(1) RSMo sets forth the standard for medical causation applicable to this claim and provides, in relevant part, as follows:

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.

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We have found most persuasive Dr. Musich's medical causation opinion. We conclude that the accident of December 1, 2005, is the prevailing factor causing the resulting medical conditions of (1) acute strain syndromes referable to the cervical and lumbar spine with multilevel cervical disc pathology and (2) symptomatic lumbar spondylosis and left lower extremity radiculopathy over the left L5 dermatome; we find that these conditions result in permanent partial disability to the extent of 50% of the body as a whole.

Past medical expenses

Section 287.140.1 RSMo provides, as follows:

In addition to all other compensation paid to the employee under this section, the employee shall receive and the employer shall provide such medical, surgical, chiropractic, and hospital treatment, including nursing, custodial, ambulance and medicines, as may reasonably be required after the injury or disability, to cure and relieve from the effects of the injury.

Once a compensable injury is shown (as it was here) an employee seeking an award of past medical expenses must prove that the disputed medical treatments "flow" from the work injury. *Tillotson v. St. Joseph Med. Ctr.*, 347 S.W.3d 511, 519 (Mo. App. 2011). We have found unpersuasive Dr. Musich's opinion that employee's work injury resulted in a need for cervical spine surgery. We conclude that the disputed treatments do not flow from the work injury, and accordingly that employer is not liable under § 287.140.1 for employee's past medical expenses incurred after April 5, 2006.

We note that employee, in her brief, provides a list of past medical expenses that includes charges incurred in connection with dates of service *before* April 5, 2006. Namely, employee identifies charges from Cape Radiology for dates of service on December 1 and 23, 2005. Employee, in her testimony, did not specifically indicate that employer has failed to pay any of her past medical expenses incurred before April 5, 2006, and her attorney represented to the administrative law judge that, "the first treatment that [employee] got on her own would have been in May [2006]." *Transcript*, page 29. Given these circumstances, there is no support on the record for a conclusion that employer failed to pay charges incurred before April 5, 2006.

Our findings and conclusions with respect to this issue render moot employee's claims for temporary total disability benefits referable to the surgeries and for mileage incurred in connection with the disputed past medical treatments; accordingly, we will not further discuss those issues herein.

Mileage

Section 287.140.1 RSMo provides, in relevant part:

When an employee is required to submit to medical examinations or necessary medical treatment at a place outside of the local or metropolitan area from the employee's principal place of employment, the employer or its insurer shall advance or reimburse the employee for all necessary and reasonable expenses; ... In no event, however, shall the employer or its

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insurer be required to pay transportation costs for a greater distance than two hundred fifty miles each way from place of treatment.

We have found persuasive employee's evidence that employee travelled 85.92 miles for a December 23, 2005, authorized treatment with Bluff Radiology Group in Poplar Bluff, Missouri, which is outside the local or metropolitan area from employee's principal place of employment in Stoddard County, Missouri.

The Mileage Reimbursement Rate set by the Division of Workers' Compensation provided for a rate of \$0.375 per mile from June 1, 2005, to June 30, 2006. Utilizing the applicable Mileage Reimbursement Rate, we conclude that employee's travel expenses amount to \$32.22. We conclude employee is entitled to, and employer is obligated to pay, \$32.22 for employee's travel expenses pursuant to § 287.140.1.

Future medical treatment

The parties dispute the issue whether employee is entitled to future medical treatment as a result of the work injury of March 28, 2003.

An employer is required to compensate for future medical care only if the evidence establishes a reasonable probability that additional medical treatment is needed and, to a reasonable degree of medical certainty, that the need arose from the work injury.

ABB Power T & D Co. v. Kempker, 236 S.W.3d 43, 52 (Mo. App. 2007)(citations omitted).

We have found Dr. Musich's opinion lacking persuasive force with respect to this issue. We find employee does not have a need for future medical treatment that flows from the work injury. We conclude employer is not obligated under § 287.140 to provide future medical care in connection with the work injury of December 1, 2005.

Employer's liability for permanent partial disability benefits

Section 287.190 RSMo provides for the payment of permanent partial disability benefits in connection with employee's compensable work injury. We have found that employee sustained a 50% permanent partial disability of the body as a whole as a result of the primary injury. This amounts to 200 weeks of permanent partial disability at the stipulated rate of \$264.46. We conclude, therefore, that employer is liable for \$52,892.00 in permanent partial disability benefits.

Second Injury Fund liability

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

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

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

The parties stipulated that, at the time employee sustained the compensable work injury, she suffered from a 12.5% permanent partially disabling condition of the body as a whole referable to preexisting cancer with an associated pain condition. We are convinced that this condition was serious enough to constitute a hindrance or obstacle to employment. This is because we are convinced employee's preexisting pain condition had the potential to combine with a future work injury to result in greater disability than would have resulted in the absence of the conditions. See *Wuebbeling v. West County Drywall*, 898 S.W.2d 615, 620 (Mo. App. 1995).

We have found that employee's primary injury amounts to a 50% permanent partial disability of the body as a whole referable to the lumbar and cervical spine, and credited Dr. Musich's opinion that employee's preexisting disability combines synergistically with the effects of the primary injury. We conclude that the Second Injury Fund is liable for permanent partial disability benefits.

We calculate Second Injury Fund liability as follows. Employee's primary injury resulted in 200 weeks of permanent partial disability. Employee's preexisting permanent partially disabling condition equals 50 weeks of permanent partial disability. The sum of preexisting and primary permanent partial disability is 250 weeks. When we multiply the sum by the stipulated 12.5% load factor, the result is 31.25 weeks.

The Second Injury Fund is liable for 31.25 weeks of permanent partial disability benefits at the stipulated rate of \$264.46, for a total of \$8,264.38.

Conclusion

We modify the award of the administrative law judge as to the issues of (1) medical causation; (2) employer's liability for permanent partial disability; (3) employer's liability for mileage employee incurred in travelling to an authorized treatment provider on December 23, 2005; and (4) Second Injury Fund liability.

Employer is liable for, and is hereby ordered to pay to the employee, \$52,892.00 in permanent partial disability benefits, and \$32.22 in mileage for employee's treatment with Bluff Radiology Group on December 23, 2005.

The Second Injury Fund is liable for, and is hereby ordered to pay to the employee, \$8,264.38 in permanent partial disability benefits.

The award and decision of Administrative Law Judge Gary L. Robbins, issued April 26, 2013, is attached hereto and incorporated herein to the extent not inconsistent with this decision and award.

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

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

Given at Jefferson City, State of Missouri, this 6th day of February 2014.

LABOR AND INDUSTRIAL RELATIONS COMMISSION

John J. Larsen, Jr., Chairman

DISSENTING OPINION FILED
James G. Avery, Jr., Member

Curtis E. Chick, Jr., Member

Attest:

Secretary

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DISSENTING OPINION

Based on my review of the evidence as well as my consideration of the relevant provisions of the Missouri Workers' Compensation Law, I agree with the majority's decision to deny employee's claim for permanent total disability benefits and \$277,836.66 in past medical benefits; however, I believe the administrative law judge correctly found that the primary injury resulted in a 12% permanent partial disability of the body as a whole, and I would affirm the award without modification.

The administrative law judge thoroughly documented and catalogued the problems with employee's claim, so there is no reason to repeat them here. I would add that it appears to me that employee's primary failure of proof is her reliance on the wholly unpersuasive testimony from Dr. Musich in a case involving multiple issues and an unusual medical timeline. Dr. Musich rendered his reliably liberal opinions in reliably conclusory fashion, and nobody asked him to explain what he meant by "multilevel cervical disc pathology," or how employee's surgery in October 2007 can reasonably be seen to have been required as a result of a December 2005 work injury where employee returned to her physically demanding full-time job for well over a year in the interim. In my view, the analysis should stop there, because employee had the burden of proof in this matter.

The majority, however, goes out of its way to reject Dr. Kitchens's opinion and then credits Dr. Musich only so far as to justify a greater award of permanent partial disability benefits. I would agree that neither of these paid experts provided their most thorough or convincing work in this case, but because it was employee's burden to prove her claim for benefits, I am convinced that an award consistent with a finding of 12% permanent partial disability of the body as a whole is as much as employee should recover in this matter.

For the foregoing reasons, I would affirm the award of the administrative law judge without modification. Because the majority has determined otherwise, I respectfully dissent.

James G. Avery, Jr., Member

ISSUED BY DIVISION OF WORKERS' COMPENSATION

FINAL AWARD

Employee: Linda S. McLeary Injury No. 05-123810
Dependents: Johnny G. McLeary
Employer: Arvin Meritor
Additional Party: Second Injury Fund
Insurer: Self Insured
Appearances: Ronald L. Little, attorney for the employee.
Amanda J. B. Richert, attorney for the employer-insurer.
Jonathan Lintner, attorney for the Second Injury Fund.
Hearing Date: January 28, 2013 Checked by: GLR/rm

SUMMARY OF FINDINGS

1. Are any benefits awarded herein? Yes.
2. Was the injury or occupational disease compensable under Chapter 287? Yes.
3. Was there an accident or incident of occupational disease under the Law? Yes.
4. Date of accident or onset of occupational disease? December 1, 2005.
5. State location where accident occurred or occupational disease contracted: Stoddard County, Missouri.
6. Was the employee in the employ of the 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? Self Insured.
11. Describe work employee was doing and how accident happened or occupational disease contracted: The employee was struck by a Buckhorn causing injury.
12. Did accident or occupational disease cause death? No.
13. Parts of body injured by accident or occupational disease: Back, neck and body as a whole.
14. Nature and extent of any permanent disability: Permanent partial disability. See Award.
15. Compensation paid to date for temporary total disability: \$0.
16. Value necessary medical aid paid to date by employer-insurer: \$6,345.64.
17. Value necessary medical aid not furnished by employer-insurer: \$277,836.66.
18. Employee's average weekly wage: \$396.69.
19. Weekly compensation rate: \$264.46 per week for all purposes.
20. Method wages computation: By agreement.
21. Amount of compensation payable: \$12,694.08. See Award.
22. Second Injury Fund liability: None.
23. Future requirements awarded: None.

Said payments shall be payable as provided in the findings of fact and rulings of law, and shall be subject to modification and review as provided by law.

The Compensation awarded to the employee 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 employee: Ronald L. Little.

STATEMENT OF THE FINDINGS OF FACT AND RULINGS OF LAW

On January 28, 2013, the employee, Linda S. McLeary, appeared in person and with her attorney, Ronald L. Little for a hearing for a final award. The employer-insurer, Arvin Meritor was represented at the hearing by their attorney, Amanda J. B. Richert. Assistant Attorney General Jonathan Lintner represented the Second Injury Fund. Prior to going on the record the employee dismissed a companion case that was pending against the employer-insurer. That case is Injury Number 07-132794. At the time of the hearing, the parties agreed on certain undisputed facts and identified the issues that were in dispute. These undisputed facts and issues, together with a statement of the findings of fact and rulings of law, are set forth below as follows:

UNDISPUTED FACTS:

1. Arvin Meritor was operating under and subject to the provisions of the Missouri Workers' Compensation Act, and they duly qualified as a self-insured employer.
2. On December 1, 2005, Linda S. McLeary was an employee of Arvin Meritor and was working under the Workers' Compensation Act.
3. On December 1, 2005, the employee sustained an accident arising out of and in the course of her employment.
4. The employer had notice of the employee's accident.
5. The employee's claim was filed within the time allowed by law.
6. The employee's average weekly wage was \$396.69, resulting in a compensation rate of \$264.46 for all purposes.
7. The employer-insurer paid \$6,345.64 in medical aid.
8. The employer-insurer paid \$0 in temporary disability benefits.
9. The employer paid \$2,973.89 in short term disability.
10. The employer-insurer refused to provide additional medical treatment following the April 5, 2006 physical therapy appointment.
11. If the employer-insurer is not determined to be liable for permanent total disability then the Second Injury Fund is not liable for permanent total disability and agrees that the employee has a 12½% permanent partial disability for her pre-existing cancer with a 12½% loading factor.

ISSUES:

1. Medical Causation: The employer-insurer disputes whether the employee's injuries/disabilities requiring treatment after April 5, 2006, were medically causally related to the accident of December 1, 2005.
2. Previously Incurred Medical Aid: The employee is making a claim for previously incurred medical aid in the amount of \$277,836.66. The employer-insurer disputes said charges based on authorization, reasonableness, necessity and causal relationship.
3. Mileage under Section 287.140 RSMo.: The employee is making a claim for mileage in the amount of \$2,331.21.
4. Additional/Future Medical Aid: Does the employee need additional future medical aid as

- a result of the December 1, 2005 work accident?
5. Temporary Total Disability: The employee is making a claim for temporary total disability benefits for the periods October 15, 2007 to April 13, 2008; May 22, 2008 to May 31, 2008 and March 1, 2009 to October 29, 2009 in the amount of \$16,169.84.
 6. Permanent Total Disability: Whether the employee is permanently and totally disabled?
 7. Permanent Partial Disability: Whether the employee is permanent and partially disabled?
 8. Maximum Medical Improvement: The employer-insurer claims that March 7, 2006 is the date of maximum medical improvement. The employee claims that October 29, 2009 is the date of maximum medical improvement. The parties agree that if the Administrative Law Judge finds that employee was not at maximum medical improvement on March 7, 2006, the proper date for maximum medical improvement is October 29, 2009.
 9. Whether the employer-insurer is entitled to a credit for short term disability payments against an award of temporary total disability benefits?
 10. Dependency under Schoemehl: Was Johnny G. McLeary, a dependent of the employee, entitled to a determination of dependency under **Schoemehl v. Treasurer of the State of Missouri**, 217 S.W.3d 900 (Mo. 2007)?
 11. Second Injury Fund: What is the liability of the Second Injury Fund?

EXHIBITS:

The following exhibits were offered and admitted into evidence:

Employee Exhibits:

- A. March 13, 2012 deposition of Thomas F. Musich, M.D. with exhibits.
- B. May 2, 2012 deposition of James M. England Jr. with exhibits.
- C. Medical record and bills from St. Francis Medical Center.
- D. Medical records and bills from Cape Radiology Group.
- E. Medical records and bills from Regional Primary Care - Dr. David Boardman.
- F. Medical records and bills from Missouri Southern Healthcare - Pam Klosterman.
- G. Medical records of Beverly Peters, D.C.
- H. Medical records and bills from Bluff Radiology Group.
- I. Medical records and bills from Healthsouth Rehab.
- J. Medical records and bills from Cape Neurological Surgeons.
- K. Medical records from Orthopaedic Associates of Southeast Missouri.
- L. Medical records and bills of Walter A. Schroeder, Jr. D.O.
- M. Medical records and bills from Midwest Neurosurgeons.
- N. Medical bills from Cape Lab & Pathology.
- O. Medical bills from Missouri Southern Healthcare, Department of Radiology.
- P. Medical bills from St. Francis Medical Center Anesthesia.

- Q. Medical bills from Wal-Mart Pharmacy.
- R. Unpaid Temporary Total Disability (chart).
- S. Unpaid Mileage (chart).
- T. Divorce Decree for Linda S. McLeary and Darrell Bostic.
- U. Certificate of Marriage for Linda S. McLeary and Johnny G. McLeary.
- V. Attorney Contracts of Linda S. McLeary and Johnny G. McLeary.

Employer-insurer Exhibits:

- 1. Original Claim for Compensation.
- 2. Medical report of Russell C. Cantrell, M.D.
- 3. Deposition of Delores E. Gonzalez with attachments.
- 4. Deposition of Daniel L. Kitchens, M.D. with attachments.
- 5. Surveillance Video.

The Second Injury Fund offered no exhibits.

STATEMENT OF THE FINDINGS OF FACT AND RULINGS OF LAW:

STATEMENT OF THE FINDINGS OF FACT:

The employee, Linda S. McLeary was the only witness to personally testify at trial. All other evidence was presented in the form of written records, medical records or deposition testimony.

A trial of this matter was necessary to resolve the disputes of the parties concerning a work accident suffered by employee on December 1, 2005, when she was working on an assembly line for Arvin Meritor in Dexter, Missouri. She was performing her duties when a "Buckhorn" struck her on the left side of her body. The fact of the accident, notice to the employer, and the employee's timely filing of her claim for compensation are not disputed by the parties. The employer-insurer does dispute the nature and extent of employee's injuries resulting from the December 1, 2005 work accident including whether or not she was in need of surgical intervention for her cervical spine injury and her entitlement to other related benefits.

The crux of this case surrounds the determination of whether the medical care that the employee received after she was released by Dr. Cantrell is medically related to her accident of December 1, 2005. The medical care in question is generally the care and treatment that was provided by Dr. Park, Dr. Schroeder and Dr. Fonn. If it is determined that the care that Dr. Park, Dr. Fonn and Dr. Schroeder provided is medically causally related to the employee's accident then many of the other issues would follow suit and be decided in favor of the employee. However, if it were determined that the care provided was not medically causally related to the accident, then many of the surrounding issues will be decided against the employee and are moot. Dr. Kitchens, Dr. Cantrell and Dr. Musich provided critical opinions. Those opinions that are found to be more credible will be critical in determining the issues in this case.

Ms. McLeary lives in Zalma, Missouri, is 59 years old and stands 5'3" tall with an approximate weight of 164 pounds. She is married to Johnny G. McLeary. She has two children: Anthony Lynn Bostic, age 37 and Justin Darrell Bostic, age 29. Both of her children were on their own and self-supporting at the time of her accident in 2005. They were not dependent upon her for support. She has seven grandchildren that range from eleven months to nineteen years old.

The employee started working for the employer in March of 2004 making muffler parts on an assembly line. She was injured in December 2005 when she was placing a finished product into a Buckhorn and was knocked into the Buckhorn by a forklift. She was hit on her left side. On cross examination, she confirmed that she was not struck in the neck. She felt tingling and numbness in her left hip down to her foot and testified that somehow she had tingling in her left arm as well. She was kind of woozy and had pain in her neck, shoulder and down the whole left side of her body. At the time of the accident she had only been back to work for four days having been off for unrelated health issues.

Following the incident, the employer's nurse was not there at the time of her shift. The employee was taken to the nurse's office for approximately two hours. Following the December 1, 2005 incident, the employee was initially taken for medical treatment at Missouri Southern Healthcare emergency room by a supervisor. She complained of pain in the left side of her neck, left shoulder and left low back. X-rays of her cervical spine showed mild straightening of the lordotic curvature, evidence of muscle spasm was suggested. The lumbar spine x-ray showed straightening of the lumbar curvature suggesting spasm. The employee was diagnosed with a strain of her lumbar and cervical spine and a contusion of her shoulder. She was given medications for her complaints. She was released to return to work light duty. The employee was instructed to go home but she went back to work and finished her shift.

The medical records from the December 1, 2005 emergency room visit document the employee's initial complaints of "moderate severity" and "worse with movement" immediately following the Buckhorn accident. She was noted to complain of:

Pain at left side of neck, left shoulder and left low back with pins and needles feeling in left leg and arm. Was hit by a "Buckhorn" (large plastic bin) and knocked into another Buckhorn. No loss of consciousness, did not fall to ground. Denies head, chest or abdominal injury.

The nursing assessment indicated that the employee's "chief complaint" to be of "left shoulder pain and left side of neck and left leg pain with tingling sensation and numbness." The musculoskeletal drawing contained within the nursing assessment have markings to indicate left neck, left shoulder, low back and left leg pain and symptoms. The emergency room doctor ordered x-rays of her neck, left shoulder and low back. The x-rays revealed "straightening of the lordotic curvature of the cervical spine" and "straightening of the normal lumbar lordosis" both suggesting muscle spasm in her neck and low back. There was no fracture or dislocation noted on any x-rays.

Ms. McLeary was given a shot of Toradol 60 mg/Norflex 60 mg, diagnosed with a left shoulder

contusion, lumbar strain and cervical strain and released with prescriptions for medications including Robaxin, Ultracet and Ibuprofen. Upon release from the hospital that evening she was instructed not to return to work for the remainder of the shift and to follow up with the “work comp doctor” on December 5, 2005. Until then she was on restricted duty which included:

- No lifting over 20 pounds.
- No use of arm above shoulder, waist level.
- No pulling-pushing.
- No repetitive bending, twisting at waist level.
- No repetitive kneeling, stooping, squatting.
- No ladder/scaffold work.
- No stairs/climbing.
- Sit down work.

Ms. McLeary was authorized to see Nurse Practitioner Pam Klosterman. Nurse Klosterman saw the employee on December 5, 2005. She reported the accident at work and the treatment she received at the emergency room. The employee told Nurse Klosterman that her “neck [wa]s feeling better”; that her “shoulder [wa]s doing a little better, but she [wa]s still complaining of a lot of pain in her lumbar region and radiating down in to her left leg.” Nurse Klosterman’s assessment was the same as the ER: “left shoulder strain, lumbar strain and cervical strain.” Linda’s medications and restricted duty were continued by Nurse Klosterman with a follow up set for ten days later.

On December 16, 2005, Ms. McLeary returned to Nurse Klosterman. The employee acknowledged that her shoulder and neck were some better. Nurse Klosterman assessed the employee with having “lumbar strain with radicular symptoms”. A lumbar MRI was ordered and performed at Bluff Radiology Group on December 23, 2005. The employee was started in physical therapy for her low back pain and radicular symptoms. A lumbar MRI showed some straightening of the lumbar lordosis, a small right foraminal disc herniation at L4-5 and mild lower lumbar facet arthropathy. The employee was prescribed therapy. Nurse Klosterman released the employee on March 6, 2006 with no restrictions. At that time she still had some pain in her low back, shoulders, and neck, but her pain could not be reproduced with palpation. She also had a negative straight leg test on March 6, 2006.

The employee was asked about the note in the physical therapy records of February 6, 2006, where it says her “back is better today but she wished they would do something for her back.” She testified that if that was really what she said it is not what she meant. Physical therapy was already treating her back - it was her neck that she was wishing to have worked on.

The employer-insurer then arranged for an evaluation with Dr. Cantrell on March 7, 2006. The employee reported no radiating symptoms in her upper extremities. Her chief complaint was her low back. Dr. Cantrell felt the MRI scan showed evidence of multi-level facet joint degenerative changes from L3 to S1 with a right paracentral disc protrusion at L4-5 with no focal disc extrusion. He did not see any evidence of left lateralizing discogenic pathology at L3-4, L4-5 or L5-S1 that would explain her complaints of left leg numbness and pain. He diagnosed cervical and lumbar strains and an abrasion to her left shoulder. He assigned a 4% permanent partial

disability of the body as a whole for the cervical strain, a 5% permanent partial disability of the body as a whole for the lumbar strain and a 2% permanent partial disability of the left shoulder.

After Dr. Cantrell placed her at maximum medical improvement, the employee had one physical therapy appointment left on her prescription and then the employer-insurer authorized no additional treatment. She went back to work full duty doing the same job that she had been doing before and even worked overtime. The employee then went on to receive unauthorized treatment from several different providers, one of whom was her primary care physician, Dr. Boardman.

The employee had also been treating with Dr. Boardman prior to Dr. Cantrell placing her at MMI. She saw him on January 9, 2006 and February 15, 2006. However, she made no reference to an injury at work, back pain, or neck pain until March 13, 2006. A physical exam produced only mild tenderness in her mid-low back. She did not report neck pain. The rest of the physical exam was normal. Dr. Cantrell prescribed therapy. In May of 2006 she reported back and neck pain and a cervical spine MRI was ordered. In the meantime, she continued to work her full duties for the employer.

On May 30, 2006, the employee had an MRI of her cervical spine. It was read as showing central spinal canal stenosis at C4-5 secondary to a broad based central and left paracentral disc protrusion, stenosis at C6-7 from an osteophyte complex, small disc protrusions at C2-3 and C3-4, and severe left C4-5, minimal left C5-6, and severe bilateral C6-7 foraminal stenosis. X-rays of the cervical spine also taken on May 30, 2006, showed mild loss of normal cervical lordosis suggesting paraspinous muscle spasm, but no evidence of fracture or intervertebral disc space narrowing.

The employee saw Dr. Boardman on August 14, 2006, and had no complaints of neck or back pain. Her physical exam was completely normal. On September 25, 2006, she complained of a "back ache" but her physical exam was normal as was her neurological exam. The purpose of her appointment was for chronic fatigue and depression. Again, on October 2, 2006 she had no complaints pertaining to her back or her neck. She was there for a follow-up concerning her fatigue and depression. Her physical exam was normal. She saw Dr. Boardman again on October 18, 2006, and there is no reference to back or neck pain and her physical exam was normal.

The employee saw Dr. Boardman again on February 27, 2007, primarily for unrelated digestive issues, but she also complained of neck and shoulder pain which she related to the work injury of December 2005. She requested physical therapy. Examination of the neck revealed mild posterior muscular tenderness and full range of motion but with mild pain. Her neurological examination was normal. She was seen again on March 26, 2007. Again, the primary reason for the visit was her unrelated diabetic condition, but it was noted that she was in physical therapy for neck pain and the therapist had recommended continuation of treatment. It was noted that she had neck pain with extreme range of motion. She was continued in therapy for an additional four weeks. When she returned on August 20, 2007, after the second injury at work, it was for follow up of her neck pain. She also wanted to be evaluated for her hours at work; she had not requested any sort of work up for her hours prior to this appointment. She wanted to stay at forty hours per week. She had completed physical therapy. Examination of her neck revealed decreased range of

motion and mild posterior tenderness. The assessment was neck pain, abdominal pain and depression. She was to avoid heavy lifting due to her neck pain and was instructed to continue working only forty hours per week.

The employee confirmed that when she saw Dr. Boardman she did not ask him to treat her neck or her back. She also did not report any neck or back symptoms to him. This was in spite of the fact that she testified that her multiple requests for treatment to her neck during this very time frame were rejected by the employer-insurer.

Ms. McLeary testified that she worked her full duties from March of 2006 until October of 2007.

On direct examination she testified that following the incident in 2005 she did have a subsequent accident on August 10, 2007 during her employment. The employee indicated that she did not report this accident to her doctors. The Claim for Compensation filed for that date of injury was dismissed the morning of trial. On August 10, 2007, she was moving some tooling and had increased pain. She was prescribed medication. She testified that she missed no work. However, on cross examination she conceded when confronted with her deposition testimony that after the 2007 incident her symptoms were worse in her neck and down into the left shoulder. Specifically, after the subsequent injury she felt burning pain down the left side of her neck into her arm. She also testified that prior to the 2007 accident her symptoms had gotten better.

The employer-insurer didn't provide treatment for Ms. McLeary after she was released by Nurse Klosterman and Dr. Cantrell on March 6th and 7th respectively. She was limited to light duty work until being released from treatment in March 2006. After she was released from Arvin provided treatment, she was put back on the exact same job she was doing at the time of the 2005 accident.

The employee began a course of medical treatment that was not authorized by the employer-insurer. After her accident of August 10, 2007, the employee sought the care of Dr. Park in September 2007. She chose Dr. Park from a list of physicians provided to her by her attorney.

She first saw Dr. Park on September 19, 2007. She reported an injury date of December 2005. Her chief complaint was left sided neck and back pain. She denied any previous history of neck and back trouble. Dr. Park's assessment was that the employee had an injury at work in December of 2005. He thought that she had a cervical disc herniation at the C4-5 level which was causing her spinal cord compression and correlated with her symptoms. A repeat MRI of the employee's lumbar and cervical spine was obtained on October 10, 2007. She followed up with Dr. Park that same day. He read her cervical spine MRI to show a C4-5 disc herniation on the left with spinal cord compression. He found the lumbar spine MRI to be unremarkable. As far as her lumbar spine was concerned, he felt that she might need to undergo a discography to further evaluate her lower back pain. With regard to the neck, given the degree of spinal cord compression, he recommended a C4-5 discectomy, interbody fusion and plating from a right sided approach. The operative note of October 15, 2007, indicates that the employee underwent a C4-5 anterior cervical discectomy interbody fusion with placement of an interbody spacer and plating.

The employee followed up with Dr. Park four weeks post surgery on November 14, 2007. Her neck pain was much improved and her x-rays showed that the fusion and plating were stable. Dr. Park planned to keep her off of work for ten additional weeks and to reassess her at that time.

As of January 23, 2008, a CT scan of the cervical spine showed an anterior plate fixation from C4-5 with interbody fusion which appeared to be solid. Her pre-operative neck pain was much better. Dr. Park released her from care, but kept her off of work until April 2008.

On April 2, 2008, the employee returned to Dr. Park and was having hoarseness. He referred her to Dr. Schroeder for further evaluation and treatment. The employee did not return to Dr. Park and returned to full duties at work.

The employee was off about six months from October 15, 2007 through April 13, 2008 for Dr. Park's surgery and recovery time. She was not able to work during that time. Dr. Park released her and she returned to work full duty and was working overtime.

There was a complication with the employee's vocal cords during Dr. Park's surgery and she required some voice therapy at St. Francis and was then ultimately sent to Dr. Schroeder for treatment. The employee underwent surgery with Dr. Schroeder on May 22, 2008, in the form of a left thyroplasty I (Boston Implant System), for left vocal cord paresis following her cervical spine surgery. Thereafter she underwent a course of therapy. As of March 2, 2009, she was doing well. Her repeat fiberoptic exam revealed excellent glottic closure. Her left vocal cord had been medialized and the right cord remained mobile and clear. He wanted to see her back in one year. She returned on March 1, 2010. She could talk much better but reported unrelated sinus problems. Dr. Schroeder ordered additional diagnostic tests for her sinuses, but provided no further treatment for the vocal cords.

Ms. McLeary testified that she was off of work and received short term disability benefits for about six months after her surgery with Dr. Park. She returned around April 13, 2008, to her full duties and continued to work her full duties but for a week off in May for her throat surgery with Dr. Schroeder. She was off from May 22, 2008 through May 31, 2008.

The surgery with Dr. Park helped at the time but the employee indicated it started getting worse again when she went back to work. She worked up to March 1, 2009, and then sought treatment with another doctor. Dr. Park had left, so at that point she sought treatment from Dr. Fonn. She first saw Dr. Fonn on January 21, 2009. Dr. Fonn obtained another cervical MRI and a CT scan. He then followed up with the employee on February 18, 2009, and recommended surgery for herniations at C5-6 and C6-7. He does not address causation.

On March 16, 2009, the employee underwent removal of the plates at C4-5 and C5-6 with C5-6 and C6-7 anterior cervical discectomy, and interbody fusion at both levels. The pre and post-operative diagnosis was C5-6 and C6-7 degenerative disc disease with spinal cord compression. Ms. McLeary continued to follow-up with Dr. Fonn post-surgery and on June 24, 2009, he prescribed a course of therapy which took place at St. Francis Medical Center.

On August 18, 2009, the employee returned to Dr. Fonn reporting pain in the neck. A CT scan obtained in the office showed excellent fusion and good placement of the plate and screws. He noted that at some point, the employee also started to develop a significant amount of pain in her back radiating down to her left leg. Upon examination, she had some decreased sensation in the L4 distribution on her left and a positive straight leg raise to 60% on the left. Dr. Fonn advised that he was going to start the employee on some home exercises and obtain an MRI of her lumbar spine. She also underwent another course of physical therapy.

An MRI of the employee's lumbar spine was obtained on September 3, 2009, by Dr. Fonn for low back pain, left leg pain, and radiculopathy, four years post injury. It showed mild multi-level degenerative changes. Dr. Fonn also noted mild degenerative disc disease at multiple levels with some mild foraminal stenosis at L4-5 and L5-S1. She was set up for lumbar epidural steroid injections, at L4-5 and L5-S1.

On September 29, 2009, the employee underwent an L4-5 and L5-S1 transforaminal epidural steroid injection on the left. The injection was repeated on October 13, 2009 and again on October 20, 2009. The employee did well with the injections. She returned to Dr. Fonn on December 31, 2009. She reported that she was continuing to have pain, but was scared about surgery. They discussed a discogram if she decided to pursue surgical intervention. She returned to Dr. Fonn on May 12, 2010 with disability forms. Her history, symptoms, and exam were unchanged from the previous visit. Dr. Fonn wanted an FCE before he completed the forms. He recommended an FCE again on July 29, 2010. There is no record of her ever having the FCE.

The employee did not return to Dr. Fonn until over a year later on October 15, 2011, and almost seven years after her injury of December 2005. She reported a severe aggravation of her low back pain, but reported no fall or trauma. Dr. Fonn obtained x-rays which showed moderate lumbar spondylosis with degenerative changes at L4-5 and L5-S1. He does not address causation and ordered an MRI. The MRI obtained on October 28, 2011, shows superimposed facet joint arthropathy most severe at L4-5 comparable to the prior study. Dr. Fonn recommended another course of epidural injections at L4-5 and L5-S1 on the left. The employee had three injections with excellent relief of her symptoms. On June 20, 2012, she returned to Dr. Fonn as her symptoms had returned. She underwent another course of three injections ending on July 19, 2012, and again with excellent relief of her symptoms. She underwent a third round of three injections in December 2012. Causation is not addressed.

The employee last saw Dr. Fonn on January 2, 2013. The injections gave her some relief but she did not feel they were as effective as before. She was prescribed Norco and Valium. The plan was to repeat the injections in four to six months. Although the employee testified at trial that Dr. Boardman is also presently prescribing medications for her back and neck, the records are unclear.

Dr. Fonn told her she needs to have another surgery, but she doesn't want anymore, that's why they are doing the injections. If the injections stop helping then she will have to have the surgery. Although she couldn't recall the specifics, she testified that Dr. Fonn gave her permanent

restrictions of no lifting more than 20 lbs., no bending, and no overhead lifting. This is not corroborated by the medical records. She conceded that no doctor has told her that she needs to lie down throughout the day.

The employee testified that as far as maintenance for pain she continues to get injections about every three months in her back. She does not want any more surgery. She takes several medications. Dr. Boardman prescribes her Tramadol and Flexeril. Dr. Fonn prescribes her hydrocodone and valium. She testified that the first surgery with Dr. Park helped, but she started getting worse when she went back to work. The second surgery helped with her pain levels too, but she still has pain. She testified that her neck is about the same, but her back is getting worse even though she has been off of work for four years.

She has a GED. She attended school through the 11th grade and has no college credits. She does have some past employment experience in customer service. She worked at Western Auto and at a pharmacy. She has no restrictions on her driver's license. The employee testified that she calculated her mileage expenses from her home and not her employer's place of business.

Ms. McLeary admitted to receiving chiropractic care before the 2005 accident with Dr. Peters for her neck and back. She treated from March 29, 2004 to March 28, 2005. When she first presented on March 29, 2004, she reported back pain of five weeks duration and exacerbating since then. There was no reference to any inciting injury or incident. On August 16, 2004, she reports having neck pain for the first time. The notes specifically reference the C4-5 level. The employee reported continued neck pain at her last appointment and reports pain in the thoracic and cervical spine ongoing for three weeks. The employee has admitted that she would have continued with the chiropractor if she could have afforded it that is why she stopped. She testified that she got up one morning and couldn't straighten up. The adjustments made her symptoms go away, but she testified that her neck pain at the time was radiating down into her back.

Presently, she complained of ongoing symptoms in the whole left side of her body. Her neck is the worst and rated it at a 5/10. She has good days and bad days. On a typical day she will get up and make coffee. She makes her husband's lunch and breakfast and helps get him ready for work. She will then lay back down when he leaves for the day because her neck is hurting. She will take a pain pill and then do some housework such as the dishes or dusting. She also watches TV. Some days she just goes back to bed to rest. Then she will get up and get dinner ready. She starts that around 2:00 p.m. They eat around 6:00 p.m.

She testified that she has to lie down due to pain almost every day, but some days she doesn't because she has stuff that she needs to get done. If it is a really bad day she will only get up to go to the bathroom. On those days her pain is a 10-12/10.

She does do some shopping. She can push a shopping cart. Her husband does the heavier lifting. She used to walk with her husband every day for about 45 minutes. They also used to ride bikes. She has only done it a few times over the last year and she has to stop and rest. She testified that she no longer goes to yard sales or flea markets and cannot garden as much as she would like.

She doesn't go out to eat much anymore. She also used to take more vacations, although she had difficulty recalling the last vacation she went on before her accident. She also testified that she cannot interact with her grandchildren as much as before. She cannot sit for very long because of the pain in her neck, back and leg. She has to move around to relieve pressure. She also cannot sleep very well because of the pain in her back and neck. She can drive but usually she rides in the passenger seat and she takes special measures to make sure she is comfortable. Her husband does the yard work. She has difficulty carrying a purse.

The employer-insurer introduced surveillance at trial from June 20, 2012, July 19, 2012 and October 4, 2012. The video from June 20, 2012, shows the employee running errands with her husband over a six hour time period, and was presumably able to complete all of her errands without having to lie down. The employee is observed to move freely and fluidly without any obvious signs of impairment. She is observed to raise the hatch of her vehicle, lift several shopping bags, and push and pull a shopping cart. Moreover, she was inside Wal-Mart for almost an hour and testified at trial that she does not use a motorized shopping cart.

On July 19, 2012, the video again shows the employee out and about running errands for nearly nine hours. Again, the employee is observed to move freely and fluidly without any signs of obvious impairment. She is again observed to lift shopping bags without difficulty.

The last day of footage presented is from October 4, 2012. On this date, the employee was observed to work on her property. Although positioned behind the bed of a pick-up truck, she is observed to repeatedly bend down and stand back up for several minutes. This is contrary to her testimony at trial that Dr. Fonn had placed restrictions on her as far as bending and that she has great difficulty with the activity due to pain. Later that afternoon she was also observed to run errands and showed no signs of difficulty entering or exiting her vehicle. Obviously the surveillance footage speaks for itself. The employee testified that she had difficulty carrying her purse yet she is carrying it in some of the video footage. The video surveillance only occurred for a portion of three days.

Expert Opinion

Dr. Musich

The employee was evaluated by Dr. Musich. He saw her on August 26, 2011, and did not provide any treatment. He prepared a report dated August 26, 2011, and testified by deposition on March 13, 2012. The employee reported that on December 1, 2005, she was struck by a very large commercial container in her back, contrary to her testimony that she was struck in the side, throwing her forward into another large commercial container. Dr. Musich also agreed that the employee was not struck in the head or the neck. She reported complaints in her left neck, left shoulder and low back immediately after the work trauma.

Dr. Musich admitted that he reviewed a note from Dr. Boardman from January 9, 2006, which indicated no acute concerns and no reference to back or neck pain at that appointment. He also

admitted that the inspections of the neck on both January 9, 2006 and March 13, 2006, were listed as normal.

With respect to the May 2006 cervical spine MRI, Dr. Musich testified that it identified significant cervical disease at multiple levels and loss of normal cervical lordosis, which usually indicates chronic pain in the neck. Dr. Musich also admitted that herniations in the cervical spine and disc bulges are often degenerative in nature and can occur without any trauma to the back or neck.

Dr. Musich agreed that according to the radiologist's report there was no identification of acute or traumatic herniation described. Dr. Musich admitted that in looking at this report there is no objective way to determine specifically when these abnormalities occurred. Dr. Musich stated that some of the anatomic pathology seen in the report may certainly have pre-existed the December 1, 2005 work injury, but the employee stated she was asymptomatic referable to her neck and left upper extremity before the work accident.

However, after being shown the records of Dr. Peters, Dr. Musich admitted that the employee did have neck pain and was not completely asymptomatic prior to the December 2005 work injury. He testified that throughout the chiropractic records, specifically on September 3, 2004 and March 28, 2005, the employee reported consistent neck pain as well as back pain in the thoracic and cervical spine.

The employee only briefly mentioned her subsequent accident to Dr. Musich during the examination and failed to report it at all on the intake questionnaire. She reported that in October 2007, she was lifting and carrying a 45 pound tool when she suffered additional complaints.

Dr. Musich stated that he was aware that Dr. Cantrell had released the employee to work full duty in March 2006 and she was able to work full duty up until her neck surgery in 2007. He also agreed that the neck surgery did not take place or was even recommended until after her subsequent injury in August 2007.

At the time of his examination, the employee reported to Dr. Musich that she had 24/7 cervical pain and that she also had pain complaints radiating into her left arm, left shoulder and left posterior shoulder blade. In addition, she also had pain in her low back and lumbar region and persistent weakness referable to her neck, left arm, lower arm and left buttock. She also reported significant pain complaints with activities of daily living.

Dr. Musich reported that the employee was taking Flexeril and Tramadol related to her cervical and lumbar spine. However, on his medical questionnaire she indicated her pain is still at a level 10. Dr. Musich admitted that it was possible that her pain medication can plateau to the point where it is not useful anymore and that it is also possible that she may be exaggerating her pain complaints.

Dr. Musich stated that it was his opinion based on a reasonable degree of medical certainty that the employee suffered an acute work related trauma on or about December 1, 2005, and that it

was the prevailing factor in the development of, “acute cervical lumbar pathology,” which necessitated all of the treatment employee received referable to her neck and low back between December 2005 and August 2011. He provided no testimony as to what pathology on either MRI is acute. He testified that the work trauma of December 1, 2005 resulted in, “acute strain syndrome,” referable to the cervical and lumbar spine with accompanying multilevel surgical disc pathology which necessitated cervical surgeries and resulted in a level of corticoid paresis and subsequent dysphasia.

Dr. Musich believed that as a result of the December 5, 2005 work accident, the employee had a permanent partial disability of 50% of the person as a whole secondary to the work related symptomatic cervical pathology, along with additional permanent partial disability of 25% of the person as a whole referable to the lumbosacral spine. He also indicated that the employee had pre-existing left breast cancer that was surgically treated before her work related trauma, which resulted in chronic pain symptomology and a permanent partial disability of 15% of the person as a whole.

Dr. Musich concluded that the employee should have permanent restrictions including no repetitive lifting over ten pounds, no frequent bending, stooping, kneeling, working at or above waist level, and should not operate any commercial power equipment and mechanical devices. He believed the combination of the employee’s past and present disabilities is significantly greater and will continue to create a chronic hindrance to routine activities of daily living. He recommended that the employee undergo vocational rehabilitation and that she could not obtain and maintain full time employment in the open labor market given her permanent restrictions. He therefore concluded that the employee was permanently and totally disabled as a result of the work trauma on December 5, 2005.

Dr. Musich stated that all of the treatment for the employee’s neck and low back she received was medically necessary to cure and relieve the effects of her work related injuries. He also stated that the 2007 incident merely exacerbated the complaints that were ongoing since December 2005.

Dr. Musich further stated that the reason the employee was permanently and totally disabled was because of her December 2005 work injury. He believed that no additional surgical intervention was imminent, but the employee may require pain medication on an intermittent basis for an indefinite period of time. Dr. Musich also stated that there was no indication in the records that the employee had any problem with her radiculopathy down either upper extremity prior to December 1, 2005.

Dr. Kitchens

Dr. Kitchens is a board certified neurosurgeon. He performed an IME on behalf of the employer-insurer on December 7, 2011. He prepared a report dated December 7, 2011, and testified by deposition on July 12, 2012. It was his understanding that at the time of the alleged injury on December 1, 2005, the employee was struck by a Buckhorn. Specifically, she reported that she was struck in her left flank, not her back or her neck. Following the incident, the

employee reported pain in her left side, pain in her left shoulder, as well as numbness in both arms and hands.

The employee reported to Dr. Kitchens that following the work injury, she returned to full duty until she had surgery on her cervical spine in late 2007. He testified that the employee did not report to him the subsequent injury that took place in 2007.

After the first neck surgery with Dr. Park, the employee did return to full duty but she had ongoing hand numbness and weakness which worsened. She did not report any incident or accident associated with that ongoing hand numbness and weakness.

Contrary to the records of her chiropractor, he testified that she did not report any prior history of neck or back pain.

From his review of the medical records, Dr. Kitchens testified that from December of 2005 to April 2006, the extent of her neck pain complaints to the treating physicians consisted of presentation at the emergency room on December 1, 2005, with the complaint of left sided neck pain. Then on December 5, 2005, she reported to Ms. Klosterman left shoulder pain at which time she was diagnosed with a left shoulder strain and cervical strain. By December 15th, Ms. Klosterman noted that the employee's neck was feeling better. At that time, her chief complaint was her back. Throughout the rest of her records from Ms. Klosterman in 2006, specifically January and February, as well as the records of Dr. Boardman from 2006, the employee never reported any ongoing neck pain.

He testified that he read the cervical spine MRI from May 30, 2006, as showing a herniation at C4-5. He testified that if the employee had sustained that herniation as a result of the December 2005 accident, immediately following the injury he would have expected the medical records to document neck pain and left C5 radiculopathy such as radiating or shooting pain into the left arm. Specifically, he would expect the symptoms to follow the C5 nerve root which would be down the left arm to about the elbow or upper forearm. She might have also had associated weakness of her left deltoid.

He testified that cervical radiculopathy is diagnosed based on a combination of symptoms and neurologic signs or findings such as weakness or sensory loss in the specific dermatome. He testified it can be reproduced with neck movement or applying extra force to the head such as a Spurling's test to try and produce some mechanical nerve irritation. It is also diagnosed by MRI findings which would correlate with the patient's symptoms and physical examination findings. Specifically, the MRI would show nerve root compression either from stenosis, such as bony or foraminal stenosis, or degenerative conditions of the spine or disc herniation leading to compression of the nerve root. He testified that just because a patient complains of symptoms extending into the arms, it does not necessarily mean that they have radiculopathy.

He testified that the findings on the MRI of the lumbar spine did not reveal anything that looked acute in nature. It showed a small disc bulge to the right side of L4-5. She had no disc herniation, foraminal narrowing, or nerve impingement. In short, there was nothing on the MRI

that would correlate with the radicular symptoms or pain into her leg that she was complaining of.

Dr. Kitchens diagnosed the employee with degenerative disc disease of the cervical and lumbar spine. He testified that the mechanism of injury that she described did not apply any super physiological force to her neck or head. She had been struck in the left flank. He also focused on the fact that there was no medical evidence or diagnosis of cervical radiculopathy or cervical myelopathy shortly after the work incident. Again, he testified that upon his review of the medical records he did not see any evidence of persistent neck pain from the time of the work injury until she saw Dr. Park in 2007. Likewise, within the records of Dr. Boardman and Nurse Klosterman, there were no ongoing complaints of neck or shoulder pain into the upper extremity documented following the work injury. He also saw no evidence in the medical records of radicular symptoms or numbness or tingling into her left arm or left hand. Within a reasonable degree of medical certainty, he did not see any evidence of cervical radiculopathy immediately following this accident contained in the medical records. In his opinion, the work incident of December 1, 2005, was not the prevailing factor in causing her cervical disc herniation at C4-5. Again, this is because there was no evidence of cervical radiculopathy particular to a C4-5 disc herniation. With respect to the work injury itself, he diagnosed a thoracic strain from the Buckhorn striking her left flank. In his opinion, she reached MMI in March of 2006.

Dr. Kitchens reported that the surgery Dr. Park performed on Ms. McLeary's cervical spine was not reasonable and necessary as related to the work injury. Instead the surgery was necessary because of the cervical disc herniation at C4-5 and the prevailing factor in causing that herniation was the degenerative disc disease in her cervical spine.

Likewise, he testified that after she was placed at MMI by Dr. Cantrell in March 2006, the treatment she received subsequent to that date was not reasonable and necessary as related to the work injury. He does not feel that she requires any restrictions on her work activities as related to the work injury. He reiterated that she continued to work full duty after the 2005 work injury up until her surgery with Dr. Park in October 2007. He did assign a rating of 2% permanent partial disability to the body as a whole as a result of musculoskeletal injury to her thoracic spine as related to the work injury.

He testified that after he prepared his report of December 2011, he was provided additional records to review, specifically chiropractic records from March 2004 to March 2005. He also reviewed the reports of Dr. Musich, Ms. Gonzalez and Mr. England. That report was dated April 27, 2012. In reviewing these additional records, he testified that none of his previous opinions changed.

Upon cross examination, Dr. Kitchens testified that discogenic pain is pain attributable to degenerative disc disease. When asked if it could be attributable to a disc problem or traumatic, Dr. Kitchens testified that if a patient has a herniated disc then he would not use the term discogenic pain. He testified that a torn annulus is a degenerative condition. He testified that an individual cannot tear a disc from an injury unless the disc is already degenerated. He testified that not everyone between the ages 40 to 45 has degeneration in their spine; there is a bell shaped

curve like in most biologic systems. Dr. Kitchens testified that an individual could have a tear in the annulus from degenerative disc disease, but would not necessarily have to have trauma. He testified that a torn disc following trauma could only have occurred had the disc been degenerated to begin with. He testified that the torn disc would not be a consequence of the accident. Instead, the torn disc would be a consequence of the degenerative disc disease. Just because an individual has a degenerated disc, it does not mean that they are more likely to have a torn disc after trauma. It would depend on the nature of the degenerative disc disease and the type of trauma. With respect to the trauma, it would depend on the type of impact and type of force and where the impact was and how it was related to the disc.

He testified that whether or not a disc rupture is acute or non-acute is determined based upon the patient's symptoms and the timing of the symptoms. Assuming the employee had an MRI shortly after the accident and it showed a herniated disc, whether or not the tear in the annulus actually occurred at or around the time of the trauma, would depend upon what symptoms she exhibited and if she had a diagnosis of cervical radiculopathy. He testified that if she did complain of pins and needles feeling in the arm, it would depend on the distribution of the pins and needles.

Finally, he testified that in the history that she provided to him and the medical records that he reviewed, he did not see anything documenting a direct blow to Ms. McLeary's neck or head at the time of the trauma.

Mr. England

Mr. England examined the employee on November 28, 2011. He prepared a report dated December 5, 2011, and testified by deposition on May 2, 2012. Mr. England noted that during his interview with the employee, she came across as tired and depressed and stated that she had not rested well at night. However, he admitted that none of the treating physicians had diagnosed her with depression in relation to the work injuries. He also testified he did not review any records that establish causation between depression and the work injuries.

The employee reported that she could not reach up or out very well with either arm without significant neck pain. She estimated she could stand for about 15 minutes before her pain would increase in the neck or back. She believed she could walk about a block before experiencing pain, and further stated she avoided bending over very far at the waist.

In addition, the employee reported that she could not lift more than a gallon of liquid or a 12 pack of soda. She also described her grip as poor in the left hand and stated she wakes up with numbness in her fingers occasionally. When walking up steps, the employee stated she cannot do them in a tandem fashion any longer, and instead, has to drag her left leg behind her. She also indicated her balance was thrown off by the weakness in her left leg and she could not drive for more than about 45 minutes at a time.

Mr. England admitted what the employee reported to him as being physically capable of doing or incapable of doing, was subjective information. He also stated it was not within his area of

expertise to determine whether or not the employee was physically capable of doing the things she said that she could. He did not review Dr. Boardman's records.

He testified that with respect to the employee's functional restrictions and limitations, Dr. Park and Dr. Fonn did not address restrictions. Dr. Cantrell released the employee to return to full duty in March 2006 with no restrictions. Moreover, she worked until approximately March 2009, which was approximately 3½ years after the time period when she first suffered her alleged work injury.

He testified that Dr. Musich was the only physician that assessed specific restrictions. He admitted that Dr. Musich saw the employee approximately six years after the 2005 injury. He identified Dr. Musich's restrictions as no repetitive lifting over ten pounds, no frequent bending, stooping, kneeling, no working at or above waist level, and no use of any commercial power equipment or mechanical devices. As a result, Mr. England admitted that Dr. Musich did not place any restrictions on how long she could sit or stand, and did not mention anything about the employee having to lay down frequently to alleviate her pain. In addition, Dr. Musich did not place any restrictions on the employee's ability to drive, or her ability to climb stairs.

Mr. England testified that the employee is of advanced age under the Department of Labor Guidelines for Employment. He noted that the employee had finished the 11th grade and dropped out of school. The last training or education she received was her GED around 1989. But, with vocational testing she scored at a post high school level on reading, and 7th grade level in math, which was actually pretty good and would be adequate for a variety of different jobs.

Mr. England stated that the employee also provided a work history during her evaluation. He indicated that it was important this history was accurate, as it would impact his opinions. She indicated she worked for Emcon Technologies [Arvin] from March 2004 through March 2009 as a production worker. The employee also worked for Advance Pharmacy as a pharmacy assistant for approximately nine years, but Mr. England did not get any details from the employee on this particular job position. She also identified working in housekeeping in a nursing home for about a year, as well as working in a pet shop for approximately three years.

Mr. England admitted that the employee informed Ms. Gonzalez, the employer's vocational rehabilitation expert, that as part of her job working as a pharmacy assistant, she made entries into the computers as well as received and stored incoming supplies. Mr. England believed that because she did that particular job for nine years, if she could be on her feet most of the day, this would be considered a transferable skill. Mr. England further admitted that there is actually quite a bit of job availability in the field of pharmacy technicians or assistant positions. But, he did not believe she could work as a pharmacy assistant due to the problems she reported regarding remaining on her feet for extended periods of time. However, no physician has restrictions on her ability to stand. Mr. England believed she would not have any skills below a light level of exertion. A pharmacy assistant is light, semi skilled work. He also admitted that due to her academic testing, the employee would be academically able to learn new skills.

Mr. England was also asked about the employee's history of working as a retail sales clerk, which she failed to report to him. He indicated that this type of work would be considered light work as well, and that the DOT classifies retail sales work as semi skilled work.

The employee told Mr. England that also she has to lie down frequently because of the pain in her neck and back, which Mr. England believed would essentially negate her ability to sustain a regular job.

Following his evaluation, Mr. England concluded it did not appear that the employee could go back to work with Arvin Meritor, which he believed required a medium level of exertion. Considering Dr. Musich's restrictions, Mr. England believed the employee would be limited to sedentary activity at best. However, due to the presentation she made and the problems she had with sleep and needing to lay down during the day to alleviate her pain, Mr. England did not see how she would be able to sustain any type of work activity. In addition, he did not believe the employee had any particular skills that would make her someone that an employer would want to hire. He concluded that the employee would not be employable in any capacity or that vocational rehabilitation would be any benefit to her. As a result, Mr. England concluded that the employee was unemployable in the open labor market. However, he also testified that it is easier to assist a person in finding employment when they want to return to work. Mr. England further testified that he was unaware of whether the employee made any effort to look for employment since 2009.

Ms. Gonzalez

Ms. Gonzalez evaluated the employee on March 16, 2012, at the request of the employer. She prepared a report dated April 20, 2012 and testified by deposition on May 4, 2012. She testified that she reviewed the employee's deposition testimony in conjunction with her evaluation. She considered her testimony when formulating her opinions. This is because she had to compare her subjective complaints to the objective findings of the doctors. The employee reported to her that she is 58 years old and lives in Southeastern, Missouri. She has a valid drivers' license. No physicians have any restrictions on her drivers' license.

She also obtained an educational history from the employee. She completed the 11th grade, and then later in 1999 received her GED. She was an average student. She really did not take any college preparatory courses except for algebra and biology.

Ms. Gonzalez testified that she interviewed Ms. McLeary as part of her evaluation. Although the employee was taking several different medications, she did not find that any of these medications would inhibit her from employment. She did report experiencing some nervousness, depression, anxiety, and problems with insomnia. She testified that depending upon the severity of these conditions they might impact her employment, but it did not appear that she was extremely nervous, depressed, or anxious when she met with her.

The employee reported that she cannot sit for more than 10 to 15 minutes, depending on the chair in which she was seated. The employee also reported that she cannot stand for more than 10 to

15 minutes or walk or more than 10 to 20 minutes before needing to sit and rest. The surveillance footage offers some insight into the employee's statements regarding her disabilities.

The employee said that she could not lift more than twenty pounds and that reaching overhead caused increased bilateral arm pain. She had difficulty bending, but no problems with balance. She reported that stooping caused increased neck pain. She could kneel, but had to hold on to a stationary object. She could climb one step at a time, but had to hold a railing for support. Her fingers would occasionally get stiff. Talking for long periods caused hoarseness. She could drive approximately one and a half hours before needing to get out of the vehicle, stretch, and walk around. She reported not sleeping well at night and she would awaken twice per night. She reported taking two naps a day for one hour each time. She could cook and do the dishes. She can do laundry as it was on the main floor of her home. She cleaned the kitchen, baths, and bedrooms, but did not do deep cleaning. She does do the grocery shopping.

Ms. Gonzalez testified that within the records that she reviewed, she did not see anything where a physician placed restrictions on the employee's ability to sit or stand. There was also nothing in the records indicating a physician had placed restrictions on her regarding her need to lie down in intervals throughout the day.

Ms. Gonzalez also obtained a more detailed vocational history from the employee than Mr. England. Aside from her work at the employer, the employee also reported working as a housekeeper, which was medium, unskilled work as well as at Advance Pharmacy from 1999 to 2004 and from 1994 to 1996 as a pharmacy technician. That work was classified as light, semi-skilled work. She also reported working for Western Auto from 1998 to 1999 as a retail sales clerk, which was classified as light, semi-skilled work. She also had a history of working at Paramount Headwear as embroidery machine operator from 1992 to 1993. Again, this was light, semi-skilled work. She had also worked as a hand packager for Golden Cat from 1989 to 1992 from was a medium, un-skilled position. Finally, she was self employed as a daycare provider from 1987 to 1988, which was classified as medium, semi-skilled work.

With respect to her work at Advance Pharmacy, Ms. Gonzalez testified that this was light work, which means no lifting more than twenty pounds and the ability to stand and walk six hours out of an eight hour work day. Job duties that the employee described as having to perform at Advance Pharmacy included assisting the pharmacist to prepare and dispense medication. She also processed records of medication and equipment, dispensed it, and entered it into the computer. She also received and stored incoming supplies. Her work at Western Auto was also light work. There, she had reported computing sales prices of merchandise, totaling purchases, receiving payments, making change, and processing credit transactions. She also greeted customers, cleaned shelves, counters and tables.

Ms. Gonzalez testified that working at Advance Pharmacy for around seven years was a significant time to develop skills regarding the job activities that she was doing there, such that she had developed transferable skills.

She testified that after surgery, the employee did have some restrictions, but nothing was permanent. She reviewed the report of Dr. Musich. Dr. Musich placed permanent restrictions to include no repetitive lifting over ten pounds, no frequent bending, stooping, kneeling, working at or above waist level and no operation of any commercial power equipment or mechanical vehicles. She also reviewed the report of Dr. Kitchens. Dr. Kitchens did not place any permanent restrictions upon the employee. He said that she was capable of working full time.

She testified that she did administer some vocational testing on Ms. McLeary. She did not feel that her academics and the scores that she achieved would inhibit her from finding employment. She also performed a transferability of skills analysis. In this case, she found that the employee does have transferable skills based upon her work as a pharmacy technician and as a retail sales clerk. She had customer service skills and clerical skills that can be used in a sedentary job within her residual functional capacity. This is based upon the medical records and the restrictions the physicians had placed upon her. The jobs that Ms. Gonzalez was able to come up with included a credit clerk or an order control clerk, a diet clerk, an automobile locator, a telemarketer, a food and beverage order clerk, an information clerk, or a surveillance system monitor. All of these jobs would be within her residual functional capacity based upon both Dr. Kitchens and Dr. Musich. She testified that these jobs are available in sufficient numbers and within the area in which Ms. McLeary lives. She confirmed this with the Bureau of Labor Statistics Information and MERIC from the State of Missouri. She also testified that she has recently placed people in these positions.

In addition to possessing transferable skills, she testified that it is also possible that the employee could learn new skills as well as perform unskilled work

From a vocational perspective, the employee has the ability to perform at least sedentary exertional work based on her physical residual functional capacity if one gives credence to Dr. Musich. However, she testified that if one gives credence to Dr. Kitchens, she would be capable of working full time and does not require restrictions as a result of the December 1, 2005 work incident. In consideration of both of these physicians' restrictions, the employee would be capable of performing at least sedentary, unskilled to semi-skilled work and there are jobs that exist in sufficient numbers in the southeast Missouri non-metropolitan fiscal area that she could perform.

Ms. Gonzalez did not believe that the employee had applied for or looked for any employment since departing with Arvin Meritor. She also thought that she was receiving disability benefits. From her past experience, it is easier to assist a person in finding employment after an injury when they are motivated to return to work.

She testified that a lot of people take pain medication and it does not affect their ability to work. However, depending upon the severity of pain, if a person was having difficulty performing the job, they would probably not be able to obtain or maintain employment. She testified that if a prospective employee has problems sleeping because of back or neck pain and is tired during the day that would be a negative factor in terms of finding a job. She testified that there are a lot of people working every day with the same issues and problems that the employee reiterated to her.

With respect to the activities of daily living that the employee reported to her, she again testified that these were all subjective complaints and were not consistent with what the doctors had indicated.

On cross examination, she was asked to assume that Ms. McLeary did in fact have all of the subjective limitations that she complained of. In that case, Ms. Gonzalez testified that as far as being able to sit 10 to 15 minutes, stand for 10 to 12 minutes or walk for 10 to 20 minutes, there were jobs that a person could perform with a sitting option as cited in her report. Moreover, a lot of jobs do not require reaching overhead and a lot of jobs do not require any bending. However, she does not know any employer that would allow the employee, or anyone, to take naps at will during the day. But again, in this case, there was no indication in any of the medical records that a doctor said that she needed to lie down throughout the day.

Finally, she testified that she does consider an individual's subjective complaints of pain, mannerisms, and how they are acting when she interviews them, but only to the point where it is consistent with what the doctors have said in their restrictions.

In general the employee testified that the medical bills that she presented were for care from her December 1, 2005 accident.

RULINGS OF LAW:

Medical Causation

The employer-insurer disputes that the employee's injuries/disabilities requiring treatment after April 5, 2006, were medically causally related to the accident of December 1, 2005.

The employee claims serious injury to her neck, back and body as a whole from the December 1, 2005 work accident requiring multiple surgeries and resulting in severe constant pain in her neck and back with pain and symptoms radiating into her left upper extremity and left lower extremity. The employer-insurer does not dispute that the employee suffered sprain/strain injuries to her neck and back from this work accident. However, the employer-insurer denies the full nature and extent of this employee's work-related injuries resulting from the December 1, 2005 work accident.

"The Claimant has the burden of proof to establish that she sustained an injury by accident arising out of and in the course of her employment, and that the accident resulted in the alleged injuries." **Choate v. Lily Tulip, Inc.**, 809 S.W. 2d 102, 105 (Mo. App. S.D. 1991). The question of the causal connection of an injury to an accident is to be decided in "light of the particular facts and circumstances of each case." **Ford v. Bi-State Development Agency**, 677 S.W. 2d 899, 904 (Mo. App. E.D. 1984); **Smith v. Terminal Transfer Co.**, 372 S.W. 2d 659, 669 (Mo. App. W.D. 1963). Employee does not have to establish the medical causal relationship element of the claim on the basis of absolute certainty but is sufficient that causation be supported only by reasonable probability. **Martin v. City of Independence**, 625 S.W. 2d 940, 941 (Mo. App. W.D. 1981); **Downing v. Willamette Industries, Inc.**, 895 S.W. 2d 650,

653 (Mo. App. W.D. 1995). "Probable means founded on reason and experience which inclines the mind to believe but leaves room for doubt." **Tate v. Southwestern Bell Telephone Co.**, 715 S.W. 2d 326, 329 (Mo. App. S.D. 1986).

"Where the condition presented is a sophisticated injury that requires surgical intervention or other highly scientific technique for diagnosis . . . the proof of causation is not within the realm of lay understanding." **Silman v. William Montgomery & Assoc.**, 891 S.W. 2d 173, 175, 176 (Mo. App. E.D. 1995). "This requires [Employee's] medical expert to establish the probability [Employee's] injuries were caused by the work accident." **McGrath v. Satellite Sprinkler Systems, Inc.**, 877 S.W. 2d 704, 708 (Mo. App. E.D. 1994). "The ultimate importance of the expert testimony is to be determined from the testimony as a whole and less than direct statements of reasonable medical certainty will be sufficient." **Id.** A finding of causation is not, however, "solely dependent on medical evidence given by expert witnesses, but [the] findings are to be judged on the basis of the evidence as a whole." **Fischer v. Archdiocese of St. Louis-Cardinal Ritter Inst.**, 793 S.W. 2d 195, 199 (Mo. App. E.D. 1990) (citing **Nelson v. Consolidated Housing Development and Management Co.** 750 S.W. 2d 144, 148 (Mo. App. S.D. 1988)). "The testimony of the Claimant . . . can constitute substantial evidence of the nature, cause and extent of the [injury], especially when taken in connection with, or where supported by, some medical evidence." **Fischer**, 793 S.W. 2d at 199. Medical proof of causation need not have the quality of absolute certainty and may be buttressed by lay testimony. See **Johnson v. City of Duenweg Fire Dept.**, 735 S.W. 2d 364 (Mo. banc 1987).

Section 287.800 RSMo. requires the provisions of the Missouri Workers' Compensation Act to be strictly construed. The burden is on the Claimant to prove all material elements of her claim. **Melvies v. Morris**, 422 S.W.2d 335 (Mo. App. 1968). The Claimant has the burden of proving that not only the Claimant sustained an accident that arose out of and in the course and scope of employment, but also that there is a medical causal relationship between the accident and the injuries and the medical treatment for which the Claimant is seeking compensation. **Griggs v. A.B. Chance Company**, 503 S.W.2d 697 (Mo. App. 1973).

Under Section 287.140 RSMo., the Claimant is entitled to receive all medical treatment that is reasonably required to cure and relieve her from the effects of the work injury. In order to prove a medical causation relationship between the alleged accident and the medical condition in cases such as this, the Claimant must offer competent medical testimony to satisfy her burden of proof. **Brundige v. Boehringer Ingelheim**, 812 S.W.2d 200 (Mo. App. 1991). Moreover, competent medical evidence must show that the medical care requested flows from the accident before the Employer is responsible. **Landers v. Chrysler Corporation**, 963 S.W.2d 275 (Mo. App. 1997). The Court finds that the employee has not met her burden of proof on the issue of medical causation.

The Court finds that the employee's injuries and need for medical care after April 5, 2006, are not medically causally related to her accident of December 1, 2005. The Court further finds that the opinions and testimony of Dr. Kitchens and Dr. Cantrell are more credible than the opinions of Dr. Musich. In addition, the Court finds that the entire medical evidence in this case does not support the opinions of Dr. Musich. This causes the Court to view Dr. Musich's opinions on

prevailing factor and medical causation as being deficient and lacking support and therefore not credibility. The Court finds that the entire medical evidence in this case supports the opinions of Dr. Kitchens and Dr. Cantrell and not Dr. Musich.

In no certain order, and not intended to be a full comprehensive list, the Court has listed various items of evidence which substantially affects the employee's case and causes the Court to reject the notion that the employee's need for medical care after April 2006 is medically causally related to her accident of December 1, 2005.

- The Court does not find the expert opinions of Dr. Musich to be credible.
- The Court does not believe that the underlying medical evidence and the general evidence in the case support the opinions drawn by Dr. Musich.
- The chronology of the case detracts from the employee's evidence regarding medical causation. The employee was injured on December 1, 2005. The employee had another injury on August 10, 2007. It was not until after that injury that she sought the care of Dr. Park. Dr. Musich did not see the employee until almost six years after the accident. It is relevant that the employee did not immediately report the intervening accident to either her treating or rating physicians.
- The Court finds that the original assessment of the diagnostic testing by the treating doctors and the rating experts as being degenerative in nature is more persuasive than the testimony and opinion of Dr. Musich who is the employee's main expert supporting causation. Dr. Musich was not able to specifically indicate how the MRI testing supported his position that the employee's injuries were acute in origin.
- The employee failed to advise the treating doctors and Dr. Musich of her pre-existing chiropractic care with Dr. Peters. The employee was not asymptomatic regarding her neck and back prior to December 1, 2005, which is an important part of her case and an important factor that Dr. Musich relied on in formulating his opinions.
- No treating doctor put any permanent restrictions on the employee's physical condition.
- After treatment the employee returned to work full duty and except for short intervals worked full time, full duty including some overtime right up until her surgery with Dr. Park.
- The employee was injured on December 1, 2005. It was not until 2007 that she first sought the care of Dr. Park.
- The employee claims that she tried to get the employer-insurer to provide care for her neck but they denied it. She was treating with Dr. Boardman at the same time she was being treated by doctors authorized by the employer. Despite the employee's assertions of significant cervical problems, there is no record that she ever complained to Dr. Boardman. It is not realistic to believe that she would not complain about the severity of her cervical problems when she is seeing her family physician if the problems were truly as bad as the employee claims.
- Overall the employee's position lacked credibility.

Based on all of the evidence in the case, the Court finds that the employer-insurer has no liability or responsibility to provide medical care to the employee for any medical treatment that she received after April 5, 2006. This would cover all of the medical care provided by Dr. Park, Dr.

Fonn, Dr. Schroeder or any other physician providing care and treatment after April 5, 2006 that the employee claims is related to the employee's accident of December 1, 2005.

Previously Incurred Medical Aid

The employee is making a claim for previously incurred medical aid in the amount of \$277,836.66. The employer-insurer is disputing said charges based on authorization, reasonableness, necessity and causal relationship. The employee is requesting that the Court order the employer-insurer to reimburse her for certain medical expenses incurred for treatment of her alleged work-related injuries.

Missouri workers' compensation law provides that the employee receive all medical care reasonably required after the injury to cure or relieve her from the effects of the work injury. The employer-insurer has the opportunity to control medical treatment through the selection of medical providers. In this case, the employer-insurer refused to provide further medical treatment following the April 5, 2006 physical therapy visit. (See Stipulation 10) At that point, the employee sought medical care on her own and now seeks reimbursement from the employer-insurer.

Section 287.140.1 RSMo. provides, in relevant part:

"In addition to all other compensation, the Claimant shall receive and the employer shall provide such medical, surgical, chiropractic, and hospital treatment, including nursing, custodial, ambulance and medicines, as may reasonably be required after the injury or disability, to cure and relieve from the effects of the injury..."

The employer shall have the right to select the health care provider. Section 287.140.10. Only when the employer fails to provide medical care is the Claimant free to choose her own provider, and to assess those costs against her employer. **Poole**, 328 S.W.3d at 291. The Claimant bears the burden to prove that past medical treatment flowed from the work injury. **Bowers v. Hiland Dairy Co.**, 188 S.W.3d 79, 87 (Mo. App. S.D. 2006).

With respect to the alleged past medical expenses, as the Court finds that the employee reached maximum medical improvement following Dr. Cantrell's evaluation, the treatment she received beyond then was not reasonable and necessary as related to the work injury. As such, the employer-insurer is not responsible for those expenses as the employee has failed to prove that the past medical treatment at issue flowed from the work injury. Instead, the evidence supports the finding that the employee's treatment following her evaluation with Dr. Cantrell was necessitated by the degenerative condition of her lumbar and cervical spine.

Dr. Kitchens credibly testified that the employee's cervical surgeries were necessitated by degeneration. Likewise, the injections to her lumbar spine, also for degeneration, were not administered or prescribed until almost four years after her accident and after a two year hiatus in her complaints regarding same to her treatment providers. As such, the Court finds that the

employee has failed to meet her burden of proof with respect to the past medical expenses. The employer-insurer is not ordered to reimburse the employee for \$277,836.66 in medical aid.

Temporary Total Disability and Mileage

As the Court found that the employee has failed to meet her burden of proof with respect to medical causation for the treatment she received following her evaluation with Dr. Cantrell, it follows that the employer-insurer is not responsible for providing temporary total disability benefits during the employee's lost time from work while obtaining that treatment.

The employer-insurer is not ordered to pay the employee \$16,169.84 in temporary total disability benefits.

With respect to the issue of mileage, it also follows that the employee is not entitled to reimbursement for same as she has failed to prove that the treatment she received was causally related to the work injury.

The employer-insurer is not ordered to pay the employee any mileage benefits in this case.

Additional/Future Medical Aid

Similarly, if the employee shows by reasonable probability that she needs additional medical treatment as a result of her work-related accident, such evidence will support an award of future medical benefits. **Poole**, 328 S.W.3d at 292.

The employee has also failed to meet her burden of proof with respect to future medical care. The evidence supports the finding that the employee's condition that is in need of treatment is that of degeneration in her cervical and lumbar spine. At a minimum the employee has not shown by credible evidence that any need for additional medical care is related to her December 1, 2005 accident.

The only recommendation for additional treatment as specifically related to the work injury comes from Dr. Musich whom the Court has already found not to be credible. He testified that the employee may require pain medication on an intermittent basis for an indefinite period of time. However, at the same time, he also testified that although the employee reported taking Flexeril and Tramadol her pain levels were still at a 10. He explained that it was possible that her pain medication had plateaued to the point where it was no longer useful and/or she is exaggerating her pain complaints. Dr. Musich made no other recommendations for treatment and did not recommend any further surgical intervention. Likewise, there is also no expert testimony or evidence suggesting the lumbar injections that the employee is presently receiving are related to the work injury.

The employer-insurer is not ordered to provide any future or additional medical care to the employee.

Maximum Medical Improvement

Based on the prior findings of the Court and based on a consideration of all of the evidence in this case the Court finds that the employee reached maximum medical improvement as of March 7, 2006.

Short Term Disability

Based on the prior findings of the Court and based on a consideration of all of the evidence in this case the Court finds that the issue regarding short term employment is moot.

Schoemehl

Based on the prior findings of the Court that the employee is not permanently and totally disabled due to the accident of December 1, 2005, or in combination with her pre-existing disabilities, the issue of benefits and dependency is moot.

Permanent Total Disability and Permanent Partial Disability and Liability of the Second Injury Fund

The employee offered the testimony of Dr. Musich and Jim England in support of her claims for disability. The only testimony or expert opinion that indicated that the employee was permanently and totally disabled was that of Dr. Musich. The Court has rejected his opinions as lacking credibility. Mr. England's opinions regarding permanent total disability are based and founded on the opinions of Dr. Musich, therefore they lack credibility.

The Court finds that the employee is not permanent and totally disabled due to the last accident alone or in conjunction with her pre-existing disabilities. The Court finds that the employee has failed to meet her burden of proof to present clear and credible evidence that she is permanently and totally disabled. The Court finds that neither the employer-insurer nor the Second Injury Fund has any liability for permanent total disability.

The parties stipulated to accident. The Court finds that the employee has presented credible evidence that she had an accident on December 1, 2005, that resulted in strains and sprains to her body as a whole. The employee and the employer-insurer provided expert opinion as to the disability that the employee has from her accident.

Dr. Cantrell provided ratings of four percent permanent partial disability to the body as a whole due to the employee's cervical injury, five percent permanent partial disability to the employee's body as a whole due to the employee's lumbar injury and two percent permanent partial disability to the employee's left shoulder.

Dr. Musich says that the employee received a fifty percent permanent partial disability to her body as a whole due to her cervical injury, a twenty-five percent permanent partial disability to her body as a whole due to her lumbrosacral injury and a fifteen percent permanent partial disability to her body as a whole due to her pre-existing breast cancer.

Dr. Kitchens gave the employee a two percent permanent partial disability to the employee's body as a whole due to her cervical injury.

The Court does not believe that the employee's claimed disabilities are related to her December 1, 2005 accident. The overall evidence in the case, including the video surveillance supports a position that the employee is not as disabled as she claims or at a minimum the employee does not provide evidence that requires the employer-insurer to be required to pay disability for the levels that the employee claims.

After a consideration of all of the credible evidence in this case, the Court finds that the employee has a twelve percent permanent partial disability due to all of the injuries, including the sprain strain injuries that she received from her December 1, 2005 accident.

The Court orders the employer-insurer to pay \$12,694.08 to the employee as permanent partial disability.

The Second Injury Fund has no liability for permanent partial disability as the primary injury does not meet the threshold requirements of the law.

ATTORNEY'S FEE:

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

INTEREST:

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

Made by:

Gary L. Robbins
Administrative Law Judge
Division of Workers' Compensation