

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

Injury No. 02-125272

Employee: Gregory Miller
Employer: Jack Cooper Transport (Settled)
Insurer: Liberty Mutual Insurance Co. (Settled)
Additional Party: Treasurer of Missouri as Custodian
of Second Injury Fund

The above-entitled workers' compensation case is submitted to the Labor and Industrial Relations Commission (Commission) for review as provided by § 287.480 RSMo. Having reviewed the evidence and considered the whole record, the Commission finds that the award of the administrative law judge is supported by competent and substantial evidence and was made in accordance with the Missouri Workers' Compensation Law. Pursuant to § 286.090 RSMo, the Commission affirms the award and decision of the administrative law judge dated April 30, 2015. The award and decision of Chief Administrative Law Judge Grant C. Gorman, issued April 30, 2015, is attached and incorporated by this reference.

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

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

Given at Jefferson City, State of Missouri, this 1st day of December 2015.

LABOR AND INDUSTRIAL RELATIONS COMMISSION

John J. Larsen, Jr., Chairman

James G. Avery, Jr., Member

Curtis E. Chick, Jr., Member

Attest:

Secretary

AWARD

Employee: Gregory Miller

Injury No. 02-125272

Dependents: None

Employer: Jack Cooper Transport (Settled)

Additional Party: Second Injury Fund

Insurer: Liberty Mutual Insurance, Co.

Hearing Date: August 20, 2014

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

Checked by: GCG/kr

FINDINGS OF FACT AND RULINGS OF LAW

1. Are any benefits awarded herein? Yes
2. Was the injury or occupational disease compensable under Chapter 287? Yes (Settled)
3. Was there an accident or incident of occupational disease under the Law? Yes
4. Date of accident or onset of occupational disease: October 31, 2002
5. State location where accident occurred or occupational disease was contracted: St. Charles County, Missouri
6. Was above employee in employ of above employer at time of alleged accident or occupational disease? Yes
7. Did employer receive proper notice? Yes
8. Did accident or occupational disease arise out of and in the course of the employment? Yes
9. Was claim for compensation filed within time required by Law? Yes
10. Was employer insured by above insurer? Yes
11. Describe work employee was doing and how accident occurred or occupational disease contracted:
Claimant was loading cargo vans onto a truck when a chain released causing Claimant to fall landing on his right shoulder and back, in the course and scope of employment.
12. Did accident or occupational disease cause death? No
13. Part(s) of body injured by accident or occupational disease: Right Shoulder and low back
14. Nature and extent of any permanent disability: 25% Right shoulder and 19.5% low back (permanent and total disability)
15. Compensation paid to-date for temporary disability: \$32,929.80
16. Value necessary medical aid paid to date by employer/insurer? \$48,393.14

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- 17. Value necessary medical aid not furnished by employer/insurer? None
- 18. Employee's average weekly wages: \$975.00
- 19. Weekly compensation rate: \$649.32 TTD (PTD)/\$340.12 PPD
- 20. Method wages computation: Stipulation

COMPENSATION PAYABLE

- 21. Amount of compensation payable: \$46,250.00 from settlement with Employer

- 22. Second Injury Fund liability: Yes

Permanent total disability benefits from Second Injury Fund:
Weekly differential (\$309.20) payable by SIF for 136 weeks beginning
January 25, 2007 and, thereafter, \$649.32 for Claimant's lifetime.

TOTAL: SEE AWARD

- 23. Future requirements awarded: None

Said payments to begin as of the date of this Award and to be payable and be subject to modification and review as provided by law.

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

Jonathan Isbell

Employee: Gregory Miller

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FINDINGS OF FACT and RULINGS OF LAW:

Employee: Gregory Miller

Injury No: 02-125272

Dependents: None

Before the
**DIVISION OF WORKERS'
COMPENSATION**

Employer: Jack Cooper Transport (Settled)

Department of Labor and Industrial
Relations of Missouri
Jefferson City, Missouri

Additional Party Second Injury Fund

Insurer: Liberty Mutual Insurance, Co.

Checked by: GCG/kr

PRELIMINARY STATEMENT

Hearing in the above referenced case was held August 20, 2014, in St. Charles County before the undersigned Administrative Law Judge. Gregory Miller (Claimant) was present and represented by attorney Jonathan Isbell. Employer/Insurer previously settled liability. The Second Injury Fund (SIF) was represented by Assistant Attorney General Jennifer Sommers. Mr. Isbell requested a lien for attorney fees in the amount of 25%. The parties submitted post-trial briefs.

The parties entered into the following stipulations:

STIPULATIONS

1. On or about October 31, 2002 Claimant sustained an accidental injury arising out of and in the course of employment that resulted in injury to Claimant. The injury occurred in St. Charles County, Missouri.
2. Claimant was an employee of Employer pursuant to Chapter 287 RSMo.
3. Employer received proper notice.
4. The Claim was filed within the time prescribed by law.
5. Venue is proper in St. Charles County, Missouri.
6. Claimant earned an average weekly wage of \$975.00 resulting in applicable rates of compensation of \$649.32 for total disability (TTD) benefits and \$340.12 for permanent partial disability (PPD) benefits.
7. Employer paid TTD benefits of \$32,929.80 for a period of 50 5/7 weeks.
8. Employer paid \$48,393.14 in medical benefits.

In addition, the Court took administrative judicial notice of the Claim filed, and Claimant withdrew his claim for repetitive trauma.

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The following issues were presented for resolution in this hearing:

1. Nature and extent of Claimant's disability from the primary injury.
2. Permanent total disability.
3. Liability of the Second Injury Fund for permanent partial disability (PPD) or permanent total disability (PTD) benefits.
4. Date of maximum medical improvement.
5. Medical causation for shoulder injury.
6. Ruling regarding alleged typographical error in Stipulation for Compromise Settlement between Claimant and Employer as to whether the parties intended resolution of PPD to left shoulder or right shoulder.

SUMMARY OF THE EVIDENCE

Only evidence necessary to support this award will be summarized. Any objections not expressly ruled upon during the hearing or in this award are now overruled. Certain exhibits offered into evidence may contain handwritten markings, underlining and/or highlighting on portions of the documents. Any such markings on the exhibits were present at the time they were offered by the parties and had no impact on any ruling in this case.

Claimant offered the following Exhibits which were received into evidence without objection:

1. Deposition of David T. Volarich, D.O. taken June 18, 2013, including deposition exhibits:
Curriculum Vitae; Independent Medical Examination report.
2. Deposition of Delores E. Gonzalez taken June 17, 2013, including deposition exhibits:
Curriculum Vitae; Vocational Rehabilitation Evaluation.
3. Deposition of Terrence Piper, M.D. taken on August 14, 2007, including deposition exhibits.
4. Deposition of Mitchell B. Rotman, M.D. taken on May 21, 2009, including deposition exhibits.
5. Deposition of Theodore Rummel, M.D. taken on August 17, 2007, including deposition exhibits.
6. Deposition of William Wang, M.D. taken on July 10, 2007, including deposition exhibits.
7. St. Joseph Hospital West Medical Record– 3 pgs d/o/s 8/8/89.

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8. Neurosurgical Associates, Inc. Medical Record. – 19 pgs d/o/s 8/30/88 to 12/6/02.
9. Professional Rehabilitation Services Medical Record – 13 pgs d/o/s 4/23/93 to 4/6/94.
10. Professional Rehabilitation Services Medical Record - 252 pgs d/o/s/ 1/20/98 to 7/20/04.
11. Tri-Co Occupational Health Services (Ronald L. Pearson, DO) Medical Record - 11 pgs d/o/s 11/15/02 to 1/8/03.
12. NYDIC Open MRI of America-St. Peters Medical Record - 3 pgs d/o/s 11/15/02 & 12/6/02.
13. Northland Mid-America (Dr. Randall Roush)Medical Record)18 pgs d/o/s 11/19/02 to 12/9/03.
14. SSM DePaul Ortho Bridge (Dr. Randall Roush) Medical Record - 22 pgs d/o/s 11/19/02 to 11/22/05.
15. James Coyle, M.D. Medical Record - 23 pgs d/o/s 1/27/03 to 1/27/04.
16. Pain Treatment Center (Dr. John Graham) Medical Record - 55 pgs d/o/s/ 1/29/03 to 7/30/03.
17. Aquatic Fitness, Inc. Medical Record - 32 pgs d/o/s 1/30/03 to 3/18/03.
18. St. Joseph Hospital West Medical Record - 26 pgs d/o/s 2/26/03.
19. St. Louis Orthopedic Institute, Inc. (Dr. Bernard Randolph) Medial Record - 9 pgs d/o/s 3/19/03 to 5/15/03.
20. The Work Performance Center, Inc. Medical Record - 20 pgs d/o/s 4/21/03 to 5/14/03.
21. St. Joseph Health Center Medical Record– 1 pg d/o/s 5/17/03.
22. St. Peters Bone & Joint Surgery Medical Record - 93 pgs d/o/s 8/5/03 to 9/18/06.
23. Missouri Bone & Joint Center Medical Record – 76 pgs d/o/s 8/26/03 to 10/24/03.
24. Excel Imaging Medical Record - 2 pgs d/o/s 10/28/03.
25. Benrus Surgical (Dr. Kenneth Hacker) Medical Record - 4 pgs d/o/s 1/16/04 to 4/14/04.
26. Barnes-Jewish St. Peters Hospital Medical Record - 127 pgs d/o/s 2/4/04 to 2/8/04.
27. Advance Physical Therapy Medical Record - 187 pgs d/o/s 8/2/04 to 10/13/06.
28. Timberlake Surgery Center Medical Record - 21 pgs d/o/s 11/1/06.

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29. Advance Physical Therapy Supplemental Medical Record - 71 pgs d/o/s 11/28/06 to 6/23/08.
30. Dr. Krishnan Medial Record– 108 pgs d/o/s 10/12/12 to 6/17/13.
31. Original Claim for Compensation; Two Amended Claims for Compensation – group.
32. Contract of Employment for Legal Services.
33. Approved Settlement Stipulation between Employee and Employer/Insurer in Injury Number 02-125272.

The Second Injury Fund offered the following Exhibits which were received into evidence. The objection by Claimant to the admission of SIF Exhibit II in its entirety, for the stated purpose of providing additional information to the ALJ, was overruled:

- I. Deposition of James M. England, Jr., taken on November 19, 2013, including deposition exhibits: Curriculum Vitae and Vocational Rehabilitation Evaluation .
- II. Deposition of Claimant Gregory Miller, taken on September 26, 2011.

At the commencement of the proceedings, counsel for Claimant announced that he was withdrawing all claims for repetitive trauma due to insufficient medical causation proof.

Live Testimony

Claimant testified at trial. He testified that he has been a transport driver or car hauler, working out of the employer's Wentzville facility since 1985. Car haulers transport vehicles in tractor trailer rigs from the point of manufacture to dealerships. Claimant would make these deliveries, over the road, all around the country. Claimant testified that the most difficult aspect of his job was the loading and unloading of vehicles, which entailed a variety of strenuous activities including chaining down the vehicles tightly to the trailer using a winch-ratchet assembly and a winch bar. Heavy chains weighing up to 50 pounds had to be carried to each of the 4 attachments on the vehicle's frame to different levels of the unit. Both arms were used to pull the winch bar, one arm at a time or in combination, against the resistance of the vehicle's suspension system – to attach the vehicle tight to the trailer - sometimes exceeding 100 lbs. of pulling force. On October 31, 2002 the Claimant was in the "belly" of the trailer tying down a unit when the chain, which was wrapped around the barrel of the winch, got snagged or caught up. Attempting to release the snag, Claimant pulled on the winch bar with more force and the chain un-snagged releasing all slack in the chain causing Claimant to fall backwards onto the concrete below. Claimant testified that he tried to cushion his fall by instinctively reaching backwards with his right arm, but he fell onto the concrete with his right arm pinned behind his back, directly onto his right shoulder right hip and left low back – in a twisted fashion. He testified that after the initial shock, his right shoulder, low back, hips and left leg became extremely painful.

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The claimant testified that shortly after the accident, he informed his physicians, Dr. Pearson and Dr. Roush that his low back, hips, legs and right shoulder (not his *left* shoulder) was painful and he demonstrated in open court that the pain diagram he drew for Dr. Roush (Exhibit #13) on November 19, 2002, reflected aching, stabbing and burning pain in those areas. Claimant testified that he did not experience any pain in his left shoulder prior to the accident or as a result of the accident. The claimant testified that workers compensation paid for right shoulder treatment and the first right shoulder surgery following the accident. The claimant testified that the approved stipulation for settlement (Exhibit #33) with the employer mistakenly listed PPD attributable to the *left* shoulder as opposed to the *right* shoulder.

Claimant testified that in addition to his painful right shoulder, as a result of the accident he experienced severe aching stabbing pain in his low back, buttocks and hips, with pain going down his legs – his left leg primarily. The claimant testified that he had two right shoulder surgeries and a low back fusion, as well as a very recent low back surgery as a result of this accident. The claimant also testified that he became exceedingly fearful and depressed to the point of dysfunction, following this accident.

In the intervening time since the primary injury, the claimant has undergone several other procedures which he does not relate to the accident: surgeries to his left shoulder, his knees, his arms and hands - which he attributes to his many years of heavy labor as a car hauler. He testified that none of his physicians performing these other surgeries have told him that they were caused by the accident or his work activities. He testified that he was told these other conditions were caused by arthritis or overuse. He said that his left shoulder has not been giving him any significant problems presently, since his surgery, but that his right shoulder remains painful and limited when he tries to lift anything.

As the Claimant testified he asked for permission to stand up several times during his testimony. His discomfort level appeared to worsen over time. He indicated a number of times he was in pain while testifying.

The claimant testified at length about being raised on a farm and that starting at age 4 or 5 through high school, he devoted all of his time outside of school to helping raise crops and animals on the family farm, from dawn to dusk. Without detailing Claimant's extensive testimony on the subject, there's no doubt that Claimant developed innumerable skills on the farm and was left with a solid work ethic as a result. Claimant went to college for one year, but had to drop out due to financial constraints. He did obtain a certificate in heating and air conditioning. He obtained a commercial drivers license at age 18 and also recounted his work and educational experience, which is referred to in the vocational exhibits.

With regard to pre-existing conditions, Claimant testified that he had his first low back surgery in 1988. He was injured in the process of unloading vehicles, when he stepped off his tractor-trailer into the path of oncoming traffic and was struck on the left hip and left leg by a vehicle and dragged down the road. He testified that he was returned to work in January of 1989, after low back surgery, physical therapy and work hardening with no restrictions. Claimant testified that since that time he never been pain free while working, especially when loading and unloading vehicles; but he was able to work slowly and carefully. He testified that having to

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work slowly and carefully adversely affected his productivity and income. Claimant testified that his low back and left leg pain increased over time. Finally, he returned to his surgeon Dr. Mollman, for a second surgery to repair another herniated disc in his low back, in September of 1993. Claimant testified that the surgery alleviated the sharp pain he was experiencing, but it basically left him in the same situation as he was, following his first back surgery – working slowly and enduring the pain. Claimant stated that some of his co-workers were earning up to \$100,000 a year and he was convinced that he could have earned comparable wages, had it not been for his loss of productivity attributable to his painful back.

Claimant testified that he suffered another injury in October of 1998 when he fell off the top rail of his car carrier, onto the ground “landing like a cat”. He testified that he was fortunate to hit the ground in that manner, because he was back to work in a few months after some physical therapy, performing the same job in the same fashion as he had been, following the second back surgery.

After the primary injury on October 31, 2002, the Claimant testified he had to leave his job as a transport driver because he was no longer physically capable of performing his job duties. At age 41, he applied for “an early out” to receive a substantially reduced retirement pension with the union. He was aware of co-workers who had worked into their seventies. He applied for and received social security disability benefits. He testified that he has not been employed since. His only venture into self employment was a brief failed attempt to raise a few cattle for profit with his brother on one occasion. He split the cost of purchasing some calves with his brother, but soon realized that he had to depend upon his brother to perform all the physical labor. Even stepping out of the truck was too painful. He testified that he would accept any job, if he was capable of performing it.

For many years before the primary injury, in his 30’s, Claimant had been prescribed medication for depression; which he described as adequately controlled in the past. He had never seen a psychologist. Following the primary injury he has been seeing a psychiatrist or psychologist and/or mental health counselor on a regular basis. He describes his depression and fears as having increased dramatically. He described his low back pain since the primary injury as fluctuating – but almost always between moderately severe and severe upon activity. He testified that he has received ongoing treatment for pain ever since the primary injury and underwent a recent surgical procedure in 2013 to treat a failed disc at the adjacent level above the fusion and to implant a stimulator with wire leads to mask the pain to his back and legs. He has a remote control unit which contains different settings for sitting, standing, lying down and such. He testified that his spine surgeon who performed the spine fusion following the October 2002 injury, Dr. Piper, had warned him to expect a failure of the adjacent disc, as the fusion transfers stress to the adjacent flexible level. There isn’t a single activity of daily living, when done, or done for too long, that doesn’t cause his pain to spike. He testified that he wakes up frequently throughout the night from pain resulting from the primary injury and does not feel rested throughout the day, needing naps.

Claimant testified that he now lives an isolated existence, rarely venturing out of the house. He lives in a farming community where everyone works hard and people “just don’t” go

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to a psychologist or have mental health disorders. He testified that he feels ashamed of having a mental health condition that requires treatment.

Claimant testified that he and his wife received a settlement as a result of a third party products liability civil lawsuit.

Stipulation for Compromise Settlement with Employer

The Stipulation for Compromise Settlement (Exhibit #33) with the employer is in evidence. The Claimant settled with the employer for the injury of October 31, 2002 as stated in the document; for a lump sum of "\$46,250 plus MSA" based upon approximate disability of 25% of the left arm and 19.5% of the body as a whole referable to the low back (L4-S1). The employer is acknowledged to have paid TTD for 50 5/7 weeks in the amount of \$32,929.80.

Deposition Testimony

DAVID T. VOLARICH, D.O.

Dr. David T. Volarich prepared a written report containing the details of his examination, method and opinions; and testified on behalf of the Claimant by deposition on June 18, 2013. Regarding causation, in his written report Dr. Volarich opined:

It is my opinion the accident that occurred 10/31/02, when Mr. Miller was tightening down a van using a wrench and ratchet assembly, when it broke away causing him to fall 6 feet off the truck to the concrete below, landing on his back and extended right upper extremity, is the substantial contributing factor, as well as the prevailing or primary factor causing his lumbar left leg radicular syndrome that ultimately required anterior lumbar fusion with instrumentation of both L4-5 and L5-S1 due to discogenic pain. It is further my opinion that his back injury of 10/31/02 would not have been as severe had it not been for the preexisting discectomies performed at L4-5 and L5-S1 causing his back to be in a weakened condition and in turn, causing a more severe injury requiring fusion with instrumentation. As a result of this fall and jamming his right shoulder, he developed impingement that required two separate arthroscopic repairs. Regarding the nature of the primary injury, his report states:

1. Lumbar left leg radicular syndrome secondary to discogenic pain L4-5 and L5-S1 – S/P [surgical procedure] anterior lumbar discectomy, fusion and instrumentation L4-5 and L5-S1.
2. Postlaminectomy syndrome.
3. Right Shoulder impingement – S/P arthroscopic acromioplasty.
4. Persistent right shoulder pain – S/P arthroscopic subacromial decompression and distal clavicle excision.

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Regarding pre-existing conditions, his report states:

1. Herniated nucleus pulposus L-4-5 to the left causing left leg radiculopathy – S/P microdiscectomy.
2. Herniated nucleus pulposus L5-S1 to the left causing left leg radiculopathy – S/P microdiscectomy L5-S1 on the left.
3. Postlaminectomy syndrome.

Regarding disability ratings and opinions, his report states:

Pertaining to and as a direct result of the injuries sustained on 10/31/02, while in the employ of Jack Cooper Transport Company, it is my opinion that the following industrial disabilities exist that are a hindrance to his employment or re-employment:

1. There is a 40% permanent partial disability of the body as a whole rated at the lumbar spine, due to the left leg radicular syndrome caused by discogenic pain from the L4-5 and L5-S1 levels that required anterior lumbar discectomy with fusion and instrumentation at both L4-5 and L5-S1. The rating accounts for this injury's contribution to pain, lost motion and ongoing lower extremity paresthesias. Additional disability exists in the low back, see below.
2. There is a 35% permanent partial disability of the right upper extremity rated at the shoulder, due to the impingement that required arthroscopic acromioplasty followed by a second repair that included arthroscopic subacromial decompression and distal clavicle excision. The rating accounts for ongoing discomfort, lost motion, weakness, crepitus and atrophy in the dominant arm.

Pertaining to his medical conditions preexisting 10/31/02 it is my opinion that the following permanent industrial disabilities exist and are a hindrance to his employment or re-employment:

1. There is a 30% permanent partial disability of the body as a whole rated at the lumbar spine, due to the disc herniation at L4-5 on the left . . . and the subsequent herniation at L5-S1 on the left . . . The rating accounts for his ongoing back syndrome due to disc bulging at L3-4, L4-5 and L5-S1, as well as scarring at the operative sites causing postlaminectomy syndrome that continued to cause back pain, lost motion and intermittent lower extremity paresthesias prior to 10/31/02.

Disability exists as a result of his psychiatric disorders. I defer to psychiatric evaluation for that assessment.

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Dr. Volarich further opined in his report that: "The combination of his disabilities creates a substantially greater disability than the simple sum or total of each separate injury/illness, and a loading factor should be added." He stated: "Mr. Miller is unable to engage in any substantial gainful activity nor can he be expected to perform in an ongoing working capacity in the future." Furthermore: "Based upon my medical assessment alone, it is my opinion that Mr. Miller is permanently and totally disabled as a direct result of the work related injury of 10/31/02, in combination with his preexisting lumbar syndrome and psychiatric disorders." Concerning the other surgeries claimant had over the years following the primary injury, which, according to Dr. Volarich, were not the result of pre-existing conditions or the primary injury; he stated that Mr. Miller "was permanently and totally disabled as a result of the above noted work related injuries and prior to the development of the subsequent left shoulder, bilateral elbow, bilateral wrist and hand, neck and bilateral knee conditions."

Pertaining to physical restrictions in the work place, both before and after the primary injury, Dr. Volarich expressed the opinion that essentially prior to the primary injury, he would have not imposed any absolute restrictions, but he would have cautioned Claimant not to overdo it at work, learn to lift and carry weights safely, rest and change positions as needed. However, following the primary injury, Dr. Volarich imposed numerous specific restrictions affecting his ability to work, which were considered and discussed by the vocational experts.

Regarding MMI Dr. Volarich wrote that at the time of his examination Claimant had achieved MMI but "requires ongoing pain management for his postlaminectomy syndrome and chronic whole body pain syndrome as well as his psychiatric disorders."

In Deposition, about the two prior low back surgeries and the other incident when Claimant fell off the truck:

Q: Do you have an opinion as to whether any one of these or each of these three prior incidents were of such severity as they might -- as they would have constituted a hindrance or obstacle to employment or employability?

A: Yes, they did.

Q: Could you tell me why?

A: Because his outcome was not very good. I mean, even as early as 1999 he was diagnosed with post-laminectomy syndrome. That means failed back syndrome in layman's terms. What happened is he didn't heal properly. He healed with more scar tissue than expected and he didn't respond like we like to see. We want to see the leg symptoms or pain to be minimal. None of those things happened with him. So these hindered his ability to do his job. He just could not move as freely, lift as much, drive as long, pull as hard as he could before his work injuries in the early '80s.

Regarding objective testing of the lumbar spine during his examination of the Claimant, Dr. Volarich testified as follows:

A: In the lumbar spine, motion was restricted there as well. Again, after measuring with an inclinometer, there was a 37 percent loss of flexion, 92 percent loss of extension due to the fusion, 44 percent loss of right side bending and a 20 percent loss of left side bending.

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Q: With regard to the lumbar spine, do you attribute any of these losses to either the primary or the pre-existing conditions?

A: That's a combination of the primary and pre-existing. The worst pain in his low back occurred with flexion. Palpation elicited pain in the paraspinous muscles from L2 through S1, the gluteal muscles bilaterally, the sacroiliac joints bilaterally and the sciatic notches on each side. Multiple trigger points were found in the gluteal regions bilaterally.

Q: What does that mean?

A: Trigger points are objective findings on physical examination. When palpating the soft tissues I noted there was small nodules underneath the skin about BB size. When you push on those, they cause considerable pain but they cause the muscle to twitch. That's an objective finding. The patient has no control over that.

Q: And do these relate to the lumbar injury?

A: Yes.

Q: And how were these produced?

A: It's chronic muscle, nerve root irritation. It's basically the foundation of his pain syndrome.

Regarding objective testing of the right shoulder during his examination of the Claimant, Dr. Volarich testified as follows:

A: . . . In the right shoulder, I found a 20% loss as evaluated by the Apley Scratch test with circumduction. I checked motion in all six planes. Impingement testing was weakly positive. Apprehension, clunk, Adson's and O'Brien's were negative. Trace crepitus was found with circumduction. One over five atrophy, that's mild, of the deltoid rotator cuff was also identified.

A: The arm above the elbow on the right measured 33 centimeters, left was 34. Both forearms were 27. This gentleman is a right hand dominant individual. I would expect the right arm to be larger than the left so this shows there is atrophy in this arm from the shoulder injury.

Regarding his prognosis for the chance of improvement, Dr. Volarich testified that "he's not going to get any better." Dr. Volarich testified that Claimant is permanently and totally disabled.

Q: And so is it your opinion that the combination of the pre-existing and the primary renders him permanently and totally disabled?

A: Yes.

Q: And is that as a result of the primary injury alone?

A: No, it's a combination.

Q: Of?

A: Of his work related injury of 10/31/12 and his pre-existing lumbar syndrome.

Dr. Volarich testified that as a medical expert he is often called upon to render opinions concerning whether or not his patients are capable of performing substantial, gainful employment. "I do that all the time". Dr. Volarich testified that if Claimant was sent to him for a pre-employment physical "I would flunk him."

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TERRENCE PIPER, M.D.

Dr. Terrence Piper, a spinal surgeon, testified by deposition on August 14, 2007 regarding the low back surgery he performed on February 4, 2004.

Regarding causation:

A: Sure. I do have an opinion that this is a man who unquestionably had back problems, as I've chronicled here in my testimony so far. Apparently he was functioning satisfactorily up to the time of this event in October of '02. . . . and he was unable to work subsequently. So it certainly exacerbated, and brought to the forefront a problem that had been plaguing this guy for a long time. And I guess it would be the catalyst, or the straw that broke the camel's back that precipitated the symptoms that eventually resulted in the surgery. [Depo p 29]

Q: And, Doctor, would you agree that it would be a combination of his pre-existing degenerative changes, prior surgeries, and this incident [10/31/02] that brought him to the point where he came to your office – in August, 2003?

A: Yes, I would.

Q: It was a combination of the prior and that incident that necessitated the surgery; is that right?

A: Yes, sir. [Depo p 77]

Regarding the issue of MMI:

Although Dr. Piper had never issued a written statement that Claimant had achieved MMI on a certain date, , on cross examination, Dr. Piper testified that based upon a physical therapy note dated November 1, 2004 in which the therapist stated: "I do feel that patient could return to work status", that Dr. Piper would also opine if asked, that as of that date [November 1, 2004]

Claimant had achieved a good result from his surgery; a solid fusion, good lifting strength, good range of motion and if he was able to work, he would have released him.

Q: And that's where you left him with the low back?

A: Correct. [Depo pps 58,63,57-63]

Q: Have you seen any records dated prior to November 1st, 2004 indicating that Mr. Miller could go back to work, assuming his back was his only problem?

A: No. [Depo p 65-66]

Regarding Claimant's testimony that Dr. Piper had informed him to expect a failure at the L-3 level eventually:

The problem with fusion is that frequently long-term it causes problems to the adjacent discs next door, and prematurely causes it to wear out.

As I . . . lightly touched on earlier, he's got the lowest two discs in his back fused. They don't work anymore. There is nothing going on there. They're solidly fused. The x-rays showed that. I looked at that when we were out. So the guy next door, the 3-4 disc has to work overtime, and triple time. So he can wear out prematurely, and he may have back problems related to that. . . . But certainly he's at a higher risk than the general population to have disc problems upstairs from where he had his previous surgery, in the future.

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MITCHELL B. ROTMAN, M.D.

Dr. Rotman, an orthopedic surgeon with a specialty in the upper extremities, testified by deposition taken on May 21, 2009. Concerning causal connection, the doctor testified that since his first right shoulder surgery by Dr. Roush for the primary injury:

Well, my impression at that point was he continued to have pain from his AC joint which had not been relieved from the first surgery because the AC joint basically was not addressed, so that continued to be a problem. [Depo p 12]

The shoulder, there's two issues there. There's the fall on the shoulder on the outer side which certainly could aggravate anybody's AC joint. When you fall on the outer side of the shoulder, the acromion jams right into the clavicle, and if you have any kind of problem with that joint, it will aggravate it. If you don't have a problem with it, it may cause a problem such as a separation. So there's a direct impact on the AC joint. He has AC joint arthritis; however, AC joint arthritis wouldn't have been caused already from the fall. That had to have been preexisting. Folks who get AC joint arthritis that have problems with the AC joint do a lot of heavy labor with the shoulder. He did some heavy use of the right shoulder in the course of his work. He's right-handed. He would have used his right shoulder a lot. He would have done overhead pulling and wrenching for those several years that he worked, so some of the problems that he had in his shoulder were already there. They were chronic. He may not have been painful from them and then this accident where he fell right on his shoulder was the first time that the pain was generated from those chronic conditions that were coming on over the years of work. [Depo pps 14-15]

Q: And the specific trauma you're talking about where Mr. Miller fell onto his shoulder, is it your opinion within a reasonable degree of medical certainty that that's what caused his shoulder to become symptomatic such that he required medical treatment?

A: Correct.

Q: That includes medical treatment that you administered and also the prior medical treatment that you described, correct?

A: Yes. [Depo p 15]

Regarding the right shoulder surgery, he testified that he could observe the rotator cuff tear and the prominent spurring of the AC joint causing clear inflammatory changes in the area of the AC joint. "I took care of all that by removing the rest of the undersurface of the acromion that had a hook to it and then I took out the end of the clavicle, and that pretty much took care of the bone spurs that were digging into everything else." In addition he shaved the rotator cuff tear. [Depo p 19]

Q: What is your opinion within a reasonable degree of medical certainty as to the injuries that Mr. Miller sustained and received for which you provided treatment as a result of the October 31, 2002, trauma he reported to you where the chain slipped and he fell to the ground onto his shoulder?

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A: the portion of what I treated him for related to that accident was the shoulder arthroscopy which included the rotator cuff debridement and distal clavicle resection and repeat acromioplasty. [Depo p 24]

THEODORE RUMMEL, M.D

Dr. Rummel an orthopedic surgeon testified by deposition taken on August 17, 2007:

Dr. Rummel testified that he first saw Claimant on April 13, 2004 regarding the left shoulder. Claimant informed Dr. Rummel that after using a weight machine 11 months earlier in rehabilitation, the shoulder “popped” and was now painful. Dr. Rummel testified that he performed surgery on the left shoulder on May 10, 2004. During surgery Dr. Rummel found that there was a fraying of the supraspinatus and a large thickened bursa. He also found two structural anomalies which were hereditary; namely a Burford complex and a hooked acromion. Dr. Rummel then performed a second left shoulder surgery on December 8, 2004 due to the persistence of pain following the first surgery. On direct examination he opined that years of overuse of the shoulder as a car hauler could cause or contribute to the painful condition of the left shoulder. He also opined that the incident during rehabilitation was “commensurate” with the type of pain he was feeling and the findings. On cross examination he testified that pain resulting from a hooked acromion could be induced by something as minor as reaching for something on a shelf; and that age related arthritis could also be the cause of the arthritis he found and treated in Claimant’s left shoulder. Dr. Rummel testified that he was unaware of the incident on October 31, 2002 and did not ascribe any of Claimant’s left shoulder problems to that incident. After the Mumford procedure, the doctor agreed that the Claimant was “A-okay to go back to work” as regards the left shoulder.

WILLIAM WANG, M.D.

Dr. William Wang, a psychiatrist, testified by deposition taken on July 10, 2007:

Dr. Wang testified that he first started treating Claimant on May 16, 2005, referred by Claimant’s primary care physician, for depression secondary to chronic pain. Thereafter, he saw Claimant every two to three months. Dr. Wang diagnosed major depressive disorder and generalized anxiety disorder. At the initial visit Claimant was assessed as having a severe depressive mood, loss of interest, feelings of hopelessness and helplessness; irritability, anger issues, loss of appetite, loss of weight, difficulty sleeping, anxiety, agitation, lack of energy, memory problems, loss of concentration, loss of sexual desire. Dr. Wang attempted different anti-depressant medications, which didn’t seem to help. He then recommended that Claimant discontinue the narcotic pain medication which had been prescribed by his surgeons and suggested treatment at a pain clinic. He also referred Claimant to a mental health counselor for psychotherapy. Having seen Claimant for several years, by the time of his deposition, Dr. Wang didn’t feel as if there was any significant improvement. Dr. Wang described him as dysfunctional.

Q: When you say dysfunctional, does that mean medically not capable of employment?

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A: I'm a psychiatrist. To me, it's more mentally he's not able to function well, including concentrate, regulate his mood, and be at a reasonable work stress.

Dr. Wang opined that the work injury of October, 2002 was a substantial factor in causing the dysfunction. He noted that claimant was able to function prior to the October 2002 accident, but not afterwards. He agreed with counsel on cross examination that a variety of events prior to the October, 2002 injury made him more vulnerable and pre-disposed to his current mental status. Dr. Wang testified that Claimant's pain was the major focus of their discussions and Dr. Wang opined that Claimant's pain was a substantial factor in causing Claimant's depression and anxiety. Dr. Wang agreed that most of his conclusions were based upon information supplied by the patient; however, he did not find any signs of exaggerating or lying.

Delores Gonzalez

Delores Gonzolez, a vocational rehabilitation expert, prepared a written report and testified on behalf of Claimant by deposition taken on June 17, 2013. Ms. Gonzolez tested and evaluated Claimant in person and reviewed the medical records she was provided. She testified that the purpose of her vocational evaluation was to assess Claimant's employability and potential for vocational rehabilitation. In her report she opined:

According to the medical evidence of record, Gregory Miller has significant limitation of functional capacity secondary to injuries he sustained to his low back and right shoulder in combination with his pre-existing lumbar spine and psychiatric disorders/disabilities. His current residual functional capacity is less than sedentary work. The medical evidence corroborates continued significant, residual complaints that present a chronic hindrance in his ability to perform basic work functions and some activities of daily living. The documentary evidence supports this finding.

Mr. Miller's impairments have severely compromised his ability to either return to his past relevant jobs or to perform any job on a sustained basis. It is my opinion that Gregory Dean Miller is not a candidate for vocational rehabilitation as he is not currently capable of any competitive work for which there is a reasonably steady, stable job market as a result of his primary injury in combination with his pre-existing physical disabilities and conditions.

In testimony Ms. Gonzolez opined that constant pain such as Claimant's, additionally impacts vocationally on a person's ability to focus, concentrate on what they're doing and perform tasks without breaks. "It's very difficult for a person to work at a consistent rate when they're at a pain level of seven."

Ms. Gonzolez also testified that Claimant's psychiatric condition was taken into account, in rendering her opinion.

Ms. Gonzolez ultimately opined that since the primary injury of October 31, 2002, Claimant has not been capable of any substantial gainful employment.

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James M. England, Jr.

James M. England, Jr., a vocational rehabilitation expert, prepared a written report and testified on behalf of the Fund by deposition taken on November 19, 2013. Mr. England did not evaluate or test the Claimant in person, however he reviewed the medical records and depositions which were given him and testified that he had “sufficient information to base opinions, in this case, upon a reasonable degree of vocational certainty.”

In his deposition testimony, as regards the primary injury, Mr. England noted that neither Dr. Piper nor doctor Rotman placed any “specific restrictions upon him.” Furthermore, he testified, as regards the pre-existing two low back surgeries, Dr. Mollman did not impose any “specific restrictions”. He acknowledged the imposition of specific restrictions upon Claimant by Dr. Volarich as a result of the primary injury and noted that Dr. Wang did not impose any specific restrictions as a result of the psychiatric condition. Mr. England acknowledged that Claimant had said that the prior two back surgeries had slowed him down somewhat and he had to be more careful doing all the things he had to do. In performing a vocational evaluation, he testified:

I look at the person’s age, education, work experience. I look at how the person did on the various testing. I look at the specific medical restrictions to see what the doctors feel that the person is capable of doing and then put that data together to try to determine whether or not a person would still be capable of some kind of employment or not.

Q: Okay. And what do you do if you have two diametrically opposed opinions from physicians regarding restrictions?

A: I think I have to address it from both ways. If one doctor says one thing and the other says something else, I just have to look at it as, assuming what this doctor says, this is what the person can do; assuming what the other doctor says, this is what the person can do. And, obviously, the trier of fact is the one who actually has to decide in the end which he or she thinks is more credible as far as the restrictions.

Assuming the restrictions placed upon Claimant by Dr. Volarich:

I thought if I assumed Dr. Volarich’s restriction with regard to assuming a recumbent position, I think that could, in and of itself, prevent him from going back to any kind of work activity. If you have to lie down unpredictably, I don’t think such a person would be employable in the open labor market.

Based upon the lack of any specific restrictions imposed by Drs. Mollman, Roush, Piper and Wang; which Mr. England characterized as their opinion that Claimant was not restricted in any manner whatsoever, Mr. England testified:

I thought even if he could not do the heavy level of work that was involved in that, there would certainly be other work in the light to sedentary ranges that would be less physically demanding. On cross examination, Mr. England testified that he did not take into account any limitations upon Claimant’s employability caused by pain, although he was aware that Claimant had been

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receiving palliative care and pain control treatment over the years since being discharged by Dr. Piper and Dr. Rotman. However, he testified:

Q: Do you believe that pain can be disabling in terms of one's ability to perform substantial gainful employment?

A: Sure. [Depo p 20]

Q: Okay. Is there anywhere within your report that you correlate the extent of this gentleman's pain with any issues relating to his employability?

A: I don't think anywhere in my report I specifically mentioned his pain in relationship to working per se, no. [Depo p 21]

On cross examination Mr. England admitted to performing more than 1,000 vocational evaluations for the Fund, accumulating income of approximately \$1 million from the Second Injury Fund alone.

Medical Records

-Pre-Existing Conditions

- Dr. Dennis Mollman (Exhibit #8) 8-23-88:

Mr. Miller is a 27 year old male who was initially injured on November 6, 1986. He was jumping from an 18-wheel vehicle down onto the side of a road when a passing car struck him from the left side, striking his left leg and hip. -----

At present he complains of a very sharp electrical pain shooting into the left leg, at times causing his knee to buckle. The pain occurs when moving his right or left leg and sometimes when moving the left arm. He states coughing and sneezing severely exacerbate his pain.

- Low back microdiscectomy surgery was performed by Dr. Mollman at St. Lukes Hospital (Exhibit #8) on 8-31-88 for a herniated disc at L4-5 with root compression on the left.

Dr. Dennis Mollman (Exhibit #8) 1-13-89:

Mr. Miller is now five months status post a microdiscectomy L4-5. He has completed physical therapy at this point, states he is having no pain and is ready for a return to work.

Seven months later

- Emergency Department Record of St. Joseph Hospital West (Exhibit #7) 8-8-89:

28 year old white male with chronic low back pain status post laminectomy 9-88 tonight fell on left buttock complaining of left buttock pain radiating to lower back
Fell while standing, landing on lower back and right buttocks.

About five years later

- Physical therapy records of Professional Rehabilitation Services (Exhibits 9 and 10) 4-21-93 through 5-25-93:

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Dr. Johnson ordered therapy for worsening low back pain with para spinal spasms. The Claimant was complaining of pain bilaterally in the L-S area, but worse on left than right and radiating pain into left lower extremity daily and right lower extremity to the knee at times. It was noted that the patient has a history of disc surgery in 1988. An MRI (Exhibit 21) showed moderate left paramedian herniated nucleus pulposus at L5-S1.

- St. Lukes Hospital operative report (Exhibit #8) 9-20-93:

Low back microdiscectomy surgery at L5-S1 Left Side.

- Dr. Dennis Mollman (Exhibit #8) 11-23-93:

Mr. Miller is two months postop from a lumbar microdiscectomy at L5-S1 on the left side. He is continuing to complain of pain in his left hip, left buttock, and occasional pain radiating all the way to the thigh. He has been in physical therapy. The physical therapy does not seem to alleviate any of his symptoms. He states that the deep heat and ultrasound help him initially, but then when he does the exercises, he has back pain again. He finds that the leg pain is related to activity, the more that he is up, the more he has the pain. His back pain is not related to activity and in fact improves as the day progresses. -----

Assessment: I think that the patient continues to have symptoms somewhat radicular in nature. I am going to repeat his MRI scan at this point. If that is negative, I will suggest that he see a physiatrist.

- MRI/CT report (Exhibit #8) 11-29-93: showed new postoperative changes at L5-S1 possibility of recurrent disc herniation on the left; myelography was recommended.
- Professional Rehabilitation Services (Exhibits 9 and 10) 2-9-94: Patient was reporting pain in the L-S area and in the left lower extremity radiating down to the foot, he rated it a 7 on a 0-10 scale. He also complained of occasional pain in the right leg down to the level of the shin and rates it at a 4.
- Dr. Mollman (Exhibit #8) 2-10-94:

He presents at this time complaining of pain radiating down the left leg to the foot. It is aggravated by motion, being jarred, coughing, and sneezing. It is not a burning quality sensation; it is a dull, aching sensation. -----

At this point, I have insisted that the patient proceed with myelography.

- Lumbar Myelogram with Post Myelogram CT (Exhibit #8) 2-24-94 showed a small central disc protrusion at L3-4 but otherwise interpreted by Dr. Mollman as "unremarkable" and patient is discharged to the care of a physiatrist Dr. Tate.
- Professional Rehabilitation Services (Exhibits 9 and 10) 4-6-94: At the final physical therapy session prior to returning to work, it was reported that the patient was having increased pain in the L-S area but it is more centralized. Hip and leg pain has decreased. He rates his back pain as a 7 and leg pain as a 3 on a scale of 0-10. The

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therapist stated that Mr. Miller was making slow steady progress. Work hardening was recommended.

About four years and six months later

- Professional Rehabilitation Services (Exhibit 10) 11-20-98: Patient fell off a truck and landed on his feet on 10-3-98; reporting that it felt like everything got pushed up. Claimant complained of pain in the L-S area radiating into both lower extremities. He rated his pain as a 5 on a scale of 0 to 10. It was noted that he has a chip fracture on the right little toe.
- Professional Rehabilitation Services (Exhibit 10) 2-24-99: Upon discharge from physical therapy and work hardening, it was noted: Greg Miller has a diagnosis of L-S strain. He has finished 5 days of work conditioning and simulation for 4 hours a day. He reported stiffness in the L-S area but no pain. He worked hard while in therapy. He is to return to work 2-26-99.

About five and a half months later

- Professional Rehabilitation Services (exhibit 10) 8-3-99: Patient was involved in a motor vehicle accident on 6-24-99 and was complaining of neck, upper and lower back pain, rating his pain as a 4+ on a 1 to 10 scale. Patient reports he has gotten worse since onset.

Physical therapy was performed for 11 visits ending on 8-18-99. At the time of discharge from physical therapy, it was reported that the patient was feeling better; that the muscles just feel tight. The patient stated that his low back feels okay when he is taking his pain medication; however, the pain keeps him up at night when he does not take his pain medication. Range of motion measurements at discharge showed that cervical rotation was 75% of normal bilaterally, that cervical side bending was at 75% bilaterally, trunk flexion was at 75% and trunk extension was at 50%.

The primary injury - about 2 years and 5 months later 1-31-02

- Dr. Ronald L. Pearson of Tri County Occupational Health (Exhibit #11) 11-15-02:

This 41 year old while male was referred to the Occupational Medicine Clinic today by his employer for evaluation of right shoulder, low back and right hip pain. Mr. Miller reports that he was pulling on a wench bar to tighten down a vehicle when the chain slipped and he subsequently fell to the ground, landing on his right shoulder, right hip and low back areas. He has had essentially persistent pain in all of these regions since the fall which have progressively

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gotten [worse], especially so with right shoulder. . . He has had some radiating pain down into the right leg. . .

He has not had any prior history of a shoulder injury in the past. He has had a prior history of low back injury and has had two prior disc surgeries in the lumbar region at the L4-5 and L5-S1 levels. The first one being in 1986 and the second in 1993 with good outcomes. He has continued to work since the injury date and has been taking over-the-counter Aleve for pain.

Dr. Pearson noted acute contusions of the right shoulder, right hip and pelvis. Dr. Pearson referred Claimant for an orthopedic consultation with Dr. Roush and took Claimant off work.

- MRI report (Exhibit #12) 11-15-02: Impressions: advanced degenerative change in the right acromioclavicular joint with undersurface spurring that impinges upon the supraspinatus anteriorly. There is a joint effusion of the right acromioclavicular joint with capsular distention.”
- MRI report (Exhibit #12) 12-6-02: Degenerative changes from L3-4 through L5-S1. [Details omitted]
- Dr. Pearson (Exhibit #11) 12-17-02: Dr. Pearson noted that while physical therapy had provided some benefit to patient’s low back pain, he was having increased left leg pain with some numbness over the medial aspect of the foot. He noted that, on occasion, but less commonly, he also gets some pain radiating down the right leg.

Mr. Miller and I had a very lengthy conversation today regarding his MRI findings and the proposed treatment plan. He is quite concerned about being able to return to work. I told him at this point that I would have to rely on the evaluation of a spine specialist to better delineate our course of treatment, especially more so since he has had two prior surgeries. Also because of his increased left leg pain, I told him that it is much more likely that there is a new disc causing some nerve irritation. This case will be discussed both with his employer and the insurance company case manager.

- Dr. Randall Roush (Exhibit 13) 11-19-02: The medical record includes a pain diagram annotated by Claimant, showing the only areas of pain to be his right shoulder and low back, buttocks and upper thighs. The symbols placed by Claimant on the diagram characterized the nature of the pain as aching, burning and stabbing. On the diagram, Claimant reported that the right shoulder pain was 8 on a 1-10 scale; the low back/hips were noted to be 7 and the leg pain was noted as 4. Dr. Roush diagnosed a right shoulder impingement and shoulder sprain. He noted that the MRI showed AC joint arthrosis in the right shoulder. Dr. Roush injected the shoulder with a steroid and deferred to Dr. Person to treat the back.
- Professional Rehabilitation Services (Exhibit #10): 11-20-02 through 1-24-03: referral by Dr. Roush for the right shoulder and Dr. Coyle for the lumbar spine. At the

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time of discharge on 1-24-03 as regards the shoulder: Patient continues to report pain in AC Joint and lateral shoulder. He has a painful catch during shoulder flexion and abduction at 90 degrees. Progress has slowed. Patient rates right shoulder pain as a 5 on a scale of 1-10. As regards the low back: Patient reports pain is in the L-S area that radiates into left leg. Pain is increased with weight bearing (standing/walking). If he sits or lays down pain will go away. He is better in the AM and worse the longer he is up. He has had times when his back has felt better and other times his pain is increased and he has problems standing erect. Progress on his back has been slow.

- Further records of Dr. Roush show (Exhibit #18) show that despite the injection and physical therapy, the right shoulder symptoms persisted.
- Dr. Roush performed an arthroscopy, bursal debridement and acromioplasty on the right shoulder on February 26, 2003 (Exhibit #18).
- After more physical therapy and work hardening, Dr. Roush released Claimant on May 7, 2003 to return to work full duty, no restrictions, as to the right shoulder. On December 9, 2003 Dr. Roush issued a permanency rating of 10% disability of the upper right extremity. (Exhibit #18)

At the initial visit with spine surgeon James Coyle, MD (Exhibit #15) on January 27, 200[3], Claimant reported that he had lived with some degree of chronic back pain since his second back surgery in 1993, but since the work accident of October 31, 2002; he developed lumbosacral pain radiating to the left lower extremity. Dr. Coyle noted left sided gluteal pain, posterior thigh pain and posterior calf pain. He has numbness on the top of this left foot, as well as on the outside of his foot. He notes that symptoms are aggravated by standing for any longer than thirty minutes. He also reports right sided groin pain and right sided knee pain. Dr. Coyle opined that "he does have substantial preexisting back problems with two prior surgeries and degenerative changes at the L3/4 level." He described the work accident on October 31, 2002 as "a substantial contributing factor to his current symptoms." He recommended a "transforaminal injection at L5/S1 . . . for diagnostic and therapeutic purposes" Following a lumbar myelogram and CT scan, Dr. Coyle opined that he did not see anything that is amenable to surgical correction" and referred Claimant to pain management "to see if anything can be done from the pain management standpoint."

John D. Graham, MD of Pain Treatment Center, Inc. (Exhibit 16) 1-31-13 noted the referral by Dr. James Coyle. Dr. Graham performed a left L5-S1 selective nerve root block which provided "significant benefit for Claimant's low back and left leg pain for several days but then the pain returned". Another L5-S1 selective nerve root block was performed on February 13, 2003. Again, Dr. Graham noted a good initial response but then a return of symptoms. He stated: It is my best medical opinion that Mr. Miller's left leg pain is coming from the L5-S1 level. As we have seen some excellent short-term benefit, but unfortunately not significant long-term benefit, we will have Mr. Miller follow-up with you [Dr. Coyle] for a re-evaluation to see if there is anything else that you have to suggest for him. From my standpoint, I feel that the L5-S1 level is the problem level.

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Barnard C Randolph, Jr. MD, a physical medicine specialist, was asked to provide medical consultation by the employer's nurse case manager (Exhibit #19) as a result of the suggestion of Dr. Coyle that a physiatrist become involved in Claimant's care. It was his observation at the initial visit with Claimant on March 19, 2003 that "most of his symptoms at this stage are discogenic in nature." He managed Claimant's medication and prescribed physical therapy, monitoring his progress.

Dr. Graham then performed another left L5- S1 selective nerve block upon referral by Dr. Bernard Randolph, on April 4, 2003. Mr. Miller called Dr. Graham's office on April 7, 2003 reporting that his pain was much better. On June 20, 2003 Dr. Graham again performed a left L5-S1 selective nerve block on the referral of Dr. James Coyle. Immediately afterwards, the Claimant reported "some good benefit, though not complete resolution of his left leg complaints". However 15-20 minutes later the pain returned the same as when he presented. Afterwards Dr. Graham wrote Dr. Coyle:

I do not doubt that he has pain complaints, though despite my best efforts I am unable to localize those pain complaints to any specific level in his lumbar spine. Based upon Mr. Miller's subjective response to the selective nerve root blocks immediately following the injection, I cannot make any recommendation as to specific surgery. Medical studies indicate that when a patient has an excellent response to a selective nerve root block for the expected period of time, depending on the local anesthetic used, that there is a very high correlation of success with surgical procedure at that level. Unfortunately, we do not see an excellent improvement in the patient's subjective reports of pain despite a technically successful selective nerve root block

-The Work Performance Center, Inc. record (Exhibit #20) May 14, 2003:

Overall, progress with functional performance has steadily decreased over the past 4 weeks. Even with reduction in clinic exercise routine and frequent re-vamping of entire program, Mr. Miller continues to c/o increasing LBP & radiating symptoms. He continues to guard trunk with many/all activities and avoids any forward bending motion. Waddell signs were initially negative but tested positive with Axial Compression and Passive Rotation tests on 5/14/03. -In Dr. Randolph's medical record (Exhibit #19): He stated that after reviewing the procedure notes of Dr. Graham for the selective nerve blocks, and physical therapy progress reports from the Work Performance Center of 5/14/03 noting an actual decline in Claimant's functional performance, Dr. Randolph opined in his last office note addressed to the workers compensation insurance representative and nurse case manager on May 15, 2003 "He is approaching maximum medical improvement. I am not sure that significant functional improvement to the point that he will be able to return to full duty activities are reasonable."

On June 23, 2003 Dr. Coyle stated in his medical note: "I do not see anything that is amenable to surgical correction" and asked Dr. Graham "to see if there is anything that can be done from the pain management standpoint as his symptoms are primarily referable to pain." (Exhibit #15)

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Dr. Graham saw Claimant again at the request of Dr. Coyle on June 30, 2003, prescribing Gabitril for the radicular pain and issuing work restrictions of limited bending, twisting and lifting no more than 25 pounds. Dr. Graham states in a letter to Dr. Coyle:

I would also like to point out that a self-administered psychologic test was given to the patient and computer scored. This showed very significant elevations on his somatization scale and his anxiety scale, both of which being into the 99th percentile. He also has elevations of his depression scale, as well as his obsessive-compulsive scale. These findings on the psychologic testing would suggest that there may be some functional overlay that could be having a negative impact on the patient's subjective complaints. This would also make the outcome for any invasive treatment such as surgery for subjective complaints only to be quite guarded in nature.

Dr. Graham saw the patient again on July 14, 2003, at which time the Claimant complained that his low back pain was not improving and he complained of increasing pain in his right leg. Dr. Graham modified his medications. "Mr. Miller is still quite adamant that there is something wrong in his back that needs to be fixed." Dr. Graham stated that he would anticipate the patient to be at maximum medical improvement within the next 2-4 weeks.

On July 14, 2003 Dr. Graham prescribed a TENS unit and instructed the claimant on its use and continued his prior work restrictions. On July 30, 2003 Dr. Graham modified Claimant's medication and stated:

At this point, Mr. Miller would be at maximum medical improvement with me and we would simply be in a maintenance phase.

On August 26, 2003 Claimant attended an IME (Exhibit #23) by orthopedic surgeon Robert J. Bernardi, MD. In the medical information pain drawing he was asked to fill out, the Claimant indicated that both of his shoulders ached and that he had aching, stabbing and burning pain in various areas all over his low back, buttocks, hips and legs. Dr. Bernardi took a history, conducted an examination, reviewed medical records and included in his report:

- Claimant informed him that he worked until November 15, 2002 following the October 31, 2002 work accident;
- That Claimant had lingering problems with back pain since his second back surgery in 1993;
- That since the October 31, 2002 work injury Claimant reports that he has slowly worsening back pain and that any type of activity will aggravate it; that the pain is much more intense after he has been on his feet for any length of time; that he can hardly stand for more than 10 minutes; he has improvement in his left leg when he lies down but develops right leg pain in a recumbent position;

Mr. Miller presents a difficult problem. He describes back pain and left sided leg pain following a work related accident. Certainly his back symptoms could be due to aggravation of the underlying degenerative disease seen in his lumbar spine on both his MRI and his

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myelogram. Indeed, with two prior lumbar discectomies, this would fall under the category of so-called post discectomy instability. His leg pain may well represent left L5 radiculopathy. I do believe that both these symptoms are related to the work injury he describes of 10-31-02. His symptoms have been persistent despite aquatic therapy, work hardening, selective nerve root injections, various medications and the use of a TENS unit. The difficult question at this point is how best to proceed. Mr. Miller tells me that he cannot work with his current level of pain. I don't think that further conservative treatment is likely to be of much benefit to him. Unfortunately, I don't think that a decompressive lumbar procedure is likely to provide him with much benefit either.

I don't believe that Mr. Miller is able to return to work at this time. I do not believe that he is at maximum medical improvement.

I am not sure that there is an "ideal" treatment for this gentleman and I think to optimize his outcome is going to require making quite certain that Mr. Miller understands as fully as possible the nature of his current situation.

- On October 24, 2003, without any further interaction with Claimant or the review of any additional medical records, Dr. Bernardi found the Claimant to be at maximum medical improvement for his back injury and issued a permanency rating of 5% to the person as a whole. "This would be over and above any rating he has related to his prior back injuries."

In a letter to Liberty Mutual Insurance Company dated January 27, 2004 (Exhibit #15), Dr. Coyle stated:

After extensive evaluation both clinically and diagnostically, I advised Mr. Miller that I did not see anything that was amenable to surgical correction. Mr. Miller was then seen by Dr. Robert Bernardi for another surgical opinion. An EMG nerve conduction study was obtained by Dr. Peebles that show radiculopathy with no acute changes. Dr. Bernardi concluded that imaging studies showed multilevel degenerative disc disease with no evidence of significant nerve root entrapment and an EMG nerve conduction study showed no evidence of acute radiculopathy. This was taken in context with a nonfocal neurologic exam.

Because of the diffuse findings, Dr. Bernardi pointed out that addressing his symptoms of pain with surgery would require L3 through sacrum fusion and that the outcome of this procedure would carry a poor prognosis. Dr. Bernardi determined that Mr. Miller was at maximum medical improvement on October 24, 2003.

Mr. Miller was seen by Dr. Terry Piper in August and November of 2003. Dr. Piper recommended a three level discogram. The discogram revealed abnormalities at L3/4, L4/5 and L5/S1. Dr. Piper recommended an L4/5 and L5/S1 anterior and posterior fusion.

In answer to your questions concerning Mr. Miller, . . . I am in agreement with Dr. Bernardi and I differ with Dr. Piper's recommendations regarding further treatment. . . . for the simple reason that the prognosis from such a surgery would not be very good. From the standpoint of Mr. Miller's work status, a functional capacity evaluation would be helpful to sort

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out whether or not he is able to function in a reasonable manner. He is at maximum medical improvement from the standpoint of his work injury.

On August 5, 2003 Claimant had gone to orthopedic surgeon Terrence Piper, MD (Exhibit #22) complaining of left leg and low back pain, but primarily in the leg. "The leg is much worse than his back." Dr. Piper ordered a three level discogram. In the lumbar discogram procedure notes of October 28, 2003 Dr. Daniel Abodeely reported that there was no pain with the injection of L4-4 and L4-5 but severe pain reproduction with injection of L5-S1. In the post discogram CT report Dr. Abodeely notes that the L5-S1 level demonstrates a "severely narrowed degenerative disc. . . . There is very little normal disc material remaining." (Exhibit #24) In his November 11, 2003 note, Dr. Piper interpreted the post discogram CT as showing "gross annular disruption and discogenic changes at 5-1 and 4-5. 3-4 has some radial annular tears anteriorly with direct posterior tear that probably extends in the anterior epidural space." He wrote, "as I said, 4-5 and 5-1 appear to be the culprits." Claimant agreed to surgery stating that he was "anxious to try to get back to work and get back into a more normal lifestyle."

The operative report of February 4, 2004 (Exhibit #26] shows that Dr. Piper performed a complete anterior discectomy and instrumented fusion at L4-5 and L5-S1 with caged iliac crest bone graft and then a subsequent posterior instrumentation surgery.

-Advance Physical Therapy notes show that Claimant received PT from 3-4-04 through 4-29-04 and then again from 8/2/04 through 12/1/04. At the time of discharge to a home exercise program from PT, the reason stated for discharge was that 100% of the goals were met. "The patient reported that he felt pretty good about his back and some apprehension about a return to work." It was noted that his symptoms tend to depend upon his activity level. (Exhibits 10 & 27)

On 10-14-04 Claimant reported to Dr. Roush (Exhibit #14) that he believed he was close to being released to work from his recent back surgery and still had some concerns relating to his right shoulder. Claimant complained of increasing pain to his right shoulder during his back rehabilitation and a grinding feeling. Claimant mentioned to Dr. Roush that he also had a recent left shoulder surgery that was not work related. Dr. Roush diagnosed recurrent right shoulder bursitis and impingement syndrome and administered a steroid injection into the right shoulder joint. On May 24, 2005 Claimant saw Dr. Roush again, reporting that although the injection helped for about two weeks, he's had on again and off again pain about every two weeks lasting for about two weeks at a time. Dr. Roush noted that a recent MRI of the shoulder showed AC joint arthrosis. He administered another steroid injection. On November 22, 2005 Claimant reported to Dr. Roush that the last injection worked well, but his pain returned about a month ago. Dr. Roush administered another steroid injection into the shoulder joint.

Thereafter Claimant sought treatment from Dr. Mitchell Rotman for his right shoulder. (Exhibit #28) Dr. Rotman performed a right shoulder subacromial decompression and distal clavicle resection surgery on 11-1-06.

-Advance Physical Therapy notes (Exhibit 29) show that Claimant received PT from 11/28/06 through 1/25/07 and as of the last date of therapy, it was noted that "Minor subjective complaints persist. Range of motion and strength are currently within normal limits. Patient has progressed

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as anticipated and appears ready to return to normal activities, with regard to his right upper extremity

There are no records of treatment until Claimant sought the services of Suresh Krishnan, MD, Interventional Pain Care LLC (Exhibit 30) on 9-10-12: These medical records do not include the most recent treatment testified to by Claimant regarding the implantation of the spinal stimulator and repair of L3-L4. At Claimant's initial consultation with Dr. Krishnan on September 10, 2012, a variety of positive findings were noted and Claimant complained of low back pain, right lower leg pain, right lower leg weakness, left lower leg tingling, left lower leg numbness, right hip pain, left hip burning, right ankle/foot pain, left ankle/foot pain, left ankle/foot weakness, left ankle/foot burning, left ankle/foot tingling, left ankle/foot numbness and right shoulder pain. "The patient states that his low back pain is much more uncomfortable due to lifting, walking, standing, sitting, getting out of bed, getting in and out of the car, pulling and pushing but taking pain pills, sleeping and heat causes him to be more at ease." The Claimant reported that pain limited his ability to walk, lift, sit for more than 10 minutes, stand, travel and sleep. The Claimant reported fatigue, loss of energy, uncontrolled sweating, irritability, depression, disturbed sleep and anxiety. The doctor noted that the patient's Oswestry pain index on that date was 60, "indicating that the patient is severely disabled by pain in several areas of life." The doctor advised the Claimant that he "likely has post-laminectomy syndrome of the back. Based upon the exam findings and supporting data, I recommend spinal cord stimulator trial considering his symptoms and the nature of his lesion. He has agreed to go ahead with the recommended procedure. This will be scheduled at a later date. " The doctor diagnosed (1) postlaminectomy syndrome of lumbar region, (2) degeneration of lumbar or lumbosacral intervertebral disc, (3) nerve root compression, lumbar. Dr. Krishnan began by managing Claimant's medications. Dr. Krishnan stated:

Mr. Miller has suffered from chronic disabling pain which has caused psychological, social, and physical impairment. He has tried unsuccessfully to have this pain relieved using conservative treatments for pain management. It is presently medically necessary that the patient undergo an interventional pain management technique to alleviate the painful syndrome and to return him to a more functional quality of life. Radiological findings and my evaluations are consistent with the pre-procedural diagnosis, supporting this procedure.

Dr. Krishnan began the process by administering a series of 3 lumbar epidural steroid injections on November 19, 2012. He then administered a steroid injection into the right shoulder joint on January 9, 2013. An MRI of the right shoulder on January 15, 2013 showed a partial tear of the supraspinatus tendon, tendinopathy of the infraspinatus tendon and degenerative changes in the glenohumeral joint. A second right shoulder injection was administered on March 26, 2013. It was noted on April 9, 2013 that Claimant still had low back pain shooting down both legs and right shoulder pain which at its worst is 9/10 and at its best is 6/10 on a pain scale of 1-10. At his office visit on May 7, 2013 Claimant described constant dull aching pain radiating into his left hip and right hip which at its worst is 9/10 and at its least is 5/10. Injections, lying flat, taking medications and resting seem to make the pain better according to the note. Right shoulder pain was still reported in the range between 6/10 and 9/10. The doctor performed an epidurogram showing "no spread of dye below the L3-4 level." The doctor administered a Dexamethosone Sodium Phosphate injection into the area of the low back. On June 11, 2013,

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the last office note in evidence of Dr. Krishnan, Claimant reported no improvement in the low back and right shoulder pain. He reported an average of only 4 hours of sleep during the night, waking up about 30 times during the night due to pain.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Based on the competent and substantial evidence presented, including the testimony of the Claimant, my personal observations, the expert medical testimony, and all other exhibits received into evidence, I find:

- (1) Gregory Miller testified at the final hearing herein. He is found to be credible both in his testimony and in the history provided to his physicians. I find that any inconsistencies are unintentional. Also, I find that it is consistent with what appears to be his general character and commitment to working, that if he were capable of gainful employment, he would be working.
- (2) The medical evidence is uncontroverted regarding Mr. Miller's pre-existing conditions. I find, that prior to the October 31, 2002 injury, claimant suffered from a herniated L-4-5 disc for which he received microdiscectomy surgery in 1988 and a herniated L5-S1 disc for which he received microdiscectomy surgery in 1993, as well a bulging L3-4 disc and that he suffers from ongoing post laminectomy syndrome resulting from those injuries and surgeries. Regarding disability from these prior injuries and surgeries, Dr. Volarich offered the only medical causation testimony, which I find to be credible and based upon substantial evidence. I find that Claimant had a pre-existing 30% permanent partial disability of the body as a whole related to the lumbar spine, due to the prior disc herniations and surgeries, taking into account the ongoing back syndrome due to disc bulging at L3-4, L4-5 and L5-S1, as well as scarring at the operative sites causing postlaminectomy syndrome that continued to cause back pain, lost motion and intermittent lower extremity parasthesias prior to 10/31/02. I also find that the substantial medical evidence establishes that the pre-existing condition of Claimant's lumbar spine made it unstable and more predisposed to further injury. Additionally, I find that Claimant had taken antidepressant medication for many years to treat a pre-existing depression and anxiety condition.
- (3) The medical evidence and testimony is further uncontroverted, that on October 31, 2002, the Claimant sustained a further injury to his lumbar spine and a right shoulder injury, arising out of and in the course of his employment with Jack Cooper Transport. I find that as a result of this injury, the Claimant suffered lumbar left leg radicular syndrome secondary to discogenic pain at L4-5 and L5-S1 for which Claimant received an anterior lumbar discectomy, fusion with instrumentation at L4-5 and L5-S1 and now suffers from constant pain due to postlaminectomy or "failed back syndrome" which is only somewhat controlled by a recent spinal stimulator implant. In addition, as a

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result of this injury, Claimant has had two right shoulder surgeries; an arthroscopic acromioplasty and an arthroscopic subacromial decompression and distal clavicle excision. Regarding disability from the shoulder injury and surgeries, the opinion of Dr. Volarich is credible and is based upon substantial and competent evidence. I find that there is a 25% permanent partial disability of the right upper extremity rated at the shoulder, due to the impingement that required arthroscopic acromioplasty followed by a second repair that included arthroscopic subacromial decompression and distal clavicle excision. The rating accounts for ongoing discomfort, lost motion, weakness, crepitus and atrophy in the dominant arm. The only other rating in evidence is an earlier rating by Dr. Roush for 10% permanent partial disability which was made immediately following the first right shoulder surgery and therefore did not take into account significant medical treatment and the subsequent surgery and therefore is based upon an incomplete treatment record. Regarding disability from the lumbar injury sustained on October 31, 2002, I find that there is a 19.5% permanent partial disability of the body as a whole related to the lumbar spine, due to the left leg radicular syndrome caused by discogenic pain from the L4-5 and L5-S1 levels that required anterior lumbar discectomy with fusion and instrumentation at both L4-5 and L5-S1. This rating accounts for this injury's contribution to pain, lost motion and ongoing lower extremity paresthesias. The only other rating in evidence is the earlier rating of 5% permanent partial disability to the body as a whole by Dr. Bernardi on 10/24/03, which did not take into account significant further medical treatment including the multi-level fusion and is therefore based upon an incomplete treatment record. I further find that the injury of 10/31/02 substantially aggravated and exacerbated Claimant's pre-existing psychiatric depression and anxiety disorder.

- (4) With regard to the combined effect of the pre-existing and primary injuries, Dr. Volarich offered the only medical causation testimony in that regard, which I find to be credible and based upon substantial and competent evidence. I find that the combination of the disabilities caused by the pre-existing injuries together with the primary injury of October 31, 2002 results in a total which exceeds the simple sum; and from a medical standpoint has resulted in the permanent and total disability of the Claimant.
- (5) I find that the prior medical conditions and disabilities from the lumbar spine injuries and surgeries and post laminectomy syndrome constituted an obstacle and hindrance to employment and prospects for re-employment. There is no evidence to the contrary.
- (6) I find that the Claimant attained maximum medical improvement as of January 25, 2007, when he was released from physical therapy at maximum benefit, following his second right shoulder surgery. After that time, although numerous modalities were employed, Claimant has been essentially receiving treatment of a maintenance and

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palliative nature to address his ongoing symptoms of severe pain and unquantifiable emotional dysfunction, resulting from his pain.

- (7) I find that based upon credible and substantial evidence in the record, the claimant suffered permanent and total disability from a vocational standpoint as a result of a combination of his last injury of 10/31/02 and his prior disabilities taking into consideration his age, education, past relevant work history, lack of transferable skills, his restrictions and his inability to perform even sedentary work. I find that claimant cannot compete in the open labor market and that no employer would reasonably be expected to hire the claimant. This is based upon the record as a whole and the medical opinion of Dr. Volarich and the testimony of Claimant's vocational witness, Delores Gonzolez. In addition, the Fund vocational expert James England agrees that if the restrictions of Dr. Volarich were to be given weight, that Claimant would indeed be permanently and totally disabled. The Fund expert, James England, however, testified to an alternative hypothesis that if he were to base a vocational opinion solely upon the lack of functional restrictions imposed by Claimant's treating orthopedic surgeons, then, he opined, that Mr. Miller could "perform a variety of less physically demanding work in the sedentary to light ranges of employment." However, Mr. England explicitly excluded from that analysis any consideration of the vocational effect of claimant's pain; accordingly Mr. England's alternative hypothesis is less credible than the substantial evidence to the contrary. Furthermore, reading the record as a whole, it would not be reasonable to assume that it is the opinion of all these physicians that Claimant's ability to work should be unrestricted. Mr. England's reliance upon that assumption is unwarranted and by his own testimony does not account for Claimant's pain, as vocationally limiting.
- (8) Regarding the assertion that there was a typographical error in the settlement with the employer, based upon the competent and substantial evidence in the record, I the Stipulation for Compromise Settlement should have been for a settlement to the "right arm at the shoulder" as the medical evidence and Claimant's testimony demonstrate his injury from the primary injury affected his right arm and shoulder, not the left.
- (9) I find the Second Injury Fund liable for the permanent and total disability of the Claimant.
- (10) I find the employer is allocated the responsibility for the payment of temporary total disability benefits from November 15, 2002 until the date of MMI, January 25, 2007.
- (11) Thereafter, from the date of MMI forward, I find the employer's responsibility for permanency resulting from the work injury of October 31, 2002, to be 25% PPD of the right arm at the level of the shoulder and 19.5% PPD to the body as a whole related to the low back. The employer is therefore allocated the responsibility for the payment of 136 weeks of compensation from the date of MMI, January 25, 2007 at

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the rate of \$340.12 weekly. I award benefits to Claimant against the Second Injury Fund in favor of Claimant in the amount of \$649.32 weekly for claimant's lifetime commencing January 25, 2007 with a credit of \$46,250.00 for the permanency attributable to the employer hereunder. The SIF shall pay claimant all accrued weekly benefits from the date of MMI with credit to the extent of employer's responsibility, as a lump sum, and thereafter future weekly PTD benefits of \$649.32 weekly.

- (12) All compensation awarded to the claimant shall be subject to a lien in the amount of 25% of all payments hereunder in favor of attorney Jonathan Isbell for necessary legal services rendered to the claimant.

The request of the Second Injury Fund for a ruling or determination regarding any equitable lien or subrogation rights it might have as a result of the settlement of the third party civil lawsuit, are rejected as this tribunal does not have jurisdiction to do so. *Banks v. Zweifel*, 298 S.W. 3d 869 (MO. 2009)

Made by: _____

Grant C. Gorman
Chief Administrative Law Judge
Division of Workers' Compensation