

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

Injury No.: 07-086381

Employee: Ralph Mountjoy
Employer: Curators of the University of Missouri
Insurer: Self-Insured
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 February 20, 2014. The award and decision of Chief Administrative Law Judge Robert J. Dierkes, issued February 20, 2014, 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 24th day of September 2014.

LABOR AND INDUSTRIAL RELATIONS COMMISSION

John J. Larsen, Jr., Chairman

James G. Avery, Jr., Member

Curtis E. Chick, Jr., Member

Attest:

Secretary

AWARD

Employee: **Ralph Mountjoy**

Injury No. **07-086381**

Dependents:

Employer: **Curators of the University of Missouri**

Before the
**DIVISION OF WORKERS'
COMPENSATION**

Additional Party: **Second Injury Fund**

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

Insurer: **Self-Insured**

Hearing Date: **November 26, 2013**

Checked by: **RJD/njp**

FINDINGS OF FACT AND RULINGS OF LAW

1. Are any benefits awarded herein? **Yes.**
2. Was the injury or occupational disease compensable under Chapter 287? **Yes.**
3. Was there an accident or incident of occupational disease under the Law? **Yes.**
4. Date of accident or onset of occupational disease: **September 7, 2007.**
5. State location where accident occurred or occupational disease was contracted: **Boone 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: **Employee was on a ladder changing a ballast in a light fixture when he received an electric shock, causing him to fall from the ladder.**
12. Did accident or occupational disease cause death? **No.** Date of death? **N/A.**
13. Part(s) of body injured by accident or occupational disease: **Left shoulder; head; body as a whole.**
14. Nature and extent of any permanent disability: **20% permanent partial disability of the left shoulder; 12.5% permanent partial disability of the body as a whole.**
15. Compensation paid to-date for temporary disability: **\$11,973.13.**
16. Value necessary medical aid paid to date by employer/insurer? **\$97,494.84.**

Employee: **Ralph Mountjoy**

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- 17. Value necessary medical aid not furnished by employer/insurer? **None.**
- 18. Employee's average weekly wages: **\$821.68.**
- 19. Weekly compensation rate: **\$547.79 for temporary total disability and permanent total disability; \$389.04 for permanent partial disability.**
- 20. Method wages computation: **Stipulation.**

COMPENSATION PAYABLE

From Employer:

**96.4 weeks of permanent partial disability benefits,
minus TTD overpayment of \$313.02** **\$37,190.44**

Employer is also ordered to provide future medical benefits as may reasonably be required to cure and relieve Claimant from the effects of his headaches.

Second Injury Fund liability:

36.225 weeks of permanent partial disability benefits **\$14,092.97**

Said payments to begin immediately and to be payable and be subject to modification and review as provided by law.

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

Jonathan McQuilkin

Employee: **Ralph Mountjoy**

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FINDINGS OF FACT AND RULINGS OF LAW

Employee: **Ralph Mountjoy**

Injury No. **07-086381**

Dependents:

Employer: **Curators of the University of Missouri**

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

Additional Party: **Second Injury Fund**

Insurer: **Self-Insured**

Hearing Date: **November 26, 2013**

ISSUES DECIDED

The evidentiary hearing in this case was held on November 26, 2013 in Columbia. The record was left open for the filing of the deposition transcript of witness Anita Ness; the transcript was filed on December 3, 2013. The parties requested leave to file post-hearing briefs, which leave was granted, and the cases were submitted on January 13, 2014.

The hearing was held to determine the following issues:

1. The liability, if any, of Employer for permanent partial disability benefits or permanent total disability benefits;
2. The liability, if any, of the Second Injury Fund for permanent partial disability benefits or permanent total disability benefits;
3. The liability, if any, of Employer for future medical benefits pursuant to Section 287.140, RSMo; and
4. Whether the work accident of September 7, 2007 was the prevailing factor in the cause of any or all of the conditions alleged in the evidence.

STIPULATIONS

The parties stipulated as follows:

1. That the Missouri Division of Workers' Compensation has jurisdiction over this claim;
2. That venue for the evidentiary hearing is proper in Boone County;
3. That the claim for compensation was filed within the time allowed by the statute of limitations, Section 287.430, RSMo;
4. That both Employer and Employee were covered under the Missouri Workers' Compensation Law at all relevant times;

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5. That Claimant's average weekly wage is \$821.68, with compensation rates of \$547.79 for temporary total disability benefits and permanent total disability benefits, and \$389.04 for permanent partial disability benefits;
6. That Claimant sustained an accident arising out of and in the course of his employment with the University of Missouri on September 7, 2007;
7. That Employer paid medical benefits in the amount of \$97,494.84;
8. That Employer paid temporary total disability ("TTD") benefits of \$11,973.13 for the period September 8, 2007 through February 7, 2008;
9. That Claimant returned to work on February 4, 2008, and therefore Employer is entitled to a credit for 4/7 weeks TTD overpayment; and
10. That the University of Missouri was and is an authorized self-insurer for Missouri Workers' Compensation purposes at all relevant times.

EVIDENCE

The evidence consisted of the testimony of Claimant, Ralph Mountjoy, as well as the deposition testimony of Ralph Mountjoy; the testimony of Cynthia Mountjoy, Claimant's wife; medical records; hunting records from the Missouri Department of Conservation; records from the Missouri Division of Workers' Compensation; the narrative report and deposition testimony of Dr. P. Brent Koprivica; the narrative report and deposition testimony of James England, Jr., a vocational rehabilitation consultant; a letter from Anita Ness at Broadspire posing questions to Dr. James Kessel and Dr. Kessel's hand-written answers; the narrative report and deposition testimony of Dr. Dave Rengachary; the narrative report and deposition testimony of Dr. William Frisella; the narrative report and deposition testimony of Michael Dreiling, a vocational rehabilitation consultant; testimony of Christopher Haile, a former private investigator; surveillance videos; Internet information regarding Claimant; and the deposition testimony of Anita Ness.

DISCUSSION

Ralph Mountjoy ("Claimant") was born November 16, 1955 and has lived in Columbia, Missouri since an early age. Claimant graduated from Hickman High School in 1974 and has not attended college or technical school. Claimant worked as a plumber and pipefitter for several companies from 1974 to 1982; in 1982 Claimant began working for the University of Missouri ("Employer") as a pipefitter. Claimant worked continuously for Employer from 1982 until his 2007 discharge effective June 30, 2008. Until early 2007, Claimant's work consisted primarily of design and installation of fire suppression sprinkler systems.

In the spring of 2007, Claimant transferred to a position in the Custodial Maintenance Department performing small plumbing jobs and general maintenance. On September 7, 2007, Claimant was changing a light ballast when he received an electrical shock and fell approximately 10 feet from a ladder. He spent eleven days at University Hospital where he underwent a splenectomy and received treatment for a pneumothorax and several broken ribs.

Employee: **Ralph Mountjoy**Injury No. **07-086381**

After being discharged, Claimant was seen in follow-up by Dr. James Kessel. In November, Dr. Kessel recommended Claimant see Dr. Steven Kane, an orthopedic surgeon, for evaluation of shoulder pain. Dr. Kane recommended an MRI because he felt Claimant might have a rotator cuff tear. The MRI showed evidence of a large tear of the supraspinatus with retraction and atrophy, atrophy of the infraspinatus, subscapularis tendinosis, a torn bicep tendon, a superior labrum tear that was likely degenerative in origin, multiple cysts and osteophytes, and anchors in the humeral head consistent with a prior shoulder surgery. Dr. Kane described the MRI as showing a massive rotator cuff tear with retraction. Although he was not sure the tear could be successfully repaired, he recommended arthroscopic evaluation. Surgery was performed on December 3, 2007 and consisted of an arthroscopic subacromial decompression, an arthroscopic repair of a massive rotator cuff tear, and debridement of diffuse intra-articular synovitis. Claimant began physical therapy focused on passive range of motion after the surgery. On 1/11/08, Dr. Kane stated that Claimant was progressing quite nicely and had excellent range of motion. Dr. Kane recommended the therapy progress to active range of motion as of that date. When he re-examined Mr. Mountjoy in February, Dr. Kane noted 3+/5 strength and recommended continued therapy. While receiving therapy on 3/17/08, Claimant reported considerable pain in conjunction an audible pop while performing active range of motion. When he was seen by Dr. Kane the next day, Claimant reported having no strength in his arm and decreased range of motion. Dr. Kane recommended a repeat MRI. The MRI was performed on 3/28/08 and showed that the supraspinatus repair had re-torn. Dr. Kane advised Claimant to continue with a home exercise program and released him to return to work with permanent restrictions. In his follow-up note dated 5/1/08, Dr. Kane stated that no further surgery would be of benefit.

On December 18, 2007, approximately 3-1/2 months after the work accident, and two weeks after the shoulder surgery, Claimant consulted his personal physician, Dr. Ellen McQuie, with complaints of headaches. He gave a history of a gradual onset of frontal left and front right headaches following the accident in September. He described the headache symptoms as pressure, sharp, squeezing, and throbbing. Dr. McQuie documented associated symptoms of blurred vision and dizziness and noted "about 60% are migraine (has had previously)". She recommended Amitriptyline for headache prevention and Imitrex to be taken at the onset of a migraine. Claimant continued to treat with Dr. McQuie periodically through the date of the hearing. Claimant has also seen a neurologist, Dr. Allyn Sher, on three occasions. On 7/14/08, Dr. Sher evaluated Claimant and suggested that he continue the Imitrex and initiate a trial of Topamax for headache prophylaxis. When Dr. Sher re-examined Claimant on 10/16/08, he noted Claimant was no longer having daily headaches and that the headaches were less severe. Dr. Sher recommended Claimant continue on Amitriptyline and a reduced Topamax dosage. He instructed Claimant to return in six months or earlier if needed. Claimant cancelled the follow-up appointment in April of 2009 and did not return to Dr. Sher's office until late August of 2013. When seen on that date, Claimant reported that he was still having headaches most days that lasted 2-1/2 hours. Claimant was continuing to take Amitriptyline in the same dosage, but had discontinued taking Topamax. He was supplementing the Amitriptyline with over-the-counter medication or Sumatriptan (Imitrex). Dr. Sher felt Claimant had reached maximum medical improvement with regard to his chronic common migraine and was in need of no further neurological evaluation. Dr. Sher's only recommendation was that Claimant "stay on his Amitriptyline".

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Claimant was examined by Dr. P. Brent Koprivica at the request of his attorney. Dr. Koprivica provided permanent partial disability ratings for Claimant's injuries. Although Dr. Koprivica had no way to verify the severity or frequency of the migraine complaints, he testified that Claimant's description of his headaches, if true, made him permanently and totally disabled.

James England performed a vocational evaluation on April 27, 2009 at the request of Claimant's attorney. In his report dated June 17, 2009, Mr. England opined that Claimant was permanently and totally disabled as a result of "a combination of his various medical problems and injuries over the years rather than the last injury by itself". On the morning he gave his deposition in October of 2012, Mr. England reviewed Dr. Koprivica's report and revised his opinion. He acknowledged that he had not seen Dr. Koprivica's report until the day of the deposition and had never reviewed the report of Dr. Dave Rengachary, Employer's neurological expert.

Dr. Rengachary examined Claimant on January 11, 2012 and made a diagnosis of posttraumatic headaches. He indicated Claimant should continue to see a neurologist and internist for medication management. Dr. Rengachary did not feel any further neurological testing or treatment was indicated and assessed the residual neurological disability at 5% of the body. He felt Claimant could continue to perform light or sedentary work as long as it did not include heights, ladders, or unguarded machinery.

Dr. William Frisella evaluated Claimant's shoulder on behalf of the employer. Dr. Frisella, a fellowship trained shoulder and elbow specialist, examined Claimant on February 14, 2013. After taking a history from Claimant, reviewing the records regarding his 2002 left shoulder surgery, and personally reviewing the 2007 shoulder MRI, he testified that the September 7, 2007 work accident was not the prevailing factor in causing the massive rotator cuff tear shown on the 11/14/07 scan. Dr. Frisella testified that the 9/7/07 work accident caused a shoulder sprain but did not cause the surgical pathology treated by Dr. Kane. He felt the work injury left Claimant with permanent partial disability of 5% of the left shoulder in addition to pre-existing disability of 25% of the shoulder.

Anita Ness, a nurse case manager, testified by deposition about the contact she had with Claimant while he was hospitalized and at the time of his post-surgical follow-up appointments with Dr. Kane.

Christopher Haile, the former owner of Investigative Services Group, testified at the hearing about the surveillance he conducted on Claimant and the videotape he obtained of Claimant riding his motorcycle and taking target practice at a firing range. Mr. Haile also testified about materials he obtained from the internet regarding Claimant's motorcycle riding and firearms activity.

Claimant had substantial disability of the left shoulder before the September 7, 2007 work accident. The medical records from Columbia Orthopaedic Group document a left shoulder rotator cuff tear that was treated surgically by Dr. Eckenrode in July of 2002. Claimant reported to multiple healthcare providers that he had significant ongoing weakness of the left shoulder after the 2002 surgery. He reiterated this testimony at the hearing.

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Claimant's medical expert, Dr. Koprivica, testified that the MRI performed prior to the 2002 left shoulder surgery showed a complete tear of the supraspinatus and infraspinatus tendons, which he described as a massive tear, and testified that Claimant told him on January 24, 2011 that he continued to have significant ongoing weakness of the left shoulder after the 2002 surgery. Dr. Koprivica was told by Claimant that the 2002 left shoulder injury had never completely healed. Dr. Koprivica felt the final postoperative physical therapy note dated 7/30/02 contained "very significant clinical findings" that documented weakness and substantiated Claimant's history of needing assistance from co-employees with heavy activity or overhead work. Dr. Koprivica confirmed that the history given by Claimant and the 2002 treatment records were consistent with Claimant having to hunt with a crossbow after the 2002 surgery because he no longer had the strength in his left arm to control a long bow. Although he assigned a rating of 15% to the 2002 left shoulder injury consistent with the workers' compensation settlement Claimant received, Dr. Koprivica admitted that he would have rated the disability at 25% had he examined Claimant after he was released from treatment following the 2002 left shoulder surgery. Dr. Koprivica also agreed that at least some of the pathology shown on the 2007 left shoulder MRI probably predated the 9/7/07 work injury.

Claimant was examined by Dr. William Frisella on February 14, 2013. Dr. Frisella is a board certified orthopedic surgeon with extensive experience diagnosing and treating shoulder pathology. Claimant gave a history to Dr. Frisella of chronic left shoulder complaints after the 2002 left shoulder injury and surgery as noted:

He was involved in a work accident when he slipped and injured his left shoulder in 2002, and subsequently had surgery by Dr. Eckenrode in 2002 for a rotator cuff repair. He states today "it never really did get better after that." . . . He continued to have problems with his left shoulder after the 2002 surgery. He states that he continued to have pain since and difficulty with lifting overhead, reaching overhead, and with strength between 2002 and the subsequent 2007 injury. He states he had to ask co-workers to help him with overhead activities because of his left shoulder. His co-workers knew he had shoulder problems and would help him with job duties requiring overhead use of the shoulder and arm. (Frisella Report, pg. 1).

Dr. Frisella testified that the 2/20/02 left shoulder MRI showed significant longstanding pathology. Dr. Frisella testified that the hypertrophic degenerative changes at the AC joint described degenerative arthritic bone spurs at the joint between the shoulder blade and the collarbone. These changes were the result of a slow, longstanding arthritic process that takes years to develop. Dr. Frisella testified these changes predated the 2002 work accident.

The 2002 MRI also described the humeral head as being largely bare at the anticipation of insertion of the infraspinatus and supraspinatus. Dr. Frisella testified this means the tendon covering the top of the humerus had been pulled back away. This finding is usually suggestive of a very large tear of the rotator cuff. Dr. Frisella testified that one of the functions of the rotator cuff is to depress or hold down the head of the humerus so that the larger muscles of the arm can pick it up. With individuals who have chronic rotator cuff tears, the head of the humerus will start to migrate up because there is no longer a tendon holding it down. Claimant's 2002 MRI

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showed this type of “high riding humerus”. Dr. Frisella testified that the high riding humerus and the bare humeral head meant that Claimant’s rotator cuff tear had to have been present for at least one year, if not several years.

The 2002 MRI described thinning and attenuation of the bicep tendon at the upper bicipital groove. Dr. Frisella explained that when the head of the humerus is bare and begins to ride up, it starts to abrade the bicep tendon against the shoulder blade. This is a slow degenerative process that had been occurring in Claimant’s shoulder for much longer than one month. In addition, a high riding humerus causes the head of the humerus to grind against the acromion resulting in curvature of the underside of the acromion resembling the shape of the humeral head. This process had been occurring in Claimant’s left shoulder long before the 2002 MRI. Dr. Frisella testified that the cystic changes in the humeral head were findings commonly seen with patients that have a chronic degenerative rotator cuff tear and were consistent with a high riding humerus grinding against the undersurface of the acromion. The grinding of the high riding humerus against the acromion was causing changes in both bones as well as in the bicep tendon. Finally, Dr. Frisella testified that the global degeneration of the labrum described on the 2002 MRI was likely the result of the chronic rotator cuff tear causing abnormal wear inside the shoulder joint.

Dr. Frisella testified that the 2002 MRI showed Claimant had complete tears of the supraspinatus and infraspinatus along with chronic degenerative findings in the left shoulder. Although Dr. Eckenrode performed a rotator cuff repair on 4/8/02, Dr. Frisella was not surprised that Claimant continued to have significant problems after that surgery. Dr. Frisella testified as follows:

- A. Well, when you review literature regarding the repair of large or massive rotator cuff tears, there is a very high incidence of re-tear. And I think I put in my letter in the discussion - - and I just reiterate - - that massive tears like that where literally the bone is grinding against the other bone in the spot where the rotator cuff should live and be, are very difficult to successfully repair. And some studies have shown failure rates as high as 100 percent. A study that I participated in when I was a fellow, we showed I believe it was in patients with large to massive - - large to massive tears that 100 percent of them failed within three months. And these are people who have been doing shoulder surgery since - - they’re now in their fifties and have been doing it for 20 or 30 years and they can’t get them to heal. Dr. Yamaguchi’s study from 2004 where we looked at his large to massive tears that were repaired showed that 17 out of 18 of them had re-torn. I don’t remember the time period he looked at. Within a year or two I believe. So it’s just very, very common for tears that are this large where there is this much pathology and probably been there for so long, that re-tears are extremely common.

- Q. Okay. And just from an anatomical physiological standpoint I mean why would that be?

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- A. The reason that it's difficult or impossible in many cases to successfully repair a very large to massive rotator cuff tear is that the tendon quality based on factors associated with chronicity, blood flow, retraction, scarring becomes very poor. So the quality of the tendon is very poor. And the analogy I use with patients is if you tear a rope in two and you tie it back together, then you can use that rope to pick up a bucket. If you tear a piece of tissue paper in two or your rope is turned into tissue paper, you can tie it back together. You're still not going to be able to pick up that bucket. And the first time you try it, the tissue paper is going to tear. So it's really a reflection of the poor quality of tissue that's often present in this type of tear. Why - - it's a reflection of why there's such a high rate of re-tearing.
- Q. Okay.
- A. You might even argue it's almost impossible to get a tear like that to heal. And that's what the literature would suggest.

Dr. Frisella personally reviewed the MRI performed in November of 2007 and testified that the pathology shown on this study was, for all intents and purposes, identical to the description of the pathology contained in the 2002 MRI report. He stated that what he saw on the 2007 MRI was exactly what he would expect to see with an individual who had suffered a failed repair of a massive rotator cuff tear. For that reason, he did not believe that the 2007 accident caused the recurrent massive rotator cuff tear. He testified that Claimant had a chronic degenerative rotator cuff tear that was present before 9/7/07. While Dr. Frisella couldn't say exactly when the 2002 repair failed, he believed that the rotator cuff had been re-torn by the time Claimant was released by Dr. Eckenrode on 7/11/02. He testified that when the rotator cuff re-tears, it does not necessarily create any increased symptoms. In this regard, Dr. Frisella testified:

- Q. And would you - - when that re-tear happens, would you expect there to be some increase in symptoms that the patient would have? Like will they notice that it's been re-torn?
- A. That's a great question. And the answer to it is no, they don't. It's very difficult to understand. And I think in a medical legal environment it's very hard to understand. But the literature is very clear on this. Re-tears in the rotator cuff are often unnoticed and never detected. Because you would think, yeah, you re-tore it. It starts to hurt again or hurts more. But that's not the case. It really isn't. ... Like studies have shown that take two groups of patients - - or, well, take one big group of patients. Follow them out for six months. Get MRIs on everybody. Some of them are going to have re-tears. It's just the way it is. Take those out. Most of the time we don't even know that because they don't know that they had a re-tear. They're just going about their business and they think their shoulder is fine. But now we're going to put them in a study and

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we're actually going to look at six months, at a year. We put them all in an MRI machine. Some of them re-tore. Put those in group one. Some of them didn't re-tear. Put those in group two. Those aren't guys like Mr. Mountjoy who have giant tears. They're little tears. The patients that did not re-tear and the patients that did re-tear are identical from the outcomes / measures we can apply to them. So how do you feel? Is it painful? Can you do what you want? They're identical patients. So they don't know that they re-tore. ... And they go about their life and they still have a tear in there and they don't even know it, just like Mr. Mountjoy.

In addition, Dr. Frisella explained that the MRI findings from 2007 are absolutely inconsistent with an acute injury.

- Q. And if you are not correct and he did not have the re-tear before September 7, 2007, that action could have caused that re-tear that we see on the MRI in November of 2007?
- A. I would say that - - I would not - - I would say no. Based on just the appearance of the MRI, it really - - that - - that accident and that MRI cannot be connected really. I mean - - so you're asking if I'm wrong and he had an intact rotator cuff repair, then he had this accident - - and I'm assuming I'm wrong, he had an attached rotator cuff repair, could that have caused the MRI findings that we see in 2007 and 2008 after the accident? In my opinion it would be no. Those findings are absolutely inconsistent with an acute injury even if he had an intact repair right immediately prior. There is no edema in the greater tuberosity. There is no - - the atrophy is present and hasn't changed. It's just - - when I look at that MRI and you ask me that question, I can't say that I could say that, no. ... I would just say it's not possible that the MRI finding in 2007 after his injury is consistent with tearing what had previously been an intact repair in my opinion.

Finally, Dr. Frisella testified that he did not believe the 2007 work accident caused any additional tearing of the pre-existing failed rotator cuff repair.

Dr. Koprivica testified that the 2007 fall caused the recurrent rotator cuff tear, the labral tear, and the bicep tear shown on the 2007 MRI. He described these as "new structural injuries". He acknowledged, however, that he did not personally review the 2007 MRI and admitted that "there's contribution from the pre-existent as to the overall severity of the structural changes that followed 2007". He felt it would be difficult to measure the extent of each injury and agreed "that there probably were some changes that were present, even at the time of the injury". Had an MRI of the left shoulder been performed before the 2007 accident, Dr. Koprivica said it would not surprise him to see evidence of rotator cuff pathology.

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In addition to the aforementioned 2002 left shoulder injury (which resulted in a settlement of 15% of the left shoulder), in 1994 Claimant sustained a right shoulder rotator cuff tear which was surgically repaired, and which resulted in a settlement of 15% of the right shoulder. Claimant also suffered a low back injury in 1997 which resulted in a settlement of 6.5% of the body as a whole. In January 2005, Claimant injured his left knee and received a settlement of 20% of the left knee. In 2006, Claimant developed bilateral carpal tunnel syndrome, had bilateral carpal ligament release surgeries performed, and received a settlement of 5% of each wrist.

Notwithstanding the pre-existing injuries and the re-injury of the left shoulder on September 7, 2007, Claimant's claim of permanent total disability depends principally upon the nature, frequency and severity of the migraine headaches which are claimed to be as a result of the September 7, 2007 accident.

Claimant described having daily headaches when seen by Dr. Koprivica on January 24, 2011; the severity of the headaches varied, but Claimant reported being bedridden four times a week. Claimant reported to Dr. Koprivica that he had received treatment from Dr. McQuie and Dr. Sher for the headaches and used Excedrin Migraine and Imitrex to manage the symptoms.

Dr. Koprivica testified that the frequency, severity, and randomness of the headaches were sufficient to make Mountjoy totally disabled. Dr. Koprivica made clear that this opinion relied on the truthfulness of the information Mountjoy provided in his medical history. In this regard, he testified:

And that - - and I've said this earlier, but let me reiterate it. I'm relying on a factual base that based on what he's telling me, and I don't - - unfortunately, with headache, we don't have a good diagnostic tool to try to objectify that. I can just tell you that, clinically, in individuals I've treated in an emergency setting for migraine headaches, patients I've treated over the years that have had posttraumatic migraines, they can be so severe that they're totally disabling, and that's how I interpreted what he told me, but that's relying on the truthfulness of what he is saying. (Exhibit 3, Koprivica deposition, at pp. 72-73).

Although Dr. Koprivica provided the permanent total disability opinion with regard to the headaches, Dr. Koprivica also opined that Claimant's permanent partial disability residual to the head injury and migraines was 35% of the body. Dr. Koprivica testified that the permanent partial disability from the 2007 work injury would combine with the pre-existing permanent partial disability of both shoulders to render Claimant permanently and totally disabled.

Dr. Koprivica acknowledged the information in some of Dr. McQuie's notes was not consistent with the history Claimant provided him. Moreover, while Dr. Koprivica knew Claimant had been seen by neurologist Allyn Sher, he did not have Dr. Sher's records and did not know how frequently Claimant had been seen by a neurologist.

Dr. Koprivica testified that Claimant told him that he had attempted to return to work after the shoulder surgery but was unable to sustain employment. He acknowledged that the comments Claimant made in late 2007 and early 2008 about obtaining disability rather than

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returning to work raised a question of whether Claimant had made a true, good faith attempt to resume employment.

A. Yeah. Again, that's something hard for me to measure without speculating, but I would say that if you review information like that, that would be a clinical concern.

Q. Okay. You mean - - while somebody is still under active treatment, if they're already voicing interest in and intention to pursue disability rather than go back to work, that - -

A. Yup.

Q. - - That that's a concern for the clinician?

A. Yes.

Q. Okay.

A. Yeah, motivation's a big key in getting people back to work, in my opinion. And so that would be - - you'd be worried about that, I would think. (Exhibit 3, Dr. Koprivica deposition, at p.84).

Dr. Koprivica didn't ask Claimant whether he had made any attempt to seek alternative employment or pursue assistance through the Department of Vocational Rehabilitation because Claimant was already receiving disability benefits and emphasizing that he couldn't work. Dr. Koprivica testified that Claimant's attorney did not provide him with any surveillance video of Claimant riding his motorcycle or shooting a variety of firearms at a firing range. Dr. Koprivica agreed that this information might be important in assessing Claimant's ability to work.

Dr. Dave Rengachary, a board certified neurologist, examined Claimant on January 11, 2012. Claimant gave Dr. Rengachary a history of daily headaches as well as more severe migraine headaches 3-4 days per week. Claimant told Dr. Rengachary he was bedridden on days he had the migraines. Dr. Rengachary performed a neurological exam and found no abnormalities. He testified that Claimant displayed no signs of a migraine headache at the time of his exam. Claimant did not appear to be in discomfort and was alert, conversant, and appropriate. Dr. Rengachary felt that Claimant continued to have some headaches, but questioned the severity of the symptoms being reported.

He was reporting headaches that were causing him to be bedridden three to four days out of the week. The typical experience is that these types of people are being seen by a neurologist quite frequently, on the order of every couple of weeks or once a month being the most common frequency that we would see with that frequency and severity of headaches. (Exhibit B, Rengachary deposition, at p. 13).

Dr. Rengachary felt there was a "disconnect" between the degree of symptoms that Claimant was reporting and the frequency of treatment he was receiving. He emphasized that

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patients with symptoms similar to those described by Claimant made frequent emergency room visits, required hospitalizations, and received much more frequent consults with primary care physicians and neurologists. The records Dr. Rengachary reviewed from Dr. McQuie did not document that Claimant was having severe headaches that left him bedridden three to four times each week. Moreover, Dr. Rengachary felt the medications Claimant was taking for the headaches were not consistent with the symptoms he described. Dr. Rengachary testified:

A. The discrepancy that I am concerned about, the Imitrex and Topamax are what I would consider to be first line agents, and for somebody who's suffering from this degree of headaches for this frequency, this severity for this long, we would expect by this point for them to be on fourth, fifth, or sixth line agents, even intravenous agents that are administered in a hospital if they're bedridden four days out of the week.

Q. Okay. So there are, I guess you just kinda said, there are different, different - - there's a progression of different treatments that can be tried for someone with severe headaches?

A. Correct.

Q. And that Topamax and Imitrex aren't the last option?

A. They are the first option. They're one of the first options, or what I consider first line agents. (Exhibit B, Rengachary deposition, at pp.16-17).

Dr. Rengachary testified that the typical patient would demand to be on other medication if the medication being used left him bedridden several days each week. This was a factor he considered when providing his opinion on Claimant's neurological permanent partial disability.

I was asked to assess the degree of disability entailed in the headaches, and in order to do that, tried to balance the subjective and objective data that we had regarding the headaches, and for me the types of medications and the number of trials of different types of medications being on the few side that I could see supported the lesser degree of disability overall. (Exhibit B, Rengachary deposition, at pp. 18-19).

Dr. Rengachary testified that there was no neurologic contraindication to Claimant working as long as he didn't work at extreme heights, operate heavy machinery or lift extreme weights. He disagreed that Claimant was permanently and totally disabled and provided a permanent partial disability rating of 5%.

I took into account both the objective and the subjective complaints regarding the headaches and frequency of the headaches and I felt that in balance, it would be just that, I found no neurologic contraindication to light or sedentary work. (Exhibit B, Rengachary deposition, at p. 22).

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Dr. Rengachary felt Claimant's willingness and ability to ride a motorcycle and use firearms raised a question about the severity of his migraine complaints.

A. I compare him to my previous migraine population and in those folks, and we did see people who were quite severely affected by migraines, the most common or typical behavior would be to avoid anything that would potentially exacerbate headaches. The numbers 1, 2, and 3 types of triggers related to loud sounds, rapid movements of the head, or loud - - or bright lights, and these seemed to the precise types of things that he sought out as enjoyment per the surveillance report, and I had no way to reconcile those discrepancies, and it has to be taken into account when assessing the overall degree of his disability.

Q. So, I mean, have you ever had, to your knowledge, had a patient with migraines who rides a motorcycle?

A. I have had certainly patients with migraines who ride a motorcycle, but the typical frequency that they would describe is perhaps one or two headaches a month or a year of mild to medium severity. I've never had anybody who is bedridden from headaches seek out the sounds and vibratory forces involved with a motorcycle. (Exhibit B, Rengachary deposition, at p. 23).

Dr. Rengachary felt it would be very unusual for someone with the complaints that Claimant reported to ride a motorcycle. He felt this could precipitate a migraine. He also felt that the cognitive issues Claimant described were inconsistent with the ability to operate an 800 pound Harley. In short, the motorcycle riding behavior was the exact opposite of what he would expect from someone with the complaints Claimant reported.

A. It seems to involve every trigger. It seems to involve the sound, it seems to involve the vibratory forces, it seems to involve the potential for a head injury, and seems to involve the potential for exposure to unprotected light. It would seem to be the worst trigger for migraines possible.

Q. What do you mean by exposure to unprotected light?

A. Typically for somebody with very, very severe frequent migraines they would seek out the most covered type of transportation possible and not the one that's exposed to the most amount of elements possible. (Exhibit B, Rengachary deposition, at p. 35).

Dr. Rengachary emphasized the difference between operating a motorcycle and driving or riding in a car. He testified that a car provides more protection against the elements, particularly light and sound.

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Dr. Rengachary made similar comments with regard to the use of firearms:

- Q. Well, you're suggesting that the noise is potentially a trigger for migraines; correct?
- A. The noise and the recoil. So if we had to, again, compare it to previous migraine patients, the majority of my migraine patients don't, you know, seek out types of activities that result in high noise or certainly of the potential for recoil of the body or head.

Dr. Rengachary felt it was challenging to come up with individual migraine triggers for Claimant because he reported having headaches every day. (Dr. Koprivica reached the same conclusion based on the information Claimant provided him. "... [B]ut what I'm relying on is the fact that he's telling me he's having headaches that he can't tell you when they're going to occur, there's no way he knows what's going to precipitate them ..." .)

Dr. Rengachary testified that a large, large majority of the patients he treated for migraines were capable of working. With regard to Claimant, he ultimately concluded that Claimant was having migraines, but that the headaches were not sufficiently disabling to prevent him from working or riding a motorcycle.

It's highly inconsistent with the population of migraine patients that I have, or had. And so the degree of headaches that he was describing just does not behave in any way like the patients that I would see. And so you're correct that if you examine one particular day or one particular hour and try to ask could that have just been a fluke or a good day, it's certainly possible. But at the same time, I was charged with trying to discover is this person's overall behavior consistent with somebody that's having migraines to this degree of frequency and severity? My conclusion was that it absolutely was not consistent with an overall degree of headaches of that degree and severity, the overall behavior not only in the surveillance reports but also in the medical records that were supplied. (Exhibit B, Rengachary deposition, at pp. 43-44)

The records of Dr. McQuie and Dr. Sher do not answer the questions raised by the testimony of Dr. Rengachary. Despite testifying to chronic, devastating headaches that severely limit his ability to function, Claimant has made only three visits to a neurologist since the 2007 work accident. The first two visits were in 2008. Dr. Sher's note for the second 2008 visit states that the headaches had improved, both in frequency and intensity. Instead of daily headaches, he reported having only one or two each week and indicated they were less severe. There is no description of Claimant being bedridden in the 2008 records of Dr. Sher. Dr. Sher recommended that Claimant return to follow-up in April of 2009 or sooner if needed. Claimant admitted he cancelled the appointment in April of 2009 and did not return to Dr. Sher or see any other neurologist for nearly five years. When he was re-evaluated in late August of 2013, he reported he was still having headaches most days that lasted 2.5 hours. He advised Dr. Sher that he was still taking Amitriptyline but had discontinued Topamax because of side effects. He had replaced the Topamax by over-the-counter migraine medication or Sumatriptan (Imitrex). There is

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nothing in the 2013 note that suggests Claimant was regularly bedridden because of his headache. It does not appear that he requested further evaluation, further testing, or a trial of any other medication. There were no abnormalities on physical exam and Dr. Sher made no recommendations other than that Claimant stay on Amitriptyline. He recommended that Claimant follow-up with Dr. McQuie for his chronic migraine and indicated he would be available for consultation if needed.

The records of Dr. McQuie contain multiple references to headaches. She prescribed Amitriptyline and Imitrex in December of 2007 and Claimant continued to take those medications over the ensuing years. Dr. McQuie describes improvement in the headaches and significant benefit from the medication in multiple office notes. In addition, there are office notes regarding several visits for other medical problems that contain no specific mention of Claimant's headache status. In any event, none of the notes of Dr. McQuie mention Claimant being bedridden, much less document him being bedridden 3-4 times each week, because of headaches. Other than the trial of Topamax suggested by Dr. Sher in 2008, it does not appear that the medication was ever changed.

As noted above, Claimant was scheduled to return to Dr. Sher for neurological follow-up in April of 2009. This is the same month he traveled to St. Louis to see James England for a vocational evaluation. He told Mr. England that four times each week he had headaches that required him to lie down in a quiet, dark room for 60 to 90 minutes and left him non-functional for 4 to 6 hours. Although this represented a significant deterioration in his condition compared to the complaints reported to Dr. Sher the previous October, Claimant chose to cancel the follow-up appointment with Dr. Sher in April of 2009. He offered no logical explanation for doing so at the time of the hearing. Moreover, he had no credible explanation for why Dr. McQuie's 5/5/09 office note described his migraines as well-controlled with current medication rather than reflecting the history he gave James England of headaches which rendered him bedridden and non-functional for up to 4 to 6 hours several days each week. He seemed to suggest that Dr. McQuie didn't understand how severe his headache complaints were, but offered no explanation for why Mr. England was able to record a more accurate history than his long-time personal care physician. He suggested that he never discussed the migraines in detail with Dr. McQuie other than to tell her that the medication was working. If Claimant is to be believed, he was able to open up to individuals he saw for the purposes of pursuing his disability benefits -- Dr. Koprivica and James England -- but was much more reticent when conferring with the physicians he was seeing for medical treatment. This explanation is unpersuasive and flies in the face of logic and common sense. Claimant had every incentive to report all his complaints to his treating physicians so they could properly diagnose and treat his condition. One would expect that anyone with complaints similar to Claimant's would be, as Dr. Rengachary suggested, making repeated visits to his primary care physician, neurologist, and to emergency rooms in hopes of obtaining relief. It would seem that someone like Claimant would use the Internet to research migraine headaches or locate a headache specialist. (Claimant clearly knows how to use the Internet, as he is very active on social sites.) Claimant, however, has never done any of this. Rather than return to Dr. Sher early because of increasing symptoms, he cancelled his six month follow-up appointment in 2009 and did not schedule a return visit for nearly five years. During this interval he did not seek further evaluation or treatment with any other neurologist or chronic pain specialist. Although he is clearly capable of internet activity, he admitted that he has made

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no attempt to obtain additional information about migraine headaches, potential treatment options, or physicians with additional expertise in treating this condition. This behavior is simply not consistent with someone who is having frequent, severe, disabling headaches.

There is no question that Claimant was injured in the work accident of September 7, 2007 and that some of those injuries were serious. It is equally clear, however, that Claimant decided shortly after this accident that he would prefer to receive long-term disability benefits rather than return to work.

Anita Ness was the nurse/case manager in Claimant's case, and testified by deposition. Ms. Ness communicated with Employer's workers' compensation third-party administrator ("TPA") by email and monthly reports. She testified about a concern she conveyed to the TPA in her 11/27/07 report.

Well Mr. Mountjoy verbalized to Dr. Kane and to myself that he did not plan to return to his regular job and that if he was off for six months then he could get long-term disability. (Exhibit E, Ness deposition, p. 14).

These comments were made before Claimant underwent shoulder surgery on 12/3/07. Following the surgery, Ms. Ness attended multiple post-op visits with Dr. Kane. She testified that on January 11, 2008 Claimant advised Dr. Kane that he wanted to secure long-term disability. On February 13, 2008, Ms. Ness prepared an email detailing a telephone conversation in which Claimant advised her that Employer's HR had told him he could qualify for long-term disability if he could not return to work. On 2/19/08, Ms. Ness prepared another email detailing comments Mountjoy made that day during an office visit with Dr. Kane. In this regard she testified:

- A. He asked Dr. Kane directly, you know, if he would state that he could not do his job so he could start the long-term disability.
- Q. Okay. You were there and you heard him say that?
- A. Yes. (Exhibit E, Ness deposition, p. 18).

At the hearing, Claimant testified that he applied for Social Security disability benefits at or about the time of the shoulder surgery in December of 2007, claiming that he was required to do so by Employer. He also testified that when he filed his disability report appeal form, he advised the Social Security Administration that he had been having migraine headaches since September of 2007 and had failed to mention that in his previous application. Claimant testified:

- Q. Okay. But when you first applied for Social Security disability in December of '07 it doesn't appear that you raised headaches as part of your reason for the application; is that correct?
- A. It probably slipped my mind.

It is difficult for me to believe that the most critical aspect of Claimant's disability (the alleged severely disabling migraines) simply slipped Claimant's mind.

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Claimant's recreational activities raise further question about the credibility of his subjective complaints. On April 27, 2009, Claimant was evaluated in St. Louis by James England. Claimant told Mr. England that he had enjoyed hunting in the past but no longer hunted because of difficulty with uneven ground. Claimant gave similar testimony 2-3 weeks later when deposed on May 13, 2009:

Q. I think there were some references in the records to your being a hunter and it looks like you've got an NRA hat on. Do you hunt?

A. I used to be a real avid hunter.

Q. What do you mean by you used to be?

A. I don't - - last year I didn't hunt.

Q. In 2008 you didn't hunt?

A. No, I didn't and this year I've already sold my 4-wheeler. I sold it to the family, though, in case I change my mind and I want to go out and shoot one day or something. No, I believe I'm going to go ahead and get out of it. I have no business being out there with a gun taking the medications that I take and - -

Q. What do you mean by that ?

A. Well, you know, I'm on that Imitrex and all that and it's so goddam cold - - excuse my language - - and I can't take that cold anymore. See, I lost 90 pounds and since that time I lost that 90 pounds I can't handle the cold anymore so it's just - - and I'd hate to get out there when it's cold and with that not knowing that spleen I'm worried about the elements, you know, and if I get that - - get some kind of bug, you know what I mean, so I'm just kinda wanting to let my boy take over and let him do all of his hunting.

Q. So, did you hunt in 2007 after this accident?

A. Very little. I just did - - I don't think I got a deer but I just - - I went out a couple times and - - Mrs. Mountjoy: In 2007?

A. No, I didn't. No 2007, no.

This testimony is contradicted by the records of the Missouri Department of Conservation. Although Claimant denied hunting in 2007 after the work injury, he actually killed deer in two different counties while off work recovering from the 9/7/07 work accident. On 11/10/07 at 11:20 a.m. he called the Department of Conservation to report that he had killed a doe in Boone County. On 11/17/07 at 9:46 p.m. he called in to report killing a doe in Howard County. Both of these kills took place while he was under the care of Dr. Kane but before undergoing the MRI which showed the massive rotator cuff tear. If the September 2007 accident

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had in fact caused a dramatic change in his chronic shoulder symptoms, it seems odd that Claimant would risk going hunting at least twice before the imaging study had been completed and the diagnosis confirmed. It's also hard to imagine why Claimant would have such poor recall of having shot two deer in 2007. When questioned in the spring of 2009, Claimant initially indicated he had gone out "a couple of times" in 2007 without getting a deer. He then revised his answer to say that he had not hunted at all in 2007. Neither answer is accurate. The discrepancy about hunting in 2007 pales in comparison to the statements in the spring of 2009 that he no longer hunted, was "going to go ahead and get out of it", and let his son do all of the hunting. In reality, Claimant called in 11 deer kills in the 2009 hunting season. This includes does in Howard County on 9/17/09 and 9/19/09, two does in Boone County on 10/10/09, two does in Howard County on 11/14/09, a button buck in Randolph County on 11/17/09, a button buck in Howard County on 11/19/09, a 10 point antlered buck in Howard County on 11/21/09, a doe in Howard County on 11/21/09, and a doe in Howard County on 12/7/09. It is clear from the Department of Conservation records that Claimant was hunting extensively throughout the fall of 2009. On 11/21/09 he drove to Howard County in the morning, killed the antlered buck, called it in at 11:37 a.m., brought it back to Columbia, watched some football, drove back to Howard County, killed the doe, called that in at 8:17 p.m., and then brought that deer back to Columbia to be processed. Claimant admitted that he and "Mike" field dressed the deer they killed, used his 4-wheeler to drag the animals back to the truck, and then loaded the animals onto the bed of the truck. Claimant insisted that Mike did most of the labor associated with loading the deer into the truck and skinning / butchering the animals. Claimant admitted, however, that he did "slice the meat up" and help with the processing.

The deposition excerpt cited above is also of interest with regard to Claimant's comments regarding cold weather. Claimant seems to attribute his difficulty coping with the cold to having lost significant weight and makes no mention of cold weather precipitating migraine headaches. His primary concern about cold weather during hunting season seemed to be that he might "get some kind of bug" that he might have trouble shaking because he no longer had a spleen. He mentioned nothing about cold weather triggering migraines, contrary to his trial testimony in 2013 that cold weather was the primary trigger of his headaches. Indeed, when he was deposed in 2009, Claimant linked headaches to stress and wet weather, rather than cold weather. Regardless, there is no way to reconcile the history Claimant gave to James England and in his deposition testimony, with the truth of his hunting activity in 2009 as documented by the Department of Conservation. This is not the only discrepancy revealed by the hunting records. When seen for a vocational evaluation on November 13, 2013, Claimant told Michael Dreiling that he hadn't hunted deer in the last several years. The Department of Conservation records show that he harvested a deer in Boone County in 2012. When confronted with this inconsistency at the hearing, Claimant denied telling Dreiling that he hadn't hunted in several years.

It is also clear from Claimant's testimony that he continues to enjoy riding his 800 pound Harley-Davidson motorcycle. While Claimant contends that he rides much less frequently now than he did prior to the 2007 accident, this statement must be viewed with some skepticism. Much as he went hunting when he first came under the care of Dr. Kane in the fall of 2007, Claimant continued to ride his motorcycle despite the headache complaints. He testified at deposition that he began having bad headaches when he was receiving physical therapy for his

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shoulder. He described complaints that became so severe he had difficulty getting out of bed. Nevertheless, in early March of 2008, he advised his physical therapist that he had been able to ride his motorcycle to Lake of the Ozarks the previous Sunday.

In his May 13, 2009 deposition, Claimant testified that he had ridden his motorcycle three times in 2008, each time taking his wife to work, a distance of 9 miles. The surveillance evidence indicates otherwise. Claimant was observed riding his motorcycle to Mid America Harley-Davidson on Saturday, 4/5/08, and then proceeding north on Highway 63 toward Moberly with two other motorcycles. Investigator Chris Haile was unable to keep up with the group, returned to Claimant's residence, and waited for 90 minutes before suspending surveillance. Claimant had not returned home at that point. Haile observed and videotaped Claimant riding the motorcycle for the second time in 2008 on Saturday, June 28. Neither of these trips occurred during the work week and neither involved dropping Mrs. Mountjoy off at work.

Claimant testified at deposition that he began to ride more frequently in 2009. According to Claimant's deposition testimony, as of 5/13/09 his trips were limited to taking his wife to work, the only exception being a one way trip to Holts Summit, a distance of 40 miles one way. On Saturday, August 15, 2009, Claimant and his wife were observed and videotaped riding the motorcycle from Columbia to the Mark Twain National Forest. Claimant was also observed and videotaped riding his motorcycle in October of 2010. In addition, an internet search revealed that Mountjoy joined the Central Missouri Riders, a motorcycle group, on May 8, 2010. Claimant subsequently posted numerous comments on the Central Missouri Riders internet page regarding group rides that he attended or planned to attend. On several occasions he posted pictures he had taken while on the rides. He admitted posting comments in 2010 about having had to put on his rain gear while participating in rides on two consecutive weekends. On May 16, 2010, Claimant commented that he had ridden in line with a group of other riders, all of whom were traveling 40 miles per hour because of the rain. Given that Claimant has no knowledge of what triggers his migraine headaches (per Dr. Koprivica) or believes they are triggered by rain and stress (per Claimant's deposition testimony), it is difficult to imagine why he would risk riding his motorcycle in these conditions. Although it is difficult to determine exactly what rides he participated in from the internet information, Claimant admitted at the hearing he has traveled from Columbia to Kirksville and from Columbia to Macon.

I am extremely concerned about Claimant's credibility. In his deposition testimony as well as in the histories given to Dr. Koprivica and Dr. Rengachary and to vocational counselors England and Dreiling, Claimant was untruthful about his hunting activities, his shooting activities at the firearms range, and his motorcycle riding activities. Only when confronted with the surveillance videos and his Internet history did Claimant reluctantly admit to activities he previously denied, offering some obtuse rationalization for his prior prevarications. Claimant quite simply has difficulty telling the truth, even listing himself as "single" on an Internet dating site.

Claimant's claim of permanent total disability hinges upon the nature, frequency and severity of the migraine headaches. As Dr. Koprivica testified, a determination of the nature, frequency and severity of Claimant's migraine headaches depends almost exclusively on the Claimant's credibility. It would be the epitome of understatement to say that Claimant's credibility has been undermined. Claimant's hunting, target shooting, and motorcycle riding

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activities are wholly inconsistent with his claim of multiple weekly debilitating migraine headaches. Claimant's treatment and medication history are likewise wholly inconsistent with his claim of multiple weekly debilitating migraine headaches. Further, Claimant's hunting, target shooting, and motorcycle riding activities are simply inconsistent with a claim of total disability.

I find the deposition testimony of Dr. Dave Rengachary to be credible and persuasive regarding the nature of Claimant's residual migraine headaches.

FINDINGS OF FACT AND RULINGS OF LAW

In addition to those facts and legal conclusions to which the parties stipulated, I find the following:

1. The work accident of September 7, 2007 was the prevailing factor in a significant re-injury of Claimant's left shoulder;
2. The work accident of September 7, 2007 was the prevailing factor in the cause of mild migraine headaches which are well controlled by medication;
3. Claimant was not a credible witness and his testimony regarding the nature, frequency and severity of his migraine headaches should be given no weight;
4. Claimant was not a credible witness and his testimony regarding the nature and extent of his disability should be given no weight;
5. Under section 287.020.7, "total disability" is defined as the inability to return to any employment and not merely the inability to return to the employment in which the employee was engaged at the time of the accident. *Fletcher v. Second Injury Fund*, 922 S.W.2d 402, 404 (Mo.App. W.D.1996). The test for permanent and total disability is the worker's ability to compete in the open labor market in that it measures the worker's potential for returning to employment. *Knisley v. Charleswood Corp.*, 211 S.W.3d 629, 635 (Mo.App. E.D. 2007). The primary inquiry is whether an employer can reasonably be expected to hire the claimant, given his present physical condition, and reasonably expect the claimant to successfully perform the work. *Id.*
6. Second Injury Fund liability exists only if Employee suffers from a pre-existing permanent partial disability that constitutes a hindrance or obstacle to employment or re-employment, that combines with a compensable injury to create a disability greater than the simple sums of disabilities. §287.220.1 RSMo 2000; *Anderson v. Emerson Elec. Co.*, 698 S.W.2d 574, 576, (Mo.App.E.D. 1985). When such proof is made, the Second Injury Fund is liable only for the difference between the combined disability and the simple sum of the disabilities. *Brown v. Treasurer of Missouri*, 795 S.W.2d 479, 482 (Mo.App. 1990).
7. In order to find permanent total disability against the Second Injury Fund, it is necessary that Employee suffer from a permanent partial disability as a result of the last compensable injury, and that disability has combined with prior permanent partial disability(ies) to result in total disability. 287.220.1 RSMo 1994, *Brown v.*

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Treasurer of Missouri, 795 S.W.2d 479, 482 (Mo.App. 1990), *Anderson v. Emerson Elec. Co.*, 698 S.W.2d 574, 576 (Mo.App. 1985).

8. Claimant is currently able to compete in the open market for employment;
9. Claimant is not permanently and totally disabled;
10. The work accident of September 7, 2007 resulted in a permanent partial disability of 20% of the left shoulder;
11. The work accident of September 7, 2007 also resulted in a permanent partial disability from mild migraine headaches which are well controlled with medication, such disability being 12.5% of the body as a whole;
12. Prior to September 7, 2007, Claimant had a pre-existing permanent partial disability to the right shoulder which meets the statutory threshold of 15% permanent partial disability of a major extremity, and is of such seriousness as to constitute a hindrance or obstacle to employment or reemployment, being 15% of the right shoulder (34.8 weeks);
13. Prior to September 7, 2007, Claimant had a pre-existing permanent partial disability to the left shoulder which meets the statutory threshold of 15% permanent partial disability of a major extremity, and is of such seriousness as to constitute a hindrance or obstacle to employment or reemployment, being 15% of the left shoulder (34.8 weeks);
14. Prior to September 7, 2007, Claimant had a pre-existing permanent partial disability to the left knee which meets the statutory threshold of 15% permanent partial disability of a major extremity, and is of such seriousness as to constitute a hindrance or obstacle to employment or reemployment, being 20% of the left knee (32 weeks);
15. Prior to September 7, 2007, Claimant had a pre-existing permanent partial disability of the low back of such seriousness as to constitute a hindrance or obstacle to employment or reemployment, being 6.5% of the body as a whole (26 weeks);
16. Prior to September 7, 2007, Claimant had a pre-existing permanent partial disability of the left wrist of such seriousness as to constitute a hindrance or obstacle to employment or reemployment, being 5% of the left wrist (8.75 weeks);
17. Prior to September 7, 2007, Claimant had a pre-existing permanent partial disability of the right wrist of such seriousness as to constitute a hindrance or obstacle to employment or reemployment, being 5% of the right wrist (8.75 weeks);
18. The credible evidence establishes that the injuries from the last compensable accident (left shoulder and body as a whole due to mild migraine headaches), combined with the pre-existing permanent partial disabilities (right shoulder, left shoulder, left knee, low back, left wrist, right wrist) cause greater overall disability than the independent sum of the disabilities, and that a 15% loading factor should be applied. The Second Injury Fund liability is calculated as follows: 96.4 weeks for the last compensable accident + 145.1 weeks for the pre-existing injuries = 241.5 weeks x 15% = 36.225 weeks of overall greater disability;
19. "The standard for proof of entitlement to an allowance for future medical treatment cannot be met simply by offering testimony that it is "possible" that the claimant will need future medical treatment. Neither is it necessary, however, that the claimant present conclusive evidence of the need for future medical treatment. To the contrary, numerous workers' compensation cases have made clear that in order

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to meet their burden claimants such as Ms. Dean are required to show by a “reasonable probability” that they will need future medical treatment.” *Dean v. St. Luke’s Hospital*, 936 S.W.2d 601, 603 (Mo.App. W.D. 1997);

20. There is a reasonable probability that Claimant will continue to need medications and doctors’ visits for his migraine headaches for the foreseeable future, and, therefore, an order of future medical benefits is required; and
21. Employer’s liability for permanent partial disability benefits of \$37,503.46 (96.4 weeks x \$389.04 = \$37,503.46) shall be reduced by \$313.02 to reflect the stipulated credit for TTD overpayment of 4/7 weeks.

ORDER

Employer is ordered to pay to Claimant the sum of \$37,190.44 for permanent partial disability benefits.

Employer is ordered to provide future medical benefits as may reasonably be required to cure and relieve Claimant from the effects of his headaches.

The Treasurer of the State of Missouri, as custodian of the Second Injury Fund, is ordered to pay to Claimant the sum of \$14,092.97 for permanent partial disability benefits.

Claimant’s attorney, Jonathan McQuilkin, is allowed 25% of all disability benefits awarded herein as and for necessary attorney’s fees, and the amount of such fees shall constitute a lien on those benefits.

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

Made by /s/ Robert J. Dierkes 2/20/2014

Robert J. Dierkes
Chief Administrative Law Judge
Division of Workers’ Compensation