

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

Injury No.: 04-108158

Employee: Byron Proffer
Employer: Federal Mogul Corp.
Insurer: St. Paul Travelers
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 section 287.480 RSMo. Having reviewed the evidence and considered the whole record, the Commission finds that the award of the administrative law judge is supported by competent and substantial evidence and was made in accordance with the Missouri Workers' Compensation Law. Pursuant to section 286.090 RSMo, the Commission affirms the award and decision of the administrative law judge dated January 28, 2010. The award and decision of Administrative Law Judge Matthew W. Murphy, issued January 28, 2010, 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 September 2010.

LABOR AND INDUSTRIAL RELATIONS COMMISSION

William F. Ringer, Chairman

Alice A. Bartlett, Member

John J. Hickey, Member

Attest:

Secretary

ISSUED BY DIVISION OF WORKERS' COMPENSATION

FINAL AWARD

Employee: Byron Proffer Injury No.: 04-108158
Dependents: N/A
Employer: Federal Mogul Corp.
Additional Party: Missouri State Treasurer as Custodian of the Second Injury Fund
Insurer: St. Paul Travelers
Appearances: Mr. James Guirl for Claimant
Ms. Sabrina Merritt for Employer/Insurer
Mr. Clifton Verhines for Second Injury Fund
Hearing Date: October 29, 2009 Checked by: MM/rf

SUMMARY OF FINDINGS

1. Are any benefits awarded herein? Yes.
2. Was the injury or occupational disease compensable under Chapter 287? Yes.
3. Was there an accident or incident of occupational disease under the Law? Yes.
4. Date of accident or onset of occupational disease? October 13, 2004.
5. State location where accident occurred or occupational disease contracted: Malden, Dunklin County, MO.
6. Was above employee in employ of above employer at time of alleged accident or occupational disease? Yes.
7. Did employer receive proper notice? Yes.
8. Did accident or occupational disease arise out of and in the course of the employment? Yes.
9. Was claim for compensation filed within time required by law? Yes.
10. Was employer insured by above insurer? Yes.

11. Describe work employee was doing and how accident happened or occupational disease was contracted: Employee was pushing a 55 gallon drum of oil. The dolly on which the drum rested got hung causing Employee to strain and injure his neck.
12. Did accident or occupational disease cause death? No.
13. Parts of body injured by accident or occupational disease: Body as a whole due to the cervical spine.
14. Nature and extent of any permanent disability: Permanent total disability.
15. Compensation paid to date for temporary total disability: \$8,252.91.
16. Value necessary medical aid paid to date by employer-insurer: \$53,608.51.
17. Value necessary medical aid not furnished by employer-insurer: \$71,064.63.
18. Employee's average weekly wage: \$902.70.
19. Weekly compensation rate: \$601.80 for TTD and PTD, \$354.05 for PPD.
20. Method wages computation: Stipulation.
21. Amount of compensation payable:

Back Medical:	\$71,064.63
TTD:	\$16,420.54
Disfig.:	\$3540.50
Perm. Total:	\$601.80/week beginning 9/15/2006
22. Second Injury Fund liability: None.
23. Future requirements awarded: Payment of permanent total disability benefits pursuant to RSMo. §287.200.

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

The Compensation awarded to the 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: Mr. James Guirl.

FINDINGS OF FACT AND RULINGS OF LAW

On October 29, 2009, the employee, Byron Proffer, appeared in person and by his attorney, James Guirl, for a hearing for a final award. The employer, Federal Mogul Corp., was represented at the hearing by its attorney, Sabrina Merritt. At the time of the hearing, the parties agreed on certain undisputed facts and identified the issues that were in dispute. These undisputed facts and issues, together with the findings of fact and rulings of law, are set forth below as follows:

UNDISPUTED FACTS

1. **Covered Employer** - Employer was operating under and subject to the provisions of the Missouri Workers' Compensation Law, and liability was fully funded by: St. Paul Travelers.
2. **Covered Employee** - On or about the date of the alleged accident or occupational disease, the employee was an employee of Federal Mogul Corp. and was working under the Workers' Compensation Law.
3. **Accident/Occupational Disease** - On or about Wednesday, October 13, 2004 the employee sustained an accident arising out of and in the course of his employment.
4. **Notice** - Employer had notice of Employee's accident.
5. **Statute of Limitations** - Employee's claim was filed within the time allowed by law.
6. **Average Weekly Wage and Rate** - Employee's average weekly wage rate was \$902.70. The rate of compensation for temporary total disability and permanent total disability is \$601.80. The rate for permanent partial disability is \$354.05.
7. **Medical Aid Furnished** - Employer/Insurer has paid medical aid in the amount of \$53,608.51.
8. **Temporary Total Disability Paid** - Employer/Insurer has paid \$8,252.91 as temporary total and temporary partial disability benefits for the following periods: 10/21/04 - 1/17/05 (12 5/7 weeks of TTD benefits) and 1/17/05 - 2/10/05 (3 3/7 weeks of TPD benefits).
9. **Mileage or other medical (\$287.140 RSMo)** - There is no claim for mileage or other medical expenses under §287.140 RSMo.
10. **Additional or Future Medical** - There is no claim for additional or future medical aid.

ISSUES

1. **Medical Causation** - There is a dispute as to whether the employee's injury was medically causally related to the accident.
2. **Previously Incurred Medical** - Employee is claiming previously incurred medical in the amount of \$71,064.63. There is a dispute as to authorization, reasonableness, necessity, and casual relationship. Employer is claiming a credit for amounts that are not the responsibility of the employee.
3. **Additional TTD or TPD** - Employee is claiming additional TTD or PTD in the amount of \$15,045.00 for the period from 3/8/05 - 9/15/05.

- 4. **Permanent Total Disability** - Employee is claiming permanent total disability benefits.
- 5. **Permanent Partial Disability** - Employee is claiming permanent partial disability benefits.
- 6. **Second Injury Fund Liability** - Second Injury Fund liability for permanent partial benefits or permanent total benefits.

EXHIBITS

Judicial notice has been taken of the entire division file. Additionally, the following exhibits were offered and admitted into evidence:

Employee's Exhibits

Identifier	Description
A	Medical Records - Methodist South Hospital
B	Medical Records - Poplar Bluff Regional Medical Center
C	Medical Records - Malden Medical Center
D	Medical Records - Missouri Southern Healthcare
E	Medical Records - Cape Neurological Associates
F	Medical Records - Tesson Heights Orthopedic Group
G	Medical Records - John Hunt, M.D.
H	Medical Records - Excel Imaging
I	Medical Records - D.L. Davis, M.D.
J	Medical Records - Des Peres Hospital
K	Medical Records - Southeast Missouri Hospital Pain Clinic
L	Medical Records - HealthSouth
M	Medical Records - Des Peres Hospital
N	Medical Records - Michael Chabot, D.O.
O	Medical Records - Paul E. Shea, M.D.
P	Medical Records - St. Francis Medical Center
Q	Medical Records - Dr. Kee Park
R	Deposition - Dr. Kee Park, M.D.
S	Deposition - Thomas F. Musich, M.D.
T	Deposition - James N. England
U	Photographs (2)
V	Stipulation for Compromise Settlement (Lumbar Spine, 91)
W	Stipulation for Compromise Settlement (Lumbar Spine, 97)
X	Stipulation for Compromise Settlement (Right Knee, 97)

Employer-Insurer's Exhibits

Identifier	Description
1	Deposition - Dr. Chabot
2	Deposition - Dr. Mikulec
3	Deposition - Dr. Cizek
4	Deposition - Donna Abram
5	Medical Records Mid-America Rehab
6	Medical Records - Dr. Michael Chabot
7	Medical Bills- St. Francis Medical Center
8	Medical Bills - Dr. Kee Park
9	Certified Copy of Division Records
10	Medical Records - Dr. Yingling
11	Medical Records - Dr. Patterson

Second Injury Fund Exhibits

No Exhibits Identified

SUMMARY OF EVIDENCE

TESTIMONY OF BYRON PROFFER

Byron Proffer, hereinafter referred to as "Claimant" testified on his own behalf at the hearing of this matter.

Claimant is 59 years old and lives in Malden, Missouri. Claimant is not currently employed and has not worked full-time since October 13, 2004. Claimant last worked for the employer, Federal Mogul. Employee obtained his high school diploma in 1968 in Campbell, Missouri at the age of 18. Immediately thereafter, he began working at Federal Mogul Corp. Claimant has never worked for any other employer. Claimant has no other vocational training.

Claimant first started working for Employer in the finishing department using saws to make pistons. He manufactured pistons for cars, trucks, etc. This was essentially assembly line work. After a couple of years at this position, Claimant began using fork trucks, turning lathes, and working in maintenance. While working in general maintenance, Claimant would periodically repair furnaces, replace commodes, pick up channel iron and other scrap metal, move 80 pound bags of dry lime, and other various heavy lifting type work.

In 1981, Claimant injured his lower back. He was filling a liquid propane gas tank which required picking up a 25-30 pound part. While picking up this part, he was twisting his back resulting in an injury. In October of 1991, Claimant underwent a laminectomy at the L4/5 with a good result. Claimant returned to work 6-8 weeks after the surgery.

In 1997, Claimant aggravated his lower back. He was lifting something heavy when he strained his back. He went to the hospital and was given pain pills. He believes he missed one day of work. No MRI was performed and no surgery was required. He returned to work and resumed his usual work activities.

In November of 1997, Claimant injured his right knee when he tripped over some metal. In January of 1998, Claimant underwent arthroscopic medial menisectomy. In March of 1998, Claimant had to undergo a second surgery to his knee. A third procedure was performed in August of 2000. Claimant testified that he did not receive complete relief until after the third surgery. After his third surgery, Claimant resumed normal function. He does not recall missing anytime after the third procedure. Claimant testified that the knee was not a hindrance or obstacle to employment. Claimant resumed his normal duties after the third procedure.

In October of 2004, Employee was unloading 55 gallon drums of oil from a truck. Claimant was pushing these drums with a two-wheeled dolly. As he was pushing one of the drums, the dolly hit a rut in the concrete causing it to stop abruptly. This resulted in Claimant twisting and straining his back. Employer took Claimant to Malden Medical Center. After undergoing diagnostic studies, the doctor instructed Claimant to return if he was still experiencing pain on the following day. On the following day, Claimant was experiencing numbness down his right arm and shooting pain through his neck and rest of his body. His primary complaint was numbness and pain. His pain caused problems with his daily living, including headaches, and caused trouble at night while he was trying to sleep. Claimant testified that he could not get comfortable.

Claimant was sent to Dr. Chabot. Dr. Chabot performed a CT scan and MRI. Claimant then underwent pain management including an injection and an oral steroid. Claimant testified that the doctor did not believe that it was going to do any good however, it was a necessary step. Claimant then testified that once Dr. Chabot saw the MRI and myelogram, surgery was recommended. Claimant testified that prior to the surgery performed by Dr. Chabot, he was experiencing headaches and pain down his shoulder and arm. After the surgery, Claimant was experiencing dizziness to the point of nausea.

Claimant testified that the surgery did not provide relief from the neck, shoulder, and arm complaints. Additionally, after the surgery, Claimant had pain in both arms, the pain was constant, and he felt dizzy and nauseous. Claimant testified that he told Dr. Chabot about these problems and Dr. Chabot explained that the problems would eventually go away. Physical therapy was recommended 6-8 weeks after the surgery. Claimant returned to work at Federal Mogul on a part-time basis during the physical therapy. Claimant reported problems with stumbling at work during this period.

Claimant was advised by Dr. Chabot that he might be suffering from vertigo. Claimant saw Dr. Shea in Memphis regarding the dizziness/vertigo complaints. Dr. Shea performed a laser surgery in Claimant's ears in an attempt to resolve the dizziness/vertigo.

Claimant testified that the last time he saw Dr. Chabot was at the end of April in 2005. Dr. Chabot reported everything to be fine however Claimant still had pain down his neck, both arms, and was still experiencing dizziness/vertigo. Claimant testified that he told his Employer of these problems and was advised by his Employer that he was on his own. It was Claimant's own doctor that sent him to Dr. Shea.

Eventually, Claimant contacted Dr. Kee Park to address his ongoing complaints. Dr. Park told Claimant that one of the bones wasn't fused and it was hitting a nerve. Dr. Park explained to Claimant that this was causing the dizziness. According to Claimant, Dr. Park performed a surgery at C5/6 and C6/7. Claimant reports that Dr. Park's surgery did not help. Claimant still complains of dizziness however he is not experiencing the nausea symptoms. Dr. Park placed Claimant on a 10 pound lifting restriction. Dr. Park did not prescribe physical therapy after his surgery.

Claimant's current complaints include dizziness all of the time. He testified that he constantly hurts and both of his arms go numb. He further testified that his knees will periodically "give way" causing Claimant to stumble. He testified that his back hurts from the lower back surgery. He testified that he cannot sit or stand for a long period of time. He can walk no longer than four to five blocks. He can sit for a maximum of one hour due to his neck. He can stand for a maximum of thirty minutes due to his neck. Claimant currently takes Darvocet and Tylenol PM. He testified that he sleeps for no more than three hours per night. He testified he has problems sleeping because of his neck. Claimant has not sought employment since Dr. Park released him. He testified that there is no way that he could stay at a job for eight hours per day. Claimant is aware of no job that he can perform.

On cross-examination, Claimant testified to the pre-existing injuries referenced above as well as a partial amputation of one or more fingers on his left hand and a prior shoulder injury. Claimant testified that he is not under active treatment of any physician and no additional treatment was recommended. Claimant testified that Dr. Park told him he was totally disabled due to the neck alone.

On cross-examination, Claimant further testified regarding the incident giving rise to his claim. He testified that he did not fall nor drop the dolly/drum. Claimant was able to finish the task to which he was assigned. The incident was not witnessed. Claimant testified to this course of treatment with Dr. Chabot in a fashion similar to that described above. Claimant testified that Dr. Chabot told him that there was evidence of solid fusion. Two days after Dr. Chabot released Claimant, he sought treatment with Dr. Park. Claimant testified that the only evidence he had of demand for additional care was when the Employer told him he was "on his own". Claimant was referred to Dr. Park by a friend/neighbor who was a former patient of Dr. Parks.

Claimant testified that he treated with Dr. Park only shortly after he was released by Dr. Chabot. Claimant testified that the treatment rendered by Dr. Park did not help. Claimant testified that he continued to have breakthrough pain that is treated by Dr. Hunt.

On cross-examination, Claimant testified regarding his pre-existing injuries. In 1982, Claimant had a partial amputation of the middle and ring finger of his left hand. Later in 1982, Claimant

lacerated his pinky. In 1989, Claimant strained his lower back. In 1989, Claimant twisted one of his knees. In 1991, Claimant strained his lower back while lifting a desk. In October of 1991, Claimant suffered an injury while filling the liquid propane tank as described above. As a result of that injury, Claimant settled a workers' compensation claim for 20% permanent partial disability of the body as a whole due to his lower back. When Claimant returned to work he did not ask for help or take any more breaks than is customary. Claimant testified that he does continue to have problems with his back. These problems include pain on rainy days, problems walking, and pain after a busy day of working. Claimant testified that he settled his right knee workers' compensation claim for 25% permanent partial disability of the right knee. Claimant testified that the knee continues to bother him. He testified that he does fall periodically but he does not believe it is because of the knee. Claimant testified that the knee will periodically give way. He further testified that the weather will hurt his knee. Prior to 2003, Claimant took medication for pain in his knee.

Claimant testified that he is still able to drive and that he drove himself to this hearing. His driver's license is not restricted. Claimant does not use a cane or crutch. He is currently not using orthotics or splints. He is able to complete his daily household chores including carrying groceries as heavy as a gallon of milk or a twelve pack of soda. Claimant is able to go out and eat with friends and family. He is able to use a water hose and can get in and out of his vehicle.

Claimant has not sought any employment since he has been released by Dr. Park. Claimant testified that he can read and write but he is not great at math. He is able to make change and can operate a phone.

On cross-examination by the Second Injury Fund, Claimant testified that he was working full time until 2004. Prior to 2004 Claimant was not under any medical restrictions nor was he actively treating for his lower back or knee. He did not require special accommodations. Claimant was not experiencing dizziness prior to 2004 and did not need to lie down during the day. He did not have any pain down his left or right arm prior to 2004.

HISTORY OF TREATMENT

The incident giving rise to this claim occurred on October 13, 2004 when he was moving a 55 gallon oil container. Claimant was using a 2-wheeled dolly when one of the wheels got caught in a rut causing claimant to strain. Shortly thereafter he began experiencing right posterior shoulder pain which began radiating down his right upper extremity. Claimant was evaluated by Dr. Howard who felt his complaints were not associated with the shoulder but may be associated with Claimant's neck.

On October 21, 2004 Claimant was seen by Dr. Chabot. Dr. Chabot's examination revealed evidence of neurological deficits with decreased sensation involving the right lateral arm, right extensor and volar surface of the forearm and the right first web space. Claimant was noted to have right bicep and tricep weakness and right hand adductor weakness. X-rays were performed of Claimant's cervical spine. They revealed evidence of advanced degeneration from C4 through C7. An MRI was performed of the cervical spine revealing evidence of cervical spinal stenosis from C3-C7 with significant pathology involving all levels. Dr. Chabot diagnosed cervical

radiculopathy, cervical myelopathy, cervical spinal stenosis and cervical herniated discs. Dr. Chabot recommended a cervical myelogram and post myelogram CT.

On October 29, 2004, the cervical myelogram and post myelogram CT revealed evidence of advanced degenerative disease involving cervical spine with disc protrusions and stenosis from C3-C7. Claimant's physical examination revealed significant neurologic deficits and myelopathy. Surgery was recommended. Patient underwent anterior cervical fusion from C3-C7 on November 8, 2004.

Claimant started undergoing physical therapy in December 2004. The physical therapy reports and follow-up visits with Dr. Chabot reported progress. Claimant continued to complain of some stiffness and difficulty swallowing. In February 2005, Claimant's progress at physical therapy indicated that he was able to return to work.

During follow-up of March 7, 2005, Claimant complained of dizziness and nausea to Dr. Chabot. His preoperative arm symptoms had completely resolved. His strength had returned to normal. It was recommended that he be evaluated by an ear, nose and throat specialist for his complaints of dizziness and nausea. Dr. Chabot opined that these symptoms were not work related.

Claimant saw Dr. Shea on March 21, 2005 who diagnosed Meniere's disease. In April 2005, Claimant underwent a cervical myelogram and post myelogram CT. The studies revealed no evidence of persisting neural compression. There appeared to be satisfactory healing from C3-C7. The fusion was complete from C3-C7. Claimant was released by Dr. Chabot on August 8, 2005 at MMI. Dr. Chabot opined that Claimant suffered a 13% permanent partial disability of the body as a whole due to his work related injury and follow-up treatment. Claimant was seen by Dr. Paul Shea in March of 2005. Claimant reported dizziness and off balance since November of 2004. This primarily occurred when looking up or turning side-to-side. Claimant additionally reported that any movement could set off one of these episodes. The episodes include brief but intense dizziness lasting for approximately 30 seconds. Dr. Shea diagnosed Claimant's condition as Meniere's disease.

Claimant first saw Dr. Kee Park on April 12, 2005. Claimant reported being injured at work on October 13 and undergoing surgery by Dr. Chabot on November 4, 2004. Claimant reported that he had been experiencing dizziness since the procedure and had been referred to the Shea Clinic for evaluation but he was not sure what was going on. Claimant complained of neck pain with grinding and popping which had not improved since the surgery. Dr. Park assessed Claimant and ordered a cervical CT to assess the surgery and take stock of the fusion and Claimant's cervical spine. Dr. Park interpreted that CT scan on April 27, 2005. Dr. Park opined that the bottom of the strut graft appeared to have not fused. Dr. Park prescribed a bone growth stimulator to see if that would help Claimant fuse at this level.

On May 11, 2005, Dr. Park reviewed the cervical myelogram performed on Claimant on April 25, 2005. Dr. Park was of the opinion that the C6/7 interface where the strut grafted is, appeared not to be fused. He further opined that the mechanical neck pain was coming from this non-union of C6/7 and recommended the Claimant undergo a posterior augmentation of the fusion with posterior fusion. Dr. Park performed the procedure on May 20, 2005. Dr. Park's

preoperative diagnosis was C5-6-7 previous cervical fusion with non-union. Dr. Park's postoperative diagnosis was C5-6-7 previous cervical fusion with non-union.

Claimant was seen by Dr. Park for follow-up. Claimant reported improvement of his neck and arm pain as well as the dizziness. On September 15, 2005 Dr. Park releases Claimant from his care. Claimant reported that his dizziness was all better. Dr. Park reported that the CT scan showed a good fusion. Dr. Park released Claimant with a permanent 10 lb. lifting restriction.

Claimant began physical therapy on December 28, 2004. During the initial evaluation, Claimant exhibited cervical pain consistent with limited cervical range of motion. Claimant exhibited good exertion levels throughout the evaluation. He rated his pain at between a 6 and 7 out of 10. Additionally, he reported frequent nausea, light-headedness, loss of balance, and difficulty swallowing.

On December 29, 2004, Claimant reported a pain level of 3/10. He also reported that the pain increased with exercises. Claimant reported problems with rotating his head left and right, frequent light-headedness, loss of balance, nausea, and difficulty swallowing. Throughout the course of physical therapy, Claimant complained of increased pain with changes in weather and pain in his hip from the donor site.

On January 25, 2005, Claimant reported stiffness. He reported pain complaints between 7 and 5 for that week. On February 8, 2005, Claimant reported that he no longer had dizziness but his neck continued to be sore. Claimant felt like he could perform his job duties at work as needed. He reported that his neck was stiff when trying to tilt his head to his shoulder but other than that, everything else felt fine. His pain level on that date was 0/10. He did complain of muscle soreness in his neck when he turned his head.

EXPERT TESTIMONY

DEPOSITION OF DR. KEE PARK

Dr. Kee Park testified on behalf of Claimant. Dr. Park testified that Claimant came to see him after his November 8, 2004 surgery performed by Dr. Chabot. Claimant was complaining of dizziness and had been referred to an ear, nose and throat clinic for evaluation. His primary complaint was persistent neck pain with grinding and popping sensation which had not improved since the surgery. Dr. Park did not know what was causing Claimant's dizziness or blurred vision. Dr. Park believed that dizziness and blurred vision complaints would not usually be related to the neck.

Dr. Park opined that when one has persistent neck pain and a grinding sensation that there must be a concern for non-union of the fusion. He suspected that this was the Claimant's problem. He prescribed a CT scan for Claimant that confirmed to Dr. Park that the bottom of the graft had not fused. Dr. Park opined that the April myelogram also demonstrated that the C6/7 interface was not fused.

Dr. Park performed an augmentation procedure on claimant. Dr. Park used a posterior approach. Due to the posterior approach, Dr. Park was unable to visually appreciate any non-union of the anterior fusion.

Subsequent to the surgery, Dr. Park was surprised to learn of Claimant's reported lack of dizziness. Dr. Park did not think that the surgery would relieve these symptoms.

Dr. Park released Claimant with a 10 lb. lifting restriction. At the time of Claimant's release from Dr. Park's care, Claimant was reporting no pain in his neck to Dr. Park.

DEPOSITION TESTIMONY OF DR. THOMAS S. MUSICH

Dr. Musich, a physician board certified in family practice, testified on behalf of Claimant. Dr. Musich reviewed Claimant's medical records and performed a medical examination.

Dr. Musich's examination and history revealed that Claimant was reporting a pain level of 7 on a scale from 0-10. He also reported diminished neck motion and ongoing symptoms consistent with right upper extremity radiculopathy. Claimant told Dr. Musich that sitting or laying for any length of time over two hours produced aggravated neck and right upper extremity symptoms. Dr. Musich's examination revealed an 8 centimeter, well-healed scar over the left anterior neck and an 11 centimeter, well-healed, mid-line vertical scar over the posterior neck. There was paresthesia to light touch and pin prick over the scarred surfaces and adjacent soft tissue. Claimant's cervical extension was diminished by 75% of normal. When Dr. Musich asked Claimant to touch his chin on his chest, his maximum forward flexion was only 45 degrees. Normal for such a test is between 60-70 degrees. Also, Claimant's cervical rotation was diminished by 50% due to aggravated neck pain.

Dr. Musich opined that the treatment rendered by Drs. Chabot and Park were reasonable and necessary in order to attempt to cure or improve Claimant's post traumatic symptomatology. He rated Claimant's disability at 55% of the man as a whole due to the injury of October 13, 2004. Dr. Musich opined that Claimant had suffered a 25% permanent partial disability of the body as a whole referable to Claimant's lumbosacral spine and 50% permanent partial disability of the right lower extremity due to the previous knee procedures. Finally, Dr. Musich opined that the combination of Claimant's past and present disabilities is significantly greater than their simple sum and will produce a chronic hindrance in his routine activities of daily living. Further, Dr. Musich opined that Claimant is totally and permanently disabled due to a combination of his present and past disabilities.

Dr. Musich was unable to say specifically what caused the vertigo; however, Dr. Musich did opine that the surgery that was performed on Claimant was the substantial cause of him developing vertigo symptomatology.

Dr. Gary Musich then proceeds to give the opinion that the October 13, 2004 injury, in and of itself, was the substantial cause in Claimant's permanent and total disability.

Dr. Musich examined the bills associated with Claimant's second surgery in the amount of \$62,833.63 for Claimant's admission at St. Francis Medical Center. Additionally, Dr. Musich examined Dr. Park's bills in the amount of \$17,725.00 for the second surgery performed on Claimant. Dr. Musich opined that these charges were reasonable and necessary.

On cross-examination Dr. Musich testified that Claimant was permanently and totally disabled due to a combination of his injuries suffered on October 13, 2004 and those injuries which preexisted. After several more questions on the subject, Dr. Musich appears to be of the opinion that Claimant is permanently and totally disabled due to a combination of his primary neck complaints and the preexisting injuries and that the primary injury is the most significant of these various complaints, however, it is not the sole cause of Claimant's permanent and total disability.

DEPOSITION OF MR. JAMES M. ENGLAND

Mr. England testified by deposition on behalf of Claimant. Mr. England reviewed the medical records pertaining to Claimant. Additionally, Mr. England subjected Claimant to testing, an interview and evaluation.

Mr. England opined that Claimant is permanently and totally disabled as a result of the last injury alone. However, on cross-examination, the employer elicited testimony from Mr. England which suggests that Mr. England based this opinion on the assumption that the nausea and dizziness was due to the neck injury. Mr. England also indicated that his opinion regarding the permanent and total disability due to the last injury alone may be modified if the nausea and dizziness were not due to the primary injury.

EXPERT TESTIMONY OF DR. MICHAEL CHABOT

Dr. Michael Chabot testified by deposition on behalf of the employer. Dr. Chabot provided a medical history from the time of the incident giving rise to this claim. Dr. Chabot testified that after the surgery performed by Dr. Chabot, Claimant progressed well and his symptoms resolved. Claimant returned to Dr. Chabot with complaints of dizziness and nausea. He stated that he experienced dizziness when he turned his head due to the limits of his range of motion. Dr. Chabot testified that Claimant's range of motion was near normal at this time; he did not appear to experience imbalance with maximums of extension and forward flexion or rotation. His upper extremity and neurological examination was normal. X-rays of the cervical spine revealed satisfactory position of the plate screws and implants from C3-C7 and the fusions appear to be complete. Dr. Chabot's impression at that time was that the symptoms associated with the work injury had resolved following the surgical intervention and that the present complaints of dizziness and nausea were not related to the surgical intervention.

Shortly thereafter a cervical myelogram and a post myelogram CT were performed. The study revealed no evidence of persistent cervical spinal stenosis or neural compression. The fusion appeared to be intact.

Dr. Chabot also opined that he would not have recommended the second procedure based on the CT scan. Dr. Chabot opined that Claimant suffered a 13% permanent partial disability to the

body as a whole as a result of the October 13, 2004 incident and the surgery performed by Dr. Chabot.

EXPERT TESTIMONY OF DR. ANTHONY MIKULEC

Dr. Mikulec testified by deposition on behalf of the Employer. He is a board certified otolaryngologist. He performed an independent medical review of Claimant's medical records, particularly, the records regarding his visits with Dr. Shea.

Dr. Mikulec opined that Claimant did not satisfy the criteria for a diagnosis of Meniere's syndrome. Furthermore, Dr. Mikulec opined that cervical injuries and cervical fusions are not factors in causing Meniere's syndrome.

Dr. Mikulec did opine that patients who have undergone cervical treatment can develop dizziness and vertigo. Dr. Mikulec does not treat such patients. Dr. Mikulec's practice involves determining whether or not the complaints are related to the patient's ear. If they are not related to the ear, than the patient is passed to another specialist for diagnosis and treatment. Dr. Mikulec did not have an opinion regarding the cause of Claimant's dizziness and vertigo.

DEPOSITION TESTIMONY OF DR. GREGORY R. CIZEK

Dr. Cizek testified by deposition on behalf of the Employer. Dr. Cizek is a board certified radiologist. Dr. Cizek reviewed myelogram and post myelogram CTs that were performed in April of 2005 after Dr. Chabot's surgery but before Dr. Park's surgery. Dr. Cizek testified that the aforementioned diagnostic studies reveal a complete and in-tact fusion.

Dr. Cizek testified that his role as a radiologist is to review and interpret the films. It is the role of the surgeon to make a determination as to whether or not surgery is indicated. Certainly the surgeon makes this determination based in part on the interpretation of the diagnostic studies by a radiologist. However, the surgeon must also consider the symptomatology and history as reported by the patient in making the determination as to whether or not surgery was appropriate. In fact, Dr. Cizek deferred on the issue of whether or not Dr. Park's surgery was appropriate. Dr. Cizek, appropriately, limited his opinion to the interpretation of the radiological studies that were performed.

DEPOSITION OF DONNA ABRAM

Donna Abram testified by deposition on behalf of the Employer. Donna Abram is a vocational rehabilitation counselor and consultant. Donna Abram performed a vocational assessment of the claimant. Ms. Abram testified that based on her assessment of Claimant, he is employable in numerous positions. However, Ms. Abrams testified that it was likely that he would be unable to find a job. In other words, Claimant could perform several jobs; however, he is unable to obtain any job in his current condition.

FINDINGS OF FACT AND RULINGS OF LAW:***Issues 1. and 2.: Medical Causation and Previously Incurred Medical***

There is a dispute as to whether the employee's injury was medically causally related to the accident. Employee is claiming previously incurred medical in the amount of \$71,064.63. There is a dispute as to authorization, reasonableness, necessity, and casual relationship. Employer is claiming a credit for amounts that are not the responsibility of Claimant.

The record is clear that Claimant suffered a compensable neck injury as a result of the incident that occurred on October 13, 2004, giving rise to this claim. Dr. Chabot, the authorized treating surgeon, testified that claimant suffered an injury/aggravation that required a fusion of Claimant's cervical spine from C3-C7. The primary point of contention, it seems, is the causal relationship of the subsequent fusion augmentation performed by Dr. Park and the complaints of dizziness and nausea.

“In addition to all other compensation, the employee shall receive and the employer shall provide such medical, surgical, chiropractic, and hospital treatment, including nursing, custodial, ambulance and medicines, as may reasonably be required after the injury or disability, to cure and relieve from the effects of the injury. ...” **§287.140.1¹**

Dr. Chabot released Claimant on April 8, 2005. Claimant credibly testified that he requested additional care after his release from Dr. Chabot; however, the employer told him he was “on his own” in this regard. There was no testimony contradicting Claimant on this issue. Claimant presented to Dr. Park with complaints of grinding and popping in his neck as well as problems with dizziness and nausea on April 12, 2005. Dr. Park recommended a CT scan to assess the integrity of the fusion. Claimant returned to Dr. Chabot on April 18, 2005 with complaints of neck pain and dizziness. Dr. Chabot recommended a myelogram and post-myelogram CT. On April 25, 2005, Dr. Chabot interpreted the CT and released Claimant at MMI. Claimant continued his care with Dr. Park.

It is apparent from the record that the Employer/Insurer were not willing to provide any additional care after April 25, 2005. For these reasons, I find that Employer's defense to the additional medical care and charges associated therewith for lack of authorization is without merit.

Dr. Park credibly testified that the subsequent fusion augmentation performed on May 20, 2005 was medically necessary. Dr. Park's decision to perform this procedure was made after taking a history from Claimant, examining him and reviewing diagnostic studies that had been performed on his neck. Dr. Chabot was asked his opinion regarding Dr. Park's decision to perform the May 20, 2005 procedure and whether or not it was medically necessary. Dr. Chabot did not say whether or not the May 20, 2005 procedure was medically necessary. Rather, Dr. Chabot

¹ Unless stated otherwise, all statutory references are to RSMo 2000.

testified that he would not have performed the surgery based on the CT study that he reviewed.² Dr. Chabot's answer to this question is non-responsive to the issue at hand: Was the May 20, 2005 procedure medically necessary to cure and relieve Claimant from his symptoms? Dr. Chabot was asked three times and never testified why he wouldn't have recommended or performed the surgery. He did not opine that it was not medically necessary. To the extent that Employer would suggest that Dr. Chabot's testimony should be inferred to stand for the proposition that the May 20, 2005 procedure was not medically necessary, I find the testimony to be non-credible. Each time Dr. Chabot was asked the question, he cited the CT scan of April 25, 2005 as the sole basis for his opinion. Employer's own expert, Dr. Cizek, testified that diagnostic imaging, alone, does not form the basis for a decision to perform surgery or not.

Q. ... You interpret the films, give your opinion, and then at that point on you don't make a decision as to whether a certain patient has surgery, doesn't have surgery, or whatnot; correct?

A. Correct.

Q. Would you agree with me that the treating physician, Dr. Chabot or Dr. Park, not only has to take into account your findings as a radiologist and respect the same, but also has to take in account – into account, the patient's symptomatology?

A. Yes.

Exhibit 3, pp. 14-15

Q. Would you agree that Dr. Park as Mr. Proffer's treating physician would be in a better position taking on all fours [sic] symptomatology, radiologist's opinions, and he reviewed the films himself, he's probably in a better position to determine whether this gentleman needed further medical procedures as opposed to you?

A. Yes.

Exhibit 3, p. 19

For these reasons, I find that the procedure performed by Dr. Park on May 20, 2005 to be medically necessary to cure and relieve Claimant from the injury suffered as a result of the incident giving rise to this claim.

Drs. Park and Musich both credibly testified that the \$71,064.63 in charges were reasonable for the procedure performed. Employer suggests that it should get a credit for those amounts paid by health insurance or written off pursuant to the providers' agreement with the health insurer. Employer put on no evidence that Employee may not eventually be responsible for satisfaction of these charges. In order to receive a credit for write-offs, Employer must establish by a preponderance of the evidence that Claimant is not legally subject to further liability. Employer

² In fact, Dr. Chabot was asked three separate times regarding the necessity of the May 20, 2005 procedure and each time Dr. Chabot responded that he would not have recommended or performed the procedure based on the CT scan that he reviewed. Exhibit 1, pp. 30, 39.

did not carry its burden in this regard. **Farmer-Cummings v. Personnel Pool of Plate County, 110 S.W.3d 818, 823 (Mo 2003).**

Employee is awarded \$71,064.63 of back medical charges.

Dr. Park testified that the dizziness and nausea was medically, causally related to the incident that occurred on October 13, 2005 and that the incident was a substantial factor in same. Dr. Chabot disagreed and opined that the dizziness and nausea was unrelated and possibly a vascular issue. Dr. Mikulec, Employer's ENT specialist, testified regarding Claimant's complaints of dizziness and nausea. He testified that he will occasionally see patients with similar complaints when they have neck problems, whether they have had surgery or not. He testified that the finding did not surprise him. Based on these opinions, I find that Claimant's complaints of dizziness and nausea are medically caused by Claimant's injury suffered on October 13, 2004.

Issue 3. Additional TTD or TPD

Employee is claiming additional TTD or PTD in the amount of \$15,045.00 for the period from 3/8/05 - 9/15/05.

I have previously found that Dr. Park's subsequent procedure was medically necessary, reasonable, and causally related to the compensable accident of October 13, 2004. Therefore, I find Claimant was not at MMI when he was released by Dr. Chabot. I do find that Claimant was at MMI when he was released by Dr. Park on September 15, 2005. Dr. Hunt first took Claimant off of work on March 8, 2005. This is a period of 27 2/7ths weeks. At the stipulated rate of \$601.80, I find that Claimant is entitled to \$16,420.54 of back TTD. That amount is awarded.

Issues 4, 5, and 6. Permanent Total Disability, Permanent Partial Disability and Liability of the Second Injury Fund

There is no dispute that the anterior cervical fusion was necessary to cure and relieve Claimant from the effects of his injury. I have previously found that the posterior augmentation was also medically necessary. Claimant has suffered disfigurement as a result of these procedures. Claimant offered into evidence the photos of the surgical site shortly after the procedure. These photos bear little if any relevance on the issue of disfigurement. Obviously, Claimant's appearance improved over time due to the natural healing process. Based on Claimant's appearance at the time of the hearing of this matter, I award Claimant 10 weeks of disfigurement for the scarring due to the neck procedures and the resulting scars. This amounts to an award of $(10 * \$354.05 =) \$3,540.50$ for disfigurement. **§287.190.4.**

Both vocational experts opined that Claimant is unemployable in the open labor market. I find that Claimant is permanently and totally disabled. **§287.020.7, §287.200**

Mr. England testified that the last injury alone resulted in Claimant becoming permanently and totally disabled. He based this on the 10 pound lifting restriction imposed by Dr. Park, Claimant's dizziness, his neck pain and his need to lie down, all of which were as a result of the neck injury that is the subject of this claim. Ms. Abram testified that Claimant was

unemployable in the open labor market. Taking Ms. Abram’s deposition as a whole, it appears that Ms. Abram believes and testified that Claimant’s primary barriers to employment are his neck injury, his dizziness and his need to lie down. Prior to October 13, 2004, Claimant was working in a heavy labor position without any medical restrictions. He credibly testified that his prior injuries were not a hindrance to his employment or performing his duties. His employer did not make any special accommodations for him.

For these reasons, I find that Claimant is permanently and totally disabled due to the compensable accident that occurred on October 13, 2004. Employer is ordered to provide permanent total benefits at the rate of \$601.80 per week pursuant to §287.200 beginning September 15, 2005.

I find no liability on the part of the Second Injury Fund.

ATTORNEY’S FEE

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

INTEREST

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

Made by:

Matthew W. Murphy
Administrative Law Judge
Division of Workers' Compensation

A true copy: Attest:

Naomi Pearson
Division of Workers' Compensation

Date: _____