

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

Injury No.: 05-141652

Employee: Arthur Skidmore  
Employer: Gilster Mary Lee Corporation  
Insurer: Self c/o Gallagher Bassett  
Additional Party: Treasurer of Missouri as Custodian  
of Second Injury Fund (Open)  
Date of Accident: July 22, 2005  
Place and County of Accident: Perry County, Missouri

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 Act. Pursuant to section 286.090 RSMo, the Commission affirms the award and decision of the administrative law judge dated May 14, 2008, and awards no compensation in the above-captioned case.

The award and decision of Administrative Law Judge Lawrence C. Kasten, issued May 14, 2008, is attached and incorporated by this reference.

Given at Jefferson City, State of Missouri, this 26th day of November 2008.

LABOR AND INDUSTRIAL RELATIONS COMMISSION

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William F. Ringer, Chairman

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Alice A. Bartlett, Member

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John J. Hickey, Member

Attest:

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Secretary

ISSUED BY DIVISION OF WORKERS' COMPENSATION

**FINAL AWARD**

Employee: Arthur Skidmore

Injury No. 05-141652

Employer: Gilster Mary Lee Corporation

Additional Party: Second Injury Fund

Insurer: Self c/o Gallagher Bassett

Appearances: Aaron Lefton for the employee. David Remley for the employer.

Hearing Date: February 11, 2008

Checked by: LK:kh

**SUMMARY OF FINDINGS**

1. Are any benefits awarded herein? No.
2. Was the injury or occupational disease compensable under Chapter 287? No.
3. Was there an accident or incident of occupational disease under the Law? There was an accident but not a compensable injury.
4. Date of accident or onset of occupational disease? July 22, 2005
5. State location where accident occurred or occupational disease contracted: Perry 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? Undetermined
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 contracted: The employee pulled a pin to release a trailer.
12. Did accident or occupational disease cause death? No.
13. Parts of body injured by accident or occupational disease: None.
14. Nature and extent of any permanent disability: None.

15. Compensation paid to date for temporary total disability: None.
16. Value necessary medical aid paid to date by employer-insurer: \$9,105.02.
17. Value necessary medical aid not furnished by employer-insurer: None.
18. Employee's average weekly wage: Undetermined.
19. Weekly compensation rate: \$696.97/\$365.08
20. Method wages computation: By agreement.
21. Amount of compensation payable: None.
22. Second Injury Fund liability: None.
23. Future requirements awarded: None.

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

The Compensation awarded to the 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: N/A

## **FINDINGS OF FACT AND RULINGS OF LAW**

On February 11, 2008, the employee, Arthur Skidmore, appeared in person and by his attorney, Aaron Lefton, for a temporary or partial award. The employer was represented at the hearing by its attorney, David Remley. The Second Injury Fund claim was left open by agreement of the parties. At the time of the hearing, the parties agreed on certain undisputed facts and identified the issues that were in dispute. These undisputed facts and issues, together with a summary of the evidence and the findings of fact and rulings of law, are set forth below as follows:

### **UNDISPUTED FACTS:**

1. Gilster-Mary Lee Corporation was operating under and subject to the provisions of the Missouri Workers' Compensation Act and was duly qualified as a self-insured employer through their third party administrator, Gallagher Bassett.
2. On July 22, 2005, Arthur Skidmore was an employee of Gilster-Mary Lee Corporation and was working under the Workers' Compensation Act.
3. On July 22, 2005, the employee sustained an accident arising out of and in the course of his employment.
4. The employee's claim was filed within the time allowed by law.
5. The employee's rate of compensation for temporary total disability is \$696.97 per week and for permanent partial disability is \$365.08 per week.
6. The employer has paid \$9,105.02 in medical aid.
7. The employer has not paid any temporary disability benefits.

### **ISSUES:**

1. Notice

2. Medical causation
3. Claim for previously incurred medical
4. Claim for additional medical aid.
5. Temporary total disability

Judicial notice of the contents of the Division's file for the employee were taken.

**EXHIBITS:**

The following exhibits were offered and admitted into evidence:

Employee's Exhibits

- A. Medical record of Dr. Murry
- B. Medical records of Dr. Walls
- C. Medical bill of Dr. Walls
- D. Medical record and bill from HealthSouth Diagnostic Center
- E. Certified medical records of Dr. Schultz
- F. Bill from Dr. Schultz and Radiology Consultants of Mid-America
- G. Deposition of Dr. Simowitz including exhibits
- H. Medical records of VA Hospital
- I. Medical records of VA Hospital
- J. Certified copy of the Division of Workers' Compensation file.
- K. Correspondence pertaining to the claim for compensation

Employer-Insurer's Exhibits

1. CV of Dr. Chabot
2. Medical report of Dr. Chabot dated February 1, 2007
3. Medical report of Dr. Chabot dated May 1, 2007
4. Medical report of Dr. Chabot dated November 30, 2007
5. Medical record of Dr. Murry
6. Medical record of Redbud Regional Hospital
7. Deposition of Dr. Chabot

**WITNESS:** Arthur Skidmore, the employee

**BRIEFS:** The employee's brief was received on February 26, 2008. The employer's brief was received on February 27, 2008.

**FINDINGS OF FACT:**

Testimony of the employee:

The employee is 61-years-old and has been an over the road truck driver for forty years. Prior to working at Gilster-Mary Lee, he worked for Hoosier Air Transport. He started working for Gilster-Mary Lee on April 15, 2005, and worked for them through August of 2005. He had no problems with the DOT physicals.

On March 8 or 9 of 2005, the employee slipped and fell on ice and hurt his left shoulder. He was treated at the VA Clinic and was diagnosed with a worn out rotator cuff. He had therapy. Prior to July 22, 2005, he did not take medicine for arthritis but did for his left shoulder.

Prior to July 22, 2005 he had no problems, no injury and no treatment to his neck. On July 22, 2005, he hurt his neck when pulling a fifth wheel pin. He thought he had pulled a muscle in his neck and went to a chiropractor, Dr.

Murry, the next day. The employee did not think he told Dr. Murry about pulling the pin. The employee testified that the injury was to his neck and has always been to his neck. Dr. Murry asked him what was wrong. The employee told Dr. Murry what was wrong and why he was there. Dr. Murry did not physically examine or touch his low back and did not do any range of motion testing. The employee testified that Dr. Murry did not tell him to contact his office as needed. The employee did not go back to see Dr. Murry because Dr. Murry told him he would have to see another doctor.

Between the time he saw Dr. Murry and when he saw Dr. Walls on August 18, he did not go to any other healthcare provider. He continued to work and drive a truck including continuing to pull fifth wheel pins. He was able to do everything he did prior to the accident. He waited the approximate three weeks between Dr. Murry and Dr. Walls because he thought he had just pulled a neck muscle and thought he would get over it. It was during their busy season and he was waiting for a break to get in to a doctor. He took a lot of Aleve. He told Dr. Walls how he hurt himself pulling the fifth wheel. Dr. Walls thought he had a herniated disc and ordered an MRI. The employee then thought he might have more than a pulled muscle, and the day after his first visit with Dr. Walls, he called Russell Reinhart, the outgoing dispatch person and reported it. Dr. Walls referred the employee to Dr. Schultz, a neurosurgeon. Dr. Schultz performed injections, physical therapy, muscle relaxers and a discogram.

He worked for Hoosier Air until June 16, 2006 when Dr. Walls took him off work. On August 20, 2007, Dr. Walls put him back to work because he needed money. He worked for Hoosier until September 23, 2007. On September 23, the employee thought that the back of his head was going to blow out and he could not continue to work. Since then he has been unable to work and is on disability. As of the date of the hearing, he was still under active medical care.

#### Medical Records Prior to July 22, 2005:

On July 6, 2004 the employee saw a VA nurse for shooting pain in the upper right arm and X-rays were ordered. On July 7, the employee went to the VA clinic for pain in the right upper extremity between the shoulder and the elbow. The nurse practitioner noted that the x-rays were essentially normal. She did not believe it involved the joint and did not believe it to be neurological in nature. He was prescribed Etodolac for pain. On July 16, x-rays of the right humerus showed degenerative changes.

On March 11, 2005 the employee went to the VA emergency room after falling on ice and landing on the left shoulder. The employee had severe pain and loss of use of his left arm and shoulder. He had restricted range of motion and was unable to sleep. The doctor prescribed ibuprofen and a Toradol injection for pain. The employee went to the VA emergency room on March 12 with a tender left shoulder in the dorsal left rotator cuff and decreased range of motion. The x-ray of the left shoulder showed degenerative changes of the acromioclavicular joint. The doctor diagnosed a rotator cuff strain, prescribed ibuprofen and referred the employee for an orthopedic consultation.

On March 25, 2005 the employee saw the doctor at the VA with a shoulder sprain/strain and chronic left shoulder pain with limitations of motion. The employee had ten out of ten pain with movement; tightness along the left upper trapezius; and tightness and tenderness in the left pectoralis minor muscle. The employee had limitation of motion secondary to pain. The employee was prescribed therapy for pain and lost motion. At the initial therapy consultation on March 25, it was noted that employee had limitation of motion; and tightness along the left upper trapezius and tightness and tenderness along the left pectoralis minor muscle. The employee had physical therapy several times in March and April. On April 7, the employee had chronic left shoulder pain with limitation of motion with spasms in the left upper arm.

#### Records after July 22, 2005:

The employee saw Dr. Murry, a chiropractor on July 23, 2005, and reported moderate pain between the shoulder blades, moderate low back pain, moderate low back muscle spasms and moderate restricted motion in the lower back. In the objective findings, there was moderate muscle hypertonicity noted bilaterally in the mid thoracic region. There was moderate muscle spasms and reduced motion bilaterally in the lumbar region. The employee was administered manipulation to the thoracic and the lumbar regions. Dr. Murry noted that the employee will contact his

office as needed.

On August 18, 2005, the employee saw Dr. Walls. Dr. Walls' handwritten notes are extremely difficult to interpret. A radiology report showed a history of neck pain. The impression of the radiologist was degenerative arthritis and degenerative disc disease with marked narrowing of the C6-7 intervertebral space; and C3-4 and C4-5 facet arthropathy. Dr. Walls ordered an MRI.

On August 22, 2005, an MRI of the cervical spine was performed for cervical radiculitis, neck and left arm pain. The findings were degenerative disc changes mainly at C6-7 with a mild anterior extra-dural defect present; mild disc changes from C3-4 to C5-6; and relative stenosis of the bilateral C7 foramina. The impression of the radiologist was degenerative disc changes mainly at C6-7 compatible with spondylosis; no definite disc herniation or significant focal lateralization; and relative stenosis of the bilateral C7 foramina.

On August 22, the employee returned to see Dr. Walls with a diagnosis of C8 radiculitis and radiculopathy. It appeared that Dr. Walls stated that the employee was a semi driver and had degenerative discs at several levels. On August 29, Dr. Walls set up an appointment with Dr. Santiago, a neurosurgeon for November 1. On September 8, it appeared that Dr. Walls prescribed a soft collar and Lortabs.

On December 26, 2005, it appeared that Dr. Walls put "WC related neck trouble" in his records and noted that the employee had not had a neurosurgical consult. It appears that he diagnosed C7 stenosis. He continued to prescribe Lortabs.

On February 17, 2006, Dr. Walls stated that the employee had not had a neurosurgical consult and needed one as soon as possible. On February 24, the employee went to the VA mainly for lower abdominal pain but had aching musculoskeletal joints from arthritis.

On June 16, 2006 Dr. Walls indicated that the employee was on work leave and had an appointment scheduled in July with Dr. Schultz, a neurosurgeon.

The employee went to the emergency department at the VA on June 22, 2006 with intractable neck pain. The employee stated he was injured at work one year ago. The employee's neck pain was worsening. The employee noted that he had been fighting with workers' compensation for treatment. He has had progressively worsening neck pain with some intermittent tingling in both hands. He had been driving a truck until one week ago. The doctor assessed cervicgia with history of questionable C7 herniated disc per patient. There was no clinical evidence of radiculopathy or myelopathy. Flexeril was prescribed for muscle spasms.

The employee's original claim was dated June 26, 2006, and was filed on June 27, 2006, listing a date of accident of August 5, 2005. The Division acknowledged the claim on July 24, 2006.

On July 6, 2006, at the VA, x-rays of the right humerus was performed which showed degenerative osteophytes seen in the acromioclavicular joint. The impression was degenerative changes. On July 7, the employee was at the VA with a history of severe neck pain for one year. e HHe was on chronic pain medications.

On July 26, 2006, the employee saw Dr. Schultz, a neurosurgeon. It was noted that the employee injured his neck in July of 2005 pulling on a pin to release the trailer from the cab and developed neck pain but no arm pain. He did have pain in his left triceps muscles. Extending his neck seems to reproduce his symptoms. He has not noticed any weakness in his arms or numbness in his hands. The employee had an MRI in July of 2005 which was not available. The employee was on Hydrocodone. In the physical examination, compression in the extended position produced pain radiating down to his left triceps muscle. The impression of Dr. Schultz was neck pain and history of ruptured disc. Dr. Schultz ordered an MRI.

The history of the August 7, 2006, MRI stated left sided neck pain, strained neck last year while pulling on a pin on a semi, no arm tingling or pain. The impression was C6-7 cervical spodylitic changes resulting in a mild to moderate left C7 nerve root foramen stenosis and a left C5 foraminal disc protrusion with a soft tissue stenosis from

the protruding left foraminal C4-5 disc. At C4-5, the right C5 nerve root foramen is narrowed due to joint spurring with disc material projecting beyond resulting in a left C5 nerve root foramen stenosis. At C5-6, there was disc desiccation and disc space height loss with a posterior central high signal intensity zone consistent with a central annular fissure. At C6-7 there was disc space height loss with posterior spurring. The joint spur projects into and narrow the bilateral C7 nerve root foramen, right more than left.

The employee's amended claim was dated and filed on August 31, 2006, which changed the date of accident from August 5, 2005 to July 22, 2005. The Division acknowledged the amended claim on October 17, 2006.

On September 12, 2006, Dr. Schultz noted that the MRI scan showed a soft herniated disc at C4-5 on the left and foraminal stenosis secondary to degenerative disc disease and spurring at C6-7 on the left. Dr. Schultz stated that the C4-5 disc was probably causing his problems but at that time was not impinging on the cord. Dr. Schultz ordered epidural blocks.

The Report of Injury was filed with the Division on September 19, 2006 which stated that the injury date was August 5, 2005 and the last date worked was August 19, 2005. The employer was notified on June 27, 2006. The administrator was notified on September 14, 2006.

On September 19, 2006 the employee saw Dr. Modali, a neurologist at the VA. The chief complaint was constant neck pain since July of 2005. The employee stated that he injured his neck while working on his semi truck and pulling on some object. Since that incident he had been having constant neck pain but denied any radiation of the pain from the neck to his upper extremities, and denied weakness or numbness of his extremities. Dr. Modali's impression was chronic neck pain secondary to cervical spondylosis. The neurological examination did not reveal any deficit and there was no clinical evidence for cervical radiculopathy. Dr. Modali recommended conservative treatment. The employee was to bring the copies of the x-rays and MRI at his next visit.

On September 27, 2006, the employee's attorney faxed a letter to the employer's attorney enclosing the original claim, the amended claim, and the medical records from Dr. Walls and Dr. Schultz. Included in Dr. Walls' records was an information sheet dated August 18, 2005 which included cervical radiculopathy that was circled and appeared to be in the left neck.

Cervical epidural steroid injections at C5-6 were performed on October 4 and October 18, 2006. The October 4 history stated the employee had multi-level osteoarthrosis changes. The October 18 history stated cervical degenerative spondylosis changes. The employee had improvement with the first injection but had intermittent headaches.

On October 30, 2006 the employee went to the VA clinic for a headache the employee stated was connected to a work related injury. He had a history of a neck injury with disc disease one year ago on the job. The doctor's assessment was chronic neck pain with disc disease.

On November 3, 2006, Dr. Schultz stated that after the cervical epidural blocks the employee's arm pain was gone. His neck was bothering him more which Dr. Schultz thought was due to irritation from the blocks. Dr. Schultz prescribed Robaxin for muscle spasms. On November 17, Dr. Schultz prescribed Motrin and therapy.

On February 2, 2007 the employee was miserable. Dr. Schultz noted the degenerative discs at C4-5 and C6-7 and ordered a discogram at C4-5, C5-6 and C6-7. Dr. Schultz noted that if there was any significant reproduction of the symptoms surgical intervention was warranted.

In February the employee went to the VA with shortness of breath which started after his last injection. The employee was diagnosed with neck pain and history of degenerative disc disease in the cervical spine.

On March 5, 2007, Dr. Walls stated that he had kept the employee off work since June 16, 2006 for cervical disc disease. His treatment continued and he had not been released to return to work. An epidural injection was performed at the C6-7 level on March 7, 2007 for neck and bilateral arm pain. On March 20, 2007 Dr. Schultz noted that the blocks did not help and he was going to schedule the employee for a discogram at C4-5, C5-6 and C6-7 and

fix the positive levels by surgery.

The employee went to Dr. Walls on June 28, 2007. The hand written notes indicated that the employee injured his neck while releasing a tractor and the pain was getting worse due to arthritis. The employee was taking Tylenol for arthritis and Lortabs were not tolerated well. Dr. Wall diagnosed degenerative disc disease that was not responsive to conservative treatment and indicated that the employee needed surgery and may need another MRI. The employee saw Dr. Walls in August and September of 2007 but his medical records are difficult to interpret.

On December 24, 2007, Dr. Schultz noted that the employee had not had the discogram because it was denied by his insurance company. The discogram and CT of the cervical spine at C4-5, C5-6 and C6-7 were done on January 14, 2008. The history for the discogram noted a 61-year-old with severe posterior neck pain, posterior head pain and multi-level osteoarthritis changes in the cervical spine. The discogram showed degeneration at C4-5, C5-6 and C6-7 levels which was most severe at C6-7 level without reproduction of the typical pain with injection of contrast. There was a typical reproduction of pain at C4-5 and C5-6. At C6-7 the needle placement was difficult due to the collapsed disc space. Injection of contrast showed dye extension throughout the disc level correlating with advanced degeneration. The employee had no complaint of typical pain at this level until the needle was removed. There was a markedly degenerated C6-7 disc level. The impression of the CT cervical spine was multi-level degenerative changes. Dye was in the C4-5, C5-6, C6-7 disc levels but only minimal dye at C5-6. In the history it is noted a 61-year-old with posterior neck pain, back pain and shoulder pain. The radiologist noted at C4-5 the dye was throughout the disc which correlated with the discogram. At C5-6 there was minimal dye in the anterior aspect of the disc. At C6-7 there were advanced degenerative spondylosis changes, collapse of disc space and marginal spurring with dye throughout the disc which correlated with the discogram.

#### Dr. Simowitz:

The employee was sent by his attorney to Dr. Simowitz, a neurologist on September 1, 2006. The employee told Dr. Simowitz as he was pulling a pin he exerted greater force than usual and noted an immediate somewhat dull discomfort in his left trapezius area but no radiating symptoms. He continued to work and over the first hour or two of driving, he noted a progressively worsening of the pain in his left posterior cervical and trapezius area. He had to interrupt his trip to buy Aleve. He continued to work on a regular basis and did not seek medical attention for about a month after the incident. During that time the pain migrated to both the posterior cervical areas and both occipital areas and was less in the left trapezius. Over time no radiating pain occurred but he began to have variable degrees of tingling in the tip of the third digit of his left hand. The employee denied ever having any type of neck pain prior to July 22, 2005. For approximately ten years, he had intermittently seen a chiropractor for left low back and left buttock pain. At the time of the injury, he was working for Gilster-Mary Lee. He left and worked for Hoosier Air until June 16, 2006 when he stopped working due to worsening of his neck pain.

Dr. Simowitz stated that Dr. Walls' August 18, 2005 records are difficult to decipher. It appeared that the employee's initial complaint was a stiff neck. Dr. Walls' records include a diagram which Dr. Simowitz assumed was made on August 18, 2005. The notations are in Dr. Walls' handwriting presumably dictated by the employee. Dr. Simowitz showed the employee the diagram and he remembered telling Dr. Walls the symptoms as entered. The records and diagram indicate the employee complained of left neck and trapezius pain and a weakness and tightness in the left upper arm but no radiating pain into the arm. There is a notation of a symptom in the left hand which he presumed was tingling but the entry was difficult to interpret. It appeared there was no major radiating component. Dr. Walls ordered an MRI which Dr. Simowitz did not have. On August 26, 2005, Dr. Walls made an entry presumably based on the MRI report but Dr. Simowitz could definitely not make any conclusions. The notation suggested degenerative changes at several levels. Dr. Simowitz did not note any mention of disc herniation in Dr. Walls note even though he diagnosed radiculopathy.

Dr. Simowitz's impression was: 1) Chronic cervical strain syndrome which referred to a soft tissue injury to the neck. It was his opinion that the injury of July 22, 2005 was the prevailing factor in causing the condition. 2) Degenerative disc disease of the cervical spine including spurring and disc degeneration with herniation. Dr. Simowitz stated it was likely that that condition at least in part pre-existed the July 22, 2005 injury but was asymptomatic and it was made symptomatic by the injury of July 22, 2005.

Dr. Simowitz stated that part of the employee's neck pain related to a soft tissue injury which would not be helped by surgery. Part of the complaints may relate to disc disease which might be helped by surgery. Dr. Simowitz stated it is difficult to discern how much each of these conditions contributed to his current symptoms. From the standpoint of pain relief alone, it was difficult to justify surgery at that time. In addition the employee had no radiating pain and no motor or reflex signals involving the upper extremity. The tingling in the third digit of the left hand may relate to the degenerative cervical disease but is not an indication for surgery. Dr. Simowitz wanted to obtain a copy of the initial MRI scan. It was Dr. Simowitz's opinion that the employee had not reached maximum medical improvement and he recommended conservative treatment including physical therapy, medication, and trigger point injections. It was his opinion that the employee was temporarily totally disabled from gainful employment and that the prevailing factor causing the disability is the July 22, 2005 injury.

In an October 13, 2006 letter Dr. Simowitz noted that he had reviewed additional medical records including the August 22, 2005 MRI. The report indicated considerable degenerative arthritis including degenerative disc disease but did not describe a frank disc herniation. By contrast, the August 7, 2006 cervical MRI described a disc herniation. It was Dr. Simowitz's opinion that the employee had pre-existing asymptomatic degenerative cervical arthritis and on July 22, 2005, sustained an injury that caused the arthritis to become symptomatic and resulted in an acceleration of the progression of the degenerative condition ultimately (sometime over the ensuing year) leading to a disc herniation.

In his July 27, 2007 deposition Dr. Simowitz noted that the employee stated his initial pain was in his left posterior cervical and trapezius area. As time went on, on the back of the neck on the right side and the back of the skull on the right side became involved. The pain migrated to both posterior cervical areas and both occipital areas. Dr. Simowitz stated that the migration of pain pattern was significant because the initial pain in the left trapezius muscle was related to a strain of that muscle because it improved as time went on. The migration of the pain into the other side and up into the back part of the neck is related to progressive arthritic changes in the neck. Since there was no radiating pain after the accident there was no significant pressure on any of the nerves that come out of the neck from whatever process was going on in his neck. The tingling in the tip of his third finger may indicate pressure on the nerve root but since there are other things that could cause it that have not been excluded; Dr. Simowitz could not say it is related to the neck. Dr. Simowitz said that the weakness and tightness in the left upper arm on the pain diagram was not in a neurologic distribution and was more consistent with muscle strain as was the trapezius pain.

Dr. Simowitz stated that Dr. Walls diagnosed radiculopathy and was under the impression that the pain that the employee was experiencing related to pressure on the nerves in the neck which extended into the arms. Dr. Simowitz disagreed with Dr. Walls' diagnosis because there were not any physical complaints or evidence that there was significant pressure.

The second MRI done on August 7, 2006, indicated degenerative changes of the discs at C3-4, C4-5, C5-6 and C6-7. At C4-5 level there was an actual disc herniation into the right lateral recess and more advanced degenerative arthritic changes. It was Dr. Simowitz's opinion that the fact that the earlier MRI scan showed degenerative changes but no disc herniation indicated that something happened in the interim to cause the C4-5 disc herniation. It was Dr. Simowitz's opinion that the injury accelerated the progression of the pre-existing degenerative changes in his neck to the point that the disc eventually herniated and the arthritic changes became more severe. Dr. Simowitz stated that if there was a significant disc herniation, it would have shown up on the first MRI scan. The first MRI report indicated findings consistent with disease in the discs which could predispose to herniation at a later time, which Dr. Simowitz believed happened between the first and the second MRI.

It was Dr. Simowitz's opinion that the accident caused a change in the dynamics of the degenerative arthritis which was already pre-existing. The accident changed the dynamics and injured the disc to the point that between the first and second MRI, one of the discs herniated due to the changes produced by the accident. There was a progressive herniation of that disc that had not occurred shortly after the accident, but the accident set up or worsened the degenerative changes to the point that the disc subsequently herniated.

The neck examination was normal with no evidence of any impingement or injury to any nerve or nervous system structure. It was Dr. Simowitz's opinion that the employee had a strain or soft tissue injury to the neck. It was

Dr. Simowitz's opinion that the degenerative disc disease and the degenerative joint disease pre-existed the July 22, 2005 injury but was asymptomatic and it became symptomatic due to the injury. It was Dr. Simowitz's opinion that the July 22, 2005 injury was the main cause or prevailing factor in the cause of the soft tissue injury.

Dr. Simowitz stated that some of the employee's neck complaints were related to the soft tissue injury and some to the disc herniation. Before definitely recommending surgery, he wanted to see the response to a more concentrated effort to treat his problems conservatively. It was his opinion that the employee was unable to work and was temporary total disabled from gainful employment since the employee left work on June 16, 2006.

After a review of the additional medical, it was Dr. Simowitz's conclusion that the employee had asymptomatic degenerative cervical arthritis prior to the July 22, 2005 accident. The July 22, 2005 accident and injury that the employee sustained caused the arthritis to become symptomatic and resulted in an acceleration of the progression of the degenerative condition which over the ensuing year led to a disc herniation.

Dr. Simowitz's stated that the employee had not reached maximum medical improvement and should continue to receive non-surgical treatment for his neck complaints. Dr. Simowitz stated that assuming that the employee failed to respond to all of the conservative treatment, he would then recommend surgical intervention.

It was Dr. Simowitz's opinion that the employee strained to pull the pin which caused a tightening of the muscles of the neck which strained the muscle which is responsible for some of the residual neck complaints and also caused a compressive dynamic on his cervical spine that set up the disc for an accelerated herniation that may or may not have occurred over a period of time without the accident. The event changed the relationship of the vertebral bodies and accelerated the failure of the disc and the arthritic changes that were previously asymptomatic. Dr. Simowitz stated that it could be caused by a different traumatic event other than pulling that pin, and that a fall on the ice potentially could. Dr. Simowitz did not know anything about a fall on ice and had not been provided with the medical records from the VA Hospital.

Dr. Simowitz was asked to assume in March of 2005, the employee fell on ice and injured his left shoulder; he had problems and pain, and sought medical treatment. Dr. Simowitz stated it was improbable that the fall on the ice rather than the pulling of the pin was a triggering event for the chain of changes that happened to the employee because if the employee had injured his neck enough on the fall on the ice, he would have expected some complaints of at least a soft tissue injury to his neck. Dr. Simowitz stated if the employee did not complain of neck problems, it is highly unlikely that those events would have caused an acceleration of his neck condition.

Dr. Simowitz agreed that discs throughout the spine rupture or herniated spontaneously in some people; are a recognized consequence of the degenerative disc disease and osteoarthritis of the vertebral bodies of the spine; and herniate in some people without a traumatic event.

#### Dr. Chabot:

The employee was seen on February 1, 2007 by Dr. Chabot, an orthopedic surgeon. The employee told Dr. Chabot that he injured himself on July 22, 2005 when he was pulling a pin on a fifth wheel. He was evaluated by Dr. Murry, a chiropractor and did not inform his employer of the injury at that time. He stopped working in June of 2006. Dr. Chabot stated that Dr. Wall's handwritten notes were extremely difficult to interpret. The employee was diagnosed with C5 radiculopathy. X-rays and an MRI study were ordered. On August 26, 2005, the employee was diagnosed with radiculitis but Dr. Chabot noted the handwritten note was extremely difficult to interpret. On December 26, 2005, the employee was diagnosed with cervical disc disease. Dr. Chabot's diagnosis was neck pain and cervical spondylosis. Dr. Chabot noted that the employee's prior MRI and records from Dr. Murry and the neurosurgeon were not available for review. Dr. Chabot wanted to review those records and diagnostic studies before he addressed causation.

On May 1, 2007, Dr. Chabot had reviewed the additional medical records. In the July 23, 2005 record from Dr. Murry there was no mention of neck complaints. The August 7, 2006 MRI study showed evidence of degenerative changes at C6-7 with mild to moderate left C7 nerve root foraminal stenosis and evidence of a left C5 foraminal disc

protrusion with soft tissue stenosis at the foramen on the left at C4-5. Dr. Chabot noted that the records shed little light on whether or not the employee's complaints were causally related to the work injury. Dr. Chabot noted it would be important to obtain the medical records from his primary care physician that predated the alleged date of injury by at least six months to gain insight into treatment and conditions prior to the injury. Dr. Chabot concluded the medical records failed to reveal the employee sustained a significant or substantial work injury on July 22, 2005 or August 5, 2005. The medical records do not clearly indicate that he sustained a work injury. He had evidence of advanced degenerative disease involving the cervical spine at multiple levels. It was Dr. Chabot's opinion that the majority of the employee's present complaints are associated with the advanced degenerative disease which, as best as he can determine, was not aggravated or exacerbated by his alleged injury. His present complaints appear to be the progression of the degenerative disease.

On November 30, 2007, Dr. Chabot noted that he reviewed additional medical records from the VA Hospital beginning in March of 2004 and continuing through April of 2005, and also subsequent to July 22, 2005. Dr. Chabot noted there was no documentation of an ER visit shortly after the employee's alleged injury. Dr. Chabot noted the records from Dr. Walls are difficult to interpret and it would be important to obtain a typed written interpretation of the August 18 and August 26, 2005 records. There is no clear documentation of a work injury on July 22, 2005 or a substantial July 22, 2005 injury in the medical records. There is no indication that he sustained an injury significant enough to warrant an immediate evaluation at an urgent care center or an ER. The employee was not evaluated by Dr. Walls until three and a half weeks after his alleged injury date. The record from Dr. Murry, a chiropractor who evaluated him on July 23, 2005 showed complaints of moderate pain between the shoulder blades, moderate low back pain, moderate low back muscles spasms and restricted motion of the lower back. There was not a mention of a specific work injury associated with the onset of his complaints. Dr. Chabot stated that the employee had extensive degenerative disease involving the cervical spine which was most likely the main reason for his neck complaints. It was Dr. Chabot's opinion that the employee did not need additional treatment with respect to an alleged work injury claim.

In his January 31, 2008, deposition, Dr. Chabot stated that the employee complained of back and neck pain involving the base of the neck worse on the right than the left and pain in the right posterior shoulder. He denied any pain radiating into the upper extremities and denied any neurologic deficits. The range of motion in both shoulders was reduced quite significantly. Dr. Chabot stated that based on the VA's records, the employee had a considerable history of shoulder problems including right upper extremity pain and x-rays of the right shoulder that showed degeneration; and a fall and injury to the left shoulder. Dr. Chabot stated that restricted range of motion in the shoulder often leads to scapular thoracic tissue inflammation by overusing the muscles between the shoulder blades. Dr. Chabot indicated the pre-existing shoulder problems could be responsible to some degree to the employee's complaints.

Dr. Chabot diagnosed neck pain and cervical spondylosis. Cervical spondylosis is a degenerative condition independent of traumatic causation except from a prior traumatic event such as a fractured neck. The general assumption is it progresses on its own and there is very little to prevent the progression. It was Dr. Chabot's opinion that the degenerative changes were present prior to July 22, 2005. An August 18, 2005 x-ray revealed degenerative arthritic changes of the cervical spine most pronounced at C6-7 level. It was his opinion that the employee's condition was not caused by the event of pulling a pin on a fifth wheel on July 22, 2005. There was insufficient documentation that the employee sustained a substantial work related injury on July 22, 2005 that could be related to the symptoms that he had in February of 2007.

The first medical treatment after July 22, 2005 was by Dr. Murry a chiropractor on July 23, 2005. That medical record does not give any history of the employee's complaints being work related; there is no mention of a work injury, and no documentation of any injury to the neck. Dr. Chabot stated that if the employee sustained a substantial or significant injury, it would be expected for the employee to have recounted that history to a treating physician the following day. Dr. Chabot stated that a person who injures the tissue to a specific region will usually complain of symptoms to that region. Dr. Murry reported that the employee complained of moderate pain between the shoulder blades which is in the mid thoracic region, just below the shoulders, in the mid-scapular area around T5 or T6. The employee also had complaints of low back pain. Dr. Chabot stated that it would be expected that his condition would have been similar to his complaints but there is no mention of any neck and upper extremity complaints in Dr. Murry's record. Dr. Chabot stated that if the employee's condition was significant, he questioned why the employee saw Dr.

Murry only one time and did not seek additional treatment from him. Dr. Chabot stated significant or substantial is something related to an event, injury or activity that resulted in acute onset of symptoms that usually required evaluation in a timely manner. Dr. Murry treated the employee for mid-scapular and low back pain and there was no mention of neck and upper extremity complaints. Dr. Walls treated the employee for neck and left arm pain which appeared to develop around August of 2005. It was Dr. Chabot's opinion that the medical records did not support that the employee sustained a significant or a substantial injury that was responsible for the employee's complaints.

Dr. Chabot indicated that there was a patient questionnaire completed on August 18, 2005 which he believed the employee probably completed himself. Regarding specific complaints there is nothing written. All that is circled is left neck or radiculopathy and no mention of a specific work injury. It indicates that his occupation is truck driver. Dr. Chabot stated that the first reference in the medical records that his condition was work related was on December 26, 2005 which said WC neck trouble and next to it he interpreted as a question mark, but there was no mention of a specific injury or type of injury.

It was Dr. Chabot's opinion that the employee did not have a symptomatic disc. In his review of the August 2006 MRI, there was no specific mention of a specific disc herniation. It suggested multi-level degeneration with evidence of a disc spur complex on the left at C4-5 but Dr. Chabot did not see the conclusion of a specific disc herniation. When asked if someone that pulled the pin of a fifth wheel could develop the condition that resulted and was shown in the MRI, Dr. Chabot stated that the MRI reveals multi-level degeneration that involved all levels and there was no specific mention of a focal acute injury or ligament injury that happened. In light of the employee's complaints at that time and the MRI report, Dr. Chabot did not think there was an acute injury.

Dr. Chabot recommended conservative measures be continued. It was Dr. Chabot's opinion that the employee did not require medical treatment due to any work related activity and the need for future medical treatment was from degeneration. Dr. Chabot did not think the employee's complaints were causally related to his work. Dr. Chabot stated the employee will most likely continue to have exacerbation of his degenerative neck condition in the future.

Dr. Chabot stated that the employee's condition is associated with chronic degenerative changes involving the cervical spine that predated any injury. There is insufficient documentation that he injured himself and developed neck and arm pain associated with that injury especially since the employee saw a physician the day after July 22 with no mention of a specific injury and no mention of neck or upper extremity complaints.

## **RULINGS OF LAW:**

### ***Issue 2. Medical Causation***

The employer stipulated that the employee sustained an accident arising out of and in the course of employment. The employer has denied that the employee's injuries and need for medical treatment were medically causally related to the July 22, 2005 accident.

The employee filed his original claim for compensation on June 27, 2006 and his amended claim for compensation on August 31, 2006. In the original claim the date of accident was listed as August 5, 2005. In the amended claim, the date of accident was listed as July 22, 2005. Both claims stated that "Claimant was pulling a pin to release a trailer when he felt onset of pain." Both claims listed the "Neck" as the part of body injured. The Division acknowledged the original claim on July 24, 2006, and the amended claim on October 17, 2006. The employer did not file answers to the claims. Under 8 C.S.R. 50-2.010(8)(B), if an answer is not filed within 30 days from the date of the acknowledgement of receipt of the claim by the Division the statement of fact in the claim shall be deemed admitted.

The Court of Appeals in Lammert v. Vess Beverages, Inc. 968 S.W.2d 721 (Mo. App. 1998) held that if the employer does not file an answer within the deadline, the factual statements are deemed admitted. The employee argued that the accident and the causal relationship were admitted by failure to file a timely answer. The Court held that the failure to file a timely answer cannot result in the admission of legal conclusions. In the claim, the employee stated that "Working as a soda truck driver for thirty three years and both knees sustained occupational disease from the repeated trauma of jumping off the trucks." The Court held that the admission goes only to the facts alleged and

that there was no admission that the employee had suffered arthritis as a result of jumping off the trucks, that arthritis was an occupational disease, that claimant suffered a “compensable” occupational disease or that the work was a substantial factor in causing the arthritis. The Court held that no facts were alleged and admitted which would support a conclusion that the employee suffered arthritis as a result of jumping off trucks or that his arthritis was a compensable occupational disease. The Commission was free to resolve the issue of whether arthritis was an occupational disease and whether it was compensable under the statutory definition of occupational disease.

In this case, I find that the admission is that the employee pulled a pin and felt pain in his neck. There was no admission that the employee sustained a compensable injury or that the employee’s neck condition, injury, and treatment were medically causally related to pulling the pin. The failure by the employer to file an answer did not constitute an admission as to the legal conclusion of medical causation or whether the employee sustained a compensable injury.

The employee has the burden of proving both that there was an accident and that there is a medical causal relationship between the accident, the injuries, and the medical treatment for which he is seeking compensation. See Dolan v. Bandera’s Café and Bar, 800 S.W.2d 163 (Mo. App. 1990). It has long been accepted that there is a distinction between an accident and an injury. The employee must prove that he had an injury and that the injury was caused by an accident which arose out of and in the course of his employment. Thus, the “accident” is the cause, and the “injury” is the result. See Errante v. Fisher Body Div., General Motors Corp., 374 S.W. 2d 521 (Mo. App. 1964). In Anderson v. Electric Storage Battery Company, 433 S.W.2d 73 (Mo. App. 1968), the Appellate Court upheld the denial of a claim where the employee slipped while lifting a battery but did not aggravate a pre-existing condition. There can be a showing that an incident occurred at work but there was no resulting injury.

In order to prove a medical causal relationship between the accident and the medical conditions, the employee in cases such as this one involving any significant medical complexity must offer competent medical testimony to satisfy his burden of proof. See Brundrige v. Boehringer Ingelheim, 812 S.W.2d 200 (Mo. App. 1991) and Downs v. A.C.F. Industries, Inc., 460 S.W.2d 293 (Mo. App. 1973).

Section 287.020.2 RSMo states that an accident is an unexpected or unforeseen identifiable event happening suddenly and violently and producing at the time objective symptoms of an injury. An injury is compensable if it is clearly work related and an injury is clearly work related if work was a substantial factor in the cause of the resulting medical condition or disability. An injury is not compensable merely because work was a triggering or precipitating factor.

Section 287.020.3 RSMo defines the term “injury” as an injury which has arisen out of and in the course of employment. The injury must be incidental to and not independent of the relation of employer and employee. An injury shall be deemed to arise out of and in the course of the employment only if: (a) It is reasonably apparent, upon consideration of all the circumstances, that the employment is a substantial factor in causing the injury; and (b) It can be seen to have followed as a natural incident of the work; and (c) It can be fairly traced to the employment as proximate cause; and (d) It does not come from a hazard or risk unrelated to the employment to which workers would have been equally exposed outside of and unrelated to the employment in normal non-employment life.

Given the applicable case law and the required statutory findings of accident and injury, there are numerous evidentiary problems which support a finding that the employee has failed to meet his burden of proof that he sustained a compensable injury and that the employee’s injuries and his medical treatment were medically causally related to the accident. The evidentiary problems are summarized as follows:

**The lack of a contemporaneous corroborating medical history to the initial medical provider that the employee was having neck problems that were related to a work incident does not support a causal relationship between the pulling of the pin and his neck condition.**

When discussing the employee’s March of 2005 shoulder incident, Dr. Simowitz stated if the employee injured his neck, he would have expected some complaints of an injury to the neck, and if the employee did not complain of neck problems, it is highly unlikely that that event would have caused an acceleration of his neck condition. Dr.

Chabot stated that if a person sustained a substantial or significant injury, it would be expected for them to have given a history of the injury to the treating physician the following day; and a person who injures a specific body part will usually complain of symptoms to that specific region. In the visit to Dr. Murry on July 23, 2005, the day after pulling the pin, there is nothing in the medical record regarding complaints to his neck or any work related incident. This makes it difficult to medically causally connect the pulling of the pin to the employee's neck condition.

**The employee's testimony has several inconsistencies when compared to the other evidence.**

The employee testified that the injury is and has always been to his neck. He stated he told Dr. Murry what was wrong and why he was there. Dr. Murry's records show that the employee reported pain between the shoulder blades and to his low back. Dr. Murry's record does not contain any reference to the neck.

The employee testified that he saw Dr. Murry on July 23, 2005 for his neck. The employee told Dr. Simowitz that he did not seek medical treatment for his neck for one month after July 22, 2005.

The employee testified that Dr. Murry did not physically examine or touch his low back and did not do any range of motion testing. The record from Dr. Murry showed that the employee had muscle spasms and reduced motion bilaterally in the low back and was administered manipulation to the low back.

The employee testified that Dr. Murry told him that he would have to see another doctor and did not tell him to contact his office as needed. The medical records of Dr. Murry show that the employee was to contact his office as needed.

These inconsistencies have an adverse affect on the employee's credibility.

**The employee's delay in seeking medical treatment for his neck does not support a causal relationship between the pulling of the 5th wheel pin and his neck condition.**

Dr. Chabot stated that if there is an event, activity or injury that resulted in an acute onset of symptoms there usually would be a timely medical evaluation. The employee did not seek medical treatment on his neck until August 18, 2005, which is 3 weeks and 6 days after July 22, 2005. This delay in treatment has a negative impact on the employee's claim that his neck condition is related to pulling the 5th wheel pin.

**The lack of contemporaneous corroborating medical history concerning an incident at work to the subsequent health care providers does not support a causal relationship between the pulling of the 5th wheel pin and the employee's neck problems.**

The employee started treating for his neck with Dr. Walls on August 18, 2005. The first mention to any health care provider that his neck problems might be related to work was in the December 26, 2005 visit with Dr. Walls. This is over 5 months after July 22, 2005. The next mention regarding that the neck problems are related to a work incident was the June 22, 2006 visit to the VA. It was a year after July 22, 2005 before there is a medical record that specifically connects the employee's neck complaints to the pulling of the 5th wheel pin. This was on July 26, 2006, when the employee saw Dr. Schultz. This makes it difficult to support a medical causal relationship between the pulling of the 5th wheel pin and the employee's neck problems.

**The fact that the employee did not miss any time from work until June 16, 2006, does not support a finding that the employee sustained an injury as a result of the pulling of the 5th wheel pin on July 22, 2005.**

The employee continuing to work for 47 weeks after the incident makes it difficult to find that the employee sustained an injury from the pulling of the 5th wheel pin on July 22, 2005.

**The fact that the employee did not have a herniated disc in August of 2005 and had a herniated disc in August of 2006 does not support a medical causal relationship between the pulling of the 5th wheel pin and the employee's neck condition.**

The August 22, 2005 MRI showed mild degenerative disc changes from C3-4 through C6-7 and that the degenerative disc changes were mainly at C6-7 but there was no disc herniation. There was foraminal stenosis at C6-7. The employee stopped working at Gilster-Mary Lee in August of 2005. The employee then worked at Hoosier Air until June 16, 2006. The employee went to the VA on June 22, 2006 with neck pain that had been progressively worsening with intermittent tingling in both hands. Dr. Schultz stated that the August of 2006 MRI scan showed a herniated disc at C4-5 on the left and foraminal stenosis secondary to degenerative disc disease and spurring at C6-7 on the left; and that the C4-5 disc was probably causing his problems. Dr. Simowitz noted that the August 22, 2005 MRI did not show a disc herniation and the August 7, 2006 MRI showed a disc herniation at C4-5. I find the fact that the herniated disc was not present in August of 2005, but was present in August of 2006 makes it difficult to medically causally connect the herniated disc with the pulling of pin on July 22, 2005 and supports a conclusion that the pulling of the pin did not have a significant impact on the employee's neck condition.

**There is insufficient medical evidence to support a finding that the employee's pulling of the 5th wheel pin was a substantial factor in either causing the employee's injuries or aggravating his pre-existing condition.**

It was Dr. Simowitz's opinion that the employee had pre-existing asymptomatic degenerative disc and joint disease and arthritis. It was Dr. Simowitz's opinion that on July 22, 2005 the employee sustained an accident and injury that caused those conditions to become symptomatic which resulted in an acceleration of the progression of the degenerative condition which sometime over the ensuing year led to a disc herniation. The accident caused a change in the dynamics of the arthritis and injured the disc which accelerated the arthritis and the failure of the disc which led to the disc herniation after the first MRI.

The opinion of Dr. Simowitz is substantially affected by the numerous evidentiary problems that are stated above. In addition, Dr. Simowitz's opinion is based on an inaccurate history. Dr. Simowitz testified that if someone had an incident but did not complain of neck symptoms to a physician, it was highly unlikely that the incident would have caused an acceleration of his neck condition. Dr. Simowitz was not aware that the employee was treated by Dr. Murry on July 23, 2005, had no neck complaints and did not state that he had a work incident the day before. The fact that Dr. Simowitz was not aware that the employee saw Dr. Murry on July 22, 2005 and had no neck complaints substantially affects his opinion.

It was Dr. Chabot's opinion that the employee did not have an acute injury and that his complaints were not causally related to his work. It was Dr. Chabot's opinion that the medical records did not support a finding that the employee sustained an injury that was responsible for the neck complaints and condition. It was Dr. Chabot's opinion that the employee's symptoms are the progression of the advanced degenerative disease which was not aggravated or exacerbated by a work injury. It was his opinion that the employee's condition was not caused by the pulling of the pin on July 22, 2005.

Based on a thorough review of all the evidence, I find that the opinion of Dr. Chabot is more credible than the opinion of Dr. Simowitz.

### **Conclusion:**

Under the detailed definitions of accident and injury as set forth in Section 287.020 RSMo., and the case law, the evidence does not support a finding that the employee sustained a compensable injury on July 22, 2005 or that the employee's medical conditions are medically causally related to the accident. I find that there is insufficient evidence to support a finding that the problems with the neck and the need for treatment to the neck are medically causally related to the pulling of the pin. I find that the employee's pulling of the pin was not a substantial factor in causing or aggravating the employee's neck condition; and did not cause or aggravate the employee's degenerative cervical disc disease. I further find that the employee has failed to prove that pulling the pin caused an injury that was clearly work related and was a substantial factor in the cause of the resulting medical conditions or disability. I find that the employee's medical conditions did not follow as a natural incident of and cannot be fairly traced to the pulling of the pin as the proximate cause. I further find that the employee's medical conditions and need for treatment were not medically causally related to the pulling of the pin on July 22, 2005.

Given the employee's failure to prove that he sustained a compensable injury and his failure to prove a medical causal connection between his neck condition and the July 22, 2005 accident, the employee's claim for compensation is denied. Although this case was heard as a temporary hearing, the award is final. Given the denial of the employee's claim on the issue of medical causation, the remaining issues are moot and will not be ruled upon. Based on the denial of the employee's claim against the employer, the employee's claim against the Second Injury Fund is also denied.

Date: \_\_\_\_\_

Made by:

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Lawrence C. Kasten  
*Administrative Law Judge*  
*Division of Workers' Compensation*

A true copy: Attest:

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Mr. Jeff Buker  
*Division Director*  
*Division of Workers' Compensation*