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

Injury No. 11-049336

Employee: Alfred Valdez

Employer: Gilster Mary Lee Corp.

Insurer: Self-Insured

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

**Preliminaries**
The parties asked the administrative law judge to determine the following issues: (1) accident; (2) medical causation; (3) past medical aid, including sub-issues of authorization, reasonableness, necessity, and causal relationship; (4) future medical aid; (5) temporary total disability from August 22, 2011, through August 30, 2011, and from December 23, 2011, through February 13, 2012; and (6) permanent partial disability.

The administrative law judge rendered the following determinations: (1) employee sustained an accident on June 21, 2011; (2) employee was not a credible witness on the issue of his herniated disc and the need for surgery; (3) the opinion of Dr. Chabot is more persuasive than the opinion of Dr. Poetz on the issue of medical causation; (4) employee's work was the prevailing factor in causing employee to suffer a strain/sprain injury, but employee did not meet his burden of proof that the work accident was the prevailing factor in causing employee's current medical condition which required surgery; (5) the medical care rendered after September 9, 2011, is not causally connected to the accident of June 21, 2011, and therefore employer is not obligated to pay any part of that past medical care; (6) employer is not obligated or responsible for the payment of future medical aid; (7) employer is not obligated to pay temporary total disability benefits; and (8) employee sustained a 7.5% permanent partial disability to the body as a whole referable to the low back sprain/strain from a work injury employee sustained on June 21, 2011.

Employee filed a timely application for review with the Commission alleging the administrative law judge erred with regard to the following issues: (1) medical causation; (2) previously incurred medical aid; (3) future medical aid; (4) temporary total disability; and (5) permanent partial disability.

For the reasons stated below, we modify the award of the administrative law judge as to the following issues: (1) medical causation; (2) past medical expenses; (3) future medical treatment; (4) temporary total disability; and (5) permanent partial disability.

**Discussion**

*Medical causation*

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

> An injury by accident is compensable only if the accident was the prevailing factor in causing both the resulting medical condition and disability. "The prevailing factor" is defined to be the primary factor, in relation to any other factor, causing both the resulting medical condition and disability.

In her award, the administrative law judge expressly credited the opinion from employer's expert, Dr. Michael Chabot, with respect to the issue of medical causation. Yet, implicit in the administrative law judge's award of permanent partial disability benefits is a rejection of the ultimate opinion from Dr. Chabot that employee suffered a mere lumbar strain that did not result in any permanent disability. We agree with the administrative law judge's (implied) finding that Dr. Chabot's ultimate opinion is not persuasive.

Much has been made of employee's statements in July 2011 to the treating physician Dr. Laurie Womack. Employer urges that because employee downplayed his low back symptoms to Dr. Womack, he is a "liar" who is not deserving of workers' compensation benefits. We are not persuaded. Employee's expert, Dr. Robert Poetz, persuasively testified that symptoms from a herniated disc vary widely and can wax and wane in severity. As of the July 1, 2011, visit with Dr. Womack, employee had been restricted from heavy lifting at work for over a week, and had been taking muscle relaxers to treat his pain complaints. Especially in this context, we cannot adopt employer's rather hyperbolic characterization of employee as someone "unwilling to speak the truth." Rather, as employee forthrightly admits, he minimized his symptoms when he saw Dr. Womack in July 2011 because he was eager to get back to work in order to provide for his family. We find that employee wanted to get back to work and simply overestimated his ability to return to his normal daily work duties of continually lifting 100 pound bags of sugar. In our view, the fact that employee was ultimately unable to do so without further medical treatment is persuasive evidence that employee suffered more than the mere lumbar strain identified by Dr. Chabot.

In any event, where the issue of medical causation turns on the question whether the accident caused employee to suffer complex internal pathology affecting the discs in his lumbar spine, we do not view employee's lay testimony as dispositive of the issue of medical causation. Rather, our analysis turns on weighing the persuasive value of the competing expert medical opinions. After careful consideration, we are more persuaded by the opinions from Dr. Poetz.

As noted by the administrative law judge, Dr. Poetz explained that employee's symptoms, which included the sudden onset of severe low back and radiating left leg pain, indicate that he suffered traumatic disc herniations in his lumbar spine, as opposed to herniations resulting from degenerative changes, which would not be consistent with the sudden onset of symptoms employee experienced. We find this testimony from Dr. Poetz persuasive. Notably, Dr. Chabot testified that "everything that's noted *other than the disk changes at*

*L5-S1* are chronic and degenerative." *Transcript*, page 996 (emphasis added). In light of this tacit concession from Dr. Chabot, it appears to us that the uncontradicted evidence in this case compels a finding that, at the very least, the accident of June 21, 2011, caused employee to suffer a herniated L5-S1 disc in his lumbar spine.

Employer argues that the MRI taken on October 24, 2011, shows an objective change in pathology contrasted with the earlier MRI of August 22, 2011, because one radiologist, Dr. John Markle, described "herniations" at L3-4 and L4-5 in October where another, Dr. Gaspar Fernandez, described "bulges" at the same levels in August. But employer did not solicit an opinion from Dr. Chabot or Dr. Womack in this regard, and does not direct us to any other expert medical testimony that would support a finding that the October MRI shows an objective change in pathology. Absent such evidence, we are not persuaded to make a finding that the October MRI reflects a clear change in pathology, as there are many possible reasons (e.g. differences in the quality of the study, differences in training, differences in terminology) why one radiologist might describe an MRI study differently from another.

Importantly, all three physicians deposed in this case, Drs. Womack, Chabot, and Poetz, agree there is no record that employee was having any symptoms in his back or left leg leading up to the accident of June 21, 2011. In our view, Dr. Poetz's opinions more persuasively track employee's history of immediate radicular symptoms following the accident, contrasted with Dr. Chabot's assumption that all of employee's current low back problems must be the product of preexisting conditions that were asymptomatic prior to June 2011. As noted above, where employee had the benefit of light duty and prescription muscle relaxers to manage his symptoms, and was minimizing the severity of his symptoms because of an understandable desire to get back to work, we do not read the July 2011 Dr. Womack treatment notes as persuasively establishing employee's work injury as resolved at that time. Nor do we find evidence of any intervening injury or other event to explain employee's need for additional treatment after he returned to lifting 100 pound bags for employer. Rather, it is quite clear to us that employee's symptoms referable to the work injury worsened in August 2011 because his low back injury was more serious than he thought, and would not permit him to return to such heavy duty work absent additional treatment.

Accordingly, we adopt Dr. Poetz's causation opinion and find that the accident of June 21, 2011, was the prevailing factor causing employee to suffer the resulting medical conditions of lumbar disc herniations at L3-4, L4-5, and L5-S1, exacerbation of employee's preexisting degenerative disc disease, and attendant disability. Dr. Poetz rated employee's permanent partial disability referable to the accident at 45% of the body as a whole. As noted above, Dr. Chabot did not provide a competing permanent partial disability rating. Employee credibly endorses complaints of continuing severe low back pain, for which he daily takes the prescription pain medications morphine, Tramadol, Hydrocodone, and the muscle relaxer Tizanidine. When he is not at work, employee spends his time lying down, and he needs his wife's help to get dressed. Although employee continues to work for employer, it is in a substantially accommodated fashion. In light of this evidence, we find that employee suffered a 40% permanent partial disability of the body as a whole as a result of the accident.

*Past medical expenses*

Section 287.140.1 RSMo controls as to the issue of past medical expenses, and provides, in relevant part, as follows:

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

We have credited Dr. Poetz's opinion with regard to the issue of medical causation. Because we are convinced that the accident caused employee to suffer the more serious lumbar spine pathology at issue, we are likewise persuaded by Dr. Poetz's opinion that the additional treatment employee received was reasonably required to cure and relieve the effects of his work injury. We so find.

The courts have consistently held that an award of past medical expenses is supported when the employee provides (1) the bills themselves; (2) the medical record reflecting the treatment giving rise to the bill; and (3) testimony identifying the bills. *Martin v. Mid-America Farm Lines, Inc.*, 769 S.W.2d 105, 111-12 (Mo. 1989). If employee does so, the burden shifts to employer to prove some reason the award of past medical expenses is inappropriate (such as employee's liability for them has been extinguished, the bills are not reasonable, etc.). *Farmer-Cummings v. Pers. Pool of Platte County*, 110 S.W.3d 818, 822-23 (Mo. 2003). Employee put his bills in evidence, the medical records showing the treatment giving rise to the bills, and identified the bills in his testimony. Employer, on the other hand, did not advance any evidence to suggest that employee's liability for the bills have been extinguished, or that the charges are not fair and reasonable. Nor does employer provide any argument or evidence to suggest that the identified amount in dispute of $701,892.59 was incorrectly totaled or otherwise unsupported by the bills or medical records themselves. In the absence of any contrary evidence, we are persuaded by and adopt Dr. Poetz's opinion that the charges reflected in the bills are fair and reasonable; we so find.

Although employer identified an "authorization" defense at trial, it is uncontested that employer formally rejected employee's request for additional medical treatment by letter dated September 30, 2011, and employee credibly testified (and we so find) that his supervisors refused his requests for additional treatment and employer thereby denied this claim on or about August 15, 2011. "If the employer is on notice that the employee needs treatment and fails or refuses to provide it, the employee may select his or her own medical provider and hold the employer liable for the costs thereof." *Reed v. Associated Elec. Coop., Inc.*, 302 S.W.3d 693, 700 (Mo. App. 2009). The rationale is that an employer "waives" its statutory right to direct care if it denies medical treatment for an injury that is later determined to have been compensable. *Shores v. General Motors Corp.*, 842 S.W.2d 929, 931 (Mo. App. 1992). We conclude that employer is liable for employee's past medical expenses in the amount of $701,892.59.

*Future medical treatment*

Section 287.140.1 RSMo provides for an award of future medical treatment where the employee can prove there is a reasonable probability of a need for future medical treatment that flows from the work injury. *Conrad v. Jack Cooper Transp. Co.*, 273 S.W.3d 49, 51-4 (Mo. App. 2008). Dr. Poetz opined that there is a reasonable probability employee will need to see an orthopedic surgeon to monitor the status of the lumbar fusion he underwent as a result of the work injury, and that employee should also receive continuing pain management care. Dr. Chabot agrees employee needs additional treatment, although as noted above, he believes all of employee's current problems are related to preexisting degeneration.

Consistent with our findings with respect to the issue of medical causation, we find most persuasive Dr. Poetz's testimony that employee's need for medical treatment is a product of the work injury. We are convinced (and we so find) there is reasonable probability that employee has a need for future medical treatment flowing from his work injury. We conclude that employer is obligated to provide that future medical treatment that may reasonably be required to cure and relieve the effects of employee's injury.

*Temporary total disability*

Section 287.170 RSMo provides for temporary total disability benefits to cover the employee's healing period following a compensable work injury. Employee claims two periods of temporary total disability: from August 22, 2011, through August 30, 2011, and from December 23, 2011, through February 13, 2012.

With regard to the first period, employee testified that he took some vacation time from work because he was having trouble getting into clinics, was having trouble getting excused for light duty, and was waiting for employer to send him a letter about getting additional treatment. However, employee did not testify specifically as to his physical condition or ability to perform his work duties during this time period, nor did he procure an opinion from Dr. Poetz with regard to his ability to work during this period. In his brief, employee fails to direct us to any medical treatment record that would suggest a doctor restricted employee from working from August 22, 2011, through August 30, 2011. Faced with this dearth of relevant evidence, we decline to make a finding that employee was temporarily and totally disabled from August 22, 2011, through August 30, 2011. Employee's claim for temporary total disability benefits for this time period is accordingly denied.

With regard to the second period, employee has provided records from the treating surgeon Dr. Fonn demonstrating that the doctor took employee off work in connection with his lumbar fusion surgery from December 23, 2011, through February 13, 2012. In light of this evidence, we are persuaded that employee was temporarily and totally disabled during the period from December 23, 2011, through February 13, 2012, which amounts to 7 and $^{4}/_{7}$ weeks.

Consequently, we conclude that employee is entitled to, and employer is obligated to pay, weekly payments of temporary total disability benefits for 7 and $^{4}/_{7}$ weeks at the stipulated temporary total disability benefit rate of $345.45 for a total amount of $2,615.55 in temporary total disability benefits.

*Permanent partial disability*

Section 287.190 RSMo provides for the payment of permanent partial disability benefits in connection with employee's compensable work injury. We have found persuasive Dr. Poetz's opinion that employee suffered a 40% permanent partial disability of the body as a whole referable to his low back work injury. We conclude that employer is liable for 160 weeks of permanent partial disability benefits at the stipulated weekly permanent partial disability benefit rate of $345.45 for a total of $55,272.00 in permanent partial disability benefits.

**Conclusion**

We modify the award of the administrative law judge as to the issues of: (1) medical causation; (2) past medical expenses; (3) future medical treatment; (4) temporary total disability; and (5) permanent partial disability.

Employer is liable for $701,892.59 in past medical expenses.

Employer is ordered to provide that future medical treatment that may reasonably be required to cure and relieve the effects of employee's injury.

Employer is liable for $2,615.55 in temporary total disability benefits.

Employer is liable for $55,272.00 in permanent partial disability benefits.

The award and decision of Administrative Law Judge Maureen Tilley, issued March 18, 2015, is attached hereto and incorporated herein to the extent not inconsistent with this decision and award.

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

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

Given at Jefferson City, State of Missouri, this 20th day of November 2015.

LABOR AND INDUSTRIAL RELATIONS COMMISSION

_____

John J. Larsen, Jr., Chairman

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James G. Avery, Jr., Member

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Curtis E. Chick, Jr., Member

Attest:

_____

Secretary

ISSUED BY DIVISION OF WORKERS' COMPENSATION

# FINAL AWARD

| | | |
|---|---|---|
| Employee: | Alfred Valdez | Injury No. 11-049336 |
| Dependents: | N/A | |
| Employer: | Gilster Mary Lee Corp. | |
| Additional Party: | N/A | |
| Insurer: | Gilster Mary Lee Corp c/o Parker Services, LLC | |
| Hearing Date: | December 17, 2014 | Checked by: MT/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? June 21, 2011.

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? 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 contracted: The employee worked as a mixer which required him to dump 50- and 100-

pound bags of sugar and flour into hoppers to be mixed into finished batches. On June 21, 2011, the employee was in the process of taking 100-pound bags of sugar from a pallet and dumping them into the hopper. As he was moving to reach for a bag of sugar toward the back of the pallet, his left foot got stuck between the leg of the elevator and the bottom of the pallet. When he reached and twisted to grab the bag of sugar, his pinned left foot kept his lower body from moving and only his upper body twisted and reached. He had immediate pain in his low back.

12. Did accident or occupational disease cause death? No.

13. Parts of body injured by accident or occupational disease: Body as a whole referable to the low back and left leg

14. Compensation paid to date for temporary total disability: $0

15. Value necessary medical aid paid to date by employer-insurer: $2,156.62.

16. Value necessary medical aid not furnished by employer-insurer: See findings.

17. Employee's average weekly wage: $518.14.

18. Weekly compensation rate: $345.45.

19. Method wages computation: By stipulation.

20. Amount of compensation payable: See findings.

21. Second Injury Fund liability: N/A

22. Future requirements awarded: See Award.

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

The Compensation awarded to the employee shall be subject to a lien in the amount of 25% of all payments hereunder in favor of the following attorney for necessary legal services rendered to the employee: Sarah Elfrink.

# STATEMENT OF THE FINDINGS OF FACT AND RULINGS OF LAW

On December 17, 2014, the employee, Alfred Valdez, appeared in person and with his attorney, Sarah Elfrink, for a hearing for a final award. The employer-insurer was represented at the hearing by their attorney, David Remley. At the time of the hearing, the parties agreed on certain undisputed facts and identified the issues that were in dispute. These stipulations and issues, together with a statement of the findings of fact and rulings of law, are set forth below as follows:

**STIPULATIONS:**

1. Gilster Mary Lee Corp. was operating under and subject to the provisions of the Missouri Workers' Compensation Act, and its liability was fully self-insured and administrated by Parker Services, LLC.
2. On June 21, 2011, Mr. Alfred Valdez was an employee of Gilster Mary Lee Corp. and was working under the Workers' Compensation Act.
3. The employer had notice of the employee's accident.
4. The employee's claim was filed within the time allowed by law.
5. The employee's average weekly wage was $518.14. The employee's PPD/ TTD rate is $345.45.
6. The employer-insurer paid $2,156.62 in medical aid.
7. The employer-insurer paid $0 in temporary disability benefits.

**ISSUES:**

1. Accident/Occupational Disease.
2. Medical causation.
3. Additional medical aid – past.
4. Additional medical aid – future.
5. Nature and extent of disability – past TTD.
6. Nature and extent of disability – PPD.

**EXHIBITS:**

The following exhibits were offered and admitted into evidence:

Employee's Exhibits:

1. Claim.
2. Report of Injury and Gilster Mary Lee Corp.'s Accident/Incident Report.
3. Perry County Memorial Hospital emergency department records from 6/22/2011.
4. Dr. Womack medical records from 6/24/2011 and 7/1/2011.
5. Perry County Memorial Hospital emergency department records from 8/15/2011.
6. Ste. Genevieve Hospital emergency department records from 8/19/2011.
7. Ste. Genevieve Hospital MRI report from 8/22/2011.
8. Dr. Antonio medical records from 8/24/2011 and 9/6/2011.

9. Ste. Genevieve Hospital emergency department records from 9/9/2011.
10. Perry County Memorial Hospital emergency department records from 9/13/2011.
11. Dr. Torrento medical records from 10/17/11 to 4/11/2012.
12. Perry County Memorial Hospital MRI report of 10/24/2011.
13. Dr. Fonn medical records from 11/9/2011 to 6/27/2012.
14. St. Francis Medical Center operative report and inpatient records from 12/27/2011 to 1/1/2012.
15. Perry County Memorial Hospital x-ray report of 4/11/2012.
16. Mid America Rehab physical therapy records from 5/8/2012 to 7/17/2012.
17. Advanced Pain Center medical records from 8/13/12 to 7/18/2014.
18. Medical bills totaling $701,892.59.
19. Denial letter.
20. Correspondence from The Webb Law Firm.
21. Deposition transcript of Alfred Valdez – 9/12/2011.
22. Deposition transcript and report of Dr. Robert Poetz – 5/6/2014.
23. Personnel file of Alfred Valdez.
24. Off work/light duty slips with summary calendars.

Employer/Insurer's Exhibits:

A. Deposition of Dr. Laurie Womack.
B. Dr. Laurie Womack office notes 6/24/11to 7/1/11.
C. Deposition of Dr. Michael Chabot .
D. Dr. Chabot IME report dated 9/9/2011.
E. Dr. Chabot CV.
F. Perry County Memorial Hospital ER record of 8/15/2011.
G. Perry County Memorial Hospital ER record of 9/13/2011.
H. Ste. Genevieve Hospital MRI report of 8/22/2011.
I. Ste. Genevieve Hospital ER record of 8/24/2011.
J. Dr. Torrento record of 10/17/2011.

Judicial Notice of the Contents of the Division's file was taken.

**STATEMENT OF THE FINDINGS OF FACT:**

The employee, Mr. Alfred Valdez, began working at Gilster Mary Lee Corp. in January of 2003 as a mixer. The employee was still working in this capacity when the injury occurred on June 21, 2011.

The employee testified that on June 21, 2011, he was in the process of taking 100-pound bags of sugar from a pallet and dumping them into the hopper. As he was moving to reach for a bag of sugar toward the back of the pallet, his left foot got stuck between the leg of the elevator and the bottom of the pallet. When he reached and twisted to grab the bag of sugar, his pinned left foot kept his lower body from moving and only his upper body twisted and reached. The employee testified that he had immediate pain.

The employee testified that he had to remain still for a few minutes due to his pain. He then went into the office and reported the injury to Mr. Don Weibrecht. The employee stated that they filled out an accident report together. The employee testified that he then went home because he was unable to continue working due to his pain level. The employee testified that he continued to have severe back and leg pain throughout the night. He stated that he was still hurting "really bad" in the morning so he went to the local emergency room after calling his employer.

The Perry County Memorial Hospital medical records indicate that Employee was seen at the emergency department on June 22, 2011, for back and left leg pain from a work injury. Specifically, the Nursing Documentation record states that the employee complained of low back pain, radiating down the left lower extremity, that his foot was caught between a pallet and an elevator yesterday, and that he twisted his lower back. The employee's pain was recorded as being 7/10 and it was recorded that he had radiation into the left leg. The Emergency Physician Record notes that the employee complained of back pain from twisting at work and that the pain in the low back radiated to the left leg. Dr. Paul Salmon diagnosed a back sprain/strain and prescribed Flexeril and Motrin. Dr. Salmon also completed and signed the employer's Medical Treatment Record indicating that his findings were consistent with the reported work injury, that the employee should have limited duty at work, and that he should follow up with a workers' compensation doctor in three days.

The medical records indicate that the employee was next seen by Dr. Laurie Womack at the Perryville Family Care Clinic on June 24, 2011. The record further indicates that the medications from the emergency department physician were helping, that his course had improved, that he was able to do his job during the day, but gets stiff at night, and that he had associated symptoms including pain to the left lower leg just above the ankle. In the HPI section of the record it is noted that the patient had no pain with bending, however in the Exams section on the following page, it is noted that the employee had pain with range of motion in the back. Dr. Womack's assessment was low back strain improved and left ankle pain. Dr. Womack did not change to the current medication regimen. She recommended that the employee avoid heavy lifting at work to prevent re-injury to the back as it continues to heal. A follow-up appointment was scheduled for one week later. This visit was authorized by the employer/insurer.

The employee testified that he did feel a little better during this time period due to the prescribed medications and the light duty work. The employee also testified that he was concerned about getting back to regular duty because light duty did not allow him to work overtime. He stated that his family was experiencing financial problems and he was the sole income provider.

The medical records indicate that the employee returned to see Dr. Womack on July 1, 2011. In the first paragraph of the HPI section of the record it is noted that the employee had improved; that this was an acute episode with no prior history of back pain; that the discomfort was most prominent in the lower, left lumbar spine; that it does not radiate; that the pain started on 6/22/11 at GML; that stiffness, radicular leg pain and numbness and weakness were denied; that the course has been improved; and that he was not requiring any pain medications. The second paragraph of the HPI section notes that some pain relief is observed with 50-pound weight restriction at work, and that there was no more pain. The exam section also noted no pain with

palpation. The assessment was low back strain resolved, left ankle pain resolved and the employee was released to full duties to follow up on a p.r.n. basis. This visit was authorized by the employer-insurer.

The employee testified that although he did have some continuing pain at his July 1, 2011 follow-up appointment, he told Dr. Womack he was doing okay. The employee testified that he thought his back strain would continue to get better and he needed the overtime hours. He had been restricted from working on light duty to address his family's financial issues.

The employee testified that he returned to his regular job as a mixer, but that instead of his pain continuing to improve, his pain worsened. He testified that despite taking ibuprofen, he was still experiencing sharp pains in his back that ran down his left leg. The employee further testified that he began to have difficulty putting pressure on his left leg and foot which caused him to walk with a limp. He testified that he spoke to his lead man, Mr. Clovis Tucker, and reported that his pain was getting "worse and worse" and that he was "probably going to have to go to the doctor." The employee further testified that he took one or two "P" days due to his worsening pain and difficulty working. The personnel records verify that the employee took a personal day on August 1, 2011.

The employee testified that on August 15, 2011, he could no longer tolerate his pain and he knew that he needed additional medical treatment. Specifically, the employee testified that he went to Mr. Clovis Tucker and told him that his pain was getting really bad and that he needed to go to the doctor. The employee testified that Mr. Tucker referred him to his supervisor Mr. Don Weibrecht. The employee testified that Mr. Weibrecht was working on the paperwork and called Mr. Ricky Moll, the safety coordinator for assistance. The employee testified that after waiting and waiting for Mr. Moll to return Mr. Weibrecht's call, he finally told Mr. Weibrecht that he needed to go downstairs and sit down because he was in pain. The employee further testified that Mr. Moll came and asked him to try to do some sedentary duty reworking potatoes while they waited for an answer about medical treatment. The employee further testified that at approximately 2:00 p.m. Mr. Moll told him that "workman's comp" had said no to treatment. The employee further testified that he was hurting "really bad" and was upset that no treatment would be provided so he went into Mr. Alan Byrd's office to complain. He testified that he told Mr. Byrd that his back and leg were hurting and that he had to get some treatment. He testified that Mr. Byrd told him to go to the doctor on his own and that they would see about getting him some kind of treatment at a later date. The employee further testified that he was not able to return to his work duties that day, and that he went home to wait for his wife to accompany him to the emergency room and to look for an attorney.

The medical records indicate that the employee went to the Perry County Memorial Hospital emergency department at 4:40 p.m. on August 15, 2011. The Nursing Documentation record notes that the employee reported a June 2011 injury from lifting an object at work and twisting when felt a "pop". That record further notes that the employee reported burning pain from the lower back radiating down to the left foot and that his pain was 10/10. The pain diagram completed by the nurse on page 4 of the record indicates pain in the low back and pain from the left lower buttock down to the left ankle area. The Emergency Physician Record notes a chief

complaint of "hurt back at work in late June". That record further notes the employee's report of pain that "radiates down his left leg" and that he "has not had any imaging studies since his injury." Dr. Paul Salmon's discharge instructions indicate that the employee was referred to Kevin Vaught, MD for lumbar radiculopathy and prescribed Tylenol #3, Flexeril and a Medrol Dosepak.

The employee testified that his daughter-in-law also worked at Gilster Mary Lee. He stated that she turned in the work excuse from the hospital for August 15th and August 16th for him. The employee further testified that he was not able to get an appointment with Dr. Vaught because his injury was a "comp case".

The records indicate that the employee next reported to the Ste. Genevieve County Memorial Hospital emergency department on August 19, 2011. The emergency department records show that the employee was administered 60mgs of Orphenadrine Citrate and 60mgs of Ketorolac Tromethamine. Page 2 of the record notes the employee's pain as "burning" in the back and left leg and an 8 out of 10; the onset is documented as 6/22/11. The nurse's note on page 5 indicates that the employee was improved "a little" and that he was agreeable to discharge with prescriptions and an MRI scheduled. The Emergency Department Physician Note that begins on page 7 of the record states as follows:

> PT PRESENTS WITH C/O LOW BACK PAIN WITH RADIATION DOWN LEFT LEG THAT BEGAN IN JUNE AFTER INCIDENT AT WORK; PT SUBMITTED WORK COMP PAPERWORK BUT STATES HIS JOB IS REFUSING TO PAY; HAS HIRED A LAWYER WHO IS TRYING TO GET PT'S MEDICAL EXPENSES COVERED BY WORK COMP AND IS TRYING TO GET HIM APPT WITH NEUROSURGEON; PT CONTINUES TO WORK BUT HAS CONSTANT BACK PAIN; PT STATES LAWYER TOLD HIM TO GO TO E.R. TO BE EVALUATED; HAS BEEN SEEN IN PERRYVILLE AND HAD XRAYS DONE; HAS BEEN ON TYLENOL #3, FLEXERIL AND MEDROL DOSE PACK; HAS 2 DAYS LEFT OF DOSE PACK; REPORTS T3'S DON'T WORK AND IS OUT OF FLEXERIL; STILL C/O RADIATION INTO LEFT BUTTOCK AND PAIN DOWN LEFT LEG TO FOOT; STATES LEFT GREAT TOE DRAWS UP AT TIMES AND HAS "BURNING PAIN" INTO FOOT; NO LOSS OF BOWEL OR BLADDER CONTROL.

The exam portion of the record notes tenderness to palpation at the lumbar spine, the left lumbar paraspinals, and the left sciatica; the straight leg raise was positive at 45 degrees on the left and caused pain down the leg. The emergency room physician wrote a referral to Dr. Antonio and instructed the employee to take his medications, rest, avoid heavy lifting, and follow up with Dr. Antonio after the MRI was completed. The employee was given prescriptions for Vicoprofen and Flexeril and taken off work until 8/22/11.

The employee testified that he called his employer and requested to take a week of vacation because he was in pain and knew he could not work. The personnel records indicate that the employee did take vacation from August 22 to August 27, 2011, and that he also took two personal days following that vacation on August 29 and August 30, 2011.

The MRI report of August 22, 2011, finds "degenerative changes seen at the disk. There is some diffuse disk bulging noted with, what appears to be, a broad based left paracentral protrusion seen on axial image #23 of 25. This deforms the ventral aspect of thecal sac and approaches the nerve roots as they course posteriorly in the thecal sac on the left…" at the L5-S1 level.

The records indicate that the employee next reported to Dr. Nirmal Antonio on August 24, 2011. The record indicates that the employee had injured his back at work two months ago. The record also indicates that the employee actually got better but the employee got worse the last two weeks. The employee reported the twisting injury at work and that he had initially improved. The employee reported shooting pains down his back, tingling and numbness, that he was not able to put weight on his left side, and that he had not been able to work on his feet because of the pain. Dr. Antonio's examination of the back notes paraspinal spasm present in the lumbar region and significant pain in the lateral lumbar region also on the left side. The ankle reflex was absent and sensation was diminished over the dorsum of the foot and also some areas of the plantar foot region. There was painful restriction of the dorsiflexion of the foot noted as well. Dr. Antonio diagnosed severe low back pain with sciatica. He changed the employee's medications to Percocet, Soma and Naproxen. He referred the employee to a back surgeon and gave him a light duty excuse for work through 9/2/2011. The records indicate that the light duty excuse was later extended through 9/9/2011 when the employee was provided an IME by the employer-insurer.

On September 9, 2011, at the direction of the employer-insurer, the employee reported to the office of Dr. Michael Chabot at Orthopedic Specialists in St. Louis. Dr. Chabot's report indicates that the employee told him about the twisting injury at work and the above course of unauthorized medical treatment. The report further notes that the employee complained to Dr. Chabot of lower back pain that was severe and that radiated from his left hip and buttock region down into the left foot, numbness in the left foot, and nocturnal tightening and shooting-type pains down the left leg. Dr. Chabot's examination section notes that the employee moved cautiously in a forward flexed position, that his gait favored the left leg, that there was "tension" in the lumbar paraspinal musculature, that the lumbar range of motion was reduced, that his wife removed his shoes and socks, and that the employee complained of a "diffuse tenderness to palpation". Dr. Chabot's impressions were listed as 1) back pain, 2) sciatica, 3) congenital spinal stenosis L2-3, L3-4, L4-5, and 4) HNP L5-S1 to the left. In the discussion section of his report, Dr. Chabot opines that the patient's present complaints are not causally related to his alleged work injury. He further states that the employee "may have symptoms associated with a combination of a disc protrusion at L5-S1 and congenital stenosis at L2-3, L3-4, and L4-5." Dr. Chabot opines that the prevailing factor in the employee's present complaints is "advanced degeneration involving the lumbar spine at multiple levels with congenital spinal stenosis, disc degeneration, and a disc protrusion to the left at L5-S1." Finally, Dr. Chabot opined that the

employee was at MMI and could return to regular work duties as related to his June 21, 2011 injury.

The employee testified that he was in so much pain after the Dr. Chabot appointment and the drive to and from St. Louis, that he and his wife stopped in Ste. Genevieve. The employee testified that he was seen at the Ste. Genevieve emergency department and the records indicate that he was examined by Dr. Bruce Harrison. The emergency room records indicate that the employee complained of chronic low back pain, two months in duration, from a work injury. The emergency room physician's exam revealed a decreased range of motion and muscle spasm in the back. The nurse also noted that when she entered the room she found the employee lying on the stretcher with his legs on the floor and his wife at the bedside.

The employee also testified and the records support the fact that the employee had contacted Dr. Antonio on September 9, 2011, after the Dr. Chabot appointment but was not able to get treatment.

On September 13, 2011, the employee reported to the Perry County Memorial Hospital emergency department. The Nursing Documentation indicates he reported the work injury and was requesting pain medications and light duty. The Emergency Physician Record notes a history of an injury and chronic back pain, three months in duration; prior workers' compensation injuries with an ongoing case, and that the employee was actively working on medications. The record further indicates that the employee's associated symptoms included difficulty walking and pain worsened by movement and relieved by nothing. The record further notes that the employee had tried to work today but his pain increased and he couldn't continue. The physical exam section notes decreased range of motion and muscle spasm. The doctor prescribed Robaxin, Tylenol #3, and Feldene and referred the employee to the "work comp" doctor. The employee was given a work release form for that day.

The record indicates that on September 22, 2011, the employee's attorney requested a denial letter so that Employee could attempt to seek treatment through his health insurance. The record further indicates that the employee's attorney received a denial letter from the employer-insurer on October 5, 2011, dated September 30, 2011, and stating that the insurer was respectfully denying the claim.

The record indicates that the employee visited Dr. Marlon Torrento on October 17, 2011, to establish primary care for complaints of severe low back pain with radiation to the left leg. As to his history, Mr. Valadez told Dr. Torrento that "he was seen by Dr. Womack for follow-up and apparently he was noted to have improvements in his symptoms. According to the patient, at that time, he did feel "all right" and he just wanted to go back to work soon, which was his sole source of income. However, as days went on, his low back pain worsened with radiation to the L leg." The exam section notes that the employee appears to be in severe pain, he was limping toward the left, he had decreased range of motion, pain with the left straight leg raising test, and tenderness. Dr. Torrento's assessment was severe low back pain and an MRI with contrast was recommended along with Percocet, Flexeril and lifting restrictions at work.

The employee provided the employer with work restriction documentation from Dr. Torrento on October 17, 2011, October 24, 2011, October 31, 2011 and November 15, 2011. Lifting restrictions were recommended through December 31, 2011.

The October 24, 2011 MRI report from Perry County Memorial Hospital interpreted by Dr. John Merkle concluded congenital spinal stenosis at L2-3, a 2 mm left paracentral and left lateralizing herniation at L3-4, a 2 mm right lateralizing herniation at L4-5 and a 5 mm posterocentral subligamentous herniation with slight asymmetry to the left at L5-S1.

The employee followed up with Dr. Torrento on October 31, 2011. The exam section of the record notes that the employee had decreased motors on the left lower extremity and decreased plantar flexion and dorsiflexion on the left foot. Dr. Torrento assessed lumbar disc herniation and indicated that he would have the employee seen by Dr. Fonn earlier than planned.

The record indicates that the employee was first examined by Neurosurgeon Sonjay Fonn on November 9, 2011. The history section consistently discusses the June 2011 work injury and the employee's multiple symptoms. Dr. Fonn's neurological examination found weakness of the left extensor hallucis longus and the left plantar flexion, decreased sensation in the L5 and S1 distribution on the left and loss of the left Achilles reflex. Dr. Fonn reviewed the 10/24/2011 MRI report and recorded that he agreed with the conclusions. He assessed lumbar radiculopathy and recommended a course of epidural injections at L5-S1. He further opined that the employee would need surgical correction, probably at the L5-S1 level, pending results of the CT myelogram and discogram.

The records indicate that the employee underwent lumbar epidural steroid injections at L5-S1 on November 9, 2011, November 16, 2011 and December 1, 2011. The December 7, 2011 note indicates that the employee had poor relief of his symptomatology and would like to proceed with surgical intervention. Additional pre-op testing and orthotic fitting took place on December 22, 2011, and a three-level posterior lumbar interbody fusion and stabilization was scheduled for December 27, 2011.

The employee's personnel file indicates that the employee provided documentation from Dr. Fonn indicating that he would be continuously disabled beginning on December 22, 2011, until an undetermined date.

The St. Francis Medical Center records indicate that the employee was admitted on December 27, 2011, and underwent a L3-4, L4-5, and L5-S1 bilateral laminotomy, decompression, partial facetectomy, foraminotomy, excision of herniated intervertebral disc, arthrodesis, autograft of bone, application of intervertebral biomechanical device with interbody spacers and posterior fixation. The records further indicate that on December 28, 2011, Dr. Fonn requested a consult by Dr. Matthew Shepard due to the employee having fever. Dr. Shepard's examination concluded that the employee's fever was likely from cellulitis and possible MRSA from a lesion on his chin after lying face down for surgery. He also concluded that the nausea and vomiting were probably due to postop ileus. Additional scans revealed both postoperative ileus and atelectasis versus pneumonia in the right lung. The records indicate that the employee

temporarily required a feeding tube due to the ileus. The discharge summary dated January 1, 2012, indicates that the employee recovered from these complications and that his old previous leg pain had completely resolved. He was discharged on Percocet, Keflex, Levofloxacin, Bactroban cream and Diazepam.

The records indicate that the employee next saw Dr. Fonn on January 6, 2012, when his sutures were removed and again on January 10, 2012, when the wound was inspected. The January 25, 2012 record indicates that the employee was progressing very well and was advanced to driving and a 20-pound weight limit with no excessive bending or stooping.

The employee's personnel file indicates that Dr. Fonn kept him off work until February 12, 2012, and that he was allowed to return to work on February 13, 2013, with specific restrictions including no heavy lifting, sitting with minimal walking, no bending, stooping or twisting, no over the shoulder work, and light duty defined as 4-6 hours per day 2-3 days per week. The 2012 calendar indicates that the employee took a personal day on February 13, 2012, and began restricted duty on Tuesday, February 14, 2012.

The employee testified that his return to light duty on February 14th was not limited to 4-6 hours per day and 2-3 days per week and that he was required to work 5 days a week but was restricted to 8 hours per day.

A March 12, 2012 note indicates that Dr. Fonn approved the employee to go up to 7.5mg of Norco. The records indicate that the employee was next examined by Dr. Fonn on April 25, 2012. That record notes physical therapy was recommended and the employee would be kept on light duty for two months. The radiographs revealed good bony fusion occurring and no migration. The records further indicate that Dr. Fonn's final examination took place on June 27, 2012. That record notes that the employee had met all surgical goals and had increased mobility significantly with a substantial reduction in pre-operative symptoms. The employee's medications were refilled and he was released to return only as needed.

The 2012 calendar in the employee's personnel file verifies that the employee's restricted duty ended on June 26, 2012.

The employee testified that although his left leg symptoms were vastly improved by the surgery and he was able to put pressure on the leg and walk normally, he continued to have pain in his back and limitations from that pain. He further testified that he called Dr. Fonn's office after his release and asked for help with this pain. The employee testified that he was referred to the Advanced Pain Center.

The initial Advanced Pain Center record dated August 13, 2012, indicates that the employee was referred by Dr. Fonn for chronic low back pain; the pain was scored as a 10. The history discusses the work injury in June of 2011 and the course of treatment including surgery. Specifically, the record notes that the employee's left leg pain improved totally but his low back pain worsened. The employee was given a urine drug screen and then started on the following pain medications: Flexeril 10mg, 3 times a day; Gabapentin 300mg, 3 times a day;

Hydrocodone-Acetaminophen 5-325 mg, 4 times a day; and a Lidoderm patch. At the next appointment on August 27, 2012, the strength of both the Hydrocodone-Acetaminophen and the Gabapentin dosages were increased. At the January 14, 2013 appointment the Hydrocodone-Acetaminophen dosage was again increased. At the August 26, 2013 appointment, the employee reported worse pain with lifting required at his job and that he has had to take more pain medications as a result. Due to these complaints, Opana 10mg (oxymorphone hydrochloride) was added to the employee's medications. The September 23, 2013 record indicates that the Opana was changed to MS Contin 15mg (morphine). The March 31, 2014 record indicates that the employee underwent left medial branch blocks x4 with no extended relief and that after consultation with Dr. Romero the patient would be scheduled for radiofrequency ablation (RFA). A later note, however, indicates that the RFA was put on hold due to a high co-pay required by the employee.

The last record in evidence from the Advanced Pain Center is dated July 18, 2014, and indicates that the employee's complaints are of constant achiness and throbbing in the low back and into the left leg. The pain is rated as a 7/10 and the employee's medications were as follows:

- Zanaflex 4 mg, 3 times a day.
- MS Contin 15mg, 3 times a day.
- Tramadol HCI 50mg, 2 tablets every 6 hours.
- Gabapentin 400 mg, 3 times a day.
- Hydrocodone-Acetaminophen 10-325 mg, 4 times a day.

At the hearing the employee testified that he continues to take these medications and that he continues to see Dr. Romero at the Advanced Pain Center every month. In addition, he testified that he would like the new procedure recommended by Dr. Romero to be approved by work comp as he believes it may help and he cannot afford to get it through his health insurance. The employee further testified that his unauthorized medical treatment including his appointments and procedures at the Advanced Pain Clinic through July of 2014 totaled $701,892.59.

The employee further testified that he continues to have severe low back pain. He testified that his pain affects his ability to bathe and sleep and to be intimate with his wife. He testified that his pain affects his ability to get dressed and that on most days his wife must assist him with his socks and shoes; he has even switched to a slip-on loafer type of shoe. He testified that when he is not working he is in his room lying down due to pain. He testified that he believes he will be able to continue working as a mixer at Gilster Mary Lee because his supervisor allowed him to move to the third floor. He testified that on the third floor he is only required to mix 1-2 batches per shift as opposed to the 7-8 batches required on the fourth floor. In addition, he testified that he has access to a large floor jack on the third floor which he uses to raise the ingredient bags to the same level as the hopper, resulting in much less lifting than his previous job on the fourth floor.

The employee further testified that he was not able to work during the 9-day period from August 22, 2011 to August 30, 2011, and the 53-day period after his surgery from December 23, 2011 to February 13, 2012. The employee further testified that he would like his medical treatment after

July of 2014 and on into the future with Dr. Romero at the Advanced Pain Center to be covered by work comp.

The records indicate that the employee was examined by Dr. Robert Poetz, a board certified family practice physician, on February 5, 2013, for the purpose of an IME on behalf of the employee. On examination, Dr. Poetz's report notes a reduced range of motion of the lumbar spine in all planes, a positive straight leg raising test, and a 15 cm vertical lumbar scar. Dr. Poetz diagnosed pre-existing lumbar degenerative disc disease, L3-4, L4-5 and L5-S1 disc herniations with exacerbation of degenerative disc disease, and status post L3-4, L4-5, and L5-S1 laminectomies, decompression, partial facetectomy, foraminotomy, arthrodesis, placement of spacers, posterior fixation, and bone graft harvest and bone grafting. Dr. Poetz recommended that the employee avoid heavy lifting, prolonged sitting, standing, walking, stooping, bending, squatting, twisting, or climbing. Dr. Poetz opined that due to his fusion, the employee is at a higher risk for further disc pathology and should follow up with an orthopedic surgeon to monitor the status of the hardware. Dr. Poetz further opined that the employee should remain under the care of pain management, that he may benefit from a series of epidural steroid injections and that if he has no response, he should undergo a myelogram and CT followed by additional surgery if indicated. Dr. Poetz further opined that the diagnostic testing, surgery, and medical care the employee had was medically necessary and that the medical charges were reasonable and customary. Dr. Poetz opined that the injury which occurred on June 21, 2011, was the substantial and prevailing factor to the disability to the employee's lumbar spine. Dr. Poetz further opined that the employee suffered a 45% PPD to the body as a whole measured at the lumbar spine directly resultant from the June 21, 2011 work-related injury.

In addition, Dr. Poetz described the employee's surgery which included laminectomies, a facetectomy, a foraminotomy, and a fusion. Dr. Poetz testified about the employee's significant complications during his inpatient stay following surgery. Specifically, Dr. Poetz explained that the employee's atelectasis vs. pneumonia was caused by inflammation secondary to surgery and inhalation; the employee's bowel was paralyzed due to surgery and postoperative complications; and the employee's cellulitis caused redness, swelling, drainage, and several types of IV antibiotics. Dr. Poetz testified that the employee would have been unable to work for approximately seven weeks after his surgery. Dr. Poetz testified that the cost of the employee's medical care totaling approximately $688,000.00 was reasonable and necessary to cure and relieve the effects of his June 21, 2011 work injury. Dr. Poetz also testified that there is a reasonable probability that the employee will need future medical care including continued pain management and monitoring of the spinal hardware.

Dr. Poetz testified that the employee did have some degenerative disc disease and that herniated discs are sometimes a natural consequence of degenerative disc disease but that that is not what happened in this case. Specifically, Dr. Poetz explained that herniated discs that occur from degeneration are a slow-moving progression and not a sudden onset of acute pain with radicular symptoms different from the day before and associated with an activity that caused it. Finally, Dr. Poetz testified that symptoms from congenital short pedicles or congenital spinal stenosis is always bilateral and would be long term and chronic, starting gradually and progressively over time, and not abruptly or acutely.

Dr. Laurie Womack's deposition testimony was taken on August 15, 2013. Dr. Womack testified consistent with her medical records of June 24, 2011 and July 1, 2011. Specifically, Dr. Womack testified that her nurse took the employee's history, that the employee reported to her that the medications he received from the emergency room physician were helping him, that the employee had slight pain with range of motion in his back on June 24, 2011, and that she recommended continued medications and avoidance of heavy lifting to prevent re-injury. With regard to her July 1, 2011 record and examination of the employee, Dr. Womack testified that the employee "stated he had pain in the left -- lower left lumbar spine, but it did not radiate at that time." Dr. Womack testified the employee "continued to not have pain with palpation over the lower back or left leg" Dr. Womack further testified that based on the history she had documented, it was her understanding that the employee did not have complaints of radiating pain at anyone else's evaluation.

Dr. Michael Chabot's deposition testimony was taken on October 25, 2013. Dr. Chabot testified consistent with his medical report of September 9, 2011. Specifically, Dr. Chabot testified that the employee's primary complaints to him included lower lumbar back pain rated as 10/10, pain that radiated from the left hip and buttock region down to the left leg and left foot, numbness involving the left foot, and nocturnal lightning/shooting type radiating pain down the left leg. Dr. Chabot also testified that the employee reported his work injury as a twisting injury when his foot got caught and that his back "popped". Dr. Chabot further testified that his opinion that the employee had sustained a back strain and left ankle sprain from the June 21, 2011 episode, was based on the medical records and the employee's history that he continued to work following his injury. Dr. Chabot testified that the employee's diagnoses at the time he evaluated him in September of 2011 included "back pain, sciatica, congenital spinal stenosis, L2-3, L3-4, L4-5, and herniated disk, L5-S1 on the left." Dr. Chabot further testified that the conditions he observed in the MRI study dated August 22, 2011, where "primarily degenerative." Dr. Chabot stated that he assumed that the disk protrusion on the left side was degenerative. He stated that there was not a "prior study" to compare the MRI to. He also stated that "I can assume it's chronic and degenerative, but—and also in light of the fact that his physical examination does not reveal evidence of a truly active L5 or S1 radiculopathy, but without the prior MRI study issues on that disk are less clearly defined."

Finally, Dr. Chabot testified that, so far as he could tell, when Dr. Womack returned Employee to work full duty after her visit with him on July 1, 2011, Employee's low back strain or sprain was essentially resolved and he had returned to his normal state of pre-accident health. This opinion was based upon the medical history obtained by Dr. Womack as well as from Employee regarding his existing complaints and physical limitations as of the date of Dr. Womack's evaluation on July 1.

**RULINGS OF LAW**:

***Issue 1. Accident.***

In this instance the evidence is clear and virtually undisputed that Employee did, in fact, sustain an accident in the plant on June 21, 2011. His live testimony and the medical histories he

provided to virtually all of his healthcare providers clearly establishes that on June 21, 2011, while lifting and twisting holding a 100-pound bag of sugar, his left foot became wedged between a pallet and an elevator resulting in an injury to his left leg and low back. Therefore, based on all of the evidence presented, I find that the employee sustained an accident arising out of and in the course of his employment with Gilster Mary Lee Corporation.

***Issue 2. Medical causation.***

Dr. Poetz diagnosed pre-existing lumbar degenerative disc disease, L3-4, L4-5 and L5-S1 disc herniations with exacerbation of degenerative disc disease, and status post L3-4, L4-5, and L5-S1 laminectomies, decompression, partial facetectomy, foraminotomy, arthrodesis, placement of spacers, posterior fixation, and bone graft harvest and bone grafting. Dr. Poetz opined that the injury which occurred on June 21, 2011, was the substantial and prevailing factor to the disability to the employee's lumbar spine.

Dr. Chabot opined that the employee had sustained a back strain and left ankle sprain from the June 21, 2011 episode based on the medical records and the employee's history that he continued to work following his injury. Dr. Chabot opined that the employee's present complaints are not causally related to his alleged work injury.

Dr. Womack testified that she first examined and evaluated the employee on June 24, 2011. She indicated that at that time Employee was complaining of low back pain radiating into the left leg, perhaps as far down as his knee. She made the diagnosis of a lumbar strain/sprain and placed Employee on light duty. She also told him to continue to use the medication prescriptions he had received from the emergency room on June 21. These prescriptions were for Flexeril and 600 mg Motrin tablets.

Dr. Womack also noted that even though she placed him on light duty, he had told her that he had been able to do his regular duties and that he had no pain with bending and no limping. His only significant complaint was that he got stiff at night. She also indicated that by way of history he told her that his medications were helping and that his overall condition from his evaluation at the emergency room was better.

Dr. Womack also testified that when Employee returned to her for a second office visit on July 1, 2011, he was improved. She indicated that the radiation of the pain into the left leg had stopped. By that time, he was also denying all stiffness, any radicular leg pain and numbness or weakness in the legs. She recalled specifically asking him whether he was in pain and he denied it.
As to his examination results, she recorded that Employee's gait was normal and that he had a full and normal range of motion in all muscle groups, including his back. He had no pain whatsoever with palpation over the lower back or left leg.

Based upon Employee's report to her about his condition, she released Employee to return to work at full duty.

On August 24, 2011, the employee had an appointment with Dr. Antonia. In his history and physical, he told the intake person that he had had "minor pain since an incident at work on 6/21/11, but pain has become more severe past week or two." The medical records note that "two months ago he had an injury at his work where his back was twisted and he had pain which actually got better but now for the past two weeks it is a lot worse."

Employee was examined by Dr. Marlon Torrento in Ste. Genevieve on October 17, 2011. As to his history, Mr. Valadez told Dr. Torrento that "he was seen by Dr. Womack for follow-up and apparently he was noted to have improvements in his symptoms. According to the patient, at that time, he did feel "all right" and he just wanted to go back to work soon, which was his sole source of income. However, as days went on, his low back pain worsened with radiation to the L leg."

During his testimony, the employee claimed that he had lied to Dr. Womack because he was afraid that if he remained on light duty he would not get overtime pay for additional hours that he needed.

Based on all of the evidence presented, I find that the employee was not a credible witness on the issue of his herniated disc and the need for surgery because of the employee's inconsistent statements contained within the medical records.

Based on all of the evidence presented, including the medical records and the employee's testimony, I find that the opinion of Dr. Chabot is more persuasive than the opinion of Dr. Poetz on the issue of medical causation. I find that Employee's work was the prevailing factor in causing Employee's sprain/strain injury. I also find that Employee's sprain/strain was medically causally related to the accident that occurred on June 21, 2011. However, I find that the employee did not meet his burden of proof that the work accident was the prevailing factor in causing Employee's current medical condition which required surgery. I also find that the employee did not meet his burden of proof that his medical condition that required surgery was medically causally related to his accident that occurred on June 21, 2011.

***Issue 3. Claim for previously incurred medical aid.***

There was evidence introduced at the hearing indicating that the total cost of the medical care rendered by Dr. Fonn at St. Francis Medical Center, together with pain management and physical rehabilitation afterwards, is $701,892.59.

Based on the finding regarding medical causation, I do not find that any medical care rendered after Dr. Chabot's evaluation of the claimant on September 9, 2011, is medically causally connected to the accident of June 21, 2011. Therefore, I find that the employer is not legally obligated to pay any part of the cost of that additional medical care.

***Issue 4*. *Claim for future medical aid.***

Based on the finding that the accident of June 21, 2011, is not medically causally related to Employee's current medical condition which required surgery, I conclude that the employer is not obligated or responsible for the payment of future medical aid.

***Issue 5. Claim for additional temporary total disability.***

Employee claims an entitlement to receive past temporary total disability benefits from August 22, 2011 until August 30, 2011, as well as from December 23, 2011 through February 13, 2012. The total amount claimed is $3,059.70.

Employer is not responsible for any injury to Employee beyond a low back strain/sprain. Furthermore, there is no evidence in the record indicating that the employee should not be working as the result of that strain/sprain injury. Therefore, based on all the evidence presented, I find that the employer is not obligated to pay temporary total disability benefits.

***Issue 6. Permanent partial disability.***

Based on all of the evidence presented, I find that Employee sustained 7.5% (30 weeks) permanent partial disability to the body as a whole referable to the low back sprain/strain from a work injury that Employee sustained on June 21, 2011. Employee's rate for permanent partial disability is $345.45. Therefore, the employer is directed to pay the employee the sum of $10,363.50.

**ATTORNEY'S FEE:**

Sarah Elfrink, 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:

Maureen Tilley
*Administrative Law Judge*
*Division of Workers' Compensation*