

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

Injury No. 10-074011

Employee: Robert G. Wright, Jr.
Employer: TG Missouri Corporation
Insurer: The Hartford Insurance Co.

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) previously incurred medical aid; (4) future medical aid; (5) temporary total disability; and (6) nature and extent of permanent partial disability.

The administrative law judge rendered the following determinations: (1) employee sustained an accident arising out of and in the course of employment on July 6, 2010; (2) the July 6, 2010, accident was the prevailing factor in causing a low back strain, resulting disability, and the need for medical treatment provided by the employer through the visit with Dr. Chabot on February 10, 2012; (3) the employee's low back strain and the medical care and treatment for the low back strain through the visit with Dr. Chabot on February 10, 2012, was medically causally related to the July 6, 2010, accident and injury; (4) the July 6, 2010, accident was not the prevailing factor in causing the disc herniations at L3-4 and L4-5 with annular tears, foraminal stenosis, and the L3-4 and L4-5 surgery performed by Dr. Fonn in September of 2012, and were not medically causally related to the July 6, 2010, accident; (5) any medical bills for medical treatment to the employee's low back after February 12, 2012, are not medically causally related to the July 6, 2010, accident and were not necessary as a result of the July 6, 2010, accident; (6) the employee has failed to meet his burden of proof that future medical treatment is medically causally related to the condition caused by the work-related accident; (7) employee's claim for temporary total disability is denied; and (8) as a direct result of the July 6, 2010, accident, the employee sustained a 10% permanent partial disability of the body as a whole referable to his low back.

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

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For the reasons stated below, we modify the award of the administrative law judge as to the issues of medical causation, past medical expenses, future medical care, temporary total disability, and the nature and extent of permanent disability.

Discussion

Medical causation

Section 287.020.3(1) RSMo sets forth the standard of 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.

We note that, although the administrative law judge expressly indicated that he found the testimony from employer's medical expert, Dr. Michael Chabot, to be more persuasive than the contrary testimony from employee's expert, Dr. Robert Poetz, the administrative law judge ultimately rejected Dr. Chabot's conclusion that employee did not suffer any permanent disability as a result of the accident, when he determined that employee suffered a 10% permanent partial disability of the body as a whole referable to the lumbar spine. We agree with the administrative law judge's (implied) finding that Dr. Chabot's opinion with regard to permanent disability is not credible.

After careful consideration, we also find unpersuasive Dr. Chabot's theory that the accident caused employee to suffer a mere lumbar strain. Employer makes much of a purported inconsistency between employee's testimony and the treatment records from Dr. David Kapp, arguing that employee's history changed from identifying left-sided to right-sided lower extremity complaints at some point following the accident. We have thoroughly reviewed the record and we perceive no material inconsistency. In fact, Dr. Kapp's very first treatment note of August 4, 2010, documents *bilateral* lower extremity problems. Although it's clear that the severity of symptoms and complaints referable to the work injury waxed and waned over time, we are persuaded by employee's credible testimony that his general complaints referable to the work injury continued unabated thereafter.

We note also that Dr. Chabot fails to identify any alternative cause (i.e. any other "factor," prevailing or otherwise) causing the disc pathology shown on the May 31, 2012, MRI, apart from vague allusions to "genetic" or "degenerative" issues, along with the unstated suggestion that these conditions must have become, for unknown reasons, spontaneously symptomatic in May 2012. Where employee was only 36 years of age on the date of injury and had no preexisting low back injuries or treatment, Dr. Chabot's theory of spontaneously symptomatic degeneration does not strike us as particularly persuasive in this case.

Ultimately, we find Dr. Poetz's medical causation opinion the more persuasive expert medical evidence on record. We find that the accident of July 6, 2010, was the prevailing factor causing employee to suffer the resulting medical conditions of disc

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herniations with annular tears at L3-4 and L4-5, radiculopathy, and exacerbation of preexisting degenerative disc disease, as well as a 30% permanent partial disability of the body as a whole.

Past medical expenses

Section 287.140.1 RSMo governs 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. If the employee desires, he shall have the right to select his own physician, surgeon, or other such requirement at his own expense.

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 has 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 \$388,011.29 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 advanced an "authorization" defense in its brief and at oral argument, it is uncontested that employee made numerous demands upon employer for additional medical treatment, but that employer rejected employee's requests. "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

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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).

Nevertheless, employer suggests that employee was required under the law to demand additional treatment from employer after he obtained, on his own, the results of the MRI study of May 31, 2012, and that employee's failure to do so is preclusive of an award of past medical expenses. We are not persuaded. On April 4, 2012, employee specifically requested that employer authorize an MRI when his low back complaints referable to the work injury did not improve despite Dr. Chabot's opinion that employee had suffered a mere lumbar strain. By letter dated April 17, 2012, employer unequivocally denied that request, citing Dr. Chabot's opinions.

Certainly employer was entitled to rely on the causation opinion of Dr. Chabot and deny additional compensation, but likewise, employee was entitled to disagree with that opinion and seek further treatment for his work injury. At that point, both parties assumed the risk inherent in their respective positions. Employee assumed the risk a fact-finder would agree with Dr. Chabot or find that employee's additional treatment was not reasonably required to cure and relieve the effects of his work injury, with the result that he would have to pay for his own treatment. Employer, on the other hand, assumed the risk that Dr. Chabot's theory would be rejected and that it would be deemed to have waived its right to direct care and also be held liable for employee's self-directed care. As it turns out, we were not persuaded by the opinions from Dr. Chabot.

Employer cites *Blackwell v. Puritan-Bennett Corp.*, 901 S.W.2d 81 (Mo. App. 1995), which stands for the proposition that where an employer had provided treatment following a work injury, but the employee never returned to work after having been released by employer's authorized treating doctor, and thereafter never contacted employer at all, but instead pursued extensive additional treatment on his own, the employee was not entitled to an award of past medical expenses. *Id.* at 84-5. The Court reasoned that: "[a]s far as [employer] was aware, [employee] was not in need of any further medical attention." *Id.* at 85. Subsequent decisions have followed the *Blackwell* rule in circumstances where the employee's conduct deprived employer notice and an opportunity to direct medical treatment. See, e.g., *Poole v. City of St. Louis*, 328 S.W.3d 277, 291 (Mo. App. 2010).

Because employee specifically requested additional treatment including an MRI, but employer rejected that request, the *Blackwell* facts are not present here, and our research reveals no authority for employer's argument that an employee must make continual requests for additional medical treatment at each step of the way following an unequivocal denial by an employer. Simply stated, if employer wished to have the benefit of an MRI study showing employee's low back pathology, it could have authorized that diagnostic treatment when employee specifically requested it. Ultimately, we are persuaded (and we so find) that employer had notice and a reasonable opportunity to provide medical treatment, but that employer failed to take advantage of that opportunity. We conclude that employee is entitled to, and employer is obligated to pay, \$388,011.29 in past medical expenses.

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Future medical care

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 believes 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, as well as any symptoms that may develop; that employee may need to undergo repeat diagnostic studies followed by appropriate treatment as indicated; and that employee should also receive continuing pain management care in the form of non-steroidal anti-inflammatory medications and topical treatments. Dr. Chabot, on the other hand, believes employee probably will not need any additional care, provided he continues to experience a good result from Dr. Fonn's lumbar spine surgery.

Consistent with our findings with respect to the issue of medical causation, we find most persuasive Dr. Poetz's testimony. We are convinced (and we so find) there is a 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

Sections 287.149 and 287.170 RSMo provide for the payment of temporary total disability benefits while an employee is engaged in the rehabilitative process following a compensable work injury. *Greer v. Sysco Food Servs.*, SC94724 (Dec. 8, 2015). Employee claims temporary total disability benefits during the period from September 18, 2012, through January 23, 2013, to account for the time period following the lumbar surgery by Dr. Fonn during which employee was restricted from working. We have modified the administrative law judge's award and determined that the surgery by Dr. Fonn was reasonably required to cure and relieve the effects of the work injury.

Consequently, we conclude that employee is entitled to, and employer is obligated to pay, weekly payments of temporary total disability benefits for 18 and $\frac{2}{7}$ weeks at the stipulated temporary total disability benefit rate of \$349.72 for a total amount of \$6,394.88 in temporary total disability benefits.

Nature and extent of permanent 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 that employee suffered a 30% permanent partial disability of the body as a whole referable to his low back work injury. We conclude that employer is liable for 120 weeks of permanent partial disability benefits at the stipulated weekly permanent partial disability benefit rate of \$349.72 for a total of \$41,966.40 in permanent partial disability benefits.

Conclusion

We modify the award of the administrative law judge as to the issues of medical causation, past medical expenses, future medical care, temporary total disability, and nature and extent of permanent disability.

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Employer is liable for \$388,011.29 in past medical benefits.

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 temporary total disability benefits during the time period from September 18, 2012, through January 23, 2013, for a total of \$6,394.88.

Employer is liable for a total of \$41,966.40 in permanent partial disability benefits.

The award and decision of Chief Administrative Law Judge Lawrence C. Kasten, issued June 26, 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 22nd day of January 2016.

LABOR AND INDUSTRIAL RELATIONS COMMISSION

John J. Larsen, Jr., Chairman

James G. Avery, Jr., Member

Curtis E. Chick, Jr., Member

Attest:

Secretary

ISSUED BY DIVISION OF WORKERS' COMPENSATION

FINAL AWARD

Employee: Robert G. Wright, Jr. Injury No. 10-074011
Dependents: N/A
Employer: TG Missouri Corporation
Additional Party: N/A
Insurer: The Hartford c/o CCMSI
Appearances: Sarah Elfrink, attorney for the employee.
Eric Kukowski, attorney for the employer-insurer.
Hearing Date: March 26, 2015 Checked by: LCK/kg

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? July 6, 2010.
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 was moving a mold when he injured 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.
14. Nature and extent of any permanent disability: 10% permanent partial disability of the body as a whole referable to the low back.
15. Compensation paid to date for temporary total disability: None.
16. Value necessary medical aid paid to date by employer-insurer: \$11,621.30.
17. Value necessary medical aid not furnished by employer-insurer: None.
18. Employee's average weekly wage: \$524.55.
19. Weekly compensation rate: \$349.72.
20. Method wages computation: By agreement.
21. Amount of compensation payable: \$13,988.80 for permanent partial disability.
22. Second Injury Fund liability: N/A.
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 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 March 26, 2015, the employee, Robert G. Wright, Jr., appeared in person and with his attorney, Sarah Elfrink, for a hearing for a final award. The employer-insurer was represented by their attorney, Eric Kukowski. The parties agreed on certain undisputed facts and identified the issues that were in dispute. These undisputed facts and issues, together with a statement of the findings of fact and rulings of law, are set forth below as follows:

UNDISPUTED FACTS:

1. TG Missouri Corporation was operating under and subject to the provisions of the Missouri Workers' Compensation Act, and its liability was fully insured by The Hartford c/o CCMSI.
2. On or about July 6, 2010, Robert G. Wright, Jr. was an employee of TG Missouri Corporation and was working under the Workers' Compensation Act.
3. The employer had notice of the employee's alleged accident.
4. The employee's claim was filed within the time allowed by law.
5. The employee's average weekly wage was \$524.55. The rate of compensation for temporary total disability and permanent partial disability benefits is \$349.72 per week.
6. The employer-insurer paid \$11,621.30 in medical aid.
7. The employer-insurer did not pay any temporary disability benefits.

ISSUES:

1. Accident
2. Medical causation
3. Claim for previously incurred medical aid
4. Claim for additional or future medical aid
5. Temporary total disability
6. Nature and extent of permanent partial disability

EXHIBITS:

Employee's Exhibits:

1. Claim for Compensation
2. Report of Injury
3. TG Missouri Corporation Injury/Illness/Incident Report dated July 19, 2010
4. TG Missouri Corporation Injury/Illness/Incident Report dated August 2, 2010
5. Medical records of Perryville Family Care Clinic
6. Medical records of Perry County Memorial Hospital
7. Medical records of Dr. Fonn
8. Medical records of St. Francis Medical Center
9. Physical therapy records of Therapy Solutions
10. Bills of Dr. Fonn, St. Francis Medical Center, Perryville Family Care Clinic, Perry

- County Memorial Hospital, and Therapy Solutions
11. Joe Webb and the Webb Law Firm correspondence to Dale Weppner and Greensfelder, Hemker, & Gale, P.C., dated: 6/29/2011, 7/19/2011, 8/30/2011, 9/26/2011, 11/9/2011, 11/15/2011, 11/22/2011, 12/30/2011, and 4/4/2012
 12. Dale Weppner and Greensfelder, Hemker & Gale correspondence to Joe Webb and the Webb Law Firm dated 4/17/2012
 13. Dr. Robert Poetz's deposition transcript, CV, and report
 14. Mr. Robert Wright's deposition transcript
 15. Ms. Sarah Stueve, Mid America Rehab Custodian of Records deposition transcript and exhibits
 16. Request for Medical Leave completed forms, off work slips

Employer-Insurer's Exhibits

- A. TG Missouri Corporation Injury/Illness/Incident Report dated July 19, 2010
- B. Dr. David Kapp's deposition transcript, CV and records
- C. Dr. Michael Chabot's deposition transcript, CV and reports
- D. Dr. Sonjay Fonn's deposition transcript and exhibits
- E. Ms. Brenda Hanle's, St. Francis Medical Center deposition transcript and exhibits
- F. Joe Webb and the Webb Law Firm correspondence to the Division of Workers' Compensation dated June 8, 2012
- G. Dale Weppner and Greensfelder, Hemker, & Gale, PC correspondence to Joe Webb and the Webb Law Firm dated July 23, 2012
- H. Joe Webb and The Webb Law Firm correspondence to DOL/ERISA Appeals dated September 17, 2012
- I. Joe Webb and The Webb Law Firm correspondence to Office of General Counsel, Subrogation Department dated September 17, 2012
- J. Robert Wright Wage Statement
- K. TG Missouri Corporation Medical Treatment Records
- L. TG Missouri Incident Report dated July 9, 2010

Judicial Notice of the contents of the Division's file for the employee was taken.

During the hearing, the employee requested a party dismissal for TG Missouri and Tokio Marine Management. The Orders of Party Dismissal for TG Missouri and Tokio Marine Management were signed on April 6, 2015.

STATEMENT OF THE FINDINGS OF FACT:

The employee testified that he is 41 years old and has been married to his wife for three years. He started working at TG in June of 2010. When he started he did not have any prior back pain or back injuries. Prior to being hired at TG, he worked for Kelly Services at TG. He remembers being at a November 13, 2009 examination at Mid America Rehab but does not remember much about it.

On November 3, 2009, the employee underwent a Post-Offer Employment Evaluation for Kelly Services at Mid America Rehab. The employee had a moderate decrease of motion in the hamstrings. On palpation there was minimal lumbar and thoracic stiffness. There was some range of motion restrictions in flexion and extension and bilateral side bends of the lumbar spine. The summary was that the employee was capable of performing the essential functions of the position sought and did not have any present or past medical condition/impairment.

When asked about the Post-Offer Employment Evaluation where the therapist found minimal lower thoracic stiffness and minimal lumbar stiffness, the employee testified that he could never touch his leg due to tightness in the hamstrings. He had just come off a 12 hour shift and might have had some stiffness or soreness in the lower back.

The employee testified that on July 6, 2010, he was performing a mold change at work. He was pushing a mold that weighed about 1,000 pounds. The mold was on top of a table that had wheels. When the mold slammed into a machine he felt a sharp pain in his low back and had right buttock pain. The pain was a 5-6 out of 10 and was enough to make him wince. The employee could not remember if he had pain in his legs. He reported the injury to Cindy Kirkland. On the day of the accident he had pain in the low back and right butt cheek. After the accident, the pain was not exactly the same every day and progressed to both legs. Prior to the accident, he had no severe low back pain or right butt cheek pain.

In his August 6, 2013 deposition, the employee testified that when he pushed the mold he felt pain from the very lower back down into the right butt cheek and partially down the right leg between the buttocks and knee, but at that point there was not any left-sided pain or discomfort.

The TG Missouri injury/illness/incident report completed on July 9, 2010, showed that on June 29 the employee hit his forehead. The employee requested to be seen by the nurse for headaches. The medical treatment records from TG Missouri show that the employee received treatment with an icepack on July 9 for an indentation on his forehead, and he was given a supply of home-use ice packs.

The employee testified that the accident report that he and Cindy Kirkland completed lists the body parts injured as lower back, right and left side. The report was not completed until July 19 because the plant was shut down from July 12 through July 16. On July 9 he saw the company nurse and was given over-the-counter pain medications and had his back massaged with warm oils which really did not help.

The TG Missouri injury/illness/incident report completed on July 19, 2010, showed a date of incident of July 6, 2010. The type of injury was lower back soreness and body parts were lower back, right half and left half. The report stated he was injured moving a changing table with a mold which caused lower back pain. It was noted the employee had seen the company nurse on July 9, 2010, for his back.

The medical treatment records from TG Missouri show that on July 20, 2010, the employee had heat applied to his lower back and had an evaluation to his left lower back. He

received a massage to the left SI into the piriformis muscle, into the head of the femur, and was given stretching exercises.

The report of injury showed the date of injury was on July 6, 2010. There was a specific injury to the lumbar back due to pulling on a mold change table. The date it was prepared was August 5, 2010.

The employee testified that he filled out a second report of injury on August 2, 2010. He reported the July 6, 2010 injury a second time because he was still having pain which was triggered when pushing molds out of the machine.

The TG Missouri injury/illness/incident report completed on August 2, 2010, stated that the employee had hurt his lower back about two weeks ago cleaning a 580 mold when pulling it out. The employee had seen the nurse and wanted to follow-up due to his back still hurting. The employee had medical treatment at TG on August 3 for his low back, and an appointment with Dr. Kapp was scheduled for August 4.

The employee saw Dr. Kapp at Perryville Family Clinic on August 4, 2010, for low back pain. In the chief complaint section, the employee told Dr. Kapp that on July 6, 2010, he was pushing on something, strained his low back, and now had pain in the left buttock and left leg. In the HPI, the employee had low back pain that radiated to the left buttock and right leg, and just to the left thigh. The pain started on July 6, 2010, as he was pushing a heavy mold at work. He had no previous back problems or surgery. On examination the employee had left gluteal tenderness. Dr. Kapp diagnosed the employee with left sciatica and that the prevailing cause of the employee's complaints appeared to be job related. Dr. Kapp prescribed a Medrol Dosepak and referred him to physical therapy.

The employee was asked about Dr. Kapp's August 4 record that showed he was having pain in the left buttock and left leg. The employee testified that on August 4, 2010, he was having pain to the right leg, but sometimes he gets his right and left mixed up.

The employee had his initial physical therapy evaluation at Mid America Rehab on August 6, 2010. The therapist noted that the employee reported his current complaints as "Left lumbosacral pain, hip pain, and mid-thigh pain. No complaints of any pain on the right side."

The employee was asked about the records from his initial physical therapy evaluation on August 6, where the therapist noted his current complaints of left lumbosacral, hip, and mid-thigh pain, with no right-sided pain. The employee testified that he is not disagreeing with what was in the report and did not know if he was changing his testimony that the primary leg involved when he first had the injury was his right leg. The employee testified that at the time of the July 6, 2010 injury the pain was in the low back and in the center of his right buttocks, but he does not remember if the pain went down the right leg. However, if the medical records were to the left leg, he would not disagree.

On August 10, the employee reported that he had 1-2 out of 10 pain and the therapist recommended continued therapy. On August 16, 2010, the therapist noted that the employee had reduced pain complaints and increased range of motion.

The employee returned to Dr. Kapp on August 18, 2010. Sciatica was noted, but the symptoms had improved. On examination there was left gluteus maximus gluteal tenderness. Dr. Kapp diagnosed left sciatica and continued physical therapy.

The employee was asked about Dr. Kapp's August 18 record, where on examination there was left gluteus maximus gluteal tenderness with a diagnosis of left sciatica. The employee testified that he was certain that he was having right leg complaints and not left leg complaints.

On August 23, the therapist noted that the employee only experienced pain at the end of his work schedule, which was eight to ten hour days. His pain was a 1 out of 10. On August 31, the employee reported just some general soreness in the 1-2 out of 10 pain level. On September 14, 2010, the employee was doing well and was released from physical therapy on a home physical therapy program.

The employee saw Dr. Kapp on September 17, 2010. In the HPI, the employee had complaints of sciatica with the discomfort most prominent in the lower, left lumbar spine that radiated to the left leg and hip. There was radicular left leg pain and numbness in the legs. On examination there was some tenderness over the left paraspinal muscles. Dr. Kapp assessed left lower back pain with mild radicular symptoms and prescribed Naproxen and therapy. Dr. Kapp placed restrictions of no lifting over 15 pounds.

The employee was asked about Dr. Kapp's September 17, 2010 record that showed complaints of sciatica with the discomfort most prominent in the lower, left lumbar spine that radiated to the left leg and hip, with radicular left leg pain. The employee testified that he does not remember if he had problems with his right or left leg but does not think that Dr. Kapp took his history inaccurately.

The employee returned to physical therapy on September 20, 2010. In the chief complaint it was noted that the employee injured his back on September 5, 2010, while pushing and pulling real hard on a part when he experienced pain in his mid-thoracic and low back. He was having difficulty sleeping. It was noted that the employee had a prior back injury about a month or two ago, for which he had physical therapy and did very well at that time. The therapist noted negative straight leg raise, hip, and SI joint tests. He had bilateral tenderness over his paraspinals and lumbosacral region with some lower thoracic complaints. On September 28, 2010, the therapist noted that the employee's reported pain was a 3-4 out of 10, which was less than the 5 initially. He had some range of motion limitations.

On September 30, 2010, the employee saw Dr. Kapp with mild pain to the right leg if he was on his feet for prolonged periods of time, but his discomfort was most prominent in the lower left lumbar spine. On examination there was minimal bilateral lumbar paraspinal muscle

tenderness with improved lower back pain. The lifting restrictions and physical therapy were continued.

The employee was asked about Dr. Kapp's September 30, 2010 records that he had mild pain to the right leg if he was on his feet for prolonged periods of time. The employee testified that he did not recall when he started experiencing right leg pain.

The therapist noted on October 5 that the employee reported that he was doing much better and his pain was a 1-2 intermittently. On October 14, the therapist noted that the employee had pain in the 2-3 out of 10 level with some range of motion limitations. The employee seemed to be worse when on his feet for extended periods of time.

The employee saw Dr. Kapp on October 15, 2010. His lower back pain was improving with therapy and his discomfort was most prominent along the lower left lumbar spine. He still had some pain with standing for long hours. Dr. Kapp released the employee to return to work on full duty and to complete one more therapy visit. The employee was discharged from therapy on October 18, 2010, after he fully accomplished all the therapy goals.

On January 5, 2011, the employee returned to Dr. Kapp stating that he had increased pain last month while performing a lot of mold changes. He had lower lumbar spine pain and had tingling that went around the sides of his body to his abdomen. Dr. Kapp diagnosed recurrent lower back pain. Dr. Kapp stated that the employee appeared to be having chronic difficulty with his job duties and he was not sure if it would completely resolve. Dr. Kapp stated that the employee's tall thin body build may be at risk for continued problems. Dr. Kapp ordered lumbar x-rays to rule out underlying pathology and prescribed Naprosyn. The x-rays did not reveal any abnormalities.

The employee testified that after his last visit with Dr. Kapp on January 5, 2011, he continued to have back pain but it was not as intense. His back and leg pain was helped after TG changed his job, and he no longer worked on the mold machine. Some months later he was put back on the mold machine which caused a flare-up with pain in the lower back at the belt loop, and pain and some numbness down the right leg and sometimes the left leg. The employee thought it was connected to the original injury because the pain was in the similar location. He requested treatment from his supervisor at least five times. The employee was still able to work and he never received any more medical treatment from TG. He eventually hired his attorney in June of 2011 to get additional medical treatment.

The employee filed a claim for compensation on July 1, 2011, with a date of injury of July 6, 2010. The body parts claimed to be injured were back, right shoulder, and left shoulder. In the additional statements it noted that the employee needed medical treatment.

The employee's attorney Joseph Webb wrote a letter to Dale Weppner, prior counsel for the employer-insurer on June 29, 2011, making demand for additional medical treatment for his back and both shoulders. Mr. Webb wrote additional letters on July 19, 2011, August 30, 2011,

September 26, 2011, November 9, 2011, November 22, 2011, and December 30, 2011, demanding additional treatment.

The employee testified that TG sent him to Dr. Chabot in February of 2012. Dr. Chabot ordered an x-ray and tested him for leg numbness. His back was hurting very little when saw Dr. Chabot, because after sitting for a long period of time he had less back pain. He had been sitting in the waiting room and the examination room a long time before seeing Dr. Chabot. His back continued to hurt after he left Dr. Chabot's office and he continued to ask for treatment through his attorneys.

The employee was sent to Dr. Chabot by the employer-insurer on February 10, 2012. The employee stated that on July 6, 2010, he strained his low back in the process of moving a heavy mold. He was subsequently taken off the prior mold machine and placed on a new machine that did not require moving heavy items. His low back pain improved, but he still had low back pain that was less severe and less frequent with numbness involving the lower extremities. His pain was a 3 out of 10 and he was not using any medications to control his back complaints. His current work duties did not require him to lift in excess of 20 pounds. On examination, the employee was not in any distress and moved about the room without difficulty. He removed his socks in a cross-legged position without distress or assistance. He had no list or limp and was able to heel and toe walk. He was not tender to palpation over his thoracic or lumbar spine. There was no muscle spasm. He had some range of motion restrictions with tight bilateral hamstrings. Dr. Chabot diagnosed the employee with a history of back strain and back pain that caused, at the time, left proximal lower extremity complaints. The employee's symptoms responded to conservative measures over a period of time. The employee's complaints were re-aggravated after returning to his prior work duties, and after he was switched to different work duties he tolerated them very well.

Dr. Chabot stated that the examination was devoid of any objective physical findings to indicate residuals associated with the employee's prior alleged work accident on July 6, 2010. There was no evidence of tissue spasms or tenderness, no restrictions in range of motion, and his neurologic examination was normal. It was Dr. Chabot's opinion that the employee had reached maximum medical improvement as it related to the July 6, 2010 injury. It was his opinion that that the employee did not sustain any permanent partial disability as a result of his alleged work accident on July 6, 2010. It was his opinion that the employee could return to full and unrestricted work duties, but it would be prudent that he not return to his prior job involving moving molds, as he could not tolerate those work duties without aggravating his back complaints.

It was Dr. Chabot's opinion that the employee's prior complaints were associated with a muscle strain. There was no documentation of specific neurologic changes involving the lower extremities or evidence of tension signs to suggest that the employee had evidence of an active radiculopathy. The findings were most consistent with a tissue strain with referred pain. It was his opinion that the symptoms associated with his strain injury had resolved. It was Dr. Chabot's opinion that the treatment rendered regarding the injury of July 6, 2010, was reasonable and

necessary to address the complaints associated with the injury. Any additional treatment or additional diagnostic studies were not warranted for the alleged July 6, 2010 work injury.

The employee testified that he told Dr. Chabot that he was having numbness down the legs, but Dr. Chabot's examination did not find the numbness that he was complaining about. The employee stated that the drive to the doctor's office and the wait to be examined had made most, if not all, of his back pain wane by the time Dr. Chabot performed his examination.

On April 4, 2012, the employee's attorney wrote to the employer-insurer's former attorney Mr. Weppner and demanded additional medical treatment including an MRI. On April 17, 2012, Mr. Weppner responded and stated that the demand for additional treatment was denied, based upon Dr. Chabot's medical findings and opinion that the employee was at maximum medical improvement and did not recommend any further diagnostic studies to diagnose, cure, and relieve the employee's alleged injuries.

The employee testified that after getting the April 17, 2012 letter, he started treating on his own because he wanted to get better. At that point his pain was a 3-4 out of 10.

On May 30, 2012, the employee returned to the Perryville Family Care Clinic and saw nurse practitioner Brad Henneman for low back pain. Nurse Henneman noted the employee's prior treatment with Dr. Kapp. The employee stated that the discomfort was most prominent in the lower lumbar spine which radiated to the bilateral legs. It was a constant aching and tingling in legs especially when waking in the morning. Associated symptoms were radicular bilateral leg pain and numbness in the legs. The employee reported posterior neck complaints that radiated down both upper extremities. Nurse Henneman noted in his examination that the employee reported lumbar spinous process, interspace, and right paraspinal muscle pain, left paraspinal muscles and right posterior superior iliac spine tenderness. Noted was sensation deficit in the right L4, L5, and S1, and 4/5 strength in the right tibialis anterior. There was pain with forward flexion and extension. Low back and neck pain were diagnosed. The employee's complaints were greatest in the right lower extremity. An MRI of the lumbar spine was ordered.

The lumbar MRI was performed on May 31, 2012, with a history of lumbar pain radiating to both lower extremities to the level of the foot, right greater than left with numbness. The MRI showed a small right lateralizing bulge without focal herniation, narrowing the right lateral recess at the L3-L4 disc level. At the L4-L5 disc level there was a small circumferential bulge with superimposed 2mm left lateralizing herniation that mildly narrowed the left lateral recess. Posterior facet changes were noted at L3-4 and L4-5.

The employee testified that he went to Dr. Fonn on July 5, 2012, and he performed three injections to his low back which provided very little relief.

The employee saw Dr. Fonn on July 5, 2012, with a chief complaint of back and right leg pain. It was noted in the history that his symptoms started after working "on the job from 2/10 to 1/11, whereupon he was pushing, pulling and twisting a large mold weighing about 1200 pounds. Around 8/10 his symptoms were severely aggravated. He has shooting pain in his back radiating

into his right leg into the thigh and knee region, right is worse than the left today, and today both are just as bad. He has had paresthesia and weakness secondary to the pain. His legs are worse than the back.” On examination, the employee had pain to palpation in the low back region with decreased sensation in the L3 distribution on the right to light touch and pin prick. Straight leg raise test to 45 degrees was positive on the right. Dr. Fonn stated that the MRI of the lumbar spine showed an annular tear at L4-L5 and a bilateral foraminal disc herniation at the L3-4 disc level on the right causing impingement of the exiting nerve root. Dr. Fonn stated that the employee had signs and symptoms of lumbar radiculopathy. He recommended a course of three lumbar epidural steroid injections at L3-4 on the right. If he did not improve, the employee may be a surgical candidate with a possible microdiscectomy at L3-4 on the right versus a fusion at that level, pending results of a CT myelogram, and lumbar discogram.

Dr. Fonn performed right-sided lumbar epidural steroid injections at L3-4 on July 19, July 26, and August 2, 2012. On August 9, 2012, the employee told Dr. Fonn that the epidural steroid injections gave him poor relief from his pain. Dr. Fonn recommended a fusion at L4-5 with a possible microdiscectomy at the L3-4 level on the right, pending results of a lumbar CT myelogram and a discogram from L2 through S1.

The CT myelogram at Midwest Neurosurgeons was performed on August 30, 2012. The post myelogram CT scan showed right DOC at L3-4 causing moderate to significant right foraminal stenosis and a left-sided disc herniation at L4-5 causing moderate left foraminal narrowing with impingement of the exiting nerve root. The impression of Dr. Fonn was disc herniation at L3-4 on the right with collapse of the disc height and disc herniation causing moderate left foraminal narrowing and stenosis at L4-5.

A post discogram CT scan on September 5, 2012, showed extravasation of dye at the L3-4 and L4-5 disc levels suggestive of annular tears at both levels. The discogram showed 10/10 concordant pain at the L4-5 disc level and 4/10 discordant pain at the L3-4 disc level.

On September 5, 2012, Dr. Fonn reviewed the results of the myelogram and discogram with the employee. He stated that the myelogram showed the disc/osteophyte complex causing stenosis primarily at the L3-4 and L4-5 levels, and the discogram showed concordant pain at the L4-5 level with the L3-4 not showing any concordant pain. Dr. Fonn again reviewed the MRI findings in conjunction with the myelogram and discogram and identified the primary surgical pathology to be at the L3-4 and L4-5 levels. Dr. Fonn scheduled the employee for a fusion at L4-5 level and a microdiscectomy at L3-4 on the right.

On September 18, 2012, Dr. Fonn performed L4-L5 bilateral laminotomies with decompression of nerve roots, partial facetectomy, foraminotomy, and excision of herniated intervertebral disc, and L4-5 fusion. Also performed was a L3-L4 laminotomy foraminotomy, and microdissection on the right. There was a disc fragment that was removed in several large pieces. There were broad based disc herniations at both levels which were completely removed. The post operative diagnosis was L4-5 scoliosis, degenerative disc disease, disc herniations and foraminal stenosis, and foraminal stenosis right L3-4 with right L3 radiculopathy. He was discharged from St. Francis Medical Center on September 22, 2012.

The employee testified that he had immediate relief after surgery. He could feel his foot which was something different than before, but he still continued to have back pain.

The employee saw Dr. Fonn on October 18, 2012. It was noted that the pre-operative signs and symptoms had significantly resolved. The employee was released to return to work light duty with a 20 pound weight limit and no excessive bending or stooping of the surgical site. On October 22, Dr. Fonn kept the employee off work until at least January 2, 2013.

The employee saw Dr. Fonn on January 2, 2013. A CT and plain x-rays showed good fusion occurring with good placement of the instrumentation. Therapy was prescribed. The employee was put on light duty for two months. Dr. Fonn stated that the employee may return to work with no heavy lifting and 20 pounds lifting maximum, sitting job with minimal walking, no bending, stooping or twisting, no over the shoulder work, and light duty of 4-6 hours a day 2-3 days a week.

The employee had his initial physical therapy on January 7, 2013, at Therapy Solutions. He told the therapist that his symptoms had improved since the surgery. He is no longer having to take pain medication and only takes Advil. On exam the employee had decreased sensation in the right L5 and S1 dermatomes and it was within normal limits on the left. On January 7, the employee completed a Request for Medical Leave of Absence form with TG Missouri, due to recovery from back surgery that was related to his occupation.

On January 21, the employee told the therapist that his lower extremities were sore from cleaning house but his back was doing ok. On January 23, he was doing better. On January 23, 2013, Dr. Fonn noted that the employee was doing "excellent." Dr. Fonn recommended additional physical therapy and released him to return to work without restrictions.

The employee testified that he was off work from September 18, 2012, until he was released to return to work on January 24, 2013. He asked Dr. Fonn for an early release due to his FMLA time extension running out. He returned to work at TG. His work was rather rough when he was changing tables out with the mold. After he was on his feet for two hours at time it was more difficult. He asked for help from his two co-workers.

In the progress note on February 15, 2013, the employee reported to the therapist that he has definitely progressed and no longer has the pain down his leg, only some minimal soreness with working. He had mild limitation on walking and lifting. The dermatomes at L5 and S1 on the right were within normal limits.

The employee reported to the therapist on March 1 that he was pretty sore from work, and standing on his feet so long caused some pain down his right leg. The progress note of the therapist on March 5, 2013, noted continued discomfort from the left lateral pelvic area across the low back. The employee had returned to work, which may be part of the reason for the aggravation. His low back pain currently was 2-3 out of 10, with the worst being 5. He had mild limitation of walking and lifting.

On March 6, 2013, the employee saw Dr. Fonn who noted that the employee had made good progress and had increased mobility with substantial reduction in pre-operative symptoms. Physical examination was normal with no acute neurological findings. The employee was released to return as needed.

On March 8, 2013, the employee reported that he was doing very well overall and had no limitations in functional or work-related activities. The pain was very minimal. The therapist recommended discharge with home exercise program since he achieved all of his goals.

The employee saw Dr. Poetz on August 23, 2013. The employee stated that his current complaints were some lower back pain that will occasionally spike at work if he had to push a part or lean over. He had regained the feeling in his right leg and foot, and occasionally had a pulsating pain along each side of his spine. The history showed that as he forcefully pushed on a mold he felt a sharp pain in his lower back which traveled down his right leg, and the symptoms progressively worsened over time. Dr. Poetz's lumbar spine examination revealed good thoracic and spinal range of motion, flexion to 60 degrees, negative straight leg raising test in both seated and supine position without any radicular signs present, and no neurologic deficits. Dr. Poetz diagnosed pre-existing lumbar degenerative disc disease, disc herniations at L3-4 and L4-5 with annular tears, foraminal stenosis, radiculopathy and exacerbation of lumbar degenerative disc disease resulting from his work accident on July 6, 2010, with surgery to cure and relieve same performed on September 18, 2012, that resulted from the July 6, 2010 work injury. Dr. Poetz recommended that the employee avoid pushing and pulling, heavy lifting, strenuous activity, prolonged sitting, standing, walking stooping, bending, squatting, twisting, or climbing. With regard to future medical, he recommended anti-inflammatory medication and to follow-up with an orthopedic surgeon to monitor the status of the hardware or if the symptoms out of the ordinary develop. It was Dr. Poetz's opinion that the diagnostic testing, surgery and medical care were medically necessary in the treatment of the employee, and from a review of the medical bills, that the charges are reasonable and customary. It was Dr. Poetz's opinion that the employee had a 5% permanent partial disability due to pre-existing lumbar spine problems and a 45% permanent partial disability of the body as a whole due to the work accident on July 6, 2010.

The employee testified that he returned to Dr. Fonn on August 7, 2014, due to low back pain around the belt loop and numbness in his legs and feet, but mostly in his right leg. He related it to the 2010 injury because the back pain was very similar. Dr. Fonn performed three injections in lower back which gave him some relief.

The employee returned to Dr. Fonn on August 7, 2014. It was noted that after the post lumbar surgery in 2012 he was doing excellent. About three weeks ago he developed a new pain in his right knee that radiated into the right ankle. He denied any fall or trauma and also noted that he has numbness and tingling from his back down to his legs, with the right worse than the left. The back is worse than the legs. X-rays showed stable fusion at L4-5 with no evidence of subluxation, migration, or fragmentation of the fixation device. Dr. Fonn noted his examination was normal and scheduled a new MRI.

The MRI on August 29, 2014, showed mild desiccation without decrease in disc height at L3-L4, with a very small circumferential bulge noted with asymmetry to the right narrowing the lateral head recess. The L4-5 level showed postoperative changes from the bilateral laminectomy with fusion noted.

Dr. Fonn reviewed the MRI with the employee on September 4, 2014. The prior fusion was shown at L4-5, and there was a disc bulge asymmetric to the right at L3-4 which caused narrowing of the recess and causing the problems. X-rays showed stable fusion at L4-5. Dr. Fonn recommended another series of lumbar epidural steroid injections at L3-4 on the right. Dr. Fonn performed the injections on October 21, October 28, and November 4, 2014. The employee saw Dr. Fonn on November 11, 2014, and the employee stated that the injections provided excellent relief and requested he hold off on any further surgical intervention.

The employee testified that he last saw Dr. Fonn in November of 2014 and was to return if he had any further problems. As to his current condition, his back is doing better but he still has pain in his lower back every day, which will at times spike to a 5-6. He has 2-3 pain that radiates down the right leg and sometimes left leg. He uses Aleve and aspercreme 2-3 times a week. He is still working at TG and is able to do his job okay, with the exception of carts. He asks for help when the cart jams. When performing chores around the house, he squats down instead of leaning over, such as getting things out of the dishwasher. He has problems jumping and running distances. Pushing or pulling medium to heavy objects is an issue. After the surgery was the first time he stopped having numbness, and he continues to have very little numbness in the leg. He still has some low back pain. Both the pain and numbness are much less frequent now with less severity.

Opinions:

Dr. Poetz's deposition was taken on April 7, 2014. Dr. Poetz testified that the surgical procedures performed on September 18, 2012, were all as a result of the injury that occurred at work on July 6, 2010. Dr. Poetz further opined that the employee should follow-up with an orthopedic surgeon to monitor the status of the hardware and that it may be necessary for him to undergo repeat studies. Dr. Poetz testified that there are a significant number of patients who will need further surgery. Dr. Poetz testified that the prevailing factor in causing both the resulting medical condition and disability in the amount of 45% permanent partial disability to the body as a whole measured at the lumbar spine was the employee's work injury on July 6, 2010. Dr. Poetz testified that it is reasonable that the employee would have been taken off work for approximately four months following his surgery, that the treatment the employee received was necessary to cure and relieve the effects of his July 6, 2010 work injury, and the cost of treatment was reasonable. Dr. Poetz only reviewed the diagnostic reports. It was his opinion that there was not an intervening cause other than his work incident that resulted in his condition.

On July 25, 2014, Dr. Kapp's deposition was taken. Dr. Kapp testified that when he saw the employee on August 4, 2010, he was having low back and left buttock area tenderness, with full range of motion. Dr. Kapp thought the employee might have left sciatica, which is inflammation of the nerve through the buttocks and lower back. He ordered therapy and ordered a

short course of steroids to decrease inflammation and swelling. On September 17, 2010, the employee had some paraspinal muscle tenderness on the left side of his low back. The tenderness had moved up out of the buttock and into the lower back at that point. He was placed on Naprosyn an anti-inflammatory medication. Dr. Kapp referred him back to therapy and put restrictions of no lifting, pushing, or pulling greater than 15 pounds. He diagnosed left lower back pain with mild radicular symptoms. On October 15, 2010, the employee had no tenderness and full active range of motion and normal neurologic testing. He diagnosed low back pain, improving, was released to full duty, and was to return as needed. The employee returned to Dr. Kapp on January 5, 2011, and told him that his pain started increasing when he was doing a lot of mold changes, which is a fairly aggressive activity at work. He had full range of motion and no real significant tenderness on exam, and he diagnosed recurrent lower back pain.

The next visit to his office regarding the low back was on May 30, 2012. Nurse practitioner Henneman found lumbar left sided paraspinal tenderness, normal reflexes, normal range of motion with some pain with forward flexion, and extension in the lower back. An MRI was ordered and showed a L3-4 small right lateralizing bulge without focal herniation mentioned, narrowing of the right lateral recess, some posterior facet degenerative changes, at L4-5 a small circumferential bulge with two millimeter left lateralizing herniation, mildly narrowing the left lateral recess. The L3-4 without focal herniation means a bulge, but the disc has not actually herniated out of it casing or sheath. At L4-5 there was a bulge in a small area (two millimeters) that pushed out of the left side to some degree. When asked if the report suggested any type of nerve root impingement involved, Dr. Kapp stated it mentioned that it mildly narrowed the left lateral recess but it did not make mention of nerve compression or indentation. Dr. Kapp did not review the actual MRI film but stated that if the radiologist had noticed nerve root impingement as a general rule he would have mentioned it.

It was Dr. Kapp's opinion that there was no way to tell when the disc bulges at L3-4 or L4-5 happened from looking at the MRI report, and there was no way to tell whether the MRI findings are related to the July 6, 2010 incident. Dr. Kapp testified that his concerns for the employee were based on a pattern of low back discomfort that would improve and then recur with his continued work duties. Dr. Kapp stated that the mold changes that the employee did at TG were "fairly heavy" and that "you have to reach into machines, push them in and out, and sometimes you have to contort your body to get into certain positions." It was a physical job.

When asked if he had an opinion whether or not the work accident of July 6, 2010, could have been the prevailing factor in his injuries or disabilities, Dr. Kapp testified that it was difficult to give an opinion on causation because he did not know what transpired after the employee's care at his clinic. Dr. Kapp stated that his initial impression of the MRI was that the findings were very minimal, and based on that alone, he would not recommended surgical correction. Dr. Kapp did confirm that the causation statement in his assessment on August 4, 2010, was correct and that it was his opinion that the prevailing cause of the employee's back pain was the initial pushing of the object at work.

On October 20, 2014, Dr. Chabot issued an addendum to his earlier February 12, 2012 report. Dr. Chabot summarized additional medical records he received from Perryville Family

Care Clinic, Dr. Fonn, St. Francis Medical Center, physical therapy, Dr. Poetz's medical report and deposition, Dr. Kapp's deposition, and diagnostic films including x-rays taken on January 2, 2013, a lumbar myelogram on August 30, 2012, and the MRI performed on May 31, 2012.

Dr. Chabot noted that the MRI film conducted on May 31, 2012, showed at L3-4 there was evidence of a right foraminal/lateral disc protrusion. At L4-5 there was evidence of mild disc bulging, but no evidence of a focal disc herniation at L4-L5. The lumbar myelogram on August 30, 2012, showed evidence of disc bulging at L3-4, L4-5, and L5-S1, with the disc bulging more prominent at L4-5 and L5-S1. The post myelogram CT showed extravasation of dye outside the thecal sac which was quite pronounced at the L5-S1 level. At L4-5 there was evidence of circumferential disc bulging with mild foraminal narrowing. Dr. Chabot stated that he did not appreciate evidence of a disc herniation at L4-5. There was evidence of a lateral/foraminal disc protrusion on the right at L3-4. The discogram study showed evidence of a broad pattern of dye filling in the L4-5 disc space and a well-confined pattern of dye in the L3-4 disc space. The post-discogram CT showed at L4-5 there appeared to be broad pattern of dye filling within the disc space. There may be mild extravasation of dye on the right, but it is unclear from which side the injection was performed and may represent needle tracking. At L3-4 the dye pattern is relatively confined and only a limited amount of dye is present within the disc space. The disc material does not readily extravasate toward the right sided foraminal /lateral disc protrusion.

Dr. Chabot stated that when the employee presented to Dr. Kapp in July of 2010 he had back pain radiating into the left lower extremity, and after conservative measures his condition improved. Dr. Chabot stated that when he saw the employee on February 10, 2012, the employee had aching low back pain, was not using medication, was working full time, and there was no mention of right leg pain complaints. The employee was then seen by his primary care doctor with increased back complaints radiating into the right greater than left lower extremity that he could not relate to any specific new injury. The employee then saw Dr. Fonn for back pain radiating into the right lower extremity, and to some degree the left lower extremity. No neural defects were noted on any of his examination from 2010 to 2012. Dr. Chabot stated that his review of the additional medical records did not change his opinion that the employee had reached maximum medical improvement for the July 6, 2010 injury when he saw him in February of 2012.

Dr. Chabot stated that Dr. Fonn's findings on July 5, 2012, revealed sensory nerve loss involving the right lower extremity which was not present on his prior examinations. Dr. Chabot stated that there was not any short-term relief with the injections at L3-4 and should have offered some indication whether his symptoms originated from that L3-L4 disc level. Dr. Chabot stated that it was possible that the employee developed disc extrusion at the L3-L4 level in performing activities of daily living, as his MRI confirmed disc desiccation, indicating evidence of pre-existing degenerative disc disease involving the lumbar spine. The pre-existing degenerative disc disease could be the reason why he developed predominantly back and right leg pain at the time he was evaluated by Dr. Fonn.

Dr. Chabot noted that the employee's complaints at examination and at the time of the employee's deposition were unchanged and in the moderate range. It was Dr. Chabot's opinion that due to the change in his complaints, specifically pain radiating down the right lower extremity, that the employee developed a disc protrusion after he saw the employee in February of 2012, most likely just prior to being evaluated by his primary care doctor in May of 2012. It was Dr. Chabot's opinion that the herniated disc was not related to any specific work duties. It was his opinion that any additional treatment following his evaluation of February 12, 2012, was related to the pre-existing degenerative disc disease and/or new disc pathology unrelated to his work activities. It was Dr. Chabot's opinion that when he saw the employee in February of 2012 that the employee exhibited no evidence of functional deficits that could indicate that he developed persisting functional deficits associated with his alleged work injury. His opinion that the employee had no permanent partial disability was unchanged.

On December 12, 2014, Dr. Chabot's deposition was taken. It was Dr. Chabot's opinion that the employee suffered a back injury as a result of an incident that occurred on July 6, 2010, and diagnosed him with a back strain. Dr. Chabot testified that the employee reported to him that on July 6, 2010, he strained his low back in the process of moving the molds. The employee had left buttock pain that radiated into his left proximal leg to his left thigh with gluteus maximus tenderness. At his examination, the employee rated his pain as 3 out of 10, which is mild to moderate pain. The employee had normal range of motion, moderate hamstring tightness on both sides, and no evidence of spasms. Dr. Chabot was not able to find any objective sign of injury, and his examination was essentially normal. Up to seeing the employee in February 2012, the employee underwent seven physical therapy visits and his pain level significantly reduced relatively quickly to a mild level.

It was Dr. Chabot's opinion the employee was at maximum medical improvement on February 10, 2012, the date of his examination, and the employee sustained a simple muscle strain injury. It was Dr. Chabot's opinion that on February 10, 2012, the employee did not show any persisting functional deficits or neurologic abnormalities that could be related to his alleged work injury of July 6, 2010, and the employee did not sustain any permanent partial disability. It was Dr. Chabot's opinion that the employee's employment at TG Missouri Corporation was the prevailing factor in causing his back pain on July 6, 2010. It was his opinion that the employee did not need any further medical treatment as a result of that back strain. It was his opinion that the employee was not a surgical candidate and could return to full and unrestricted work duties, with the exception that he should continue in his current position which did not require him to lift more than 20 pounds.

Dr. Chabot testified with that after he reviewed additional medical records dated from February 16, 2011, through May 31, 2012, he prepared a second report dated October 20, 2014. Dr. Chabot specifically looked for any mention of back pain. Dr. Chabot stated that the first mention of any new back complaints after he saw the employee in February of 2012 was on May 30, 2012. On May 30, 2012, the employee had new onset of back complaints, radiating into both legs. The symptoms were worse upon awakening in the morning, and he did not specify any specific events that precipitated the new complaints. The bilateral leg complaints, as well as the constant aching and tingling in his legs especially when waking in the morning, were different

complaints from his initial 2010 complaints. The employee's complaints to Dr. Kapp originally were primary in the left buttock and left proximal leg. Dr. Chabot stated that the May 31, 2012 MRI showed a lateral/foraminal disc protrusion on the right at L3-4. At L4-5 there was evidence of mild disc bulging and he did not appreciate evidence of a focal disc herniation. At L5-S1 there was no evidence of a focal disc herniation or neural compression. Dr. Chabot stated that the radiologist suggested evidence of a small circumferential disc bulge at L4-5 and a left lateralizing herniation at L4-5 which he did not appreciate.

Dr. Chabot stated that the history to Dr. Fonn was shooting pain radiating down into his right leg thigh and knee, and his right side was worse than the left. Dr. Chabot stated that the symptoms appear to be very different than what the employee had previously had following the onset of symptoms in 2010. The right-side complaints with symptoms of paresthesia and weakness secondary to pain were all new complaints. Dr. Fonn thought the disc herniation at L3-4 was symptomatic because the third nerve root supplies the anterior thigh and he thought it could be responsible for some of his complaints. Dr. Chabot stated that generally when injecting the nerve there will be at least short term and sometimes longer term improvement of complaints. Dr. Chabot stated that the discogram did not provide provocation or duplication of the complaints and it should have reproduced the leg pain on the right. Since it did not, it would strongly suggest that even though there may be disc pathology at L3-4 on the right, it was most likely not contributing to the complaints.

Dr. Chabot testified that in the CT scan performed by Dr. Fonn on September 5, 2012, the report indicated extravasation of dye at L3-4 and L4-5 which suggested annular tears at those levels. The report did not mention any herniated discs. It Dr. Chabot's opinion that most likely the annular tears are related to degenerative changes.

Dr. Chabot stated on the date of his evaluation in February of 2012, the employee was using no medication, had very little complaints, and had no neurologic changes. For some reason around May of 2012, his condition changed and he had terrible back and right leg pain with some changes of loss of sensation, which was significantly different than when he examined the employee. Dr. Chabot was not convinced that the L3-4 disc was symptomatic. The L4-5 disc herniation was not going to produce right leg pain, so that herniation would be suspected to be an asymptomatic disc. It was Dr. Chabot's opinion that the employee had disc degeneration, chronic changes in his back, and the disc herniation reported in the MRI do not appear to be primarily responsible for his complaints. Dr. Chabot stated he would have been extremely hesitant on performing surgery, and based on his neurologic examination, he would have probably been unlikely to perform surgery.

It was Dr. Chabot's opinion that ordinary wear and tear resulted in the disc desiccation, loss of disc height and disc herniation, and that the disc herniation that was seen was not a result of the July 6, 2010 injury. The employee's complaints to Dr. Fonn in July of 2012 suggested that the L3-4 disc herniation on the right may have been symptomatic because he had new onset of back and right leg complaints of a severe magnitude, which he did not have previously. Dr. Chabot would have suspected that there was a new herniation at L3-4 which was responsible for his complaints based on the numbness involved in the thigh, but the studies never confirmed that.

It was Dr. Chabot's opinion that the fact that the employee had not made right-sided complaints until almost two years after his back strain very strongly weighs against them being related to the back strain. It was Dr. Chabot's opinion that the employee's accident at TG was not the prevailing factor in causing the disc desiccation, herniated discs, and resulting surgery on September 18, 2012.

Dr. Chabot stated that the employee's complaints to Dr. Fonn of pain shooting down his right leg and numbness in his right leg were categorically different than anything previously documented or represented to him when he examined the employee, or to Dr. Kapp or any other treater. It was possible that the employee developed disc pathology at L3-4 after the February of 2012 evaluation that was responsible for the employee's complaints. Dr. Chabot testified that his opinion might change if the employee had the exact same symptoms at the time of the onset of his complaints.

On March 11, 2015, the deposition of Dr. Fonn was taken. Dr. Fonn testified that when he first saw the employee on July 5, 2012, he complained of back pain and bilateral leg pain but he had shooting pain in his back radiating into his right leg into the thigh and knee region. The right was worse than the left. It was his diagnosis that the employee had signs and symptoms of lumbar radiculopathy. His sensory examination suggested a decreased sensation in the L3 distribution on the right. The straight leg raising test to 45 degrees on the right could be any of the nerve roots in the lumbar spine. He recommended injections at the L3-4 level on the right to decrease inflammation. The three injections had a limited effect on his complaints. Dr. Fonn was concerned with multiple levels, but felt at that time the focus was at the L3-4 level. Dr. Fonn stated that if the injections did not have any effect, it would not necessarily rule out that the L3 level was the cause of his pain generator. Dr. Fonn stated that the myelogram showed problems primarily at the L3-4 and L4-5 level, and the discogram showed concordant pain at L4-5 but did not at L3-4. The myelogram showed a stenotic problem at L3-4 which was narrowing. When he performed surgery there was an L3-4 herniation. Dr. Fonn reviewed the May 31, 2012 MRI and stated that there was a foraminal disc herniation at the L3-4 level on the right.

Dr. Fonn testified that he saw the employee's disc injuries and reported the findings as listed in his records. He further testified that his records, tests, reports and operative reports are an accurate reflection of his observations. It was Dr. Fonn's opinion that the charges of \$148,049.00 for 2011 and 2012 and the charges of \$8,077.00 for 2014 from him and his office were reasonable and customary for the treatment provided to the employee. It was Dr. Fonn's opinion that the employee will require additional care or observation to monitor his treatment or the hardware that is in his back.

RULINGS OF LAW:

Issue 1. Accident; and Issue 2. Medical causation.

It is disputed that on or about July 6, 2010, the employee sustained an accident arising out of and in the course of his employment, and that the employee's low back injury was medically causally related to the alleged accident.

Section 287.020.2 RSMo. defines “accident” as “an unexpected traumatic event or unusual strain identifiable by time and place of occurrence and producing at the time objective symptoms of an injury caused by a specific event during a single work shift.” Section 287.020.3 RSMo. defines the term “injury” as an injury which has arisen out of and in the course of employment. 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.

The burden of proof is on the employee to prove all material elements of his claim. See *Marcus v. Steel Constructors, Inc.*, 434 S.W.2d 475 (Mo. 1968) and *Walsh v. Treasurer of the State of Missouri*, 953 S.W.2d 632,637 (Mo. App. 1997). The employee has the burden to prove that his injuries arose out of and in the course of employment. *Smith v. Donco Construction*, 182 S.W.3d 693, 699 (Mo. App. 2006).

At the hearing the employee testified that on July 6, 2010, the approximate 1,000 pound mold that he was pushing slammed into a machine and he felt a sharp pain in his low back and had right buttock pain. In his August 6, 2013 deposition, the employee testified that when he pushed the mold he felt pain from the very low back down into the right butt cheek and partially down the right leg between the buttocks and knee. At that point there was not any left-sided pain or discomfort. The TG incident report corroborated his testimony that he injured his low back on July 6, 2010, while moving a mold.

The initial medical records show that the employee was having left-sided and not right-sided symptoms. On July 20, 2010, the TG treatment records show an evaluation to his left lower back with a massage to the left SI into the piriformis muscle and into the head of the femur. Dr. Kapp’s initial visit on August 4, 2010, was for low back, left buttock and left leg pain. The employee had left gluteal tenderness and Dr. Kapp diagnosed left sciatica. On August 6, in the initial physical therapy evaluation, the employee reported left lumbosacral pain, hip pain, and mid-thigh pain, and that he did not have any pain on the right side. On August 18, the employee had left gluteus maximus tenderness. On September 17, Dr. Kapp noted complaints of sciatica with the most prominent discomfort in the lower left lumbar spine that radiated to the left leg and hip with numbness in the legs. On September 30, Dr. Kapp noted mild pain to the right leg if he was on his feet for prolonged periods of time, but his discomfort was most prominent in the lower left lumbar spine. In October the employee reported to the therapist that he was much better with pain of 2-3 out of 10. In mid October, Dr. Kapp noted improved low back pain, most prominent along the lower left lumbar spine.

The employee saw Dr. Chabot on February 10, 2012. The employee reported to him that on July 6, 2010, he strained his low back in the process of moving the molds. The employee had left buttock pain into his left proximal leg that radiated into his left thigh with gluteus maximus tenderness. The employee’s symptoms responded to conservative treatment. At the time of the February 2012 examination, the employee had less severe and less frequent low back pain with mild to moderate pain of 3 out of 10. The employee was not using any medications. Dr. Chabot stated that the employee was not in any distress, moved without difficulty, had no list or limp,

was able to heel and toe walk, and was not tender to palpation over the lumbar spine. The employee had normal range of motion and no evidence of spasms. Dr. Chabot stated that examination was essentially normal and devoid of any objective physical findings. The neurologic examination was normal with no documentation of specific neurologic changes involving the lower extremities or evidence of tension signs to suggest evidence of an active radiculopathy. The findings were most consistent with a muscle strain with referred pain.

It was Dr. Chabot's opinion that the employee suffered a back strain injury as a result of the July 6, 2010 work incident, and that the employment at TG was the prevailing factor in causing his back pain on July 6, 2010. It was his opinion that for the July 6, 2010 injury the employee had reached maximum medical improvement, did not need any further medical treatment as a result of that back strain, and was not a surgical candidate. It was his opinion that any additional treatment or diagnostic studies were not warranted for the July 6, 2010 work injury.

On May 30, 2012, the employee sought treatment with nurse practitioner Henneman for discomfort, most prominent in the lower lumbar spine which radiated to the bilateral legs. It was a constant aching and tingling in the legs, especially when waking in the morning. Associated symptoms were radicular bilateral leg pain and numbness in the legs. On examination, the employee had lumbar spinous process, interspace and right paraspinal muscle pain, left paraspinal muscles, and right posterior superior iliac spine tenderness. There was a sensation deficit in the right L4, L5, and S1, and 4/5 strength in the right tibialis anterior. The complaints were greatest in the right lower extremity. The May 31, 2012 lumbar MRI showed a small right lateralizing bulge without focal herniation, narrowing the right lateral recess at the L3-L4 disc level. At the L4-L5 disc level there was a small circumferential bulge with superimposed 2mm left lateralizing herniation that mildly narrowed the left lateral recess.

It was Dr. Kapp's opinion that the May 31, 2012 MRI report showed a L3-4 small right lateralizing bulge without focal herniation mentioned, and L4-5 small circumferential bulge with two millimeter left lateralizing herniation mildly narrowing the left lateral recess. The L3-4 without focal herniation means a bulge, but the disk has not actually herniated out of its casing or sheaths. Dr. Kapp stated the report mentioned the L4-5 bulge mildly narrowed the left lateral recess, but it did not make mention of nerve compression or indentation. It was Dr. Kapp's opinion that there was no way to tell when the disc bulges at L3-4 or L4-5 happened from looking at the MRI report, and there was no way to tell whether the MRI findings are related to the July 6, 2010 incident. When asked if he had an opinion whether or not the work accident of July 6, 2010, could have been the prevailing factor in his injuries or disabilities, Dr. Kapp testified that it was difficult for him to give an opinion on causation because he did not know what transpired after the employee's care at his clinic. Dr. Kapp stated that his initial impression of the MRI was that the findings were very minimal, and based on that alone he would not have recommended surgical correction. On August 4, 2010, it was Dr. Kapp's opinion that the prevailing cause of the employee's back pain appeared to be job related when pushing the object at work.

On July 5, 2012, the employee saw Dr. Fonn with a chief complaint of back and right leg pain. Dr. Fonn noted shooting pain in his back radiating into his right leg into the thigh and knee

region, right worse than the left. There was paresthesia and weakness secondary to the pain and his legs were worse than the back. On examination, there was decreased sensation in the L3 distribution on the right with positive straight leg test at 45 degrees on the right. Dr. Fonn stated that the MRI showed an annular tear at L4-L5 and a bilateral foraminal disc herniation at the L3-4 disc level on the right causing impingement of the exiting nerve root. Dr. Fonn stated that the employee had signs and symptoms of lumbar radiculopathy. Dr. Fonn performed a CT myelogram on August 30. His impression was disc herniation at L3-4 on the right with collapse of the disc height and disc herniation causing moderate left foraminal narrowing and stenosis at L4-5. A post discogram CT scan on September 5, 2012, showed extravasation of dye at the L3-L4 and L4-L5 disc levels, suggestive of annular tears at both levels. On September 18, 2012, Dr. Fonn performed L4-L5 bilateral laminotomies with decompression of nerve roots, partial facetectomy, foraminotomy, and excision of herniated intervertebral disc, and L4-5 fusion. Also performed was a L3-L4 laminotomy foraminotomy, and microdissection on the right. There was a disc fragment that was removed in several large pieces. There were broad based disc herniations at both levels which were completely removed. The post operative diagnosis was L4-5 scoliosis, degenerative disc disease, disc herniations and foraminal stenosis, and foraminal stenosis right L3-4 with right L3 radiculopathy.

Dr. Fonn testified that when he first saw the employee on July 5, 2012, he had back and bilateral leg pain with shooting back pain radiating into his right leg into the thigh and knee region. The right was worse than the left. Dr. Fonn diagnosed signs and symptoms of lumbar radiculopathy. His sensory examination suggested a decreased sensation in the L3 distribution on the right. The straight leg raising test to 45 degrees on the right could be any of the nerve roots in the lumbar spine. Dr. Fonn stated that the myelogram showed problems primarily at the L3-4 and L4-5 levels and the discogram showed concordant pain at L4-5 but did not at L3-4.

On August 23, 2013, the employee told Dr. Poetz that when he was injured moving the mold he felt a sharp pain in his lower back which traveled down his right leg, and the symptoms progressively worsened over time. Dr. Poetz diagnosed pre-existing lumbar degenerative disc disease, disc herniations at L3-4 and L4-5 with annular tears, foraminal stenosis, radiculopathy, and exacerbation of lumbar degenerative disc disease resulting from his work accident on July 6, 2010, with surgery on September 18, 2012, that resulted from the July 6, 2010 work injury. It was Dr. Poetz's opinion that the surgical procedures performed on September 18, 2012, were all as a result of the injury that occurred at work on July 6, 2010. It was his opinion that the prevailing factor in causing both the resulting medical condition and disability was the July 6, 2010 work injury. It was his opinion that there was not an intervening cause other than his work incident that resulted in his condition.

Dr. Chabot stated that the employee's complaints to Dr. Kapp originally in 2010 were primarily in the left buttock and left proximal leg. Dr. Chabot stated that when he saw the employee on February 10, 2012, he had aching moderate low back pain, was not using medication, and there was no mention of right leg pain complaints. Dr. Chabot was not able to find any objective sign of injury, his examination was essentially normal, and there were not any persisting functional deficits or neurologic abnormalities or changes. His neurologic

examination was normal, there was no neurologic changes involving the lower extremities, or evidence of tension signs to suggest that the employee had evidence of an active radiculopathy.

Dr. Chabot stated that around May of 2012, the employee's condition changed and there was a new onset of back complaints radiating into both legs, right greater than left. The bilateral leg complaints as well as the constant aching and tingling in his legs were different complaints from the initial 2010 complaints. The employee had terrible back and right leg pain with some changes of loss of sensation which was significantly different than his examination. The pain shooting down his right leg with numbness and weakness were all categorically different than anything previously documented or represented to him when he examined the employee, or to Dr. Kapp or any other treater. Those symptoms appear to be very different than what the employee previously had following the onset of symptoms in 2010. In July of 2012 the employee had back and right leg complaints of a severe magnitude which he did not have previously, and Dr. Fonn found sensory nerve loss involving the right lower extremity which was not present on prior examinations.

It was Dr. Chabot's opinion that due to the change in his complaints, specifically pain radiating down the right lower extremity, that the employee developed a disc protrusion after he saw the employee in February of 2012. It was Dr. Chabot's opinion that the herniated discs were not related to any specific work duties, and the July 6, 2010 accident was not the prevailing factor in causing the disc desiccation, herniated discs and resulting surgery on September 18, 2012. It was Dr. Chabot's opinion that any additional treatment following his evaluation in February of 2012 was related to the pre-existing degenerative disc disease and/or new disc pathology unrelated to his work activities.

Based on a thorough review of all the evidence, I find that the opinions of Dr. Kapp and Dr. Chabot are very persuasive and more persuasive than the opinion of Dr. Poetz.

I find that on July 6, 2010, the employee sustained an accident arising out of and in the course of employment. I find that the July 6, 2010 accident was the prevailing factor in causing a low back strain, resulting disability, and the need for medical treatment provided by the employer-insurer through the visit with Dr. Chabot on February 10, 2012. I find that the employee's low back strain and the medical care and treatment for the low back strain through the visit with Dr. Chabot on February 10, 2012, was medically causally related to the July 6, 2010 accident and injury.

I find that the employee failed to meet his burden of proof that any other low back condition, including the disc problems at L3-4 and L4-5, was medically causally related to the July 6, 2010 accident and that the July 6, 2010 accident was the prevailing factor in causing any low back condition other than his low back strain. I find that the July 6, 2010 accident was not the prevailing factor in causing the disc herniations at L3-4 and L4-5 with annular tears, foraminal stenosis, and the L3-4 and L4-5 surgery performed by Dr. Fonn in September of 2012, and were not medically causally related to the July 6, 2010 accident.

It was Dr. Chabot's persuasive opinion that on February 12, 2012, the employee was at maximum medical improvement for his low back strain. I find that the employee has failed to meet his burden of proof on the issue of medical causation for the treatment received on his low back after February 12, 2012. I find that low back treatment after February 12, 2012, is not medically causally related to the employee's July 6, 2010 accident.

Issue 3. Claim for previously incurred medical aid.

The employee is claiming \$388,011.29 in previously incurred medical aid. The employer-insurer is disputing that amount with regard to authorization, reasonableness, necessity and causal relationship. The claim for previously incurred medical bills are from Perryville Family Care Clinic, Perry County Memorial Hospital, Midwest Neurosurgeons, St. Francis Medical Center, St. Francis Anesthesia, and Therapy Solutions. The dates of service for the claimed medical bills began on May 30, 2012 and ended on November 12, 2014.

Based on my ruling in Issue 2 on medical causation, I find that any medical bills for medical treatment to the employee's low back after February 12, 2012 are not medically causally related to the July 6, 2010 accident and were not necessary as a result of the July 6, 2010 accident. The employee's claim for the treatment and bills after February 12, 2012 is denied. The employee's claim for previously incurred medical is denied.

Issue 4. Claim for additional or future medical aid.

The employee is requesting future medical aid. Under Section 287.140 RSMo, the employee is entitled to medical treatment to cure and relieve the employee from the effects of the injury. The Court of Appeals in *Sifferman v. Sears, Roebuck and Company*, 906 S.W.2d 823 (Mo. App. 1995) held that future medical care must flow from the accident before the employer is to be held responsible.

It was Dr. Poetz's opinion that the employee use anti-inflammatory medication and to follow-up with an orthopedic surgeon to monitor the status of the hardware or if symptoms out of the ordinary develop. It may be necessary for him to undergo repeat studies. It was Dr. Fonn's opinion that the employee will require additional care or observation to monitor his treatment or the hardware in his back. It was Dr. Chabot's opinion that the employee had reached maximum medical improvement as it related to the July 6, 2010 injury. It was his opinion that the employee did not need any further medical treatment as a result of the back strain. It was his opinion that additional treatment or additional diagnostic studies were not warranted for the July 6, 2010 work injury.

Based on a review of all of the evidence and my rulings on medical causation, I find that opinion of Dr. Chabot is very persuasive and is more persuasive than the opinions of Dr. Poetz and Dr. Fonn.

The employee has the burden of proof that the future medical care flows from the accident. Based on my ruling on medical causation, the employer-insurer is only liable for future medical care for a low back strain and not his other lumbar conditions. Although there is

evidence that the employee is in need of future medical care for his overall condition, there is not sufficient medical evidence that the treatment that the employee needs is a result of the compensable low back strain and flows from the accident. I find that the employee has failed to meet his burden of proof that future medical treatment is medically causally related to condition caused by the work-related accident. The employee's claim for additional or future medical aid is denied.

Issue 5. Temporary total disability.

The employee is claiming temporary total disability from September 18, 2012, the day of the lumbar spine surgery, through January 23, 2013, when Dr. Fonn released the employee to go back to work. Based on my ruling on medical causation in Issue 2 that the September 18, 2012 surgery was not medically causally related to the July 6, 2010 accident, and that the low back treatment after February 12, 2012, is not medically causally related to the employee's July 6, 2010 accident, the employee's claim for temporary total disability is denied.

Issue 6. Nature and extent of permanent partial disability.

Based on the evidence, I find that the employee has sustained permanent partial disability as a result of the July 6, 2010 accident that caused a low back strain. I find that as a direct result of the July 6, 2010 accident the employee sustained a 10% permanent partial disability of the body as a whole referable to his low back. The employer-insurer is ordered to pay the employee 40 weeks of compensation at the rate of \$349.72 per week for a total award of permanent partial disability of \$13,988.80.

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:

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