

**BEFORE THE APPEALS BOARD
FOR THE
KANSAS DIVISION OF WORKERS COMPENSATION**

THOMAS JACKSON)	
Claimant)	
VS.)	
)	Docket No. 245,373
LRM INDUSTRIES)	
Respondent)	
AND)	
)	
CNA INSURANCE)	
Insurance Carrier)	

ORDER

Claimant requested Appeals Board review of Administrative Law Judge Brad E. Avery's June 4, 2001, Award. The Appeals Board heard oral argument on December 4, 2001, in Topeka, Kansas.

APPEARANCES

Claimant, Thomas Jackson, of Lawrence, Kansas, appeared pro se.¹ Gary R. Terrill of Overland Park, Kansas, appeared on behalf of the respondent and its insurance carrier.

RECORD AND STIPULATIONS

The Appeals Board (Board) has considered the record as listed in the Award. Additionally, the parties agreed the record should also contain the October 5, 1999, preliminary hearing transcript with the exception of any medical record hearsay admitted at the preliminary hearing. The Board has also adopted the stipulations listed in the Award. In addition to the stipulations listed in the Award, the record should also include the May 27, 2001, stipulation of the parties containing the Curriculum Vitae of William A. Bailey, M.D. and an April 27, 2001, stipulation of the parties containing a picture of respondent's cement truck that claimant was driving at the time of the June 17, 1999, accident.

¹ Sally G. Kelsey, attorney at law, represented the claimant in this case and filed the timely application requesting the Board to review the Award. On the same date that the application was filed, Ms. Kelsey also filed a Motion to Withdraw as claimant's attorney of record. The ALJ, in a June 11, 2001, Order to Withdraw granted Ms. Kelsey's motion.

ISSUES

Claimant alleges he suffered severe disabling neck and low back injuries as a result of a motor vehicle accident while employed by the respondent. The Administrative Law Judge (ALJ) considered the evidence and found claimant had proved he suffered only a permanent low back injury and awarded claimant a 5 percent permanent partial general disability based on functional impairment.

On appeal, claimant contends he severely injured both his neck and low back in the work-related motor vehicle accident. As a result, claimant contends the severe disabling pain has rendered him not only unable to work, but also unable to perform essential daily living activities such as putting on his shoes and socks.

Conversely, respondent requests the Board to affirm the ALJ's Award. Respondent contends the medical evidence presented in the record proves that claimant is a symptom magnifier and his disabling subjective complaints of pain are completely out of proportion with any objective physical findings of injury.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

After reviewing the record, considering the respondent's brief and the parties' arguments, the Board makes the following findings and conclusions:

The Board finds the ALJ's Award should be affirmed. The Board agrees with the findings and conclusions of law that are set out in the Award. It is not necessary to repeat those findings and conclusions. Therefore, the Board adopts the ALJ's findings and conclusions as its own as if specifically set forth in this Order.

After claimant's June 17, 1999, motor vehicle accident, claimant did not seek immediate medical treatment on the day of the motor vehicle accident. But the next day he had a headache and pain in his neck and back. He notified his supervisor of the pain and was sent to Michael Geist, M.D. in Lawrence, Kansas. Dr. Geist saw claimant on June 21, 1999, took claimant off work, prescribed medication and placed claimant in a physical therapy program. Claimant provided Dr. Geist with a history that the motor vehicle accident caused minimum damage to his truck. The record contains a picture of the large cement truck after the motor vehicle accident that shows only damage to the truck's front bumper and grill.

After the June 17, 1999, accident, claimant never returned to work and never attempted to look for other employment. He received an extensive course of conservative medical treatment for the injuries to his neck and low back. Also, claimant had extensive diagnostic studies completed in an attempt to find the source of his extreme disabling pain and discomfort. At the time claimant last testified in this case at the February 20, 2001, regular hearing, he continued to complain of disabling pain in his low back and right leg to

the extent he walked with assistance of a walker and testified he was unable to put on his own shoes or even lift a plate of food.

On October 11, 1999, orthopedic surgeon Dr. Bailey was appointed by the ALJ as claimant's treating physician. Dr. Bailey followed claimant through July of 2000, when Dr. Bailey determined claimant had met maximum medical improvement. Before Dr. Bailey was appointed as claimant's treating physician, the respondent's insurance company had referred claimant for evaluation and treatment recommendations to orthopedic surgeon William O. Reed, M.D. located in Shawnee Mission, Kansas. Dr. Reed saw claimant on August 3, 1999. At that time, claimant had complaints of severe disabling neck and back pain unresponsive to physical therapy treatment. Claimant was using a cane to ambulate at the time Dr. Reed examined claimant. Dr. Reed noted claimant would not cooperate with the physical examination. He also noted, "gross evidence of symptom magnification during the physical examination." Claimant was also belligerent and hostile during the examination.

In an effort to find objective reasons for claimant's complaints, Dr. Reed ordered claimant to undergo an MRI scan of both his cervical and lumbar spine, a bone scan and a functional capacity evaluation (FCE).

The evaluator conducting the FCE reported he was unable to obtain a physical demand category due to symptom magnification behavior of claimant. Claimant cancelled the next day testing and did not want to reschedule.

The bone scan was completed on August 9, 1999, with normal results. The MRI scan of claimant's cervical spine was completed on August 10, 1999, and was negative for abnormalities. The lumbar MRI scan was completed on the same day and indicated a small bulging disc at L4-5 which was in Dr. Reed's opinion clinically insignificant. There was no evidence of herniation compressing or impinging on a nerve root. Dr. Reed concluded he did not place any restrictions on claimant's activities because there was no objective criteria on which to base such limitations. Dr. Reed opined claimant should return to his regular work without restrictions. He went on to opine that claimant had met maximum medical improvement and was not in any need of further medical treatment.

After Dr. Bailey reviewed the August 10, 1999, MRI examination of claimant's lumbar spine, he thought some of claimant's discomfort could be the small central disc protrusion at L4-L5. But when Dr. Bailey was asked if he believed claimant's pain was genuine. He replied, "I can't tell for sure. It certainly seems to be somewhat out of proportion to what I've been able to find, objectively, but, you know, I listen to patients and I usually believe what they tell me." Dr. Bailey, however, determined from his review of the MRI scan of claimant's lumbar spine that there was not a bulge or herniation that would explain claimant's continuing disabling right leg pain. Dr. Bailey agreed claimant's subjective symptoms were more substantial than the physical findings. Dr. Bailey did conclude that in his opinion, utilizing the AMA Guides to the Evaluation of Permanent

Impairment, Fourth Edition (AMA Guides, Fourth Edition), that claimant had an unoperated degenerative disc in the lumbar spine resulting in a 7 percent permanent functional impairment to the body as a whole. Additionally, Dr. Bailey determined that claimant had met maximum medical improvement in July 2000, and at that time Dr. Bailey did not place any restrictions on his activities. But at his deposition, Dr. Bailey limited claimant's lifting to 40 pounds, with no repetitive bending or squatting and probably no sitting for more than an hour.

At claimant's attorney's request, he was examined and evaluated by Peter N. Bieri, M.D. Dr. Bieri is a physician who spends 50 percent of his time in an office practice in eye, nose and throat medicine. The other 50 percent of his time he performs independent medical examinations.

Dr. Bieri saw claimant on one occasion on September 13, 2000. He agreed that the MRI scan taken in August of 1999, of claimant's cervical spine was normal and the lumbar MRI scan revealed a bulging at L4-5, but no impingement of the nerve root. Dr. Bieri also reviewed an EMG/NCT test completed on July 6, 2000, and agreed it was negative for radiculopathy. Additionally, Dr. Bieri agreed claimant's severe low extremity complaints did not make sense from an anatomical standpoint. He also agreed that claimant's subjective complaints were out of proportion to his objective physical findings. But based primarily on claimant's subjective complaints, and in accordance with the AMA Guides, Fourth Edition, Dr. Bieri assessed claimant with a 5 percent whole body functional impairment for his cervical injury and a 5 percent whole body functional impairment rating for his lumbar injury and combined those for a 10 percent whole body rating. He attributed the 10 percent whole person rating to claimant's June 17, 1999, work-related accident.

Dr. Bieri also placed claimant in the sedentary physical demand level job category defined as limited to exerting up to 10 pounds of force occasionally and negligible amount frequently or constantly to lift, carry, push, pull or otherwise move objects including the human body. Additionally, Dr. Bieri reviewed a job task list completed by claimant which purportedly represented the job tasks claimant had performed in the 15 year period before his accident. Dr. Bieri opined that claimant was unable to perform any of those particular job tasks. Respondent objected to that opinion because claimant had not at any point in the litigation laid a foundation for the admission of the job task list through his testimony.

On February 3, 2000, physical medicine and rehabilitation physician Vito J. Carabetta, M.D., of Olathe, Kansas, conducted an independent medical examination of claimant. Claimant was referred to Dr. Carabetta by his nurse case manager. Dr. Carabetta also reviewed the MRI scans of claimant's cervical spine and lumbar spine completed on August 10, 1999. Dr. Carabetta recognized the L5-4 bulging disc but indicated there was no nerve root impingement. He also explained that such a disc bulge was not an explanation for claimant's extreme symptoms because in this case there was no pressure on the nerve root which would be viewed as a distinct lesion. Dr. Carabetta

went on to opine that the disc bulge was not the source of claimant's pain. The doctor's diagnosis was neck and back pain.

On physical examination, Dr. Carabetta found significant evidence of inconsistencies. He explained the inconsistencies as suggesting that claimant's symptoms generally outweighed anything objectively present in terms of physical abnormalities. Dr. Carabetta also opined that his overall impression suggests at least a moderate degree of symptom magnification. Utilizing the AMA Guides, Fourth Edition, he determined claimant's level of functional impairment. Because there were no objective physical findings identified in claimant's cervical spine, no functional impairment was assessed. In regard to claimant's lumbar spine, the doctor determined that claimant's condition fell under Category II of Table 72 of the AMA Guides, Fourth Edition, for a 5 percent whole body functional impairment.

The respondent's insurance company referred claimant for a second opinion to orthopedic surgeon Jeffrey T. MacMillan, M.D. of Overland Park, Kansas on April 27, 2000. Dr. MacMillan specializes in spine surgery. Dr. MacMillan reviewed claimant's previous treatment records, diagnostic tests and completed a physical examination of claimant. The MRI scans taken of claimant's cervical and lumbar spine on August 10, 1999, were reviewed. Dr. MacMillan recognized the lumbar L4-5 disc bulge, but did not describe it as an abnormal finding and indicated the bulge had no clinical significance. Dr. MacMillan could not find any explanation for claimant's extreme symptoms. Because the claimant's significant complaints of pain and numbness radiating down his right lower extremity, Dr. MacMillan thought claimant's symptoms might be connected with L5 radiculopathy. In order to make that determination, Dr. MacMillan ordered EMG and nerve conduction studies for claimant.

The EMG and nerve conduction studies were conducted by neurologist Michael E. Ryan, M.D. on June 2, 2000. Dr. Ryan found no current electrophysiologic evidence of a neuropathy, radiculopathy, or plexopathy. He also noted the test was somewhat limited by poor voluntary effort on the part of the claimant in testing certain muscles.

Dr. MacMillan saw claimant again on July 6, 2000. At that time, claimant continued to have complaints of excruciating pain radiating down his right lower extremities. The pain was completely disabling. Since the EMG and nerve conduction studies of claimant's right lower extremity were normal, Dr. MacMillan opined there was no objective evidence to corroborate complaints of right lower extremity neurological pain. Claimant's complaints appeared far out of proportion to the objective physical findings. To ensure claimant did not have an underlying systemic cause for his symptoms, Dr. MacMillan ordered a series of blood tests to rule out Lyme disease, syphilis and rheumatologic disorders. Also, Dr. MacMillan recommended a lumbar myelogram/CT scan to ensure the MRI scan did not miss any objective physical findings.

Dr. MacMillan saw claimant again on November 7, 2000. Claimant reported he had not completed the blood testing recommended or the myelogram/CT scan. Dr. MacMillan testified claimant refused those tests because claimant did not want to be stuck with a needle. Claimant continued to have extreme complaints of disabling low back and right lower extremity pain. Dr. MacMillan found no objective physical evidence to support any physical injury or impairment. Dr. MacMillan concluded claimant demonstrates extreme signs of symptom magnification. He noted that during this last office visit that claimant was hostile and generally refused to answer most questions posed to him.

Dr. MacMillan also did not place any temporary or permanent restrictions on claimant's activities. In accordance with the AMA Guides, Fourth Edition, Dr. MacMillan opined that claimant would be assessed with a 0 percent functional impairment. The doctor reviewed a list of job tasks claimant had performed in the 15 year period proceeding his injury compiled by vocational expert Monty Longacre. The doctor opined that claimant was physically able to perform all of the job tasks listed.

All five physicians who testified in this case generally agree that claimant's complaints of disabling pain are out of proportion to any objective physical findings. Most of the physicians also agree that claimant demonstrates extreme to moderate signs of symptom magnification. Thus, the Board finds, based on the whole record, that it is very difficult, if not impossible, to ascertain from the record what, if any, permanent restrictions claimant has as a result of the June 17, 1999, motor vehicle accident. The Board concludes, as did the ALJ, based on these particular circumstances, claimant has failed to prove that the minor motor vehicle accident he was involved in and the resulting minor physical injuries are the cause of his current extreme disabled condition. The Board further concludes, the greater weight of the medical evidence, proves claimant's physical injuries, if any, caused by the June 17, 1999, accident have not disabled claimant from returning to and performing full time employment including his ability to perform the cement truck driving job for respondent.

AWARD

WHEREFORE, it is the finding, decision, and order of the Board that ALJ Brad E. Avery's June 4, 2001, Award should be, and is hereby, affirmed.

IT IS SO ORDERED.

Dated this ____ day of April 2002.

BOARD MEMBER

BOARD MEMBER

BOARD MEMBER

c: Thomas Jackson, Claimant
1401 E. 24th Street, Apt. C-1
Lawrence, Kansas 66046
Gary R. Terrill, Attorney for Respondent
Brad E. Avery, Administrative Law Judge
Philip S. Harness, Workers Compensation Director