

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

Injury No.: 03-021251

Employee: Michael Bennett

Employer: Noranda Aluminum

Insurer: Self-Insured Noranda Aluminum
c/o TPA Sedgwick Claims Management Services

Additional Party: Treasurer of Missouri as Custodian
of Second Injury Fund

Date of Accident: March 4, 2003

Place and County of Accident: New Madrid County, Missouri

The above-entitled workers' compensation case is submitted to the Labor and Industrial Relations Commission (Commission) for review as provided by section 287.480 RSMo. Having reviewed the evidence and considered the whole record, the Commission finds that the award of the administrative law judge is supported by competent and substantial evidence and was made in accordance with the Missouri Workers' Compensation Act. Pursuant to section 286.090 RSMo, the Commission affirms the award and decision of the administrative law judge dated July 3, 2008. The award and decision of Administrative Law Judge Lawrence C. Kasten, issued July 3, 2008, is attached and incorporated by this reference.

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

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

Given at Jefferson City, State of Missouri, this 22nd day of December 2008.

LABOR AND INDUSTRIAL RELATIONS COMMISSION

William F. Ringer, Chairman

Alice A. Bartlett, Member

Attest: _____
John J. Hickey, Member

Secretary

ISSUED BY DIVISION OF WORKERS' COMPENSATION

FINAL AWARD

Employee: Michael Bennett

Injury No. 03-021251

Dependents: N/A

Employer: Noranda Aluminum

Additional Party: Second Injury Fund

Insurer: Self Insured Noranda Aluminum c/o TPA Sedgwick Claims Management Services

Hearing Date: Commenced November 28, 2008
Completed April 4, 2008

Checked by: LK/kh

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? March 4, 2003.
5. State location where accident occurred or occupational disease contracted: New Madrid 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? Self-Insured.
11. Describe work employee was doing and how accident happened or occupational disease contracted: The employee fell 15-20 feet onto a concrete floor.
12. Did accident or occupational disease cause death? No.
13. Parts of body injured by accident or occupational disease: Right shoulder; left shoulder, right elbow, body as a

whole referable to head, neck, upper back, mid back, and low back.

14. Nature and extent of any permanent disability: 35% permanent partial disability of the body as a whole referable to the head, neck, upper back, mid back, and low back; 20% of the right shoulder; 17.5 % of right elbow, and 20% of left shoulder against the employer. Permanent Total Disability against the Second Injury Fund.
15. Compensation paid to date for temporary total disability: \$66,416.16.
16. Value necessary medical aid paid to date by employer-insurer: \$140,257.45
17. Value necessary medical aid not furnished by employer-insurer: \$14,289.69.
18. Employee's average weekly wage: Maximum Rate.
19. Weekly compensation rate: \$649.32 per week for temporary total and permanent total disability. \$340.12 per week for permanent partial disability.
20. Method wages computation: By agreement.
21. Amount of compensation payable:
 - \$5,472.84 for temporary total disability.
 - \$14,289.67 in previously incurred medical bills.
 - \$91,679.35 for permanent partial disability

Total: \$111,441.86.
22. Second Injury Fund liability: Permanent Total Disability (See Rulings of Law)
23. Future requirements awarded: See Rulings of Law for future medical benefits and permanent total disability.

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

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

FINDINGS OF FACT AND RULINGS OF LAW

On November 28, 2007, the employee, Michael Bennett, appeared in person and by his attorney, Phil Barkett, for a hearing for a final award. The employer Noranda Aluminum, Inc. was represented at the hearing by its attorney, Larry Rost. Also present for the employer was Angie Moore, the employer's Director of Nursing. The Second Injury Fund was represented by Assistant Attorney General, Frank Rodman. Southeast Missouri Hospital had filed a direct medical fee dispute in the case. The notice of the hearing was sent both to Southeast Missouri Hospital and their attorney. No one appeared at the hearing on behalf of Southeast Missouri Hospital. At the time of the hearing, the parties agreed on certain undisputed facts and identified the issues that were in dispute. These undisputed facts and issues, together with the findings of fact and rulings of law, are set forth below as follows:

UNDISPUTED FACTS

1. The employer, Noranda Aluminum, Inc. was operating under and subject to the provisions of the Missouri Workers' Compensation Act and was dully qualified as a self-insured employer c/o TPA Sedgwick Claims Management Services.
2. On March 4, 2003, Michael Bennett was an employee of Noranda Aluminum Inc. and was working under the Workers' Compensation Act of Missouri.
3. On March 4, 2003, the employee sustained an accident arising out of and in course of his employment.
4. The employer had notice of the employee's accident.
5. The employee's claim was filed within the time allowed by law.
6. The employee's average weekly wage was sufficient to make his rate of compensation the maximum rate. The rate of compensation for temporary total and permanent total disability is \$649.32 per week. The rate of compensation for permanent partial disability is \$340.12.
7. The employer has paid \$140,257.45 in medical aid.
8. The employer paid \$66,416.16 in temporary disability from March 5, 2003 through February 17, 2005.
9. The employee's injuries to his right elbow, right shoulder and left shoulder are medically causally related to the accident.

ISSUES

1. Medical causation
2. Claim for previously incurred medical
3. Direct medical fee dispute filed by Southeast Missouri Hospital in the amount of \$4,289.18.
4. Claim for additional or future medical aid
5. Nature and extent of disability including temporary total disability, permanent total disability, and permanent partial disability.
6. Liability of the Second Injury Fund for permanent total or permanent partial disability

EXHIBITS

The following exhibits were offered and admitted into evidence:

Employee's Exhibits

- A. Curriculum vitae of Dr. Levy
- B. Various medical records (The record was left open for the employee to submit certified copies of the medical records.
The exhibit was admitted on April 4, 2008. See April 4, 2009 letter concerning this Exhibit)
- C. February 21, 2006 report from Dr. Levy
- D. March 4, 2006 report from Dr. Levy
- E. Withdrawn by the employee on April 4, 2008
- F. Withdrawn by the employee on April 4, 2008
- G. September 27, 2006 letter from Dr. Levy
- H. October 24, 2006 deposition of Dr. Levy
- I. Curriculum vitae of Timothy Lalk
- J. June 2, 2006 report of Timothy Lalk
- K. January 17, 2007 deposition of Timothy Lalk
- L. Curriculum vitae of Dr. Stone
- M. June 12, 2006 report of Dr. Stone (The admission of this exhibit was objected to in the ruling upon the

admissibility

that this exhibit was taken under advisement. The objections to this exhibit are overruled and the exhibit is admitted

into evidence.)

N. August 17, 2006 report of Dr. Stone (The admission of this exhibit was objected to in the ruling upon the admissibility

that this exhibit was taken under advisement. The objections to this exhibit are overruled and the exhibit is admitted

into evidence.)

O. Deposition of Dr. Stone

P. Deposition of Shawna Gerding

Q. Document with amount of temporary total disability in medical bills paid by the employer

R. Medical bills in the amount of \$55,701.14

S. Prescription medication expenses in the amount of \$14,964.43

T. Medical records of Ferguson Medical Group

U. Southeast Missouri Hospital records

V. Medical records of Southeast Missouri Hospital (The record was left open for the submission of a certified copy of

these records. This exhibit was admitted into evidence on April 4, 2008.)

W. Medical records of Dr. Pfefferkorn

X. Medical records of Dr. Stone

Employer-Insurer's Exhibits

1. Curriculum vitae of Dr. Marsh

2. January 18, 2005 report of Dr. Marsh

3. May 12, 2005 report of Dr. Marsh

3A. Deposition of Dr. Marsh taken on April 3, 2007

4. Curriculum vitae of Dr. Cantrell

5. September 14, 2004 report of Dr. Cantrell

6. October 6, 2004 report of Dr. Cantrell

6A. September 15, 2004 report of Scott Gallant (The record was left open for the submission of a certified copy of this record. This exhibit was admitted into evidence on April 4, 2008.)

6B. May 24, 2007 deposition of Dr. Cantrell

7. Curriculum vitae of Victor Zuccarello

8. Functional capacity evaluation dated March 22, 2005

9. August 17, 2007 deposition of Victory Zuccarello

10. Medical records of Orthopaedic Associates (The record was left open for the employer to obtain a certified copy of these records. This exhibit was admitted into evidence on April 4, 2008.)

11. Medical records of Dr. Deisher (The record was left open for the employer to obtain a certified copy of these records. This exhibit was admitted into evidence on April 4, 2008.)

12. Medical records of Dr. Vaught (The record was left open for the employer to obtain a certified copy of these records. This exhibit was admitted into evidence on April 4, 2008.)

13. Compromise settlement in injury number 82-031668

14. Compromise settlement in injury number 87-073220

15. Medical record of Dr. Guidos – Southeast Missouri Hospital (The record was left open for the employer to obtain a certified copy of these records. This exhibit was admitted into evidence on April 4, 2008.)

16. Medical record of Dr. Delonais-Turner – Southeast Missouri Hospital (The record was left open for the employer to obtain a certified copy of these records. This exhibit was admitted into evidence on April 4, 2008.)

17. Medical records of Dr. Lake – Southeast Missouri Hospital (The record was left open for the employer to obtain a certified copy of these records. This exhibit was admitted into evidence

on April 4, 2008.)

18. Medical records of Silver Springs Pain Management Center (The record was left open for the employer to obtain a certified copy of these records. This exhibit was admitted into evidence on April 4, 2008.)

The Second Injury Fund did not offer any exhibits.

NOTE: With regard to the exhibits that the record was left open for the submission of certified copies, please see April 4, 2008 confirmation letter of a telephone conference held with the parties regarding the exhibits.

Judicial notice of the contents of the Division's files for the employee was taken.

Witnesses: Michael Bennett, the employee; and Jessica Bennett, for the employee

Briefs: The employee's and employer's briefs were received on December 13, 2007. The Second Injury Fund's brief was received on December 11, 2007.

FINDINGS OF FACT

At the time of the hearing, the employee was 53 years old. The employee testified that he completed the 9th grade, never received his GED, and did not have any vocational or technical training. The employee is single and has two children. His daughter Jessica Bennett accompanied him to the hearing. After the 9th grade, he worked for his father at a gas station for three years. He then worked on a farm and then for a short time on a tow boat. On May 17, 1975, he started working for Noranda Aluminum and worked there until March 4, 2003. The employee had injuries and medical conditions prior to March 4, 2003.

Prior Conditions:

Addiction: In 1983, the employee was in a 28 day detoxification program at the Highland Center in St. Louis for Valium addiction. He was taking Valium for highness and did not have a prescription for them. As a result of the program, he stopped taking the Valium. Prior to 2003, he was diagnosed with diabetes and was prescribed Glucophage and Amaryl by Dr. Pfefferkorn.

Back: The employee had a back injury in 1982 while working for Noranda. In 1984, a compromise settlement agreement was entered into for 10% permanent partial disability of the body. The employee injured his low back in February of 1989 at Noranda. He was treated by Dr. Angelos who noted bilateral positive straight leg raising and lumbar tenderness.

Left Shoulder: The employee injured his left shoulder in 1984 at Noranda. Dr. Otto injected the shoulder twice. The employee was treated by Dr. Thorpe in 1997 and was given several cortisone injections. In October of 1997, Dr. Thorpe performed an arthroscopic intra articular debridement of the labral tears and chondromalacia, subachromial decompression, and distal clavicle resection in the AC joint. The glenoid labrum had several tears and the supraspinatus had a partial thickness tear. The employee had occasional burning.

Right Knee: In June of 1987, the employee had a work related injury to his right knee. Dr. Lents performed an excision of a small tear of the lateral meniscus. Dr. Lents rated the employee at 5% permanent partial disability of the whole person. The employee settled his case for 10% permanent partial disability of the right knee.

Low Back, Right Buttocks and Right Thigh: In November of 1992 the employee saw Dr. Thorpe for right buttock and right upper thigh area pain. A CT scan showed a small bulge at L4-5 with no evidence of nerve root impingement. Dr. Thorpe did not believe that the employee had radiculopathy or a disc herniation. Dr. Thorpe diagnosed piriformis syndrome and thought he might have early sciatica irritation.

Right Elbow: In September of 1996, the employee was treated by Dr. Thorpe for right elbow pain. Dr. Thorpe performed several cortisone injections and diagnosed a sprain/strain, a spur, and lateral epicondylitis.

Right Shoulder: The employee started treating with Dr. Thorpe in June of 1998. An August MRI showed impingement and a partial tear of the rotator cuff. Dr. Thorpe performed an arthroscopic LACS/SAD, resection of AC joint and debridement of labral tears that were unrepairable. The findings were multi-directional instability, impingement of the rotator cuff partial tear and labral tears unrepairable. At the end of November, the employee had sharp pain and Dr. Thorpe assessed a rotator cuff impingement and performed a cortisone shot.

Left Elbow: In May of 2000, the employee started seeing Dr. Thorpe for lateral epicondylitis who performed two cortisone injections. The MRI showed osteochondritis dissecans of the humeral head and thought there might be some loose bodies. Dr. Thorpe performed an arthroscopy of the left elbow with drilling of osteochondritis dissecans, synovectomy and debridement. There were multiple small loose bodies, osteochondritis dissecans of the radial capitella.

Left Rib Muscles: In 2002, the employee was treated for torn left rib muscles around the 11th or 12th rib. He was prescribed Ultracet for pain and was taken off work.

The employee testified that prior to March of 2003, he did not have problems or treatment for his low back on an ongoing basis. The employee had no neck or upper back problems. His diabetes did not affect his work. He took no pain medications or muscle relaxers. He worked 60-75 hours a week and was able to do his job duties. He had no accommodations in his job duties and worked a lot of overtime. With regard to the pre-existing injuries, he went back to work without any restrictions and performed his job. He had no significant problems with those injuries and was able to do his job. Prior to March 4, 2003, he had no back or neck pain and no severe headaches. The only prescription drug that he took was diabetic medications. He took Aleve about once every two weeks due to different parts of his body aching due to work.

Primary Injury

On March 4, 2003, the employee was in a basket that had been lifted into the air by a Hyster and was about 15 foot in the air. As he was attempting to place a fiberglass transit pipe from duct work to a reconditioning pot, he lost his footing, fell backwards, and hit something on the way down. The next thing he remembers is waking up on the concrete floor. The employee had the wind knocked out of him in addition to his head and right leg hurting.

The employee was taken by ambulance to Missouri Delta Medical Center. It was noted that the employee had fallen 15 to 20 feet and lost consciousness. The employee had pain to the left side of the head with a hematoma to the back of the head, right leg and right knee cap abrasions, left rib cage pain that hurt to breathe and left shoulder blade pain. The past medical history showed the employee was diabetic which was fairly poorly controlled and was on Glucophage and Amaryl. He had a past history of chemical abuse but had apparently had been clean for several years. The employee appeared to be in a moderate to marked amount of distress with a contusion to his occipital area. Dr. Pfefferkorn diagnosed multiple contusions and possible fractured ribs secondary to trauma. X-rays were taken of the abdomen, chest, pelvis, tibia, fibula, and cervical spine. A CT scan of the head showed an extra cranial soft tissue swelling/hematoma in the left region.

The employee testified that after he left the hospital, he saw Dr. Pfefferkorn for low back pain, a knot between his shoulder blades which caused headaches. After the fall, he had pain in his low back, between his shoulder blades, in his shoulders, and had headaches.

In March of 2003, the employee told Dr. Pfefferkorn that he had trouble getting up and down. He had popping and cracking in his chest, his ankles were weak, his calf was still swollen, and his whole upper body hurts. He had pain over his posterior right shoulder blade and his right hip. He was walking with a walker. He had swelling over the right scapula. Repeated x-rays of the left ribs show multiple fractures. Dr. Pfefferkorn diagnosed multiple fractured ribs and multiple soft tissue contusions. He prescribed Dilaudid and Naprosyn in lieu of Lorcet Plus. Towards the end

of March, the employee walked with a lot of pain in his ankle and right hip. He had pain from the fractured ribs and was having a popping sensation in the right anterior chest that went through to his back. Dr. Pfefferkorn switched the employee back to Lorcet.

On April 4, the employee was hurting all over, his right ankle and right upper leg and felt weak. Dr. Pfefferkorn referred him to Dr. Lents, an orthopedic surgeon. The employee saw Dr. Lents for left chest wall, shoulders, upper back and neck pain. Dr. Lents prescribed Vicodin for pain; Flexeril for muscle spasms; Feldene as an anti-inflammatory; and physical therapy. Towards the end of April, Dr. Lents noted the employee had headaches and neck pain and referred him to Dr. Burns.

On May 9, the employee saw Dr. Pfefferkorn and told him that the physical therapy made him stronger but made his headache worse. His ankle was unsteady and still swelled. He had pain across both shoulders, in his back and down his right leg. The employee has not smoked or drank since the accident. Dr. Pfefferkorn was to refer him to Dr. Park a neurosurgeon for his shoulders and his back.

Dr. Burns saw the employee on May 16 with diffuse pain that the employee related to the onset of a fall. Dr. Burns assessed diffuse thoracic and scapular pain, myofascial pain syndrome, and mild concussion without traumatic brain injury. Dr. Burns ordered a bone scan and continued physical therapy with addition of myofascial release. Dr. Burns prescribed Skelaxin for muscle spasms and Amitriptyline for headache and sleep disturbance.

On May 21, the whole body bone scan showed focal intense abnormal areas of increased activity in the posterior aspect of the 7-10th left ribs adjacent to the costovertebral junctions consistent with multiple rib fracture. There was increased activity in the lateral aspect of the left thoracic cage suggestive of different age of the process. There was intense abnormal increased activity in the region of the sternoclavicular joints and the proximal aspect of the sternum which could be traumatic or arthritic.

The employee saw Dr. Cheung, a neurosurgeon, on May 23, for headaches, mid-back and low back pain, and pain down the right lower extremity. The employee fell backward and landed on the back of the left side and hit his head and was unconscious for a short time. About a week later the employee started having headaches and pain between his shoulder blades with pain in the low back going down the right extremity. Prior to the accident, the employee was taking a much lower dose of Glucophage and Amaryl for diabetes and currently was taking double the dose. The employee was taking Amitriptyline at bedtime and Lorcet Plus. The employee appeared to be in a moderate amount of pain and he had a very rigid posture. Dr. Cheung's impression was myofascial pain, fractured ribs, and mild to moderate positive straight leg raising. Dr. Cheung injected the trigger points. Dr. Cheung thought the employee had a tension headache from a T6-7 ligamentous tear. Dr. Cheung recommended injections but noted it could affect his glucose level. Dr. Cheung prescribed Zanaflex and Skelaxin, and ordered a lumbar MRI.

The clinical history in the May 27, MRI showed posterior discomfort in the back of the head, the posterior aspect of the cervical spine, interscapular dorsal spine and lumbosacral spine and pain in his right buttocks and right posterior thigh. The impression of the radiologist was degenerative disc signal loss at L3-4 and L4-5 with no focal disc protrusion, canal stenosis or any evidence of a marrow signal abnormality in the spine. On May 30, Dr. Cheung stated the scan showed a small disc bulge at L5-S1 and foraminal stenosis bilaterally at L5-S1 worse on the left than the right. Dr. Cheung did not think the lumbar spine findings were significant. The injection in the mid-thoracic spine worked to some extent but not completely. His glucose came up to about 200 plus so he stopped the injections. Dr. Cheung prescribed a Lidoderm patch.

In June, Dr. Cheung recommended a portable TENS stimulator for the patient. On June 17, the employee contacted Dr. Cheung's office to request some pain medication due to his whole back hurting. Dr. Cheung prescribed Lorcet. Dr. Burns diagnosed sleep disturbance secondary to chest wall and thoracic pain, myofascial pain syndrome and resolved concussion. Dr. Burns prescribed Ambien for sleep disturbance.

The next appointment with Dr. Cheung was scheduled but the employee was sent instead to Dr. Vaught, a neurosurgeon, in July for neck and back pain. In the history, the employee stated that soon after his injury he developed interscapular burning and aching, neck pain and occipital headaches. He had pain and paresthesia radiating

down his right arm into the ring and little finger, left shoulder pain, and low back pain that radiated into the right posterior thigh and calf. It was noted that the employee had a prior low back injury in the 1980's, and subsequently changed jobs and had no back or neck pain prior to the injury. The only medication that helped was Lorcet Plus. The employee did not feel that he had been listened to with regard to the primary complaint of interscapular burning. Dr. Vaught reviewed the May MRI and stated it showed evidence of degenerative disc disease at L3-4 and L5-1 but no evidence of disc herniation. At 4-5 there was a very mild disc bulge causing foraminal stenosis on the left. At L5-S1 there was a very mild central disc bulge with no thecal sac effacement or nerve root impingement.

Dr. Vaught diagnosed neck pain, interscapular burning, occipital headaches and right arm pain and paresthesia since March 4, 2003. The back and right leg pain may be due to a musculoskeletal strain injury. Dr. Vaught ordered an MRI of the cervical and thoracic spine and continued physical therapy. Dr. Vaught noted the employee could continue on the Lorcet but discussed with the employee in depth the need to wean him off the pain medications. Since it unclear as to the etiology of his cervical complaints, it was appropriate to remain on them for comfort.

The July 29 MRI of the dorsal spine showed no evidence of an abnormality. The MRI of the cervical spine showed at C5-6 a mild to moderate extradural defect which some effacement of the dural sac but no encroachment on the cord or canals. There was some uncovertebral joint disease at C3-4 on the left with mild to moderate encroachment on the left neurocanal.

On July 30, the employee reported intrascapular aching, burning neck pain, minimal occipital headaches, and global numbness in the right arm and left hand. Physical therapy increased left shoulder and lower back pain that radiated to the posterior thigh and calf with some burning sensation of the right heel. He was taking four to eight tablets of Percocet daily for pain. The employee had a positive Tinel's sign on the right elbow, and slight diminution to light touch in the right fourth and fifth fingers. Dr. Vaught stated that the cervical MRI showed at C5-6 a very small annular bulge centrally with no evidence of spinal cord compression or significant central canal stenosis. The thoracic MRI was negative. Dr. Vaught's assessment was persistent interscapular and low back pain. Dr. Vaught continued the low back physical therapy, diagnosed possible right ulnar nerve neuropathy and recommended an EMG/NCV study of the right upper extremity by Dr. Lee, and recommended trigger point injections in the interscapular area by Dr. Chiu. Dr. Vaught refilled his narcotic medications but he had a discussion with the employee that it was not intended to be a long term solution. Dr. Vaught did not find any obvious surgical lesions involving the cervical, thoracic or lumbar spine.

On August 12, the employee saw Dr. Chiu. The employee had developed severe pain to the right side of his spine between the shoulder blades that radiated down the back of his right upper extremity into the lateral aspect of the forearm and into the lateral two fingers and middle fingers; and terrible headaches. The left rib fractures were still giving him problems. He takes two Percocet tablets a day which help ease his shoulder pain but does nothing for his headaches which are sharp drum like sensation on both sides of his head, frontal and occipital areas. His neck is stiff with pain that runs down the length of his spine which radiates across to both ribs. The pain in the shoulder area will frequently radiate to the top of his shoulder and into the interior chest wall on the right side. There is a burning between the shoulder blades. Dr. Chiu diagnosed myofascial neck and shoulder pain, headaches, and trauma secondary to fall in March. Dr. Chiu performed nine trigger point injections and due to the Depo-Medrol, the employee would need to watch his blood sugars.

On August 20, Dr. Chiu noted that the trigger point injections only helped for four days. The employee was depressed. The employee's headaches have eased up. Dr. Chiu performed six trigger point injections. Dr. Chiu released the employee to return on an as needed basis.

The employee saw Dr. Kapp in August for left shoulder complaints and ordered an MRI. Dr. Kapp stated that the August 22 MRI showed an intrasubstance tear of the superior cuff in the supraspinatus tendon and significant changes in the AC joint. Dr. Lee performed an EMG and nerve conduction study in August 22 on the right median and ulnar nerves. The impression was mild right ulnar neuropathy with a lesion at the elbow level and normal nerve conduction study of the right median nerve. At the end of August 27, Dr. Vaught stopped physical therapy and began myofascial release therapy since the pain appeared to be myofascial.

The employee saw Dr. Douglas on September 2, requesting a physical. He was having substernal chest pain and shortness of breath. In March he fell at work and sustained a head and back injury and multiple rib fractures. The employee was on Amaryl, Glucophage, and Lipitor. He quit smoking six months ago and denied significant alcohol use. His blood sugar had been poor the last few days which appeared to be due to the trigger point injections. He had headaches since the fall. He had complaints of decreased mood, irritability, and no motivation. Dr. Douglas assessed chest pain, abdominal pain, diabetes, major depression, headaches, back pain and shoulder injury. He prescribed Lexapro.

On September 5, Dr. Kapp performed a left shoulder arthroscopy, subacromial decompression, arthroscopic distal clavectomy, and mini open rotator cuff repair. After the surgery, Dr. Kapp prescribed Percocet.

On October 2, Dr. Stone noted that he was seeing the employee for the first time. The employee was very anxious and upset primarily due to chronic pain. The employee was on Percocet and on diabetes medication of Glucophage and Amaryl. The employee walked slowly with a stooped over posture and decreased range of motion on his low back. Dr. Stone assessed chronic low back pain, depression and anxiety; and prescribed Klonopin.

On October 7, 2003, the myelogram and post myelogram CT scan of the cervical, thoracic and lumbar levels ordered by Dr. Vaught was done. The myelogram demonstrated no evidence of stenosis or significant disc intrusion. There was an incidental note made on a dilatation of the right nerve root sleeve at C6-7 of uncertain etiology and significance. In the CT scan at L5-S1 there was a mild broad based disc bulge which did not significantly narrow the spinal canal or the lateral recesses. There was no evidence of disc intrusion into the canal or foramen or of stenosis from T2 through S1. The cervical CT scan at C4-5 showed a minimal disc bulge. At C6-7 there was a small out pouching of the nerve root sleeve in the foramen. The clinical significance that was unclear and correlation with the employee's significant pain pattern might determine its relevance. There was an incidental contrast filled out pouching of the right nerve root sleeve at C6-7 and no apparent mass effect upon the nerve sleeve which may be developmental or old trauma. The thoracic CT scan showed a very small central disc bulge at T2-3 which abutted the ventral aspect of the cord and did not cause canal stenosis.

On October 9, Nurse Practitioner McDowell of Dr. Stone's office noted that since the fall the employee had persistent neck and back pain. The employee had a flat affect and complained of feeling very upset, sad and had emotional trauma. The employee stated he had lost one significant person in his life to death plus a family member tried to commit suicide. Nurse McDowell assessed chronic pain, anxiety and depression; and prescribed Lexapro and Neurontin. On October 16, Dr. Stone discontinued the Klonopin. The employee was to continue taking the Valium and Lexapro. The employee denied suicidal ideations.

In mid-October 2003, Dr. Kapp prescribed Xanax as the employee appeared to be quite pensive. On October 13, the employee saw Dr. Vaught. The employee had daily stabbing and aching low back pain that radiated to his right hip and down the right posterior aspect of his leg to his ankle. He had right arm achiness which occurred daily. He had left shoulder and triceps aching daily. Dr. Vaught stated that CT scan showed a small osteophyte to the left resulting in mild foraminal stenosis at C3-4. At C5-6 there was very small central disc bulge resulting in mild central canal stenosis. There was no evidence of any significant disc protrusions in the cervical spine. At L4-5 there was a mild bilateral facet arthropathy and ligamentum flavum hypertrophy resulting in mild central canal stenosis and foraminal stenosis. Dr. Vaught did not see any surgical lesions. He continued the physical therapy and pain medications until the employee saw Dr. Frauwirth who Dr. Vaught referred him for pain management.

The employee saw Dr. Frauwirth in October 21. The employee had been receiving physical therapy for low back and pain that radiated into his right hip; and had positive tenderness of the bilateral SI joints and positive SI tests. Dr. Frauwirth's diagnosis was bilateral SI joint dysfunction and ordered physical therapy for the SI joint instability.

The employee saw Dr. Stone in October of 2003 for a recheck of his diabetes and anxiety and depression. The employee's anger had been well controlled with Klonopin. His diabetes medicine has been doubled in the last six months.

At the end of October the employee reported to Dr. Frauwirth that he had developed increased tingling in his right sacroiliac joint which occasionally went down his entire right leg. He had run out of Percocet. Dr. Frauwirth continued physical therapy targeted to the sacroiliac joints, renewed the Percocet, and added Elavil at bedtime. In mid November 13, the employee reported that his low back pain had increased over the last couple of weeks. He had a dull aching low back pain which radiated into his right hip, right hamstring and right posterior lateral thigh, and radiated into his left buttock and posterior thigh. He reported increased soreness in the left and right trapezius and left interscapular areas. The employee had positive tenderness over the bilateral SI joint. Dr. Frauwirth diagnosed bilateral SI joint inflammation/dysfunction; and multiple trigger points in his trapezius and left intrascapular. Dr. Frauwirth continued the therapy, increased Percocet, and continued Elavil. In December, the employee's sleep had improved significantly since taking the Elavil. The Percocet relieved his pain. The tenderness over the bilateral sacroiliac joint was resolved. There was positive tenderness to palpation over the right rhomboid region. Dr. Frauwirth diagnosed bilateral sacroiliac joint dysfunction and trigger points in his right rhomboid. Dr. Frauwirth continued therapy, Elavil and Percocet.

In mid-December, 2003 Dr. Kapp noted that the employee had been in work conditioning and had a worsening pain of the left shoulder. Dr. Kapp suspected an aggravation of his rotator cuff with a trapezius strain and performed a subacromial injection.

2004:

On January 6, the employee had left shoulder pain and had a re-aggravation of his right shoulder. An EMG showed mild ulnar nerve neuropathy. Dr. Kapp diagnosed right cubital tunnel syndrome, myofascial syndrome on the right, and healing left rotator cuff tear. Dr. Kapp put restrictions of no lifting greater than ten pounds on the upper extremity and placed the employee in a myofascial stretching program.

The employee saw Dr. Guidos on January 22 for neck, back and lower extremity pain. The physical exam showed marked pain on abduction of the left shoulder and marked trigger points in the left upper trapezius, middle trapezius, right rhomboid major and minor. There was pain and tenderness of the right SI joint and piriformis and hamstring muscle region. Dr. Guidos discussed his philosophy with the employee that the pain medication would have to be slowly discontinued over time and the addictive potential of pain medication was discussed. Dr. Guidos recommended trigger point injections.

On February 4 Dr. Guidos stated the employee was seen for a work related fall; with bilateral shoulder pain; left shoulder surgery; myofascial pain syndrome involving the left trapezius, right rhomboidus, major and minor muscle belly; and mid to low back pain with right sacroiliac joint and right piriformis muscle syndrome. The employee had been successful in gradually reducing his pain medication. Dr. Guidos performed a left upper trapezius trigger point injection and right rhomboidus major and right rhomboidus minor muscle belly injections. The employee had ongoing symptoms in the lower extremities. The employee had pain and tenderness with trigger points at L4, L5, and S1 bilaterally and marked pain and tenderness in the SI joints bilaterally. Trigger point injections were performed and therapy was started on the low back region including myofascial release. Dr. Guidos performed an EMG and nerve conduction study of the bilateral lower extremities for low back pain radiating through to the hamstring and calf. He has been a diabetic for four years and treated with medication. The impression was sensorimotor poly neuropathy with significant sensory axonopathy. Dr. Guidos stated that the positive findings could be related to his diagnosis of diabetes.

Dr. Kapp ordered an MRI that was done in February 4, and showed a complete full thickness rotator cuff tear, degenerative arthrosis of the acromioclavicular joint, and a soft tissue defect in the anterior deltoid muscle. On February 16, Dr. Kapp performed a left shoulder arthroscopy with mini-open rotator cuff repair. At the end of February Vicodin was prescribed. At the end of March, Dr. Kapp prescribed Percocet and Neurontin.

In mid February the employee was not doing well and had left shoulder problems. Dr. Stone refilled the Valium and noted that the employee was aware of the addictive potential of the medication but Dr. Stone thought he was probably going to need it over the long term.

The employee saw Dr. Burns in late March, who noted that pain management became more difficult with the spread of pain throughout the entire right side of the employee's body involving intrascapular and bilateral lumbar back. He was well maintained on medications for pain and found to have SI dysfunction. A CT myelogram demonstrated diffuse lumbar degenerative disc disease. Dr. Burns noted that the Dr. Kapp had the employee on OxyCodone for his shoulder. The employee had diffuse pain from the degenerative joint disease and diffuse right body pain. He was on Lexapro for mood and pain and Diazepam for anxiety. The employee's pain levels are an average of 5 and at time 9-10 with sharp and burning pain to the right buttocks, lower extremity and coccyx area. There was diffuse pain in the intrascapular lumbar thoracic level and throughout the right leg. Dr. Burns noted the employee was upset regarding control of his symptoms. Myofascial findings were noted diffusely through the cervical paraspinal muscle intrascapular thoracic and lower lumbar bilaterally. The employee had bilateral SI tenderness. Dr. Burns diagnosed chronic pain syndrome, adjustment disorder and history of SI dysfunction. He continued OxyCodone, added Skelaxin and continued therapy including myofascial release.

In early April 6, Dr. Kapp noted the employee had multi-pain chronic pain syndrome. In mid April, Dr. Burns noted that the employee had a complicated medical course and stated that his current problems were thought to be related to a March of 2003 fall. Therapy for diffuse spinal and lower extremity pain was poorly tolerated. The employee had sleep problems secondary to pain. There was worsening of the intrascapular pain. Dr. Burns noted the employee had full response to the Percocet and had almost used ninety pills since his last visit on March 26. Dr. Burns noted mild yet diffuse degenerative disc disease without any neuro entrapment; rotator cuff tear with surgery; diabetes with diabetic neuropathy; chronic pain syndrome without improvement; adjustment disorder with minimal change; and history of SI dysfunction. Dr. Burns continued OxyCodone and recommended an MRI.

The April low back MRI showed mild disc space narrowing and disc dissection at L5-S1. A transitional vertebra at the lumbosacral junction was labeled S1. He had mild concentric disc bulges at L3-4, L4-5 and L5-S1. There was no acute disc herniation or significant stenosis noted. Dr. Burns noted the employee was continuing to receive Valium and Lexapro from Dr. Stone that has helped by maintaining his mood and coping with high pain levels. Dr. Burns noted a very guarded and very exaggerated motion pattern, and mild to moderate pain behavior. Dr. Burns assessed chronic pain syndrome; diabetes with diabetic peripheral neuropathy; degenerative disc disease of the spine; status post rotator cuff with therapy; and history of SI dysfunction. Dr. Burns continued medications and therapy.

On April 27, Dr. Kapp stated the employee had left shoulder pain but excellent motion. The employee had pain in the right elbow and shoulder with mild crepitus. Dr. Kapp diagnosed right mild elbow osteoarthritis and ordered an MRI of the right shoulder. With regard to the left shoulder, Dr. Kapp stated he was at maximum medical improvement and rated him at 10% permanent partial disability.

The April 29 MRI of the right shoulder showed fluid in the AC joint and below the acromion consistent with degeneration and possible mild bursitis of the subacromial bursa; and osteophytes at the AC joint which may produce a clinical impingement syndrome. There was a high signal at the distal supraspinatus tendon consistent with full thickness tear. Dr. Kapp noted the MRI confirmed a full thickness tear of the right rotator cuff with a distal AC joint sprain.

In early May Dr. Stone saw the employee with thoracic muscle spasms and low back pain. Dr. Stone was concerned that the employee was on a narcotic and also Valium but noted that the pain control specialist was cognizant of that fact. Dr. Stone assessed severe degenerative disc disease; pain in the lumbar spine; muscle spasms secondary to degenerative disc disease; anxiety; and non insulin dependent diabetes.

On May 10, Dr. Kapp performed a right shoulder arthroscopy with subacromial decompression, distal clavicle resection and a mini open rotator cuff repair due to a complete full thickness tear of the rotator cuff and mild fraying of the glenoid labrum. After surgery, Dr. Kapp prescribed Percocet.

At the end of May, the employee saw Dr. Burns who noted diffuse low back, shoulder blade and second or third rib pain. The work up showed mild degenerative joint and disc disease of the cervical and lumbar spine. The

employee had several exams suggesting a significant peripheral neuropathy with decreased sensation to pin distally in a glove and stocking distribution in the lower and upper extremities. The employee's sleep was disturbed secondary to pain and his mood was improved with Lexapro. Dr. Burns diagnosed work fall with contusions; chronic pain syndrome; diabetic neuropathy; and degenerative joint disease/degenerative disc disease of the spine. Dr. Burns thought the employee was at maximum medical improvement from the fall, had significant pre-existing degenerative disease of the spine, and had a superimposed poly neuropathy probably from the diabetes. Dr. Burns recommend an FCE to determine his potential for work.

On June 1, Dr. Kapp gave the employee another prescription for Percocet but noted he would start reducing it. He added myofascial release to therapy. In mid-June Dr. Kapp noted the employee had a component of myofascial pain and would continue trigger massage. He gave him a script for Vicodin. He was to taper Neurontin and placed the employee on Elavil. At the end of June, Dr. Kapp continued the myofascial release program.

On June 30, Dr. Stone assessed out of control non insulin dependent diabetes, elevated blood sugar, abdominal distention and a change in bowel habits. He ordered a CT scan. The employee was referred to Dr. Freeman for the change in his bowel habits. Dr. Stone thought the employee may be developing gastroparesis from his diabetes and put him on insulin for his diabetes.

The employee went to the emergency room at Southeast Missouri Hospital on July 19 for abdominal pain and constipation. Dr. Killian stated that the employee's use of narcotics for chronic back and hip pain was a very likely cause of constipation.

The employee saw Dr. Chiu at the end of July and had tenderness over the T4-5 and T5-6 interspinus area; the right rhomboid; the bilateral upper trapezius; the scapula; and the costochondral area of the fourth rib. Dr. Chiu performed injections to the T4-5 and T5-6 interspinus ligaments, a trigger point injection to the right rhomboids, and prescribed Vicodin.

The employee went to the emergency room at Southeast Missouri Hospital on August 3, due to an increase in constipation and bloated abdomen. Dr. Delonias-Turner talked to him and recommended that he stay away from all narcotics. The employee was prescribed Bextra for chronic pain.

On August 3, the employee told Dr. Chiu that the injections did not help. Dr. Chiu assessed thoracic interspinus ligament laxity and thoracic paraspinus myofascial pain; right rhomboid myofascial pain; and right chest wall pain secondary to costochondral cartilage irritation. Dr. Chiu performed an injection to the T4-5 interspinus ligaments and trigger point injections to each thoracic paraspinus muscle at the T5-6 level. Dr. Chiu continued Vicodin.

On August 10, the employee still had severe pain but some improvement. His GI problems have not resolved. Dr. Chiu continued the Vicodin. Dr. Chiu was uncertain what he had to offer the patient other than switching the medication to a long acting opioid. On August 11, the employee saw Dr. Stone for constipation. The CT scan was negative which suggested no evidence of clear obstruction. Dr. Stone's assessment was severe constipation secondary to narcotic use; and insulin dependent diabetes.

. The employee started seeing Dr. Deisher on August 13, for his right arm. In March of 2003, he fell 15-20 feet and had problems with neck, back, shoulders, and right elbow. Dr. Deisher noted the nerve studies by Dr. Lee last August showed mild ulnar neuropathy at the elbow. Dr. Deisher diagnosed cubital tunnel syndrome and did an injection.

On September 3, the employee was seen for his thoracic spine pain by Dr. Chiu. The Vicodin was not helping and he has been complaining of occipital headaches. Dr. Chiu changed his pain medication to Percocet.

The employee saw Dr. Cantrell on September 14. The past medical history was positive only for borderline diabetes mellitus controlled with Amaryl and Glucophage. On March 4, 2003, the employee fell, landed on his head and neck, and a result developed migraine type headaches, bilateral shoulder pain, upper back pain and lower back pain. The diagnostic work up for spinal pain complaints including MRI, myelogram and CT scans of the cervical,

thoracic and lumbar spine did not reveal any significant pathology other than degenerative changes consistent for the employee's age. He had multiple left rib fractures. Dr. Cantrell stated that it was possible that he may have sustained a thoracic sprain/strain due to the fall and it was possible that persistence of his pain complaints was due to relative inactivity resulting in myofascial tightness, myofascial weakness and facet joint stiffness throughout the thoracic spine. His headaches complaints were consistent with muscular contraction headaches and his lumbar pain complaints appear to be mechanical in nature without any evidence to suggest a lumbosacral radiculopathy. Dr. Cantrell stated that the employee had chronic pain complaints despite more than adequate physical therapy and injection therapy. Dr. Cantrell suggested a one time evaluation by a manual physical therapist to see if there was isolated segmental joint dysfunction.

It was Dr. Cantrell's opinion that it would be a disservice for the employee to have greater amounts of narcotic medications particularly since his chronic pain complaints persist, his symptoms are not decreasing, and his functional status is not improving. Dr. Cantrell stated that that adverse effect that the medications caused includes constipation and other GI problems. It was Dr. Cantrell's opinion that the employee's narcotic medications should be tapered and discontinued. The employee testified that he tried to taper and discontinue the narcotics but he was in too much pain.

Dr. Cantrell stated that due to the bilateral rotator cuff surgeries and had diffuse complaints, it was not likely that he would be capable of returning to his regular duty activities. Dr. Cantrell believed that was capable of gainful employment and a functional capacity evaluation may be helpful in determining what level he could return. Dr. Cantrell put restrictions of avoiding repetitive overhead work with both upper extremities, lifting less than 20 pounds above shoulder level, lifting less than 50 pounds from floor to waist and waist to shoulder level on an occasional basis. A functional capacity evaluation would provide a more detailed analysis of his capabilities.

On September 15, the employee saw Scott Gallant at Pro Rehab at the referral of Dr. Cantrell. The employee had left sub occipital headaches and thoracic/cervical pain. Mr. Gallant noted that objectively the employee presented with forward head posture and seemingly stiff thorax. Thoracic and rib mechanical testing did not reveal any segmental dysfunction. There was decreased left A/O flexion and decreased left C-3 uncovertebral joint mobility. Mr. Gallant stated that the employee presented with mechanical findings of his upper cervical spine that might explain his subjective complaints of headaches and upper cervical spine neck pain. Over pressure of the C2-3 reproduced his left sub occipital headache.

On September 22, Dr. Kapp released the employee from care and stated that he was at maximum medical improvement with his shoulder and placed no restrictions.

On September 22, Dr. Chiu noted that the Percocet helped but did not make him pain free. Dr. Chiu started the employee on OxyContin, a long acting opioid, for his chronic pain and to continue to use the Percocet. Dr. Chiu filled out a form for the employee to get a disability plate for his car and filled out a release from work until further notice. On September 28, Dr. Chiu increased his OxyContin and refilled the Percocet.

On October 6, Dr. Cantrell noted that Scott Gallant, a manually trained therapist, saw the employee. The evaluation suggested the employee presented with a forward head posture and a seemingly stiff thorax. Otherwise, he was found to be neurologically intact. The therapist noted that there was a reduction in left anantooccipital flexion and a decrease in left C2-3 unconvertrebral joint mobility. It was felt that those mechanical findings and upper cervical findings explained his subjective complaints of headache and upper neck pain particularly since over pressure of the C2-3 segment reproduced his left sub occipital headache complaints. Dr. Cantrell recommended two to four sessions of physical therapy with a manually trained physical therapist to see if this would alleviate some of his pain complaints in the neck and head. Dr. Cantrell did not feel that the segmental dysfunction noted by the therapist in the upper cervical spine explained the diffuse nature of his complaints. The employee should progressively increase his activity level, taper and then discontinue his narcotic medications since there did not appear to be an objective basis for these medications relative to his work injury.

On October 20, Dr. Chiu noted that the increase dosage of OxyContin has helped but there was still breakthrough pain. In October Dr. Stone told the employee that he was concerned about his OxyContin due to its addictive potential. Dr. Stone assessed chronic pain syndrome.

Dr. Guidos performed an EMG and nerve conduction study of the bilateral upper extremities in October. It was Dr. Guidos' impression that the employee had bilateral carpal tunnel syndrome, right ulnar neuropraxia at the elbow, and sensorimotor polyneuropathy consistent with patient's diagnosis of diabetes and diabetic neuropathy. Dr. Deisher stated the EMG nerve conduction studies were consistent with carpal tunnel syndrome and cubital tunnel syndrome with the vast majority of the symptoms at the elbow. On November 2, Dr. Deisher performed a right cubital tunnel release with anterior intermusculature transposition.

At the end of November, Dr. Chiu saw the employee for thoracic pain. The employee's surgery on the right extremity caused him to use extra medication and the employee has been unable to keep an accurate record of his Percocet usage. On December 20, 2004, Dr. Chiu noted that the employee had run out of the Percocet due to a flare up of his back and shoulder pain. The employee increased his OxyContin dosage which decreased his pain significantly and improved his headaches. Dr. Chiu decided to maintain the patient to the level that the employee was taking but did not approve of any further increases on the employee's own.

On December 20, Dr. Stone noted the employee had numbness in his lower extremities which may be due to lower back problems and not diabetes. Dr. Stone assessed insulin dependent diabetes, chronic pain secondary to degenerative disc disease of the cervical and lumbar spine.

2005:

The employee testified that in the first part of 2005, he was having headaches and had a knot between his shoulder blades. Dr. Chiu prescribed OxyContin and Percocet which helped with the pain. The employee testified that in January of 2005, his OxyContin was stolen at his residence. He reported it to the Sheriff's Department and thought an acquaintance stole it during a visit. The employee was out of OxyContin and started having severe withdrawals. He was having chills and had the dry heaves. He was curled up in fetal position.

The employee called Dr. Chiu on January 12, 2005, and stated that he needed more OxyContin because a woman had stolen his. The employee reported the woman to the parole officer and filed a police report. Dr. Chiu did not give him a refill of OxyContin and explained to him that he had Percocet which he could use to keep from having withdraws.

On January 14, the employee's sister drove the employee to Dr. Chiu's office, left the employee in a fetal position in the truck and met with Dr. Chiu. She told him that the employee was going through withdrawal. Dr. Chiu recommended that the employee be hospitalized but his sister said that he would not go. Dr. Chiu gave the sister a prescription of OxyContin for 15 days at a reduced dosage to keep him from going through withdraw. He had the employee and his sister return later to discuss the situation. The employee was very angry. Dr. Chiu told him that he was taking more pain medication than most cancer patients and that there were 60 OxyContin tablets that were unaccounted for other than being stolen. Dr. Chiu told the employee that he could not just give him another prescription at the dosage that he was using and act like nothing happened. The employee stated that he would just go back on the Percocet that he was taking before he came to see him. Dr. Chiu told the employee when he first started seeing him that he was on Vicodin which he would prescribe again but the employee insisted on Percocet. Dr. Chiu told the employee and his sister that he was uncertain for what he had to offer and did not feel continuing him on long term high doses of OxyContin was appropriate given that they had never obtained a maintenance level. Dr. Chiu gave the employee a prescription for Percocet for a two week supply and was instructed not to use more than six per day. He also had the OxyContin at a lesser dose for fifteen days to help him keep from withdraw. He was scheduled to see Dr. Marsh on Monday.

The employee testified that Dr. Chiu cut his dosage of OxyContin in half and gave him enough to last about 15 days but did not give him a return appointment. His sister did not tell him that Dr. Chiu wanted him to go to the hospital. When he talked to Dr. Chiu on January 14, he was angry because his dosage had been cut down so low. Dr. Chiu did not tell the employee that he wanted the employee to go to the hospital. The employee testified that he would have gone to the hospital if it would have helped because he was going through severe withdrawals.

The employee saw Dr. Marsh on January 18, 2005 for multiple medical problems including chronic pain, myofascial pain, chronic low back pain, bilateral shoulder surgery, right elbow ulnar transposition, sleep disturbance, depression and anxiety. Dr. Marsh noted the employee had a complex history related in part to a work injury that occurred on March 4, 2003. Since the injury the employee has not returned to work. Dr. Marsh noted that primary ongoing destabilizing medical issues include his continued chronic low back pain which caused discomfort and pain throughout the entire torso from the neck to the lower back and right buttock. Dr. Marsh noted the studies Dr. Vaught ordered were unremarkable for any significant lesions including herniated discs.

Dr. Marsh stated that the OxyContin and Percocet use have become a much more significant concern when the employee's girlfriend reportedly stole all of his narcotic supplies. He advised her parole officer and she supposedly subsequently tested and showed positive urine for OxyContin. The employee was without his entire narcotic medications for a period of time and that abrupt discontinuance, which was not his fault, caused him to experience a very distressing narcotic withdraw over a three day period before he was able to obtain further medications from Dr. Chiu. During this three day abrupt withdraw, the employee was severely affected, was totally unable to do anything, had significant mood swings and the best that he could do was to stay in the fetal position. The employee had not been sleeping for more than two hours a day. The employee was being treated for depression and anxiety by a local provider and has been using Valium for anxiety and Lexapro for depression.

Dr. Marsh diagnosed the employee with: 1) Chronic pain complicated by pre-existing chronic sleep disturbance, suspected nutritional deficiencies, diabetic pseudosciatica and diabetic neuropathy. 2) Status post bilateral rotator cuff repairs with good results. 3) Status post right ulnar transposition, excellent recovery. 4) History of alcoholism with recurrent blackout spells. 5) Lumbar osteoarthritis. 6) Restless leg syndrome.

Dr. Marsh stated that the employee's health history includes multiple psychosocial and other chronic medical issues that are significantly magnifying and complicating his pain management. The bulk of these issues are pre-existing or associated with other medical problems that have nothing to do with his work injury. It was Dr. Marsh's opinion that the employee should undergo a detoxification program and discontinue the use of narcotic pain medication. During the discussion of Dr. Marsh's recommendations, the employee expressed that he would not discontinue his narcotic and made it clear that after his withdrawal experience, he would not undergo any rehab that caused him to experience similar symptoms. The employee was advised that in more controlled settings, the symptoms were much reduced/modified but the employee would not have consider it and left the room. Dr. Marsh stated that psychological testing and counseling would be necessary to any ongoing management of his depression and anxiety but most critical is the management of his sleep disturbance to help with pain management. Dr. Marsh stated that the employee had reached maximum medical improvement for the conditions directly related to his fall. The employee had an essentially negative work up and the continued impairment/disability related to his increasing need for OxyContin would not suggest that his current issues are related to the March of 2003 event. His previous medical condition including chronic sleep deprivation, diabetic neuropathy, anxiety and depression and history of alcoholism are more affecting his current status than this work injury.

The employee testified that on January 18, Dr. Marsh discussed with him that he needed to get off the narcotics and discussed a detoxification program. The employee told Dr. Marsh that he could not go through another withdrawal and needed something for pain. He did not give anything for pain and did not make a return appointment. The employee wanted more treatment for the problems to his neck, upper back and lower back. He had severe pain in lower back and could not move shoulders without severe pain. After his visit with Dr. Marsh he asked for more treatment from Betty Brooks, the nurse case manager. The employee testified that he received no treatment from Noranda for his upper and lower back after January 18, 2005.

On January 21, 2005, the employee saw Dr. Deisher for follow up for his post cubital tunnel decompression. The employee's biggest problem was pain control. He was having problems with his medication and was out of his OxyContin.

The employee saw Dr. Robinson at Southeast Missouri Emergency Room on January 23, 2005 for chronic pain syndrome, mild withdraw symptoms and abuse of medication. The employee had a history of chronic pain and had been following with Dr. Chiu, at the pain clinic. The employee had been on OxyContin but abused it by always taking

more than was prescribed. The employee stated that recently some of his OxyContin was stolen. Dr. Robinson stated despite his complaints of hurting all over, the employee did not appear to localize the pain very well and did not appear to have significant discomfort with movement. Dr. Robinson thought the employee was having some mild analgesic withdraw and recommended that he take Catapres twice a day for the next three days to help lessen the withdraw effects. Dr. Robinson discussed the patient with his case worker and also Dr. Chiu. It was decided that giving additional narcotics was not appropriate based his analgesic abuse history. When the employee heard that he was not going to be getting additional narcotics and he got angry and went out of the room at that time threatening the medical staff. He was allowed to leave in the care of his family. When drug rehab was discussed the employee refused to consider it and the family members wanted to take him home. The hospital later heard that the family had contacted Charter about drug rehab and Charter needed a referral. When the hospital talked to Charter, the employee needed an evaluation to see if he was appropriate for their program.

On February 1, 2005, the employee saw Dr. Kapp for right shoulder pain. He had been off OxyContin and his shoulder pain was worsening. Dr. Kapp ordered an MRI which was limited due to the artifacts from the prior surgery.

The employee testified that at the end of January of 2005, he ran out of OxyContin and due to the pain tried to kill himself by taking a lot of Elavil. He was taken to Southeast Hospital.

On February 3, 2005, the employee was evacuated by Air Evac medical helicopter from his home to Southeast Missouri Hospital due to a drug overdose and unconsciousness. Dr. Umfleet stated that the employee was in a coma with acute Amitriptyline anti-depressant overdose. The employee had a past medical history significant for diabetes, depression and suicidal attempt in the past. The employee was admitted to the intensive care unit. On February 4, Dr. Lee, a neurologist, saw the employee and stated the history was a fall resulting in an injury to his left shoulder and spine. As a result of the fall, he has chronic pain syndrome. About two weeks ago he was at the hospital emergency room requesting a refill for OxyContin. He reportedly took an overdose of Amitriptyline, which resulted in the current unresponsive state. Dr. Lee ordered an EEG which showed an abnormal awake and sleepy EEG record owing to the presence of prominent frontal beta activity on both sides. The clinical impression was that the above findings were suggestive of a mild diffuse encephalopathy probably metabolic in origin and the prominent frontal beta activity was most likely drug induced.

On February 8, Dr. Lake, a psychiatrist, saw the employee at the hospital. The employee was admitted with Amitriptyline overdose and suicide attempt. The employee had dealt with chronic pain for the past two years. He had been on escalating doses of opiates, has had accusations of pain medicine abuse that has become more and more desperate to the point that he had intense suicidal thoughts; and ended up overdosing on Elavil. He was remorseful and glad that he survived and hoped that he can get the help that he needed. He denied any active suicidal ideation, intent or plan; denied using alcohol or illicit drugs; denied abusing his pain medication; but has been very inconsistent in the amount that he has used with frequent visiting to the emergency room to fill medications and accusing people of stealing his OxyContin. Dr. Lake stated that he was tending to blame everyone else for his problems and was not wanting to take any responsibility for his medication abuse. His insight and judgment were limited. His mood was depressed. Dr. Lake stated that the employee was clearly depressed and met the criteria for major depressive episode. He was prescribed Cymbalta for his depression and some of his chronic pain. He will need a pain management consultation. Dr. Lake noted the employee would present quite a challenge as he is clearly abusing his opiates before this all happened and he will need to be set up into a fairly strategic contract with his pain management specialist. Dr. Lake thought he would benefit from psychotherapy.

On February 9, his drug overdose symptoms had resolved and his depression stabilized. He was discharged to a psych unit in stabile condition with a diagnosis of anti-depressant overdose, depression, chronic back pain and suicidal attempt. On February 10, Dr. Chaudhari performed bilateral sacroiliac joint and bilateral piriformis blocks due to intractable low back pain and bilateral leg pain. Dr. Lake discharged the employee from the hospital on February 11. The patient had a history of severe chronic back pain with subsequent development of depression. The employee had a very significant overdose and had to be intubated and treated in the intensive care unit for several days. Dr. Chaudhari diagnosed cervical spondylosis, interfacetal arthrosis, greater occipital neuralgia, and lumbar spondylosis; and treated the employee with pain medication and bilateral sacroiliac joint and bilateral piriformis blocks. He was placed on Cymbalta to address his depressive symptoms and his mood improved considerably. He was

discharged to go home with low suicide risk assessment. Dr. Lake's diagnosis was major depressive disorder, single episode; chronic pain syndrome, hypertension, diabetes and constipation.

On February 16, Dr. Kapp noted the MRI did not show any evidence of recurrent rotator cuff tear but had symptoms consistent with tendonitis.

The employee testified that after he got out of the stress unit, he did not work. In February of 2005, he went back to Dr. Stone for his pain in his low back, upper back, headaches, shoulders and elbow.

On February 28, Dr. Stone noted that the employee had been treated for chronic lumbar pain of a degenerative nature and pain in the thoracic and cervical regions. Dr. Stone noted that the employee had a rough couple of months; was seeing someone at a pain clinic; was getting pain medication; and was taking OxyContin daily. Apparently someone took the OxyContin which was reported and the person was eventually charged with the theft. Despite that, the physician did not want to refill his OxyContin. The employee went through OxyContin withdraw which resulted in diarrhea, vomiting, severe anxiety and severe pain. He was prescribed Elavil and took an overdose. He was in a coma for about five days and was admitted to the stress unit. The employee denied further suicidal ideation. He was on insulin, Percocet, Valium, Lexapro and other medications. The employee quit drinking and smoking in March of 2003. Dr. Stone noted tenderness and spasms in both the lumbar and cervical regions and limited range of motion in all directions. The straight leg raising was positive bilaterally in both lower extremities in the supine position. Dr. Stone diagnosed severe withdrawal from OxyContin with recent suicidal attempt, chronic pain syndrome with degenerative disc disease, diabetes, and generalized arthritis. Dr. Stone agreed to take on the employee's pain medication management. The agreement was that while Dr. Stone was prescribing pain medication, the employee was not to get pain medicine from any other physician. Any narcotic prescriptions or controlled substances was to be dealt with through Dr. Stone. Dr. Stone prescribed Methadone to try to reduce OxyCodone withdraw and told the employee that Methadone was addictive and is a class II substance which had to be refilled in person. The employee has apparently been cut off by the workers' compensation provider.

On March 18, Dr. Deisher stated the employee had a little bit of numbness along the posterior olecranon area but the numbness of the fourth and fifth digits were resolved. The major problem was pain control. Dr. Deisher released him on an as-needed basis.

On March 22, a functional capacity evaluation was performed by Vic Zuccarello on the employee at Dr. Marsh's request. Mr. Zuccarello stated that due to inconsistent and sub maximal effort, it was not possible to accurately access his likely true abilities and limitations. With regard to validity, the employee failed ten of twelve criteria. Mr. Zuccarello's impression was probable symptom magnification; multiple positive non-organic signs; subjective reports or out of proportion with behavior/function; and inconsistent and sub maximal effort. It was Mr. Zuccarello's opinion that the evaluation data was skewed by inappropriate illness behavior and was not likely an accurate representation of his likely true work capacity. It was his opinion that the employee was employable in a full time capacity in a job at the light work demand level.

On March 30, the employee saw Dr. Stone for insomnia, memory loss and chronic pain control. The employee had documented evidence of severe degenerative disc disease and severe arthritis in multiple other joints. He had bilateral knee surgery and bilateral surgery for rotator cuff disease. The most serious deterioration of the disc was in the cervical spine and complicating that was being an insulin dependent diabetic. The onset of intermittent confusion was associated with Methadone. Dr. Stone recommended reducing Valium for the muscle spasms in his neck since it may be contributing to his confusion. Dr. Stone assessed severe degenerative disc disease of the cervical spine, insomnia and memory loss. Dr. Stone added Ambien at night to help with sleep. Methadone was renewed.

On April 18, Dr. Kapp noted that a recent MRI failed to reveal evidence of recurrent tear. The employee had occasional pain and soreness. His other medical problems appeared to have taken precedent. Dr. Kapp released him from care and assessed a 10% permanent partial disability of the right shoulder.

On April 27, Dr. Stone stated that the employee was somewhat confused and appeared to have been taking MS Contin inappropriately. Dr. Stone discontinued the MS Contin and put the employee back to Methadone. Dr. Stone

advised the employee's daughter that she needed to be directly involved in the management of his pain medication. On May 4, Dr. Stone instructed the employee's daughter to monitor the employee's MS Contin because he was taking it too frequently. Dr. Stone indicated the pain medication needed to be maintained and not increased.

On May 12, Dr. Marsh noted that he reviewed the March FCE. The overall assessment was the inability to use the report in an effective way due to skewing of the data by inappropriate illness behavior. The main musculoskeletal deficits were felt to be secondary to inconsistent and sub maximal efforts. Dr. Marsh stated the observations noted in the functional capacity report are most informative in respects to his underlying pathology, ongoing pain issues and constant and chronic narcotic usage. There are multiple other factors associated with his ongoing pain issues which appear to have not been thoroughly explored in its relationship to his difficulty with pain being principally associated with his sleep and even his diabetic control. The employee was subsequently hospitalized following the January 18 evaluation. The psychiatric records and diagnosis were not available for his review. Dr. Vaught did not identify any objective findings that would explain his ongoing pain source and behavior. Dr. Marsh stated more likely than not the bulk of his ongoing chronic pain issues were related to non work related concerns. Dr. Marsh assessed a permanent partial disability rating associated with his back of 2%.

On June 7, 2005, Dr. Stone noted that the employee had a problem with significant withdraw from OxyContin, and that they had tried pretty well every other medication that had been available including MS Contin and Methadone without adequate pain relief and with side effects that caused significant sedation and sometimes confusion. The employee, his daughter and Dr. Stone spent a great deal of time discussing the pros and cons of OxyContin. The employee was miserable with regards to his joint pain and muscle discomfort in the upper thoracic and neck region. OxyContin was the only thing that gave him relief. The employee and his daughter agreed they would never get OxyContin from any other practitioner or any other narcotic from any other practitioner and in order to get refills, he would come in to see Dr. Stone. The employee was the only patient of Dr. Stone that is being prescribed OxyContin. Dr. Stone prescribed OxyContin three times a day but with half the dosage. Dr. Stone noted that the employee's peripheral edema in both extremities had gotten worse over the last couple of weeks. Dr. Stone diagnosed chronic thoracic discomfort in the upper back region secondary to severe disc disease; osteoarthritis of both shoulders; bilateral hip discomfort secondary to osteoarthritis; and knee pain.

On July 5, the employee saw Dr. Stone for chronic pain in the neck and shoulders. Dr. Stone was trying to maintain the OxyContin use down to as low of a quantity as possible. The employee has had no further peripheral edema. Dr. Stone found multiple tender trigger points and muscle spasms to the trapezius and paraspinal muscles of the neck region. Dr. Stone prescribed OxyContin and Celebrex, an anti-inflammatory, to help with the employee's pain control. On August 2, his occipital headaches which Dr. Stone thought were probably tension related. He prescribed a small dose of Topamax to help with neurogenic pain and tension type headaches. Dr. Stone continued the OxyContin for severe arthritis of both shoulders and the cervical spine.

The employee saw Dr. Stone on September 2, for headaches, muscle spasms in the neck and back, and mid back pain, which was 9 out of 10. Dr. Stone prescribed Zanaflex, Topamax, OxyContin, and Valium. The employee continued to treat with Dr. Stone in October, November and December of 2005 for chronic upper back and neck pain; migraine headaches; and diabetic neuropathy. He continued to refill OxyContin and Topamax.

2006:

Dr. Stone saw the employee on a monthly basis in 2006. In June of 2006, Dr. Stone noted that he sent extensive dictation to the employee's attorney that indicated that most of the diagnosis that they are currently giving him narcotic pain medication for. Dr. Stone noted they have tried every other alternative and the employee greatly benefited from OxyContin.

2007:

On January 5, the employee had neck and right scapular pain. Dr. Stone ordered an MRI of the cervical spine to see if there is anything new that might be treated surgically. OxyContin was continued.

Vic Zuccarello:

The deposition of Vic Zuccarello, a licensed and certified occupational therapist, was taken on August 17, 2007. The March 22, 2005 functional capacity evaluation lasted three hours and fifteen minutes. At some point the employee deferred further testing citing pain and fatigue. Mr. Zuccarello performed standardized lifting tests which can be used to predict lifting capacity. The employee attempted to perform those tests. There were some main musculoskeletal deficits that were secondary to inconsistent and sub maximal effort. For that reason it was not possible to accurately assess his likely true abilities and limitations. Mr. Zuccarello stated that failing ten out of twelve indicators indicate possible symptom magnification. There can be other reasons but that's for the physician to ultimately determine. It was strongly recommended that the physician consider the evaluation data in conjunction with results of other medical and rehabilitative findings in determining the final disposition. There were some inconsistencies with the employee, which began with walking. The employee arrived using a straight cane on the right but when he observed the employee walk without the cane, the gait was not substantially different. If someone truly needed a cane, their gait should have been different. There was no change in gait pattern when he was observed carrying a weighted box for a fifty foot distance. The employee was able to climb stairs and ladder demonstrating good balance. The bending and squatting were full.

Dr. Marsh:

The deposition of Dr. Marsh was taken on April 3, 2007. The employee gave a history of alcohol use and stated that he had completed alcohol rehab programs in 1983 and 1984 and had returned to alcohol usage. Dr. Marsh stated that that type of history of addiction can be a set up for having problems with even low level of narcotics.

The employee's examination, was quite variable and inconsistent and offered up little insight into his underlying difficulties because it did not follow any one dermatome pattern. It is difficult to interpret only polyneuropathies or diabetic changes but also of understanding what was truly going on. It did not appear to be any hard evidence of a significant neurological finding. His straight leg raising was inconsistent and there was no radiculopathy noted. Given his history it appeared that part or a significant portion of his ongoing problem in regards to his pain management would be an influence by a wide variety of pre-existing components to include his diabetes, his sleep disturbance and his current dysfunctional use of narcotics.

It was Dr. Marsh's opinion that the employee needed to come under the care of a board certified psychiatrist or psychologist; needed a MMPI; go through a formal detoxification program; and needed to get off his narcotics as soon as possible. He had objective testing showing a polyneuropathy which suggested that he had diabetic neuropathies. Dr. Marsh stated that given the employee's good recovery with regard to his fractures; the lack of any identified pathological problems in his back; and his release or recovery from his surgeries; the employee's presentation appeared to be more from his pre-existing sleep disturbance, diabetic neuropathies, and psychiatric problems including anxiety and depression.

In the employee's March 22, 2005 FCE. the employee did not make much of an effort to accomplish the examination; his effort was sub maximal; and there were numerous inconsistencies. Dr. Marsh agreed that there was an overall impression of symptom magnification. Dr. Marsh stated that Dr. Vaught did not identify any objective findings that would explain the employee's ongoing pain source and did not identify a surgical lesion in his neck, thoracic spine or low back.

Based upon the functional capacity evaluation that demonstrated both inconsistencies and evidence of symptom magnification and lack of desire on the individual to perform in an adequate way; and given the examination by Dr. Vaught who did not identify any underlying structural problem; Dr. Marsh assessed a 2% permanent partial disability rating. It was Dr. Marsh's opinion that the employee was not permanently and totally disabled. His permanent partial disability rating was not based upon any underlying pre-existing problem.

Dr. Marsh stated that the employee's records reflect current diagnosis of depression and anxiety. It is the employee's treating physician's opinion that the employee has chronic pain. It was Dr. Marsh's opinion that the

employee has some elements of chronic pain but diabetes can cause chronic pain. Dr. Marsh stated that depression and anxiety can affect a little bit of the employee's performance on a functional capacity evaluation.

Given the employee's underlying problems, Dr. Marsh thought that the employee would need to be on some form of duty restrictions in order to return to work. Dr. Marsh did not think that he should be put back in the same job he was involved with before. Dr. Marsh would start him off on light duty in some capacity and can start off at sedentary duty. Dr. Marsh stated that psychosocial problems are real and depression and anxiety are real and that is why he suggested that the employee see a psychiatrist or a psychologist.

Dr. Cantrell:

The deposition of Dr. Cantrell who is board certified in physical medicine and rehabilitation and electro diagnostic medicine, was taken on May 25, 2007. Dr. Cantrell does use OxyContin in his practice. It was Dr. Cantrell's opinion that the employee was not capable of returning to his regular work activities but was capable of gainful employment. With regard to the evaluation by Scott Gallant, the employee was found to be neurologically intact and there was not any segmental dysfunction of the thoracic spine. Mr. Gallant found a reduction in flexion of the atlantooccipital joint (between the skull and the first vertebrae of the neck) as well as the reduction in mobility of the left side of the vertebrae between C2-3. Mr. Gallant felt that those findings might explain some of the employee's complaints of the neck and head noting that an overpressure (a movement) of C2-3 reproduce some of the patient's left sided sub occipital headaches. Dr. Cantrell stated that given the nature of the injury and the employee not having any of these symptoms prior that he would conclude that some of the thoracic stiffness would be related to the multiple rib fractures and the fact that he landed on his head and shoulder. Some of the limitations and segmental motion of his upper cervical spine could be attributed to his work injury and was the contributing factor to the cause of his ongoing pain complaints.

Dr. Cantrell said that the employee's complaints including the migraine headaches, bilateral shoulder pain, upper back pain and lower back pain were complaints that the employee had following the March 4, 2003 injury either as a direct result of the injury or a result of participation in physical therapy. Dr. Cantrell stated that the segmental dysfunction that the therapist was documenting (the limitations and movement between the base of the skull and first vertebrae, between the second and the third vertebrae) could explain his complaints of headaches and neck pain but would not be a cause of his low back complaints or any of the extremity complaints in his arms or legs. Dr. Cantrell stated that the disc bulging and multi-level disc degeneration at L3 all the way down to S1 shown in the diagnostic studies could be a cause of the employee's low back pain but he cannot say that with certainty because there are individuals who are asymptomatic for back pain and have similar radiographic findings.

Dr. Levy:

The employee saw Dr. Levy, a board certified general surgeon, on February 9, 2006. Dr. Levy's February 21, 2006 report, March 4, 2006 letter, September 27, 2006 letter, and October 24, 2006 deposition were all included into the evidence. Prior to the March of 2003 accident, the employee had ongoing symptoms. The past history showed previous injuries to both elbows which were quite painful and bothersome prior to the current accident. The employee previously injured both of his shoulders and had surgery on them and continued to have some residual discomfort especially when doing any heavy work or working above horizontal. In his examination, the employee had no loss of motion in his neck or back, he walked normal and performed squatting without difficulty. The employee had marked diminished range of motion of both shoulders.

It was Dr. Levy's opinion that the employee had the following pre-existing medical conditions: right lateral meniscectomy of his knee; debridement on the right knee; right olecranon spur; strain of the right elbow; debridement of his left shoulder chondromalacia; debridement of the left shoulder labral tear, debridement of the right shoulder chondromalacia, debridement of the labral tears of the right shoulder; a subacromial decompression of the right shoulder; chronic strain of the right shoulder; drilling and debridement of the left shoulder; and left elbow strain. It was Dr. Levy's opinion that the employee had pre-existing permanent partial disability that was a hindrance or obstacle to employment and to re-employment and rated 20% of each upper extremity at the shoulder, 30% of the right lower extremity at the knee, 10% of the right upper extremity at the elbow.

It was Dr. Levy's opinion that as a result of the March 4, 2003, accident the employee sustained a concussion with cognitive loss; a bulging disc at C5-6; a chronic cervical strain; fractured ribs; left rotator cuff repair; chronic strain of the left shoulder; right rotator cuff repair; chronic strain of the right shoulder; right cubital tunnel release; transposition of the right ulnar nerve at the elbow; chronic strain of the right elbow; and chronic opiate use. It was Dr. Levy's opinion that as a result of the March 4, 2003 accident, that the employee sustained a 25% permanent partial disability of the left upper extremity at the shoulder a 25% permanent partial disability of the right upper extremity at the shoulder; 25% permanent partial disability of the right upper extremity at the elbow; and a 25% permanent partial disability of the man as a whole due to concussion, the cognitive loss and his neck symptoms.

Dr. Levy stated the employee had an overall disability of 45% of each upper extremity at the shoulder of which 25% is a direct result of the accident of March 4, 2003 with 20% pre-existing. In addition he has an overall disability of 35% of the right upper extremity of the elbow of which 25% is a direct result of the accident of March 4, 2003 with 10% pre-existing.

It was Dr. Levy's opinion that the combination of the impairments create a greater disability than the simple total of each and a loading factor should be added. It was Dr. Levy's opinion that with all those extensive disabilities that the employee is permanently and totally disability and unable to compete in the open labor market.

In a September 27, 2006 letter, Dr. Levy agreed with Dr. Stone pertaining to the long term care of the employee and his medications and disabilities. Dr. Levy was furnished with two letters from Dr. Stone dated June 12, 2006 and August 17, 2006. Dr. Levy reviewed those letters and testified that it did not change his opinions.

Dr. Levy was not aware of the March 2005 functional capacity evaluation done by Mid America Rehab. Dr. Levy thought the employee had a significant cognitive loss. Significant alcohol abuse and narcotics use can result in cognitive loss. Dr. Levy did not have an opinion whether the cognitive loss was from the drug use or directly from fall that he would have had even without the drug use.

Mr. Lalk:

The employee was evaluated by Timothy Lalk for a vocational rehabilitation evaluation on April 24, 2006. Mr. Lalk indicated that the employee appeared tired and displayed a strain in his face and voice. He limited most of his responses as he thought talking increased his symptoms. Throughout the interview he expressed his opinion that all of his problems were due to the neglect of the workers' compensation insurance and their doctors who do not believe that he had the symptoms he reported and did not provide the appropriate examinations and treatment. The employee's face typically had a blank expression as if he did not hear Mr. Lalk and he asked Mr. Lalk to repeat or rephrase his questions. It usually took the employee a long time to consider the questions and he seemed to have some difficulty understanding the questions. The employee's daughter tended to answer questions for him when his response was delayed. The employee's gait was very slow and he leaned forward and to the right. He used a cane in his right hand. The employee relied on a cane all the time for the last year and it was not prescribed by any physician. The employee appeared to be in pain walking, standing, sitting and changing positions.

The employee told Mr. Lalk that initially for his work injury he had no medical condition which limited him in any way. He stated several times he had no pain and no weakness before March of 2003. He specifically denied any symptoms in the shoulders after he recovered from the surgeries in 1997 and 1998. He was diagnosed with diabetes in 2000 but that was controlled with oral medication and there was no symptoms related to that.

The employee completed eighth grade and then flunked the ninth grade. He believes he had attention deficit disorder because he could never read a book, watch a television show or follow a story. The employee had no other vocational or technical training. Both he and his daughter became upset when Mr. Lalk indicated that he planned to administer tests. They explained that he was already hurting too much from the trip and had a two and a half hour drive home. Mr. Lalk felt that any effort for those tests with his increased symptoms would not produce valid results. Mr. Lalk did not perform any testing because the employee appeared to be in too much pain. The employee was 51 years old and reported academic difficulties in spelling and little interest in reading.

The employee reported symptoms and limitations to Mr. Lalk similar to those reported to Dr. Levy and which were consistent with the medical findings of Dr. Levy. Based upon the opinion of Dr. Levy and his interview with the employee, it was Mr. Lalk's opinion that the employee was not able to secure and maintain employment in the open labor market and was not able to compete for any position. Mr. Lalk did not believe that any employer would consider him for any position considering his current experience and training, due to his obvious pain behaviors and his difficulty performing even simple activities of standing, sitting and changing positions. The employee is not able to return to his former occupation or use any of the skills operating equipment without increasing symptoms. His best attempts at controlling his symptoms consist of activity at the sedentary level. He did not believe that any employer would be able to accommodate his need to recline for extensive periods of time during the day to control his symptoms in any unskilled entry level position. Mr. Lalk did not believe the employee could profit from a vocational rehabilitation services unless his condition improved to the point that he can control his symptoms without reclining during the day and he could function at the sedentary or near sedentary work level without exhibiting symptoms of pain and difficulty while performing simple activities of standing, walking, sitting and standing position.

The deposition of Mr. Lalk was taken on January 17, 2007. Mr. Lalk's interview lasted approximately two hours and eight minutes. Mr. Lalk had two opinions based on two sets of conditions whether the employee was employable in the open labor market. The first condition is the restrictions set by Dr. Cantrell and if only assuming the restrictions that he gave him and ignoring the report the employee gave to Mr. Lalk then there are positions that the employee would be able to perform and would some type of work that he would be able to do. If Mr. Lalk took into account all the symptoms and limitations that the employee reported and looked at the entire medical records specifically noting the evaluation of Dr. Levy then it was his conclusion that the employee was not able to secure and maintain employment in the open labor market and would not be able to compete for any positions. Mr. Lalk based his opinion that the employee was unable to secure and maintain employment on Dr. Levy and his subjective symptoms.

A wide range achievement test was not conducted by Mr. Lalk. Mr. Lalk felt the reason he could not work had nothing to do with his ability to read or perform computations.

Dr. Stone:

The deposition of Dr. Stone who is board certified in family medicine was on March 21, 2007. Dr. Stone began seeing the employee in October of 2003 and has continued to treat him. The employee's condition is one of chronic pain with the primary region of discomfort in the right shoulder, shoulder girdle, neck region and upper back. He also has lower back discomfort and leg discomfort. He has been seeing him about every one to two months. Dr. Stone has taken over pretty well all aspects of his medical care.

Dr. Stone identified the Employee's Exhibit M which the June 12, 2006 letter that outlined the employee's medical condition and Employee Exhibit N, which is the August 17, 2006 letter. The June 12 letter stated that the employee's current medical regimen was reasonable and necessary, that the medications were related to his work related conditions. Dr. Stone diagnosed the various medical conditions. The August 17 letter sets out the medications for those conditions and Dr. Stone's opinions contained in those letters was still his opinion at the time of the deposition.

The employee is being prescribed OxyContin, a narcotic, which is very uncommon for Dr. Stone. He is prescribing OxyContin in only two of his approximate 7,000 patients. Dr. Stone stated that if a patient starts to exhibit any drug seeking behavior, meaning that they are escalating the use of medication or asking for the medication soon or they are getting medications from other physicians, that is grounds for discharging them as a patient and he will not continue to look after them. Dr. Stone has to be really convinced that the individual is in significant discomfort to prescribe that medication. To his knowledge the employee has not violated any of the rules that he set down. Since Dr. Stone has been treating him with the pain medication, whether it is OxyContin or any of the other pain medications that he has tried before, the employee has been very compliant. He noted that the employee can be difficult at times but he has followed the rules set out by him for those medications. His daughter usually comes with him and she monitors a lot of the medications.

When Dr. Stone first saw the employee he was upset and anxious primarily because of chronic pain. He was to be his primary family physician and was initially engaged to treat depression and anxiety. At the time he was taking on his pain medication management. Dr. Stone thought the employee had a problem with alcohol in the past but was not aware that the employee had undergone a detoxification program.

Dr. Stone stated that there was a FCE in his file, but he had not reviewed it. When asked if the fact that he had failed ten out of twelve validity criteria on symptom magnification, whether that was relevant to whether or not the pain management aspect was appropriately done, Dr. Stone stated that a functional capacity evaluation done by someone he does not know is not more relevant than his opinion about the patient he had been treating for three years. Dr. Stone does use Waddle's criteria for symptom magnification but the most important factor is how the patient reacts, what support system they have, is there someone helping monitor the medication and are they displaying behaviors that clearly indicate that they are engaging in drug seeking behaviors. Dr. Stone stated that has not been a problem with the employee.

Dr. Stone has not done any Waddell's testing on the employee. Dr. Stone stated that he would do Waddell's testing if he feels that a patient is pulling his leg. Dr. Stone stated that he has thousands of patients and only two of them are on OxyContin and that says how much he believes the employee is in pain. Dr. Stone does not like the drug because it is highly addictive and can create a lot of problems. Dr. Stone stated that he has to be really convinced that the individual is in significant discomfort before he will prescribe it.

In Dr. Stone's June 12, 2006 letter, Dr. Stone diagnosed the employee with:

1. Bilateral shoulder rotator cuff repairs done February 16, 2004 on the left side and May 10, 2004 on the right. That condition was work related. The employee has persistent bilateral shoulder discomfort, worse on the right, and radiates up into the trapezius region and into the right clavicle.
2. The employee had a right ulnar nerve release in 2004 for cubital tunnel syndrome. The employee has arm discomfort in the area of the elbow with some persistent numbness in the right arm which is a work related.
3. The employee has been diagnosed with degenerative disc disease of the lumbar spine with facet joint osteoarthritis which is work related primarily. The employee had degenerative disc disease of the cervical spine which contributes to the neck and upper torso discomfort. It was Dr. Stone's opinion that that was primarily work related.
4. Chronic myofascial pain primarily in the torso more on the right than the left localizing to the trapezius muscle, rhomboid muscles, and paraspinal muscles of the cervical and thoracic spine which is work related.
5. Bilateral knee surgery. The employee has persistent discomfort in both lower extremities and walks bilaterally with antalgic gait. Dr. Stone was uncertain about the history of that injury and whether they were work related.
6. Chronic depression with suicidal ideation and suicidal attempt in 2005. That condition is certainly related to the employee's chronic pain which is primarily related to work related injuries.
7. Chronic persistent sleep disturbance which is primarily caused by persistent discomfort and depression and relates to work related injuries.
8. Insulin dependent diabetes mellitus type II with associated peripheral vascular disease. Dr. Stone did not relate that problem to work related injuries.
9. COPD. The employee has a long standing history of smoking which is the primary cause of his COPD although there has been some contribution by virtue of the work environment at Noranda.
10. Peripheral neuropathy. This is difficult to determine due to the employee's cubital tunnel injury and the degenerative disc of the lumbar spine. There is certainly some contribution from the degenerative disc disease and cubital tunnel syndrome to the patient's persistent numbness. Nerve conduction studies done on the upper extremities showed normal median nerve function bilaterally. In the lower extremities, the employee had a significantly abnormal peroneal nerve function on the left hand side. The nerve conduction studies did not meet criteria for diabetic peripheral neuropathy and therefore it is Dr. Stone's opinion that the employee has a bilateral L5 radiculopathy which is a work related problem.
11. Peripheral vascular disease likely due to smoking and insulin dependent diabetes mellitus type II which is not work related.

Dr. Stone stated that the current medical regimen noted in his records and in the enclosed medication list were reasonable and necessary for the employee's condition. The employee has chronic severe discomfort. All other medical regimens have been tried without significant relief. The employee is on OxyContin, a narcotic prescription for chronic relief of pain. The Valium is necessary for muscle spasms. The medication is definitely related to treatment of his current conditions that are work related and are reasonable and necessary. The conditions diagnosed are unfortunately likely to deteriorate and have done so while he has been caring for the employee.

In the August 17, 2006 letter, Dr. Stone noted the medications that the employee currently takes are a consequence of his work related injury are Valium, OxyContin, Cymbalta, Celebrex, Topamax, Prevacid, Synacot, Lexapro and Zanaflex. The medications for the treatment of pain are OxyContin, Cymbalta, Celebrex, Topamax, Valium, and Zanaflex. The employee needs to take Synacot because of the constipation related to the narcotics that are required for his pain control. The Lexapro and Cymbalta are for the depression which is related to his chronic pain. These medications are used for treatment to reduce pain and chronic conditions. The employee takes Prevacid due to symptoms of gastritis related to the medication that are used for the related injuries.

Employee:

The employee testified that from February of 2005 until the hearing his condition has remained about the same. At the time of the hearing, he cannot sit or stand or lay too long of a time without discomfort or pain in his lower back. He has headaches 3-4 times a week which usually last an hour and sometimes 10-12 hours. At the worst, his headache pain is 8-9 out of 10 and he has to lay down in a dark room with no sound. He has pain in his shoulder area on a daily basis up to 6 times a day which last an hour or sometimes all day. Prior to March 4, 2003, he had no loss of motion in either shoulder and could move it above his head. The pain in his neck and shoulder is 8 out of 10. He is currently is taking 40 mg of OxyContin 4 times a day which is prescribed by Dr. Stone. His daughter Jessica brings him his medicine. His right shoulder has a loss of range of motion and can only move it about a foot above his shoulder level. If he uses his shoulder a lot he has pain. He is unable to do any overhead work of any kind. His left shoulder is about the same as the right. He does not have a lot of problems with his right elbow but his hands stay tingly and he has numbness in his fingers.

Prior to his fall, he did all the housework. Since the accident he has been getting a lot of help from his daughter with cooking, cleaning, managing checkbook, driving and his medications. During the day he does not do much and mostly sits around and watches television. He might get up and do a little laundry. His daughter lives next door. She does his cooking and shopping, and handles his medicine and his checkbook. Since the injury he has only driven once or twice. He does not go out much. He no longer rides his four-wheeler.

As a result of the injury he has bought a Craftmatic bed that has heat, vibration, and can be raised or lowered. It gives him some relief but he still has trouble sleeping through night. His is only able to sleep a couple of hours at a time. The employee has been using a cane since March of 2003 but it is not prescribed by a doctor.

The employee testified that he is unable to work due to the problems with his back, shoulders, neck, headaches, and low back. Prior to March 4, 2003, he did not have any headaches, had no problems with his cervical area, shoulder blades or low back. He had never been on OxyContin before March 4, 2003, and never tried to commit suicide before.

The employee testified that OxyContin is the only thing he found that has helped him. His main complaints and problems is pain to his low back pain, upper back pain with knots in shoulder blades, and headaches. His low back problems go from his belt line down in his right buttocks and right leg in the back part of leg. Since March of 2003, he has had 4 surgeries, and multiple injections, therapy, and pain medications. Since Dr. Pfefferkorn put him on Vicodin he has been consistently on pain medications. The OxyContin he has taken since injury has been prescribed and he has not bought any off the street.

Jessica Bennett:

She has lived next door to her father for the last 3 or 4 years. She is single and is a college student. She helps

her father. She cooks and cleans for him. She mows his yard for him on a riding lawn mower, changes his oil in the car, trims his trees and flowers. He does not drive at all and she drives him around. She handles his medicines and takes him his OxyContin on a daily basis. The rest of his pills she puts in a seven day pill box but still monitors and verifies taking it because she will be over there once or twice a day. She gives him four OxyContin tablets each day. If she is not going to be there at the time for his second pill, she will leave a second one. She takes her father to the doctor. He does no lifting around house except for maybe a gallon of milk. She makes his bed and changes the sheets. She handles his father's finances and has done so for several years. She gets his mail, has a power of attorney to write checks and handles his checking account. He is on social security disability and Medicare.

RULINGS OF LAW:

Issue 1. Medical Causation

The employer stipulated that the employee's injuries to his right elbow, right shoulder and left shoulder were medically causally related to the accident. The employer is disputing that the other injuries and conditions of the employee were medically causally related to the accident.

The employee had several prior injuries to his back. He had one in 1982 while working for Noranda and settled that case for 10% permanent partial disability of the body. The employee injured his low back in February of 1989 and had bilateral positive straight leg raising and lumbar tenderness. In November of 1992 the employee had low back, right buttock and right upper thigh pain. A CT scan showed a disc bulge at L4-5. Dr. Thorpe diagnosed piriformis syndrome and possible early sciatica irritation. In 2002, the employee had torn left rib muscles around the 11th or 12th rib, was prescribed Ultracet for pain and was taken off work. The employee testified that prior to March 4, 2003, he did not have any problems with his head, neck, or shoulder blades.

A pre-existing but non-disabling condition does not bar recovery under the Workers' Compensation Act if a work related accident causes a pre-existing condition to escalate to the level of disability. See Weinbauer v. Gray Eagle Distributions, 661 S.W.2d 652, 654 (Mo. App. 1983) and Miller v. Wefemeyer, 890 S.W.2d 372 (Mo. App. 1994). The worsening of a preexisting condition is a change in pathology needed to show a compensable injury. See Windsor v. Lee Johnson Const. Co., 950 S.W. 2d 504,509 (Mo. App. 1997). The aggravation of a pre-existing symptomatic condition is also compensable. See Rector v. City of Springfield, 820 S.W.2d 639 (Mo. App. 1991) and Parker v. Mueller Pipeline, 807 S.W. 2d 518 (Mo. App. 1991). In Kelly v. Banta and Stude Construction Company, Inc., 1 S.W.3d 43 (Mo. App. 1999), the Court of Appeals held that the employer-insurer was liable for hip replacements based on a finding that the employee's work activity aggravated the employee's pre-existing osteoarthritis.

It is sufficient that causation be supported only by reasonable probability. See Davis v. Brezner, 380 S.W.2d 523 (Mo. App. 1964) and Downing v. Willamette Industries, Inc., 895 S.W.2d 658 (Mo. App. 1995).

On March 4, 2003, the employee had a very significant and traumatic accident. He fell approximately 15-20 feet onto a concrete floor and lost consciousness.

Low Back: Diagnostic tests showed the prior L4-5 disc bulge. There was also a L5-S1 disc bulge and other degenerative discs in the lumbar area. Dr. Burns stated that the employee had pre-existing degenerative disease of the spine. Dr. Frauwirth and Dr. Burns diagnosed bilateral SI joint dysfunction. Dr. Guidos diagnosed low back pain with right sacroiliac joint and piriformis muscle syndrome. Dr. Chaudhari performed bilateral sacroiliac joint and piriformis blocks.

Dr. Lee stated that the fall resulted in a spine injury. Dr. Vaught stated that the low back and right leg pain may be due to a musculoskeletal injury. Dr. Cantrell stated that as a result of the fall, the employee developed lower back pain that could be caused by the multi-level disc degeneration from L3 to S1. Dr. Stone diagnosed chronic low back pain; degenerative lumbar disc disease; muscle spasms; facet joint osteoarthritis; and bilateral L5 radiculopathy. It was Dr. Stone's opinion that those conditions were primarily work related.

Based on a review of the evidence and the credible opinions of Dr. Stone and Dr. Cantrell, I find that the March 4, 2003, work accident either caused new injuries and/or aggravated preexisting conditions to the employee's low back which caused the low back to become symptomatic and disabling. I find that the employee's March 4, 2003, accident was a substantial factor in causing the employee's low back injury, resulting medical conditions, disability, and the need for treatment including the L5-S1 bulging disc, bilateral SI joint dysfunction, right piriformis muscle syndrome, bilateral L5 radiculopathy, facet joint arthritis and aggravation of degenerative disc disease. I find that the employee's low back condition and need for medical treatment are medically causally related to the March 4, 2003, work accident.

Neck: An MRI showed a mild to moderate extradural defect which some effacement of the dural sac at C5-6. Another MRI and a CT scan showed a C5-6 disc bulge. There was joint disease at C3-4. A CT scan showed a minimal disc bulge at C4-5. Dr. Stone stated that the employee had degenerative disc disease of the cervical spine which contributed to the neck and upper torso discomfort. It was Dr. Stone's opinion that it was primarily work related. It was Dr. Cantrell's opinion the work injury was the contributing factor to the cause of the employee's ongoing pain complaints, limitations and segmental motion of his upper cervical spine. Dr. Chiu diagnosed myofascial neck pain as a result of the fall. It was Dr. Levy's opinion that the employee sustained the C5-6 bulging disc and a chronic cervical strain as a result of the March 4, 2003 work accident.

Based on a review of the evidence and the opinions of Dr. Stone, Dr. Cantrell and Dr. Chiu, I find that the March 4, 2003, work accident either caused new injuries and/or aggravated preexisting conditions in the employee's neck which caused the neck to become symptomatic and disabling. I find that the March 4, 2003, accident was a substantial factor in causing the employee's neck injury, resulting medical conditions, disability, and the need for treatment including the C5-6 bulging disc, neck strain, myofascial pain, and aggravation of degenerative disc disease. I find that the employee's neck condition and need for medical treatment are medically causally related to the March 4, 2003, work accident.

Head: Dr. Burns diagnosed a concussion that was related to the March of 2003 fall. It was Dr. Levy's opinion that as a result of the March 4, 2003, accident the employee sustained a concussion with cognitive loss. Several doctors diagnosed the employee with headaches including Dr. Cheung, Dr. Vaught, Dr. Chiu, Dr. Chaudhari, and Dr. Cantrell. It was Dr. Chiu and Dr. Cantrell's opinion that his headaches were a result of the fall.

Chest/Ribs: The employee was diagnosed with left rib fractures. It was Dr. Levy's opinion that the left rib fractures were the result of the March 4, 2003, accident.

Mid Back/Upper Back: A thoracic CT scan showed a central disc bulge at T2-3. Dr. Vaught diagnosed interscapular pain. Dr. Chiu diagnosed thoracic interspinus ligament laxity. Dr. Chiu and Dr. Guidos diagnosed thoracic paraspinus myofascial pain and right rhomboid myofascial pain. Dr. Burns diagnosed diffuse thoracic and scapular pain related to the accident. Dr. Cantrell stated that the employee may have sustained a thoracic sprain/strain due to the fall and that persistence of his pain complaints may be due to relative inactivity resulting in myofascial tightness, myofascial weakness and facet joint stiffness throughout the thoracic spine. It was Dr. Cantrell's opinion that some of the thoracic stiffness was related to the multiple rib fractures and from landing on his head and shoulder. Dr. Cantrell stated that as a result of the fall the employee developed upper back pain.

Depression/Anxiety: Dr. Lake stated that the employee was depressed. Dr. Burns diagnosed adjustment disorder. Dr. Stone diagnosed the employee with chronic depression and anxiety. It was Dr. Marsh's opinion that the employee's anxiety and depression were pre-existing. There was no evidence that the employee had been diagnosed or treated for depression or anxiety in the past. It was Dr. Stone's opinion that the depression and anxiety was due to chronic pain from the work related injuries. I find that the opinion of Dr. Stone is credible and persuasive and is more credible than the opinion of Dr Marsh.

Sleep Disturbance: Dr. Burns diagnosed the employee with sleep disturbance secondary to pain and prescribed Ambien. Dr. Stone diagnosed the employee with chronic sleep disturbance. It was Dr. Marsh's opinion that the employee's chronic sleep deprivation was pre-existing. It was Dr. Stone's opinion that the sleep deprivation was primarily caused by persistent discomfort and depression which was related to the work related injuries. I find that the

opinion of Dr. Stone is credible and persuasive and is more credible than the opinion of Dr Marsh.

Chronic and Myofascial Pain: Mr. Zuccarello stated that the employee had possible symptom magnification but that was for the physicians to ultimately determine. There were multiple doctors that diagnosed the employee with chronic and/or myofascial pain including Dr. Lake, Dr. Lee, Dr. Kapp, Dr. Burns, Dr. Vaught, Dr. Cheung, Dr. Cantrell, and Dr. Chiu.

Dr. Marsh diagnosed the employee with chronic pain but stated that it was likely that the bulk of his ongoing chronic pain issues were related to non-work related concerns including pre-existing chronic sleep disturbance, and diabetic pseudosciatica and neuropathy. It was Dr. Chiu's opinion that the myofascial neck pain was secondary to the employee's fall. It was Dr. Lee's opinion that the employee had chronic pain syndrome as a result of his fall. Dr. Stone diagnosed the employee with chronic pain primarily in the right shoulder, shoulder girdle, neck region and upper back; and in the lower back and leg. He diagnosed chronic myofascial pain primarily in the torso localizing to the trapezius muscle, rhomboid muscles, and paraspinal muscles of the cervical and thoracic spine. It was Dr. Stone's opinion that those conditions were work related. I find that the opinions of Dr. Stone, Dr. Lee, and Dr. Chiu are credible and persuasive and are more credible than the opinions of Dr Marsh and Mr. Zucarello.

Based on a review of the evidence and the various medical opinions I find that the March 4, 2003, work accident was a substantial factor in causing the employee's following injuries, conditions, limitations and disabilities; the low back and neck injuries and pain; the concussion including cognitive loss and headaches; the left rib fractures and chest pain; the mid and upper back injury and pain; his chronic pain syndrome; his myofascial pain; his depression and anxiety; and his sleep disturbance. I find that the injuries, conditions and need for medical treatment set forth above are medically causally related to the March 4, 2003, work accident.

Diabetic Neuropathy: The employee had pre-existing non-insulin dependent diabetes and was taking medication. Although Dr. Marsh stated that he had pre-existing diabetic neuropathy, there was no evidence that the employee had diabetic neuropathy before his accident. After the accident, the employee became insulin dependent. There was a question whether he developed diabetic neuropathy. Dr. Burns assessed diabetic peripheral neuropathy. Dr. Guidos and Dr. Marsh noted that the employee had objective testing showing a polyneuropathy which suggested that he had diabetic neuropathy. It was Dr. Stone's opinion that the nerve conduction studies did not meet the criteria for diabetic peripheral neuropathy. Dr. Stone did not relate his insulin dependent diabetes with associated peripheral vascular disease to the work related injuries. I find that there is no credible evidence to support a finding that the employee's insulin dependent diabetes or alleged diabetic peripheral neuropathy are medically causally related to the employee's March 4, 2003 accident.

Issue 2. Claim for previously incurred medical

The employee is claiming \$70,665.57 in previously incurred medical bills. Claimant's Exhibit R are medical bills which total \$55,701.64. Claimant's Exhibit S are bills for prescription medication in the amount of \$14,964.43. The employer is disputing those bills with regard to the authorization, reasonableness, necessity, and causal relationship.

Employee's Exhibit R contains a medical bill in the amount of \$1,652.05 for the emergency room visit to Southeast Hospital on January 23, 2005. With regard to the issue of authorization, Section 287.140 RSMo gives the employer the right to select the treating physician but also gives the employee the option of selecting his own physician at his own expense. The employer waives that right by failing or neglecting to provide necessary medical aid. See Herring v. Yellow Freight System, 914 S.W. 2d 816 (Mo. App. 1995) and Banks v. Springfield Park Care Center, 981 S.W.2d 161 (Mo. App. 1998).

The employee testified that after his visit with Dr. Marsh on January 18, 2005, he requested more treatment from Betty Brooks, the nurse case manager for his neck, upper back and low back but never received any more treatment. At the time of his visit, the employee was still under the treatment of Dr. Deisher for his elbow and Dr. Kapp for his shoulders. The employee went to the emergency room on January 23, 2005, five days after seeing Dr. Marsh.

I find that that employers have a reasonable amount of time to authorize or deny additional treatment and that 5 days is not a reasonable amount of time. I find that the visit to Southeast Missouri Hospital on January 23, 2005 was unauthorized, was not a true emergency situation, and the employee exercised his right under the statute to go at his own expense. I therefore find that the employer is not liable for the \$1,652.05 bill for the January 23, 2005 treatment.

Employee Exhibit R contains medical bills in the amount of \$49,437.09 for the employee's hospitalization from February 3 through February 11, 2005 due to the employee's attempted suicide. Under Section 287.120.3 RSMo there is no compensation allowed for injury or death due to an employee's self-inflicted injury. However, the burden of proof of intentional self-inflicted injury shall be on the employer. The employee testified that due to his pain he tried to kill himself by taking an overdose of Elavil. Approximately 10 days prior to his attempted suicide, the employee and/or his family had contacted Charter for possible drug rehabilitation. The employee had several options but chose to intentionally attempt to kill himself. I find that the employee's accident was not a substantial factor in the causing the employee's attempted suicide. I find that the employee's overdose, unconsciousness, and reason for his hospitalization on February 3, 2005, was due to his intentional self-inflicted attempted suicide and therefore no compensation for these medical bills is allowed. I find that the employer is not liable for the \$49,437.09 in medical bills and the claim for these previously incurred medical bills is denied.

The remainder of the medical bills contained in Employee Exhibit R are Dr. Stone's February 12, 2004 through October 3, 2006 in the amount of \$4,612.00. I find that prior to the employee's February 28, 2005 visit to Dr. Stone, the employer was providing treatment with various physicians for the problems to the employee's head, neck, upper back and lower back, and the treatment given by Dr. Stone prior to February 28, 2005, was unauthorized. The employee exercised his right under the statute to be treated by Dr. Stone at his own expense. The employer is therefore not liable for his medical bills for treatment from February 14, 2004 through December 20, 2004, which was his last treatment date prior February 28, 2005. I find that after January 18, 2005, the employee requested additional treatment from the employer for his chronic pain but the employer neglected or failed to provide any additional treatment. I find that the employer waived its right to select the physician and the alleged authorization defense beginning with the February 28, 2005 visit to Dr. Stone is not valid.

Based on my ruling on medical causation in Issue 1, the medical treatment and prescriptions that were received by the employee for his low back and neck; the concussion including cognitive loss and headaches; the left rib fractures and chest pain; the mid and upper back; his chronic pain syndrome; his myofascial pain; his depression and anxiety; and his sleep disturbance, are medically causally related to the March 4, 2003, work accident.

Several of the physicians recommended that the employee go through a detoxification program and stop using narcotics. Dr. Stone's credible opinion is that the employee has chronic severe discomfort, and he is prescribing OxyContin for the relief of pain. Dr. Stone has to be really convinced that the individual is in significant discomfort to prescribe OxyContin. It is important to note that Dr. Stone is prescribing OxyContin for only two of his approximate 7,000 patients. Dr. Stone testified that if a patient exhibits drug seeking behavior he will discharge that patient. Since Dr. Stone has been treating the employee with pain medication, the employee has been very compliant and has followed Dr. Stone's rules. It was Dr. Stone's credible opinion that the medical treatment and medications were reasonable and necessary for the employee's condition. I therefore find that Dr. Stone's medical treatment and bills are reasonable and necessary.

The employee is not requesting the amounts that have previously been written off by a third party insurance company. Some of medical treatment by Dr. Stone is not related to his injury and is not recoverable. The medical bills, after the medical care provider write-off, for the following dates of service and amounts are recoverable by the employee: February 28, 2005, \$103.00; March 21, 2005, \$44.00; March 30, 2005, \$103.00; April 27, 2005, \$44.00; May 4, 2005, \$44.00; June 7, 2005, \$103.00 (examination only); July 5, 2005, \$44.00; August 2, 2005, \$44.00; September 2, 2005, 70.00; October 28, 2005, \$44.00; November 23, 2005, \$70.00; December 16, 2005, \$70.00 (examination only); January 6, 2006, \$300.00; January 10, 2006, \$44.00; February 3, 2006, \$44.00; March 1, 2006, \$54.08; March 22, 2006, \$44.00; April 19, 2006, \$44.00; May 12, 2006, \$44.00; June 13, 2006, \$44.00; August 8, 2006, \$130.00; October 3, 2006, 74.00. The amount is \$1,605.08. The remaining medical bills for treatment are not medially causally related to the accident and are not recoverable.

Employee's Exhibit S is the prescription medicine expenses from 2004 through 2007 which total \$14,966.43. With regard to the 2004 bills, I find that the employee exercised his right under the statute to be treated by Dr. Stone at his own expense and the bills are not recoverable. With regard to the 2005 prescription bills from Wal-Mart in the amount of \$291.64, I find that those bills are recoverable. With regard to the 2005 RX Third Party Solutions bill in the amount of \$349.47, I find that those bills are not recoverable since they were prescribed during the employee's hospitalization for his attempted suicide. With regard to the 2006 bills, I find that \$3,504.42 in prescription bills paid by UniCare and \$5,179.70, which is the responsibility of the employee are recoverable by the employee. With regard to the 2007 medical bills, the Medical Expense Summary from Wal-Mart Pharmacy ends on April 3, 2007. I find that only the prescription bills through that date are recoverable. The UniCare forms continue through June 28, 2007, but they are not bills. Since the Wal-Mart Pharmacy bills after April 3, 2007 are not available, these bills cannot be considered. I find that \$1,745.78 paid by UniCare and the \$1,963.05 which is the responsibility of the employee is recoverable by the employee. The total amount of recoverable bills in Exhibit S is \$12,684.59 (\$291.64 (2005) + \$8,684.12 (2006) + \$3,708.83 (2007)).

I find that the employer is responsible for and is directed to pay the employee the sum of \$1,605.08 for the recoverable medical bills contained in Exhibit R and the sum of \$12,684.59 for the recoverable bills contained in Exhibit S for a total award for previously incurred medical bills in the amount of \$14,289.67.

Issue 3. Notice of services provided and request for direct payment medical fee dispute in the amount of \$4,289.18 filed by Southeast Missouri Hospital.

Southeast Missouri Hospital filed a Notice of Services Provided and Request for Direct Payment with the Division on April 27, 2006. The amount being requested was \$4,289.18 for treatment from February 9, 2005 through February 11, 2005. Section 287.140.13(6) RSMo, states that a health care provider whose services have been authorized in advance by the employer may give notice to the division of a claim for services provided for a work related injury that is covered by this chapter. An administrative law judge may order direct payment from the proceeds of any award. The Notice filed by Southeast Missouri Hospital leaves blank the name and title of the person giving authorization for the services. There was no evidence that the treatment received by the employee was authorized in advance by the employer. I find that the services of Southeast Missouri Hospital were not authorized in advance by the employer. The Notice of Services Provided and Request for Direct Payment Medical Fee dispute is denied.

Issue 4. Claim for additional or future medical aid

Under Section 287.140 RSMo the employee is entitled to receive all medical treatment that is reasonably required to cure and relieve him from the effects of the injury. The employee's credible testimony is that OxyContin is the only thing he found that has helped him with his pain. Dr. Stone's credible opinion is that the employee has chronic severe discomfort, and is on OxyContin for the relief of pain. The Valium is for muscle spasms. Dr. Stone stated that the medications that the employee currently takes as a consequence of his work related injury are Valium, OxyContin, Cymbalta, Celebrex, Topamax, Prevacid, Synacot, Lexapro and Zanaflex. The medications for the treatment of pain are OxyContin, Cymbalta, Celebrex, Topamax, Valium, and Zanaflex. The employee needs to take Synacot because of the constipation related to the narcotics. Dr. Killian and Dr. Cantrell agreed with Dr. Stone about the employee's constipation being related to narcotic use. The Lexapro and Cymbalta are for depression. The Prevacid is for gastritis symptoms related to the medication used for the injuries. These medications are to reduce pain and chronic conditions. Dr. Levy agreed with Dr. Stone regarding the long term care of the employee and his medications.

I find that the opinions of Dr. Stone and Dr. Levy are persuasive and credible on the issue of future medical. I find that the employee is in need of additional medical treatment to cure and relieve him from the effects of his work related injury. The employer is therefore directed to provide the employee with all of the medical care that is reasonable and necessary to cure and relieve the employee from the effects of his work related injuries pursuant to Section 287.140 RSMo. This obligation includes but is not limited to the medications and treatment that is being provided by Dr. Stone for pain, muscle spasm, constipation, depression, and gastritis for the causally related conditions identified in Issue 1.

I find that that the employer has denied medical aid and has therefore waived its' right to select and approve the treating physician. The employer is therefore ordered to furnish additional medical aid under the direction and control of Dr. Stone.

Issue 5. Nature and extent of disability (Includes temporary total disability, permanent total disability and permanent partial disability) and Issue 6. Liability of the Second Injury Fund for permanent total disability or permanent partial disability

The employee is claiming that he is permanently totally disabled. The term "total disability" in Section 287.020.7 means inability to return to any employment and not merely inability to return to the employment in which the employee was engaged at the time of the accident. The phrase "inability to return to any employment" has been interpreted as the inability of the employee to perform the usual duties of the employment under consideration in the manner that such duties are customarily performed by the average person engaged in such employment. See Kowalski v/ M-G Metals and Sales, Inc., 631 S.W.2d 919, 922 (Mo. App. 1992). The test for permanent total disability is whether; given the employee's situation and condition, he or she is competent to compete in the open labor market. See Reiner v. Treasurer of the State of Missouri, 837 S.W.2d 363, 367 (Mo. App. 1992). Total disability means the "inability to return to any reasonable or normal employment." An injured employee is not required, however, to be completely inactive or inert in order to be totally disabled. See Brown v. Treasurer of State of Missouri, 795 S.W.2d 479, 483 (Mo. App. 1990).

The key question is whether any employer in the usual course of business would reasonably be expected to employ the employee in that person's present physical condition, reasonably expecting the employee to perform the work for which he or she entered. See Reiner at 367, Thornton v. Haas Bakery, 858 S.W.2d 831, 834 (Mo. App. 1993), and Garcia v. St. Louis County, 916 S.W.2d 263 (Mo. App. 1995). The test for finding the Second Injury Fund liable for permanent total disability is set forth in Section 287.220.1 RSMo.

The first question that must be addressed is whether the employee is permanently and totally disabled. If the employee is permanently and totally disabled, then the Second Injury Fund is only liable for permanent total disability benefits if the permanent disability was caused by a combination of the preexisting injuries and conditions and the employee's last injury of March 4, 2003. Under Section 287.220.1, the preexisting injuries must also have constituted a hindrance or obstacle to the employee's employment or reemployment.

There is both medical and vocational evidence that addresses whether the employee is permanently and totally disabled.

It was Mr. Zucarello's opinion that the employee was employable in a full time capacity in at least the light work demand level. It was Dr. Cantrell's opinion that the employee was not capable of returning to his regular duty work activities but was capable of gainful employment. Dr. Cantrell put restrictions of avoiding repetitive overhead work with both upper extremities, lifting less than 20 pounds above shoulder level, and lifting less than 50 pounds from floor to waist and waist to shoulder level on an occasional basis. It was Dr. Marsh's opinion that the employee was not permanently and totally disabled but would need to be on work restrictions, should not go back to his regular job, and should start with sedentary or light duty work. In September of 2004, Dr. Chiu filled out a release from work until further notice. It was Dr. Levy's opinion that the employee is permanently and totally disability and unable to compete in the open labor market. Mr. Lalk was the only vocational opinion. It was his opinion that the employee was not able to secure and maintain employment in the open labor market and was not able to compete for any position. Mr. Lalk did not believe that any employer would consider the employee for any position considering his experience and training; his obvious pain behaviors; and his difficulty performing activities of standing, sitting and changing positions.

Based on a review of all the evidence, I find that the opinions of Dr. Chiu, Dr. Levy and Mr. Lalk are credible and persuasive and more credible than the opinions of Mr. Zucarello, Dr. Cantrell and Dr. Marsh regarding whether the employee is permanently and totally disabled.

In addition to both the medical and vocational evidence, I find that the employee and his daughter were very

credible and persuasive witnesses on the issue of permanent total disability. The employee and his daughter offered detailed testimony concerning the impact his injuries have had on his daily ability to function either at home or in the work place. Their testimony supports a conclusion that the employee will not be able to compete in the open labor market. With his physical limitations, restrictions and pain it is extremely unlikely that any employer would reasonably be expected to hire the employee in his present physical condition.

The observations and opinions of the following physicians and vocational expert corroborate the testimony of the employee and his daughter at the hearing. It was Dr. Marsh's opinion that the employee had chronic pain. Mr. Lalk stated that the employee appeared tired and displayed a strain in his face and voice. The employee's face typically had a blank expression as if he did not hear Mr. Lalk. He asked Mr. Lalk to repeat or rephrase his questions and seemed to have some difficulty understanding the questions. The employee appeared to be in pain walking, standing, sitting and changing positions. Mr. Lalk did not perform any testing because the employee appeared to be in too much pain. The testimony of Dr. Stone was very credible and persuasive. It was his opinion that the employee is in significant pain and discomfort. These observations and opinions were important evidence on the issue of permanent total disability.

Based on the credible testimony of the employee and his daughter; and the supporting medical and vocational evidence, I find that no employer in the usual course of business would reasonably be expected to employ the employee in his present physical condition and reasonably expect the employee to perform the work for which he is hired. I find that the employee is unable to compete in the open labor market and therefore is permanently and totally disabled.

The next question to be answered is whether the employee's preexisting conditions were a hindrance or obstacle to his employment or reemployment.

The employee had multiple injuries and treatments to various parts of his body prior to his 2003 fall. The employee had a 1982 back injury that he settled for 10% of the body as a whole. He had a 1989 low back injury and in 1992, had treatment on his low back, right buttocks and right thigh. A CT scan showed a bulge at L4-5. The employee tore his right meniscus, had surgery, and settled for 10% permanent partial disability. The employee was treated on several different occasions for his left shoulder and ultimately had a debridement of labral tears, a subacromial decompression and distal clavicle resection. The employee was treated for right elbow lateral epicondylitis. The employee had surgery on his right shoulder and had an arthroscopic subacromial decompression, resection of AC joint and debridement of labral tears that were unrepairable. The employee had left elbow surgery including drilling of osteochondritis dissecans, synovectomy and debridement. The employee was treated for torn left rib muscles.

It was Dr. Levy's opinion that the employee had pre-existing medical conditions of right lateral meniscectomy of his knee; debridement on the right knee; right olecranon spur; strain of the right elbow; debridement of his left shoulder chondromalacia; debridement of the left shoulder labral tear, debridement of the right shoulder chondromalacia, debridement of the labral tears of the right shoulder; a subacromial decompression of the right shoulder; chronic strain of the right shoulder; drilling and debridement of the left shoulder; and left elbow strain. Dr. Stone stated the employee had persistent discomfort in both lower extremities. Dr. Levy stated that prior to the March of 2003, accident, the employee had ongoing symptoms in both elbows which were quite painful and bothersome; and residual discomfort in both shoulders especially when doing any heavy work or working above horizontal. Dr. Levy rated 20% of each upper extremity at the shoulder, 30% of the right lower extremity at the knee, and 10% of the right upper extremity at the elbow. It was Dr. Levy's opinion that the pre-existing disabilities were a hindrance or obstacle to employment and to re-employment.

Based on a review of the evidence I find that the employee's preexisting disability and conditions constituted a hindrance or obstacle to his employment or to obtaining reemployment.

It was Dr. Levy's opinion that as a result of the March 4, 2003 accident, the employee sustained a 25% permanent partial disability of the left upper extremity at the shoulder; a 25% permanent partial disability of the right upper extremity at the shoulder; 25% of the right upper extremity at the elbow; and a 25% permanent partial disability

of the man as a whole due to concussion, the cognitive loss and his neck symptoms. Dr. Levy stated the employee had an overall disability of 45% of each upper extremity at the shoulder of which 20% was pre-existing. He has an overall disability of 35% of the right upper extremity of the elbow of which 10% was pre-existing. It was Dr. Levy's opinion that the combination of the impairments creates a greater disability than the simple total of each and a loading factor should be added. It was Dr. Levy's opinion that with all those extensive disabilities that the employee is permanently and totally disabled and unable to compete in the open labor market.

The Second Injury Fund's position is that if the employee is permanent and totally disabled it is from the last injury alone. Dr. Levy's opinion is the only medical opinion that addresses whether the employee was permanently and totally disabled as a result of the last accident alone or from a combination of the primary injury and the pre-existing conditions. The employee credible testimony is that he is unable to work due to the problems with his head, neck, shoulders and low back.

I find that the prior injuries to the employee's back, the prior bilateral shoulder surgeries, left elbow surgery, and right elbow injury combined synergistically with the primary injuries to the head, neck, upper back, mid back, and low back, bilateral shoulders, and right elbow to cause the employee's overall condition and symptoms. Based on the supporting medical evidence including Dr. Levy's credible and uncontradicted testimony, I find that the employee is permanently and totally disabled as a result of the combination of his preexisting injuries and conditions and the March 4, 2003 injuries and conditions.

The employer paid temporary disability benefits from March 5, 2003 through February 17, 2005. The employee was treated for his right shoulder by Dr. Kapp until April 18, 2005. I find that the employee was in his healing period through April 18, 2005. I find that from March 5, 2003 through April 18, 2005, the employee had not reached the point where further progress was not expected. I find that the employee is entitled to an additional period of temporary total disability from February 18, 2005 through April 18, 2005. The employer is therefore ordered to pay the employee 8 3/7 weeks of compensation at the rate of \$649.32 per week for a total of \$5,472.84 in additional temporary total disability. I find that as of April 19, 2005, the employee was no longer able to compete in the open labor market and was permanently and totally disabled.

Based on the evidence, I find that as a direct result of the last injury the employee sustained a permanent partial disability of 35 % of the body as a whole referable to the head, neck, upper back, mid back, low back, chest, ribs, chronic pain syndrome, and depression; a 20% permanent partial disability of the left shoulder at the 232 week level, a 17.5% permanent partial disability of the right elbow at the 210 week level, and a 20% permanent partial disability of the right shoulder at the 232 week level. The employee is therefore entitled to 140 weeks of permanent partial disability to the body as a whole (400 weeks x 35%), 46.4 weeks of permanent partial disability to the left shoulder (232 weeks x 20%), 46.4 weeks of permanent partial disability to the right shoulder (232 week x 20 %) and 36.75 weeks of permanent partial disability to the right elbow (210 weeks x 17.5 %). The employer-insurer is therefore ordered to pay 269.55 weeks of permanent partial disability payable at the rate of \$ 340.12 per week commencing on April 19, 2005 and ending on June 19, 2010 for a total of \$ 91,679.35.

Since the compensation paid by the employer-insurer was less than the amount payable for permanent total disability, the Second Injury Fund is liable for the difference between what the employee is receiving for permanent partial disability from the employer and what he is entitled to receive for permanent total disability under Section 287.220.1 RSMo. The difference between the permanent total disability rate of \$649.32 per week and the permanent partial disability rate of \$340.12 per week is \$309.20 per week. The Second Injury Fund is therefore ordered to pay to the employee the sum of \$309.20 per week for 269.55 weeks commencing on April 19, 2005 and ending on June 19, 2010. Commencing on June 20, 2010, the Second Injury Fund is responsible for paying the full permanent total disability benefit to the employee at the rate of \$649.32 per week. These payments for permanent total disability shall continue for the remainder of the employee's lifetime or until suspended if the employee is restored to his regular work or its equivalent as provided in Section 287.200 RSMO.

Since the employee has been awarded permanent total disability benefits, Section 287.200.2 RSMo mandates that the Division "shall keep the file open in the case during the lifetime of any injured employee who has received an award of permanent total disability". Based on this section and the provisions of 287.140 RSMo., the Division and

Commission should maintain an open file in the employee's case for purposes of resolving medical treatment issues and reviewing the status of the employee's permanent disability pursuant to Sections 287.140 and 287.200 RSMo.

ATTORNEY'S FEE:

Phil Barkett, 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.

Date: _____

Made by:

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

A true copy: Attest:

Mr. Jeff Buker
Division Director
Division of Workers' Compensation