

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

Injury No.: 06-130147

Employee: Shawn Claspill  
Employer: Fed Ex Freight East, Inc.  
Insurer: Self-Insured  
Additional Party: Treasurer of Missouri as Custodian  
of Second Injury Fund

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 Law. Pursuant to section 286.090 RSMo, the Commission affirms the award and decision of the administrative law judge dated August 18, 2010. The award and decision of Administrative Law Judge Margaret Ellis Holden, issued August 18, 2010, 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 19<sup>th</sup> day of April 2011.

LABOR AND INDUSTRIAL RELATIONS COMMISSION

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William F. Ringer, Chairman

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Alice A. Bartlett, Member

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John J. Hickey, Member

Attest:

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Secretary

## AWARD

Employee: Shawn Claspill Injury No. 06-130147  
Dependents: N/A  
Employer: Fed Ex Freight East, Inc.  
Additional Party: Treasurer of Missouri, as the Custodian of the Second Injury Fund  
Insurer: Self-insured  
Hearing Date: 5/17/10 Checked by: MEH

### FINDINGS OF FACT AND RULINGS OF LAW

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: 7/31/06
5. State location where accident occurred or occupational disease was contracted: GREENE COUNTY, MO
6. Was above employee in employ of above employer at time of alleged accident or occupational disease? YES
7. Did employer receive proper notice? YES
8. Did accident or occupational disease arise out of and in the course of the employment? YES
9. Was claim for compensation filed within time required by Law? YES
10. Was employer insured by above insurer? YES
11. Describe work employee was doing and how accident occurred or occupational disease contracted:  
CLAIMANT FELL FROM A FORKLIFT
12. Did accident or occupational disease cause death? NO Date of death? N/A
13. Part(s) of body injured by accident or occupational disease: BODY AS A WHOLE
14. Nature and extent of any permanent disability: 10%
15. Compensation paid to-date for temporary disability: NONE
16. Value necessary medical aid paid to date by employer/insurer? \$746.67

Employee: Shawn Claspill

Injury No. 06-130147

- 17. Value necessary medical aid not furnished by employer/insurer? NONE
- 18. Employee's average weekly wages: \$798.00
- 19. Weekly compensation rate: \$532/376.55
- 20. Method wages computation: BY AGREEMENT

**COMPENSATION PAYABLE**

21. Amount of compensation payable:

Unpaid medical expenses: NONE

0 weeks of temporary total disability (or temporary partial disability)

40 weeks of permanent partial disability from Employer

0 weeks of disfigurement from Employer

Permanent total disability benefits from Employer beginning N/A, for Claimant's lifetime

22. Second Injury Fund liability: Yes No  Open

0 weeks of permanent partial disability from Second Injury Fund

Uninsured medical/death benefits: NONE

Permanent total disability benefits from Second Injury Fund:

weekly differential (0) payable by SIF for 0 weeks, beginning N/A  
and, thereafter, for Claimant's lifetime

**TOTAL: SEE AWARD**

23. Future requirements awarded: NONE

Said payments to begin N/A and to be payable and 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 of all payments hereunder in favor of the following attorney for necessary legal services rendered to the claimant:

JOHN NEWMAN

**FINDINGS OF FACT and RULINGS OF LAW:**

Employee: Shawn Claspill Injury No. 05-136608

Dependents: N/A

Employer: Fed Ex Freight East, Inc.

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

Insurer: Self-insured

Hearing Date: 5/17/10

Checked by: MEH

The parties appeared before the undersigned administrative law judge on May 17, 2010, for a final hearing. For convenience, three claims were heard during this hearing: Injury No. 05-136608, Injury No. 05-142649, and Injury No. 06-130147. The claimant appeared in person represented by John Newman. The employer and insurer appeared represented by Constance Warner. The Second Injury Fund appeared represented by Cara Harris. Memorandums of law were filed by June 14, 2010.

The parties stipulated to the following facts: On or about August 31, 2005, and July 31, 2006, Fed Ex Freight East, Inc., was an employer operating subject to the Missouri Workers' Compensation Law. The employer's liability was fully self-insured. On the alleged injury dates of August 31, 2005, and July 31, 2006, Shawn Claspill was an employee of the employer. The claimant was working subject to the Missouri Workers' Compensation Law. The employment occurred in Greene County, Missouri. The claimant's claims for compensation were filed within the time prescribed by Section 287.430 RSMo. At the time of the alleged accident or occupational disease the claimant's average weekly wage on both August 31, 2005, and July 31, 2006, was \$798.00, which is sufficient to allow a compensation rate of \$532.00 for temporary total disability compensation, and the maximum compensation rates for permanent partial disability on August 31, 2005, of \$365.08 for permanent partial disability compensation and on

July 31, 2006, \$376.55. No temporary disability benefits have been paid to the claimant. The employer and insurer have paid medical benefits in the amount of \$2,897.16 on Injury No. 05-136608, and \$746.67 on Injury No. 06-130147. The attorney fee being sought is 25%.

ISSUES (The same issues apply to all three claims):

1. Whether the claimant sustained an accident or occupational disease which arose out of the course and scope of employment.
2. Whether the claimant gave the employer proper notice.
3. Whether the accident or occupational disease caused the injuries and disabilities for which benefits are being claimed.
4. Whether the employer is obligated to pay past medical expenses.
5. Whether the claimant has sustained injuries that will require future medical care in order to cure and relieve the claimant of the effects of the injuries.
6. Any temporary total benefits owed to the claimant.
7. The nature and extent of permanent disabilities, including permanent total disability.
8. The liability of the Second Injury Fund for permanent total disability or enhanced permanent partial disability.

#### FINDINGS OF FACT AND CONCLUSIONS OF LAW:

The claimant testified at the hearing. He is 43 years old. He completed the 11<sup>th</sup> grade and has not obtained a GED. His work history includes; laundry service, cleaning a movie theater, warehouse, washing trucks and trailers, and as a truck mechanic. He went to work as a truck mechanic for the employer in 2002.

In addition to the work injuries alleged in this hearing, the claimant also developed carpal tunnel syndrome in both hands. He received bilateral carpal tunnel release surgeries and settled his claim with the employer. Claimant also has pre-existing conditions, for which he has had

surgery, for sleep apnea and a hernia. Claimant testified that he continues to have complaints with his hands of swelling, loss of motion, loss of strength, and dropping things since.

Claimant testified that he did not recall hurting his ankles and had no problem doing things prior to the alleged accident in August 2005. He further testified that he was very active prior to these alleged injuries and that these injuries have severely impacted his ability to function. Christopher Newton, a long-time friend of the claimant; Leslie Claspill, claimant's wife; and his two daughters, also testified to the change they have seen in the claimant. They all testified that prior to the alleged injuries the claimant was very active. They said he worked in his yard, had frequent barbeques at their home, coached his daughters in basketball, attended games and participated in many activities. They all consistently said that after the alleged injuries the claimant does not do any of these things, seldom leaves his house, and is difficult to get along with.

Claimant testified that in August 2005 he was walking to his car in the employer's parking lot when he stepped on a pebble and twisted his right foot. He says he heard it pop and others had to help him up. He says his ankle became swollen. He said he reported the injury to his boss, Tom Frizzell and he was sent to Concentra.

In his deposition, taken in August 2006, he testified that he did not know who was in charge or who he should have reported it to. He also testified in his deposition that he had not asked for medical treatment for his ankles.

Claimant said that about the time of his fall both of his feet started to fail. He said he then went to his own doctor, Dr. Kyle Smith. Dr. Smith referred him to Dr. Talley and Dr. Crites. He said he was sent to Concentra for other falls but does not recall details. Records from Concentra show he was treated in January 2006. Claimant said Concentra offered no treatment

and returned him to work. Records from Concentra show his symptoms had resolved with the use of the medications he was taking.

Claimant also testified that he had an accident in July 2006 when he fell off a forklift and struck his right hip and back. He said he was not sure if he was hurt at first and walked around for awhile. He said other workers were present and that his immediate boss, Bill Hite, was not there. He reported the injury the next week. Claimant was sent to Concentra. The claimant testified that he had a large bruise on his hip. According to the claimant, Concentra did not really look at it and sent him back to work. He said he continued to work and his back and hip continued to get worse. He described an incident when his left leg went numb one evening and his wife took him to the emergency room. He said they gave him muscle relaxers and sent him to his family doctor, Dr. Smith. An MRI was performed and claimant was referred to Dr. Mace. Claimant testified that Dr. Mace did not think he was a surgical candidate and gave him steroid injections. He testified in his deposition taken August 16, 2006, roughly 2 ½ weeks after the fall that he did not need any more medical treatment for the fall.

Claimant said he quit working and took FMLA in December 2006. He has not worked since then. He says he has not applied for jobs because he does not feel he could do them and he feels worthless. Currently he has complaints in his back, hands, hernia area in his stomach, and ankles. He said his ankles have throbbing pain, numbness, swelling, and pain to his toes. He has sharp pain in his back as well as numbness and tingling in both legs. His hands are weak and tingle. He said that he has a sharp pain in the lower left back with numbness and tingling which radiates down both legs. If he lies down for 1 – 2 hours it will subside. He cannot sleep on his stomach because his hernia is sore. At the time of the hearing he was taking medications including Percocet, Xanax, morphine, Ambien, Flonase, Flovent, albuterol, potassium, Lasix, Glucophage, Synthroid, Lamictal, bisoprol, and fish oil. He says that as a result of these

medications, he has to lie down, is edgy and he sweats. He says he has gained 40 pounds and has lost strength.

Claimant said that he spends his day between his chair and the bathroom because of the water pills. He watches television and lies down. He says he cannot do many things that he did before his injuries. He attributes this to his pain and said that it has affected his relationship with his family as he cannot go places and do things with them. He said before he was injured he liked to fish, hunt, play ball, coach basketball, go to races, work on cars, work in his yard, and that nothing physical kept him from doing what he wanted to do. He said that he had cookouts on weekends. Also, he says he is very depressed as a result of the injuries and their effect on his life.

Claimant testified that he did not recall his ankles hurting before going to work for the employer. He also said that he had no back problems before either. He again testified that he did not recall ever seeking medical treatment for his ankles before the fall in the parking lot. Claimant also testified that he did not recall taking any pain medication before the fall. On cross-examination he admitted he had some back complaints before the fall and that he was on medication before the fall.

A review of the medical records show that contrary to his testimony, claimant has, in fact, had a long history of ankle and back pain as well as anxiety and depression.

On May 24, 2000, claimant went to the St. John's Emergency Room complaining of right ankle pain after stepping on the side of a water hose and twisting his ankle. He was diagnosed with an ankle sprain. An x-ray performed showed swelling and evidence of an old trauma to the ankle.

On July 15, 2002, claimant saw Dr. Kyle Smith for issues with his asthma medication. He discussed trying to stop smoking. Dr. Smith also gave him some Wellbutrin and suggested

trying Xanax for claimant's anxiety "which apparently gets a lot worse when he tries to quit smoking, as he has tried to do in the past." Claimant returned in August 2003 with increased anxiety symptoms and reported some depression with the anxiety. His medication was changed to Lexapro. Claimant developed issues with his hand for which he saw Dr. Smith in September. The Lexapro was continued. Claimant continued to have hand and wrist pain and was treated for the carpal tunnel problems as well as continued anxiety and was referred to Dr. Wyrsh. Dr. Smith was also prescribing hydrocodone and Darvocet in addition to the anti-anxiety medications.

On May 3, 2004, Dr. Smith's note shows that another doctor, his name is not legible, had called expressing concern that the claimant was dependent on oxycodone and recommended claimant stop taking this and be referred to a pain clinic. The note states that they would begin to wean down his medications. Claimant continued to take the Xanax.

On October 24, 2004, claimant and his wife complain to Dr. Smith that claimant continues to have anxiety with some irritation. Dr. Smith indicates he is taking the claimant off Lexapro and starting him on Paxil. Claimant has also developed a new problem of pain in his lower back region over the past several weeks. In December 2004 claimant again returns and reports continued back pain. Claimant is requesting to take hydrocodone on an intermittent basis. In February 2005 a phone message in Dr. Smith's records indicates that the claimant is waiting on his pain medication refill.

In March 2005 claimant reports to Dr. Smith that he hurt his back three weeks before stepping out of a truck. He reports pain mostly in his left low back. His anxiety is more stable. He continues to take Xanax and Paxil. In May 2005 claimant returns to Dr. Smith saying his anxiety is not controlled at all. He says he has been taking hydrocodone for his knees and back and wants to know if there is anything better for this. He reported taking 3 – 4 of these a day.

In June 2005 claimant returns to Dr. Smith and reports his knees are better on the Relafen he was taking. He is having a few anxiety issues. He goes to the emergency room for chest pains a few days before an August 15, 2005, visit with Dr. Smith. The only issues that Dr. Smith's notes reflect discussed were the chest pain and hypertension.

An office note in Dr. Smith's records notes a referral to Dr. Crites and an appointment scheduled. X-ray films of the right ankle are being sent.

Dr. Crites examined the claimant on November 9, 2005. Claimant gives a history of "multiple injuries to both ankles over the years since high school. He twists them frequently, about once monthly or once every other month, mainly the right. At times it feels it may lock up on him. He has done physical therapy years ago but none recently. He has had no other treatment. He has taken hydrocodone and some oral anti-inflammatories for the pain." Dr. Crites assessed bilateral ankle pain and instability and ordered an MRI of both ankles. Claimant returned to Dr. Crites for follow-up on November 21, 2005. Dr. Crites diagnosed subtalar arthritis. Dr. Crites prescribed a brace and over-the-counter medications. He gave him a referral to Dr. Darin Talley to consult for surgical options, including a fusion.

Claimant next sees Dr. Smith complaining of recurrent ankle pain. He reported that both ankles had been bothering him for several months now. He also reported that his ankles are starting to feel a little unstable and he feels like he sprains his ankle from time to time. He reported that he last sprained his right ankle the previous Sunday night when he slipped in a small hole. Dr. Smith found no swelling and noted that "x-rays were done of the right ankle reveal quite a bit of significant degenerative changes noted in the right ankle with quite a bit of calcification and spurring." He diagnoses osteoarthritis in the ankles. The Relafen he is taking does not seem to be helping and claimant requests a refill of the Norco he had been taking. Dr. Smith said it was time to refer claimant to an orthopedist. No fall is mentioned.

On December 9, 2005, claimant returns to Dr. Smith for a follow-up for his ankle pain. Claimant reports ankle pain for several months now that does not seem to be getting better. He has been to Dr. Crites and had an MRI. Dr. Smith's diagnosis was bilateral osteoarthritic ankle pain. No mention of any fall is found in this note. He counseled the claimant and his wife about treatment options, referred him to Dr. Talley and refilled his Norco prescription.

Claimant went to Concentra Medical Centers on January 4, 2006. He gave a history of "I was walking to the parking lot and fell down. Both ankles have been bothering me for the past year." He also said that his ankles would "go out" and that he did not like to wear the ankle splints because they made his ankles weak. Dr. Jasper Wakeman saw him and diagnosed ankle/foot pain, ankle sprain and somatic dysfunction of the lower extremities. He prescribed physical therapy and released him to work with a requirement to use the ankle splint.

On January 16, 2006, a note in Dr. Smith's file indicates that the claimant is calling wanting more hydrocodone and Paxil than the pharmacy is giving him. An undated note indicates the claimant's wife is calling wanting more hydrocodone. It says "I warned Leslie that Shawn could get fired by this office by not using his medication as directed taking 2 hydro 10's is way too much."

On December 30, 2005, Dr. Talley examined the claimant. Claimant gave a history of gradual onset of ankle pain since last year. Dr. Talley diagnosed bilateral subtalar joint arthritis. Dr. Talley suggested bracing and injections, which were performed that day. He also suggested anti-inflammatory medications and possibly a subtalar joint arthrodesis. He felt the claimant was too young for a fusion at this point.

On February 17, 2006, Dr. Smith notes claimant was seen for a follow-up on medications. Claimant was "wanting to get on a more long-term narcotic medication to help him with pain relief throughout the day and we did talk about that, along with other alternative

options, which even a term of Lidoderm patch might be worthwhile.” His Norco was discontinued and he was given a Lidoderm patch and OxyContin.

On March 10, 2006, Dr. Smith increased claimant’s OxyContin and told him to take it as indicated and that he could use the Lidoderm patches for more severe pain.

In April claimant sees Dr. Smith and reports he is taking the OxyContin three times a day instead of two. Dr. Smith increased claimant’s OxyContin prescription. At his May follow-up appointment he indicated that the increased dosage was working and he was given a prescription for three months.

Claimant was seen by Dr. Smith on August 2, 2006, with complaints of abdominal pain and skin tags. Claimant reports his ankle pain is better but he had to get additional steroid shots. Dr. Smith suggested increasing claimant’s OxyContin as he was taking it 3 – 4 times a day.

Claimant’s wife called Dr. Smith’s office on August 7, 2006. The message indicates her wanting to know what he should do because he was having numbness down his leg, severe headache and neck pain. Says he woke up Saturday morning with severe back pain, which had improved but he was now having severe headache and neck pain. He was referred to the emergency room.

Claimant went to the emergency room at St. John’s Hospital on August 7, 2006. He complained of low back pain with numbness in both legs, neck pain, and the worst headache of his life. He said his back was better now. No history of a fall was given. A CT scan of the head was performed, which was unremarkable.

On August 9, 2006, claimant returns to Dr. Smith and reports severe low back pain over the weekend, requiring he go to the emergency room. He had a headache and a CT was performed. Claimant says that since then things have calmed down and he feels pretty much

back to normal. Dr. Smith recommended a follow-up if claimant's back pain became severe. There is no mention of a fall or any incident in Dr. Smith's records.

On August 11, 2006, claimant is sent to Concentra by the employer. He gives a history of falling off a forklift on July 28<sup>th</sup> and landing on his right hip and that he went to the emergency room on August 8<sup>th</sup> for low back/buttock pain and headache. The records note that claimant's symptoms have resolved on the prescribed Percocet and Flexeril. Claimant also indicated pain on the right hip where the initial bruising had resolved.

On September 29, 2006, claimant returns to Dr. Smith and requests an increase in pain medication for his ankle pain. He was given Percocet for breakthrough pain. In October claimant's OxyContin dosage was again increased by Dr. Smith.

An MRI performed on December 28, 2006, showed a disc protrusion on the left at L5-S1 which impinges on the L5 nerve root foramina and a moderate-sized, broad-based disc extrusion at L3-L4 with impingement on L3 nerves.

Dr. Smith's records indicate that in November 2006 claimant and his wife were requesting paperwork for FMLA be completed because his ankles are worse.

On January 2, 2007, claimant returns to Dr. Smith with complaints of increased low back pain for several weeks now. It was radiating into his hips. An MRI was ordered. In February he returns and tells Dr. Smith that he feels his depression is getting worse since he is not working. Dr. Smith indicated he wanted to start weaning him from pain medications. In June Dr. Smith changed claimant's medication from OxyContin because the claimant wanted a less expensive option. He prescribed MS Contin and Celexa.

On January 31, 2007, Dr. Charles Mace, a neurosurgeon, examined the claimant. Claimant gave a history of low back pain for the last month. He also recalls a fall from a forklift the previous October or November. Claimant says he has constant low back pain extending into

his hips bilaterally with intermittent numbness and tingling in his left leg. Dr. Mace's impression was "back pain and pain into hip and buttocks with L3-4 disc protrusion. His obesity makes treatment of this problematic. Discussed weight loss and regular exercise." He suggested injections and physical therapy. Claimant had epidural steroid injections in January and April 2007.

The claimant had a fall at his mother's house in February 2008. He was walking on a deck when he fell and landed on his right hand and stomach. He injured his right shoulder in that fall, also.

Dr. Shane Bennoch examined the claimant on May 22, 2006. He testified on behalf of the claimant. Dr. Bennoch diagnosed bilateral ankle pain with osteoarthritis of the subtalar joints, tears of several ligaments with tendinopathy, and tenosynovitis to some of the tendons in the ankle area. He testified that the job claimant had as a mechanic for employer "with the tremendous amount of bending and pushing and awkward positions likely was the --- created the arthritis. He -- like I said, he did have pre-existing injury or disease to his ankles and that had some trigger to it, but it was -- his job was -- was certainly a contributing factor." Dr. Bennoch also testified that when claimant twisted his ankle on the pebble it was probably the trigger because claimant was having ongoing subtalar arthritis.

He said claimant had a 25% permanent partial impairment to the right lower extremity at the ankle due to the subtalar arthritis and tearing of the ligaments. He said claimant had a 20% permanent partial impairment to the left ankle due to subtalar arthritis and ligament damage. He apportioned 25% of each of these to the preexisting condition to his ankles. Dr. Bennoch also rated claimant with a 20% permanent partial impairment to the body as a whole as a result of the sleep apnea, 5% for hypertension, 5% for his hernia, 25% for the right carpal tunnel surgery, and

25% for the left carpal tunnel surgery. He also testified that claimant will need future medical treatment and at some point will require ankle fusions.

Regarding the July 2006 back injury, Dr. Bennoch testified that "I felt he injured his back during the fall and he had two very specific disc bulges that resulted in impingement to the L4 and L5 nerves that I think were a direct result of that fall." This opinion was based on an assumption that the claimant was being truthful in his history. He also thought that the claimant had developed moderate to severe depression as a result of a combination of his ankles and back. Dr. Bennoch believes claimant will require an additional MRI and another neurosurgical opinion. Dr. Bennoch said that the claimant could not work due to a combination of his ankle and back conditions.

Dr. Norbert Belz examined the claimant on July 17, 2008. He testified on behalf of the employer and insurer. Dr. Belz noted that the claimant's history that he had no problems with his ankles prior to August 2005 and none to his back prior to July 2005 was inconsistent with the medical records. He noted that there was no history of a fall when claimant saw his own doctors in September and October 2005 and when he saw Dr. Crites and Dr. Talley but, rather, a gradual onset over the last year. Rather, it wasn't until January 2006 when he went to Concentra that he gave a history of a fall. Dr. Belz said that the particular joint involved "does pretty well on straight and level, on concrete. Problems arise, as all the doctors have said who examined him, on uneven terrain, on grass and hills when he's out hunting and that sort of thing." Dr. Bennoch also found significant the lack of history regarding claimant's back pain and fall from the forklift in the medical records. Another thing he found very significant was what he described as narcotic abuse and narcotic-seeking behaviors. He felt the claimant was someone who had addictions. He found it inconsistent to give narcotic medication for carpal tunnel and that the records show a history of claimant being continued on narcotics and having the dosage actually

increased long before the alleged occupational injuries. He also finds claimant has addiction issues with tobacco and alcohol. He notes that the claimant was having severe asthma and coughing issues but did not stop smoking.

Dr. Belz said that his physical exam was consistent with well-healed carpal tunnel surgery, a normal neurologic exam regarding his low back, and that claimant's ankles and feet were consistent with the arthritis of the subtalar joints.

Dr. Belz testified that "the occupational biomechanics as described referencing the ankles, be it due to the one-time episode of falling in the parking lot or be it the repetitive work, that these did not cause, substantially aggravate, accelerate, or precipitate the degenerative change of his ankles. The degenerative changes of the ankles are independent of work and, indeed, are progressive with or without work, and indeed, are progressing after work as well; that causation was not met referencing either an injury, a one-time injury, or cumulative exposures at work." He also said that the fact claimant was on his feet at work was helpful to his arthritis as it promoted blood flow to the articular cartilage. He said that if the claimant was completely nonweight bearing, it would be a bigger problem. He said "for a man to standing and walking about on a flat and level surface with the subtalar arthritis that he has, that's not the cause of this. It doesn't substantially aggravate it, and it doesn't change the pathology." He said the hunting and fishing was more problematic than standing on concrete because of the uneven ground involved when hunting or fishing.

Regarding the back injury, Dr. Belz testified that the records do not reflect a fall at work, but if there was a fall, it would have been a contusion-type injury, then it had healed up by August 11, 2006, when he was seen at Concentra. He said there was no radiculopathy and he returned to baseline, requiring no restrictions or further disability. He said if there was no fall, then the back was a flareup that occurred when he woke up on Saturday, August 6, 2006, with

soreness in his back. He noted that claimant's neurological exams were all negative with the exception of Dr. Bennoch's, who examined him shortly after the fall at his mother's house. But then later exams were again normal. Dr. Belz said that claimant had no permanent partial disability to his low back as a result of his employment with the employer.

Dr. Belz rated claimant with permanent partial disabilities of 12.5% of each wrist due to the carpal tunnel surgeries, with a 10% load for multiplicity. He found no permanent disability resulting from the hernia, asthma, or sleep apnea conditions. For claimant's pre-existing back and left lower extremity condition he rated 5% permanent partial disability to the body as a whole with a 50-pound lifting restriction.

For the prior bilateral degenerative joint disease to claimant's ankles, he assessed permanent partial disability of 15 - 20% of the left ankle and 10 - 12.5% of the right ankle, both at the 155-week level. He also assessed a 10% load for multiplicity. He imposed restrictions of no uneven terrain, although claimant could work in the captive standing position. He also felt he should be given the opportunity to move about and change positions. Seated work and sit/stand work were acceptable. Because he did not feel there was an occupational injury to the ankles, he found no disability or restrictions applied.

For the fall and injury to claimant's right hip and back, he found no subsequent permanent partial disability as claimant had returned to baseline. As for the recurrence of non-occupational degenerative joint disease and degenerative disc disease for which he finds responsible for the claimant's emergency room visit of August 11, 2006, Dr. Belz assessed permanent partial disability of 5% of the body as a whole. He imposed restrictions of no lifting over 45 pounds.

For the fall at the home of claimant's mother, Dr. Belz assessed permanent partial disability of 2.5% of the body as a whole and imposed a lifting restriction of 40 pounds and the

use of proper body mechanics. He also felt a 10% load would apply to all of the claimant's back disabilities.

Dr. Belz also testified that future medical would be necessary for claimant's conditions. He said narcotics are not to be utilized with the claimant, rather, anti-inflammatories are appropriate. These would be over-the-counter analgesics.

Both parties submitted vocational opinions. Wilbur Swearingin, a certified vocational rehabilitation counselor, testified on behalf of the claimant. He opined that the claimant was neither employable, nor placeable in the open labor market based on claimant's multiple impairments, work restrictions, chronic pain, narcotic medication, limited education, and history of heavy work. He, therefore, concluded that claimant was permanently and totally disabled which he attributes to a combination of the pre-existing impairments and conditions and those resulting from his work injuries with the employer.

Robert Hosutt, a professional vocational rehabilitation counselor, testified on behalf of the employer and insurer. After reviewing the claimant's medical and vocational records and history, interviewing the claimant, and vocational testing, he concluded that claimant would most likely be able to perform employment at a light level. He also found that claimant had transferable skills. He said the lack of a GED is an obstacle although if claimant obtained a GED and obtained further education he could increase his opportunities. The claimant indicated to him he would not consider further education. He identified several jobs, including shop foreman, inventory control specialist, security office, and warehouse and sales jobs as examples of available jobs the claimant could perform.

I make the following rulings:

1. Whether the claimant sustained an accident or occupational disease which arose out of the course and scope of employment.

I find that an accident occurred when the claimant fell from a forklift and struck his right hip and back.

2. Whether the claimant gave the employer proper notice.

The claimant alleges this accident occurred on July 31, 2006. The employer sent him to Concentra on August 11, 2006. I find that the employer had actual notice and directed medical treatment, so there was no evidence of prejudice to the employer. Therefore, notice was sufficient.

3. Whether the accident or occupational disease caused the injuries and disabilities for which benefits are being claimed.

Claimant denied pre-existing back problems at the hearing. The records are clear that he had pre-existing back complaints and, indeed, received treatment since at least 2003. He was, in fact, on narcotic pain medication for both back complaints and ankle complaints at the time of the fall.

Dr. Belz testified that the claimant sustained a contusion injury when he struck his right hip on the forklift and fell on his back. In his opinion this condition had resolved as of the August 11<sup>th</sup> visit to Concentra. This conclusion is supported by the medical records from Concentra. I find that he was at maximum medical improvement for the contusion injury he sustained as of August 11, 2006.

I find, based on the medical records and Dr. Belz' testimony, that the claimant sustained a contusion-type injury to his back. The fall was not a prevailing factor in causing the claimant's current pain and condition for which he has been and is currently being treated.

4. Whether the employer is obligated to pay past medical expenses.

The employer has paid for the only medical treatment I find related to this injury, the visit to Concentra on August 11, 2006. All other treatment claimant has received for his back is

treatment unrelated to any work injury and unauthorized. Therefore, the employer is not liable for any further medical treatment.

5. Whether the claimant has sustained injuries that will require future medical care in order to cure and relieve the claimant of the effects of the injuries.

I do not find claimant will require future medical treatment related to the contusion injury he sustained on July 31, 2006. I find all recommendations for future treatment are for conditions unrelated to his employment.

6. Any temporary total benefits owed to the claimant.

I find no temporary total benefits are due to claimant from the employer and insurer.

7. The nature and extent of permanent disabilities, including permanent total disability.

I find that the claimant has sustained a permanent partial disability of 10% of the body as a whole as a result of the contusion injury he sustained on July 31, 2006. Any additional disability he has as a result of any further back condition is not work related.

8. The liability of the Second Injury Fund for permanent total disability or enhanced permanent partial disability.

The Second Injury Fund is not liable for either permanent total disability or enhanced permanent partial disability.

Attorney for the claimant, John Newman, is awarded an attorney fee of 25%, which shall be a lien on the proceeds until paid. Interest shall be paid as provided by law.

Date: 8/18/10

Made by: /s/ Margaret Ellis Holden  
Margaret Ellis Holden  
Administrative Law Judge  
Division of Workers' Compensation

A true copy: Attest:

/s/ Naomi Pearson  
Naomi Pearson  
Division of Workers' Compensation