

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

Injury No. 10-066731

Employee: James Dunning
Employer: State of Missouri, Department of Conservation (Settled)
Insurer: Self-Insured (Settled)
Additional Party: Treasurer of Missouri as Custodian
of Second Injury Fund

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

Preliminaries

The parties asked the administrative law judge to determine the following issues: (1) medical causation; and (2) Second Injury Fund liability for either permanent total or permanent partial disability.

The administrative law judge rendered the following determinations: (1) the July 22, 2010, accident was the prevailing factor in causing the resulting lumbar strain and disability, and the lumbar strain, medical care, and medical treatment for the lumbar strain, and the resulting disability were medically causally related to the July 22, 2010, work accident and injury; and (2) employee is permanently and totally disabled as a result of the combination of his preexisting injuries and conditions and the low back injury caused by the July 22, 2010, accident and injury.

Employee filed a timely application for review with the Commission alleging the administrative law judge erred in finding that employee reached maximum medical improvement on September 23, 2013.

For the reasons stated below, we modify the award of the administrative law judge as to the issue of maximum medical improvement.

Discussion

Maximum medical improvement

The determination of when employee reached maximum medical improvement is important in this case because it controls the timing of the commencement of weekly permanent total disability benefits:

Courts have used various terms to determine when an employee's condition has reached the point where further progress is not expected,

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including the term maximum medical improvement. *Vinson v. Curators of the University of Missouri*, 822 S.W.2d 504, 508 (Mo. App. E.D. 1991)(interpreting a doctor's testimony of employee's maximum treatment potential to mean maximum medical improvement); *Cooper*, 955 S.W.2d at 575 (using the term maximum medical progress to define the point where no further progress is expected for an employee's condition).

After reaching the point where no further progress is expected, it can be determined whether there is either permanent partial or permanent total disability and benefits may be awarded based on that determination. One cannot determine the level of permanent disability associated with an injury until it reaches a point where it will no longer improve with medical treatment. ...

Although the term maximum medical improvement is not included in the statute, the issue of whether any further medical progress can be reached is essential in determining when a disability becomes permanent and thus, when payments for permanent partial or permanent total disability should be calculated.

Cardwell v. Treasurer of Mo., 249 S.W.3d 902, 910 (Mo. App. 2008).

Employee argues that we should find that he achieved maximum medical improvement on November 24, 2010, when he was first seen by his evaluating expert, Dr. Annamaria Guidos. While employee makes a rather strong argument that his condition did not actually improve after that date, we cannot ignore Dr. Guidos's unequivocal testimony that employee was not at maximum medical improvement when she first examined him. On the other hand, we agree that Dr. Guidos's opinion that employee did not achieve maximum medical improvement until she saw him on September 23, 2013, is not particularly persuasive, especially where the evidence reveals that employee's pain was worse on that date than on November 24, 2010.

After careful consideration, we find most persuasive the opinion from employer's expert, Dr. Brett Taylor, with regard to the issue of maximum medical improvement. In his report dated February 15, 2011, Dr. Taylor ruled out the prospect of additional back surgery, indicating his belief that employee might not survive another surgery in light of his preexisting conditions of ill-being. In our view, it was at that point that it became clear that employee's condition referable to the work injury was permanent. Accordingly, we find that employee reached maximum medical improvement on February 15, 2011. In order to account for the 50 weeks of permanent partial disability resulting from the work injury, the Second Injury Fund's liability for weekly permanent total disability benefits begins 50 weeks from that date, or on January 31, 2012.

Conclusion

We modify the award of the administrative law judge as to the issue of maximum medical improvement.

Employee: James Dunning

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The Second Injury Fund is liable for weekly permanent total disability benefits beginning January 31, 2012, at the stipulated weekly permanent total disability benefit rate of \$247.57. The weekly payments shall continue for employee's lifetime, or until modified by law.

The award and decision of Chief Administrative Law Judge Lawrence C. Kasten, issued July 22, 2015, is attached hereto and incorporated herein to the extent not inconsistent with this decision and award.

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

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

Given at Jefferson City, State of Missouri, this 17th day of February 2016.

LABOR AND INDUSTRIAL RELATIONS COMMISSION

John J. Larsen, Jr., Chairman

James G. Avery, Jr., Member

Curtis E. Chick, Jr., Member

Attest:

Secretary

ISSUED BY DIVISION OF WORKERS' COMPENSATION

FINAL AWARD

Employee: James Dunning Injury No. 10-066731
Dependents: N/A
Employer: State of Missouri, Department of Conservation (settled)
Additional Party: Second Injury Fund
Insurer: Self Insured (settled)
Appearances: Michael Moroni, attorney for the employee.
Da-Niel Cunningham, attorney for the Second Injury Fund.
Hearing Date: April 20, 2015 Checked by: LCK/kg

SUMMARY OF FINDINGS

1. Are any benefits awarded herein? Yes.
2. Was the injury or occupational disease compensable under Chapter 287? Yes.
3. Was there an accident or incident of occupational disease under the Law? Yes.
4. Date of accident or onset of occupational disease? On or about July 22, 2010.
5. State location where accident occurred or occupational disease contracted: Cape Girardeau County, Missouri.
6. Was above employee in employ of above employer at time of alleged accident or occupational disease? Yes.
7. Did the employer receive proper notice? Yes.
8. Did accident or occupational disease arise out of and in the course of the employment? Yes.
9. Was claim for compensation filed within time required by law? Yes.
10. Was employer insured by above insurer? Yes.

11. Describe work Employee was doing and how accident happened or occupational disease contracted: The employee was pulling stakes and injured his low back.
12. Did accident or occupational disease cause death? No.
13. Parts of body injured by accident or occupational disease: Body as a whole referable to the low back.
14. Nature and extent of any permanent disability: 12.5% permanent partial disability to the body as a whole referable to the low back.
15. Compensation paid to date for temporary total disability: None.
16. Value necessary medical aid paid to date by the employer-insurer: \$4,323.10.
17. Value necessary medical aid not furnished by the employer-insurer: N/A.
18. Employee's average weekly wage: \$371.35.
19. Weekly compensation rate: \$247.57.
20. Method wages computation: By agreement.
21. Amount of compensation payable: Permanent total disability against the Second Injury Fund.
22. Second Injury Fund liability: Permanent total disability.
23. Future requirements awarded: See Rulings of Law.

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

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

STATEMENT OF THE FINDINGS OF FACT AND RULINGS OF LAW

On April 20, 2015, the employee, James Dunning, appeared in person and with his attorney, Michael Moroni, for a hearing for a final award. The Second Injury Fund was represented at the hearing by Assistant Attorney General Da-Niel Cunningham. The parties agreed on certain undisputed facts and identified the issues that were in dispute. These undisputed facts and issues, together with a statement of the findings of fact and rulings of law, are set forth below as follows:

UNDISPUTED FACTS:

1. The State of Missouri, Department of Conservation was operating under and subject to the provisions of the Missouri Workers' Compensation Act, and was duly qualified as a self-insured employer c/o CARO.
2. On or about July 22, 2010, James Dunning was an employee of the State of Missouri, Department of Conservation and was working under the Workers' Compensation Act.
3. On or about July 22, 2010, the employee sustained an accident arising out of and in the 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 \$371.35. His rate for temporary total disability and permanent partial disability is \$247.57.
7. The employer paid \$4,323.10 in medical aid.
8. The employer paid no temporary disability benefits.

ISSUES:

1. Medical Causation
2. Liability of the Second Injury Fund

EXHIBITS:

Employee Exhibits:

1. Deposition of Dr. Guidos, including her CV and reports, and report of Dr. Taylor.
2. Deposition of Susan Shea, including her CV and reports.
3. November 14, 2012 lumbar MRI report from Cape Radiology.
4. Stipulation for Compromise Settlement of the claim against the employer in Injury Number 10-066731.
5. Stipulation for Compromise Settlement in Injury Number 01-157088.
6. Medical Records from 2001 low back injury.
7. Witness Statements
8. April 6, 2012, deposition of James Dunning with work schedule calendar
9. Medical Records of Woods Medical Clinic

Second Injury Fund Exhibits:

- I. Prior Temporary Award
- II. Medical Report of Dr. Taylor

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

WITNESS:

James Dunning, the employee.

BRIEFS:

The employee and the Second Injury filed proposed awards on May 29, 2015.

STATEMENT OF THE FINDINGS OF FACT:

The employee testified that he lives in Puxico, Missouri. He was born on December 10, 1961. When he was eight years old he fell out of tree, burst his spleen, and had surgery to remove his spleen. The employee graduated from high school and had some technical training when he worked at Briggs and Stratton. He had pre-employment training of 45 hours each on hydraulic pneumatics, electrical 1, electrical 2, machines, and engine anatomy.

The employee testified that his first job after high school was working at a shoe factory in Advance, Missouri. He moved to Oklahoma and worked on an oil rig. He moved back to Missouri and worked at Briggs and Stratton as a die caster. That job involved heavy lifting of around 150-200 pounds. He then worked at the Department of Conservation at Duck Creek Conservation Area and helped tear down two old boat docks and build new boat docks. He performed carpentry, concrete, and dirt work. He then worked in St. Louis for the Department of Conservation for about three years. His mother was taking care of his son, and when his mother got ill he left St. Louis to take care of his son. He worked as a welder at Arvin Automotive for eight years.

The employee testified that after having his spleen removed, he stayed sick all of the time. If his son brought something home from school, he would get sick and it would take a long time for him to heal.

On March 20, 2001, the employee saw Dr. Woods with sinus pressure and congestion. The employee had a cough with drainage and tenderness over the sinuses. Diagnosed was sinusitis and bronchitis. A Rocephin shot was done and medication was prescribed.

The employee testified that while working at Arvin he injured his low back while attempting to unload a cart. He felt his back pop and it hurt so much he went down to his knees. He ended up having back surgery.

The employee saw Dr. Yingling on September 20, 2001, due to severe pain across the lower back and radiation into the anterior thighs bilaterally, with occasional right foot numbness. Dr. Yingling ordered an MRI which was performed on October 2, 2001. The history showed low back pain since July with aching lower back pain, with sharp pain down the top of the legs extending down the front of both legs. The employee had numbness in the right foot. The impression of the radiologist was degenerative changes at L4-5 and L5-S1, most severe at L4-5 with significant reduction in disc height and a posterior disc bulge impressing the ventral thecal sac with spinal canal stenosis at L4-5. There was a posterior disc bulge at L5-S1 which impressed the ventral thecal sac. On October 4 Dr. Yingling stated that the employee had degenerative spondylosis, stenosis and a disc herniation causing back and leg pain.

On October 31, 2001, Dr. Yingling performed surgery, noting that the MRI showed a disc rupture at L4-5 with lateral recessed stenosis at L4-5 and L5-S1. Dr. Yingling diagnosed L4-5 and L5-S1 stenosis and a L4-5 disc rupture, and performed a bilateral segmental decompression at L4-5 and L5-S1 with bilateral L4-L5 discectomy. On December 13 Dr. Yingling noted the employee was feeling much better and no longer had any pain, numbness, or tingling in his legs. The employee continued to have muscular soreness in his back and spasms. Dr. Yingling ordered therapy and prescribed medications.

On January 31, 2002, Dr. Yingling noted that the employee had pain and stiffness in his back when he walked very far and developed pain and spasm in his right leg if he drove a vehicle too far. On exam there were palpable spasms and tenderness of the lumbar muscles with difficulty standing fully erect due to the spasms. The employee had moderate right sciatic tenderness with good leg strength and a stable gait.

On April 23, 2003, the employee saw Dr. Coyle. Dr. Coyle reviewed the October 2, 2001 MRI and noted that the clinical picture was severe degenerative spinal stenosis, greater than one would expect in a 39 year old. Dr. Coyle noted that as late as January of 2002, the employee had pain and spasms in his right leg if he drove a vehicle too far. The employee had intermittent chronic back pain with persistent standing or driving. On the day of the exam, he drove several hours and had back and buttock pain. The employee was taking Darvocet on an occasional basis and Xanax for anxiety. On exam he had mild buttock tenderness bilaterally and straight leg test was negative bilaterally. There were no focal motor or sensory deficits, although the employee had intermittent numbness in his feet from standing too long. Dr. Coyle diagnosed preexisting degenerative spinal stenosis and degenerative disc disease. The employee had residual back pain secondary to arthritis which correlated with weather changes. Dr. Coyle did not believe that the employee would have any restrictions and rated him at 20% disability for the lumbar spine and body as a whole with 10% referable to the work incident and 10% referable to the preexisting arthritis.

The employee testified at his April 6, 2012 deposition that since his first low back injury, he has been taking hydrocodone, two tablets a day, Soma for sleep and as a muscle relaxer, Xanax for his nerves, and prescription ibuprofen.

On July 23, 2002, the employee saw Dr. Woods with sinus pressure and congestion and was diagnosed with sinusitis. An injection of Rocephin was given and medication was prescribed.

On March 27, 2003, the employee saw Dr. Woods due to sinus cough, sore throat, head congestion, and body aches. Diagnosed was sinusitis and bronchitis. Medication was prescribed. On April 1, 2003, the employee was not better. The employee had a few coarse lung sounds. Additional medication was given. The employee was taken off work until April 4.

On June 4, 2003, the employee had abdominal pain with nausea and vomiting. He had an elevated temperature and appeared to be ill. Dr. Woods was concerned about the employee's extremely high elevated white blood count, but noted that the employee had a splenectomy which may have played a part. Dr. Woods did not think it was an appendicitis or gallbladder, and thought it was more like a bacterial intestinal infection. Dr. Woods gave an injection of Rocephin and prescribed medications.

On July 28, 2003, the employee saw Dr. Woods with facial pressure and pain with diarrhea. Sinusitis and diarrhea was diagnosed and medications were prescribed. On October 30, 2003, the employee had migraines and told Dr. Woods that he got several of them a year. A Toradol injection was given and medication was prescribed.

On March 18, 2004, the employee had nausea and vomiting. Dr. Woods prescribed medication. On April 5, 2004, the employee had nausea, vomiting, diarrhea, cough, scratchy throat, and drainage. The employee stated that he had no spleen and tended to run a high white count. The employee saw Dr. Woods' nurse practitioner who diagnosed vomiting and diarrhea. Rocephin and Phenergan injections were given. The employee saw Dr. Woods on April 6 with vomiting and dehydration. Diagnosed was gastroenteritis. Medications were prescribed.

On September 2, 2004, the employee had cough, chills, and body aches, and was running a fever when he saw Dr. Woods. The employee had a spider bite. An injection was given and medications were prescribed. On September 7, additional medications were prescribed. On March 10, 2005, the employee had a cough, head and chest congestion with body aches, and sinus pressure. Diagnosed was sinusitis and bronchitis. Medications were prescribed.

In Injury No. 01-157088, the employee settled his claim against Arvin and its insurance company on July 26, 2007, for 25% permanent partial disability of the body as a whole for his July 16, 2001 low back injury.

The employee testified that after he injured his low back at Arvin, he was off work for about one and a half years. When he went back to work at Arvin, he got sick and had to leave work early. Dr. Woods gave him a doctor's excuse. When he gave them the doctor's excuse, Arvin sent him home and told him that they were going to fire him. His missing work due to sickness is why he lost his job at Arvin.

The employee testified that after being terminated from Arvin, he went back to work at the Department of Conservation. He was involved in constructing and remodeling buildings, including electrical work and painting; installing water structures including culverts; building a lake; and constructing a parking lot. He operated a bulldozer and back hoe. After the surgery, his back hurt, but it did not keep him from doing his job. He received help from other employees and did not take as big of a load. He treated with Dr. Woods for his back and then switched to Dr. Varma. When Dr. Varma died, he went back to Dr. Woods. He continued to treat with Dr. Woods for back pain up to the 2010 injury. He has been taking hydrocodone since the 2001 back injury and the dosage went up a year or two ago.

The employee testified in his deposition that after the low back surgery his leg pain was gone, but he still had pain in his lower back. He was able to go back and do most of the things had had done prior. His low back ached all of the time and it hurt worse if he did more strenuous work.

After March of 2005, the employee did not see Dr. Woods until September 17, 2009, when he reestablished a doctor patient relationship. Dr. Woods noted that the employee needed refills on his medications and had a history of degenerative disc disease, migraine headaches, muscle spasms, and anxiety. He had surgery for degenerative disc disease of the lumbar spine about five years ago and had lumbar spine tenderness. Dr. Woods diagnosed degenerative joint disease and degenerative disc disease. The employee was taking Vicodin 5/500, 1 tablet daily, and 600 mg of ibuprofen a day, medication for migraine headaches, and Soma for muscle spasms.

The employee saw Dr. Woods on December 18, 2009, for medication refills. The neurologic exam was intact and he was tender over the lumbar spine. Dr. Woods diagnosed degenerative joint disease and degenerative disc disease for which he took Vicodin and ibuprofen; migraine headaches; muscle spasms for which he took Soma; wheezing; bronchial spasms; and anxiety. Dr. Woods prescribed an inhaler with 2 puffs every 4 hours and Xanax.

The employee treated with Dr. Woods on February 22, 2010, for multiple sores which started on his left arm and spread to his right wrist, and there were a couple of sores on his neck. Dr. Woods thought the employee had a staph infection due to the puss-like fluid and watery drainage, and he prescribed several different medications.

On March 19, 2010, the employee needed medication refills. The neurological exam was intact with some tenderness over the lumbar spine. Dr. Woods diagnosed degenerative joint disease and degenerative disc disease for which he takes ibuprofen 600 mg, Vicodin on an occasional basis; he will frequently break that in half and take a half in the morning and a half in the evening, and Soma for muscle spasms. Dr. Woods diagnosed bronchial spasms and prescribed an inhaler and anxiety with Xanax being prescribed. The employee had faint wheezes bilaterally in the lungs.

The employee testified that he has had emphysema for at least 20 years. He cannot walk or do as much due to running out of breath. While working for the Department of Conservation,

his emphysema bothered him and he had to take breaks. He used an inhaler every four hours to help with breathing.

The employee testified that the Department of Conservation required their employees to keep a calendar of what duties they performed, where, and for how long. In his April 6, 2012 deposition, he testified as to the calendars and Exhibit A of the deposition were the calendars that showed the days he worked, how long he worked, and what job duties were performed. The employee usually worked four 10 hour days with one hour of driving time included.

The April of 2010 work schedule calendar showed that the employee worked 4 days a week, 10 hours a day except for April 5-8, when it was noted that he was sick and did not work.

The employee saw Dr. Woods on April 6, 2010, with coughing, congestion and wheezing. It was noted that the employee had been working around insulation. A couple of nights ago he had fever and chills with night sweats. There were faint wheezes bilaterally in the lungs. Dr. Woods diagnosed bronchitis and sinusitis with a lot of nasal congestion. Medications and an inhaler were prescribed.

The May of 2010 work schedule calendar showed that the employee was off work on May 6, on May 11 when he went to the doctor for an ear ache, and on May 31 which was Memorial Day.

On May 11, 2010, the employee saw Dr. Woods with left ear pain and swelling of the ear canal with a lot of tenderness and redness. Diagnosed was cellulitis. A Rocephin injection was given, and prescribed were steroids, ear drops, and antibiotics.

The July of 2010 work schedule calendar showed that the employee did not work on July 4. On July 14, the employee worked five hours and left to go to the doctor because he was dizzy and weak. The employee was off work on July 15 due to a doctor's excuse.

On July 14, 2010, the employee went to Dr. Woods. The complaints listed in the continuation sheet were ears ringing and back pain. The narrative record listed several problems but no back pain. The employee was very weak and fatigued; he had been working outside and was sweating excessively and felt dizzy; and had a blister-like rash on the upper portion of the buttock. Dr. Woods diagnosed hyponatremia and prescribed sodium; shingles and prescribed medication including Darvocet for pain; and cellulitis and prescribed an antibiotic.

The employee testified that in July of 2010 they were working at the Cape Girardeau Conservation Office constructing a wheelchair accessible sidewalk next to a lake. They were pouring concrete for a sidewalk six inches from the water. It was very muddy and they used concrete pins driven down into form board.

The employee testified in his deposition that prior to the July of 2010 injury; he was not having any symptom in his leg.

The work schedule calendar showed that he worked 10 hours on July 21 at the Cape office pouring concrete, finishing concrete, putting up more forms, and cutting rebar.

The employee testified that on July 22, 2010, they had poured concrete and had to take the concrete forms off. They had to pull the nails out and then pull the steel rods out of the mud by hand. It was hard to pull them out by hand and there was a lot of suction due to the mud. When he was pulling the stakes out of the mud, his back started hurting really bad and he told his supervisor.

The work schedule calendar on Thursday, July 22, 2010, stated that he was working with steel rebar set forms at the Cape office, and he left work at 11:30 a.m. due to his back hurting. He worked a total of five hours. The employee did not work the next week on his scheduled Monday through Thursday, which was July 26-29, due to his back hurting.

On July 29, 2010, the employee saw Dr. Woods for low back pain. The employee had a history of degenerative disc disease and muscle spasms, and had prior lumbar spine surgery due to disc problems. On examination, the employee was tender over the lumbar spine and had pain which radiated down the right leg. The employee had pain with straight leg raise at 30 degrees. Dr. Woods diagnosed degenerative disc disease and prescribed ibuprofen and Vicodin; muscle spasms and prescribed Soma, and added a Prednisone Dose-Pak; and anxiety and prescribed Xanax.

The employee testified that he went back to work in August. The work schedule calendar showed that the employee worked ten hours every scheduled day in August except for August 10 when he worked five hours putting down grass seed and straw. The employee did not work on Wednesday, September 1, due to his back hurting. On September 2, it noted that Ronnie picked him up at 6:30 and went to Duck Creek. He brought the employee home and said the employee should not be riding in a vehicle with his back hurting. The employee worked for one hour.

The employee testified that the last day he worked was September 2, 2010. On that day, he was picked up by his supervisor Ronnie Thurston at 6:30 and was going to Duck Creek to change a couple of gas pumps. He told the employee he was not able to ride in a truck or drive one and took him back home. He more or less fired him, and told him to sign up for disability. The employee has never been back to work and is on social security disability.

The employee saw Dr. Guidos on November 24, 2010. The employee had low back pain with radicular symptomology to the right anterior thigh. After his back surgery by Dr. Yingling, he had been treated for chronic low back pain by his primary physician. On or around July 22, 2010, he was bent over pulling stakes out of the ground after pouring concrete when he noted the immediate onset of severe low back pain that radiated to the right anterior thigh. He continued to work despite the pain until he could no longer work and was told to go home by his supervisor. The employee stated that his pain was at least 50 to 75 percent worse since the work-related event and was quite severe. The employee had a history of emphysema and was status post splenectomy. He uses an inhaler 4 times a day for his underlying respiratory problems that interfere with his ability to work, particularly on hot days. He has seen his family doctor due to

diffuse sweating on hot days and was treated with antibiotics and inhalers. He has a history of frequent infections and states he gets short winded with activity. His current pain was eight out of ten. In the review of systems, he has a history of chronic wheezing secondary to emphysema and stated that he has wheezing as a baseline.

On exam to the lumbar and thoracic spine, the employee had limited flexion with mild tenderness to palpation. Motor exam function of the lower extremities revealed 5/5 strength in all major muscle groups. Muscle bulk and tone were symmetrical and normal with no evidence of fasciculations. Reflexes were symmetrical. The straight leg raise test and sitting straight leg raise test were positive on the right and negative on the left. There was normal sensation of the lower extremities.

It was Dr. Guidos' opinion that the work-related event of July 22, 2010, was the prevailing factor for his current symptomology of low back pain that radiated to the right anterior thigh. Dr. Guidos recommended an MRI for further evaluation of his low back and right leg symptomology. If further workup and treatment was not possible, then the employee would be entitled to an additional 30% disability of the whole person over and above the preexisting 25% impairment for the work-related injury that occurred on July 16, 2001. Dr. Guidos stated that the employee was completely and totally disabled secondary to a combination of the underlying preexisting medical problems of splenectomy, chronic infections, emphysema, and the prior low back surgery with his current low back pain. It was Dr. Guidos' opinion that the combination of disabilities creates a synergistic effect between the prior disabilities, and a current disability of the low back pain giving a combined effect greater than a simple sum of the components and resulting in permanent total disability.

The employee saw Dr. Taylor for an evaluation on February 15, 2011. The employee reported that in 2001 he had injured his low back and had surgery. Two years after his surgery he returned to work and worked at the Missouri Department of Conservation. The employee stated that his colleagues on the job had to help him get the job done because he had significant back problems prior to the July 2010 event lifting. In July 2010 he reinjured his back pulling up stakes and has been out of work since then. His back hurts more than his leg, with the pain being 90% back and 10% leg. His problems have been present for ten years. The past medical history showed high blood pressure, diabetes, and lung disease. He had a significant past medical history, including a 2-3 pack per day smoking history of 31 years and he has emphysema. He was status post splenectomy as a child, with a history of needing antibiotics and steroids for minor infections.

On exam, Dr. Taylor noted an antalgic gait, and the employee was not able to heel and toe gait due to pain. Lateral bending was decreased by 50%. Motor function was notable for 4/5 bilateral EHL. There was negative straight leg raising and no evidence of atrophy. X-rays showed loss of disc height at L4-5, retrolisthesis L4 on 5, osteophyte formation at L4-5, and some loss of disc height at L5-S1 status post laminectomy. Dr. Taylor reviewed the 2001 MRI which revealed short pedicles with hypertrophic changes, all consistent with congenital pathology that would contribute to the development of his spine condition. The degenerative changes noted clarified that the employee's condition was severe and significant in 2001. Dr.

Taylor stated that it was clear that the employee had documented preexisting degenerative disc disease in combination with congenitally short pedicles, all resulting in the need for the 2001 surgery. That surgery never alleviated his back pain and he had persistent low back pain since the surgery which affected his condition. Dr. Taylor stated that the employee had clear evidence of post-laminectomy syndrome, status post prior decompression for disc pathology.

It was Dr. Taylor's opinion that the employee's back problem persisted since the 2001 surgery and his condition was degenerative disc disease, post-laminectomy syndrome, and failed back syndrome that was due to his previous surgery in 2001 with persistent degeneration of his discs after surgery. It was Dr. Taylor's opinion that the episode at work in July 2010 was an aggravation of the preexisting pathology which was severe degenerative condition and was not the prevailing factor causing the lumbar spine condition.

It was Dr. Taylor's opinion that any additional treatment would not be due to the 2010 work event, but from preexisting disc disease. Dr. Taylor stated that individuals with degenerative disc disease can consider surgery as a last resort, which would likely be an anterior and posterior surgery. However, due to the employee's emphysema, splenectomy, and other medical morbidities, that option was fraught with complication and the employee may not be able to survive an anterior-posterior lumbar surgery.

Dr. Woods ordered a lumbar MRI with and without contrast that was performed on November 14, 2012. The findings included disc space narrowing, disc desiccation, and endplate irregularity at L4-5 and L5-S1. At L3-4 there was a mild disc bulge which effaced the anterior subarachnoid space with mild bilateral facet hypertrophy and an enhancing left lateral and far lateral annular tear. Those findings produced mild spinal stenosis and mild bilateral neural foraminal stenosis. At L4-5 there was a mild disc bulge that was asymmetric to the right with a small right paracentral disc protrusion that effaced the right anterior subarachnoid space. Bilateral facet arthropathy was present and the findings produced triangulation of the spinal canal and mild to moderate bilateral neural foraminal stenosis. At L5-S1 there was retrolisthesis of L5 on S1 that was associated with a minor disc osteophyte complex and a broad-based central disc protrusion. There have been bilateral hemilaminectomies and medial facetectomies. There was mild irregularity of the posterior thecal sac with flattening left posteriorly due to increased fat. There was mild bilateral facet hypertrophy and mild bilateral neural foraminal stenosis. The impression of the radiologist was "1. Small right paracentral disc protrusion L4-5 and mild spinal stenosis. 2. Prior bilateral hemilaminectomies and medial facetectomies L5-S1 with broad based central disc protrusion."

On January 9, 2013, Dr. Guidos stated that she had reviewed the November 14, 2012 lumbar MRI. It was Dr. Guidos' opinion that the prevailing cause of the employee's low back pain was a lumbar sacral strain that he sustained as a result of the work related injury on around July 22, 2010, while pulling stakes out of the ground.

Dr. Guidos issued a supplement report July 30, 2013. Dr. Guidos stated that in her November 24, 2010 report, it was her opinion that the employee had sustained a 30% disability of the whole person over and above the preexisting 25% impairment from the July 16, 2001

accident. Dr. Guidos stated that the employee also had chronic infections and emphysema requiring antibiotics, steroids, and inhalers over many years. It was her opinion that the employee had a 10% impairment for the chronic infections and 10% impairment for the emphysema. It was her opinion that the employee sustained a 5% impairment for status post splenectomy. It was her opinion that the combination of disabilities creates a synergistic effect between the prior disabilities and disability of low back pain, resulting in a combined effect greater than the simple sum of the components, resulting in permanent total disability. The above disabilities resulted in a hindrance/obstacle for employment.

The employee saw Dr. Guidos on September 23, 2013. Dr. Guidos noted that the employee had chronic low back pain that radiated bilaterally, primarily to the right greater than the left anterior thigh with numbness. His pain has gotten worse since he last saw Dr. Guidos three years ago. Dr. Guidos noted that the employee walked in a forward flexed position which improves after prolonged walking. On examination the employee had moderate limited flexion and limited mild extension in his lumbar and thoracic spine. Dr. Guidos noted the employee continued to experience chronic low back pain. Although he had preexisting low back surgery, it was her opinion that the work related event that occurred in July 2010 is the prevailing factor for his chronic low back pain. It was her opinion that the employee continued to be permanently totally disabled secondary to a combination of underlying preexisting medical problems and current symptomology, as outlined in her 2010 report.

Dr. Guidos' deposition was taken on October 3, 2013. Dr. Guidos reviewed Dr. Taylor's report and it was her opinion that the accident was more than an aggravating factor and was the prevailing factor in his current medical condition and his inability to return to work. Dr. Guidos diagnosed the employee's condition as a lumbosacral strain, and that the prevailing factor in the employee's low back pain was a lumbosacral strain suffered as a result of the work-related accident. It was her opinion that a lumbosacral strain is a change in pathology and that the July 22, 2010 stake-pulling incident was the prevailing factor in the lumbosacral strain. It was Dr. Guidos' opinion that the employee's preexisting conditions that she listed in her report, and particularly together, were a hindrance or obstacle to employment.

It was Dr. Guidos' opinion that the employee was permanently and totally disabled, but not solely from the lumbosacral strain. It was Dr. Guidos' opinion that the employee is permanently and totally disabled due to a combination of the primary lumbosacral strain and the preexisting conditions of low back surgery, emphysema, chronic infections, and splenectomy, which have a synergistic effect.

It was Dr. Guidos' opinion that if the employee did not consider surgery that he was at maximum medical improvement, and it was her understanding that he does not wish to consider additional surgery due to the status of his underlying emphysema, splenectomy, and other medical problems. It was her opinion that it was reasonable for him not to undergo elective surgery due to his previous conditions. Dr. Guidos did not list a date of maximum medical improvement, but did not believe he was at maximum medical improvement when she first saw the employee. Dr. Guidos' opinion was that he had recovered from his accident, as much as he would, when she saw him in September of 2013. Dr. Guidos stated that she would not defer to a

vocational expert as to opinions on employability because she was confident that the employee is unable to be gainfully employed with all of his comorbidities, breathing problems, and back problems, and did not feel that the employee was employable.

The employee saw Susan Shea on July 2, 2013, for a vocational evaluation. She noted that in addition to his low back injury in July of 2010, and his prior low back surgery, the employee had a long history of about 25 years of emphysema and has been wheezing since he was about nine years old. He uses an inhaler regularly. As a young boy he had his spleen removed, and due to that his immune system is not adequate and he gets sick easily. Ms. Shea noted that during their meeting, the employee sat no more than 20 minutes and moved around in his chair while he sat. The employee told her that he laid down for about three hours during the day. He moves around a lot and could maybe sit for one hour. When he sits he moves around, and may be able to sit for 20-30 minutes.

Ms. Shea stated that the employee is 51 years old with a high school education. His work has involved semi-skilled and skilled work. Most of his vocational history involved physically demanding work and he has an excellent work history. The employee has preexisting conditions which cause him to be susceptible to illness and infections, which are demonstrated throughout his medical history. His surgical history includes the removal of his spleen and back surgery. He has a history of anxiety.

It was Ms. Shea's opinion that the employee is unemployable as per regular work in the national labor market. Ms. Shea stated that specific factors adding to this opinion are Dr. Guidos' opinion that the employee is permanently and totally disabled; the Social Security Administration determining that the employee is permanently and totally disabled; the employee having limitations on sitting and standing that preclude any work; the employee having a pain factor which precludes the performance of any work as regularly performed; the employee taking narcotic medications for pain and medication for anxiety, which both may cause an individual to become drowsy or otherwise impair functioning; the employee being susceptible to infections and illnesses due to the removal of his spleen; the employee having emphysema which affects his ability to work and causes him to become ill at times and he uses an inhaler; the employee not being able to undergo additional surgery due to his lung and breathing problems; the employee being diagnosed with arthritis, emphysema, anxiety, gastric ulcer, and hypertension, as well as his work related injuries; the employee looking uncomfortable and moved around constantly; the employee being over the age of 50, which makes it less likely that an employer or agency would invest in new training or education which might allow an individual with his restrictions to attempt some work; the employee having to lie down during the day; and the employee having to have help even putting his shoes and socks on.

Ms. Shea stated that after his prior back surgery he had ongoing back pain and returned to work. After the back surgery he had trouble coming out of the anesthesia due to lung problems, and it was determined that he cannot undergo additional surgery. He has emphysema for which he must carry an inhaler; anxiety for which he takes medication; and back pain with severe limitations, for which he takes narcotic medication, and which cause him to only be able to sit or

stand for short period of time. He has to lie down during the day. It was Ms. Shea's opinion that the employee is unemployable, as per regular work in the open labor market.

Ms. Shea's deposition was taken on May 14, 2014. Ms. Shea testified that she was with the employee for about an hour and half and possibly up to two hours. The employee looked very uncomfortable and moved around constantly. She thought that somebody drove the employee to the interview. Ms. Shea testified that based upon her interview with the employee, the review of the records, and her training and expertise, it was her opinion that the employee is not employable in regular work. Ms. Shea did not believe the employee is employable in the open labor market. It was Ms. Shea's opinion that that prior to the last injury, the employee's preexisting conditions of being more susceptible to infections and illnesses, his emphysema, his anxiety disorder, and his prior back injury were obstacles to employment. With regard to his prior back injury, he had pain and worked through the pain, but considered that to be a hindrance or obstacle to employment. The reason that the employee is not able to have additional surgery relates to his preexisting lung problems.

Ms. Shea testified that the pain that precludes performance of any work that is regularly performed would not be referable to just the primary work injury only, but would be considering all the employee's factors and limitations. The lying down during the day was not something he had to do prior to the work injury. From a vocational standpoint, that would not be something that an employer would be able to accommodate, unless the individual can plan his lying down and lie down during 15 minute breaks and lunch period.

Ms. Shea testified that she observed the employee's ability to sit, stand and move. While he was sitting in the chair, he pretty much moved around every few seconds or so and then stood up after about 15-20 minutes, walked around and then sat back down. He was obviously uncomfortable and had some pain. That would make it impossible for him to stay at any workstation, whether standing or sitting for long enough periods to maintain a required or adequate pace. If the employee went for a job interview and his behaviors were the same, it would be very unlikely that anyone would consider hiring him. It was Ms. Shea's opinion that the employee would not be able to do any part-time work as typically performed or without modifications.

In January of 2015, the employee settled his Claim for Compensation in Injury Number 10-066731 against the employer for 12.5% permanent partial disability of the body as a whole referable to the lumbar spine.

The employee testified that after his prior back surgery, he had a hard time recovering out of anesthesia. He had two doctors telling him that he needs back surgery, but due to his lungs being so weak, he needed to see a lung specialist. The employee decided not to have surgery, since he questioned whether he could make it through another surgery, and he was told that the surgery would not get rid of all of his pain.

The employee testified that he cannot use a computer and does not have any typing skills. He can sit without moving for about an hour and lies down at least once or twice during the day.

His back is worse when it is damp, foggy, or the weather is about to change. His low back continues to get a little worse as time goes by. On an average day, he usually gets only 4-6 hours of sleep because he cannot get comfortable.

The employee testified in his deposition that after the July 22, 2010 accident he has had trouble sleeping. He tosses and turns and cannot get comfortable. He has to get up out of bed at night and sits and watches television for awhile and then goes back to bed. The employee asked to take a break during his deposition and testified in his deposition that he needed the break due to his back hurting from sitting too long. The employee testified that he is able to sit for about an hour or sometimes maybe a little over an hour.

The employee testified that during the day he sits in his house. He does a little laundry, washes dishes, and runs the vacuum. The day before the hearing he did two loads of laundry, including folding them, and after that he felt like he had been hauling hay all day long and was very sore. As to medication, he is now taking hydrocodone for pain, a muscle relaxer, anxiety medication, and uses an inhaler. The most he can lift is a gallon of milk. He can no longer go rabbit hunting with his beagles and he has gotten rid of them. He can no longer hunt and has trouble walking. The more he walks, the tighter his back gets and his right leg throbs.

RULINGS OF LAW:

Issue 1. Medical Causation

Section 287.020.3 RSMo states that “An injury by accident is compensable only if the accident was the prevailing factor in causing both the resulting medical condition and disability. ‘The prevailing factor’ is defined to be the primary factor, in relation to any other factor, causing both the resulting medical condition and disability.”

The employee has the burden of proof that he suffered a work-related injury and the accident was the prevailing factor in causing both the resulting medical condition and disability. See *Armstrong v. Tetra Pak, Inc.*, 391 S.W.3d (Mo. App. 2012) and *Bond v. Site Line Surveying*, 322 S.W.3d 165 (Mo. App. 2010).

In order to prove a compensable accident and injury, the employee has the burden of proof that the accident was the prevailing factor in causing both the resulting medical condition and disability.

It was Dr. Taylor’s opinion that the employee’s back condition was degenerative disc disease, post-laminectomy syndrome, and failed back syndrome that was due to his previous surgery in 2001, with persistent degeneration of his discs after surgery. It was Dr. Taylor’s opinion that the episode at work was an aggravation of the preexisting pathology and was not the prevailing factor causing the lumbar spine condition.

The employee testified in his deposition, that after the low back surgery his leg pain resolved, but he still continued to have low back pain. Prior to the July of 2010 accident, he was

not having any symptom in his leg. The employee testified that on July 22, 2010 his back started hurting really bad as he was pulling the stakes out of the mud. The work schedule calendar on Thursday, July 22, 2010, stated that he was working with steel rebar set forms at the Cape office, and he left work at 11:30 a.m. due to his back hurting. The employee missed his next scheduled four work days the following Monday through Thursday. On July 29, 2010, the employee saw Dr. Woods for low back pain. On examination, the employee was tender over the lumbar spine and had pain which radiated down the right leg. The employee had pain with straight leg raise at 30 degrees. In addition to his usual medication, Dr. Woods prescribed a Prednisone Dose-Pak.

Dr. Guidos stated that after the employee's 2001 back surgery, he had chronic low back pain. On or around July 22, 2010, the employee was bent over pulling stakes out of the ground when he noted the immediate onset of severe low back pain that radiated to the right anterior thigh. The low back pain was 50%-75% worse after the July 22, 2010 accident. Dr. Guidos diagnosed the employee's condition as a lumbosacral strain. It was her opinion that a lumbosacral strain is a change in pathology and that the July 22, 2010 stake-pulling incident was the prevailing factor in the lumbosacral strain. It was Dr. Guidos' opinion that the prevailing cause of the employee's low back pain was the lumbosacral strain that he sustained as a result of the work-related accident on or around July 22, 2010, while pulling stakes out of the ground. It was Dr. Guidos' opinion that the July of 2010 accident was the prevailing factor in the employee's current medical condition and his inability to return to work.

Based on a thorough review of the evidence, I find that the opinion of Dr. Guidos is very persuasive and is more persuasive than the opinion of Dr. Taylor regarding medical causation for the lumbar spine.

I find that the July 22, 2010 accident was the prevailing factor in causing the resulting lumbar strain and resulting disability; and that the lumbar strain, medical care and medical treatment for the lumbar strain, and the resulting disability were medically causally related to the July 22, 2010 work accident and injury.

Issue 2. Liability of the Second Injury Fund for permanent partial or permanent total disability.

The term "total disability" in Section 287.020.7 RSMo, 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 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 first question that must be addressed is whether the employee is permanently and totally disabled.

I find that the employee was a very persuasive witness on the issue of permanent total disability. The employee offered testimony concerning the impact his condition has had on his daily ability to function in the work place or at home. The employee was observed during the hearing. After a short time the employee started moving around in his seat and continued to do so. The employee appeared to be in pain. He was observed walking very gingerly.

The employee asked to take a break during his deposition and testified in his deposition that he needed the break due to his back hurting from sitting too long.

Ms. Shea was with the employee for an hour and half to two hours. Ms. Shea observed the employee and noted that the employee looked very uncomfortable and moved around in his seat constantly. He stood up after about 15-20 minutes, walked around, and then sat back down. Ms. Shea stated that the employee was obviously uncomfortable and was in pain. She noted that if the employee went for a job interview and his behaviors were the same, it would be very unlikely that anyone would consider hiring him.

The testimony and observed behavior of the employee supports a conclusion that the employee will not be able to compete in the open labor market and is permanently and totally disabled.

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

It was Dr. Guidos' opinion that the employee is permanently and totally disabled and unable to be gainfully employed. It was Ms. Shea's opinion that the employee is not employable in the open labor market.

Based on a review of all the evidence, I find that the opinions of Dr. Guidos and Ms. Shea are persuasive on whether the employee is permanently and totally disabled.

Based on the persuasive testimony of the employee and the persuasive supporting medical and vocational rehabilitation evidence, I find that no employer in the usual course of business would reasonably be expected to employ the employee in his present 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 is permanently and totally disabled.

Given the finding that the employee is permanently and totally disabled, it must be determined whether the July 22, 2010 accident alone and of itself resulted in permanent total disability.

It was Dr. Guidos' opinion that as a result of the July 22, 2010 accident that the employee sustained a 30% disability of the whole person. It was Dr. Guidos' opinion that the employee was permanently and totally disabled but not solely from the lumbosacral strain. It was Dr. Guidos' opinion that the employee is permanently and totally disabled due to a combination of the primary lumbosacral strain and the preexisting low back surgery, emphysema, chronic infections, and splenectomy.

It was Ms. Shea's opinion that the employee is unemployable in the open labor market not just from the primary work injury only, but considering all the employee's factors and limitations. The factors and limitations include limitations on sitting and standing; pain; the use of narcotic medications for pain; medication for anxiety can cause drowsiness or otherwise impair functioning; being susceptible to infections and illnesses due to the removal of his spleen; having emphysema which affects his ability to work and causes him to become ill at times; not being able to undergo surgery due to lung and breathing problems; his work related injuries; and having to lie down during the day.

The employee's Claim against the employer for the July 22, 2010 accident was settled for 12.5% permanent partial disability of the body as a whole referable to the lumbar spine.

I find that the opinions of Dr. Guidos and Ms. Shea that the July 22, 2010 accident alone did not cause the employee to be permanently and totally disabled are very persuasive.

There is no evidence that the primary July 22, 2010 injury alone caused the employee to be permanently and totally disabled. I find that the employee's July 22, 2010 injury alone did not cause the employee to be permanently and totally disabled. I find that as a result of the July 22, 2010 accident and injury alone that the employee sustained permanent partial disability.

Based upon the evidence, I find that as a direct result of the July 22, 2010 accident and injury alone, the employee sustained a permanent partial disability of 12.5% of the body as a whole referable to the low back.

It must be determined whether the employee's preexisting conditions were a hindrance or obstacle to his employment or reemployment.

The evidence shows that as a result of having his spleen removed, the employee would often get sick and it would take longer for him to recover. The employee missed time from work at Arvin due to being sick, which led to his termination. The employee has had emphysema for at least 20 years and he cannot do as much due to running out of breath. While working for the Department of Conservation, his emphysema bothered him and he had to take breaks. He used an inhaler every four hours to help with breathing.

The employee settled his July 16, 2001 low back injury with Arvin for 25% permanent partial disability of the body as a whole. He continued to have low back problems and treated with his family doctor who prescribed prescription pain medication, ibuprofen, and a muscle relaxer. The employee's low back ached all of the time and it got worse when he performed more strenuous work. Prior to July of 2010, the employee's co-workers helped him get the job done due to back problems. In December of 2009, Dr. Woods noted that due to his low back condition, he took Vicodin and ibuprofen for pain and Soma for muscle spasms. Due to wheezing and bronchial spasms, Dr. Woods prescribed an inhaler to use every four hours. In March of 2010, the employee continued to be prescribed those same medications. Dr. Woods stated that the employee had faint wheezes bilaterally in the lungs. In April of 2010, the employee had coughing, congestion, and wheezing; and had fever and chills with night sweats. The employee continued to have faint wheezes bilaterally in the lungs and Dr. Woods diagnosed bronchitis and sinusitis. Medications and an inhaler were again prescribed.

Dr. Taylor stated that the employee had a history of needing antibiotics and steroids for minor infections due to not having a spleen. Dr. Taylor stated that due to the emphysema, splenectomy, and other medical morbidities, the option of having low back surgery was fraught with complications and the employee may not be able to survive it.

It was Ms. Shea's opinion that that prior to the July 22, 2010 injury the employee's preexisting conditions of being more susceptible to infections and illnesses, his emphysema, his anxiety disorder, and his prior back injury were obstacles to employment. With regard to his prior back injury, the employee had pain that he worked through, but it was a hindrance or obstacle to employment. The employee was not able to have additional surgery due to his preexisting lung problems.

Dr. Guidos stated the employee had a history of emphysema and was status post splenectomy. He uses an inhaler four times a day for his underlying respiratory problems that interfere with his ability to work, particularly on hot days. He has a history of frequent infections and stated he got short winded with activity. He has a history of chronic wheezing secondary to emphysema and has wheezing as a baseline.

It was Dr. Guidos' opinion that the employee had a preexisting 25% impairment from the July 16, 2001 work-related low back injury. The employee had chronic infections and emphysema requiring antibiotics, steroids and inhalers over many years. It was her opinion that the employee had a 10% impairment for the chronic infections, a 10% impairment for the emphysema, and a 5% impairment for status post splenectomy. It was her opinion that those preexisting conditions and disabilities resulted in a hindrance or obstacle to employment.

The evidence is very persuasive and supports a finding that the employee's preexisting conditions and disability regarding his low back, emphysema, lungs, respiratory system, loss of spleen, and chronic infections were hindrances or obstacles to his employment or reemployment. I find that the employee's preexisting disabilities constituted hindrances or obstacles to his employment or obtaining reemployment.

The final question that must be addressed is whether the employee is permanently and totally disabled as a result of the primary July 22, 2010 accident in combination with the preexisting conditions and disabilities.

It was Dr. Guidos' opinion that the combination of disabilities creates a synergistic effect between the prior disabilities and disability of low back pain, resulting in a combined effect greater than the simple sum of the components, resulting in permanent total disability. It was Dr. Guidos' opinion that the employee was completely and totally disabled secondary to a combination of the underlying preexisting medical conditions of splenectomy, chronic infections, emphysema, and the prior low back surgery with his current low back pain. It was Dr. Guidos' opinion that the employee is unable to be gainfully employed with all of his comorbidities, breathing problems, and back problems.

It was Ms. Shea's opinion that the employee is unemployable in the open labor market considering all the employee's factors and limitations. The factors and limitations include limitations on sitting and standing; pain, the use of narcotic medications for pain can cause drowsiness or otherwise impair functioning; being susceptible to infections and illnesses due to the removal of his spleen; having emphysema which affects his ability to work and causes him to become ill at times; not being able to undergo surgery due to lung and breathing problems; his work-related injuries; and having to lie down during the day.

I find that the opinions of Dr. Guidos and Ms. Shea on the cause of the employee's permanent and total disability are very persuasive.

Based on a review of the evidence, I find that the employee's preexisting injuries and conditions to his low back, lungs, respiratory system, removal of spleen with chronic infections, combined synergistically with the primary injury to the low back, to cause the employee's overall condition and symptoms.

Based on the evidence, I find that the employee is permanently and totally disabled as a result of the combination of his preexisting injuries/conditions and the low back injury caused by the July 22, 2010 accident and injury.

On November 24, 2010, Dr. Guidos recommended that the employee undergo a lumbar MRI. The MRI was performed on November 14, 2012. It was Dr. Guidos' opinion that the employee was not at maximum medical improvement when she saw the employee on November 24, 2010. It was Dr. Guidos' opinion that when she saw the employee on September 23, 2013 the employee had recovered from his accident as much as he was going to. Based on the opinion of Dr. Guidos, I find that the employee was in his healing period and had not reached the point where further progress was not expected until September 23, 2013. I find that for the purpose of determining liability of the Second Injury Fund, the 12.5% permanent partial disability of the body as a whole referable to the low back would have been payable in 50 weekly installments commencing on September 24, 2013, the end of the healing period, and continuing through September 9, 2014. The Second Injury Fund is therefore ordered to pay to the employee the sum of \$247.57 per week commencing on September 10, 2014, for permanent total disability benefits.

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.

ATTORNEY'S FEE:

Michael Moroni and Donald Rhodes, attorneys at law, are allowed a fee of 25% of all sums awarded under the provisions of this award for necessary legal services rendered to the employee. The amount of this attorney's fee shall constitute a lien on the compensation awarded herein.

INTEREST:

Interest on all sums awarded hereunder shall be paid as provided by law.

Made by:

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