

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

Injury No.: 00-025748

Employee: James Ignatz
Employer: Phillips Getschow Co. (Settled)
Insurer: Fidelity and Guaranty Insurance Co.
c/o Gallagher Basset (Settled)
Additional Party: Treasurer of Missouri as Custodian
of Second Injury Fund
Date of Accident: March 8, 2000
Place and County of Accident: Franklin County, Missouri

The above-entitled workers' compensation case is submitted to the Labor and Industrial Relations Commission (Commission) for review as provided by section 287.480 RSMo. Having reviewed the evidence and considered the whole record, the Commission finds that the award of the administrative law judge is supported by competent and substantial evidence and was made in accordance with the Missouri Workers' Compensation Act. Pursuant to section 286.090 RSMo, the Commission affirms the award and decision of the administrative law judge dated January 5, 2006. The award and decision of Administrative Law Judge Leslie E. H. Brown, issued January 5, 2006, 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 23rd day of August 2006.

LABOR AND INDUSTRIAL RELATIONS COMMISSION

William F. Ringer, Chairman

Alice A. Bartlett, Member

John J. Hickey, Member

Attest:

Secretary

AWARD

Dependents: ----

Employer: Phillips Getschow Co. (previously settled)

Additional Party: State Treasurer, as custodian of the Second Injury Fund

Insurer: ----

Hearing Date: June 27, 2005

Before the
**DIVISION OF WORKERS'
COMPENSATION**
Department of Labor and Industrial
Relations of Missouri
Jefferson City, Missouri

Checked by: LEHB/bfb for df

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: Yes
5. State location where accident occurred or occupational disease was contracted: Franklin County, Missouri
6. Was above employee in employ of above employer at time of alleged accident or occupational disease?

7. Did employer receive proper notice? ----
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? ----
11. Describe work employee was doing and how accident occurred or occupational disease contracted:

12. Did accident or occupational disease cause death? No Date of death? ----
13. Part(s) of body injured by accident or occupational disease: left elbow
14. Nature and extent of any permanent disability: Permanent partial disability against the Second Injury Fund
15. Compensation paid to-date for temporary disability: ----
16. Value necessary medical aid paid to date by employer/insurer? ----

17. Value necessary medical aid not furnished by employer/insurer? ----
18. Employee's average weekly wages: maximum
19. Weekly compensation rate: \$578.48/\$303.01
20. Method wages computation: by agreement of the parties

COMPENSATION PAYABLE

21. Amount of compensation payable: ----

Unpaid medical expenses: ----

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

---- weeks of permanent partial disability from Employer

---- weeks of disfigurement from Employer

----Permanent total disability benefits from Employer beginning ----, for Claimant's lifetime

22. Second Injury Fund liability: Yes X Permanent partial disability liability

TOTAL: \$15,832.88

23. Future requirements awarded: ----

Said payments to begin as of the date of this Award 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 25% of all payments hereunder in favor of the following attorney for necessary legal services rendered to the claimant:

Mathew J. Padberg, Attorney for Claimant

FINDINGS OF FACT and RULINGS OF LAW:

Employee: James Ignatz

Injury No: 00-025748

Before the
**DIVISION OF WORKERS'
COMPENSATION**

Department of Labor and Industrial Relations of Missouri
Jefferson City, Missouri

Dependents: ----

Employer: Phillips Getschow Co. (previously settled)

Additional Party State Treasurer, as custodian of the Second Injury Fund

Insurer: ----

Checked by: LEHB/bfb for df

This is a hearing in Injury Number 00-025748. The claimant, James Ignatz, appeared in person and by counsel, Matthew Padberg, Attorney at Law. The claim against the employer/insurer was previously settled and the employer/insurer was not present at this hearing. The Second Injury Fund appeared by and through Assistant Attorney General Jennifer

Sommers.

The parties entered into certain stipulations, and agreements as to the complex issues and evidence to be presented in this hearing.

STIPULATIONS:

On or about March 8, 2000: a. the claimant while in the employment of Phillips Getschow Company, sustained an injury by accident arising out of and in the course of his employment in Franklin County, Missouri; b. the employee's average weekly wage was at the maximum, the rate being \$578.48 over \$303.01.

c. A Claim for Compensation was filed within the time prescribed by law.

ISSUES:

1. Nature and extent of permanent disability - whether or not partial or total
2. Liability of the Second Injury Fund

EXHIBITS:

The following exhibits were admitted into evidence:

Claimant's Exhibits:

No. A: Deposition transcript of Dr. Robert Margolis, M.D., taken on behalf of the employee on November 16, 2004 (Admitted subject to objections therein)

No. B: Report of Robert P. Margolis, M.D., dated March 30, 2004

No. C: Deposition transcript of Samuel Bernstein, Ph.D., taken on behalf of the employee on November 12, 2004 (Admitted subject to objections therein)

No. D: Report of Samuel Bernstein, Ph.D., dated April 8, 2003

No. E: Records of St. John's Mercy Medical Center

No. F: Records of Missouri Bone & Joint Clinic

No. G: Records of Dr. Martin Boyer, M.D.

No. H: Records of Gateway Rehabilitation

No. I: Records of Anderson Hospital

No. J: Records of Orthopedic & Sports Medicine

No. K: Records of Belleville Memorial Hospital

No. L: Records of Dr. Dale Rosenberg, M.D.

No. M: Records of Associated Orthopedic Surgeons

No. N: Records of Oliver Anderson Hospital

No. O: Records of Christian Hospital Northeast

No. P: Records of Dr. James Strickland, M.D.

No. Q: WITHDRAWN

No. R: Records of Dr. Stephen Benz, M.D.

No. S: Records of Dr. Gregg Ginsburg, M.D.

No. T: Record of Dr. Erik Houttuin, M.D.

No. U: Record of Dr. Christopher Speidel, M.D.

No. V: Record of Dr. Michael Rallo

No. W: Prior Workers' Compensation records

Second Injury Fund's Exhibits:

No. 1: Deposition transcript of James M. England, Jr. taken on behalf of the Second Injury Fund on May 5, 2005 (Admitted subject to objections therein)

FINDINGS OF FACTS AND RULINGS OF LAW

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James Ignatz, the claimant, testified that he is fifty-nine years old, date of birth January 14, 1946. I have two years of community college with a degree in computer processing in 1968, Ignatz said, but further stated that he has no modern

computer skills as he has never worked in computers. After computer school I went into construction work, a boilermaker, the claimant said, and I worked as a boilermaker up until the March 8, 2000 accident.

Ignatz explained a boilermaker's duties. We build power plants, safety pollution devices; build tanks and ships, he said. My job duties required me to bend, lift, stoop, climb ladders and stairs and get into awkward positions, he stated. I carried a tool belt that weighed about 35 pounds, Ignatz said. He agreed that it was a heavy labor job. I worked out of a union hall, the claimant testified, and could work for five employers in one week, or on a big job, and around the country. I was a journeyman boilermaker after two and a half years working, he said.

Testifying about his work related injury on March 8, 2000, Ignatz stated that he was working as a boilermaker and foreman at the Labadie Power Plant and the crew had just gone into a boiler. When I turned a release valve off a one-half inch diameter hose blew off and hit me across the left arm; mud hit my face and hit my watch leaving an indent of the watch in my hand, the claimant testified, and my left arm went numb. I reported the injury, the claimant said. While working a few weeks later, I picked up an object at work and experienced more pain in my left elbow and forearm, and decided to seek treatment, Ignatz said.

I got treatment at St. John's Mercy Hospital two days later, Ignatz testified. X-rays were taken and I was told I had a bone chip in the left wrist, and it was immobilized until I could go see another doctor, he said. I was taken off work, the claimant said, and ended up missing two years of work because of treatment. The Labadie Power Plant job was my last job, he said. Discussing his treatment, Ignatz stated that his arm in a cast did not get any better. I came under the care of Dr. Scherer, the claimant said, who diagnosed me with a severe contusion of the forearm. Dr. Scherer treated me into the summer of 2000; my symptoms were pain radiating down my forearm and weakness in my left arm, the claimant said. Dr. Scherer referred me to Dr Galatz who also kept me off work, the claimant testified. Dr. Galatz' treatment included nerve shots which gave me temporary relief; continued problems were that my arm would go numb with lifting my hand, he said. Dr. Galatz sent me to physical therapy but I continued to have pain upon trying to lift anything with my left arm, Ignatz stated. I was sent for a functional capacity evaluation, the claimant said. I was then examined by Dr. Boyer who offered surgery, the claimant stated. Ignatz noted that Dr. Cantrell performed an electrical test on him, and with testing my arm popped; the doctor said I should retire because I could not control my left arm, Ignatz stated. Another functional capacity evaluation was performed and I had difficulty while doing the activities, the claimant said.

I can't go back to being a boilermaker because in that job I have to climb steel ladders and I can't do that anymore.

The claimant testified about prior injuries and conditions. In November 1999 I had a heart attack; I died and was brought back; they put a stent in my heart, he said. I returned to work after this in January or February 2000, the claimant said. On the job I experienced chest pain with moving stuff and was taken to the hospital by ambulance, he said. I was moved to another job and the employer made accommodations, and three weeks later I got hurt (March 8, 2000). Continuing problems with my heart that caused problems with working, Ignatz said, are tightness in my chest, fatigue particularly with going up and down stairs and it feels like my blood pressure goes up with excitement. I take cardiac medications, blood pressure medicine and cholesterol medication, he said. In 1976 I fell backwards onto a hangar rod and knocked my tailbone off, Ignatz said. I missed work for this injury because everything a boilermaker does is heavy, he said. Continuing problems from the 1976 injury are that I lose feeling in my right leg, I have to watch what I am lifting to avoid pulling my back out. Also, I have problems with walking because of the pressure on my spine; the discs are crushed together and causes the pressure, the claimant said. I would miss time from work from time to time because of my back, Ignatz said. I have had surgery on both of my knees, the claimant said. In June of 1994 I injured my right knee at work and had two surgeries, the claimant said. I had an injury to the left knee in January 1996 and surgery in February 1996, Ignatz stated, they took bone chips out and there was ligament damage. Infection developed and they had to go back in again, he stated. This was also a workers' compensation case, the claimant said. Continuing problems from the knee injuries are that I can't stoop, crawl, squat, climb ladders or stairs, or kneel for very long; I can't walk more than a block, the claimant said. In 1980 I fell off of a ladder landing on the left side of my body, Ignatz said, I suffered facial fractures for which I had to have surgery, and I had surgery on my left elbow. Continuing problems are that I have permanent loss of feeling on the left side of my face, and my left elbow is weak, he said. In 1986 I injured my left shoulder, Ignatz stated, and with treatment I tore a muscle and had to have surgery. Continuing problems with the left shoulder are that I experience pain when I pick things up or pull on things, he said. I have had two hernia surgeries and both were worker compensation cases, the claimant said.

The claimant testified about a typical day for him now. In the morning I must roll out of bed because of my back condition, he said. I perform exercises for my heart, Ignatz stated. I then attempt to do some work around the house, but for every 5 minutes of work I do I must rest 15 minutes, the claimant said. Sitting and standing for significant periods of time puts pressure on my back, he said. I spend most afternoons lying down because of the pain in my knees and back, the claimant said. Activity increases my pain; for example, if I attempt to cut the grass I have to spend the entire next day laying

down, Ignatz stated. Going up an down stairs is difficult because of back problems, he said. The claimant testified that due to his prior injuries and his work related left forearm injury he does not feel that he is able to work.

During cross examination, Ignatz agreed that during the over 30 years that he worked as a boiler maker up to the date of the March 8, 2000 work related injury, he performed his boiler maker duties which required him to bend, lift, stoop, climb ladders and stairs, crawl, kneel and get into awkward positions.

Medical records in evidence included:

Records of **St. John's Mercy Medical Center** (No. E) concerned the treatment of Ignatz on March 20, 2000. The chief complaint was noted as: Left arm injury. History of injury was:

54-year-old white male presents to the Emergency Department with complaint of left arm injury. Patient states he began having problems with this two weeks ago whenever a pneumatic air hose off and hit him in the left arm. The patient states how he is starting to get a little numbness and it is still hurting him when he kind of moves his arm around the elbow.

Past medical history was noted as: MI on 11/12/99; has had both knees replaced; has had a hernia; the left elbow had a rotator release; some facial surgeries; is right hand dominant; has arthritis. Medications were noted as: Monopril daily, aspirin daily and Multi-Vitamin. Written in the Emergency room course section of the record was the following:

The patient went over and had x-rays performed and read by radiologist as a positive fracture on the proximal radius, questionable age, and possibly postop. The patient does have a huge amount of DJD arthritis type changes in this region as well as in the wrist but difficult to rule out an acute fracture over the last couple of weeks. It was shown to the patient.

The clinical impression was: 1. Left arm fracture of the radial head; 2. Paresthesias in the left arm; and 3. Severe degenerative joint disease. The record indicated that Ignatz was placed in a splint, prescribed Vicodin, was taken off work for two days, and advised to see Dr. Chalk in 2-two or three days.

Records of **Dr. Martin Boyer, M.D.** (No. G) concerned treatment of Ignatz for the March 8, 2000 work related left arm injury. The record reflected that Ignatz reported on 08/22/00 sharp and aching severe pain in the left forearm when using it at anytime that had recently been getting worse in the last few weeks; Ignatz indicated that what made the problems/pain better was – no use. The record indicated that Ignatz was returned to work on 9/1/00 with restrictions that included no use of the left upper extremity and limits on overhead work, outstretched motion, vibratory machines repetitive work and on gripping/twisting/pinching. Physical therapy progress reports in the record noted Ignatz' comments that he continued to have significant pain. The 12/5/00 treatment entry indicated that Ignatz was taken off work with a diagnosis of left extensor tendonitis. Work hardening was prescribed on 3/20/01. An April 2, 2001 Work Capacity Evaluation reported noted that Ignatz had been referred for assessment of his current physical/functional capabilities with regard to his usual and customary job as a boilermaker and for determination of his potential to safely return to that job situation. The Comments Section of the April 2, 2001 Work Capacity Evaluation report included the following:

Mr. Ignatz evaluation was originally scheduled for late March but was postponed a week due to a recent spine injury he incurred while lifting at home. When called to confirm appointment client stated that he had injured his back and could not due to much activity. From the evaluation, Mr. Ignatz is currently demonstrating the ability to work in the medium physical demand level, where his job requires a heavy physical demand level. He was limited in lifting ability mostly due to recent back injury and his weakness in his left upper extremity. Patient rated his pain before testing as a 5 out of 10 and after evaluation as a 5 out of 10 on the 0 to 10 pain scale. Before the evaluation, he stated that the pain was burning at the top of the left forearm and stabbing at the left wrist. Following the evaluation, he stated that it was throbbing throughout the left forearm. Frequently throughout the test, Mr. Ignatz had to stop and take breaks due to shortness of breath. He also demonstrated profuse sweating with moderate activity. Patient stated he did not want to push it too much his back had not fully recovered from recent injury. (sic)

Recommended in the April 2, 2001 Work Capacity Evaluation report was: 1. Work conditioning exercises to improve flexibility/endurance/aerobic capacity; 2. Job simulation to improve from Medium to Heavy physical demand level; and 3. Increase strength of left elbow flexion, left forearm supination and left wrist flexion. A Work Hardening Discharge Summary report, dated 05/03/01, noted that Ignatz had attended 21 days of work hardening, and it was written that Ignatz relayed that his arm did feel stronger over all, but he had not noticed any improvement in his ability to lift any weight in the front of him; it was written that Ignatz might require further medial intervention. Dr. Boyer wrote in a May 15, 2001

examination report to Dr. Paul J. Scherer, M.D. that Ignatz continued with persistent pain and that a cock-up splint would be tried, and the doctor discussed possible surgery if required; Ignatz was continued off work. In the next examination report of July 17, 2001, Dr. Boyer wrote that Ignatz' physical findings were completely unchanged; an injection was given. Dr. Boyer released Ignatz to return to work on 07/18/01 with the restriction of - no use of the left arm. In an August 21, 2001 examination report, Dr. Boyer wrote that once again Ignatz' exam was unchanged. I have offered him surgery and he is going to think about it and get back to me, the doctor wrote. In an October 16, 2001 examination report to Dr. Scherer, Dr. Boyer wrote the following:

I have seen Jim Ignatz in the office today. Radial tunnel and distal radial sensory compression are improved, although not completely gone. Additionally, he complains of pain on the ulnar side of his wrist. We have taken x-rays today which show DRUJ arthrosis. I do not feel that the DRJU arthritis is accident related. I have advised Mr. Ignatz to seek a Functional Capacity Evaluation vis-à-vis his further employment as a steel worker. I will see him back on an as needed basis for surgical intervention as necessary.

In the October 16, 2001 entry reflecting that Ignatz needed a functional capacity evaluation, the diagnosis included not only left radial tunnel syndrome, but also left DRJU arthritis; the entry further indicated that Ignatz was taken off work. A Functional Capacity Evaluation report, dated 10/31/01, included the following in the Summary and Recommendations section:

During the FCE, the worker did appear to provide a good and consistent level of effort. In addition to providing a consistent level of effort during the FCE, the worker did demonstrate an inability to perform the essential functions of his job as a boiler maker. The worker had difficulty performing ladder climbing and lifting tasks with the left upper extremity and due to the deficits, the worker may be at risk for injury or injuring other workers if he is required to return to full duty at this time. During the FCE, the worker was limited not only due to left upper extremity discomfort, but was also limited by complaints of left knee pain and back pain.

It was indicated on the 10/31/01 Functional Capacity Evaluation report that it was not recommended that Ignatz return to work, that modified duty was recommended, and that a rehabilitation program was not recommended. Dr. Boyer wrote in an 11/13/01 report that he was in receipt of a functional capacity evaluation performed on 10/31/01 on Ignatz. The doctor wrote of the FCE findings, that Ignatz could carry a maximum of 60 pounds, was unable to climb ladders and unable to perform lifting tasks with the left upper extremity. Dr. Boyer further wrote: "The functional capacity evaluator felt that 'the worker may be at risk for injury or injuring other workers if he is required to return to full duty at this time'. Accordingly, the limitations are as outlined and I will see Mr. Ignatz back for follow-up on a prn basis."

Records of **Anderson Hospital** (No. I) began with an order for a CT scan of the left elbow, dated 04/10/00, and ordered by Dr. Paul Scherer, M.D. A report of a CT of the left elbow performed on 04/18/00 stated the impression of: Suggested on the coronal and sagittal reconstructed images are fractures through the proximal diaphysis of the ulna and the neck of the radius with approximately 1mm displacement. An addendum report concerning the 04/18/00 CT scan of the left elbow stated the following impression:

Suggested on the coronal and sagittal reconstructed images are fractures through the proximal diaphysis of the ulna and the neck of the radius with approximately 1mm displacement.

Review of images demonstrates that the suggested fractures are secondary to volume averaging artifact and do not represent acute abnormalities. There is noted to be several small bone fragments in the region of the head of the radius and humeral radial joint that likely represent a chronic traumatic and/or post surgical change. No acute bony abnormality is seen.

The Anderson Hospital record next contained a report of a cardiac scan performed on 05/04/00; the written indication for the study was – "54-year-old white male with precordial chest discomfort; history of coronary artery disease and prior inferolateral wall myocardial infarction". A report of a Thallium Stress Test performed on 05/04/00 noted a history of: "54-year old white male with a history of coronary disease and prior inferior lateral wall myocardial infarction He has been experiencing a vague form of chest discomfort". The written interpretation for the Thallium Stress Test was: "1. Normal sinus rhythm; and 2. Normal EKG.

The Anderson Hospital record continued with physical therapy progress notes, beginning with a 10/24/00 evaluation date, which reflected that Ignatz was referred for services for extensor tendonitis of the left forearm as a result of the March 8, 2000 work related accident. The written goals were: decrease pain in two to three levels; restore pain free ROM of the left shoulder, elbow and wrist; patient independence in a home exercise program; and decrease tenderness with palpation.

The progress notes reflected continued complaints from Ignatz with statements of no change in his symptoms; by 11/15/00 Ignatz was reporting that he was feeling better; the 12/11/00 entry stated that strengthening exercises were to be started. An 11/27/00 Progress Report included the following:

James states he continues to have significant pain when he attempts to lift anything. He states the elbow often catches & he has to rotate the forearm to allow the elbow to pop before he is able to extend the elbow. His pain along the distal forearm is a level 5 on 0-10 scale (with) 10 being the worst & proximal pain a level 8.

His pain is now more local – distal & proximal. He no longer has pain (with) end ranges of elbow flex & ext. Pain (with) active pron, RO & ext. Pain (with) resistance testing for all wrist motions but mostly RO & ext. Grip strength 88 (pounds) uninvolved, 75 (pounds) involved.

Treatment initially consisted of UC (with) HCC until his pain became more local – then initiated iontophoresis. MFR along extensors of the forearm. Stretching & ice. He did not tolerate strengthening exercises – too painful.

In the recommendation section of the 11/27/00 Progress Report, it was written that Ignatz was returning to the Dr. Galatz' office on 11/28/00.

The next entry in the Anderson Hospital record was a 12/28/00 emergency room report which indicated that Ignatz presented with complaints of chest tightness onset that day, BP increased, some nausea – pointing to his right side of chest. After examination, the written impression on 12/28/00 was: Atypical chest pain.

Physical therapy progress notes in a 12/19/00 entry that Ignatz reported that he was very sore from shoveling snow. A 01/02/01 entry noted that Ignatz stated he had to go to the hospital due to chest pain, and that he has not been able to exercise due to this. The physical therapy record indicted that strengthening exercises were continued, and Ignatz continued to report symptoms of pain and swelling with any increase in activity. In a 03/16/01 Progress Report, it was written that Ignatz reported a pain level of 6 on a 0-10 scale, and that he also continued to complain of his elbow locking and popping; it was written that range of motion was within normal limits except supination lacked 10 degrees, that strength for the wrist/forearm was 4+/5, and that grip strength was 72 pounds on the left and 90 pounds on the right. Further written in the 03/16/01 Progress Report was:

James feels he would not be able to return to work at this time due to (increased) pain/swelling (with increased) activity. I mentioned work hardening may be more appropriate but pt had work hardening before and did like it. (sic) I feel work hardening activities are needed for return to work.

The Anderson Hospital record contained a Pain Clinic Note by a Dr. Lin, M.D., dated 12/27/01, in which it was written that Ignatz had been referred by Dr. Bernardi. Dr. Lin noted the following:

I had the pleasure of seeing one of your patients. He is a 55-year-old man who has been suffering from low back pain. The pain is worse on standing and he also has trouble walking long distances and especially when he stands straight up.

PAST MEDICAL HISTORY: This gentleman tells me that he has been having back problems off and on for quite some time. He has been very aggressive about doing the muscle exercises. Also he has been having cardiac problems and he told me that he had a cardiac arrest and his life was brought back again. He has been taking a lot of cardiac medications and also he had a stent put in on 11/19/99. He was sent over here hoping that conservative treatment will help him to try to stay away from surgery. He has been on medication with Vioxx, Lotrel, Zocor, aspirin, Allegra, and Prilosec. The patient had arthroscopy of both knees. He had left arm surgery.

Physical examination findings on 12/27/01 included:

This is a 55-year-old man, body weight 257 pounds, blood pressure 130/76 and temperature 98.6.....He is morbidly obese....Heart has regular rhythm. Abdomen is soft and nontender, abdomen shows huge protrusion, distended and obese. The spine shows increased lordosis. Both upper extremities show normal biceps and triceps reflexes. Both lower extremities also show normal reflexes at the knees and ankles.

Review of the x-rays show the patient has spondylolisthesis Grade II L4-L5 and also shows spinal stenosis.

Dr. Lin wrote in his 12/27/01 examination report that it was his impression that Ignatz suffers from spondylolisthesis of the lumbar spine, spinal stenosis and low back pain. Treatment recommendations, the doctor wrote, were that Ignatz definitely needed to lose weight, and he was shown some spine stretching exercises. The doctor wrote that a follow-up appointment

was scheduled.

Another Thallium Stress and Rest Spect Examination was performed on Ignatz on 01/10/02. It was written that the indication for the study was: Increasing nonexertional chest discomfort. The written impression was:

1. Subtle reversible defect involving the inferior segment. Clinical correlation for evidence of ischemia would be recommended. These findings were not present on prior examination of 01/04/01.

A 01/16/02 Pain Clinic Note by Dr. Lin in the record noted that Ignatz had remained the same. His body weight is 259 pounds, the doctor wrote. His spine exercises is slightly better, it was noted. Dr. Lin wrote that he still encouraged Ignatz to try and lose weight. He has spinal stenosis and he definitely needs to lose weight, the doctor wrote. There was no indication that a return appointment had been scheduled.

Records of **Gateway Rehabilitation** (No. H) indicated that on 12/04/01 Dr. Russell Cantrell, M.D. referred Ignatz for physical therapy. The initial physical therapy evaluation report, dated 12/17/01, noted a diagnosis of - soft tissue injury to left distal upper extremity. It was written that Ignatz stated that he pain in the left upper extremity was similar to what it was during the Functional Capacity Evaluation that was performed at that facility, and no significant improvement. It was written that Ignatz stated that he did appear to have more shooting pain into the thumb since approximately one week earlier, and that he also had a great deal of soreness in the lateral epicondyle, explaining that the pain started getting worse following hanging Christmas decoration overhead at home. The 12/17/01 report indicated that treatment given was; "Myofascial Release and Friction massage being utilized at this point to decrease adhesions and possible scar tissue formation and will be increased to neural tension stretches as tolerated by the patient." Written in a 12/25/01 comments section of the record was: "Pt. states the forearm is a little more sore today (secondary) to playing pool for an extended period yesterday". In a 01/09/02 Physical Therapy Note, written in the Assessment Section was the following:

During the treatment program the patient did have periods of decreased complaints of discomfort. Overall, the patient does continued to have subjective reports of discomfort and reported difficulties associated with combined wrist extension and radial deviation lifting activities. The patient was cooperative during the treatment, but due to his continued complaints may benefit from additional means of medical treatment as per Dr. Cantrell.

The record indicated that Dr. Cantrell on 01/16/02 prescribed continued physical therapy. The final Physical Therapy Note of 02/08/02 noted that Ignatz was continuing to describe discomfort in the left forearm, and some degree of numbness in the dorsal aspect of the left upper extremity occasionally radiating down into the fingers; it was written that Ignatz described his pain level as a 7/10 on a pain scale of 10/10. The written assessment on 01/16/02 was:

The patient's degree of discomfort was variable during the treatment program. The patient continues to complain of a relatively high level of discomfort associated with the epicondyle and brachioradialis muscles. The patient remains compliant with the treatment program, but due to lack of results, it is felt that the patient may benefit from being discharged from physical therapy at this point.

Records of **Orthopedic & Sports Medicine** (No. J) began with a December 4, 2001 examination report by Dr. Russell C. Cantrell, M.D. to the workers' compensation insurance company. Dr. Cantrell noted that he was seeing Ignatz for the purpose of evaluating Ignatz' complaints of the left forearm pain attributed to a March 8, 2000 reported work injury. The doctor further wrote:

Mr. Ignatz reports that he has worked as a boilermaker for 30 plus years. This job is physically heavy in nature. It requires heavy lifting, climbing, and working in overhead positions on a frequent basis. He indicates that on the date of his injury he was loosening a Chicago fitting on what he thought was a bleed airline to a jack-hammer. The valve, he believes, may have malfunctioned, causing the line to not bleed fully. This resulted in the Chicago fitting abruptly coming off of its attachment, striking him bluntly in the left dorsal forearm at approximately the middle and distal one-thirds. He developed acute swelling and bruising as a result of this trauma. E happened to have been scheduled off work for the following two weeks because he was working at that time as a foreman. When he returned to work he was lifting a small piece of plywood, but was unable to hold the grip secondary to complaints of pain in his left forearm. He subsequently initiated treatment, initially with Dr. Galatz, who referred him for six weeks of physical two times per week, and did an x-ray, which did not show any bony trauma. It was suspected by Dr. Galatz that he may have had an additional injury to his left elbow because of symptoms he was reporting of intermittent locking and popping in his left elbow. Mr. Ignatz, however, had advised his treating physician that he had had a remote injury of a fracture to his left radial head that required surgical treatment many years ago. Therefore, Dr. Galatz referred Mr. Ignatz for a second opinion with Dr. Martin Boyer. Dr. Boyer opined that his

symptoms may have been related to a radial nerve injury in the distal forearm, and suggested consideration of radial nerve decompression. It is noteworthy, however, that Dr. Boyer never ordered or reviewed any electrodiagnostic studies of Mr. Ignatz's left upper extremity. He did suggest a wrist splint, which Mr. Ignatz wore, with temporary relief of pain, although Mr. Ignatz reminded Dr. Boyer that he would not be able to return to his regular duty activities with any type of splint in place. Mr. Ignatz had undergone a Functional Capacity Evaluation, most recently in October of 2001, at which time it was suggested that he be placed on permanent restrictions. This would not allow him to continue working as a boilermaker.

Dr. Cantrell wrote that Ignatz' present complaints were: pain that originates in the junction of the middle and distal one-third of his forearm on the dorsal radial aspect; this pain will radiate proximally to his lateral elbow and radiate distally into the 3rd and 4th fingers, particularly with radial deviation movements of his wrist. The doctor wrote of his examination findings; he wrote of his review of the medical records and tests. Dr. Cantrell noted: "He underwent a Functional Capacity Evaluation on April 2, 2001. At the time his physical demand level was considered medium. He was then advanced into a work hardening program." Dr. Cantrell wrote of subsequent treatment by Dr Boyer, and that Ignatz' physical findings were completely unchanged. The doctor noted that another Functional Capacity Evaluation was completed at Gateway Rehabilitation on October 31, 2001 which also indicated that at that time, given treatment to date, Ignatz would not be able to resume his physically heavy level of work. Dr. Cantrell wrote in his December 4, 2001 report of his impressions:

At this time, Mr. Ignatz presents with symptoms that in my opinion are most likely related to musculotendinous injury as a result of the blunt trauma sustained in March of 2000. There may be a component of distal radial neuropathy, although he does not have any fixed neurologic symptoms such as numbness, paresthesias, or weakness which would be consistent with this diagnosis. I have suggested Mr. Ignatz resume physical therapy three times a week for three weeks, with the goal of therapy being to address myofascial tightness in the extensor forearm musculature and the brachioradialis muscles, as well as to continuing to progress a strengthening exercise program. I would suggest that Mr. Ignatz undergo electrodiagnostic studies, since it has only been based on clinical criteria previously that he has evidence of a radial tunnel syndrome. I would certainly not recommend proceeding with any type of surgical intervention unless there is definite neurologic compromise on electrodiagnostic studies. At this time, I do not feel Mr. Ignatz could safely resume his regular duty activities as a boilermaker, but would believe he could return to limited duty activities in which he is not required to do any ladder climbing, lifting over 50 pounds occasionally and 25 pounds frequently, and is not required to do any repetitive pronation and supination of his forearm. I agree that the abnormalities located proximally at the radial head are not related to this work-related injury, and I also agree that the arthritic changes noted at the distal, radial, and ulnar joint of his wrist are additionally not related to this work-related injury.

In the next examination report of January 16, 2002, Dr. Cantrell wrote of his review of therapy for Ignatz with the physical therapist and with Ignatz. He will continue on limited duty activities, Dr. Cantrell wrote, and if upon his next appointment his symptoms do not improve substantially we will plan to perform electrodiagnostic studies. Dr. Cantrell wrote the following in a February 12, 2002 report:

These (electrodiagnostic studies) findings suggest that Mr. Ignatz's ongoing pain complaints may be related to a radial neuropathy at the elbow, although a limited needle EMG of the extensor indicis proprius did not reveal any evidence of denervation potentials, suggesting that the pathology at the radial nerve may be that of a local demyelinating process rather than axonal injury. I have suggested that Mr. Ignatz discontinue physical therapy, continue with a home exercise program, and being a trial of a Medrol Dosepak, followed by Vioxx 25 mg. daily. He will remain on restrictions until a follow up scheduled for March 6, 2002.

In his final examination report, dated March 6, 2002, Dr. Cantrell wrote that Ignatz returned reporting continued complaints of pain in the proximal dorsal forearm, with radiation throughout the entire dorsal forearm, and further physical therapy had not altered these subjective symptoms, and the Medrol Dosepak was equally not beneficial. The doctor noted, after examination of Ignatz, that "(H)is pain complaints originate not at the lateral epicondyle specifically, but approximately 2 to 3 cm distally in the dorsal forearm." Dr. Cantrell finally wrote:

At this time, I feel Mr. Ignatz has reached maximum medical improvement in regards to non-surgical care of his pain complaints. He has some electrodiagnostic findings suggestive of a radial neuropathy at the elbow, and I have suggested consideration of a second opinion by a hand surgeon. At this point, no further follow up will be scheduled, and restrictions will be kept in place as before until evaluation by a hand surgeon.

Records of Missouri Bone & Joint Clinic (No. F) included one Office Note by **Dr. Robert J. Bernardi, M.D.**, dated December 5, 2001, which reflected that Ignatz was seen for back complaints. Dr. Bernardi wrote the following:

Mr. Ignatz was seen in the office today, 12/5/01. This 55 year old right handed gentleman works as a boiler maker but he has been off of work since 3-20-00 because of a work related injury to his left arm. He suffered a back injury in the 1970s while at work. He was treated with physical therapy and did well. He returned to work and never lost any more work because of back problems. In July of 2000, he was lifting some boxes at home and over the course of the day became sore in his low back. The next morning he had more severe lower back pain that extended upward to the mid back. About two weeks later he began developing right sided leg pain. This leg pain involved the anterior aspect of his right thigh and extends variably down the knee but only occasionally past the knee. These symptoms have all been persistent. He has had chiropractic treatment and has also had x-rays and a MRI scan performed. He has received acupuncture therapy. He says this helped for about two months. He was evaluated by Dr. David Kennedy in September 2000 and apparently the possibility of a lumbar fusion was discussed. He was subsequently evaluated by Dr. Sprich in Belleville in June of 2001 and again, the possibility of surgery utilizing interbody cages was discussed. Mr. Ignatz tells me that his pain has been getting progressively worse over about the last year. The absolute worst pain is located across the lower back and again radiates up from here to the thoracolumbar region particularly on the right side. It is worse with prolonged standing and walking. He says he really can't walk more than about 100 feet without getting severe pain and having to stop. He ambulates very slowly because of this. He also says going up stairs is very difficult for him. He really doesn't have any buttock pain. He denies any bowel or bladder dysfunction. He has not noticed any focal lower extremity weakness.

Mr. Ignatz has no known drug allergies. His current medications include Lotrel, Toprol, Zocor, Vioxx, aspirin, Allegra, Prilosec, and Levaquin. He has had surgery on his left arm as well as his left eye. He has also had bilateral knee surgery and surgery for hernia repair. His past medical history is notable for coronary artery disease and hypertension. He tells me he has recently suffered a myocardial infection. Review of systems is notable for an inner ear infection. Mr. Ignatz is divorced. He does not smoke. He drinks alcohol occasionally. His work as a boiler maker requires very heavy lifting and bending as well as high climbing.

Dr. Bernardi wrote of his examination findings, and wrote of what plain films revealed:

Plain films of the lumbar spine were reviewed and demonstrate the presence of four mobile lumbar vertebra. The 5th lumbar vertebral is sacralized. At L4-5, a grade I-II isthmic spondylolisthesis is present. There is essentially complete loss of disc height at this segment. At L3-4, there is a compensatory hyperlordosis noted with associated degenerative disc disease. This is manifested by asymmetric anterior splaying of the L3-4 disc space and posterior subluxation of the body of L3 on L4. The remaining lumbar discs are unremarkable.

Dr. Bernardi's written conclusions were:

I have had a long discussion with Mr. Ignatz today regarding his symptoms. Undoubtedly the back pain he describes is related to the changes seen at L3-4 and L4-5 on his plain x-rays. He does not appear to have lumbar radiculopathy. He has a non-focal neurologic examination with no nerve root tension signs. We talked about his various treatment options today. I think surgery certainly is an option for him but at this point I don't think he has exhausted all his non-operative treatment alternatives. I have written him a prescription today for a formal course of physical therapy. He is going to have this done locally. I also think a series of lumbar epidural steroid injections would be a reasonable alternative for him. He would like to have these done locally and I have referred him to Dr. Calvin White in Belleville, IL for the injections. I would like to see him back in the office in four to six weeks. If he is still having significant symptoms at that point, we may have to revisit his surgical options. At that time, we would need to proceed with repeat imaging of the lumbar spine as his previous MRI scan is well over a year old. I would also like to check a set of flexion and extension films. With Mr. Ignatz's history of heart disease we would certainly need to have preoperative cardiac clearance prior to surgery. I have also explained to him that if he did require a lumbar fusion, he would almost certainly have to retire from work as a boiler maker. I don't think he would be able to get back to very heavy lifting, high climbing following such an operation. Mr. Ignatz is going to think all these matters over. We can discuss them again when he sees me back in the office.

The **Missouri Bone & Joint Clinic** record (No. F) included one other record, a March 18, 2002 examination entry by a doctor with the initials DMB. A claim number, an adjuster, and a case manager were noted in the entry. It was written that Ignatz was referred for evaluation for a problem with his left upper extremity. Ignatz states that he first started working for Phillips Getschow Co. in February of 2000, and he last worked there 3-20-00, the doctor wrote. The doctor discussed the March 8, 2000 work related injury and the subsequent treatment Ignatz received. After discussing physical findings and radiologic exam findings, the doctor wrote the following impression/recommendations:

Mr. Ignatz does have some findings on examination and symptoms consistent with radial tunnel syndrome. He also has supportive diagnostic evidence for that diagnosis. He has also had extensive conservative treatment and continues to be symptomatic. It is possible that radial tunnel release may improve some of the symptoms but it would not relieve all of his symptoms. His symptoms related to his elbow are likely related to his previous radial head excision. This would not be related to his injury that occurred to his left forearm. He also has evidence of distal radioulnar joint arthritis of the wrist and some degenerative changes at the radiocarpal joint which would not be related to his injury to his forearm. Mr. Ignatz clearly states that he is not interested in surgical intervention at this time. To address his work ability I would recommend he undergo a functional capacity evaluation. I will see him back after he has obtained his functional capacity evaluation to address his final work status. In the meantime, I recommend he continue with his current work restrictions.

Records of prior treatment included the following:

Records of **Belleville Memorial Hospital** (No. K) consisted of physical therapy treatment notes reflecting physical therapy treatment of Ignatz in 1976 for the diagnosis of low back strain. The first entry of January 2, 1976 noted the following history: "Stocky, well-muscled, young man. Who was pulling on a cable at work which hung up and then came loose suddenly causing him to wrench his back". A March 22, 1976 entry stated that Ignatz was back to work and had some stiffness and soreness after working; in the next entry of March 31, 1976, it was written that Ignatz was feeling better while he was working. The September 20, 1976 entry stated the following: "Pt continuing excellent improvement. Very pleased. Working heard now doing his thins and having minimal difficulties w/just very mild occasional achiness in the leg. Not wearing his back brace." The last treatment entry of October 8, 1976 noted Ignatz' comments that he did some unusually hard work and had some additional tension in the back but the pain and sciatica was still cleared. It was written in the next and last entry, dated January 9, 1977, that Ignatz had not returned for treatment since October 8 1976, and he was considered discontinued.

Records of **Dr. Dale Rosenberg, M.D.** (No. L; See, also No. N)) concerned the treatment of Ignatz beginning in May of 1980 for injuries sustained in a fall from a ladder at home when he was painting. A May 31, 1980 hospital record included an operative report indicating that Dr. Rosenberg performed the procedure of open reduction for a fracture intraorbital rim, orbital floor, zygoma, maxilla/tripod –type fracture. The final diagnosis in the May 1980 hospital records was: Possible contusion of left shoulder, depressed zygoma fracture with fracture of intraorbital rim, the orbital floor, the zygoma, aygomatic arch and maxilla. In a June 1, 1980 consultation report, a Dr. Serot wrote that he was seeing Ignatz for pain in the left elbow area. Dr. Serot wrote:

34 year old white male who fell off a ladder sustaining facial injuries to his left elbow. Dr Rosenberg admitted the patient and operated on his face. However, the patient complaining of pain in his left elbow. Neurovascular supply is in tact. X-rays reveal displaced intraarticular fracture of the radial head.

Dr. Serot wrote that Ignatz was advised of the need for excision of the radial head and that Ignatz might have some residual weakness.

Post-operative entries of Dr. Rosenberg included this July 11, 1980 entry:

There is no diplopia. The occlusion of the teeth is good. The patient's left eye is just slightly wider than the right, very slight. The patient has infra-orbital numbness in the distribution of the infra-orbital nerve to the nose, cheek and lip. The teeth apparently are all right. Hopefully, most of this will regenerate over a period of another six months. He is to return in six months for re-evaluation.

In the next and last entry, dated December 5, 1980, Dr. Rosenberg wrote that Ignatz' occlusion was good, the configuration of the bones is good, but Ignatz still had numbness in the distribution of the infra-orbital nerve on the left side. Since it has gone more than six months now, possibly part of this will be permanent, the doctor wrote.

Records of **Associated Orthopedic Surgeons** (No. M) included the June 3, 1980 operative note which reflected that the procedure of excision of the left radial head was performed by Dr. Serot. The diagnosis was – Comminuted displaced intra-articular fracture of the left radial head. A December 9, 1981 x-ray report concerning the left elbow stated the impression: Most likely non-fused old fracture of radial head. A February 12, 1982 entry was somewhat illegible, but indicated that there was full pronation and supination of the left arm and full extension and flexion of the left elbow.

Records of **Christian Hospital Northeast** (No. O) concerned the May 2-3, 1991 hospitalization of Ignatz. The

written history was:

This is a 45-year-old patient who was admitted to the hospital through the Emergency Room last night with history that while at work that a steel bar slipped on the left arm and then developed a sudden pain over the left shoulder that radiated into the right trapezius muscle and down into the lower back. There were not any other symptoms associated with this pain. It got better soon after but later on when he was trying to hold the scaffold, he developed a more severe pain also localized about the left shoulder and radiated into the left deltoid behind the left upper arm and into the left thoracic area posteriorly. The pain was more severe than before and this time was persistent. After work, he tried to eat but he noticed some mild nausea and became rather warm. As the pain continued, then he started noticing like his chest was getting tight and for this reason he was brought to the Emergency Room. The patient denies any shortness of breath, denies any cough. He denies any recent respiratory infections. He thinks that maybe for the last week he might be having some mild cold and a rather queasy stomach and until this event he was feeling fine and in no distress. He has been working a rather heavy job especially with heavy lifting but did not have any problems until this occurred. When brought to the Emergency Room an EKG was normal but there was an elevated CPK of 293.

The written impression on May 3, 1991 was: appears Ignatz has an acute left shoulder strain involving muscles in the shoulder girdle. It was written that the left shoulder seemed to have full range of motion and it was doubted that this represented any cardiovascular problem, but in view of Ignatz' age of 45 and history of hypertension, a stress test would be done on an outpatient basis. A report of a May 4, 1991 electrophoresis study reflected an interpretation of: No enzymatic evidence of myocardial injury of infarction.

Records of **Dr. James Strickland, M.D.** (No. P) concerned the treatment of Ignatz for a right knee injury sustained when he stepped on some pipe on 4/11/94 twisting his right knee and apparently striking the medial aspect of the knee on a fixed metal pipe when he twisted and fell. Dr. Strickland's diagnosis was: Torn medial meniscus and small non-displaced osteochondral fracture of the medial femoral condyle. An operative report reflected that on June 17, 1984, Dr. Strickland performed on Ignatz the procedure of: diagnostic arthroscopy, chondroplasty of the medial femoral condyle with debridement of meniscal tear. The post-operative diagnosis was: chondral fracture of the medial femoral condyle with loose chondral flaps; small inferior vertical tear of the posterior horn of the medial meniscus, non-displaceable; anterior cruciate ligament injury and insufficiency. The record indicated after a period of immobilization, Ignatz was started in therapy. Dr. Strickland wrote in an October 20, 1994 examination report that Ignatz had minimal problem with just a little bit of swelling when he did a lot of squatting, but there was no swelling on the day of the exam. He can discontinue the work hardening and put him back to work at normal activity, the doctor wrote. In a March 16, 1995 rating report, Dr. Strickland wrote the following:

He has excellent range of motion in his right knee. He is having no locking or catching, but is still having some mild welling (sic) when he is on his legs all day long doing heavy work and a lot of stair and ladder climbing. He, otherwise, seems to be doing reasonably well. He has been working seven days a week, twelve hour days, and he seems to be tolerating this reasonably well. There is no swelling noted on exam. He does have a positive Lachman's test, indicative of the anterior cruciate ligament insufficiency. McMurray's test is normal

Dr. Strickland wrote that he would rate Ignatz at 20% permanent partial disability at the level of the right knee.

A March 5, 1997 Independent Medical Evaluation report by Dr. Strickland concerning a January 30, 1996 work related injury to the left knee was in the record. It was written that Ignatz was injured when he was unloading a load of material and the load shifted causing him to be pushed aside and twisting his left knee; arthroscopic evaluation was performed on April 30, 1996 by Dr. Stephen Benz who found a tear of the medial meniscus and possibly an old tear of the anterior cruciate ligament and chondromalacia of the medial femoral condyle, the doctor noted. Dr. Strickland further wrote:

He was treated with partial meniscectomy and debridement of the anterior cruciate ligament and chondroplasty of the medial femoral condyle. After the surgery the patient had persistent problems with his knee and really has not done well.....

It is felt at this time he is most likely not a good candidate for repeat arthroscopic surgery of his left knee. I have told him that he need to work very diligently on rehabilitating his quads which are still slightly diminished. A cortisone injection may be of some temporary help. Consideration would be for the possibility of partial joint replacement if he does not get better.

At the present time I believe he has a 35% permanent partial disability at the level of the left knee.

Records of **Dr. Stephen Benz, M.D.** (No. R) concerned treatment for a January 30, 1996 work related left knee injury sustained when a load shifted and it twisted the left knee and caused Ignatz to fall over some scrap metal. A MRI scan done on 2/26/96 demonstrated a displaced medial meniscus fragment as well as a complete tear of the anterior cruciate ligament, the doctor wrote. A surgical report reflected that on April 30, 1996, Dr. Benz performed the procedure on Ignatz of: Examination under anesthesia, Diagnostic arthroscopy, partial medial meniscectomy, debridement of anterior cruciate ligament, chondroplasty of medial femoral condyle. The postoperative diagnosis was: torn medial meniscus and anterior cruciate ligament with chondromalacia of the medial femoral condyle. In a July 12, 1996 examination report to the insurance company, Dr. Benz wrote the following:

Mr. Ignatz is a gentleman that is now about two months out from an arthroscopy of the knee. He is back to cutting his grass and climbing ladders. He has a little bit of swelling with that, but otherwise he is doing pretty well.

On examination today he has full range of motion, with no tenderness to palpation in the area of the knee. There is no effusion.

I am going to allow him full activities. He will come back and see me prn. I have released him to go back to full duty.

In a January 6, 1998 letter, Dr. Benz answered the question of whether or not Ignatz would need a partial joint replacement. Noting that Ignatz had sustained a fairly serious injury on January 30, 1996, Dr. Benz wrote that a small lesion he had seen during surgery had progressed as demonstrated by the fact of narrowing of the joint space on standing radiographs, and he suspected that this was a progression of the cartilage damage which occurred at the time of the January 30, 1996 injury, and that may be a need for a partial or a total knee replacement.

Records of **Dr. Gregg Ginsburg, M.D.** (No. S) concerned the surgery performed on February 18, 1998 for a right groin injury. Dr. Ginsburg wrote:

He states that while at work around December 17, 1997, he was carrying a 90 pound door. The other person that was helping him carry this slipped and fell causing him to carry all of the weight. He did feel a sharp pain in his right groin at that time.

An operative report indicated that on February 18, 1998, Dr. Ginsburg performed on Ignatz the procedure of: laparoscopic right inguinal hernia repair. The postoperative diagnosis was: direct right inguinal hernia.

Record of **Dr. Erik Houttuin, M.D.** (No. T) consisted of an April 13, 1998 examination report by Dr. Houttuin in which the doctor wrote that Ignatz had presented with complaints that the pain subsequent to the February 18, 1998 right inguinal hernia repair was the same as it was before the surgery. Since his symptoms are improving I do not want to intervene in any form, specifically I discussed with him injection with steroids, but I would like to wait at least on more month before even considering that, Dr. Houttuin wrote.

Record of **Dr. Christopher Speidel, M.D.** (No. U; See, also No. V) concerned treatment of Ignatz for heart problems beginning in November 1999. In a St. Mary's Health Center Discharge Summary, it was indicated that Ignatz was hospitalized November 13-16, 1999. The history was Ignatz, with no prior history of coronary artery disease had been experiencing episodic chest discomfort for 2-3 days prior to admission. In the Hospital Course of the discharge summary was written the following:

Cardiac catheterization demonstrated an abrupt occlusion of his right coronary artery. This was addressed percutaneously. Immediately after reperfusion, he developed Brady arrhythmias and hypotension. This Brady arrhythmias responded to atropine. However, he remained hypotensive and was placed on intravenous Dopamine.

The discharge diagnosis was: 1. Acute inferior wall myocardial infarction; and 2. History of hypertension. Discharge activities were: no heavy exertion; no lifting more than 5 pounds and no walking more than two blocks at a time. In an 11/29/99 entry, it was written that Ignatz had been informed that he could likely return to work after the first of the year. In the next entry of 01/11/00 it was written that Ignatz had called reporting that he had chest tightness radiating to both arms and nausea. It was noted that Ignatz had just gone back to work today and was at a construction site working when symptoms began, and symptoms are only slightly relieved by rest; it was written that Ignatz was instructed to call 911 and go to the emergency room. Further written in the typed 01/11/00 entry was that Ignatz was pain free in the emergency room, testing revealed no abnormalities, and he was discharged home from the emergency room with a prescription for

sublingual nitroglycerin. In a 01/18/00 entry it was written that a Thallium stress test demonstrated a fixed posterior inferior defect compatible with prior myocardial infarction; it was written that Ignatz was informed of this information and had been informed that he could return to work. The record reflected continued, regular treatment of Ignatz by medication and testing. A 12/28/00 entry noted that Ignatz was in the emergency room with complaints of chest discomfort; it was noted that his evaluation was unremarkable, and his pain had resolved. The next entries of 01/04/01 and 01/09/01 noted that a stress test had been performed and it was felt to be no definite evidence for ischemia. In a 07/13/01 entry, the following was written:

55 year old white male with a history of coronary artery disease and a remote inferior wall myocardial infarction. He is being sent today to evaluate his progress. He is not experiencing any chest wall discomfort suggestive of angina. He continues to have symptoms of a vague type of discomfort associated with jaw numbness which has been a recurring problem for a number of years. That symptom is not related to exertion and prior stress tests performed to evaluate that problem have been normal. He reports that he has recently been diagnosed with asbestosis and occasionally experiences wheezing with heavy activities and environmental exposure. He has conveyed a number of other health related issues including that he believes that he has carpal tunnel syndrome and may be having an operation for that in the near future. He also believes he needs a left knee replacement. I informed him that in light of his favorable stress test approximately six months ago I would expect that his risks for those types of surgical procedures would not be increased.

The diagnosis on 7/13/01 was: 1. Coronary artery disease; 2. Hypertension; 3. Asbestosis; and 4. Hyperlipidemia. Treatment recommendations were to continue current medications, and a stress test in six months. Medications Ignatz was taking were listed: Vioxx, Meridia, Lotrel, Zocor, TOPROL, Aspirin, Prilosec, and Allegra. In a 01/10/02 entry it was written the Ignatz had been having a little bit more nonexertional chest discomfort; medication was administered, and a stress test was scheduled. Dr. Speidel wrote in the 01/16/02 entry: Stress test reports to demonstrate a subtle reversible defect involving the inferior segment. This stress test as a whole has previously demonstrated a relatively fixed inferior defect and therefore I have suspected the most recent interpretation may not represent ischemia, but please obtain the images from this thallium stress test for me to review". In the next entry of 01/18/02, Dr. Speidel wrote:

Thallium stress test images are now available for review. The subtle inferior reversible defect identified by the radiologist is apparent on the images. There is a non-transmural partially reversible defect. The patient will be contacted later today. If he is having any type of chest discomfort then we will make arrangements for him to undergo cardiac catheterization and possible angioplasty.

The doctor further wrote in the 01/18/02 entry that he had relayed to Ignatz the findings on the stress test which he would characterize as a new abnormality. Dr. Speidel further wrote:

I informed him that although the finding was new it was not markedly abnormal and that the one course of action would be conservative in which close clinical follow-up and repeat stress testing would be appropriate. He reminded me at the time of his initial presentation with his myocardial infarction he apparently presented with sudden cardiac death which required CPR. In light of that, it seems most appropriate to proceed with left heart catheterization with possible revascularization.

In a 01/22/02 entry, Dr. Speidel wrote that Ignatz had undergone cardiac catheterization that day and the study demonstrated no significant epicardial coronary disease with no significant in-stent restenosis. It is felt that his stress test likely represents a false result. His LV function is at the lower limits of normal. I have advised him to continue all his regular medications. Follow-up appointment with me in six months. The last document in the record was a report of the 01/22/02 cardiac catheterization performed on Ignatz by Dr. Speidel was in the record and noted the following impression: 1. Normal left ventricular systolic function without wall motion abnormalities; and 2. Mild epicardial coronary disease.

Dr. Robert Margolis, M.D. testified on behalf of the claimant. (No. A). Board certified in internal medicine and in neurology, Dr. Margolis testified as to his opinions:

"My opinion included that as a direct result of the incident that occurred while in the course of his normal employment on March 8th, 2000, this patient suffered a contusion to his left forearm. This resulted in contusions to the lateral epicondyle, brachioradialis muscle, and he also developed a radial tunnel syndrome. This was supported by an abnormal nerve conduction study as documented in the records. And because of this injury, I felt that this patient had a permanent partial disability of 25 percent of his left upper extremity at the level of the elbow. This patient, with a known history of a radial head fracture that was treated surgically, I believe has a pre-existing

disability of 35 percent of his left upper extremity at the level of the elbow. I felt that the two elbow disabilities were synergistic. This patient has degenerative disease of his low back. He has ongoing complaints, and the documentation was made radiographically in regard to the appearance of his spine. I feel that because of this, a 25-percent permanent partial disability of his person as a whole exists. He's had a prior surgery on his right knee as indicated in my report. For this, I felt that the patient has a 45-percent disability of the right lower extremity at the level of the knee. And the same is true for the left knee where he's had prior surgery. I feel that 45-percent permanent partial disability at the level of the knee is in place there as well. I felt that all of his disabilities combined to create a greater disability to his person as a whole and create the simple sum and, therefore, it was my opinion that a loading factor should be added. I felt that all of his disabilities were hindrances and obstacles to obtaining and maintaining of employment. I did feel that some restrictions were appropriate to include, in regard to his left arm, repetitive reaching and grabbing and limited one-arm lifting of 15 pounds. I felt in regard to his knees that he should avoid repetitive squatting and kneeling and that he should avoid ladder and step climbing. In regard to his low back, I felt that repetitive bending, twisting, and stooping should be avoided, and he should limit lifting to 25 pounds frequently and 40 pounds occasionally. I also felt that this patient, because of all of his disabilities was permanently and totally disabled from his prior employment as a boilermaker. And because of multiple factors, including his disabilities, age, work experience, education level, I did not feel that this patient was employable in the open labor market. However, I would, of course, defer to a vocational rehabilitationist as I do not hold myself out to be one. And I did not feel that there was any significant disability in regard to the asbestosis, coronary artery disease, as well as prior hernia repairs. And that, of course, references not crossing the threshold. I didn't imply that there wasn't 'a' disability, just not a significant disability. And those are my opinions." (Margolis Dp. pp. 5-7)

On cross examination by the Second Injury Fund, Dr. Margolis agreed that he saw Ignatz on February 11, 2003 and his evaluation report was dated March 30, 2004; the doctor agreed his evaluation was three years after Ignatz' primary left arm injury. The doctor was asked if he was aware of Ignatz' specific job duties prior to the left arm injury. Dr. Margolis answered:

"Well, it was my understanding he was a boilermaker, and that's a fairly physical job to my understanding and requires heavy lifting and welding and inside work and outside work, and it's pretty intense." (Margolis Dp. pg. 9)

Dr. Margolis agreed that as far as he was aware, Ignatz was working full time in this occupation leading up to his left arm injury. The doctor agreed that the restrictions he had recommended were the ones he thought Ignatz should be under. The doctor was asked to tell the date of the last medical treatment record regarding Ignatz' back prior to March of 2000 he had; did he have Dr. Bernardi's report of December 2001. Dr. Margolis responded: "Yeah. It's dated December 5th of '01." (Margolis Dp. pg 12) The following testimony occurred:

Q. And at that time, Dr. Bernardi takes a history, and this is, let's see, the third and fourth sentences of the report that Mr. Ignatz has suffered a back injury in nineteen – in the nineteen seventies. He was treated with physical therapy and did well. He returned to work and never lost any more work because of back problems

A. That's what this says, yeah.....

Q. And does that give any history anywhere in there about any back treatment after the nineteen seventies?

A. Dr. Bernardi did not offer any comments in regard to that.

Q. Alright. And he then also took a history at that time of a July, 2000, low back injury; is that correct?

A. That's right.

Q. And the ongoing pain and problems he had resulting from that injury; is that correct?

A. That's right.

Q. In forming your opinion of his disability, did you take into consideration the complaints he gave to you on the date of your exam in 2003?

A. Well, I took into consideration the complaints he gave me; plus I also took into consideration what the appearance of his back is by imaging. And in the same report from Dr. Bernardi, he talks about the severity by description of this man's low back. And that -- those are the kind of changes that don't occur overnight....

Q. Says he did well and returned to work and lost no more time.

A. That doesn't mean he didn't have any symptoms. I work with back pain every day of my life.

Q. But according to your report, the history he gave – And by "he," I mean Mr. Ignatz gave to you was that he had back pain on a level of 10 out of 10 and couldn't walk greater than one block, is that correct?

A. At that time that I saw him, those were his complaints, that is correct.

Q. Do you know what his complaints were in March of 2000?

A. No. I didn't see this patient in March of 2000.

Q. So but you took his complaints into consideration in forming your opinion of his disability, is that correct?

A. Well, that's right. Because I think that his back complaints are a continuum of his disability and continuum of what's going on in his back and what his back looked like on the neuroimaging that I was given to review.

Q. But his symptoms have increased; is that correct?

A. Well, but that's why it's a permanent disability, Jennifer. I mean, you know, back problems progress over time. They're a degenerative process, and as the back is disintegrating or the discs start degenerating, there's new bone being laid down. There's new things being pressed on. There's new inflammation, and it's a continuum. That's what makes it a permanent disability.

Q. So basically every year or every other year or every few months, some degree of time, his back's going to continue to get worse and worse; is that correct?

A. Yeah. If I saw this man in six months and if I re-evaluated him, I may give him a higher disability.

Q. Would it be true if you had seen him in March of 2000, you might have given him a lower disability in regards to the low back?

A. It's speculative within a certain window.....

Q. And you didn't have any records – treatment records regarding the low back dated anywhere around that time; is that correct?

A. That's correct. But at the same time, if you extrapolate out and you, you know, reference the fact that this patient was studied, you know, in December of 2001, you know, with some imaging of his low back and that he had such significant changes in his low back in December 2001, which is only six months, seven months.

Q. A year and a half.

A. Oh, it was March of 2000. I'm sorry. You're correct. I -- I apologize.

Q. That's okay.

A. I was taking it as March, 2001. But still a year and a half is not enough time to develop those kind of severe degenerative changes, even if you were a hockey player being slammed into the boards every day of your career. I mean, it – (Margolis Dp. pp. 12-13; 14-15; 16)

The doctor admitted that he did not know how much Ignatz was lifting on a daily basis in March of 2000, or how many hours a day Ignatz was working in March 2000; or how many hours a day in March 2000 Ignatz was standing, sitting, squatting, walking, or climbing. Dr. Margolis further stated: "Specifically, no. But as a full-time boilermaker who's working full time, I would think he works a minimum 40 hours." (Margolis Dp. pg. 17) Dr. Margolis stated that at the time he evaluated Ignatz in February 2003 he did not ask Ignatz the specific question if his back symptoms had gotten better, worse or stayed about the same since he had stopped working in March of 2000; the doctor stated that at the time he evaluated Ignatz in February 2003 he did not ask Ignatz the specific question if the conditions of his left and knee and the pain he had in his knees had gotten better, worse or stayed about the same since March of 2000. The doctor was queried, wasn't it correct that in regards to the back he had based his opinion of disability on the medical records he had reviewed, his physical examination of Ignatz in February of 2003 and Ignatz' complaints in regards to his back in 2003? Dr. Margolis answered: "That's correct. But don't forget to include in there my experience as a physician and my knowledge of low backs and what happens to them over the course of time." (Margolis Dp. pg. 18) Agreeing that what Ignatz has in his low back is a degenerative condition that has and is going to continue to increase over time, Dr. Margolis further testified: "I think it would have had to because of the severity of his changes. Those kind of things don't stop. They don't arrest. Even if you stop working." (Margolis Dp. pg. 19)

Dr. Margolis agreed, during cross examination, that it was Ignatz' relayed history to him that prior to his March 2000 left arm injury his left arm was symptom free. After reviewing his report, Dr. Margolis further testified: "He was symptom free in regard to his prior injury which he said was an epicondylitis. But in my review of the records, that was a radial head fracture." (Margolis Dp. pg. 21) The doctor agreed, though, that either way, Ignatz said he was symptom free in the left arm leading up to March 2000.

Samuel Bernstein, Ph.D. testified on behalf of the claimant. Dr. Bernstein stated that he evaluated Ignatz on the claimant's behalf and that he prepared a report dated April 8, 2003. At Dr. Bernstein's deposition, the report was admitted into evidence without objection (See Bernstein Dp. pg. 6); the report was offered into evidence at the hearing as Exhibit No. D. In the Medical History section of his report, Dr. Bernstein discussed the treatment and testing Ignatz underwent in regards to the March 8, 2000 work related left forearm injury. Prior injuries were discussed by Dr. Bernstein, including that Ignatz had suffered a heart attack on November 13, 1999; Dr. Bernstein also noted the following about the heart problem:

Dr. Speidel has indicated that he should be careful with activities, and he has prescribed Lotrel, 520 capsule 241, once a day, and Toprol, XL, 100 mg., once a day, and a 325 mg., aspirin a day; the medicine sometimes causes dizziness. Mr. Ignatz sees the doctor for following at least every six months for examination and stress tests.

In terms of his heart problems, he finds that he fatigues much easier. He also suffers angina pain every day. He carries nitroglycerin around the clock as a precautionary measure. When this pain occurs, he has to stop his activity, but he takes the nitroglycerin only when the pain becomes severe; he indicates that he has only taken this medication three or four times during the past couple of years. As indicated previously, he tries to refrain from taking the medication unless it is absolutely necessary.

Concerning a prior back injury, Dr. Bernstein wrote the following:

In the mid 70's he suffered an injury to his tail bone and lower spine. He underwent physical therapy and returned to work even though he had pain from time to time, particularly with bending and torsional motions. He tells me today that his back problems have increased and doctors have recommended a surgical fusion. However, there is concern about performing the prolonged surgery because of risks related to his heart condition and his age.

In his summary discussion, Dr. Bernstein wrote the following:

Mr. Ignatz indicates that his main problems today relate to fatigue and pain when trying to use the left upper extremity, as well as pain with sitting, standing, and bending because of the back. He has problems with his knees with any weight bearing activities. He also has trouble with kneeling and crouching. He is also bothered by cold and dampness.

At the deposition, Dr. Bernstein testified as to his vocational and psychological conclusions in regard to Ignatz

“Well, there’s the – The conclusion is clear. First of all, he’s unemployable in the open competitive labor market. And there-- It’s due to a combination of reasons. First of all, you’re talking about someone – Well, actually 2003, so he’s 58 years of age. He is definitely of advanced age from an employment point of view. He’s essentially done heavy labor work, so he brings that to the table. He’s not gonna be professional, clerical, technical type of worker. Now, you add to that which he brings to the table, he has a combination of impairments. These impairments include back injury, crushed right foot injury, hernia problem, a left shoulder injury, a right knee injury, left knee injury. In addition to all those orthopedic problems, the forearm injury, which was the last injury. And then in addition to that, he’s undergone angioplasty and stint insertion. He’s also a diabetic. You put all that together and how it affects him, he’s unemployable – unemployable. He would have problems carrying out any work activities because of fatigue related to the heart. In terms of the orthopedic problems, he’s affected with bending, torsional motions, walking, crouching, kneeling, climbing. He’s affected in terms of use of the upper extremities. Now, so you put all those things together, there’s no way he would be hired, nor could he carry out substantial gainful work activities on a consistent and persistent basis. Those are the reasons why he is unemployable in the open competitive labor market.” (Bernstein Dp. pp. 4-5)

On cross examination by the Second Injury Fund, Dr. Bernstein agreed that he saw Ignatz on the one occasion in April 2003, and it was on the claimant’s own behalf. Dr. Bernstein stated that testing, Ignatz is okay cognitively; cognitively and psychologically those are not factors, his problems are “(O)rthopedic and the heart”, Dr. Bernstein said. (Bernstein Dp. pg. 8) Dr. Bernstein was asked how he would classify Ignatz’ job duties as a boilermaker. He answered: “It’s heavy duty stuff. Real heavy duty stuff.” (Bernstein Dp. pg. 8) When queried, wasn’t he working in performing all of the duties of a boilermaker up until the time of the last injury, Dr. Bernstein responded: “He was with – You know, he had pain from time to time, but he was doing his work, yes.” (Bernstein Dp. pg. 8) Dr. Bernstein stated that he did not know how many hours Ignatz was working in general at the time of his primary injury, but he thought it was full time. Agreeing that Ignatz’ job as a boilermaker leading up to the March 2000 injury included bending, Dr. Bernstein stated: “Included everything. As I said it’s heavy duty.” (Bernstein Dp. pg. 9) He was asked if he had asked Ignatz if his conditions - including heart, back, knees – had gotten better, gotten worse, or stayed about the same since he stopped working in March of 2000. “I don’t have anything on the here”, Dr. Bernstein responded. (Bernstein Dp. pg. 10) “Well, if I had asked it, it would be included, yeah”, he admitted, so “I didn’t” ask. (Bernstein Dp. pp. 10 and 11) Dr. Bernstein acknowledged that the restrictions imposed or implied by the functional capacity exam of October 31, 2001, would put Ignatz at the medium category. “Well, based on the lifting alone”; “But nothing else”, Dr. Bernstein further noted. (Bernstein Dp. pg. 14) Bernstein noted that the medium category was lifting up to 50 pounds. Concerning the second functional capacity exam at Providence, Dr. Bernstein noted: “Well the ones at Providence showed basically the same results”; “That’s about medium, sure”. (Bernstein Dp. pp. 17 and 18)

Dr. Bernstein was asked, during cross examination, with the March 2003 left arm injury alone would Ignatz be capable of returning to his job as boilermaker. "I would say he'd have difficulty", Dr. Bernstein answered. (Bernstein Dp. pg. 19) He explained: "Because as I said, a boilermaker is heavy duty work. It involves the use of both extremities. It involves climbing, all those things." (Bernstein Dp. pg. 19) He was asked if Ignatz had any transferable skills, and Dr. Bernstein answered:

"Some to the mechanical area, yes."

"Well, he could do certain assembly type things. He could do welding as an example, because boilermakers do use – They do welding. There's some pipefitting involved. He could do things like that." (Bernstein Dp. pp. 19 and 20)

Dr. Bernstein was queried about whether or not Ignatz was, at the time of his March 2000 injury, approaching advanced age but not advanced age. When I saw him Ignatz was 57 years old, Dr. Bernstein stated; it was noted that Ignatz was injured back in 2000, and Dr. Bernstein responded – "When I saw him – I did it as of the date I saw him." (Bernstein Dp. pg. 21) Dr. Bernstein agreed that on the day of Ignatz' March 2000 injury he was in the category of approaching advanced age, which is 50-54 years of age. Dr. Bernstein was asked if he would defer to a medical doctor in regards to what restrictions exist and what percentage of disability Ignatz should be given, and he responded: "Yes. They do that. I don't. I make conclusions on what they can and cannot do from a work point of view." (Bernstein Dp. pg. 22) He was queried – would you defer to a medical expert as to what restrictions should be imposed on Ignatz. Dr. Bernstein answered: "Yeah. But I'd give greater weight to the treating doctors, yes." (Bernstein Dp. pg. 22)

James M. England, Jr. testified by deposition on behalf of the Second Injury Fund. (No. 1) England stated that in his profession, vocational rehabilitation counselor, I defer to doctor's restrictions and limitations in regards to physical injuries, England agreed. He was further queried if this was something he felt as a vocational expert that he was qualified to impose restrictions or infer restrictions. England answered:

"No. I mean, and that's true whether it involves forensic rehab or just regular vocational rehab. Part of the profession involves reviewing medical reports and records to see what the doctors indicate the person's specific restrictions are, and then taking those into consideration and looking at what effect that has on the person's ability to work." (England Dp. pg. 7)

England agreed restrictions were imposed on Ignatz by physicians in this case, and he had listed and summarized them in his report. England testified as to his ultimate conclusion regarding Ignatz' employability:

"Well, it really kind of came down to looking at and making various assumptions. In other words, based on what Dr. Brown had indicated, there would be no contraindications to the man going back to doing what he was doing before.....He was working as a boilermaker."

"There are other restrictions, however, and that would include both the restrictions recommended by Dr. Cantrell and as well as the restrictions recommended by Dr. Margolis. Those, I think, would really limit the man more to a medium level of exertion which would prevent him from being able to go back to doing the kind of work that he did before as a boilermaker, because that went into the heavier range of exertion rather than medium.

Assuming that he is limited to no more than the restrictions then of Dr. Margolis or Dr. Cantrell, he would not be able to be a boilermaker. But I think within a medium level of exertion there would still be some welding jobs. Because welder, as it's defined in the *Dictionary of Occupational Titles*, is a medium job in many instances, so there would still – he would still have the ability to do that. But I think even limiting him down more, I mean, say, if the best he could do was sedentary to light kinds of employment, I think there's still alternative work that a person like this could do.

We have a gentleman who's apparently retained information that he's learned quite well. He's still able to read and do math, and particularly the math, at a high school level years and years after he was in a formal academic environment. In addition to high school, he has college, some college training. I think about two years of college. And I think with the knowledge that he acquired in the past combined with his education, I think we could look at related work of either sales involving calling on contractors with welding supplies. He would be a good person for that kind of a position. And I think an instructor in a welding school would be another good type of job to put a guy like this into if he had an interest in doing it and based upon the physical restrictions that Dr. Cantrell or Margolis talked about.

So I think regardless of what medical I looked at here, it still appeared to me that he would be employable. It's just to what degree as far as the physical involvement. But the least talked about in the medical, I think, would still have him functioning up to a medium level of exertion." (England Dp. pp. 7-9)

England explained the requirements for a medium level of exertion:

"Medium level exertion normally involved 40 to 50 pounds occasionally and 20 to 25 pounds frequently. And, I mean, that's essentially what the cutoff is and 50 would be the maximum under medium. And then if you go over that, then you're up into the heavy range of exertion which goes up to 100 pounds occasionally." (England Dp. pg. 10)

It was noted that in his report England had listed some of the activities Ignatz had described as having to perform as a boilermaker, and England was asked how would a job of a boilermaker be categorized:

"That would be a heavy job because there were times that he had to lift over 50 pounds. And it would be a heavy job as far as how he had to perform it and then how it's normally performed out there in the labor market." (England Dp. pg. 10)

England agreed that from his review of the records and deposition, it appeared that Ignatz was performing all of the job duties of a boilermaker leading up to his March 2000 injury.

At his deposition, England's February 11, 2005 evaluation report was admitted into evidence without objection (See, England Dp. pg. 6). England included the following in the Summary and Conclusions section of his report:

Mr. Ignatz is a 59-year-old gentleman who has a very steady and well-established work history as a boilermaker.

He indicated that he chose to retire because he no longer felt physically able to do his prior line of work. Some doctors have agreed with that opinion while at least one has indicated that he believes the man could go back to his regular job....

There are no medical restrictions indicated by the doctors in this file that would lead me to believe that this man is totally disabled from all types of work activity.

On cross examination by the claimant, England agreed that he was retained by the Second Injury Fund for an expert opinion in this case. He agreed that other than reading the April 2003 deposition of Ignatz he had never spoken to Ignatz. England agreed that his opinions about Ignatz' employability are based solely on his review of the medical records and Ignatz' deposition. England was queried, isn't it true that if Ignatz testified about subjective problems that prevent him from doing things like sitting for long periods of time and standing for long periods of time, he did not take those into consideration in his opinions. England responded:

"Well, no, actually, if you look at the end of my report, I talked about even assuming if he were limited to a job where he needed to sit for awhile, stand for awhile, which would be in the sedentary to light range. I still think that – that's what I was talking about before with the welding supply sales, being an instructor at a welding school, or even entry-level service employment, that would allow for flexibility for sitting for awhile, standing for a while and not really having to bend over and do much physically. It would be a more of a cerebral job than it would be a physical." (England Dp. pg. 14)

England admitted that he had assumed a hypothetical inability to stand and sit for prolonged periods of time, testifying: "I didn't have any specific parameters beyond that, no." (England Dp. pg. 15)

During cross examination, England was queried wasn't it correct that Ignatz was out of his lifelong profession of a boilermaker as a result of his work injuries. England responded:

"Well, he's out of that particular aspect of it. I think with what Dr. Margolis or Dr. Cantrell, either one, I think there's still some bench welding things that would be very closely related to what he did before that would still fall in a medium range of exertion." (England Dp. pg. 17)

He was questioned about his earlier testimony and whether or not he was talking about Ignatz being an instructor at a union hall or something like that. England answered:

“That’s one possibility. Another possibility would be between North County Tech, South County Tech, Vatterot, there are a number of propriety schools also that train people to be welders that would hire someone that doesn’t have to have a degree. They just want the actual practical knowledge to come in and teach people how to weld. That’s the kind of thing we’ve done with HVAC people and plumbers, a number of different trades.” (England Dp. pg. 18)

Agreeing during cross examination that it was his opinion that Ignatz is capable of doing a medium level of exertion in the open labor market, meaning forty hours a week, England testified: “Based on either Margolis or Cantrell on what they indicated as far as what they thought he could do physically.” (England Dp. pg. 33) England was queried – isn’t it true that with a welder job that Ignatz may or may not be able to do he would have to have some accommodations to do this job. “No., no -- Assuming that he could do medium work, that’s what welding is normally described as in the *Dictionary of Occupational Titles*. So if he could do a medium level of work, then he should be able to do welding.” (England Dp. pp. 33-34) (**Ruling:** Second Injury Fund’s objection is overruled. England Dp. pg. 33) England agreed that most employers would not be open-minded about hiring somebody who needed to lay down and rest from time to time during the day.

On redirect, England agreed that while he did not do any testing himself on Ignatz, he did rely on and review the vocational testing done by the claimant’s own vocational expert, Samuel Bernstein. In his review of the records and depositions, no doctor imposed on Ignatz any physical restriction on his ability to sit or stand, or imposed a restriction of lying down during the day, England agreed. Agreeing that from his review of the records and depositions, after every one of Ignatz’ pre-existing injuries Ignatz returned to his same heavy-labor job as a boilermaker, England stated: “That’s what he indicated, that he was still working full-time and overtime with doing the same kind of work up until the time of the primary injury.” (England Dp. pg. 38) Before March of 2000, England agreed, Ignatz’ job as a boilermaker involved being on his feet a lot during the day, involved being in awkward positions. England stated that in Ignatz’ job as a boilermaker he would not have been able to lie down during the day. He agreed that physically the boilermaker job involved squatting, twisting, bending, standing, lifting, kneeling, caring, climbing, working overhead, pushing and pulling. England agreed that according to Ignatz’ deposition and the medical, Ignatz continued to work at the boilermaker job leading up to March of 2000 and was working more than forty hours a week.

During redirect, England was asked – with just the restrictions by Dr. Margolis and Dr. Cantrell would Ignatz be able to return to his regular job duties as a boilermaker. “I don’t think as a boilermaker, no”, England answered. (England Dp. pg. 41) “I think he could as a welder but not as a boilermaker”, England added. (England Dp. pg. 41) England was queried – on page 6 of his report and during cross examination he was talking about Dr. Bernardi descriptions of the low back problems and complaints Ignatz had, and wasn’t the date of Dr. Bernardi’s report December of 2001, which was approximately a year and a half after Ignatz’ March of 2000 injury. England’s response was – “Correct”. (England Dp. pg. 43) England stated that from his review of the medical records and the restrictions there was no one indicating that because of Ignatz’ March 2000 left arm injury he would need to lie down during the day because of pain, or any doctor who imposed any restrictions on Ignatz’ ability to sit or stand because of the March 2000 work injury.

On recross examination, England was queried – didn’t Dr. Margolis give the opinion that Ignatz could not work in the open labor market? “Well, he said that he thought it would totally disable him, but then he also said that he would defer to a rehabilitation counselor as to what would be out there”, England responded. (England Dp. pg. 44) It was noted that Dr. Margolis stated – “it is my opinion that based upon this patient’s disabilities and as well as his age, work experience and educational background, that the average employer would not hire him in the normal course of business”. When queried – that’s an opinion you don’t agree with, England answered – “Correct”. (England Dp. pg. 45) England was further questioned if the kind of work he was opining that Ignatz could do is physical or labor jobs and not computer jobs, and England responded:

“No. I’ve listed jobs in the report that go all the way down to sedentary to light work with a sit-stand option. The sales would certainly be a light job, the instructor position would be a light job. The only things that I think would be medium would be to go back to some form of bench welding, but it would be the only thing that would require a medium level of exertion.” (England Dp. pg. 46)

It is found that in this case, there are disagreements among the expert opinions on permanent disability for the claimant, Ignatz, in regards to Second Injury Fund liability. The parameters for Second Injury Fund liability is set forth in Section 287.220 RSMo 1998, and states, impertinent part:

1. All cases of permanent disability where there has been *previous disability* shall be compensated as herein provided. Compensation shall be computed on the basis of the average earnings at the time of the last injury. If any

employee who has a *preexisting* permanent partial disability whether from compensable injury or otherwise, of such seriousness as to constitute a hindrance or obstacle to employment or to obtaining reemployment if the employee becomes unemployed, and the *preexisting permanent partial disability*, if a body as a whole injury, equals a minimum of fifty weeks of compensation or, if a major extremity injury only, equals a minimum of fifteen percent permanent partial disability, according to the medical standards that are used in determining such compensation, receives a subsequent compensable injury resulting in additional permanent partial disability so that the degree or percentage of disability, in an amount equal to a minimum of fifty weeks compensation, if a body as a whole injury or, if a major extremity injury only, equals a minimum of fifteen percent permanent partial disability, caused by the combined disabilities is substantially greater than that which would have resulted from the last injury, considered alone and of itself, and if the employee is entitled to receive compensation on the basis of the combined disabilities, the employer at the time of the last injury shall be liable only for the degree or percentage of disability which would have resulted from the last injury had there been no preexisting disability. After the compensation liability of the employer for the last injury, considered alone, has been determined by an administrative law judge or the commission, the degree or percentage of employee's *disability that is attributable to all injuries or conditions existing at the time the last injury was sustained* shall then be determined by that administrative law judge or by the commission and the degree or percentage of disability *which existed prior to the last injury* plus the disability resulting from the last injury, if any, considered alone, shall be deducted from the combined disability, and compensation for the balance, if any, shall be paid out of a special fund known as the second injury fund, hereinafter provided for. If the *previous disability or disabilities*, whether from compensable injury or otherwise, and the last injury together result in total and permanent disability, the minimum standards under this subsection for a body as a whole injury or a major extremity injury shall not apply and the employer at the time of the last injury shall be liable only for the disability resulting from the last injury considered alone and of itself; except that if the compensation for which the employer at the time of the last injury is liable is less than the compensation provided in this chapter for permanent total disability, then in addition to the compensation for which the employer is liable and after the completion of payment of the compensation by the employer, the employee shall be paid the remainder of the compensation that would be due for permanent total disability under section 287.200 out of a special fund known as the "Second Injury Fund" hereby created..... (Emphasis added)

On its statutory face and recognized by case law, a claimant is not entitled to Second Injury Fund compensation for a post-accident worsening of a preexisting disease where worsening is not caused or aggravated by the primary work related injury. *See, generally, Lawrence v. Joplin R-VIII School Dist.*, 834 S.W.2d 789, 793 (Mo.App. S.D. 1992) in which the Court stated: "The Second Injury Fund provides compensation for previously existing disabilities, not increased disabilities caused by post-accident worsening of pre-existing diseases when that worsening was not caused by or aggravated by the last injury."

The permanency of a disability must be shown with reasonable certainty. *Grigs v. A.B. Chance Co.*, 503 S.W.2d 697, 703 (Mo.App. W.D. 1973). Expert testimony regarding permanent percentage of disability from an injury is necessary for award of permanent disability benefits. *See, generally, Miller v. Wefelmeyer*, 890 S.W.2d 372, 376 (Mo.App. E.D. 1994). "A medical expert's opinion must have in support of it reasons and facts supported by competent evidence which will give the opinion sufficient probative force to be substantial evidence." *Pippin v. St. Joe Minerals Corp.*, 799 S.W.2d 898, 904 (Mo.App. S.D. 1990).

In this case, there are medical records reflecting treatment the claimant received for injuries to his left knee, right knee, a hernia, left shoulder, low back, orbital fractures, left radial head fracture, left shoulder and heart problems prior to the March 8, 2000 work related left forearm injury. There are medical records reflecting treatment subsequent to the March 8, 2000 work related injury for back complaints and for the heart condition. Subsequent treatment records concerning the back are those of Dr. Bernardi of Missouri Bone & Joint clinic (No. F) and a Dr. Lin of Anderson hospital (Se, No I). In his December 5, 2001 record, Dr. Bernardi notes a July 2000 back injury Ignatz sustained from lifting some boxes at home which resulted in more severe lower back pain; the doctor wrote of the symptoms Ignatz relayed he began having two weeks after the July 2000 injury which had been persistent; Dr. Bernardi wrote of other treatment Ignatz stated he had had for his back, including an evaluation by Dr. Kennedy in September 2000 and an evaluation by a Dr. Sprich in June of 2001 and that Ignatz stated his back pain had been getting progressively worse over about the last year; Dr. Bernardi wrote of findings revealed on x-rays he took on December 5, 2001, and wrote – "Undoubtedly the back pain he describes is related to the changes seen at L3-4 and L4-5 on his plain x-rays"; Dr. Bernardi wrote in December 2001 that he certainly thought surgery was an option for Ignatz. The record of treatment to the claimant's low back prior to the March 8, 2000 work related injury was the Belleville Memorial Hospital record (No. K) which reflected physical therapy treatment given to Ignatz beginning in 1976 for the diagnosis of low back strain. The March 22, 1976 entry stated that Ignatz was back to work; the September 20, 1976 entry stated that Ignatz was continuing excellent improvement and was very pleased, and was working hard now doing his thing and having minimal

difficulties; the last entry of January 9, 1977 stated that Ignatz had not returned for treatment since October 8, 1976, and Ignatz was considered discontinued. It is found that the subsequent records of treatment in regards to the claimant's low back indicate a worsening of his back condition. There is no medical opinion that the March 8, 2000 work related injury caused the worsening of the claimant's low back condition.

The claimant offered the expert medical opinion of Dr. Margolis on the extent of permanent disability in regards to the primary, or work related, injury, as well as on preexisting injuries and conditions. Dr. Margolis admitted that in his assessment of permanent disability in regards to Ignatz' preexisting injuries and conditions, he took into consideration the claimant's complaints in regards to those injuries and conditions as of his examination of Ignatz on February 11, 2003, almost three years after the March 8, 2000 work related injury. Dr. Margolis stated that the nature of Ignatz' pre-existing back problems was that it would progress over time and would continue to get worse into the future; the doctor stated that he extrapolated back as to what type of problems Ignatz would have had in his back from the medical records and studies of December 2001, but admitted that he was taking March of 2001 as the date of the primary injury rather than the correct date of March of 2000; the doctor admitted that he was aware Ignatz was working as a full time boilermaker at the time of his March 2000 injury, and that boilermaker work was a fairly physical job that required heavy lifting and welding, and inside and outside work. Dr. Margolis admitted that he did not ask Ignatz at the February 11, 2003 exam if his preexisting back condition or his preexisting left and/or right knee injuries had gotten better, worse or stayed the same since the March 2000 primary injury.

Expert vocational rehabilitation counselor opinions were in evidence for both the claimant (Samuel Bernstein) and for the Second Injury Fund (James England). Bernstein opined that Ignatz was unemployable in the open labor market, and based his opinion in part on the back problems Ignatz relayed to him at the April 8, 2003 evaluation; Bernstein noted such things as – “He tells me today that his back problems have increased and doctors have recommended a surgical fusion.” Bernstein admitted that he did not ask Ignatz if his conditions - including heart, back, knees – had gotten better, gotten worse, or stayed about the same since he stopped working in March of 2000. Bernstein admitted that Ignatz was working performing all of his duties as a boilermaker up until the time of the March 8, 2000 injury; Bernstein noted that boilermaker work was “real heavy duty stuff”. Bernstein acknowledged that two functional capacity evaluations of Ignatz in 2001 both indicated that Ignatz was functioning at a medium work demand level in regards to the left upper extremity. Bernstein noted that the medium category for lifting was up to 50 pounds. When queried, Bernstein stated that he would defer to a medical doctor and a medical expert in regards to what restrictions exist for Ignatz; Bernstein, however, made no comments as to what role restrictions recommended by any doctor in the case played in reaching his opinions. It is found that the evidence reveals the medical opinions on restrictions for Ignatz are: a. Dr. Boyer (No. G) on 11/13/01 released Ignatz with the following restrictions - carry a maximum of 60 pounds, unable to climb ladders and unable to perform lifting tasks with the left upper extremity; b. Dr. Cantrell (No. J) on March 6, 2002 released Ignatz with restrictions of - “I do not feel Mr. Ignatz could safely resume his regular duty activities as a boilermaker, but would believe he could return to limited duty activities in which he is not required to do any ladder climbing, lifting over 50 pounds occasionally and 25 pounds frequently, and is not required to do any repetitive pronation and supination of his forearm”; and c. Missouri Bone & Joint Clinic/Dr. DMB (? Dr. Brown?) March 18, 2002 record (No. F) – “To address his work ability I would recommend he undergo a functional capacity evaluation. I will see him back after he has obtained his functional capacity evaluation to address his final work status. In the meantime, I recommend he continue with his current work restrictions.” England noted that he defers to doctor's restrictions and limitations in regards to physical injuries. Stating that a vocational expert was not qualified to impose restrictions or infer restrictions, England testified: “Part of the profession involves reviewing medical reports and records to see what the doctors indicate the person's specific restrictions are, and then taking those into consideration and looking at what effect that has on the person's ability to work.” England testified that with the restrictions of Dr. Cantrell and Dr. Margolis, these would limit Ignatz “to a medium level of exertion which would prevent him from being able to go back to doing the kind of work that he did before as a boilermaker, because that went into the heavier range of exertion rather than medium”. England further stated: “So I think regardless of what medical I looked at here, it still appeared to me that he would be employable. It's just to what degree as far as the physical involvement. But the least talked about in the medical, I think, would still have him functioning up to a medium level of exertion.” There are no medical restrictions indicated by the doctors in this file that would lead me to believe that this man is totally disabled from all types of work activity, England stated. England acknowledged that Dr. Bernardi's report of December 2001 was approximately a year and an half after Ignatz' March 2000 work related injury. From my review of the records and deposition, England testified, it appeared that Ignatz was performing all of the job duties of a boilermaker leading up to his March 2000 injury.

Considering the expert opinions, it is found that the opinion of expert vocational rehabilitation counselor England is the controlling vocational rehabilitation counselor opinion in that it is found to be based on and supported by the competent and pertinent evidence. It is found that though Dr. Margolis offered a vocational rehabilitation counselor opinion, he admitted that he is not a vocational rehabilitation counselor and would defer to a vocational rehabilitationist. It is further found that Dr. Margolis' opinion that the claimant is permanently and totally disabled is given little weight in that the opinion

admittedly encompasses a worsening of a preexisting condition, the low back, with no evidence that the work related injury was the cause of that subsequent worsening.

It is found that the claimant offered competent evidence of preexisting disability via the submission into evidence of Stipulation For Compromise Settlement forms (No. W): a. settlement between the claimant and the employer/insurer for a May 2, 1991 work related left shoulder injury, compromise settlement of 18% permanent partial disability to the left shoulder; b. settlement between the claimant and the employer/insurer for an April 11, 1994 work related right knee injury, compromise settlement of 30% permanent partial disability to the right knee; c. settlement between the claimant and the employer/insurer for a January 30, 1996 work related left knee injury, compromise settlement of 35% permanent partial disability to the left knee; and d. settlement between the claimant and the employer/insurer for a December 17, 1997 work related hernia injury, compromise settlement of 5% permanent partial disability of the body as a whole referable to the hernia. Also offered by the claimant was evidence of the permanent partial disability sustained by the claimant as a result of the March 8, 2000 work related injury herein: a copy of a Stipulation For Compromise Settlement form (See, No. W) reflecting settlement between the claimant and the employer/insurer for the March 8, 2000 work related left elbow injury, compromise settlement of 20% permanent partial disability to the left elbow. See, Section 287.190.6 RSMo 2000; and *Conley v. Treasurer of Missouri*, 999 S.w.2d 269 (Mo.App. E.D. 1999). It is found that the competent and substantial evidence supports Dr. Margolis' opinion of a synergistic effect between the disability from the work related injury and the preexisting disabilities.

Considering all of the evidence, it is found that there is substantial and competent evidence supporting a permanent partial disability award against the Second Injury Fund as follows:

Preexisting injuries with competent assessed permanent partial disability that meet the threshold for Second Injury Fund permanent partial disability liability are: (May 2, 1991 work related left shoulder injury - 18% permanent partial disability to the left shoulder, or 41.76 weeks) + (April 11, 1994 work related right knee injury - 30% permanent partial disability to the right knee, or 48 weeks) + (January 30, 1996 work related left knee injury - 35% permanent partial disability to the left knee, or 56 weeks) + (May 31, 1980 comminuted displaced intra-articular fracture of the left radial head - 35% permanent partial disability at the level of the left elbow, or 73.5 weeks) = 219.26 weeks. It is found that the competent and substantial evidence supports that the March 8, 2000 primary left elbow injury resulted in 20% permanent partial disability to the left elbow, or 42 weeks. The simple sum for the preexisting disabilities with the work related disability is: 261.26 weeks. It is found that the evidence supports a finding of a synergistic effect from the combination of the preexisting disabilities with the primary disability as follows: 261.26 weeks x 20% load = 52.252 weeks; 52.252 weeks x \$303.01/week = \$15,832.88.

Date: January 6, 2006

Made by: /s/ LESLIE E. H. BROWN
LESLIE E. H. BROWN
Administrative Law Judge
Division of Workers' Compensation

A true copy: Attest:

/s/ PATRICIA "PAT" SECREST
PATRICIA "PAT" SECREST
Director
Division of Workers' Compensation