

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

Injury No.: 01-057079

Employee: Douglas Kaempfer
Employer: G. A. Rich & Sons, Inc.
Insurer: Travelers Indemnity Company of Connecticut
Additional Party: Treasurer of Missouri as Custodian
of Second Injury Fund

The above-entitled workers' compensation case is submitted to the Labor and Industrial Relations Commission (Commission) for review as provided by § 287.480 RSMo. We have reviewed the evidence and briefs, and considered the whole record. Pursuant to § 286.090 RSMo, we issue this final award and decision modifying the April 15, 2010, award and decision of the administrative law judge (ALJ). We adopt the findings, conclusions, decision, and award of the ALJ to the extent that they are not inconsistent with the findings, conclusions, decision, and modifications set forth below.

The ALJ made numerous findings and conclusions with regard to the issues presented in this case. For the most part, we agree with the ALJ's conclusions, however, we disagree with the ALJ's decision to order employer to furnish additional medical aid under the direction and control of a specific doctor. In addition, we disagree with the ALJ's decision to sustain the objections to the introduction of Exhibits 25 and 29.

Future Medical

Section 287.140.1 RSMo requires that the employer provide "such medical, surgical, chiropractic and hospital treatment...as may reasonably be required...to cure and relieve [the employee] from the effects of the injury." The employee must prove beyond speculation and by competent and substantial evidence that his or her work related injury is in need of treatment. *Williams v. A.B. Chance Co.*, 676 S.W.2d 1 (Mo. App. 1984). However, conclusive evidence is not required. It is sufficient if employee shows by reasonable probability that he or she is in need of additional medical treatment. *Bowers v. Highland Dairy Co.*, 132 S.W.3d 260, 270 (Mo. App. 2004).

We agree with the ALJ's conclusion that employee established through the medical opinions of Dr. Chaudhari and Dr. Randolph that he is in need of additional medical treatment to cure and relieve him from the effects of his March 16, 2001, work-related injury. The ALJ went on to hold that employer waived its right to select the treating physician by denying necessary medical aid after April 15, 2002, and therefore, ordered that the employer furnish additional medical aid under the direction and control of Dr. Chaudhari. We find that the ALJ's ordering that the additional medical aid be given by a specific doctor was improper under Missouri Workers' Compensation Law.

Employee: Douglas Kaempfer

- 2 -

For the foregoing reasons, we conclude that employee has established he is entitled to future medical care to cure and relieve him of the effects of his work-related injury and we direct employer to provide the same.

Evidentiary Objections

During the June 17, 2009, hearing, employer offered into evidence as Exhibit 25, the certified and sealed record of the Social Security Administration for employee. The Second Injury Fund objected to the admittance of Exhibit 25 because it argued that the information was irrelevant and immaterial. The ALJ sustained the Second Injury Fund's objection and found that Exhibit 25 was not admitted into the record. We disagree with the ALJ's sustaining of this objection.

The Second Injury Fund's objection was based on the argument that the criteria by which the Social Security Administration finds one to be totally disabled, is different than that for a finding of permanent total disability under Missouri Workers' Compensation Law. We agree that there are different standards; however, the Social Security Administration records were being offered as relevant and material evidence that employee's injuries were disabling to some extent. Therefore, we disagree that the Social Security Administration records were irrelevant and immaterial and find that the ALJ erred in sustaining the Second Injury Fund's objection.

For the foregoing reasons, we find that Exhibit 25 is admitted because it was relevant and material evidence of employee's nature and extent of disability.

Also, during the June 17, 2009, hearing, employer offered into evidence as Exhibit 29, the deposition of employee. Employee objected to the admission of Exhibit 29. Specifically, employee objected to the use of Exhibit 29 for anything other than cross-examination purposes. The ALJ sustained the objection. On appeal, both employer *and employee* argue that Exhibit 29 should have been admitted.

Section 287.560 RSMo provides that "any party shall be entitled ... to take and use depositions in like manner as in civil cases in circuit court...." The use of depositions in court proceedings is covered by Missouri Supreme Court Rule 57.07, which provides, "[a]ny part of a deposition that is admissible under the rules of evidence applied as though the deponent were testifying in court may be used against any party who is present or represented at the taking of the deposition, or who had proper notice thereof. Depositions may be used in court for any purpose." The deposition of an opponent may be introduced as an admission even if the opponent has also testified in person. *Still v. Ahnemann*, 984 S.W.2d 568 (Mo. App. 1999).

Based upon the foregoing, we find that the ALJ erred in sustaining employee's objection. Exhibit 29 is admitted.

We modify the award of the ALJ as provided herein. In all other respects, we affirm the award.

Employee: Douglas Kaempfer

- 3 -

The award and decision of Chief Administrative Law Judge Lawrence C. Kasten issued April 15, 2010, is attached hereto and incorporated herein to the extent not inconsistent with this decision and award.

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

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

Given at Jefferson City, State of Missouri, this 22nd day of March 2011.

LABOR AND INDUSTRIAL RELATIONS COMMISSION

William F. Ringer, Chairman

Alice A. Bartlett, Member

John J. Hickey, Member

Attest:

Secretary

ISSUED BY DIVISION OF WORKERS' COMPENSATION

FINAL AWARD

Employee: Douglas Kaempfer

Injury No. 01-057079

Employer: G. A. Rich & Sons, Inc.

Additional Party: Second Injury Fund

Insurer: Travelers Indemnity Company of Connecticut

Appearances: Robert W. Meyers, Attorney for Employee, Steve Prosperi, Attorney for Employer-Insurer, and Frank Rodman, Attorney for the Second Injury Fund

Hearing Date: June 17, 2009 (commenced)
August 26, 2009 (completed)

Checked by: LCK/rf

SUMMARY OF FINDINGS

1. Are any benefits awarded herein? Yes.
2. Was the injury or occupational disease compensable under Chapter 287? Yes.
3. Was there an accident or incident of occupational disease under the Law? Yes.
4. Date of accident or onset of occupational disease? March 16, 2001.
5. State location where accident occurred or occupational disease contracted: Mississippi County, Missouri.
6. Was above employee in employ of above employer at time of alleged accident or occupational disease? Yes.
7. Did employer receive proper notice? Yes.
8. Did accident or occupational disease arise out of and in the course of the employment? Yes.
9. Was claim for compensation filed within time required by law? Yes.
10. Was employer insured by above insurer? Yes.

11. Describe work employee was doing and how accident happened or occupational disease contracted: The employee fell and injured his neck and low back.
12. Did accident or occupational disease cause death? No.
13. Parts of body injured by accident or occupational disease: Low back, neck and body as a whole.
14. Nature and extent of any permanent disability: 30% permanent partial disability of the body as a whole referable to the cervical spine and 37.5% permanent partial disability of the body as a whole referable to the lumbar spine against the employer-insurer. Permanent total disability against the Second Injury Fund.
15. Compensation paid to date for temporary total disability: \$33,855.74.
16. Value necessary medical aid paid to date by employer-insurer: \$195,207.40.
17. Value necessary medical aid not furnished by employer-insurer: \$6,901.51
18. Employee's average weekly wage: \$1,164.20.
19. Weekly compensation rate: \$599.96 per week for permanent total and temporary total disability. \$314.26 per week for permanent partial disability.
20. Method wages computation: By agreement.
21. Amount of compensation payable from the employer-insurer:
 - \$6,901.51 in previously incurred medical benefits.
 - \$88,108.41 in temporary total disability benefits.
 - \$84,850.20 in permanent partial disability benefits

Total: \$ 179,860.12
22. Second Injury Fund liability: Permanent total disability benefits. See Rulings of Law.
23. Future requirements awarded: See Rulings of Law for future medical benefits and permanent total disability.

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

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

FINDINGS OF FACT AND RULINGS OF LAW

On June 17, 2009, the employee, Douglas Kaempfer, appeared in person and with his attorney, Robert W. Meyers, for a hearing for a final award. The employer-insurer was represented at the hearing by its attorney, Steve Prosperi. The Second Injury Fund was represented by Assistant Attorney General Frank Rodman. At the time of the hearing, the parties agreed on certain undisputed facts and identified the issues that were in dispute. These undisputed facts and issues, together with the findings of fact and rulings of law, are set forth below as follows:

UNDISPUTED FACTS

1. G. A. Rich & Sons, Inc. was operating under and subject to the provisions of the Workers' Compensation Act and its liability was fully insured by Travelers Indemnity Company.
2. On or about March 16, 2001, Douglas Kaempfer was an employee of G. A. Rich & Sons, Inc. and was working under the Workers' Compensation Act.
3. On or about March 16, 2001, the employee sustained an accident arising out and in the course of his employment.
4. The employer had notice of the employee's accident.
5. The employee's claim was filed within the time allowed by law.
6. The employee's average weekly wage was \$1,164.20 per week. The rate of compensation for temporary total and permanent total disability is \$599.96 per week. The rate of compensation for permanent partial disability is \$314.26 per week.
7. The employee's injury and treatment through April 15, 2002 was medically causally related to the accident.
8. The employer-insurer paid \$195,207.40 in medical aid.
9. The employer-insurer paid \$33,855.74 in temporary total disability beginning on March 17, 2001 and continuing through April 16, 2002.

ISSUES

1. Medical causation after April 15, 2002.
2. Claim for previously incurred medical.
3. Claim for additional or future medical aid.
4. The nature and extent of disability concerning the employer-insurer.
5. The liability of the Second Injury Fund for permanent partial disability or permanent total disability.

EXHIBITS

The following exhibits were offered and admitted into evidence:

Employee and Employer-Insurer Joint Exhibits

A-1. Medical records of Dr. Chaudhari including A-1a, A-1b, A-1c, and A1-d.

- B-2. Medical records of Southeast Missouri Hospital including B-2a and B2-b.
- C-3. Medical records of Southeast Missouri Hospital including C-3a and C-3b.
- D-4. Medical records of Cape Imaging.
- E-5. Medical records of Jackson Physical Therapy (The Second Injury Fund's objection to this exhibit was sustained based on lack of certification. The record was left open for the employee and employer-insurer to provide a certified copy. The records were received on August 26, 2009. In its brief the Second Injury Fund withdrew the objection and the records were admitted into evidence.)
- F-6. Medical records of Orthopaedic Associates including F-6a and F-6b.
- G-7. Medical records of Washington Orthopedics.
- H-8. Medical records of Brain and Neurospine Clinic/Dr. Gibbs including H-8a and H-8b.
- I-9. Medical records of Neuro Associates of Cape.
- J-10. Medical records of Community Counseling Center.
- K-11. Medical records of St. Louis Orthopedic Institute.
- L-12. Medical records of Cape Girardeau Surgical Clinic including L-12a and L-12b.
- M-13. Cape Radiology Group including M-13a, M-13b, and M-13c.
- N-14. Medical records of Dr. Kamath.
- O-15. Medical records of Cape Neurological Surgeons/ Dr. Park including O-15a, O-15b, O-15c and O-15d.
- P-16. Certified records of the Division of Workers' Compensation.
- Q-17. Medical records of Dr. Lents. (Exhibit Q-17a was admitted at the hearing. The Second Injury Fund's objection to Exhibit Q-17b was sustained based on lack of certification. The record was left open for the employee and the employer-insurer to provide a certified copy. The records were received on July 17, 2009, and were admitted into evidence.
- S-19. Medical records of St. Francis Medical Center including S-19a and S-19b.
- T-20. Medical records of Health South including T-20a and T-20b.
- V-22. Medical records of Dr. Ralph.

Employer-Insurer's Exhibits

- 23. Medical records of St. Louis Neurological Institute Inc.
- 28. Deposition of Dr. Randolph.
- 30a. Report of Bob Hammond dated April 14, 2005.
- 30b. CV of Mr. Hammond.
- 30c. Report of Mr. Hammond dated September 23, 2008.

Employee's Exhibits

- W. Medical Bills
- X. Deposition of Dr. Chaudhari
- Y. Deposition of Dr. Margolis
- Z. Deposition of James England
- AA. Picture
- BB. Picture

- CC. Picture
- DD. Picture
- EE. Picture

The following records were offered but not admitted into evidence:

- R-18. Medical records of Dr. Holcomb.
- U-21. Medical records of Campbell Clinic.
- 24. Medical records of PT Associates
- 26. Medical records of Radiology Consultation.
- 27. Medical records of Campbell Clinic

(The Second Injury Fund objected to these medical records because they were not certified. The objection was taken under advisement. The objection is sustained and the exhibits are not admitted into evidence. Note: The medical records of Dr. Holcomb, Campbell Clinic, and Radiology Consultants were contained in other exhibits.)

- 25. Certified copies of Social Security Records. (The Second Injury Fund objected to the admission of these records. The ruling on the objection was taken under advisement. The objection is sustained and the exhibit is not admitted into evidence.)
- 28. Deposition of the employee. (The employee objected to the admission of this exhibit. The ruling on the objection was taken under advisement. The objection is sustained and the exhibit is not admitted into evidence.)

The exhibits not admitted into evidence shall be retained in the Division's file for purposes of appellate review.

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

WITNESSES: The employee; Jan Snyder, for the employee; and Bob Hammond for the employer-insurer.

BRIEFS: The Second Injury Fund's brief was received on September 2, 2009. The employee and the employer-insurer's briefs were received on September 4, 2009.

FINDINGS OF FACT

The employee was born on September 30, 1956. On the day of the hearing he was 52 years old. He lives with Jan Snyder. The employee graduated from high school in 1975. He worked at General Sign, Erlbacher Materials, and Penrose Plumbing. He worked at Hacker Plumbing from 1983 through 1987. The employee had problems with depression prior to 1987.

1987:

On July 7, 1987 the employee was working for Hacker Plumbing. He was in an approximate 15 foot ditch when the bank caved in and crushed him. His head was buried by 3-5 feet of dirt. He passed out before he was dug out by his co-workers. Exhibits AA through EE are pictures of the accident scene. The employee was admitted to Southeast Missouri Hospital and was discharged on July 23. He was treated by Dr. Holcomb, Dr. Shakil and Dr. Kasten. An EMG showed right brachial plexus neuropathy. In the discharge summary Dr. Kasten diagnosed traumatic right brachial plexus neuropathy, contusion of the chest, fracture of the right 5th, 7th, 9th and 10th ribs, lung contusion, and multiple contusions and abrasions. In August the employee saw Dr. Chaudhari for traumatic right brachial plexopathy involving multiple muscle groups with some atrophy of the forearm muscles. He had diminished sensation over the right arm involving almost all the dermatomes at C5 and to some extent at C4. The employee treated with Dr. Chaudhari the rest of 1987. In an August 31 letter, Dr. Kasten stated that the employee was last seen on August 19 where x-rays revealed the rib fractures to be healing and was discharged from care. Dr. Kasten noted that Dr. Shakil had been treating him for his brachial plexus injury.

The employee was treated by Dr. Holcomb from the end of July through September of 1987. On September 24, Dr. Holcomb thought there was a separation of the right shoulder and referred him to Dr. Lents. The employee saw Dr. Lents on September 25 for right arm weakness. Dr. Lents was concerned about the increasing weakness of the employee's right shoulder and a popping sensation; and thought that the employee had a diffuse cord injury involving C5-6-7. He ordered an EMG and nerve conduction study. In October, Dr. Lents stated that the EMG showed extensive brachial plexus injury and referred the employee to Dr. Wright in Memphis. Dr. Wright recommended range of motion exercising and strengthening of muscles; and stated that the employee did not have a definite need for surgical exploration of his brachial plexus or tendon transfers.

The employee saw Dr. Ralph at the end of October who diagnosed a non-displaced fracture of his coracoid secondary to a crush injury and severe brachial plexus injury. The employee had marked atrophy of his right shoulder muscles. Dr. Ralph stated the employee was probably going to eventually require a right shoulder fusion. In December Dr. Lents noted that the employee's wrist extensors were becoming more powerful. Dr. Chaudhari stated that the accident resulted in multiple rib fractures, pulmonary contusion with un-displaced fracture of the right scapula. He had sensory and motor impairment and some sympathetic disturbance involving the right upper limb and right eyeball. His neck pain and aches and pains in the right side of the chest subsided. He had global sensory deficit in the right arm and profound limitation of movements of all joints of his right upper limb. It was unlikely he would go back to plumbing but he had a positive attitude and was determined to get better.

1988:

In February, Dr. Lents noted the employee was making progress with his strength and motion. In June, Dr. Lents noted the employee was having some muscle spasms in his neck and

pain in his right shoulder that radiated into his arm. He performed an injection over the bicipital tendon. In September and November, Dr. Chaudhari stated the employee had right shoulder pain and neck stiffness with sensory deficits at the C5-6 and C7 dermatomes.

1989:

In February, Dr. Ralph noted that the employee was probably going to require a right shoulder fusion. In March, Dr. Chaudhari noted chest pain due to rib fractures. The employee's power and sensation of the right upper limb was slowly and steadily improving and he had some loss of motion at C5-6 and C6-C7. Dr. Chaudhari's impression was fairly good recovery from brachial plexus injury with residual atrophy of the right deltoid and supraspinatus muscles; rib pain; possible slight degree of intracostal neuralgia; and moderate right paraspinal spasms due to poor posturing from right arm weakness. Dr. Chaudhari released him.

In May, Dr. Ralph stated that the employee had virtually no active motion of his right shoulder and only enough strength at the right elbow to bring the hand in its proper position. The employee's condition was permanent and the only additional surgery would be a right shoulder fusion to stabilize the shoulder in a position of function and get rid of the pain. Dr. Ralph noted the employee was going to school and was a highly motivated individual who was making a real attempt to turn what could have been a real tragedy into something positive in his life. It was his opinion that the employee sustained a 75% loss of function of the right upper extremity based upon his July 7, 1987 work related injury.

Dr. Chaudhari performed a disability evaluation in June of 1989. The employee had pain and loss of motion in the cervical spine; tenderness to palpation over the right ribs; pain in the right arm with weakness and atrophy of the muscle groups of the right upper limb; and global sensory loss with the proximal level being C4. Skilled movements of the right hand were markedly limited and deep tendon jerks were almost absent. Dr. Chaudhari felt that his disabilities were more than 100% loss of the right upper limb. Dr. Chaudhari performed an addendum on July 5, 1989, and stated that the employee's disabilities were more than a 100% loss of the right upper limb and the above mentioned disabilities amounted to 25% of the body as a whole in addition to the loss of use of the right upper limb.

Certified copies of the 1987 Division of Workers' Compensation file was admitted into evidence. The Claim for Compensation noted that body parts injured were right arm, shoulder, back, head, neck, ribs, entire body, and nerve damage to face. A Compromise Lump Sum Settlement was approved on August 8, 1989 for a total lump sum settlement of \$53,000.00 which included \$12,000.00 for future medical and \$2,500.00 for future temporary disability.

The employee testified that due to the 1987 accident, he gave up playing flag and sandlot football; and had more trouble bass fishing. He started college in the spring of 1988 and in May of 1992, graduated with a B.A. in Mass Communication from Southeast Missouri State University. After his injury in 1987 until May of 1992 he was not employed because he was recovering from the 1987 accident and going to college. He never used his degree. After graduating, he started working out of the union hall as a pipefitter. He was capable of and

enjoyed that type of work; and was immediately making the amount of money that would have taken years to get with a B.A. degree.

1994:

The employee testified that he started having panic attacks and anxiety. The employee saw Dr. Chaudhari in February of 1994 for numbness and tingling in the left arm and fingers. Dr. Chaudhari diagnosed left carpal tunnel syndrome. In April and October, Dr. Chaudhari prescribed Xanax for panic attacks.

The employee testified that on October 20, 1994, he was working in Tamms, Illinois when he tripped over rebar, fell and caught himself with both hands. He injured his neck and had immediate pain in his arms. On October 20, the employee went to the emergency room due to falling at work and catching himself with his hands. He had discomfort and numbness in his hands and fingers. X-rays of the wrist were negative. He was placed in bilateral cock-up wrist splints. On October 25, the employee saw Dr. Chaudhari with diminished sensation in the left thumb and left forearm and diminished strength in the left triceps. Dr. Chaudhari stated that the employee had recent trauma with traction neuropraxia of possibly both median nerves and musculoskeletal injury to the wrists and forearms. X-rays of the cervical spine showed disc space narrowing at C3-4 and C4-5. A November 2 EMG and nerve conduction study of the left arm was normal. A right shoulder MRI on November 15 was normal. A cervical MRI was ordered due to left arm pain and shooting pain in both arms. It was moderately abnormal due to moderate discogenic degeneration at multiple levels particularly at C3-4, C4-5, C5-6 and C6-7 with bulging of the annulus and a partial herniation at C6-7 with anterior indentation but no significant compression of the spinal cord or nerve root.

On December 1, Dr. Chaudhari noted the MRI showed spondylosis with disc degeneration at C3-4, C4-5, C5-6 and C6-7 and fairly marked C6-7 partial disc herniation.

Dr. Chaudhari ordered a myelogram and post myelogram CT scan of the cervical spine which was done on December 7. The myelogram showed cervical spondylosis with a small posterior cervical bar at C3-4 and a posterior cervical bar at C4-5 with slight flattening of the spinal cord. There was an extra dural defect on the left that affected nerve rootlets. There was a small cervical bar at C5-6 and lateral recess narrowing bilaterally that compressed nerve rootlets. There was a small posterior osteophyte formation at C6-7 with slight effacement of the exiting nerve rootlets on the left. The CT scan showed early posterior osteophyte formation at C3-4 and C6-7 with no cord compression and mild neural foraminal narrowing. At C4-5 there was a posterior cervical bar with moderate bilateral neural foraminal narrowing with some nerve rootlet edema on the left. The spinal cord was mildly flattened. There was a posterior cervical bar at C5-6 due to degeneration with some early nerve rootlet edema on the right. Dr. Chaudhari's impression was cervical spondylosis with marked changes at C3-4, C4-5, C5-6, C6-7; left carpal tunnel syndrome; and recent work related trauma with traction neuropraxia of possibly both median nerves and musculoskeletal injury to the wrist and forearm bilaterally which perhaps aggravated the previous cervical condition. He referred the employee to Dr. Snyder a surgeon.

1995:

On January 9, the employee saw Dr. Snyder for persistent pain and stiffness in the neck and shoulder. Dr. Snyder performed a cervical block. On January 23, Dr. Snyder noted that the cervical block did not help his symptoms and recommended a work hardening program. On January 25, Dr. Chaudhari noted that Dr. Snyder stated that the employee was not a candidate for a C6-7 discectomy.

A work capacity assessment was performed in February. In the April discharge summary it was noted that the employee attended work hardening for cervical pain. Upon completion the employee demonstrated physical demand characteristic in the very heavy category with lifting up to 100 pounds occasionally and 70 pounds frequently. The employee had cervical and back pain but he did not allow it to interfere with assigned activities. The recommendation was a return to full work duty.

In March, the employee's neck was fairly stiff; he had diminished sensation at the lateral border of the left arm and forearm; and diminished power in the left triceps and weakness in the left supraspinatus. In April, the employee was ready to go back to full time work and Dr. Chaudhari released him to go back to work. In June, the employee had left cervical muscle stiffness and bilateral C6 radiculopathy. In September, the employee had neck stiffness with questionable diminished sensation of the lateral border of the left arm, forearm, and thumb in the C6 distribution. The employee had almost normal power in the left triceps, and surprising improvement in the power of the supraspinatus and right deltoid due to his hard work. Dr. Chaudhari diagnosed cervical spondylosis with marked changes at C3-4, C4-5, C5-6 and C6-7 with bilateral C6 radiculopathy. Dr. Chaudhari ordered a repeat MRI for neck pain with left arm and hand numbness which showed high intensity activity at C3 and C4 with evidence of discogenic degeneration with bulging of the annulus, osteophytosis, segmental stenosis, anterior indentation of the theca, but no significant compression of the spinal cord.

1996:

In January, the employee called with neck pain. Dr. Chaudhari prescribed Ultram.

1998:

In December, the employee saw Dr. Chaudhari. He noted that in November the employee had an anxiety attack, went to the emergency room, and was put on Xanax. Dr. Chaudhari noted that the bilateral C6 radiculopathy had resolved to a great extent. The moderate supraspinatus and deltoid muscle atrophy persisted but was improving.

1999:

In January, the employee's anxiety was better. Dr. Chaudhari noted the employee's right upper brachial plexus injury had an excellent result but there was right deltoid atrophy. The employee had cervical spondylosis; anxiety and panic reactions; left carpal tunnel syndrome;

work related trauma with traction and neuropraxia of both median nerves and musculoskeletal injury involving wrist and forearm bilaterally; resolved muscle stiffness in the left paraspinal and cervical regions; C6 radiculopathy bilaterally which has resolved to a great extent; and moderate supraspinatus and deltoid atrophy on the right. Dr. Chaudhari increased the Xanax and added Effexor.

2000:

In February, the employee continued to have a few panic attacks and Xanax was continued. In November, Dr. Chaudhari prescribed Xanax.

The employee testified that he thought he settled his 1994 Illinois workers' compensation case for 6%. He could not think of any activities that he gave up due to the neck injury. He became a foreman but was never told that he was made a foreman to compensate for his 1987 or 1994 injuries. Prior to March of 2001, he regained considerable use of his right arm and was able to go back to plumbing and pipe fitting. He had to adjust how he worked and he had to do everything left side dominant but was able to use his right arm to stabilize things. The pain improved but after a hard day his arm pain increased. His right arm range of motion was limited and he had loss of strength. He developed carpal tunnel syndrome in his left hand from using it so much to compensate for his right arm deficits. He continued to have rib pain and neck pain. Working aggravated his left hand, right arm, shoulder, and his ribs. He had panic attacks. Overhead work aggravated his neck and shoulder. Power tools aggravated his carpal tunnel syndrome. Prior to 2001 he was taking medications for anxiety.

2001:

The employee testified that he had been working at G.A. Rich and Sons for about a year prior to March 16, 2001. On March 16, 2001, he was working as a foreman, slipped on a muddy board, fell backwards, landed on his tailbone, and hit his head. He injured his neck and low back.

On March 26, the employee saw Dr. Ritter. The employee had been on Xanax for panic attacks on an as needed basis. He had a significant injury when he was crushed in a trench in 1987. Dr. Ritter diagnosed a lumbar spine strain/sprain, and prescribed Motrin and physical therapy. The employee had therapy for his neck and low back from March 28 through April 13.

On April 11, Dr. Gardner noted that the employee had atrophy of the anterior deltoid and pectoralis muscles on the right side with weakness. He had diffuse decrease in pin sensation in the right arm; and an area of decreased sensation along the left wrist in the approximate distribution of C7. Dr. Gardner recommended an MRI of the cervical and lumbar spine and an EMG and nerve conduction study of the left arm.

The employee had MRIs on April 20, 2001 for post traumatic neck and low back pain. The lumbar MRI showed a disc herniation at L5-S1 that could be impinging upon a nerve root with smaller disc herniations at L3-4 and L4-5 and associated degenerative changes. The

cervical MRI was markedly abnormal and demonstrated severe spinal cord compression with secondary edema at the C4 and C5 vertebral levels caused by disc herniations at C4-5 and C5-6; and a smaller disc herniation with annular tear at C6-7.

The April 22 myelogram showed an extradural defect at L3-4 with bilateral nerve root compression of L4. There was extradural defect at C4-5 through C6-7 with associated attenuated nerve roots bilaterally at C5-6 and C6-7. Dr. Gardner stated that the cervical MRI showed severe spinal cord compression with edema at C4 and C5 caused by disc herniations and degenerative changes. There was a milder disc herniation at C6-7. The lumbar MRI showed diffuse degenerative disc disease along with disc herniation extending to the right neural foramina at L5-S1. The April 23 CT scan showed a disc bulge at L3-4 which caused mild flattening of the thecal sac that extended into the inferior aspect of the left neural foramen. A left-sided herniated disc at L4-5 caused moderate narrowing of the neural foramen. There was a mild disc bulge at L5-S1 with narrowing of the neural foramen on the right secondary to degenerative facet joint disease. The post myelogram CT scan showed marked disc space narrowing at C6-7 with moderate narrowing at C4-5 and C5-6 with hypertrophic spurring. There was neural foraminal narrowing on the left at C4-5; and on the right at C5-6; and the left at C6-7. There was moderate spinal stenosis from C4-5 through C6-7.

On April 23, Dr. Park noted the employee's past history was significant for a 1987 neck injury and trouble with his right arm which recovered without much problem. In 1994, he had another neck injury, recovered uneventfully and was gainfully employed. On March 16, the employee fell at work and sustained neck pain with a new onset of left arm and back pain. He had altered sensation of the left C6 and C7 distribution and diminished strength in his biceps, triceps, and deltoids. A CT myelogram showed severe canal stenosis at C4-5, C5-6 and C6-7 with bilateral foraminal encroachment. The MRI showed spinal cord edema at C4-5 suggesting possible recent spinal cord injury. Dr. Park's impression was significant left-sided stenosis and bilateral foraminal stenosis with new symptoms of radiculopathy from the March 16, 2001 injury that involved the C6 and C7 nerve roots, and possibly the C5 nerve root. On May 3, Dr. Park performed a C4-5, C5-6, and C6-7 anterior cervical discectomy, foraminotomy and interbody fusion.

The employee saw Dr. Chaudhari on May 15, who noted that the employee sustained severe torsional trauma to his cervical and lumbar spinal axis with very intense pain in the C5-6 distribution of the left arm and significant low back pain. The employee had atrophy of the right supraspinatus and deltoid with muscle power fairly well preserved. Xanax was prescribed.

On May 31, Dr. Park noted that the left arm pain was gone. In June, Dr. Park ordered low back therapy and the employee had 21 physical therapy sessions beginning on July 9 and ending on September 5. On July 30, the employee had significant worsening of the lumbar pain. On August 30, Dr. Park stated he was at maximum medical improvement from the cervical spine. Dr. Park ordered a discogram at L2-3, L3-4, L4-5, and L5-S1. Since the employee had no significant history of back trouble prior to his injury, Dr. Park concluded that the employee's lumbar problems were a result of the March 2001 accident and injury.

On September 13, Dr. Park performed a L2-3, L3-4, L4-5 and L4-S1 discogram which showed identical pain at L5-S1, similar pain at L4-5, dissimilar pain at L3-4 and a negative injection at L2-3. The post discogram CT scan showed an annular tear and extravasation of contrast at L4-5; and small tears at L3-4 and L5-S1 could not be excluded. On September 17, Dr. Park stated that the employee's discogram showed significant findings with pain reproduction at L4-5 and L5-S1. At L3-4 the pain was somewhat unlikely. There were disc herniations at L3-4 and L4-5. On October 5, Dr. Park performed a L3-4, L4-5, and L5-S1 bilateral laminotomies and micro discectomies; and fusion with instrumentation.

2002:

On January 10, Dr. Park noted that the employee was having persistent back pain and occasional pain into the right buttock and right thigh. The employee ambulated with an antalgic gait on the right. On February 4, the employee had low back pain but no leg pain and numbness in his elbows down into his hands. He ambulated with a somewhat stooped gait, had weakness of the right tibialis anterior and extensor hallucis longus with deep tendon reflexes that were depressed at the Achilles' tendon. Dr. Park continued therapy and stated that the employee could go back to work at a sedentary job with no lifting over five pounds. On February 7, the employee was limping; was using a cane; had increased leg pain and a new onset of bilateral foot numbness and tingling. Dr. Park modified the therapy. On March 4, Dr. Park noted x-rays showed a solid lumbar fusion. He ordered work conditioning for four weeks. After that he would be at maximum medical improvement; and if he had additional problems the employee would need to see him under his health insurance. The employee had 24 physical therapy visits from January 14 through March 25.

A functional capacity evaluation was performed on March 11. Deficits in the musculoskeletal evaluation included gait posture, flexibility, range of motion, strength, neurological, soft tissue assessment and Waddell's. Isometric strength testing revealed consistency of effort on ten out of ten tests. Functional testing revealed his present lifting in the light category of work. The employee demonstrated a tolerance of walking, stair climb, stooping, overhead reaching, and forward reaching on an occasional basis and sitting and standing on a frequent basis. The results of the evaluation indicated that the employee was currently unable to demonstrate the critical job demands of a pipe fitter. The functional capacity testing was partially completed due to self limiting behaviors.

On April 15, 2002, Dr. Park stated that the functional capacity evaluation was invalid due to scoring in the maximal range on the Waddell's testing for magnified behavior. Dr. Park noted that he would use empiric data to estimate the functional capacity. It was Dr. Park's opinion that the employee should be able to lift up to fifty pounds; and that a typical person with the surgical treatment that he had, should be able to do these kinds of activities with minimal difficulty. Dr. Park restricted the employee on the frequency of bending, twisting, stooping, climbing, pushing or pulling fifty pounds and reaching overhead to one third of the time. Dr. Park stated at the employee was at maximum medical improvement and was released from care. On April 29 Dr. Park estimated the employee's partial permanent impairment rating at 40% overall with 20% for

the cervical spine and 20% for the lumbar spine. Dr. Park did not feel that the employee was permanently disabled.

On May 20, 2002, Dr. Chaudhari stated that the employee has intractable pain in the low back that radiated down into his left lower extremity. The employee was walking with a cane. Dr. Chaudhari diagnosed failed back syndrome with intractable pain.

The employee was seen by Dr. Kamath, a psychiatrist, on June 27 for depression. The 1987 traumatic accident was noted as was the March 2001 accident. Dr. Kamath stated that the employee was having chronic grief reaction due to loss of health, earning ability and self esteem. Dr. Kamath diagnosed mild depressive episode, major depression mild, single episode; prescribed Celexa, and recommended counseling. Dr. Kamath saw the employee in July, August and November. In November, Dr. Chaudhari stated that the employee had very minimal, if at all, benefit from the fusion. He had significant low back pain that radiated to the left lower extremity. Medications did not control the perpetual intractable pain.

2003:

In May, Dr. Chaudhari noted the employee had right lower leg global weakness, walked with a limp and used a cane. He had residual weakness in the right shoulder and right leg. Dr. Chaudhari diagnosed failed back syndrome and intractable pain; and prescribed Xanax and Percocet. In November, Xanax and Percocet were continued. Dr. Kamath saw the employee in May and November.

2004:

The employee went to Community Counseling Center in May. He was very frustrated and bitter about his financial situation, physical impairment, and inability to work. The diagnostic impression was adjustment problems with depressed mood. The treatment plan was to make an adjustment to his physical limitations and to seek individual counseling.

In May, Dr. Chaudhari noted the employee's back pain was worse than his neck pain but deferred on injections. Xanax was continued. In November, the employee was having intermittent numbness in the left arm and the fingers and had quite a bit of pain in the left elbow and shoulder. Xanax and Percocet were prescribed by Dr. Chaudhari. Due to left arm pain, the employee had an EMG/NCS study in November. The nerve conduction study showed that the distal latency of the left median was in the high-normal range. The EMG was normal.

2005:

In August, the employee was having a lot of pain in the neck and left arm. Dr. Chaudhari ordered an EMG and nerve conduction study of the left arm. The EMG was normal. The nerve conduction study showed carpal tunnel syndrome. A cervical MRI was ordered and Percocet was prescribed.

The employee went to Southeast Missouri Hospital on September 20 for back and neck pain. On September 21 the employee saw Dr. Chaudhari for excruciating pain in the sub occipital region with very significant tenderness of both greater occipital nerves and moderate spasms of the paraspinal cervical muscles. The employee was walking with a cane. Dr. Chaudhari performed a cervical CT scan on September 26 which showed spinal canal stenosis at C3-4, C4-5, C5-6 and C6-7. Correlation was recommended for radiculopathy.

In November the employee was having a lot of neck pain and was taking Percocet. A cervical CT scan showed stenosis at C5-6 with foraminal stenosis and problems at C6-7. The employee had C6 radiculopathy bilaterally, more prominent on the left side. Dr. Chaudhari recommended a specialist for the C5-6 and C6-7 spinal stenosis. The employee saw Dr. Riew, an orthopedic surgeon on December 6, 2005 for axial neck pain with right arm weakness and numbness. He had problems with balance due to his lumbar condition. The employee ambulated with a cane and had global right weakness and numbness in the upper extremity. Pseudoarthrosis was seen on a CT scan at C6-7. Dr. Riew did not recommend surgery since the axial pain did not seem related to the C6-7 pseudoarthrosis.

2006:

In February, Dr. Chaudhari noted that Dr. Riew did not recommend any further cervical intervention. Dr. Chaudhari prescribed Percocet and Xanax. A few days later Dr. Chaudhari performed nerve blocks at several cervical levels. A lumbar CT in March showed the fusion.

In March and May, Dr. Chaudhari performed a number of occipital and cervical blocks at several levels and blocks at several lumbar levels, the sacroiliac joint and piriformis. On May 31, the employee appeared somewhat delusioned about his back pain. In June, Dr. Chaudhari performed a left L3-4 and L5-S1 selective nerve root block, L3-4 and L5-S1 epidural and right sacroiliac joint injections and right piriformis block.

On July 5, 2006, Dr. Chaudhari stated that the employee had an injury to the right brachial plexus in 1987 when he was buried in a trench which fractured multiple ribs and caused pain and weakness in the proximal right upper extremity. He had anxiety spells and had been diagnosed with post traumatic stress disorder related to the incident. He had a fall in 1994 and sustained a neck injury and underwent cervical epidural injections. He continued to have chronic neck discomfort but was able to continue working as a pipe fitter. These multiple injuries along with the ones sustained on March 16, 2001 had a bearing on his condition. The neck and low back pathology from these accidents affected the neck and low back and the rest of the body. The employee had lumbar and cervical spondylosis with discogenic degeneration at multiple levels which reflect the accumulated trauma from his previous accidents. He had very intractable pain that dominated his life. Due to his multiple problems, Dr. Chaudhari considered him to be permanently and totally disabled from a medical standpoint; and his overall disability resulted from his last injury plus the combination of problems from his pre-existing injuries.

In August, Dr. Chaudhari noted that any amount of strenuous work caused flair up of pain. The employee's stamina and endurance are limited and he has marked difficulty doing

things. The initial act of walking is very difficult if he has been sitting for any length of time. He walks with a cane; has significant tenderness at the greater occipital nerve on either side and tenderness in the neck and low back. Dr. Chaudhari diagnosed failed back syndrome, very intractable pain, and significant disability. He prescribed Xanax, Percocet and Lunesta.

In September, Dr. Chaudhari performed a left greater occipital block at C3-4, C4-5, C5-6 and C6-7 facetal blocks, left supraspinatus blocks and a C5-6 epidural block. On November 28, the employee thought the blocks in the low back were not completely helpful but the benefit in the neck area kept his hope alive that he can get some relief.

On December 7, 2006, Dr. Chaudhari stated the employee had a work related accident in 2001 and the pathology in the neck and low back from the accident affected his entire body. Due to his multiple problems, Dr. Chaudhari considered the employee to be permanently and totally disabled. The employee will continue to need future medical care on an indefinite basis including but not limited to regular office visits, medications, pain injections and therapy which is medically necessary. In December, Dr. Chaudhari performed a right L3-4, L4-5, L5-S1, S1-2 facetal block; a sacroiliac joint block, and right piriformis block.

2007:

On January 4, Dr. Chaudhari performed a left L3-4, L4-5, L5-S1, and S1-2 facetal block; a sacroiliac joint block and left piriformis block. On January 16, Dr. Chaudhari stated that the treatment for the employee has been reasonable, necessary and is causally related to the March 16, 2001 accident. The bills which have been incurred and the care that he has been given has been reasonable and necessary and the amount of the bills were reasonable. The medical care that will be needed in the future is reasonable and necessary.

On January 24, the employee had a lot of pain. The last injections helped. Dr. Chaudhari prescribed Opana. Dr. Chaudhari noted that the employee's pain was genuine. On April 25, Dr. Chaudhari performed blocks of the left supraspinatus and left greater occipital nerve; C3-4, C4-5, C5-6 and C6-7 facetal blocks on the left; and a C5-6 epidural block. On May 3, the employee had significant pain, fairly marked weakness in the right foot with foot drop. In May and August, Dr. Chaudhari performed greater occipital blocks followed by a right supraspinatus block, right C3-4, C4-5, C5-6 and C6-7 facetal blocks and C5-6 epidural block. In August, the employee stated that he had benefit from the injections to the neck but not low back. Dr. Chaudhari prescribed Ambien. Dr. Chaudhari performed a block of the right greater occipital nerve and the right supraspinatus; and right C3-4, C4-5, C5-6, and C6-7 facetal blocks.

The employee went to the emergency room on August 25 for neck pain. He awoke with severe left sided neck pain and was unable to move. On August 26, the employee went to the emergency room for back and neck pain. On August 27, Dr. Chaudhari noted over the weekend the employee had a sudden onset of neck pain and unpleasant feeling over the left forehead and left side of the face. The pain was excruciating and he went to the emergency room twice. Dr. Chaudhari ordered a CT scan of the brain and neck due to headaches, neck pain and swelling. In September, the employee had left-sided neck stiffness and numbness over the left half of the face

and neck. Dr. Chaudhari noted that the CT scan showed changes in the cervical spine and referred him to Dr. Gibbs. The Opana and the Lyrica had been helping.

Dr. Gibbs evaluated the employee on October 18 for neck pain and left-sided facial numbness. Approximately two months ago he had severe left-sided neck pain, worse than he has ever experienced with pain and numbness along the left side of his face. The August 27 CT showed the possibility of pseudoarthrosis at C6-7. Dr. Gibbs stated that it was possible that entrapment of the left C4 nerve root was contributing to his neck pain as well as shoulder discomfort, atrophy, and left facial pain and numbness. Dr. Gibbs wanted to do EMG studies of the upper extremities as well as a cervical myelogram and post myelogram CT scan; and a lumbar image due to back and leg pain. In December, Dr. Chaudhari continued the Opana.

2008:

The employee saw Dr. Chaudhari on March 4 with numbness over the left side of the neck and lower face. On exam, there was alteration of sensation over the left half of the face; atrophy of the right deltoid and supraspinatus muscles; global weakness in the right lower extremity, particularly of the right quadriceps and dorsiflexors of the right ankle and evertors of the right foot; diminished sensation in the lateral three and half fingers of the left hand; and tenderness at the lumbosacral junction, paraspinal region and sacroiliac joint. The employee had tenderness in the paraspinal, paracervical, and supraspinatus region bilaterally; tenderness over the lumbosacral junction, paraspinal region, sacroiliac joint and greater sciatic notch; and weakness in the right lower extremities. Dr. Chaudhari diagnosed failed back syndrome, very intractable pain, and significant disability.

Opinions:

The deposition of Dr. Chaudhari was taken on May 14, 2008. Dr. Chaudhari stated that due to the employee being in chronic pain his ability to endure anything strenuous is gone, and is permanently and totally disabled from employment. With regard to restrictions, the employee should listen to his body and not do anything that provokes pain. Occasionally he might be able to lift twenty five pounds but on a repetitive basis he could maybe lift five to ten pounds. He has restricted bending and extending of his spinal axis. When asked if any of the restrictions prevented him from performing tasks as a teacher, Dr. Chaudhari was not sure if the employee would be able to stand but he has problems sitting for a long time. Assuming that a teacher could stand up and sit down when they want to, Dr. Chaudhari stated that the employee may be able to perform what generally would be the functions that were expected of a teacher.

Due to the primary injuries to his neck and back, the employee has chronic neck and low back pain and needs treatment. Dr. Chaudhari has been treating him with medications, injections and blocks. The treatment could last forever. He has prescribed Percocet and Opana which are pain killers; Lidoderm patches for localized pain; Xanax for anxiety; and Ambien to help him sleep due to pain and anxiety. Percocet and Opana are narcotics and they have the potential to cause drowsiness. Dr. Chaudhari stated that further surgery was not precluded. The additional treatment he has performed and the additional treatment in the future would be related by a

substantial factor to his March 16, 2001 accident. Dr. Chaudhari testified that the medical bills that he incurred were reasonable; and the employee's medical treatment was reasonable and necessary; and related to his neck and low back injuries to cure and relieve him of his symptoms from the accident and injury of March 16, 2001. Dr. Chaudhari stated that people who have chronic pain have depression and anxiety. He prescribed Xanax prior to the March of 2001 accident. Dr. Chaudhari stated that the accident caused an aggravation of those symptoms.

The employee has loss of motion in the neck and low back. He has wasting of the right deltoid muscle; reduction in strength of the biceps and triceps; and a reduction in muscle bulk in the right upper extremity. He had reduction in strength to the forearm wrist extensor and flexor extensor. There was a reduction in the pin prick and distal right medial nerve distribution in the right hand. His right thigh circumference was diminished which indicates that the muscles have not been put to use or the nerve supply has been compromised.

Dr. Chaudhari examined the employee on December 7, 1998 and found cervical spondylosis most marked at C3-4, C4-5, C5-6 and C6-7. The employee had some internal derangement of his cervical disc and a compromised neck prior to March of 2001. His spinal axis was not bad enough to interfere with his activities but it was damaged prior to the March of 2001 accident. The employee suffered additional injury on the neck in March of 2001, and it was very possible that the accident may have aggravated the neck. Dr. Chaudhari stated that it was possible that the March of 2001 accident, coupled with his pre-existing conditions, produced a result greater than the accident alone. Dr. Chaudhari stated the employee went back to work after the pre-existing injuries to his neck, brachial plexus, shoulder and ribs. After the March of 2001 accident the employee had a lot of neck and back pain and problems in his left arm. The March of 2001 injury appeared to be very substantial and caused a lot of problems. The employee had a pre-existing neck injury and the March of 2001 injury had an aggravating affect.

With regard to the 1987 cave-in accident, Dr. Chaudhari stated that the right upper brachial plexus injury had excellent results and the employee's initial neck pain subsided. He had no further treatment and no permanent work restrictions at the time of his release. He returned to full duty as a plumber and pipe fitter. In 1994, he was diagnosed with the possibility of panic attacks. Dr. Chaudhari thought about post traumatic stress disorder which was possibly related to the cave-in. Dr. Chaudhari released him in April of 1995 and there was no permanent work restrictions placed on him. The employee was able to do his job duties even with his anxiety. The Xanax that he prescribed was a modest dose.

Dr. Chaudhari stated in his July 5, 2006 report that the employee's overall disability resulted from his last injury plus the combination of problems from his pre-existing injuries. That was also his testimony at the deposition. On December 7, 2006, Dr. Chaudhari stated that due to his multiple problems, the employee was permanently and totally disabled from a medical standpoint. Dr. Chaudhari was asked whether he was referring to the multiple problems from his neck and back or was he referring to all of his problems including the brachial plexus injury, his prior neck injury and his rib injury as well as any other portions of the body. Dr. Chaudhari stated that the brachial plexus injury plus his anxiety and all of that combined together, the whole thing was included but the major interest was on the spinal injuries which really made him quit

his job. Dr. Chaudhari stated the employee had physiological and psychological conditions prior to the March of 2001 accident and that the accident was superimposed upon these conditions. Dr. Chaudhari stated that the basis for his opinion that the employee is permanently disabled is the super imposition of the March of 2001 accident on his previous condition combined. Dr. Chaudhari stated that the employee is a very genuine person, and has all the will and motivation to work but his life has been changed.

The employee was examined by Dr. Margolis on October 24, 2002. In 1994, the employee injured his neck. Prior to March 16, 2001, the employee had occasional neck pain. After March of 2001, he had more persistent symptoms including stiffness and loss of motion. In 1987, the employee suffered a brachial plexus injury affecting his right arm and multiple broken ribs. The employee had atrophy and loss of motion in his right shoulder; and intermittent rib pain. On exam, the employee had limited rotation of his neck; atrophy of the right deltoid with slight atrophy of the right biceps and triceps; and loss of strength in the right deltoid, right infraspinatus and right hip. He had decreased pin perception in the distal aspect of his right arm and his right leg diffusely. The employee dragged his right leg when he walked. Dr. Margolis received paperwork with regard to the 1994 neck injury and lump sum settlement of 6% of the person and the 1987 injury lump sum settlement of 237.82 weeks.

It was Dr. Margolis' opinion that as a direct result of the March 16, 2001 fall the employee suffered injuries to the cervical and lumbar spine which resulted in the exacerbation of pre-existing, degenerative changes resulting in symptoms which resulted in the employee undergoing a multi-level cervical fusion and multi-level lumbar fusion. It was Dr. Margolis' opinion that the employee sustained a 50% permanent partial disability of the person as a whole with regard to the cervical spine and a 60% permanent partial disability of the body as a whole with regard to the lumbar spine. Dr. Margolis stated the employee's settlement for the 1994 cervical injury of 6% of the person and the settlement for the 1987 accident should remain undisturbed.

It was Dr. Margolis' opinion that the above disabilities combined to create a greater disability to the body as a whole when compared to the simple sum and a loading factor should be added. It was Dr. Margolis' opinion that the above conditions were hindrances and obstacles to the obtaining or maintaining of employment. It was Dr. Margolis' opinion that due to the neck and low back injuries the employee should avoid repetitive bending, twisting, and stooping; activities which require frequent looking up or head turning; and limit lifting to 40 pounds occasionally and 20 pounds frequently. It was Dr. Margolis' opinion that based on the employee's disabilities as well as his age and work experience, that the average employer would not hire the employee in the normal course of doing business. It was Dr. Margolis's opinion that he considered the employee to be totally and completely disabled from all forms of employment but would defer to a vocational expert.

The deposition of Dr. Margolis was taken on January 27, 2005. Dr. Margolis prepared an addendum on December 13, 2003 and apportioned the lump sum settlement regarding the 1987 brachial plexus injury and rib fracture. Dr. Margolis stated that the settlement equated to 60% of the person as a whole. He apportioned 15% to the rib fractures and 45% to the brachial plexus

injury. The Second Injury Fund objected to the admission of the addendum. The Second Injury Fund's objection is overruled.

The employee was taking Xanax, Celexa, and Percocet. Based on the employee taking Percocet, a narcotic pain medication, Dr. Margolis advised against working on heights, climbing ladders, and to be cautious when driving vehicles and working around heavy machinery. Dr. Margolis did not have any recommendations for further treatment for the primary injury. It was Dr. Margolis' opinion that prior to the 2001 injury the employee had some degenerative facet changes in his low back. The work restrictions that he placed would not fit within plumbing and pipe fitting. With his restrictions alone, the employee would be able to be sedentary to light job duties. In his assessments, Dr. Margolis took into account the employee's age, work experience, pain complaints, and that he is taking narcotic medication. Dr. Margolis did not find any permanent restrictions regarding his pre-existing conditions.

The employee saw Dr. Randolph on February 8, 2005. The employee's past medical history was significant for a 1987 injury where he fractured multiple ribs and injured his right brachial plexus with pain and weakness in the right upper extremity. He had anxiety attacks and was diagnosed with post-traumatic stress disorder related to that incident. In 1994, the employee sustained a neck injury at work, and underwent cervical epidural injections. He has had chronic mild discomfort in the neck since then. He has a history of depression and anxiety. The records indicated significant pre-existing cervical spine problems.

It was Dr. Randolph's opinion that on March 16, 2001, the employee sustained cervical and lumbar contusions and sprain injuries which were superimposed upon pre-existing degenerative disc disease particularly prominent at the cervical level where he had clear evidence of severe pre-existing cervical degenerative spinal stenosis. After the March of 2001 fall, the employee developed increased neck pain and stiffness and left upper extremity symptoms. Due to the three level fusion, the employee had limited cervical mobility and had some subjective sensory disturbance in the upper extremities. He had chronic brachial plexus problems from the 1987 injury which was not affected by the March of 2001 fall. He sustained a low back sprain and contusion which was superimposed upon pre-existing lumbar degenerative disc disease. The employee had limited range of motion of the lumbar spine.

It was Dr. Randolph's opinion that the employee was at maximum medical improvement and required no additional treatment. Due to the cervical and lumbar fusions, Dr. Randolph recommended that he avoid frequent bending or twisting; frequent or continual rotational or extension/flexion movements of the neck; and a lifting restriction of approximately 25 pounds occasionally. It was Dr. Randolph's opinion that the employee could not return to his pre-accident physical status. Based upon AMA guidelines, it was Dr. Randolph's opinion that the employee had an approximate 25% permanent partial impairment of the person as a whole related to the cervical spine. Approximately 11% was due to the effects of the pre-existing cervical degenerative spinal stenosis. The remaining 14% was from the effects of the March 16, 2001 fall. It was his opinion that that the employee had 20% permanent partial impairment of the person as a whole related to the lumbar spine. Approximately 8% of the impairment was related

to the effects of the pre-existing disease and the remaining 12% was from the effects of the March 16, 2001 fall.

On March 2, 2005, Dr. Randolph prepared a supplemental report and stated that the employee was capable of returning to work within the permanent restrictions. On October 26, 2007, Dr. Randolph prepared a supplemental report after reviewing Dr. Chaudhari's records. His opinions did not change. On July 25, 2008, Dr. Randolph performed an evaluation. Dr. Randolph noted that the employee had been receiving treatment by Dr. Chaudhari including multiple lumbar and cervical spine injections. Dr. Gibbs noted findings on a CT scan that were suggestive of a pseudoarthrosis at C6-7. Given the clinical improvements with conservative management, no surgery was recommended. The employee was on Xanax, Ambien, Lyrica, and Opana. Dr. Randolph stated that his opinions in his original February 8, 2005 report did not change. The employee developed progressive degenerative changes particularly in the cervical spine. The neck and left facial symptoms appear to be related to abnormalities at C3-4 where he has had degenerative changes and some degree of degenerative spinal stenosis. With regard to his lumbar spine, he continued to have restricted range of motion related to the fusion and the degenerative disc disease. Dr. Randolph stated that the continued use of oral medications for pain control was appropriate; the employee did not require surgery and did not need additional cervical or lumbar spinal injections. Dr. Randolph recommended avoiding frequent or continual bending or twisting. Lifting light to moderate weights on an occasional basis was in his ability. He should avoid continual standing or walking due to right lower extremity weakness.

Dr. Randolph's deposition was taken on October 23, 2008. Dr. Randolph stated that the employee had residual weakness in his right upper extremity due to the 1987 brachial plexus injury. In 1994, the employee sustained a cervical spine injury and underwent conservative treatment for neck and arm pain. An MRI in 1995 showed evidence of high signal intensity in the C3 and C4 vertebrae; degenerative disc disease with bulging of the disc; and degenerative changes at C4-5, C5-6, and C6-7. Dr. Randolph stated the employee had a significant level of disability related to the brachial plexus and problems in the cervical spine. At the time of the prior injuries, he had some disability, at least temporarily, with regard to employment. Dr. Randolph stated the condition of the cervical spine at the time of his present incident combined with his pre-existing condition to produce a greater disability. The combination of this accident superimposed on the cervical spine produced a greater disability than the simple sum.

In the 2005 examination, Dr. Randolph noted significant restrictions in ranges of motion as to flexion, right and left rotation, as well as extension. With regard to the right shoulder, the range of motion was limited minimally on abduction and flexion and there was wasting of the deltoid muscle related to the 1987 brachial plexus injury. There was atrophy in the muscle groups in the upper arm including the biceps, deltoid, triceps, forearm flexors and extensors. With regard to use of the right hand, he had some weakness but had functional strength for performing most activities. There was atrophy in the muscle groups on the left thigh as a result of the injury to his low back and may be related to neurological effects of his lumbar injury. Due to the low back injury the right hip flexor, right knee extensor, and extensor hallucis longus were weak which was a consequence of his low back injury and would give potential problems walking.

Dr. Randolph stated that lifting should be restricted to occasional (no more than a 1/3 of the time) light to moderate weight of five to ten pounds up to 20 pounds. He should not continually stand or walk. A job that involved intermittent sitting and standing was the best for him with some degree of flexibility. It was Dr. Randolph's opinion that the employee is capable of some employment and was capable of working within his restrictions. The restriction did not take into account the right upper extremity, psychological problems or panic attacks. Dr. Randolph thought that pain control was an important component and thought there was a regimen that he could be on which should allow him to function in the open labor market.

Dr. Randolph thought the symptomatology in his neck and left face region was related to degenerative changes at C3-4. It was not unusual for degenerative changes in the spine after a fusion. Taking oral medications for pain control was appropriate and the ones currently being prescribed were fine. At times there may be different medications that need to be tried to find which combination works the best. Dr. Randolph thought that the oral medications to control the pain were reasonable but did not see any strong clinical indications to continue the spinal injections. A limited number of cervical epidural or selective root injections were reasonable but continual or repeat injections were not necessary.

James England performed a vocational rehabilitation evaluation on May 19, 2004. Mr. England stated that the employee came across as someone in a great deal of discomfort and who was obviously depressed and tired. The employee takes Percocet as needed for pain and Xanax as needed for panic attacks. He changes positions often; and normally will lie down about every two hours during the day for about 20 minutes or so using moist heat to relieve some of his back pain. His primary complaint was low back and right leg pain. He continues to have neck, shoulder blade and rib pain. The pain is worse when he tries to be too active or if he stays in one position too long. He has numbness in the right leg into his foot and numbness and tingling in his left arm and hand. He has difficulty reaching up overhead and has limited strength with his right upper extremity. He can stand about 30 minutes or so and can walk perhaps two blocks or so. 25 pounds would be the most he would attempt to lift and carry. He usually gets up to move around every 30 minutes or so from a seated position. He climbs only a few steps at a time and uses a cane for support. He is quite depressed and anxious. The employee generally gets about five hours of rest per night, waking two to three times during the night due to the pain. During the morning he sometimes goes back to sleep. He does what he can around his apartment, washing dishes, doing laundry, and occasionally trimming weeds. He has to pace all of his activities and recline as needed through the day.

Mr. England stated that the employee's skills would normally transfer to a medium level of exertion in plumbing and to a light level of exertion with regard to his knowledge of plumbing supplies, materials, techniques and tools. These skills could be used provided that the employee could be on his feet the majority of the workday. The employee has a bachelor's degree in mass communication but has never used his degree. He has primarily functioned as a plumber/pipe fitter the last fifteen years. Assuming only the restrictions of Dr. Park, he would not be able to go back to doing his past work but could use the knowledge and skills he has acquired in a customer service position with a plumbing supply company or at-home remodeling facility. Assuming Dr. Margolis' opinion and the employee's description of his day-to-day functioning, along with how

he comes across in the interview, Mr. England did not see how the employee would be able to successfully compete for employment. He thought that employers would obviously be aware of the employee's physical and emotional difficulties by observing him. Mr. England did not know of any work setting that would allow a person to lie down periodically through the day. The employee stated that if he doesn't lie down his pain reaches a point where he cannot think clearly and cannot concentrate or complete tasks. Assuming that level of pain, Mr. England did not believe that the employee could last in a light or sedentary job setting. Unless his pain level is dramatically improved to where he could sustain at least sedentary work, Mr. England thought that the employee was likely to remain totally disabled from a vocational standpoint.

Mr. England's deposition was taken on January 25, 2005. Mr. England stated that his report was based on the totality of all of his injuries and illnesses. The lack of knowledge or skill or education was not the problem but it was more to do with physical functioning. Mr. England did believe that the employee could perform his past relevant work, taking into account any of the doctors' restrictions. Mr. England did not think the employee could go back to plumbing due to the inability to do more than occasional bending, stooping and twisting.

With regard to being able to compete in the open labor market, Mr. England stated, assuming what Dr. Park indicated, there would probably be things that the employee could do. Assuming the other medical evidence and what the employee described to him and how the employee appeared to be functioning, Mr. England did not think the employee could. With Dr. Margolis' restrictions, the employee could use his knowledge and skills that he acquired in a customer service position in plumbing supply or apartment remodeling. It was Mr. England's opinion that the only thing that keeps the employee from successfully competing for employment is his description of his day-to-day work and how he comes across in an interview.

Bob Hammond, a vocational consultant prepared a vocational report on April 14, 2005. He reviewed medical and employment information; performed a transferrable skills analysis; and a labor market survey. He listed eleven possible jobs available to the employee and identified sixty five positions that fall within the transferable skills. After taking into account the medium level of release from Dr. Park, thirty-two positions were within the residual ability of the employee. The employee's B.A. in Mass Communications which would qualify him for other positions in the communication field as well as the general labor market. He would easily qualify for positions in sedentary categories based on his education and his past work in construction. Mr. Hammond requested an in-person interview to discuss his ability and skills that enhance his employability but his request was denied. Based on the review of the information, it was apparent that the employee was able to learn new concepts, be educated, learn varied tasks and concepts that would allow him to seek and be successful in a new career. It was Mr. Hammond's opinion that the employee was employable at or close to his usual pay rates. Positions exist where employers have hired persons with these skills and pay rates close to the employee's past earnings. Positions exist on a regular and consistent basis within the available labor market that he could work in with no accommodations and if an employer has activities that are just outside his medical abilities but within skill areas, minor accommodations could be made.

Upon reviewing additional medical and updated depositions, Mr. Hammond prepared a supplemental report on September 23, 2008. Although there was some disagreement in the medical it was agreed that the employee was at a light level of work with lifting of twenty pounds occasionally, and avoiding continual standing and walking. A wide range of positions in the light range would be available with the general labor market. Mr. Hammond's opinion on employability did not change.

Mr. Hammond attended the hearing, and was present during the employee's direct testimony. Mr. Hammond testified that he had knowledge of the local labor market within approximately 50 miles from the employee's residence; performed a labor market survey; and determined the types of positions that would be medically appropriate. He contacted employers and gave them an overview of the profile of the employee and asked if they would consider a person with that background and medical. After his initial report, he reviewed additional medical records and performed a supplemental report. In his reports, it was Mr. Hammond's opinion that the based on the restrictions and medical, the employee could be employed at gainful employment in the open labor market from the last injury alone.

Mr. Hammond testified that prior to March of 2001 the employee had no restrictions and was in the heavy labor category. Mr. Hammond was asked if the employee could be employed with the totality of the situation including his right shoulder, panic attacks/anxiety, facial problems, and carpal tunnel syndrome. It was his opinion that the employee has a lot of other medical conditions other than his last injury which may have a direct impact on his employability. Mr. Hammond testified that based upon his review of the medical and the restrictions, and without doing an interview of the employee, there would be a sufficient number of employers who would consider the employee for employment. Some of the jobs listed would allow the employee to sit and stand and some would not. None of the employers would allow the employee to lie down during the day if he was in pain. There were a number of sedentary jobs in Mass Communication which would not allow the employee to lie down due to pain.

Mr. Hammond testified that he watched the employee during the hearing and his observations of the employee changed his opinion. Just based on his review of medical, he thought with just the back and neck injury alone, the employee could work light duty and was employable. Based upon the totality of his injuries, the employee would be able to perform in a sedentary position. Based upon his observation of the employee at the hearing, Mr. Hammond wanted more medical clarification and wanted a new FCE. Based on what he saw at the hearing, it was his opinion that the employee might not grid out on the sedentary level based on the testimony that he continued to have problems with the ribs, shoulder, and carpal tunnel syndrome. There are lots of things not associated with the back or neck that would lead him to believe that the employee might not be able to perform specific activities. The employee may not be employable in the open labor market based upon everything.

His original report was that the employee was in the approximate medium duty or lower. With the additional records, his second report stated that the employee was most likely at light duty based on his neck and back. Taking into account the total person including all of his

problems, it was most likely sedentary. Based on his observations of the employee at the hearing, Mr. Hammond testified that the employee may be less than sedentary.

Jan Snyder, the employee's girlfriend testified at the hearing. She has lived with the employee since early 2000. She has known him for 22 years and first met him shortly after the 1987 accident. They were living together when he was injured on March 16, 2001. In 1996 or 1997, she worked with the Humane Society and observed him use his right arm when he and other pipefitters redid the heating and cooling system. She saw the physical evidence of the prior injury including the lack of the deltoid muscle. He had no problems using his neck or upper body prior to injury but had issues with panic attacks or anxiety. Since she has known him he has been on Xanax and he has had problems with depression before March of 2001. Prior to the March of 2001 injury he kept up with the yard, helped her with the house and did not have to lie down. Currently the employee helps some around the house including putting dishes in the sink. He can mow the lawn but should not. He tries to help her but after doing so he has a lot of pain and has to lie down. She sees the pain in his face. Just about anything he does around the house such as the yard or the dishes, generally causes him to lie down afterwards in his recliner or bed. After the accident, she went to counseling at Community Counseling Center with him for problems with anger, frustration, and trouble with their relationship.

The employee testified that prior to 1987 he was not a nervous individual. Since the 1987 cave in accident he has had periodic anxiety attacks. Due to the 1987 accident, he had deficits to the right upper extremity and ribs including loss of muscle strength, dexterity and range of motion. He continued to have problems with the brachial plexus. Since the 1994 neck accident, he continued to have problems with his neck including pain and discomfort. After the treatment and recovery from the prior injuries, he did not miss work. Prior to March 2001, he was able to handle a job as a foreman and as a pipefitter lifting up to 75 pounds. He did not have any permanent work restrictions. He owned his own house, did the upkeep and helped his girlfriend at her house.

Since the March of 2001 accident, his entire life has changed and he is miserable. He has stopped going dancing and his fishing is very limited due to back and neck pain. He cannot do any activity without a price of pain with the exception of laying down in a recliner. He cannot sleep well without the use of Ambien. He lies down and reclines during the day primarily due to neck and low back pain. He is now taking narcotics. Currently he has numbness to the left side of his neck and face. His neck is stiff, painful, and has loss of motion. Due to his restricted range of motion in his neck, he has to depend on side mirrors when driving and has had to adjust the way he drives. He has low back pain with radiating pain down into both legs and into his feet with tingling and numbness. His low back pain is worse with activity. He cannot run and walking 100 yards aggravates his back. His back is aggravated after sitting or standing for any length of time. He has trouble kneeling, crawling, stooping and squatting. He tries to wash dishes and do some laundry. He can sweep and vacuum but does not do a great amount of bending and squatting. The cost to do activities is an elevated pain level, and then he has to go to his recliner. The only time he is comfortable is when he is lying down on his bed or in his recliner. During a typical day he has to lie down several times. At night he watches television. When he goes to bed it usually takes him until 1-2 a.m. to go to sleep. The employee was using a

cane at the hearing. Around the house he typically does not use a cane as much. If he is out, he uses his cane.

He can drive 50-80 miles before he has to get out of the car to stretch. He can lift approximately 10-15 pounds with his right arm and 20-25 pounds with his left arm but cannot lift repetitively. He has limited right hand strength. He can push and pull a vacuum cleaner and can push a grocery cart that is not filled up. He could climb a ladder but it would be pretty uncomfortable. He has pain all of the time. On a scale of 0-10, his low back and neck pain while in a recliner is 3. With any other activity, his pain level goes up to 7-8. His right arm with no activity is 2 and with activity is a 5. His rib cage with no activity is 2-3 and with activity is 5.

The employee has not worked since March 16, 2001. The employee does not think that he can work and does not see how he can be productive. He does not feel that he could give any employer even a half day of work. The 2001 accident had a negative effect on his depression. The employee testified that the primary cause of his inability to work is the March of 2001 accident but it is not the only cause. The other causes include the 1987 accident which led to the lack of function in the upper right body including the right arm and aggravation from the ribs. After 1994, his neck was different and not as healthy. If he only had the primary injury, he did not think could go to work but his inability to work is because all of the injuries.

The employee is requesting more treatment and that Dr. Chaudhari treat his neck and low back condition including prescribing medications. He is currently taking Opana for pain and Xanax to help stop panic attacks which still occurs at least every couple of months.

The employee testified that at the hearing his feet were numb and tingling due to sitting in the chair that was not comfortable when he was testifying. He sat down, stood up and moved around during the hearing. His misery level was high and after the hearing, he was going to sit in the passenger seat while his girlfriend drove home. When he got home he would go to bed.

RULINGS OF LAW:

Issue 1. Medical causation after April 15, 2002.

It is disputed that the employee's injury and treatment after April 15, 2002 is medically causally related to the accident.

On March 4, 2002 Dr. Park ordered work conditioning for four weeks and stated that after that the employee would be at maximum medical improvement. Dr. Park indicated if there were additional problems the employee would need to see him under his health insurance. On April 15, 2002, Dr. Park stated at the employee was at maximum medical improvement and released him from treatment.

The employee started seeing Dr. Chaudhari on a regular basis beginning in May of 2002. Dr. Chaudhari diagnosed failed back syndrome with intractable pain. The employee saw Dr. Kamath, a psychiatrist in June of 2002 for depression. It was noted that the employee was going

through a chronic grief reaction to losses related to his health, earning ability and self esteem. He continued to see the employee in 2002. In November of 2002, Dr. Chaudhari stated that the medications that the employee was taking did not control the intractable pain. In 2003, the employee was treated by Dr. Chaudhari who prescribed Xanax and Percocet; and by Dr. Kamath. In 2004, the employee was treated at Community Counseling Center and by Dr. Chaudhari for his neck and back. This treatment included medications and diagnostic testing. In 2005, Dr. Chaudhari ordered diagnostic tests. In December of 2005, the employee saw Dr. Riew, an orthopedic surgeon, who diagnosed pseudoarthrosis at C6-7 but recommended against any additional surgery. In 2006, Dr. Chaudhari continued to treat the employee with medications; diagnostic testing, and multiple injections and blocks in the cervical and lumbar spine. In 2007, Dr. Chaudhari performed SI, lumbar and cervical blocks; ordered diagnostic testing; and prescribed medication for the employee's neck and low back pain and anxiety. Dr. Randolph thought the symptomatology in his neck and left face region was related to degenerative changes at C3-4 which was not unusual after a fusion.

In 2007, it was Dr. Chaudhari's opinion that as a result of the March 16, 2001 accident and injury the employee suffered chronic neck and low back pain and needed treatment for the pain. It was his opinion that the medical treatment that the employee received was reasonable, necessary and medically causally related to the March 16, 2001 accident. Dr. Chaudhari stated that people with chronic pain have depression and anxiety. It was his opinion that the March 16, 2001 accident caused an aggravation of those symptoms. Dr. Chaudhari stated that the March 16, 2001 accident was related to and was a substantial factor in the employee's treatment and the need for the future medical treatment.

Based upon a review of all the evidence, I find that the opinions of Dr. Chaudhari and Dr. Randolph regarding medical causation after April 15, 2002 are persuasive and are more credible than the opinion of Dr. Park. I find that the employee's work accident on March 16, 2001 was a substantial factor in causing the employee's injuries to his cervical and lumbar spine and resulting aggravation of depression and anxiety, and the need for medical treatment after April 15, 2002. I further find that the injuries to the employee's cervical and lumbar spine and resulting aggravation of the depression and anxiety and resulting medical condition and need for treatment after April 15, 2002 are medically causally related to the March 16, 2001 work accident.

Issue 2. Claim for previously incurred medical.

The employee is claiming \$9,722.09 in previously incurred medical from Southeast Missouri Hospital Physicians, Dr. Gibbs, and Neuro Sciences and Pain Center. The employee is not requesting amounts that were written off or adjusted by Medicare or Healthlink. He is requesting \$7,045.27 that was paid by Medicare/Healthlink, \$2,668.64 that is still due and owing, and \$8.18 that he has paid. Exhibit W contain the medical bills of the health care providers. After the hearing, the employee was to file a document regarding the requested bills and payouts. A letter from the employee's attorney was received on July 23, 2009. The employer-insurer is disputing the amounts requested with regard to the issues of authorization, reasonableness, necessity, and causal relationship.

With regard to the issue of authorization, under Section 287.140 RSMo, the employer has the right to select the treating physician but waives that right by failing or neglecting to provide necessary medical aid. See Banks v. Springfield Park Care Center, 981 S.W.2d 161 (Mo. App. 1998). The employer will be liable for medical expenses incurred by the employee when the employer has unsuccessfully denied compensability of the claim. Denial of compensability is tantamount to a denial of liability for medical treatment. *Beatty v. Chandeysson Elec. Co.*, 190 S.W.2d 648 (Mo. App. 1945). 1 Mo. Workers' Compensation Law Section 7.2 (Mo. Bar 3rd ed. 2004). The medical bills requested were for treatment after April 15, 2002, which the employer-insurer was denying was medically causally related to the accident. I therefore find that the employer-insurer waived its right to select the treating physician by denying the compensability of the treatment after April 15, 2002. The defense of authorization is not valid.

Dr. Chaudhari's medical record from March 4, 2008 is the most recent medical treatment record of the employee in evidence. I find that any medical bills for treatment after March 4, 2008 are not recoverable by the employee because the corresponding medical records are not in evidence. See Martin v. Mid-America Farm Lines, Inc. 769 S.W. 2d 105 (Mo. Banc 1989). This includes treatment by Dr. Gibbs on and after May 1, 2008; and from Southeast Missouri Hospital Physicians on and after June 3, 2008. There are \$71.27 in charges and payments for medical records from Dr. Gibbs. I find that these charges are not recoverable.

On December 7, 2006 Dr. Chaudhari stated the employee will continue to need future medical care including, but not limited to regular office visits, medications, pain injections and therapy which is medically necessary and will be needed indefinitely. Dr. Chaudhari stated that the additional treatment he has performed and the additional treatment in the future would be related by a substantial factor to his March 16, 2001 accident. The medical treatment and the bills were reasonable and necessary; and were related to his neck and low back injuries to cure and relieve him of his symptoms from the accident and injury of March 16, 2001.

On July 25, 2008, Dr. Randolph stated that Dr. Chaudhari has performed multiple lumbar and cervical spine injections. He did not see any strong clinical indications to continue the spinal injections but thought a limited number of cervical injections were reasonable. Dr. Randolph stated that the continued use of oral medications for pain control was appropriate.

Based on the above evidence and my ruling on medical causation in Issue 1, I find that the remaining charges were medically causally related to the March 16, 2001 accident and injury. I find that those charges were reasonable and the treatment was necessary as a result of the March 16, 2001 accident and injury. I therefore find that the employer-insurer is responsible for and is directed to pay the employee the sum of \$6,901.51 for the following previously incurred medical bills contained in Exhibit W:

Dr. Gibbs	\$ 174.11
NeuroSciences & Pain Center	\$4,828.40
Southeast Missouri Hospital Physicians	\$1,899.00

Issue 3. Claim for additional or future medical aid.

Under Section 287.140 RSMo the employee is entitled to receive all medical treatment that is reasonably required to cure and relieve him from the effects of the injury. In Landers v. Chrysler Corporation, 963 S.W.2d 275 (Mo. App. 1997), the Court held that it is sufficient to award medical benefits if the employee shows by “reasonable probability” that he is in need of additional medical treatment by reason of his work related accident.

The employee was taking Xanax, Celexa, and Percocet when he saw Dr. Margolis. Dr. Margolis did not have any recommendations for any further treatment. Dr. Randolph noted that the employee had been receiving treatment by Dr. Chaudhari, and stated that the continued use of oral medications for pain control was appropriate but there was not any strong clinical indication to continue the spinal injections. A limited number of cervical epidural or selective root injections were reasonable but continual or repeat injections were not necessary.

Dr. Chaudhari had been treating the employee for chronic neck and low back pain with medications including Percocet, Opana, and Lidoderm patches for pain; Xanax for anxiety; and Ambien to help him sleep due to pain and anxiety; and with injections and blocks. Dr. Chaudhari stated that employee will continue to need future medical care indefinitely including, but not limited to regular office visits, medications, pain injections and therapy. At the time of the hearing, the employee was taking Opana and Xanax. The employee testified that pain blocks have helped. He is requesting that Dr. Chaudhari continue to treat his neck and back.

I find that opinions of Dr. Chaudhari and Dr. Randolph are credible and persuasive with regard to the issue of additional medical treatment. I find that the employee is in need of additional medical treatment to cure and relieve him from the effects of his March 16, 2001 work related injury. The employer-insurer is therefore directed to provide the employee with all of the medical care that is reasonable and necessary to cure and relieve the employee from the effects of his work related injury pursuant to Section 287.140 RSMo.

Section 287.140 RSMo gives the employer the right to select the treating physician. The employer may waive the right to select the treating physician by failing or neglecting to provide necessary medical aid. See Herring v. Yellow Freight System, 914 S.W.2d 816 (Mo. App. 1995) and Banks v. Springfield Park Care Center, 981 S.W.2d 161 (Mo. App. 1998). I find that after April 15, 2002, the employer-insurer denied additional medical aid and has waived its’ right to select the treating physician. The employer-insurer is therefore ordered to furnish additional medical aid under the direction and control of Dr. Chaudhari.

Issue 4. The nature and extent of disability concerning the employer-insurer. Issue 5. The liability of the Second Injury Fund for permanent partial disability or permanent total disability.

Included in the nature and extent of disability are the issues of temporary total disability, permanent partial disability and permanent total disability. The employee is claiming that he is permanently and totally disabled. The term “total disability” in Section 287.020.7 RSMo, means

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

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

The first question that must be addressed is whether the employee is permanently and totally disabled. If the employee is permanently and totally disabled, then the Second Injury Fund is only liable for permanent total disability benefits if the permanent disability was caused by a combination of the pre-existing injuries and conditions and the employee’s compensable work related accident and injury. Under Section 287.220.1, the pre-existing injuries must also have constituted a hindrance or obstacle to the employee’s employment or re-employment.

There is medical and vocational evidence that addresses whether the employee is permanently and totally disabled. Dr. Park restricted the employee to bending, twisting, stooping, climbing, pushing or pulling fifty pounds and reaching overhead up to one third of the time. Dr. Park did not feel that the employee was permanently disabled. Dr. Randolph recommended that the employee avoid frequent bending or twisting; and frequent or continual rotational movements of the neck or extension/flexion movements of the neck; and recommended a lifting restriction of approximately 25 pounds on an occasional basis. Dr. Randolph recommended that due to right lower extremity weakness the employee should avoid continual standing or walking. It was Dr. Randolph’s opinion that the employee could not return to his pre-accident physical status but was capable of some employment and returning to work within the recommended restrictions.

Mr. Hammond testified that in his original report, it was his opinion that the employee was in the approximate medium duty work level. In his second report, it was his opinion that the employee was most likely at a light duty or sedentary work level. In both reports, it was his opinion that the employee was employable. Based on his observations of the employee at the hearing, it was Mr. Hammond’s opinion that the employee may be at less than sedentary level and may not be employable in the open labor market.

It was Dr. Margolis' opinion that the employee should avoid repetitive bending, twisting, and stooping; activities which require frequent looking up or head turning; and limit lifting to 40 pounds occasionally and 20 pounds frequently. It was Dr. Margolis' opinion that the average employer would not hire the employee in the normal course of doing business and that the employee was totally and completely disabled from all forms of employment. Dr. Chaudhari stated that the employee might occasionally be able to lift twenty five pounds and on a repetitive basis could maybe lift five to ten pounds. The employee should be restricted from bending and extending his spinal axis. It was his opinion that due to his chronic pain and the inability to endure anything strenuous, the employee is permanently and totally disabled from employment.

Mr. England stated that based on what Dr. Park indicated there was probably some work that the employee could perform. Based on the other medical evidence, the description of his day to day activity, and how the employee came across in the interview, it was Mr. England's opinion that that the employee was not employable in the open labor market. Mr. England did not see how the employee would be able to successfully compete for employment; thought that employers would be aware of his physical and emotional difficulties just by observing him; and did not know of any work setting that would allow a person to lie down periodically to get through the day. Assuming that level of pain, Mr. England did not believe that the employee could last in even a light or sedentary job setting. Unless his pain level can be dramatically improved where he could sustain at least sedentary work, Mr. England thought that the employee was likely to remain totally disabled from a vocational standpoint.

Based on a review of all the evidence, I find that the opinions of Mr. Hammond, Dr. Margolis, Dr. Chaudhari, and Mr. England are more credible and more persuasive than the opinions of Dr. Park and Dr. Randolph regarding whether the employee is permanently and totally disabled.

In addition to both the medical and vocational evidence, I find that the employee and Jan Snyder were very credible and persuasive witnesses on the issue of permanent total disability. The employee and his girlfriend offered detailed testimony concerning the impact his condition has had on his daily ability to function at home or in the work place. Their testimony supports a conclusion that the employee will not be able to compete in the open labor market.

In addition to his testimony, the employee was observed for an extended period of time prior to and during the course of the hearing. The employee was walking with a limp, using a cane, moving slowly, and appeared to be in pain. The employee exhibited numerous behavior and physical patterns that support a finding of permanent total disability including frequently changing positions, standing up, sitting down, and moving around. After direct examination, the employee went to his car to lie down while Bob Hammond testified. Based on these observations, it is clear that he is suffering from a constant and significant level of pain and discomfort. The observations of Mr. England corroborate my observations of the employee. Mr. England stated that the employee came across as someone in a great deal of discomfort and was obviously depressed and tired. These observations were important evidence on the issue of permanent total disability.

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

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

Nature and Extent of Permanent Disability for the Employer-Insurer:

There is no evidence that the primary injury alone caused the employee to be permanently and totally disabled. All of the evidence supports the position that the employee is permanently and totally disabled due to a combination of injuries and conditions.

Dr. Park estimated the employee's partial permanent impairment at 40% overall with 20% for the cervical spine and 20% for the lumbar spine. It was Dr. Margolis' opinion that the employee sustained a 50% permanent partial disability of the person as a whole with regard to the cervical spine and a 60% permanent partial disability of the body as a whole with regard to the lumbar spine. It was Dr. Randolph's opinion that the employee had an approximate 25% permanent partial disability impairment of the person as a whole related to the cervical spine. Approximately 11% was due to the effects of the pre-existing condition and the remaining 14% was from the effects of the March 16, 2001 fall. It was his opinion that that the employee had 20% permanent partial impairment of the person as a whole related to the lumbar spine. Approximately 8% of the impairment was related to the effects of the pre-existing condition and the remaining 12% was from the effects of the March 16, 2001 fall.

Based on a review of the evidence, I find that as a direct result of the work related accident and injury, the employee sustained a 30% permanent partial disability of the body as a whole referable to the cervical spine and a 37.5% permanent partial disability of the body as a whole referable to the lumbar spine. The employer-insurer is ordered to pay to the employee 270 weeks of compensation at the rate of \$314.26 per week for a total award of permanent partial disability of \$84,850.20. I find that employee's primary injury alone did not cause the employee to be permanently and totally disabled.

Additional Temporary Total Disability:

The employer/insurer paid temporary total disability beginning on March 17, 2001 and continuing through April 16, 2002. Temporary total disability benefits are intended to cover healing periods and are payable until the employee is able to return to work or until the employee has reached the point where further progress is not expected. See Brookman v Henry Transportation, 924 S.W.2d 286 (Mo.App.1996).

On April 15, 2002, Dr. Park stated that the employee was at maximum medical improvement. On October 24, 2002, Dr. Margolis rated the employee's neck and low back. The employee started treating with Dr. Chaudhari in May of 2002 and has continued to treat with him through the date of the hearing. The employee treated with Dr. Kamath and Community Counseling Center in 2002, 2003, and 2004. In 2005, Dr. Chaudhari ordered multiple diagnostic tests. In December of 2005, Dr. Riew diagnosed pseudoarthrosis at C6-7, but recommended against any additional surgery. In 2006, Dr. Chaudhari continued to treat the employee with medications, diagnostic testing, and multiple injections and blocks in the cervical and lumbar spine. In 2007, Dr. Chaudhari performed SI, lumbar and cervical blocks; ordered diagnostic testing; and prescribed medication for the employee's neck and low back pain and anxiety.

On February 8, 2005, Dr. Randolph stated that the employee was at maximum medical improvement and rated him. On July 5, 2006, Dr. Chaudhari stated that the employee was permanently and totally disabled.

Based on a review of the evidence, I find that from April 17, 2002 through February 8, 2005 the employee was in his healing period and had not reached the point where further progress was not expected, and was entitled to temporary total disability. I find that the employee reached the point where further progress was not expected on February 8, 2005. The employer-insurer is ordered to pay the employee \$88,108.41 which represents 146 6/7 weeks of temporary total disability at the rate of \$599.96 per week.

Liability of the Second Injury Fund:

The next issue to be addressed is whether the employee's pre-existing conditions were a hindrance or obstacle to his employment or re-employment.

Due to the 1987 accident, the employee had traumatic right brachial plexus neuropathy, four rib fractures and a chest contusion. Dr. Ralph stated that the employee had virtually no active motion of his right shoulder, had very limited strength, and it was his opinion that the employee sustained a 75% loss of function of the right upper extremity. Dr. Chaudhari stated that the employee had pain and loss of motion in the cervical spine, and tenderness to palpation over the right ribs, pain in the right arm with weakness and atrophy of the muscle groups of the right upper limb and global sensory loss with the proximal level being C4. It was Dr. Chaudhari's opinion that the employee had more than 100% loss of the right upper limb and an additional 25% of the body as a whole. The employee settled his claim in August of 1989 for \$38,500.00 in permanent partial disability compensation which is equal to 59.5% of the body as a whole or 237.83 weeks of compensation at the maximum rate of \$161.88 per week.

In 1994, the employee was diagnosed with left carpal tunnel syndrome and was prescribed Xanax for panic attacks. In October of 1994, the employee injured his neck in a work related accident. An MRI showed moderate discogenic degeneration at C3-4, C4-5, C5-6 and C6-7 with a partial disc herniation at C6-7. The employee had a cervical block, therapy and work hardening. Dr. Chaudhari diagnosed bilateral C6 radiculopathy. In December of 1998, Dr. Chaudhari stated that the employee had internal derangement of his cervical disc and a

compromised and damaged neck. In January of 1999, Dr. Chaudhari increased the employee's prescription for Xanax and added Effexor.

Prior to March of 2001, the employee had to adjust his work by using his left arm as the dominant arm and using his right arm to stabilize things. The employee continued to have pain, limited range of motion, and loss of strength in his right upper extremity. The employee developed carpal tunnel syndrome in his left hand due to compensating for his right arm deficits. Working aggravated his hand, neck, right arm, right shoulder, ribs; and he had anxiety and panic attacks.

Dr. Randolph stated that the employee's past medical history was significant for a 1987 injury where he fractured multiple ribs and injured his right brachial plexus with pain and residual weakness in the right upper extremity. He had anxiety attacks and was diagnosed with post-traumatic stress disorder related to that incident. In 1994, the employee sustained a neck injury at work, and underwent cervical epidural injections. He has had chronic mild discomfort in the neck since then. He had a history of depression and anxiety. Dr. Randolph stated that records indicated significant pre-existing cervical spine problems. The employee's right shoulder had loss of motion and wasting of the deltoid muscle from the 1987 brachial plexus injury. It was Dr. Randolph's opinion that prior to March 16, 2001 the employee had an approximate pre-existing 11% impairment of the cervical spine and 8% impairment of the lumbar spine.

Dr. Margolis stated that prior to March 16, 2001 the employee had occasional neck pain. The employee's settlement for the 1994 cervical injury of 6% of the person and the settlement for the 1987 multiple rib fractures and right brachial plexopathy should remain undisturbed.

Dr. Chaudhari stated that in 1987, the employee injured his right brachial plexus, fractured multiple ribs and had pain and weakness in the proximal right upper extremity. He had anxiety spells and post traumatic stress disorder related to the incident. In 1994, the employee sustained a neck injury, had cervical epidural injections; and continued to have chronic neck discomfort. Dr. Chaudhari stated that the employee had lumbar and cervical spondylosis with discogenic degeneration at multiple levels which reflect the accumulated trauma from his previous accidents.

It was Dr. Margolis' opinion that the pre-existing conditions were hindrances and obstacles to the obtaining or maintaining employment. Dr. Randolph stated the employee had a significant level of disability related to the prior brachial plexus and cervical problems; and at the time of the prior injuries, had some disability with regard to employment.

Based on a review of the evidence, I find that the employee's pre-existing disability and conditions prior to the March 16, 2001 accident constituted a hindrance or obstacle to his employment or to obtaining re-employment.

It was Mr. Hammond's opinion that the employee's medical conditions other than those from his last injury may have a direct impact on his employability. Based upon the totality of his injuries, the employee may not be employable in the open labor market. It was Dr. Randolph's

opinion that on March 16, 2001, the employee sustained cervical and lumbar contusions and sprain injuries which were superimposed upon pre-existing degenerative disc disease particularly at the cervical level where there was severe pre-existing cervical degenerative spinal stenosis. Dr. Randolph stated the condition of the cervical spine at the time of the present incident combined with his pre-existing condition to produce greater disability. The combination of the March 16, 2001 accident superimposed on the cervical spine produced a greater disability than the simple sum.

It was Dr. Margolis' opinion that as a direct result of the March 16, 2001 fall the employee suffered injuries to the cervical and lumbar spine which resulted in the exacerbation of pre-existing degenerative changes that resulted in the multi-level cervical fusion and multi-level lumbar fusion. It was Dr. Margolis' opinion that the disabilities combined to create a greater disability to the body as a whole when compared to the simple sum.

It was Dr. Chaudhari's opinion that the employee was permanently and totally disabled due to his multiple problems and the overall disability resulted from his last injury plus the combination of problems from his pre-existing injuries. The basis of his opinion that the employee is permanently disabled is from a combination of the March of 2001 accident and his previous conditions. Dr. Chaudhari stated that prior to the March of 2001 accident, the employee had physiological and psychological conditions and the March of 2001 accident was superimposed upon these conditions.

It was Mr. England's opinion that the employee's permanent and total disability was based on the totality of all of his injuries and illnesses.

I find that the employee's pre-existing conditions including the cervical spine, right brachial plexus, ribs, depression and anxiety combined synergistically with the primary injuries to the cervical spine and lumbar spine and resulting depression and anxiety disorder to cause the employee's overall condition and symptoms. I find that the employee is permanently and totally disabled as a result of the combination of his pre-existing conditions including the cervical spine, right brachial plexus, ribs, depression and anxiety; and the compensable work related accident and injury of March 16, 2001.

I found that the employee was in his healing period and had not reached the point where further progress was not expected until February 8, 2005. I awarded 270 weeks of compensation for permanent partial disability against the employer-insurer (30% of the body as a whole referable to the cervical spine and 37.5% of the body as a whole for the lumbar spine) for the primary compensable accident and injury. The employer-insurer's liability for permanent partial disability starts on February 9, 2005 and ends on April 14, 2010. Since the compensation rate for permanent partial disability is less than the amount payable for permanent total disability the Second Injury Fund is liable for the difference between what the employee is receiving for permanent partial disability from the employer-insurer and what he is entitled to receive for permanent total disability. The difference between the permanent total disability rate of \$599.96 per week and the permanent partial disability rate of \$314.26 per week is \$285.70 per week.

The Second Injury Fund is therefore ordered to pay to the employee the sum of \$285.70 per week for 270 weeks commencing on February 9, 2005 and ending on April 14, 2010. Commencing on April 15, 2010, the Second Injury Fund is responsible for paying the full permanent total disability benefit to the employee at the rate of \$599.96 per week. These payments for permanent total disability shall continue for the remainder of the employee's lifetime or until suspended if the employee is restored to his regular work or its equivalent as provided in Section 287.200 RSMO.

ATTORNEY'S FEE: Robert W. Myers, attorney at law, is allowed a fee of 25% of all sums awarded under the provisions of this award for necessary legal services rendered to the employee. The amount of this attorney's fee shall constitute a lien on the compensation awarded herein.

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

Since the employee has been awarded permanent total disability benefits, Section 287.200.2 RSMo mandates that the Division "shall keep the file open in the case during the lifetime of any injured employee who has received an award of permanent total disability". Based on this section and the provisions of 287.140 RSMo., the Division and Commission should maintain an open file in the employee's case for purposes of resolving medical treatment issues and reviewing the status of the employee's permanent disability pursuant to Sections 287.140 and 287.200 RSMo.

Date: _____

Made by:

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

A true copy: Attest:

Naomi Person
Division of Workers' Compensation