

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

Injury No.: 01-167196

Employee: Arlandis Kelleybrew
Employer: Plastene Supply Company (Settled)
Insurer: Hartford Insurance Company (Settled)
Additional Party: Treasurer of Missouri as Custodian
of Second Injury Fund

The above-entitled workers' compensation case is submitted to the Labor and Industrial Relations Commission (Commission) for review as provided by section 287.480 RSMo. Having reviewed the evidence and considered the whole record, the Commission finds that the award of the administrative law judge is supported by competent and substantial evidence and was made in accordance with the Missouri Workers' Compensation Law. Pursuant to section 286.090 RSMo, the Commission affirms the award and decision of the administrative law judge dated August 17, 2009, and awards no compensation in the above-captioned case.

The award and decision of Chief Administrative Law Judge Lawrence C. Kasten, issued August 17, 2009, is attached and incorporated by this reference.

Given at Jefferson City, State of Missouri, this 4th day of December 2009.

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: Arlandis Kelleybrew

Injury No. 01-167196 & 01-169117

Dependents: N/A

Employer: Plastene Supply Company (Settled)

Additional Party: Second Injury Fund

Insurer: Hartford Insurance Company (Settled)

Appearances: James Turnbow for the employee. Frank Rodman for Second Injury Fund.

Hearing Date: Commenced December 3, 2008
Completed December 11, 2008

Checked by: LCK/kh

SUMMARY OF FINDINGS

1. Are any benefits awarded herein? No.
2. Was the injury or occupational disease compensable under Chapter 287? Yes.
3. Was there an accident or incident of occupational disease under the Law? Yes.
4. Date of accident or onset of occupational disease? On or about January 8, 2001 and on or about May 30, 2001.
5. State location where accident occurred or occupational disease contracted: Pemiscot 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 sustained a low back injury due to repetitive work and sustained a lung injury due to chemical exposure.
12. Did accident or occupational disease cause death? No.
13. Parts of body injured by accident or occupational disease: Low back and body as a whole in Injury Number 01-167196 and body as whole referable to lungs in Injury Number 01-169117.
14. Nature and extent of any permanent disability: 12.5% permanent partial disability of the body as a whole referable to the low back in Injury Number 01-167196. 3.95% of the body as a whole referable to the lungs in Injury Number 01-169117.
15. Compensation paid to date for temporary total disability: None.
16. Value necessary medical aid paid to date by employer-insurer: None.
17. Value necessary medical aid not furnished by employer-insurer: None.
18. Employee's average weekly wage: \$318.66.
19. Weekly compensation rate: \$212.44.
20. Method wages computation: By agreement.
21. Amount of compensation payable: None.
22. Second Injury Fund liability: None.
23. Future requirements awarded: None.

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: N/A.

FINDINGS OF FACT AND RULINGS OF LAW

On December 3, 2008, the employee, Arlandis Kelleybrew, appeared in person and with his attorney, Jim Turnbow, for a hearing for a final hearing. The claims against the employer-insurer were settled and approved on August 22, 2007. The Second Injury Fund was represented at the hearing by Assistant Attorney General Frank Rodman and Cliff Verhines. 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 summary of evidence and findings of fact and rulings of law, are set forth below as follows:

UNDISPUTED FACTS

1. Plastene Supply Company was operating under and subject to the provision of the Missouri Workers' Compensation Act and its liability was fully insured by Hartford Insurance Co.
2. On or about January 8, 2001 and May 30, 2001, Arlandis Kelleybrew was an employee of Plastene Supply Company, Inc. and was working under the Workers' Compensation Act.
3. On or about January 8, 2001 and May 30, 2001, the employee sustained occupational diseases arising out of and in the course of his employment.
4. The employer had notice of the employee's occupational diseases.
5. The employee's claims were filed within the time allowed by law.
6. The employee's average weekly wage was \$318.66. The rate of compensation for permanent total disability and permanent partial disability is \$212.44 per week.
7. The employee's injuries were medically causally related to the occupational diseases.
8. The employer-insurer did not pay medical aid in either case.
9. The employer-insurer did not pay temporary disability in either case.

ISSUES

1. Liability of the Second Injury Fund for either permanent partial disability or permanent total disability in injury number 01-167196 (Date of injury January 8, 2001).
2. Liability of the Second Injury Fund for either permanent partial disability or permanent total disability in injury number 01-169117 (Date of injury May 30, 2001).

EXHIBITS

The following exhibits were offered and admitted into evidence:

Employee's Exhibits:

- A. Medical records (At the hearing, the Second Injury Fund reserved the right to make objections on the records of Cardiovascular Consultants, Research Belk Hospital, St. Luke's Hospital, Pemiscot Primary Care Center, Pemiscot Memorial Hospital, and Headache and Pain Center. There were no objections to the other records in the Exhibit. The record was left open for 14 days for objections.)

On December 11, 2008, the Division received a letter from the Second Injury Fund which stated that it did not object to the medical records from Pemiscot Primary Care Center (75 pages), Pemiscot Memorial Health System (10 pages), Research Belton Hospital (42 pages) and St. Luke's Hospital (46 pages). These records are therefore admitted into evidence.

The Second Injury Fund objected to 200 pages of records from Dr. Greenfield because there was no certificate of authenticity and they were not offered into evidence. On July 20, 2009, there was a telephone conference between myself, the attorney for the employee and the attorney for the Second Injury Fund. The parties agreed that the 200 pages of records from Dr. Greenfield were not offered into evidence at the hearing. The parties agreed that Dr. Greenfield's records were offered into evidence as part of the records of the Headache and Pain Center (92 pages and 43 pages).

The Second Injury Fund objected to the records from the Headache and Pain Center (92 pages and 43 pages) on the basis that only 13 pages were provided. I find that there were 13 pages of records with the Headache and Pain Center caption and the remaining pages were records from various physicians at the Headache and Pain Center. The Second Injury Fund objection is overruled and those records are admitted into evidence.

The Second Injury Fund objected to the Pemiscot Memorial Health System records because the certificate of authenticity stated there were 115 pages but there were only 111 pages of records. On July 20, 2009, there was a telephone conference between myself, the attorney for the employee and the attorney for the Second Injury Fund. I advised the parties that there were 111 pages contained in those records and not 115 as set forth in the certificate of authenticity, and that the objection would be sustained. However, the employee would have 14 days to send the Court a corrected affidavit that there were 111 pages of records or the complete 115 pages with a new affidavit. On July 27, 2009, the Division received a letter from the employee's attorney with a corrected affidavit that the records contained 111 pages. The objection is now overruled and those records are admitted into evidence. (Note: The corrected affidavit is attached to the records behind the original affidavit.)

The Second Injury Fund objected to the records from Midwest Pulmonary Consultants because the certificate of authentication stated that there were 28 pages and only 25 pages were provided. The Second Injury Fund also objected to 3 pages from Cardiovascular Consultants because there was no certificate of authenticity for that health care provider. I find that the records from Midwest Pulmonary Consultants totaled 28 pages which included a 3 page letter from Cardiovascular Consultants to Midwest Pulmonary due to a referral. The Second Injury Fund's objections are overruled and those records are admitted into evidence.

- B. Deposition of James England (subject to objections in the deposition).
- C. Deposition of Dr. Volarich (subject to objections in the deposition).
- D. Current medication list.

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

WITNESSES: Arlandis Kelleybrew, the employee and Sonya Kelleybrew for the employee

BRIEFS: The Second Injury Fund filed its brief on February 26, 2009. The employee waived the filing of his brief.

FINDINGS OF FACT:

The employee testified that he is 36 years old and was born in August of 1972. He employee completed the 10th grade and started the 11th grade. He tried two times to get a GED but was not successful. He cannot read or write very well. He can add and subtract by counting on his hands but is not good at multiplication and division. He cannot operate a computer. Prior to 2001, he liked to work on cars including changing oil and brakes. A couple of years ago, the employee got a driver's license. He took the test multiple times and took an oral and not a written test. His wife helped him study. His first job was at a city market in Indiana when he was 17 years old. He bagged and carried groceries and then went to produce. He wanted to get a promotion but needed a GED. He worked there for 4-5 years.

1992:

The emergency room records from Elkhart Hospital in June showed that the employee had trouble breathing. In August, the employee went to the emergency room due to shortness of breath and feeling light headed. The employee was felt to have hyperventilation syndrome. He had essentially the same symptoms in June which had been felt to be anxiety. The emergency room doctor stated that anxiety was probably a role in the hyperventilation syndrome. At the end of December, the employee was at the emergency room with difficulty breathing.

1993:

In March, the employee went to the emergency room at Elkhart Hospital and was diagnosed with an acute lumbar strain. In September, the employee went to Elkhart Hospital emergency room for back and chest pain from lifting at work. He had been breathing a lot of dust fumes at work and had not been wearing a mask. In December the employee went to Elkhart Hospital for shortness of breath with numbness of the extremities and anxiousness. The symptoms subsided after breathing into a paper bag. He was diagnosed with hyperventilation.

1995:

In March, the employee went to the emergency room at Elkhart Hospital for lumbar and thoracic back pain. He performed a lot of lifting at work and had prior back problems. Bilateral straight leg raising was negative. The diagnosis was probable lumbosacral strain.

1996:

In May, the employee was diagnosed with acute bronchitis.

The employee testified that in 1996, he pled guilty to selling cocaine and was incarcerated in Indiana until 1999.

1999:

In June, the employee went to Elkhart Hospital for lower back pain that radiated down the left leg and into the groin and was diagnosed with acute lumbago. In August, the employee was seen for back pain that radiated down the back of his left leg to the knee. In October, the employee went to Elkhart Hospital due to pain in his left upper chest which was worse with deep breaths. He had a past history of asthma which had been acting up. He was diagnosed with acute chest wall pain.

2000:

In early January, the employee was at Elkhart Hospital emergency room with difficulty swallowing due to nasal drainage but denied shortness of breath.

On January 27, the employee was taken to Elkhart Hospital due to mid sternum chest pain and difficulty breathing. He had a feeling like his throat was swollen shut which he had for a couple of weeks. On exam, the employee's lungs were clear with decreased breath sounds due to his subjective laryngeal spasms. Chest x-rays were normal. The employee was given Halfan, which calmed him down and his breathing was normal. The employee stated that two weeks ago had a fight with his girlfriend and that is when he started having problems. The doctor diagnosed self induced laryngeal spasm and referred the employee for anger management. On February 7, the employee went to the emergency room and felt like something was caught in his throat. He was diagnosed with dysphasia, sore throat, and possible tracheitis. The employee was put on a Z-pack and Prednisone.

The employee went to the emergency room at Elkhart Hospital on February 10 due to upper epigastric burning type discomfort. It was noted the employee made a lot of visits to their emergency room with varied and sundry complaints. The employee stated that he felt like his body was falling apart and several doctors have told him that he was a hypochondriac.

The employee testified that after he was released from prison he got a job with Venture Welding and worked there for 5-6 months. He stacked RV frames with a forklift. As the employee was stacking frames, he fell off a RV frame, injured his back and went to Elkhart Hospital. He was fired a couple of weeks later. He was in the emergency room at Elkhart General Hospital numerous times for breathing problems due to change of seasons and different chemicals at Venture Welding and for his back problems. Other jobs that he had included working in a meat market, at Hardees, and a car place.

The employee was seen at Elkhart Hospital on February 22, 2000 after falling at work. He had persistent low back pain with some spasms. He pain complaints from his shoulders down to his lower back. The past medical history was significant only for asthma. The diagnosis was lower back strain and contusion. He was kept off work until the next day and was limited to 25 pounds lifting and no heavy lifting or climbing for the next three days.

The employee testified that in 2000, he moved to Missouri. He worked at Plastene from August of 2000 until November of 2001, when he went out on medical leave. He has not worked

anywhere since he left Plastene Supply and has not looked for work. Plastene Supply closed in November of 2002. The employee testified that prior to working at Plastene, he had breathing problems but it did not change how he did things, and he did not have any restrictions or accommodations for his job. He also had back problems.

The employee testified that his job at Plastene included transferring racks of car emblems that weighed a minimum of 25 pounds. There were a lot of chemicals in the factory. He developed problems with breathing and his low back.

On October 25, the employee went to Pemiscot Primary Care Center for coughing and shortness of breath.

2001:

The employee was seen at Pemiscot Primary Care Center and the emergency room on January 8 due to low back pain which started the week before. The employee did heavy lifting at work and working made his low back pain worse. The employee was diagnosed with a severe lumbar strain, was excused from work, and given Lorcet Plus and Flexeril. In April, the employee went to Pemiscot Primary Care Center twice for back pain.

On May 10, the employee went to Pemiscot Primary Care Center due to shortness of breath with a known history of bronchial asthma. He was admitted to Pemiscot Memorial Hospital by Dr. Nwora with a two day history of shortness of breath with productive cough. The employee was anxious and in respiratory distress. He was diagnosed with an acute exacerbation of bronchial asthma, was started on IV of Solumedrol, and put on Proventil. The employee was discharged on May 11. Azmacort and meter dose inhalers were prescribed.

The employee went to the emergency room at Pemiscot Hospital on May 14 due to asthma complaints. He reported he may have gotten too hot at work that day. The employee had a history of recurrent attacks of bronchial asthma, wheezes in both lungs, and was diagnosed with bronchial asthma. Three respiratory care treatments were performed.

On May 16, the employee was admitted to Pemiscot Hospital for shortness of breath. Dr. Tippen noted that the employee had a history of asthma but the asthma did not develop until he moved back to the Bootheel about two years ago. The examination showed coarse breath sounds bilaterally with a few faint wheezes. The employee was diagnosed with asthma exacerbation and allergic rhinitis. The employee had quite a bit of bronchi spasms, was placed on IV Solumedrol, and given nebulizer dilators. The employee was started on Zyrtec to see what role allergies were playing. During the afternoon of May 17 the employee felt better, did not have significant shortness of breath, and was discharged.

The employee testified that in May and June of 2001, he missed time from work.

On July 19, the employee went to Pemiscot Primary Care Center with shortness of breath. On July 23, the employee was at Pemiscot Primary Care Center with complaints of sinus

draining, congestion and difficulty breathing. On August 9, the employee went to Pemiscot Primary Care Center with bilateral rib pain. A chest x-ray showed no active pulmonary disease.

A pulmonary function test was done on August 24, at St. Francis Medical Center. It was an abnormal study and showed a mild reduction and diffusion capacity consistent with a pulmonary parenchymal or vascular abnormality. The employee had diagnosed asthma and was on several medications. The employee had shortness of breath with exercise, was extremely anxious and got very lightheaded.

On September 19, the employee went to Pemiscot Primary Care Center for increased back pain. On September 20, the employee went to the emergency room at Pemiscot Hospital. He had been at work when he experienced chest pain and left arm numbness. On September 24, the employee went to Pemiscot Primary Care Center with increased back pain.

The employee was admitted to Pemiscot Hospital on October 30, with a two day history of progressive shortness of breath and diffuse abdominal pain. The employee had no improvement with the use of Albuterol meter dose inhaler. The employee was anxious and in obvious respiratory distress. He had diffuse inspiratory and expiratory wheezing with fair air exchange. The diagnosis was an acute exacerbation of bronchial asthma. The employee was started an IV and a Proventil nebulizer. The employee was discharged on October 31 with continued fine diffuse wheezing.

Dr. Nwora ordered physical therapy. The employee was evaluated on December 4 at Pemiscot Hospital. The employee reported low back pain with an onset of three to four months ago, which was progressively getting worse the past two to three weeks. The employee's low back pain was constant and occasionally went down to the right groin/thigh area. The employee was given therapy eight times.

On December 13, the employee saw Dr. Landry, an orthopedic surgeon, with lower back pain for many years which had come and gone. The employee worked in a factory where he did a lot of lifting but had been out of work for three weeks due to increased lower back pain. The pain had been constant for three weeks and went into the right groin and right posterior thigh. The employee had positive straight leg raising on the right. Dr. Landry ordered an MRI, kept the employee off work, and put the physical therapy on hold.

2002:

The January 10, 2002 MRI showed a loss of signal strength and a disc protrusion at L4-5. On January 10, the employee saw Dr. Landry with continued radiation of pain into the right groin and posterior thigh down to the knee. The employee had tenderness at L5-S1 and his straight leg raising was positive on the right. Dr. Landry stated that the MRI showed decreased signal intensity at L4-5 disc with a small central disc protrusion that abutted the exiting right L5 nerve root without causing compression. Dr. Landry recommended an epidural steroid injection and pain management. Dr. Landry put restrictions on of no bending or lifting and stated he was not able to work at that time. On January 17, the employee went to Pemiscot Primary Care Center for low back pain.

On February 7, Dr. Landry recommended a neurosurgical consultation with Dr. Gibbs. On February 21, the employee saw Christine Byrd, Dr. Gibbs' nurse practitioner. The employee stated that four months ago he developed low back pain with no particular precipitating event. The pain radiated into his right groin, right buttock and into the right upper thigh. The employee had physical therapy with no improvement. Two epidural steroid injections eased the pain. The employee seemed very uncomfortable and exhibited a lot of pain behaviors. The January MRI showed degenerative disc disease most marked at L4-5 with a central disc bulge at L4-5 which did not appear to be contacting the L5 nerve root. Nurse Byrd noted that the employee's pain did not follow an L5 dermatomal pattern. She reviewed the MRI and stated that it was not clear that the L4-5 disc bulge was responsible for the symptoms. She ordered therapy; and prescribed a TENS unit, Medrol-dose pack, and Celebrex.

On February 27, the employee had a physical therapy evaluation at Pemiscot Health Systems. He stated that the back pain got worse in November of 2001. The employee received therapy eight times which ended on March 15, due to non compliance.

On March 6, the employee saw Dr. Gibbs. The employee appeared comfortable at rest but seemed very uncomfortable when changing positions. There was a lot of moaning and groaning during the examination. Dr. Gibbs noted the MRI showed diminished signal at L4-5 disc and there appeared to be a small central disc bulge/herniation interposed between the L5 nerve roots. This abutted both L5 nerve roots (right greater than left) and it may slightly displace the one on the right. Dr. Gibbs stated that the pain did not clearly follow an L5 dermatomal pattern. Dr. Gibbs recommended a right L5 selective nerve root block to determine whether the L4-5 disc was symptomatic. Dr. Gibbs requested a right segmental nerve block at L5 and then at L4.

On March 13, Dr. Pjura performed a L5-S1 nerve root injection. The employee had complete relief of his low back symptoms and therefore he did not perform the L4 injection.

On April 3, 2000 the employee saw Dr. Gibbs and stated after the L5 selective nerve root block, his groin and right medial thigh pain stopped, and a portion of the back pain was relieved. The back pain returned and was particularly bothersome with any increase in activity. He has only occasional shooting pain in the right groin. During the exam the employee looked well and seemed comfortable at rest. Dr. Gibbs stated that the low back and radicular pain may be due to a small central herniated disc. Dr. Gibbs stated that since the employee did not have any leg pain, he was not confident that a microdiscectomy would be beneficial. He discussed the options of an IDET and offered to refer him to someone who did that procedure. The employee wanted to check with the insurance to make sure that would be covered. Dr. Gibbs prescribed Ultracet as needed and stated that the employee could return to work with a 20 pound lifting restriction. The employee was to return to the clinic on an as needed basis.

In May the employee went to Pemiscot Primary Care with increased back pain. The employee went to the emergency room at Pemiscot Hospital on July 1, with back pain which had began getting worse since yesterday. On July 2, the employee was at Pemiscot Primary Care and was diagnosed with asthma and back pain. On September 18 the employee went to Pemiscot Hospital emergency room for low back and right groin pain that started the day before.

The employee was admitted to Pemiscot Hospital on September 19 by Dr. Nwora with a three day history of progressive shortness of breath and productive cough. The employee was in obvious respiratory distress. His chest had diffuse inspiratory and expiratory wheezing. The employee was started on an IV and Zithromax, and nebulizers were prescribed. He was put back on Avalide and Norvasc. The next day, his air exchange had improved but he started complaining of low back pain. The employee was discharged on September 21 with a Combivent meter dose inhaler. The discharge diagnosis was acute exacerbation of bronchial asthma and low back pain.

On October 10 the employee went to Pemiscot Primary Care with shortness of breath. On October 17, the employee saw Dr. Landry who stated that the employee's epidural steroid injections and nerve block gave him temporary relief. The employee has been off work since November of 2001 because no light duty was available. Dr. Landry scheduled a repeat nerve block which was done on November 15. The selective nerve root block at the right L4-5 had significant pain improvement.

On November 29, the employee went to Pemiscot Primary Care with dizziness and shortness of breath. The employee went to the emergency room at St. Francois Medical Center on December 5 with difficulty breathing, tingling hands, mild cough, chest discomfort, being light headed and anxiety. The diagnosis was hyperventilation.

2003:

The employee was admitted to Pemiscot Hospital on January 16 by Dr. Nwora with a history of progressive shortness of breath associated with productive cough. The employee was in obvious respiratory distress and the chest showed defused wheezing with poor air exchange. The employee's breathing improved considerably and he was discharged on January 18.

On January 30, the employee saw Dr. Landry. The employee had recurrent right groin pain with more severe and constant pain in the lower back. Dr. Landry recommended pain management. The employee's initial evaluation at the Pain Management Center was on January 31 by Dr. Soeter. The employee had been having lower back pain that ran down the back of his right leg and groin on occasion which had been going on for about a year. The past medical history was significant for asthma which has been exacerbated numerous times since he moved to Southeast Missouri. The employee had mild wheezing especially in the left upper lung.

On February 11, Dr. Soeter performed a selective nerve root block at L3-4, L4-5 and L5-S1. In February and March, the employee was at Pemiscot Primary Care with tightness in his chest.

The employee went to Research Medical Center on April 12, with shortness of breath and wheezing and was diagnosed with asthma. On April 16, the employee saw Dr. Soeter and stated that the selective nerve root block gave him partial relief. On April 24, Dr. Soeter performed a selective nerve block at L3-4 and L4-5. On May 22 Dr. Schisler performed a lumbar epidural steroid injection at L4-5.

On June 2 the employee went to Pemiscot Primary Care with tightness and pain in his chest that increased with deep breaths. The employee went to Pemiscot Primary Care on June 9, with resolved chest pain and no shortness of breath. On June 9, the employee went to the Pain Management Center for low back, right thigh and groin pain. The last lumbar epidural in May gave him no pain relief. The employee stated that he cannot wash cars at the car lot where he works. Dr. Soeter performed selective nerve root blocks from L3 through L5. On June 22, the employee went to Research Medical Center due to light headedness, chest pain, and shortness of breath. On July 14, the employee saw Dr. Guerra with chronic back pain and asthma. There was an occasional and very mild expiratory wheezing in his lungs.

On July 21, 2003 the employee saw Dr. Greenfield at the Headache and Pain Center for lower back pain that developed steadily over two years after heavy lifting. The employee had shortness of breath, difficulty breathing and wheezing which came and went. The employee had normal breath sounds and respiratory effort. The employee had moderate tenderness at L4-5 and severe tenderness at L5-S1. The employee had significant bilateral muscle spasms, and positive bilateral straight leg raising. Dr. Greenfield ordered an MRI of the lumbar spine and nerve conduction/EMG studies.

The July 21 MRI showed disc dissection with an underlying bulge at L4-5 and a minimal bulge at L3-4. The employee had nerve conduction studies and EMG of his lower extremities done by Dr. Hermes on July 21. There was electrodiagnostic evidence for bilateral L5-S1 polyradiculopathies, which appear to be acute to subacute in nature.

On July 31, Dr. Greenfield performed an injection at L3-4 and L4-5 bilaterally. On August 15, Dr. Catts performed a caudal epidural injection. In August Dr. Romaker at St. Luke's Sleep Disorders Clinic noted that the employee demonstrated mild sleep apnea.

On August 11, the employee saw Dr. Guerra. The employee was using several medications for asthma and was having difficulty breathing with shortness of breath. His lungs were clear to auscultation with no wheezing and mild rhonchi that cleared with cough. Dr. Guerra diagnosed bronchitis and moderate persistent asthma and referred the employee to a pulmonologist. On August 20, Dr. Greenfield performed a second caudal injection.

On September 5, Dr. Forsythe at Midwest Pulmonary noted that the employee's shortness of breath was interfering with his ability to play with his children. The employee had an initial diagnosis of asthma in May of 2001 while working in a chrome plating facility in Hayti. The employee took medical leave in 2002 that was related to his shortness of breath and a back injury. The employee's current medications were Albuterol inhaler, Norvasc, Avalide, Advair, Xopenex, and Neurontin. Dr. Forsythe's impression was 1) Dyspnea, etiology not clear. There may have a component of vocal cord dysfunction and hyperventilation. He may have a component of irritable airway secondary to industrial exposure. 2) Herniated lumbar disc by history. 3) Questionable sleep apnea. Dr. Forsythe ordered a complete pulmonary function study and a consultation with St. Luke's speech department for a comprehensive evaluation of his vocal cord function. He ordered a high resolution CT examination of his chest due to make sure there was no interstitial lung disease.

The employee saw Dr. Greenfield on September 9, with low back pain that spread into the inguinal areas; and pain, numbness and tingling in both lower extremities. On September 11, Dr. Greenfield performed a third caudal epidural injection. On September 23 the employee told Dr. Greenfield that after the last injection his pain was better for a while but gradually increased to the same level. On October 1, Dr. Greenfield added Ultram.

The employee saw a speech pathologist at St. Luke's Hospital on October 2 and described a wheeze in his voice and the left side of his throat feeling clogged up. Physical exertion often resulted in coughing episodes and occasional instances of his throat "shutting off". The speech pathologist stated that the employee had a mildly strained vocal quality characterized by elevated pitch levels and frequent cough. Vocal cord dysfunction could not be ruled out due to a sensitive gag reflex. The employee should have therapy for vocal cord dysfunction symptoms.

In October of 2003 the employee saw Dr. Guerra due to nose congestion, drainage, sinus pressure, and sore throat. The employee's lungs were clearly bilaterally with no rales or wheezing; and was diagnosed with sinusitis and controlled asthma.

The employee saw Dr. Forsythe at Midwest Pulmonary on October 8. The employee's high resolution CT scan was normal. A complete pulmonary function was normal. The sleep study showed mild sleep apnea. Dr. Forsythe stated that he could not make a diagnosis of asthma at that time but in the past he had been told he had asthma. Dr. Forsythe advised him to discontinue Advair and use Albuterol on an as needed basis.

On October 20, a CT and myelogram showed a very minimal broad based disc bulge at L3-4. At L4-5 there was a broad based disc bulge with a central subligamentous disc which indented the thecal sac slightly but did not appear to impinge upon the nerve roots. At L5-S1 there was a central subligamentous disc bulge which impinged upon the nerve roots and barely indented the thecal sac. There were no focal disc herniation or compressed nerve roots. On October 28, the employee went to the emergency room at Research Belton Hospital with sharp stabbing pain and pressure in the chest which worsened with deep breaths. He was diagnosed with acute chest pain and viral pleurisy. Dr. Greenfield performed two low back injections in November.

On November 5, the employee saw Dr. Forsythe with vague chest discomfort and shortness of breath. The impression of Dr. Forsythe was: 1) Dyspnea, etiology unclear. He thought he had some component of vocal cord dysfunction. 2) Chest discomfort with exertion, etiology not clear. 3) Disability secondary to back discomfort and herniated disc and 4) Recent pharyngitis/bronchitis, resolving. Dr. Forsythe thought the employee's symptoms were functional and related to anxiety and frustration with not being able to be as active as he would wish due to back discomfort. He had some episodes of obstruction to air flow related to his previous employment but no evidence of lasting pulmonary dysfunction.

On November 18, Dr. Guerra diagnosed asthma but stated that Dr. Forsythe, a pulmonologist, thought that the pulmonary functions have been normal and there was no clear etiology for the shortness of breath.

Dr. Forsythe referred the employee to Dr. Conn a cardiologist who saw the employee in December for breathlessness with occasional associated chest pain. The employee's primary limitations were from chronic low back pain with radicular leg symptoms. Dr. Conn stated that the employee had no obvious cardiac causes for his breathlessness and chest pain.

In December Dr. Greenfield referred the employee to Dr. Hess, a neurosurgeon, who saw the employee on December 12. Dr. Hess stated that the myelogram and MRI showed no disc herniation or stenosis and he did not recommend surgery.

2004:

On January 14, Dr. Greenfield performed an epidural injection in the right L5. On January 19, the employee saw Dr. Guerra for back pain and breathing problems. The employee reported that sometimes his boss tells him that he has to stop doing what he doing regarding his pain. Dr. Guerra advised the employee that if he cannot find a job where physical activity is not done, then he needs to try to finish his GED and try to find a different type of job with no physical activity. The employee was advised to see a counselor for depression.

On March 29, Dr. Greenfield stated that the employee's pain was moderate to severe and the functional impairment was severe and when present it interferes with most but not all daily activities. On May 3, the employee's severity of pain was somewhat less severe and the pain was rated as moderate.

On June 15, the employee saw Dr. Guerra and was diagnosed with sinusitis and depression. When the employee did physical activity he felt chest pressure like he could not breathe very well. Dr. Guerra thought the symptoms could be related to anxiety and depression.

On August 11, the employee saw Dr. Guerra and was diagnosed with sinusitis, possible seizures and headaches. The employee was to be sent for a CT scan of the head and to a neurologist for possible seizure activity. On October 5, the employee saw Dr. Greenfield with increased low back pain.

On December 15, the employee went to St. Luke's Hospital due to coughing for the past ten days. He did not have any wheezing or shortness of breath and no chest pain. The employee was diagnosed with acute bronchitis, rhinitis, and asthma exacerbation. Dr. Parvin ordered a chest x-ray to rule out pneumonia and it showed no evidence of infiltrates, fusions or congestive heart failure. The employee was given a nebulizer treatment and Albuterol. On December 21, the employee saw Dr. Guerra for follow up for pneumonia.

2005:

On March 19, Dr. Greenfield stated the employee had some improvement in back and leg pain.

The employee went to the emergency room at Research Belton Hospital on April 6 for constant chest pain and shortness of breath. The employee had moderate wheezing on mild

expiration. The clinical impression was acute chest wall pain and asthma. A Medrol-dose pack and an inhaler were given. On April 12, the employee saw Dr. Guerra for shortness of breath, and noted the Medrol-dose pack helped. Dr. Guerra assessed shortness of breath but did not know if the employee's exacerbation was related to an asthma attack or anxiety.

On June 20, 2005 Dr. Greenfield saw the employee for lower back pain. The employee had not improved and his pain level was 10 out of 10. Qualitatively, the pain was rated as severe and the functional impairment was very severe. When present the employee was unable to carry out any daily activities. Dr. Greenfield added Tramadol in addition to his current medications of Albuterol, Avalide, Effexor, Flonase, Norvasc and Ranitidine.

In Injury Number 01-169117, the lung exposure case, a Stipulation for Compromise Settlement was approved for 3.95% of the body as a whole referable to lungs (asthma) on August 22, 2007. In Injury Number 01-167196, the low back case, a Stipulation for Compromise Settlement was approved for 12.5% of the body as a whole referable to the low back on August 22, 2007.

The employee testified that his typical day is laying on the couch and bed because he is not comfortable sitting. He watches his 4 year old son. He picks up things but his other children do the household chores. He tries to help out but it bothers him to lift something heavy. Due to the pain, he goes to church about once a month, and has no other social activities outside of church. He pays the bills, and is able to drive and take his children to doctor appointments. When he goes to the store and walks, he has trouble breathing. He has trouble riding in a car and has to stop a lot. He has to pay someone to work on his cars.

The employee testified that he has problems with sinus and allergies with changes in the weather which causes him to breath heavy and it hurts his lungs. Smells such as tar on the road, cleaning chemicals in the house, and perfume bothers him. He has breathing problems going up and down stairs and trouble walking. Hot and cold weather affects his breathing. He has chest pain and tightness when in distress. With regard to his allergies, temperature change makes it worse. His breathing becomes worse with sinus problems. The employee has low back pain all the time and has right sided leg pain and numbness. He has numbness in his feet which comes and goes. He has trouble bending and his back pain makes him depressed. He has trouble with balance but has not fallen down. He can sit for 15-20 minutes at a time due to shooting pain down the leg. Nothing helps with the pain.

The employee testified that currently he is taking about eight Hydrocodone/Vicodin every day. The medicine helps him sleep but does not help with pain. He uses a nose spray and often takes antibiotics for allergy and sinus. For asthma he uses Symbicort, which is an inhaler, Advair and Proventil. He uses Nasacort for allergies and Celebrex for his back. He has used inhalers off and on since May of 2001. Prior to those injuries he did not have pain or sleep problems. Since he moved to Kansas City in 2003, his back, leg and breathing is worse.

Sonja Kelleybrew, the employee's wife, testified that she started dating the employee in 2000 and married him in March of 2002. She worked at Plastene and was laid off in November of 2002 along with everyone else. She has relatives in Kansas City and they moved there in

2003. She works 40 hours a week as a medical assistant and works part time as a cashier at Wal-Mart about 25 hours a week. The employee has back pain and lays around and changes positions frequently. The employee has problems breathing and is not able to help with household chores. He gets the children off to school, takes the children to the doctor and pays bills. The trip from Kansas City was difficult for him and he had to stop every 30 minutes.

The employee saw Mr. James England for a vocational rehabilitation evaluation on April 20, 2005. The employee appeared to be quite uncomfortable and was moving around about every 20 minutes during the evaluation process and walked with a noticeable limp. The employee scored at the 4th grade level on word recognition and math and at the 6th grade level for reading comprehension. Mr. England stated that his academics were low enough that he would not expect the employee to do well in a job that required reading, writing, recordkeeping or fairly simple math. Mr. England stated the employee is a younger worker under the US Department of Labor guidelines. He has a limited education, was functioning only at a mid-grade school level academically and was essentially limited to work that can be performed after learning by observation. Considering the physical restrictions listed by Dr. Volarich, the employee would appear to be limited to no more than a sedentary level exertion overall and is limited to less than a full range of sedentary. His need to avoid cologne, perfume etc. would make it difficult for him to function even in some temperature controlled office environments. His academic limitations would negate his ability to do the majority of sedentary jobs since they normally involve reading, writing, recordkeeping and/or math. Considering his combination of medical problems, it did not appear to Mr. England that the employee would be able to successfully compete or sustain employment in the long run. Absent significant improvement in his functional capability, Mr. England felt that the employee was more likely to remain totally disabled from a vocational standpoint. As he is currently functioning and taking into consideration his academic limitations, Mr. England did not think vocational rehabilitation would be of any benefit.

The deposition of Mr. England was taken on August 26, 2008. Mr. England stated that other than operating the forklift, he did not believe that the employee acquired any transferable skills from any of his prior employments. Due to the employee's academic limitations, the way he comes across and the presentation he makes, Mr. England felt that would really negate the employee's ability to go out successfully to compete for or to sustain work in the long run. His opinion is based on the combination of the breathing problems, back problems, the academic limitations, and his overall presentation.

Mr. England interpreted Dr. Volarich's recommendations as limiting the employee to less than a full range of sedentary work. With some sedentary jobs there is not much of an opportunity to get up and move around. Dr. Volarich's recommendation was that the employee be able to move around frequently and to rest when needed which is not normally found even in sedentary work. The rest of the recommendation would limit him to sedentary. Mr. England stated that the employee could work within part of those restrictions.

The employee saw Dr. Volarich on August 19, 2003. Dr. Volarich stated the right calf was weak due to back pain radiating to the right leg. The employee walked with a slight limp favoring the right lower extremity. He was unable to toe walk, heel walk, tandem walk or hop on

either leg due to severe back and leg pain complaints. The employee had a positive straight leg test on the right. Dr. Volarich stated the posterior pharynx was somewhat hyperemic with evidence of post nasal drip. With regard to the lungs, there was scattered wheezing noted in the apex bilaterally.

With regard to the January 8, 2001 injury, Dr. Volarich diagnosed lumbar syndrome with disc protrusion at L4-5 to the right and aggravation of degenerative disc and joint disease. Dr. Volarich diagnosed pre-existing conditions of mild chronic lumbar syndrome, asthma and sinusitis. It was Dr. Volarich's opinion that as a result of the January 8, 2001 injury, the employee had industrial disability that was a hindrance to his employment or re-employment. It was his opinion that the employee sustained a 20% permanent partial disability of the body as a whole referable to the lumbar spine due to the disc protrusion at L4-5 to the right and aggravation of degenerative disc and joint disease.

With regard to the employee's pre-existing medical conditions, it was Dr. Volarich's opinion that the employee had industrial disability that was a hindrance to his employment or re-employment. It was Dr. Volarich's opinion that the employee had a 10% permanent partial disability of the body as a whole rated at the lumbosacral spine due to degenerative disc disease and degenerative joint disease in the lumbar spine as well as mild chronic lumbar syndrome. It was Dr. Volarich's opinion that the employee had a 15% permanent partial disability of the body as a whole due to his pre-existing sinusitis and asthma. It was Dr. Volarich's opinion that the combination of the disabilities created a substantially greater disability than the simple sum or the total of each separate injuries/illness and a loading factor should be added.

Dr. Volarich stated that the employee was able to perform most self care activities. With regard to work and other activities referable to the spine, the employee was advised to limit repetitive bending, twisting, lifting, pushing, pulling, carrying, and climbing on an as needed basis. The employee should not handle any weight greater than 25 pounds, and limit this task to an occasional basis. The employee should not handle weight over his head, away from his body, or carry weight over long distances or uneven terrain. The employee was to avoid being in a fixed position for any more than about 30 minutes at a time including sitting and standing.

On October 18, 2004 Dr. Volarich diagnosed the employee with an aggravation of pre-existing asthma due to upper airways and respiratory exposures to the multiple chemicals at Plastene Supply. It was Dr. Volarich's opinion that the employee had industrial disability that was a hindrance to his employment or re-employment. It was Dr. Volarich's opinion the employee had a 15% permanent partial disability of the body as a whole referable to the pulmonary system due to aggravation of his pre-existing asthma that required extensive medical care and required ongoing use of daily bronchodilator to control wheezing. It is Dr. Volarich's opinion that all of his disabilities combine to create to a substantial greater disability that then simple sum or total of each separate injury or illness and a loading factor should be added.

It was Dr. Volarich's opinion with regard to work and other activities referable to the pulmonary system, that the employee should continue taking all medications, should avoid weather extremes of extremely hot or extremely cold temperatures and limit exposure to sudden changes in temperature. The employee should avoid odors, fumes, dust matter, chemicals,

allergens and other elements that could trigger an attack of bronchospasms. The employee should limit strenuous activities including pushing, pulling and extreme emotional distress.

The deposition of Dr. Volarich took place on August 20, 2008. It was his understanding that the employee worked full duty at his employment prior to January 8, 2001. There was no evidence that he had asked for or received any job accommodations at work. Prior to January of 2001 there was no indication that he had seen any type of back specialist, spine surgeon or orthopedic surgeon. There was no indication of any permanent restrictions in any of the records for his back. The employee told Dr. Volarich that prior to January 8, 2001 his back issues for the most part had resolved. The employee told Dr. Volarich that he had a little bit of stiffness and soreness in his low back but other than that he had no persistent problems. The employee could not recall any persistent ongoing problems that hindered his ability to work leading up to January of 2001 back injury. Dr. Volarich did not find any leg radiculopathy. The employee told him that he had stopped working when he got laid off and the company closed in 2002. Dr. Volarich testified that in his reports of August of 2003 and October of 2004 the only rating that he provided was permanent partial disability. Dr. Volarich did not provide a permanent total disability opinion for the employee.

RULINGS OF LAW:

Permanent Total Disability:

Issue 1. The liability of the Second Injury Fund for permanent total disability in Injury Number 01-167196, the January 8, 2001 injury and Issue 2. The liability of the Second Injury Fund for permanent total disability in Injury Number 01-169117, the May 30, 2001 injury.

The employee has alleged that he is permanently and totally disabled as a result of a combination of his pre-existing conditions and the January 8, 2001 injury to his low back or a combination of his pre-existing conditions and the May 30, 2001 injury to his lungs. Under Section 287.220.1 RSMo., the Second Injury Fund is liable for permanent and total disability benefits only if the previous disability or disabilities, whether from compensable injury or otherwise, and the last injury together result in total and permanent disability.

Section 287.020.7 RSMo. provides as follows:

The term “total disability” as used in this chapter shall mean the inability to return to any employment and not merely mean inability to return to the employment in which the employee was engaged at the time of the accident.

The phrase “the 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. 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. 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". Brown v Treasurer of the State of Missouri, 795 S.W.2d 479, 483(Mo.App.1990). The key is whether any employer in the usual course of business would be reasonably expected to hire the employee in that person's physical condition, reasonably expecting the employee to perform the work for which he or she is hired. Reiner at 365. See also Thornton v Haas Bakery, 858 S.W.2d 831, 834 (Mo.App.1993).

Based on the evidence, I find that the employee failed to meet his burden of proof on the issue of permanent total disability.

The employee's pre-existing low back and lung conditions were not significant. The employee testified that prior to working at Plastene, he had breathing problems but that did not change how he did things, and he did not have any restrictions or accommodations for his job. Dr. Volarich stated that prior to January of 2001 there was no indication of any permanent restrictions in any of the records for the employee's low back. The employee told Dr. Volarich that his back condition for the most part had resolved. The employee did not recall any persistent ongoing problems that hindered his ability to work leading up to the January of 2001 back injury.

The employee's primary cases were not settled for significant permanent partial disability. There was no surgery performed on the employee's low back either prior to or after January 8, 2001. The employee settled his January 8, 2001 low back case for 12.5% of the body as a whole. Dr. Forsythe a pulmonologist stated that the employee had no evidence of lasting pulmonary dysfunction. The employee settled his lung exposure case for 3.95% of the body as whole.

Mr. England provided the only opinion that the employee is permanently and totally disabled. Mr. England stated that the employee is a younger worker. (The employee was 28 years old in 2001). Mr. England stated that considering the physical restrictions listed by Dr. Volarich, the employee would appear to be limited to no more than a sedentary level exertion overall and was limited to less than a full range of sedentary work. Mr. England stated that the employee could work within part of those restrictions but it did not appear that the employee would be able to successfully compete for or sustain employment in the long run.

In both primary cases, the employer-insurer disputed the compensability and did not provide or pay for medical treatment. The employee went to various physicians on his own and none of them opined that he was unable to work. Dr. Guerra advised the employee to get a GED and find a job with no physical activity. Dr. Gibbs stated that the employee could return to work with a 20 pound lifting restriction. Dr. Volarich, the employee's rating doctor, rated the employee with permanent partial disability and did not opine that the employee was permanently and totally disabled.

The employee testified that he stopped working at Plastene Supply in November of 2001, and has not worked anywhere since then. However, on June 9, 2003, the employee told Dr. Soeter that he worked at a car lot. On January 19, 2004 the employee mentioned his boss and his job to Dr. Guerra.

Based on a review of the evidence, I find that the opinions of Dr. Gibbs, Dr. Guerra, and Dr. Volarich are more credible than the opinion of Mr. England on the issue of employability. I find that the employee has failed to satisfy his burden of proof on the issue of permanent total disability. The evidence does not support a finding that the employee is unemployable in the open labor market. I find that the employee is not permanently and totally disabled as a result of the combination of his pre-existing disabilities and the injury to his low back on or about January 8, 2001 or the pre-existing disabilities including the low back injury on or about January 8, 2001; and the last injury to his lungs on or about May 30, 2001. The employee's request for an award of permanent total disability against the Second Injury Fund is denied in both Injury Number 01-167196 and Injury Number 01-169117.

Permanent Partial Disability:

Issue 1. The liability of the Second Injury Fund for permanent partial disability in Injury Number 01-167196, the January 8, 2001 injury.

Based on the evidence, I make the following rulings:

Primary Low Back Injury:

It was Dr. Volarich's opinion that the employee sustained a 20% permanent partial disability of the body as a whole referable to the low back. The employee settled the primary case for 12.5% of the body as a whole referable to the low back. I find that the primary injury to the employee's low back resulted in a 12.5% permanent partial disability of the body as a whole referable to his low back.

Pre-Existing Low Back Condition:

It was Dr. Volarich's opinion that the employee had a pre-existing 10% permanent partial disability of the body as a whole rated at the lumbar spine. The employee told Dr. Volarich that prior to January 8, 2001 his back issues for the most part had resolved. The employee could not recall any persistent ongoing problems that hindered his ability to work leading up to the January of 2001 back injury. I find that the employee's pre-existing low back condition resulted in a 5% permanent partial disability of the body as a whole referable to the low back.

Pre-Existing Asthma/Sinusitis Condition:

It was Dr. Volarich's opinion that the employee had a 15% permanent partial disability of the body as a whole due to his pre-existing sinusitis and asthma. I find that employee's pre-existing asthma/sinus condition resulted in a 5% permanent partial disability of the body as whole.

I find that the employee's pre-existing low back and asthma/sinusitis conditions were not of such seriousness as to constitute a hindrance or obstacle to employment or obtaining re-employment. I find that the pre-existing conditions do not meet the minimum statutory threshold level of 50 weeks for the body as whole for Second Injury Fund liability under Section 287.220.1

RSMo. The employee’s claim against the Second Injury Fund in Injury Number 01-167196 for permanent partial disability is denied.

Issue 2. The liability of the Second Injury Fund for permanent partial disability in Injury Number 01-169117, the May 30, 2001 injury.

Primary Lung Case.

It was Dr. Volarich’s opinion the employee had a 15% permanent partial disability of the body as a whole referable to the pulmonary system due to aggravation of his pre-existing asthma. The employee’s primary claim was settled for 3.95% of the body as a whole referable to lungs (asthma). I find that the primary injury to the employee’s pulmonary system resulted in a 3.95% permanent partial disability of the body as whole referable to the lungs.

I find that the primary injury does not meet the minimum statutory threshold level of 50 weeks for the body as whole for Second Injury Fund liability under Section 287.220.1 RSMo. The employee’s claim against the Second Injury Fund in Injury Number 01-1671960 for permanent partial disability is denied.

Date: _____

Made by:

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

A true copy: Attest:

Naomi Person
Division of Workers' Compensation

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

Injury No.: 01-169117

Employee: Arlandis Kelleybrew
Employer: Plastene Supply Company (Settled)
Insurer: Hartford Insurance Company (Settled)
Additional Party: Treasurer of Missouri as Custodian
of Second Injury Fund

The above-entitled workers' compensation case is submitted to the Labor and Industrial Relations Commission (Commission) for review as provided by section 287.480 RSMo. Having reviewed the evidence and considered the whole record, the Commission finds that the award of the administrative law judge is supported by competent and substantial evidence and was made in accordance with the Missouri Workers' Compensation Law. Pursuant to section 286.090 RSMo, the Commission affirms the award and decision of the administrative law judge dated August 17, 2009, and awards no compensation in the above-captioned case.

The award and decision of Chief Administrative Law Judge Lawrence C. Kasten, issued August 17, 2009, is attached and incorporated by this reference.

Given at Jefferson City, State of Missouri, this 4th day of December 2009.

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: Arlandis Kelleybrew

Injury No. 01-167196 & 01-169117

Dependents: N/A

Employer: Plastene Supply Company (Settled)

Additional Party: Second Injury Fund

Insurer: Hartford Insurance Company (Settled)

Appearances: James Turnbow for the employee. Frank Rodman for Second Injury Fund.

Hearing Date: Commenced December 3, 2008
Completed December 11, 2008

Checked by: LCK/kh

SUMMARY OF FINDINGS

1. Are any benefits awarded herein? No.
2. Was the injury or occupational disease compensable under Chapter 287? Yes.
3. Was there an accident or incident of occupational disease under the Law? Yes.
4. Date of accident or onset of occupational disease? On or about January 8, 2001 and on or about May 30, 2001.
5. State location where accident occurred or occupational disease contracted: Pemiscot 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 sustained a low back injury due to repetitive work and sustained a lung injury due to chemical exposure.
12. Did accident or occupational disease cause death? No.
13. Parts of body injured by accident or occupational disease: Low back and body as a whole in Injury Number 01-167196 and body as whole referable to lungs in Injury Number 01-169117.
14. Nature and extent of any permanent disability: 12.5% permanent partial disability of the body as a whole referable to the low back in Injury Number 01-167196. 3.95% of the body as a whole referable to the lungs in Injury Number 01-169117.
15. Compensation paid to date for temporary total disability: None.
16. Value necessary medical aid paid to date by employer-insurer: None.
17. Value necessary medical aid not furnished by employer-insurer: None.
18. Employee's average weekly wage: \$318.66.
19. Weekly compensation rate: \$212.44.
20. Method wages computation: By agreement.
21. Amount of compensation payable: None.
22. Second Injury Fund liability: None.
23. Future requirements awarded: None.

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: N/A.

FINDINGS OF FACT AND RULINGS OF LAW

On December 3, 2008, the employee, Arlandis Kelleybrew, appeared in person and with his attorney, Jim Turnbow, for a hearing for a final hearing. The claims against the employer-insurer were settled and approved on August 22, 2007. The Second Injury Fund was represented at the hearing by Assistant Attorney General Frank Rodman and Cliff Verhines. 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 summary of evidence and findings of fact and rulings of law, are set forth below as follows:

UNDISPUTED FACTS

1. Plastene Supply Company was operating under and subject to the provision of the Missouri Workers' Compensation Act and its liability was fully insured by Hartford Insurance Co.
2. On or about January 8, 2001 and May 30, 2001, Arlandis Kelleybrew was an employee of Plastene Supply Company, Inc. and was working under the Workers' Compensation Act.
3. On or about January 8, 2001 and May 30, 2001, the employee sustained occupational diseases arising out of and in the course of his employment.
4. The employer had notice of the employee's occupational diseases.
5. The employee's claims were filed within the time allowed by law.
6. The employee's average weekly wage was \$318.66. The rate of compensation for permanent total disability and permanent partial disability is \$212.44 per week.
7. The employee's injuries were medically causally related to the occupational diseases.
8. The employer-insurer did not pay medical aid in either case.
9. The employer-insurer did not pay temporary disability in either case.

ISSUES

1. Liability of the Second Injury Fund for either permanent partial disability or permanent total disability in injury number 01-167196 (Date of injury January 8, 2001).
2. Liability of the Second Injury Fund for either permanent partial disability or permanent total disability in injury number 01-169117 (Date of injury May 30, 2001).

EXHIBITS

The following exhibits were offered and admitted into evidence:

Employee's Exhibits:

- A. Medical records (At the hearing, the Second Injury Fund reserved the right to make objections on the records of Cardiovascular Consultants, Research Belk Hospital, St. Luke's Hospital, Pemiscot Primary Care Center, Pemiscot Memorial Hospital, and Headache and Pain Center. There were no objections to the other records in the Exhibit. The record was left open for 14 days for objections.)

On December 11, 2008, the Division received a letter from the Second Injury Fund which stated that it did not object to the medical records from Pemiscot Primary Care Center (75 pages), Pemiscot Memorial Health System (10 pages), Research Belton Hospital (42 pages) and St. Luke's Hospital (46 pages). These records are therefore admitted into evidence.

The Second Injury Fund objected to 200 pages of records from Dr. Greenfield because there was no certificate of authenticity and they were not offered into evidence. On July 20, 2009, there was a telephone conference between myself, the attorney for the employee and the attorney for the Second Injury Fund. The parties agreed that the 200 pages of records from Dr. Greenfield were not offered into evidence at the hearing. The parties agreed that Dr. Greenfield's records were offered into evidence as part of the records of the Headache and Pain Center (92 pages and 43 pages).

The Second Injury Fund objected to the records from the Headache and Pain Center (92 pages and 43 pages) on the basis that only 13 pages were provided. I find that there were 13 pages of records with the Headache and Pain Center caption and the remaining pages were records from various physicians at the Headache and Pain Center. The Second Injury Fund objection is overruled and those records are admitted into evidence.

The Second Injury Fund objected to the Pemiscot Memorial Health System records because the certificate of authenticity stated there were 115 pages but there were only 111 pages of records. On July 20, 2009, there was a telephone conference between myself, the attorney for the employee and the attorney for the Second Injury Fund. I advised the parties that there were 111 pages contained in those records and not 115 as set forth in the certificate of authenticity, and that the objection would be sustained. However, the employee would have 14 days to send the Court a corrected affidavit that there were 111 pages of records or the complete 115 pages with a new affidavit. On July 27, 2009, the Division received a letter from the employee's attorney with a corrected affidavit that the records contained 111 pages. The objection is now overruled and those records are admitted into evidence. (Note: The corrected affidavit is attached to the records behind the original affidavit.)

The Second Injury Fund objected to the records from Midwest Pulmonary Consultants because the certificate of authentication stated that there were 28 pages and only 25 pages were provided. The Second Injury Fund also objected to 3 pages from Cardiovascular Consultants because there was no certificate of authenticity for that health care provider. I find that the records from Midwest Pulmonary Consultants totaled 28 pages which included a 3 page letter from Cardiovascular Consultants to Midwest Pulmonary due to a referral. The Second Injury Fund's objections are overruled and those records are admitted into evidence.

- B. Deposition of James England (subject to objections in the deposition).
- C. Deposition of Dr. Volarich (subject to objections in the deposition).
- D. Current medication list.

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

WITNESSES: Arlandis Kelleybrew, the employee and Sonya Kelleybrew for the employee

BRIEFS: The Second Injury Fund filed its brief on February 26, 2009. The employee waived the filing of his brief.

FINDINGS OF FACT:

The employee testified that he is 36 years old and was born in August of 1972. He employee completed the 10th grade and started the 11th grade. He tried two times to get a GED but was not successful. He cannot read or write very well. He can add and subtract by counting on his hands but is not good at multiplication and division. He cannot operate a computer. Prior to 2001, he liked to work on cars including changing oil and brakes. A couple of years ago, the employee got a driver's license. He took the test multiple times and took an oral and not a written test. His wife helped him study. His first job was at a city market in Indiana when he was 17 years old. He bagged and carried groceries and then went to produce. He wanted to get a promotion but needed a GED. He worked there for 4-5 years.

1992:

The emergency room records from Elkhart Hospital in June showed that the employee had trouble breathing. In August, the employee went to the emergency room due to shortness of breath and feeling light headed. The employee was felt to have hyperventilation syndrome. He had essentially the same symptoms in June which had been felt to be anxiety. The emergency room doctor stated that anxiety was probably a role in the hyperventilation syndrome. At the end of December, the employee was at the emergency room with difficulty breathing.

1993:

In March, the employee went to the emergency room at Elkhart Hospital and was diagnosed with an acute lumbar strain. In September, the employee went to Elkhart Hospital emergency room for back and chest pain from lifting at work. He had been breathing a lot of dust fumes at work and had not been wearing a mask. In December the employee went to Elkhart Hospital for shortness of breath with numbness of the extremities and anxiousness. The symptoms subsided after breathing into a paper bag. He was diagnosed with hyperventilation.

1995:

In March, the employee went to the emergency room at Elkhart Hospital for lumbar and thoracic back pain. He performed a lot of lifting at work and had prior back problems. Bilateral straight leg raising was negative. The diagnosis was probable lumbosacral strain.

1996:

In May, the employee was diagnosed with acute bronchitis.

The employee testified that in 1996, he pled guilty to selling cocaine and was incarcerated in Indiana until 1999.

1999:

In June, the employee went to Elkhart Hospital for lower back pain that radiated down the left leg and into the groin and was diagnosed with acute lumbago. In August, the employee was seen for back pain that radiated down the back of his left leg to the knee. In October, the employee went to Elkhart Hospital due to pain in his left upper chest which was worse with deep breaths. He had a past history of asthma which had been acting up. He was diagnosed with acute chest wall pain.

2000:

In early January, the employee was at Elkhart Hospital emergency room with difficulty swallowing due to nasal drainage but denied shortness of breath.

On January 27, the employee was taken to Elkhart Hospital due to mid sternum chest pain and difficulty breathing. He had a feeling like his throat was swollen shut which he had for a couple of weeks. On exam, the employee's lungs were clear with decreased breath sounds due to his subjective laryngeal spasms. Chest x-rays were normal. The employee was given Halfan, which calmed him down and his breathing was normal. The employee stated that two weeks ago had a fight with his girlfriend and that is when he started having problems. The doctor diagnosed self induced laryngeal spasm and referred the employee for anger management. On February 7, the employee went to the emergency room and felt like something was caught in his throat. He was diagnosed with dysphasia, sore throat, and possible tracheitis. The employee was put on a Z-pack and Prednisone.

The employee went to the emergency room at Elkhart Hospital on February 10 due to upper epigastric burning type discomfort. It was noted the employee made a lot of visits to their emergency room with varied and sundry complaints. The employee stated that he felt like his body was falling apart and several doctors have told him that he was a hypochondriac.

The employee testified that after he was released from prison he got a job with Venture Welding and worked there for 5-6 months. He stacked RV frames with a forklift. As the employee was stacking frames, he fell off a RV frame, injured his back and went to Elkhart Hospital. He was fired a couple of weeks later. He was in the emergency room at Elkhart General Hospital numerous times for breathing problems due to change of seasons and different chemicals at Venture Welding and for his back problems. Other jobs that he had included working in a meat market, at Hardees, and a car place.

The employee was seen at Elkhart Hospital on February 22, 2000 after falling at work. He had persistent low back pain with some spasms. He pain complaints from his shoulders down to his lower back. The past medical history was significant only for asthma. The diagnosis was lower back strain and contusion. He was kept off work until the next day and was limited to 25 pounds lifting and no heavy lifting or climbing for the next three days.

The employee testified that in 2000, he moved to Missouri. He worked at Plastene from August of 2000 until November of 2001, when he went out on medical leave. He has not worked

anywhere since he left Plastene Supply and has not looked for work. Plastene Supply closed in November of 2002. The employee testified that prior to working at Plastene, he had breathing problems but it did not change how he did things, and he did not have any restrictions or accommodations for his job. He also had back problems.

The employee testified that his job at Plastene included transferring racks of car emblems that weighed a minimum of 25 pounds. There were a lot of chemicals in the factory. He developed problems with breathing and his low back.

On October 25, the employee went to Pemiscot Primary Care Center for coughing and shortness of breath.

2001:

The employee was seen at Pemiscot Primary Care Center and the emergency room on January 8 due to low back pain which started the week before. The employee did heavy lifting at work and working made his low back pain worse. The employee was diagnosed with a severe lumbar strain, was excused from work, and given Lorcet Plus and Flexeril. In April, the employee went to Pemiscot Primary Care Center twice for back pain.

On May 10, the employee went to Pemiscot Primary Care Center due to shortness of breath with a known history of bronchial asthma. He was admitted to Pemiscot Memorial Hospital by Dr. Nwora with a two day history of shortness of breath with productive cough. The employee was anxious and in respiratory distress. He was diagnosed with an acute exacerbation of bronchial asthma, was started on IV of Solumedrol, and put on Proventil. The employee was discharged on May 11. Azmacort and meter dose inhalers were prescribed.

The employee went to the emergency room at Pemiscot Hospital on May 14 due to asthma complaints. He reported he may have gotten too hot at work that day. The employee had a history of recurrent attacks of bronchial asthma, wheezes in both lungs, and was diagnosed with bronchial asthma. Three respiratory care treatments were performed.

On May 16, the employee was admitted to Pemiscot Hospital for shortness of breath. Dr. Tippen noted that the employee had a history of asthma but the asthma did not develop until he moved back to the Bootheel about two years ago. The examination showed coarse breath sounds bilaterally with a few faint wheezes. The employee was diagnosed with asthma exacerbation and allergic rhinitis. The employee had quite a bit of bronchi spasms, was placed on IV Solumedrol, and given nebulizer dilators. The employee was started on Zyrtec to see what role allergies were playing. During the afternoon of May 17 the employee felt better, did not have significant shortness of breath, and was discharged.

The employee testified that in May and June of 2001, he missed time from work.

On July 19, the employee went to Pemiscot Primary Care Center with shortness of breath. On July 23, the employee was at Pemiscot Primary Care Center with complaints of sinus

draining, congestion and difficulty breathing. On August 9, the employee went to Pemiscot Primary Care Center with bilateral rib pain. A chest x-ray showed no active pulmonary disease.

A pulmonary function test was done on August 24, at St. Francis Medical Center. It was an abnormal study and showed a mild reduction and diffusion capacity consistent with a pulmonary parenchymal or vascular abnormality. The employee had diagnosed asthma and was on several medications. The employee had shortness of breath with exercise, was extremely anxious and got very lightheaded.

On September 19, the employee went to Pemiscot Primary Care Center for increased back pain. On September 20, the employee went to the emergency room at Pemiscot Hospital. He had been at work when he experienced chest pain and left arm numbness. On September 24, the employee went to Pemiscot Primary Care Center with increased back pain.

The employee was admitted to Pemiscot Hospital on October 30, with a two day history of progressive shortness of breath and diffuse abdominal pain. The employee had no improvement with the use of Albuterol meter dose inhaler. The employee was anxious and in obvious respiratory distress. He had diffuse inspiratory and expiratory wheezing with fair air exchange. The diagnosis was an acute exacerbation of bronchial asthma. The employee was started an IV and a Proventil nebulizer. The employee was discharged on October 31 with continued fine diffuse wheezing.

Dr. Nwora ordered physical therapy. The employee was evaluated on December 4 at Pemiscot Hospital. The employee reported low back pain with an onset of three to four months ago, which was progressively getting worse the past two to three weeks. The employee's low back pain was constant and occasionally went down to the right groin/thigh area. The employee was given therapy eight times.

On December 13, the employee saw Dr. Landry, an orthopedic surgeon, with lower back pain for many years which had come and gone. The employee worked in a factory where he did a lot of lifting but had been out of work for three weeks due to increased lower back pain. The pain had been constant for three weeks and went into the right groin and right posterior thigh. The employee had positive straight leg raising on the right. Dr. Landry ordered an MRI, kept the employee off work, and put the physical therapy on hold.

2002:

The January 10, 2002 MRI showed a loss of signal strength and a disc protrusion at L4-5. On January 10, the employee saw Dr. Landry with continued radiation of pain into the right groin and posterior thigh down to the knee. The employee had tenderness at L5-S1 and his straight leg raising was positive on the right. Dr. Landry stated that the MRI showed decreased signal intensity at L4-5 disc with a small central disc protrusion that abutted the exiting right L5 nerve root without causing compression. Dr. Landry recommended an epidural steroid injection and pain management. Dr. Landry put restrictions on of no bending or lifting and stated he was not able to work at that time. On January 17, the employee went to Pemiscot Primary Care Center for low back pain.

On February 7, Dr. Landry recommended a neurosurgical consultation with Dr. Gibbs. On February 21, the employee saw Christine Byrd, Dr. Gibbs' nurse practitioner. The employee stated that four months ago he developed low back pain with no particular precipitating event. The pain radiated into his right groin, right buttock and into the right upper thigh. The employee had physical therapy with no improvement. Two epidural steroid injections eased the pain. The employee seemed very uncomfortable and exhibited a lot of pain behaviors. The January MRI showed degenerative disc disease most marked at L4-5 with a central disc bulge at L4-5 which did not appear to be contacting the L5 nerve root. Nurse Byrd noted that the employee's pain did not follow an L5 dermatomal pattern. She reviewed the MRI and stated that it was not clear that the L4-5 disc bulge was responsible for the symptoms. She ordered therapy; and prescribed a TENS unit, Medrol-dose pack, and Celebrex.

On February 27, the employee had a physical therapy evaluation at Pemiscot Health Systems. He stated that the back pain got worse in November of 2001. The employee received therapy eight times which ended on March 15, due to non compliance.

On March 6, the employee saw Dr. Gibbs. The employee appeared comfortable at rest but seemed very uncomfortable when changing positions. There was a lot of moaning and groaning during the examination. Dr. Gibbs noted the MRI showed diminished signal at L4-5 disc and there appeared to be a small central disc bulge/herniation interposed between the L5 nerve roots. This abutted both L5 nerve roots (right greater than left) and it may slightly displace the one on the right. Dr. Gibbs stated that the pain did not clearly follow an L5 dermatomal pattern. Dr. Gibbs recommended a right L5 selective nerve root block to determine whether the L4-5 disc was symptomatic. Dr. Gibbs requested a right segmental nerve block at L5 and then at L4.

On March 13, Dr. Pjura performed a L5-S1 nerve root injection. The employee had complete relief of his low back symptoms and therefore he did not perform the L4 injection.

On April 3, 2000 the employee saw Dr. Gibbs and stated after the L5 selective nerve root block, his groin and right medial thigh pain stopped, and a portion of the back pain was relieved. The back pain returned and was particularly bothersome with any increase in activity. He has only occasional shooting pain in the right groin. During the exam the employee looked well and seemed comfortable at rest. Dr. Gibbs stated that the low back and radicular pain may be due to a small central herniated disc. Dr. Gibbs stated that since the employee did not have any leg pain, he was not confident that a microdiscectomy would be beneficial. He discussed the options of an IDET and offered to refer him to someone who did that procedure. The employee wanted to check with the insurance to make sure that would be covered. Dr. Gibbs prescribed Ultracet as needed and stated that the employee could return to work with a 20 pound lifting restriction. The employee was to return to the clinic on an as needed basis.

In May the employee went to Pemiscot Primary Care with increased back pain. The employee went to the emergency room at Pemiscot Hospital on July 1, with back pain which had began getting worse since yesterday. On July 2, the employee was at Pemiscot Primary Care and was diagnosed with asthma and back pain. On September 18 the employee went to Pemiscot Hospital emergency room for low back and right groin pain that started the day before.

The employee was admitted to Pemiscot Hospital on September 19 by Dr. Nwora with a three day history of progressive shortness of breath and productive cough. The employee was in obvious respiratory distress. His chest had diffuse inspiratory and expiratory wheezing. The employee was started on an IV and Zithromax, and nebulizers were prescribed. He was put back on Avalide and Norvasc. The next day, his air exchange had improved but he started complaining of low back pain. The employee was discharged on September 21 with a Combivent meter dose inhaler. The discharge diagnosis was acute exacerbation of bronchial asthma and low back pain.

On October 10 the employee went to Pemiscot Primary Care with shortness of breath. On October 17, the employee saw Dr. Landry who stated that the employee's epidural steroid injections and nerve block gave him temporary relief. The employee has been off work since November of 2001 because no light duty was available. Dr. Landry scheduled a repeat nerve block which was done on November 15. The selective nerve root block at the right L4-5 had significant pain improvement.

On November 29, the employee went to Pemiscot Primary Care with dizziness and shortness of breath. The employee went to the emergency room at St. Francois Medical Center on December 5 with difficulty breathing, tingling hands, mild cough, chest discomfort, being light headed and anxiety. The diagnosis was hyperventilation.

2003:

The employee was admitted to Pemiscot Hospital on January 16 by Dr. Nwora with a history of progressive shortness of breath associated with productive cough. The employee was in obvious respiratory distress and the chest showed defused wheezing with poor air exchange. The employee's breathing improved considerably and he was discharged on January 18.

On January 30, the employee saw Dr. Landry. The employee had recurrent right groin pain with more severe and constant pain in the lower back. Dr. Landry recommended pain management. The employee's initial evaluation at the Pain Management Center was on January 31 by Dr. Soeter. The employee had been having lower back pain that ran down the back of his right leg and groin on occasion which had been going on for about a year. The past medical history was significant for asthma which has been exacerbated numerous times since he moved to Southeast Missouri. The employee had mild wheezing especially in the left upper lung.

On February 11, Dr. Soeter performed a selective nerve root block at L3-4, L4-5 and L5-S1. In February and March, the employee was at Pemiscot Primary Care with tightness in his chest.

The employee went to Research Medical Center on April 12, with shortness of breath and wheezing and was diagnosed with asthma. On April 16, the employee saw Dr. Soeter and stated that the selective nerve root block gave him partial relief. On April 24, Dr. Soeter performed a selective nerve block at L3-4 and L4-5. On May 22 Dr. Schisler performed a lumbar epidural steroid injection at L4-5.

On June 2 the employee went to Pemiscot Primary Care with tightness and pain in his chest that increased with deep breaths. The employee went to Pemiscot Primary Care on June 9, with resolved chest pain and no shortness of breath. On June 9, the employee went to the Pain Management Center for low back, right thigh and groin pain. The last lumbar epidural in May gave him no pain relief. The employee stated that he cannot wash cars at the car lot where he works. Dr. Soeter performed selective nerve root blocks from L3 through L5. On June 22, the employee went to Research Medical Center due to light headedness, chest pain, and shortness of breath. On July 14, the employee saw Dr. Guerra with chronic back pain and asthma. There was an occasional and very mild expiratory wheezing in his lungs.

On July 21, 2003 the employee saw Dr. Greenfield at the Headache and Pain Center for lower back pain that developed steadily over two years after heavy lifting. The employee had shortness of breath, difficulty breathing and wheezing which came and went. The employee had normal breath sounds and respiratory effort. The employee had moderate tenderness at L4-5 and severe tenderness at L5-S1. The employee had significant bilateral muscle spasms, and positive bilateral straight leg raising. Dr. Greenfield ordered an MRI of the lumbar spine and nerve conduction/EMG studies.

The July 21 MRI showed disc dissection with an underlying bulge at L4-5 and a minimal bulge at L3-4. The employee had nerve conduction studies and EMG of his lower extremities done by Dr. Hermes on July 21. There was electrodiagnostic evidence for bilateral L5-S1 polyradiculopathies, which appear to be acute to subacute in nature.

On July 31, Dr. Greenfield performed an injection at L3-4 and L4-5 bilaterally. On August 15, Dr. Catts performed a caudal epidural injection. In August Dr. Romaker at St. Luke's Sleep Disorders Clinic noted that the employee demonstrated mild sleep apnea.

On August 11, the employee saw Dr. Guerra. The employee was using several medications for asthma and was having difficulty breathing with shortness of breath. His lungs were clear to auscultation with no wheezing and mild rhonchi that cleared with cough. Dr. Guerra diagnosed bronchitis and moderate persistent asthma and referred the employee to a pulmonologist. On August 20, Dr. Greenfield performed a second caudal injection.

On September 5, Dr. Forsythe at Midwest Pulmonary noted that the employee's shortness of breath was interfering with his ability to play with his children. The employee had an initial diagnosis of asthma in May of 2001 while working in a chrome plating facility in Hayti. The employee took medical leave in 2002 that was related to his shortness of breath and a back injury. The employee's current medications were Albuterol inhaler, Norvasc, Avalide, Advair, Xopenex, and Neurontin. Dr. Forsythe's impression was 1) Dyspnea, etiology not clear. There may have a component of vocal cord dysfunction and hyperventilation. He may have a component of irritable airway secondary to industrial exposure. 2) Herniated lumbar disc by history. 3) Questionable sleep apnea. Dr. Forsythe ordered a complete pulmonary function study and a consultation with St. Luke's speech department for a comprehensive evaluation of his vocal cord function. He ordered a high resolution CT examination of his chest due to make sure there was no interstitial lung disease.

The employee saw Dr. Greenfield on September 9, with low back pain that spread into the inguinal areas; and pain, numbness and tingling in both lower extremities. On September 11, Dr. Greenfield performed a third caudal epidural injection. On September 23 the employee told Dr. Greenfield that after the last injection his pain was better for a while but gradually increased to the same level. On October 1, Dr. Greenfield added Ultram.

The employee saw a speech pathologist at St. Luke's Hospital on October 2 and described a wheeze in his voice and the left side of his throat feeling clogged up. Physical exertion often resulted in coughing episodes and occasional instances of his throat "shutting off". The speech pathologist stated that the employee had a mildly strained vocal quality characterized by elevated pitch levels and frequent cough. Vocal cord dysfunction could not be ruled out due to a sensitive gag reflex. The employee should have therapy for vocal cord dysfunction symptoms.

In October of 2003 the employee saw Dr. Guerra due to nose congestion, drainage, sinus pressure, and sore throat. The employee's lungs were clearly bilaterally with no rales or wheezing; and was diagnosed with sinusitis and controlled asthma.

The employee saw Dr. Forsythe at Midwest Pulmonary on October 8. The employee's high resolution CT scan was normal. A complete pulmonary function was normal. The sleep study showed mild sleep apnea. Dr. Forsythe stated that he could not make a diagnosis of asthma at that time but in the past he had been told he had asthma. Dr. Forsythe advised him to discontinue Advair and use Albuterol on an as needed basis.

On October 20, a CT and myelogram showed a very minimal broad based disc bulge at L3-4. At L4-5 there was a broad based disc bulge with a central subligamentous disc which indented the thecal sac slightly but did not appear to impinge upon the nerve roots. At L5-S1 there was a central subligamentous disc bulge which impinged upon the nerve roots and barely indented the thecal sac. There were no focal disc herniation or compressed nerve roots. On October 28, the employee went to the emergency room at Research Belton Hospital with sharp stabbing pain and pressure in the chest which worsened with deep breaths. He was diagnosed with acute chest pain and viral pleurisy. Dr. Greenfield performed two low back injections in November.

On November 5, the employee saw Dr. Forsythe with vague chest discomfort and shortness of breath. The impression of Dr. Forsythe was: 1) Dyspnea, etiology unclear. He thought he had some component of vocal cord dysfunction. 2) Chest discomfort with exertion, etiology not clear. 3) Disability secondary to back discomfort and herniated disc and 4) Recent pharyngitis/bronchitis, resolving. Dr. Forsythe thought the employee's symptoms were functional and related to anxiety and frustration with not being able to be as active as he would wish due to back discomfort. He had some episodes of obstruction to air flow related to his previous employment but no evidence of lasting pulmonary dysfunction.

On November 18, Dr. Guerra diagnosed asthma but stated that Dr. Forsythe, a pulmonologist, thought that the pulmonary functions have been normal and there was no clear etiology for the shortness of breath.

Dr. Forsythe referred the employee to Dr. Conn a cardiologist who saw the employee in December for breathlessness with occasional associated chest pain. The employee's primary limitations were from chronic low back pain with radicular leg symptoms. Dr. Conn stated that the employee had no obvious cardiac causes for his breathlessness and chest pain.

In December Dr. Greenfield referred the employee to Dr. Hess, a neurosurgeon, who saw the employee on December 12. Dr. Hess stated that the myelogram and MRI showed no disc herniation or stenosis and he did not recommend surgery.

2004:

On January 14, Dr. Greenfield performed an epidural injection in the right L5. On January 19, the employee saw Dr. Guerra for back pain and breathing problems. The employee reported that sometimes his boss tells him that he has to stop doing what he doing regarding his pain. Dr. Guerra advised the employee that if he cannot find a job where physical activity is not done, then he needs to try to finish his GED and try to find a different type of job with no physical activity. The employee was advised to see a counselor for depression.

On March 29, Dr. Greenfield stated that the employee's pain was moderate to severe and the functional impairment was severe and when present it interferes with most but not all daily activities. On May 3, the employee's severity of pain was somewhat less severe and the pain was rated as moderate.

On June 15, the employee saw Dr. Guerra and was diagnosed with sinusitis and depression. When the employee did physical activity he felt chest pressure like he could not breathe very well. Dr. Guerra thought the symptoms could be related to anxiety and depression.

On August 11, the employee saw Dr. Guerra and was diagnosed with sinusitis, possible seizures and headaches. The employee was to be sent for a CT scan of the head and to a neurologist for possible seizure activity. On October 5, the employee saw Dr. Greenfield with increased low back pain.

On December 15, the employee went to St. Luke's Hospital due to coughing for the past ten days. He did not have any wheezing or shortness of breath and no chest pain. The employee was diagnosed with acute bronchitis, rhinitis, and asthma exacerbation. Dr. Parvin ordered a chest x-ray to rule out pneumonia and it showed no evidence of infiltrates, fusions or congestive heart failure. The employee was given a nebulizer treatment and Albuterol. On December 21, the employee saw Dr. Guerra for follow up for pneumonia.

2005:

On March 19, Dr. Greenfield stated the employee had some improvement in back and leg pain.

The employee went to the emergency room at Research Belton Hospital on April 6 for constant chest pain and shortness of breath. The employee had moderate wheezing on mild

expiration. The clinical impression was acute chest wall pain and asthma. A Medrol-dose pack and an inhaler were given. On April 12, the employee saw Dr. Guerra for shortness of breath, and noted the Medrol-dose pack helped. Dr. Guerra assessed shortness of breath but did not know if the employee's exacerbation was related to an asthma attack or anxiety.

On June 20, 2005 Dr. Greenfield saw the employee for lower back pain. The employee had not improved and his pain level was 10 out of 10. Qualitatively, the pain was rated as severe and the functional impairment was very severe. When present the employee was unable to carry out any daily activities. Dr. Greenfield added Tramadol in addition to his current medications of Albuterol, Avalide, Effexor, Flonase, Norvasc and Ranitidine.

In Injury Number 01-169117, the lung exposure case, a Stipulation for Compromise Settlement was approved for 3.95% of the body as a whole referable to lungs (asthma) on August 22, 2007. In Injury Number 01-167196, the low back case, a Stipulation for Compromise Settlement was approved for 12.5% of the body as a whole referable to the low back on August 22, 2007.

The employee testified that his typical day is laying on the couch and bed because he is not comfortable sitting. He watches his 4 year old son. He picks up things but his other children do the household chores. He tries to help out but it bothers him to lift something heavy. Due to the pain, he goes to church about once a month, and has no other social activities outside of church. He pays the bills, and is able to drive and take his children to doctor appointments. When he goes to the store and walks, he has trouble breathing. He has trouble riding in a car and has to stop a lot. He has to pay someone to work on his cars.

The employee testified that he has problems with sinus and allergies with changes in the weather which causes him to breath heavy and it hurts his lungs. Smells such as tar on the road, cleaning chemicals in the house, and perfume bothers him. He has breathing problems going up and down stairs and trouble walking. Hot and cold weather affects his breathing. He has chest pain and tightness when in distress. With regard to his allergies, temperature change makes it worse. His breathing becomes worse with sinus problems. The employee has low back pain all the time and has right sided leg pain and numbness. He has numbness in his feet which comes and goes. He has trouble bending and his back pain makes him depressed. He has trouble with balance but has not fallen down. He can sit for 15-20 minutes at a time due to shooting pain down the leg. Nothing helps with the pain.

The employee testified that currently he is taking about eight Hydrocodone/Vicodin every day. The medicine helps him sleep but does not help with pain. He uses a nose spray and often takes antibiotics for allergy and sinus. For asthma he uses Symbicort, which is an inhaler, Advair and Proventil. He uses Nasacort for allergies and Celebrex for his back. He has used inhalers off and on since May of 2001. Prior to those injuries he did not have pain or sleep problems. Since he moved to Kansas City in 2003, his back, leg and breathing is worse.

Sonja Kelleybrew, the employee's wife, testified that she started dating the employee in 2000 and married him in March of 2002. She worked at Plastene and was laid off in November of 2002 along with everyone else. She has relatives in Kansas City and they moved there in

2003. She works 40 hours a week as a medical assistant and works part time as a cashier at Wal-Mart about 25 hours a week. The employee has back pain and lays around and changes positions frequently. The employee has problems breathing and is not able to help with household chores. He gets the children off to school, takes the children to the doctor and pays bills. The trip from Kansas City was difficult for him and he had to stop every 30 minutes.

The employee saw Mr. James England for a vocational rehabilitation evaluation on April 20, 2005. The employee appeared to be quite uncomfortable and was moving around about every 20 minutes during the evaluation process and walked with a noticeable limp. The employee scored at the 4th grade level on word recognition and math and at the 6th grade level for reading comprehension. Mr. England stated that his academics were low enough that he would not expect the employee to do well in a job that required reading, writing, recordkeeping or fairly simple math. Mr. England stated the employee is a younger worker under the US Department of Labor guidelines. He has a limited education, was functioning only at a mid-grade school level academically and was essentially limited to work that can be performed after learning by observation. Considering the physical restrictions listed by Dr. Volarich, the employee would appear to be limited to no more than a sedentary level exertion overall and is limited to less than a full range of sedentary. His need to avoid cologne, perfume etc. would make it difficult for him to function even in some temperature controlled office environments. His academic limitations would negate his ability to do the majority of sedentary jobs since they normally involve reading, writing, recordkeeping and/or math. Considering his combination of medical problems, it did not appear to Mr. England that the employee would be able to successfully compete or sustain employment in the long run. Absent significant improvement in his functional capability, Mr. England felt that the employee was more likely to remain totally disabled from a vocational standpoint. As he is currently functioning and taking into consideration his academic limitations, Mr. England did not think vocational rehabilitation would be of any benefit.

The deposition of Mr. England was taken on August 26, 2008. Mr. England stated that other than operating the forklift, he did not believe that the employee acquired any transferable skills from any of his prior employments. Due to the employee's academic limitations, the way he comes across and the presentation he makes, Mr. England felt that would really negate the employee's ability to go out successfully to compete for or to sustain work in the long run. His opinion is based on the combination of the breathing problems, back problems, the academic limitations, and his overall presentation.

Mr. England interpreted Dr. Volarich's recommendations as limiting the employee to less than a full range of sedentary work. With some sedentary jobs there is not much of an opportunity to get up and move around. Dr. Volarich's recommendation was that the employee be able to move around frequently and to rest when needed which is not normally found even in sedentary work. The rest of the recommendation would limit him to sedentary. Mr. England stated that the employee could work within part of those restrictions.

The employee saw Dr. Volarich on August 19, 2003. Dr. Volarich stated the right calf was weak due to back pain radiating to the right leg. The employee walked with a slight limp favoring the right lower extremity. He was unable to toe walk, heel walk, tandem walk or hop on

either leg due to severe back and leg pain complaints. The employee had a positive straight leg test on the right. Dr. Volarich stated the posterior pharynx was somewhat hyperemic with evidence of post nasal drip. With regard to the lungs, there was scattered wheezing noted in the apex bilaterally.

With regard to the January 8, 2001 injury, Dr. Volarich diagnosed lumbar syndrome with disc protrusion at L4-5 to the right and aggravation of degenerative disc and joint disease. Dr. Volarich diagnosed pre-existing conditions of mild chronic lumbar syndrome, asthma and sinusitis. It was Dr. Volarich's opinion that as a result of the January 8, 2001 injury, the employee had industrial disability that was a hindrance to his employment or re-employment. It was his opinion that the employee sustained a 20% permanent partial disability of the body as a whole referable to the lumbar spine due to the disc protrusion at L4-5 to the right and aggravation of degenerative disc and joint disease.

With regard to the employee's pre-existing medical conditions, it was Dr. Volarich's opinion that the employee had industrial disability that was a hindrance to his employment or re-employment. It was Dr. Volarich's opinion that the employee had a 10% permanent partial disability of the body as a whole rated at the lumbosacral spine due to degenerative disc disease and degenerative joint disease in the lumbar spine as well as mild chronic lumbar syndrome. It was Dr. Volarich's opinion that the employee had a 15% permanent partial disability of the body as a whole due to his pre-existing sinusitis and asthma. It was Dr. Volarich's opinion that the combination of the disabilities created a substantially greater disability than the simple sum or the total of each separate injuries/illness and a loading factor should be added.

Dr. Volarich stated that the employee was able to perform most self care activities. With regard to work and other activities referable to the spine, the employee was advised to limit repetitive bending, twisting, lifting, pushing, pulling, carrying, and climbing on an as needed basis. The employee should not handle any weight greater than 25 pounds, and limit this task to an occasional basis. The employee should not handle weight over his head, away from his body, or carry weight over long distances or uneven terrain. The employee was to avoid being in a fixed position for any more than about 30 minutes at a time including sitting and standing.

On October 18, 2004 Dr. Volarich diagnosed the employee with an aggravation of pre-existing asthma due to upper airways and respiratory exposures to the multiple chemicals at Plastene Supply. It was Dr. Volarich's opinion that the employee had industrial disability that was a hindrance to his employment or re-employment. It was Dr. Volarich's opinion the employee had a 15% permanent partial disability of the body as a whole referable to the pulmonary system due to aggravation of his pre-existing asthma that required extensive medical care and required ongoing use of daily bronchodilator to control wheezing. It is Dr. Volarich's opinion that all of his disabilities combine to create to a substantial greater disability that then simple sum or total of each separate injury or illness and a loading factor should be added.

It was Dr. Volarich's opinion with regard to work and other activities referable to the pulmonary system, that the employee should continue taking all medications, should avoid weather extremes of extremely hot or extremely cold temperatures and limit exposure to sudden changes in temperature. The employee should avoid odors, fumes, dust matter, chemicals,

allergens and other elements that could trigger an attack of bronchospasms. The employee should limit strenuous activities including pushing, pulling and extreme emotional distress.

The deposition of Dr. Volarich took place on August 20, 2008. It was his understanding that the employee worked full duty at his employment prior to January 8, 2001. There was no evidence that he had asked for or received any job accommodations at work. Prior to January of 2001 there was no indication that he had seen any type of back specialist, spine surgeon or orthopedic surgeon. There was no indication of any permanent restrictions in any of the records for his back. The employee told Dr. Volarich that prior to January 8, 2001 his back issues for the most part had resolved. The employee told Dr. Volarich that he had a little bit of stiffness and soreness in his low back but other than that he had no persistent problems. The employee could not recall any persistent ongoing problems that hindered his ability to work leading up to January of 2001 back injury. Dr. Volarich did not find any leg radiculopathy. The employee told him that he had stopped working when he got laid off and the company closed in 2002. Dr. Volarich testified that in his reports of August of 2003 and October of 2004 the only rating that he provided was permanent partial disability. Dr. Volarich did not provide a permanent total disability opinion for the employee.

RULINGS OF LAW:

Permanent Total Disability:

Issue 1. The liability of the Second Injury Fund for permanent total disability in Injury Number 01-167196, the January 8, 2001 injury and Issue 2. The liability of the Second Injury Fund for permanent total disability in Injury Number 01-169117, the May 30, 2001 injury.

The employee has alleged that he is permanently and totally disabled as a result of a combination of his pre-existing conditions and the January 8, 2001 injury to his low back or a combination of his pre-existing conditions and the May 30, 2001 injury to his lungs. Under Section 287.220.1 RSMo., the Second Injury Fund is liable for permanent and total disability benefits only if the previous disability or disabilities, whether from compensable injury or otherwise, and the last injury together result in total and permanent disability.

Section 287.020.7 RSMo. provides as follows:

The term “total disability” as used in this chapter shall mean the inability to return to any employment and not merely mean inability to return to the employment in which the employee was engaged at the time of the accident.

The phrase “the 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. 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. 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". Brown v Treasurer of the State of Missouri, 795 S.W.2d 479, 483(Mo.App.1990). The key is whether any employer in the usual course of business would be reasonably expected to hire the employee in that person's physical condition, reasonably expecting the employee to perform the work for which he or she is hired. Reiner at 365. See also Thornton v Haas Bakery, 858 S.W.2d 831, 834 (Mo.App.1993).

Based on the evidence, I find that the employee failed to meet his burden of proof on the issue of permanent total disability.

The employee's pre-existing low back and lung conditions were not significant. The employee testified that prior to working at Plastene, he had breathing problems but that did not change how he did things, and he did not have any restrictions or accommodations for his job. Dr. Volarich stated that prior to January of 2001 there was no indication of any permanent restrictions in any of the records for the employee's low back. The employee told Dr. Volarich that his back condition for the most part had resolved. The employee did not recall any persistent ongoing problems that hindered his ability to work leading up to the January of 2001 back injury.

The employee's primary cases were not settled for significant permanent partial disability. There was no surgery performed on the employee's low back either prior to or after January 8, 2001. The employee settled his January 8, 2001 low back case for 12.5% of the body as a whole. Dr. Forsythe a pulmonologist stated that the employee had no evidence of lasting pulmonary dysfunction. The employee settled his lung exposure case for 3.95% of the body as whole.

Mr. England provided the only opinion that the employee is permanently and totally disabled. Mr. England stated that the employee is a younger worker. (The employee was 28 years old in 2001). Mr. England stated that considering the physical restrictions listed by Dr. Volarich, the employee would appear to be limited to no more than a sedentary level exertion overall and was limited to less than a full range of sedentary work. Mr. England stated that the employee could work within part of those restrictions but it did not appear that the employee would be able to successfully compete for or sustain employment in the long run.

In both primary cases, the employer-insurer disputed the compensability and did not provide or pay for medical treatment. The employee went to various physicians on his own and none of them opined that he was unable to work. Dr. Guerra advised the employee to get a GED and find a job with no physical activity. Dr. Gibbs stated that the employee could return to work with a 20 pound lifting restriction. Dr. Volarich, the employee's rating doctor, rated the employee with permanent partial disability and did not opine that the employee was permanently and totally disabled.

The employee testified that he stopped working at Plastene Supply in November of 2001, and has not worked anywhere since then. However, on June 9, 2003, the employee told Dr. Soeter that he worked at a car lot. On January 19, 2004 the employee mentioned his boss and his job to Dr. Guerra.

Based on a review of the evidence, I find that the opinions of Dr. Gibbs, Dr. Guerra, and Dr. Volarich are more credible than the opinion of Mr. England on the issue of employability. I find that the employee has failed to satisfy his burden of proof on the issue of permanent total disability. The evidence does not support a finding that the employee is unemployable in the open labor market. I find that the employee is not permanently and totally disabled as a result of the combination of his pre-existing disabilities and the injury to his low back on or about January 8, 2001 or the pre-existing disabilities including the low back injury on or about January 8, 2001; and the last injury to his lungs on or about May 30, 2001. The employee's request for an award of permanent total disability against the Second Injury Fund is denied in both Injury Number 01-167196 and Injury Number 01-169117.

Permanent Partial Disability:

Issue 1. The liability of the Second Injury Fund for permanent partial disability in Injury Number 01-167196, the January 8, 2001 injury.

Based on the evidence, I make the following rulings:

Primary Low Back Injury:

It was Dr. Volarich's opinion that the employee sustained a 20% permanent partial disability of the body as a whole referable to the low back. The employee settled the primary case for 12.5% of the body as a whole referable to the low back. I find that the primary injury to the employee's low back resulted in a 12.5% permanent partial disability of the body as a whole referable to his low back.

Pre-Existing Low Back Condition:

It was Dr. Volarich's opinion that the employee had a pre-existing 10% permanent partial disability of the body as a whole rated at the lumbar spine. The employee told Dr. Volarich that prior to January 8, 2001 his back issues for the most part had resolved. The employee could not recall any persistent ongoing problems that hindered his ability to work leading up to the January of 2001 back injury. I find that the employee's pre-existing low back condition resulted in a 5% permanent partial disability of the body as a whole referable to the low back.

Pre-Existing Asthma/Sinusitis Condition:

It was Dr. Volarich's opinion that the employee had a 15% permanent partial disability of the body as a whole due to his pre-existing sinusitis and asthma. I find that employee's pre-existing asthma/sinus condition resulted in a 5% permanent partial disability of the body as whole.

I find that the employee's pre-existing low back and asthma/sinusitis conditions were not of such seriousness as to constitute a hindrance or obstacle to employment or obtaining re-employment. I find that the pre-existing conditions do not meet the minimum statutory threshold level of 50 weeks for the body as whole for Second Injury Fund liability under Section 287.220.1

RSMo. The employee’s claim against the Second Injury Fund in Injury Number 01-167196 for permanent partial disability is denied.

Issue 2. The liability of the Second Injury Fund for permanent partial disability in Injury Number 01-169117, the May 30, 2001 injury.

Primary Lung Case.

It was Dr. Volarich’s opinion the employee had a 15% permanent partial disability of the body as a whole referable to the pulmonary system due to aggravation of his pre-existing asthma. The employee’s primary claim was settled for 3.95% of the body as a whole referable to lungs (asthma). I find that the primary injury to the employee’s pulmonary system resulted in a 3.95% permanent partial disability of the body as whole referable to the lungs.

I find that the primary injury does not meet the minimum statutory threshold level of 50 weeks for the body as whole for Second Injury Fund liability under Section 287.220.1 RSMo. The employee’s claim against the Second Injury Fund in Injury Number 01-1671960 for permanent partial disability is denied.

Date: _____

Made by:

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

A true copy: Attest:

Naomi Person
Division of Workers' Compensation