

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

Injury No.: 04-047878

Employee: Shane Null
Employer: New Haven Care Center, Inc.
Insurer: Missouri Nursing Home Trust
Additional Party: Treasurer of Missouri as Custodian
of Second Injury Fund

The above-entitled workers' compensation case is submitted to the Labor and Industrial Relations Commission (Commission) for review as provided by § 287.480 RSMo. 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 § 286.090 RSMo, the Commission affirms the award and decision of the administrative law judge dated October 13, 2011. The award and decision of Chief Administrative Law Judge Grant C. Gorman, issued October 13, 2011, is attached and incorporated by this reference.

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

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

Given at Jefferson City, State of Missouri, this 21st day of June 2013.

LABOR AND INDUSTRIAL RELATIONS COMMISSION

John J. Larsen, Jr., Chairman

DISSENTING OPINION FILED
James G. Avery, Jr., Member

Curtis E. Chick, Jr., Member

Attest:

Secretary

Employee: Shane Null

DISSENTING OPINION

I have reviewed and considered all of the competent and substantial evidence on the whole record. Based on my review of the evidence as well as my consideration of the relevant provisions of the Missouri Workers' Compensation Law, I believe the decision of the administrative law judge should be modified.

I agree that employee is permanently and totally disabled but I believe his inability to compete in the open labor market is due to the effects of his primary injury in combination with his preexisting disabilities.

I am persuaded by the expert medical opinion of Dr. Cantrell that as a result of his work injury employee sustained a 7% permanent partial disability of the body as a whole referable to the low back. I also find that the restrictions imposed by Dr. Cantrell for the work injury most accurately reflect employee's physical limitations resultant from the work-related compression fracture and the pain associated therewith.

By contrast, some of the restrictions Dr. Volarich believed to be necessary as a result of the primary injury mirror self-imposed limitations employee was observing before the work injury. Before the work injury, employee had already adjusted the manner in which he performed his job due to his low back problems. For example, employee limited his lifting to less than fifty pounds and alternated physical work tasks with supervisory tasks to relieve pain in his low back.

Employee's vocational expert, Mr. Dolan, relied upon Dr. Volarich's physical restrictions in reaching his conclusion that employee is unable to compete in the open labor market. Mr. Dolan felt that if some of those restrictions pre-existed the work injury, then employee's inability to compete in the open labor market is due to the work injury in combination with his preexisting back problems. As noted above, some of employee's restrictions pre-existed the work injury.

I believe it is the effects of employee's work injury in combination with his many preexisting disabilities that render him unable to compete in the open labor market. I would modify the award of the administrative law judge to award permanent partial disability benefits from employer/insurer to employee. I would award permanent total disability benefits from the Second Injury Fund.

For the foregoing reasons, I respectfully dissent from the decision of the majority of the Commission.

James G. Avery, Jr., Member

AWARD

Employee: Shane Null

Injury No. 04-047878

Dependents: None

Employer: New Haven Care Center, Inc.

Additional Party: Second Injury Fund

Insurer: Missouri Nursing Home Trust

Hearing Date: July 12, 2011

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

Checked by: GCG/ln

FINDINGS OF FACT AND RULINGS OF LAW

1. Are any benefits awarded herein? Yes
2. Was the injury or occupational disease compensable under Chapter 287? Yes
3. Was there an accident or incident of occupational disease under the Law? Yes
4. Date of accident or onset of occupational disease: May 27, 2004
5. State location where accident occurred or occupational disease was contracted: Franklin County, Missouri
6. Was above employee in employ of above employer at time of alleged accident or occupational disease? Yes
7. Did employer receive proper notice? Yes
8. Did accident or occupational disease arise out of and in the course of the employment? Yes
9. Was claim for compensation filed within time required by Law? Yes
10. Was employer insured by above insurer? Yes
11. Describe work employee was doing and how accident occurred or occupational disease contracted:
Claimant was operating a mower which slid off an embankment, he fell twelve feet and the mower landed on top of him.
12. Did accident or occupational disease cause death? No
13. Part(s) of body injured by accident or occupational disease: Head, back, right ear, and psychiatric injury.
14. Nature and extent of any permanent disability: Permanent total disability
15. Compensation paid to-date for temporary disability: \$23,780.97
16. Value necessary medical aid paid to date by employer/insurer? \$74,197.92

Employee: Shane Null

Injury No. 04-047878

- 17. Value necessary medical aid not furnished by employer/insurer? \$5,639.99
- 18. Employee's average weekly wages: \$732.20
- 19. Weekly compensation rate: \$488.13 TTD/\$347.05 PPD
- 20. Method wages computation: Stipulation

COMPENSATION PAYABLE

- 21. Amount of compensation payable:

Unpaid medical expenses: \$5,639.99

Permanent total disability benefits of \$488.13 from Employer beginning January 19, 2006, for Claimant's lifetime.

- 22. Second Injury Fund liability: No

TOTAL: SEE AWARD

- 23. Future requirements awarded: See Award

Said payments to begin as of the date of this award and to be payable and be subject to modification and review as provided by law.

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

Dean L. Christianson

Employee: Shane Null

Injury No. 04-047878

FINDINGS OF FACT and RULINGS OF LAW:

Employee: Shane Null

Injury No: 04-047878

Dependents: None

Before the
**DIVISION OF WORKERS'
COMPENSATION**

Employer: New Haven Care Center, Inc.

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

Additional Party Second Injury Fund

Insurer: Missouri Nursing Home Trust

Checked by: GCG/ln

PRELIMINARY STATEMENT

Hearing on the above-referenced case was held before the undersigned Administrative Law Judge on July 12, 2011 in Franklin County, Missouri. Shane Null (Claimant) was present, and represented by Dean L. Christianson. Paul Huck represented New Haven Care Center, Inc. (Employer) and Missouri Nursing Home Insurance Trust (Insurer). Assistant Attorney General Jennifer Sommers represented the Second Injury Fund. Mr. Christianson requested a fee in the amount of 25%. The parties submitted post-trial briefs.

The parties entered into the following stipulations: Claimant sustained accidental injuries arising out of and in the course of employment on or about May 27, 2004 in Franklin County, Missouri; Claimant was an employee of Employer; venue is proper in Franklin County, Missouri; Employer received proper notice of injury; the claim was filed in a timely manner; Claimant earned an average weekly wage of \$732.20, resulting in applicable rate of compensation of \$488.13 for total disability and \$347.05 for permanent partial disability (PPD). Employer paid \$6,032.29 in temporary total disability (TTD) benefits (May 28, 2004 to August 2, 2004, and September 23, 2004 to October 11, 2004), and \$17,748.68 in temporary partial disability (TPD) benefits (August 3, 2004 to September 22, 2004, and October 18, 2004 to January 18, 2006). Employer paid medical expenses totaling \$74,197.92. If permanent total disability benefits are awarded, the benefits would begin January 19, 2006.

The issues presented for resolution by this hearing are as follows:

1. Extent of permanent disability, whether partial or total
2. Extent of Second Injury Fund liability, if any
3. Employer/Insurer's responsibility for future medical treatment, if any
4. Employer/Insurer's responsibility for past medical expenses, if any
5. Dependency

SUMMARY OF THE EVIDENCE

Only evidence necessary to support this award will be summarized. Any objections not expressly ruled on during the hearing or in this award are now overruled. Certain exhibits offered into evidence may contain handwritten marking, underlining and/or highlighting on portions of the documents. Any such marking on the exhibits were present at the time they were offered by the parties. Further, any such notes, marking and/or highlights had no impact on any ruling in this case.

Claimant offered the following exhibits into evidence:

- A. Deposition of Dr. Volarich
- B. Deposition of Dr. Stillings
- C. Deposition of J. Stephen Dolan
- D. Medical records of St. John's Mercy Hospital
- E. Medical records of Patient's First Health Care Orthopedic Division
- F. Medical records of Dr. Benecke
- G. Medical records of Dr. Williams
- H. Medical records of Dr. Merenda
- I. Medical records of Dr. Bridwell
- J. Medical records of Dr. Dunteman
- K. Medical records of Dr. Davis
- L. Medical records of Dr. Davis
- M. Certified records of Division of Workers' Compensation
- N. Records from England and Company
- O. Medical records of Dr. Davis
- P. Medical bills and summary
- Q. Prescription receipts
- R. Marriage license

Exhibits A through R were received into evidence without objection.

Employer offered the following exhibits into evidence:

- 1. Deposition of Dr. Cantrell
- 2. Deposition of James England
- 3. Medical records of Dr. Blatt
- 4. Records of New Haven Care Center, Inc.
- 5. Claimant's Health Questionnaire dated 1997 – 2002
- 6. Work release slips issued by Dr. Merenda, Dr. Bridwell, Dr. Williams and Dr. Dunteman
- 7. HealthSouth Functional Capacity Evaluation
- 8. Deposition Exhibits A through D from deposition of Dr. Stillings
- 9. Missouri Department of Conservation hunting/fishing license purchases 5/22/05 – 4/6/07

Exhibits 1 through 9 were received into evidence without objection.

The Second Injury Fund offered Exhibit Roman Numeral I which was received into evidence without objection.

Testimony of Claimant

Background Information

Claimant testified at trial that he is fifty-one years old, five feet and nine inches tall, and 238 pounds in weight. He previously weighed around 280 pounds at the time of the injury, though he has lost weight due to a lack of appetite. He currently takes several medications. He takes Protonix for stomach problems, Paxil for depression, Percocet for pain and Imitrex for migraine headaches. All of his medications are prescribed by his family physician, Dr. Davis.

Claimant is not currently married, though he was married at the time the injury occurred to Lori Null. He identified his marriage license, which was admitted into evidence as Exhibit R. He did not have any children with Lori, though she did have two children from a previous marriage. He has not adopted either of them. He does have one son from a previous marriage, though that son was not dependent upon him at the time this injury occurred.

Claimant received a high school diploma after receiving “average” grades during his schooling. Afterwards he received training as a welder, a nurse’s aide and a certified medical technician. He does not know how to type with a typewriter or a computer. Nor does he own a computer or know how to operate one. He has not been in the military, though he did apply for entry into the Marine Corp. However, he was denied entry because of his hearing problems.

Claimant is not currently working, and his last employment was with Employer. He described Employer’s facility as a 90 bed skilled nursing facility. Employer’s building is a two level structure that is on two or three acres. He began working for them on March 27, 1989 and during his tenure he held a variety of jobs. This included working as a nurse’s aide and a certified medical technician. He then worked in the maintenance department for a number of years before becoming the maintenance supervisor for approximately the last four years of his work. His last position involved supervising approximately thirteen other employees in caring for the building, outside grounds, washers and dryers. His activities would include painting, drywall work, mowing, etc. He worked with a variety of hand and power tools, and also with lawn mowers. After his accident of May 27, 2004 he did return to work on a part time basis until he could no longer perform his duties. His last day of work was September 28, 2005.

Prior to working for Employer, Claimant worked for Can Am Steel for one year as a welder. Before that he worked for Golden Gem Growers for twelve years performing welding and maintenance. Before that he worked for Zero Manufacturing for one year as a grinder. He has done other work in the past on his own in the field of construction, plumbing and electrical work.

May 27, 2004 Accident

Claimant was injured on May 27, 2004. He was operating a lawn mower on a grassy slope which led to a twelve foot wall. As he was doing this, he felt the back of the lawn mower slide toward the wall, and he then felt himself falling over the wall. He does not remember anything after that until he woke up in the emergency room at St. John's Hospital, where he was admitted for three days. During that time he was placed in a brace and medicated. After his discharge from the hospital he was sent to Dr. Rotramel, an orthopedic surgeon. He only saw him once or twice. He then referred Claimant to a spine specialist, Dr. Merenda, who he saw on two occasions with some testing being performed, though little else. He was then sent for a one-time visit to Dr. Bridwell, an orthopedic surgeon in St. Louis. No treatment was rendered. Similarly he had a one-time visit with Dr. Joseph Williams in St. Louis, another orthopedic surgeon. He was then referred to Dr. Dunteman, a pain management specialist. He saw Dr. Dunteman on four or five occasions and had one surgical procedure in the form of a rhizotomy to burn the nerve endings in his back. Dr. Dunteman also treated him with medication. He did receive some relief from the treatment through Dr. Dunteman, though he was eventually released by the Doctor. He tried to get additional medications from Dr. Dunteman after he was released, though the Doctor would not provide it to him.

Employer then provided Claimant with treatment for his right ear. Claimant said that the accident had injured the right side of his head and he therefore was sent to Dr. Benecke for a surgical procedure to "rebuild" his right ear.

Since being discharged by Dr. Dunteman, Claimant has been receiving treatment from Dr. Davis. He said that Dr. Davis has been his family physician, but that the Doctor is also Employer's workers' compensation physician, with all work injuries being directed to him for care. He said that Dr. Davis' office is in Employer's building. Currently the treatment involves monthly visits to monitor his medications. He said that the treatment helps him because he probably would not be able to walk without the medication. He is not receiving any medical treatment from any other physicians at this time, either for physical or psychological reasons. Claimant identified Exhibit P as being the medical bills that he has received from Dr. Davis since being discharged by Dr. Dunteman. He also identified Exhibit Q as being prescription receipts for pain medications ordered by Dr. Davis.

Pre-existing Medical Conditions

Claimant talked about his prior back problems. He had problems going back to 1994 when he over-exerted himself and had back complaints. He was seen by Dr. Davis for that and his symptoms then resolved. He then had a back injury at work in October of 1996 when he slipped on a wet floor and fell. He was sent by Employer to Dr. Davis for medical treatment. An MRI scan was ordered and he was found to have a bulging disc. He was then put on light duty and treated with medication, as well as physical therapy. After the 1996 injury, leading up to the 2004 injury, he continued to have some back problems in that he would get sore with lifting heavy items at work. He described this as a sharp pain in his back that went into his groin and sometimes into his left leg. It would last three to four hours. Because of this, he would ask other people to help him with his lifting at work.

He has had problems with his ears since birth. Apparently he was born without a certain bone in each of his ears, so as he was growing up he had to sit in front of the classroom because of hearing problems. He eventually had surgeries before the 2004 accident including one on the left ear and two on the right ear. The surgeries were performed to install a prosthesis into his ears and clean out infections. He said that he would get ear infections if he did things such as swimming without ear plugs, and he would then have to go to a doctor. He said that he is tone deaf, and said that he cannot hear sounds such as clothes dryers or loud sounds. He says he has trouble hearing human speech in loud environments.

Claimant had an injury to his left hand in the past which resulted in an amputation of his left index finger. The amputation is halfway between the second and third joint. This injury affected his grip and created problems with dexterity at work.

Psychologically, Claimant grew up in a very difficult home environment with an abusive father. He said that he spent a lot of time in the woods behind the house to get away from his father. His father was eventually imprisoned in a mental institution in Fulton, Missouri for trying to kill Claimant's mother and a doctor. Claimant was treated for anxiety and depression before the work injury, going back to the 1990's. His treatment was through Dr. Davis and at one point in time Dr. Davis sent him to a counselor. The doctor also prescribed medications for him such as Lexapro and Xanax. He said that he took these medications leading up to the work injury. He said that the medications made him tired and decreased his energy. This resulted in a loss of productivity at work. He also indicated that he had been treated for problems with anger before the work injury, and in 2004 he was suspended for three days due to this problem. He attended an anger management program and completed the program. Since the work injury Claimant's depression has become much worse. He said that the result of his depression was a lost marriage as he had -- and still has -- a tendency to isolate himself and not come out of the bedroom. He currently only goes out of the house once or twice per week. He has suicidal thoughts, and he has crying spells over the loss of his wife and his job.

Claimant also has had problems with migraine headaches before the work injury, which began when he was a child. He was treating with Dr. Davis before the work injury, both with shots and Imitrex. The migraine headaches would affect him at work in that he would get sick and would have to go home on occasion.

Current Complaints and Daily Activities

In addition to the worsened psychiatric state described above, Claimant has worsened back problems which he attributes to the work injury. His back pain is constant and feels like a needle stabbing in his back. This occurs from about his mid back down to an area two inches below his belt line, on both sides of his back. He has pain and trouble bending, twisting and turning. He has trouble sitting and walking. There are times when he feels like he might lose control of his bladder. He has symptoms in both of his legs in that it feels like they do not want to move. He has tingling in his legs when he is active. It was noted at trial that Claimant walked in a slow and hunched position, and during his testimony he frequently rose to a standing position.

Claimant said that his daily activities do not involve much. He watches the news and will go outside to visit his sister who lives next door. He will read books. He does not do any work around the home and does not cook. Sometimes he will go to the store but his sister generally does that for him. He does drive, though not for long distances. He has to stop after twenty-five to thirty miles at the most. He did not drive himself to the hearing, but was driven by his sister. He stayed in town and spent the night in a motel so that he did not have to drive on the morning of the trial. After he takes a trip such as that, it then takes him a day or so to recover. He said that based upon his experience he will be in bed for the entire day after the trial.

He described his sleep as being poor, as he only receives one or two hours of sleep at a time. He can stand comfortably for thirty to forty minutes. He can sit for fifteen to twenty minutes. He cannot walk very far at all. If he tries to do more than these things then he is laid up for a period of time. He spends some time each day laying in bed or laying on the couch. If he does not take time throughout the day to rest, then he is unable to walk. He is able to take care of his personal needs. He is not currently performing any hobbies. He used to hunt and fish a great deal, and he has tried to do both of these things since his accident, but it increased his pain too much. He has continued to obtain hunting and fishing licenses since the work injury even though he does not use them, because he likes to support the wildlife conservation movement.

Claimant was sent by Employer to England & Company to see if a job could be found for him. He cooperated with them and they set up two possible job situations for him as a gunsmith. He contacted both of the potential employers. The first one involved a trip that was 80 miles from his home. He and his wife tried to make the trip, but they had to turn around before they got there due to Claimant developing increased muscle spasms in his back. He concluded that he would not be able to drive 160 miles each day for work. The second job involved a gunsmith who was closer to his home, though the man told him that there was no sense in him coming in if he was on a four hour restriction from Dr. Davis. The man also indicated that the training would take four years and that there was no way that Claimant could be trained in the three month period of time that was being approved by England & Company. The second job therefore was unworkable.

Testimony of Lori Null

Also testifying at trial was Claimant's ex-wife, Ms. Lori Null. She was married to Claimant for sixteen years from 1994 to November of 2010. They were living together during the entirety of their marriage. She said that before the work injury Claimant would have back complaints and would appear to be fatigued or to have aching in his back. She also noticed depression and stress in his life before the work injury, which would flare up every couple of months. After the injury she noticed a big change in his behavior. As time went on, due to not being able to work, he had a lot of stress upon him. His depression caused him to not come out of the bedroom and to not participate in family activities. They had tried adjustments to his medications though this was not successful.

Ms. Null talked about the two gunsmith positions which had been identified by England and Company. She confirmed Claimant's statements about not being able to attend the first one

due to the distance, and not being able to take the second job due to being on part-time status and/or needing four years of schooling.

St. John's Mercy Hospital

The medical records of St. John's Mercy Hospital were admitted into evidence. (Exhibit D). On January 6, 1989 Claimant was seen for complaints of dizziness while at work. He was diagnosed with a perforated left tympanic membrane. He was later admitted to the hospital on January 31, 1989 with a diagnosis of right chronic otomastoiditis with possible cholesteatoma. Surgery was performed at that time in the form of a right tympanomastoidectomy without ossicular reconstruction.

On October 11, 1996 Claimant underwent a lumbar MRI scan which showed mild posterior bulging at the L5-S1 level.

In 1997 Claimant was admitted to the hospital with lung complaints. He gave a past medical history of Crohn's disease, asthma, migraine headaches and reflux esophagitis.

On June 18, 2001 Claimant was seen following a vehicular accident in which he was rear-ended. He complained of low back and left arm pain, and was diagnosed with strains.

On June 29, 2001 Claimant was seen for chronic esophageal complaints. He complained that he required long-term use of Prilosec to control his symptoms. A biopsy of his esophagus was performed, which was consistent with gastroesophageal reflux.

On May 27, 2004 Claimant was admitted to the hospital following his injury at work. His discharge diagnosis included: concussive injury, L1 compression fracture, and multiple contusions and abrasions.

On November 12, 2004 Claimant was seen with abdominal complaints. He was diagnosed with abdominal pain and diarrhea.

On October 28, 2005 Claimant was hospitalized due to abdominal complaints. He improved after two days of conservative treatment. His discharge diagnoses included: clostridium difficile enterocolitis; prior history of colon disease; chronic narcotic dependent back pain due to prior trauma; asthma and chronic obstructive pulmonary disease; depression under therapy; tobacco habituation and abuse; right index finger amputation; random hyperglycemia; and hiatal hernia.

Medical Records of Dr. Rotramel

The medical records of Dr. Rotramel were admitted into evidence. (Exhibit E). He monitored Claimant's back brace and performed x-rays. The films showed a 25% loss of height of the anterior body of L1. Medication was prescribed. Follow-up visits show that Claimant had complaints with increased activity. Claimant was allowed to return to work for two hours per day on July 12, 2004. Claimant later returned and complained of increased symptoms upon

return to work. Dr. Rotramel ordered an MRI scan, which did not show evidence of a nerve problem. Claimant was then referred to a spine specialist, Dr. Merenda.

Medical Records of Dr. Merenda

Claimant was evaluated on one occasion, August 11, 2004, by James Merenda, M.D. (Exhibit H). He noted that Claimant had complaints of tingling in his thighs, which was thought to be related to the back brace. He restricted Claimant to working four hours per day, and then took him completely off work at the next visit. An MRI was ordered, and Claimant was then returned to work in October 2004.

Medical Records of Dr. Bridwell

Claimant was referred by Dr. Thomas Davis to Dr. Bridwell for consideration of surgery. (Exhibit I). Dr. Bridwell saw him on one occasion, December 13, 2004. He ordered an MRI and also diagnosed two compression fractures which seemed to be healing. He ruled out further surgery due to the passage of time. He recommended physical therapy.

Medical Records of Dr. Dunteman

Claimant was referred to Dr. Edwin Dunteman on February 8, 2005 for pain management care. (Exhibit J). He was diagnosed with compression fractures, spondylosis and lumbago. Claimant had continued swelling, which indicated that the fractures were not yet stable. He was placed on medications and an MRI was ordered. He was advised to work only four hours per day, with a fifteen pound lifting restriction. On February 22, 2005 Dr. Dunteman performed facet injections at the levels of T12/L1 and L1/L2. Claimant returned on March 8, 2005, reporting relief of pain with the previous injection for a period of three days. Another set of facet injections were performed, this time also including the T11/T12 level. He returned to the Doctor on March 22, 2005 and again reported three days of relief of symptoms, followed by an increase. Claimant then began to develop leg problems, including an episode where he nearly fell, and other episodes of shaking at night.

On April 13, 2005 Dr. Dunteman performed facet rhizotomies, in which needles were inserted in Claimant's spine at the facet joints and then heated. This resulted in "heat lesions" to the levels of T11/T12, T12/L1, and L1/L2. A subsequent visit showed that Claimant had partial relief of some of his symptoms. Subsequent visits show that Claimant was trying to work up to seven hours per day, but complained of having to come home and take narcotic pain medications. He stated that if he has a particularly bad day at work then he is up for most of the night due to pain. After a functional capacity evaluation was performed, Dr. Dunteman concluded that Claimant is "unable to perform his current work duties, thereby making him disabled", and "Mr. Null is completely disabled from his employment". Dr. Dunteman stated that Claimant had reached a point of "maximum medical improvement" on June 16, 2005. He also stated that Claimant should continue with Topamax, Lexapro, Cymbalta, Tizanidine, Fosamax and Lidoderm. He was also advised to purchase over-the-counter melatonin for sleep issues, and to obtain a smaller abdominal brace.

Medical Records of Dr. Williams

Claimant was evaluated on one occasion, March 1, 2005, by Joseph Williams, M.D. (Exhibit G). He actually diagnosed two separate compression fractures, one of them being at L1, and the other being at L5. He advised Claimant to continue wearing his brace and to follow-up with Dr. Dunteman.

Medical Records of Dr. Davis

Claimant used Dr. Thomas Davis as his primary care physician, beginning in 1994. (Exhibit K). Treatment prior to the accident of May 27, 2004 has included treatment for gastroesophageal reflux/possible gallbladder disease; smoking cessation; low back pain radiating into his thighs; eczema; right lateral epicondylitis; hematachezia; asthma; chronic obstructive pulmonary disease; migraine headaches; chronic bronchitis; and chronic hearing loss.

In October of 1996 Claimant had a fall at work with subsequent low back pain and spasm radiating into his left leg. (Exhibit K). Physical therapy and light duty were ordered, and he was diagnosed with a low back strain. An MRI was performed, showing no evidence of acute herniated nucleus pulposus with mild posterior bulging at L5-S1. In June of 2001 he was prescribed medication for muscle spasms in his back.

In March of 2000 Claimant was treated for stress. (Exhibit K). He was prescribed Zoloft and later referred to a stress management clinic. He was seen in 2002 for depression and prescribed various medications, including Zoloft, Paxil, Wellbutrin, Lexapro and Xanax. On April 7, 2004 Claimant was enrolled in an anger management program.

Subsequent to the work accident of May 27, 2004 Claimant continued to treat with Dr. Davis for a variety of problems. (Exhibit K). Dr. Davis was also involved in the treatment of conditions related to the work accident as well. He was diagnosed as having severe osteoporosis on top of his traumatic L1 fracture. Dr. Davis referred him to Dr. Rotramel, and then to Dr. Bridwell. He also ordered physical therapy and maintained Claimant's medications for pain. An MRI was performed on July 22, 2004, showing a 40% to 50% compression fracture of L1; a 10% compression fracture of L4; and diffuse spondylosis. There were also several bulging discs. Another MRI was performed on September 22, 2004 which showed decreasing edema but a 20% compression fracture at L5. A third MRI was performed on February 10, 2005 which showed interval healing and mild central stenosis due to a bulge. In February of 2005 Claimant began making suicidal statements. On March 4, 2005 Dr. Davis stated that he believes Claimant is at a point of maximum medical improvement. He said in August of 2005 that Claimant is "clinically" 100% disabled. Claimant's medication was increased in September of 2005 due to increased pain with attempts to be more active. The Doctor on October 14, 2005 stated:

based on the specialty consultations, his disability evaluation, and my close observation of him while he was employed in this building, and his documented pathology, he needs to be limited to four hours of work a day, no lifting greater than twenty pounds at most, and he should not sit in a car for more than ten to fifteen minutes at a time. Any of this will result in significant pain and disability.

Claimant developed symptoms of paranoia and sleeplessness later in 2005, along with his depressive symptoms. The Doctor diagnosed fatigue, as a conversion reaction from his depression. Dr. Davis wrote a letter on February 17, 2006 in which he stated that “Mr. Null’s work-related injuries have rendered him 100% disabled in a permanent and irrevocable way”. (Exhibit F). He said “in my professional opinion of Mr. Null, there is no gray area; he is clearly and permanently disabled and should be viewed as such”.

Claimant has continued to receive treatment from Dr. Davis. (Exhibits L & O). Treatment has included medication management and monitoring. On October 29, 2007 Claimant was diagnosed with severe chronic pain. On December 10, 2007 it was noted that Claimant was suffering from somnolence and social withdrawal. On January 10, 2008 it was noted that an attempt to wean his narcotic medications was unsuccessful. He was evaluated by Dr. Davis on February 22, 2010 and diagnosed with numerous chronic medical conditions which include the following:

- personal history of colonic polyps
- family history of malignant neoplasm, bladder
- COPD, not elsewhere classified
- hyperlipidemia, other and unspecified
- hypersomnia with sleep apnea, unspecified
- enteritis, regional, unspecified site
- lumbago
- esophageal reflux
- pathologic fracture of vertebrae
- atherosclerosis of aorta
- dyshidrosis
- family history of unspecified malignant neoplasm
- family history of other digestive disorders
- anxiety state, unspecified
- irritable bowel syndrome
- long-term (current) use of other medications
- finger(s) other, amputation status
- asthma, unspecified type, unspecified
- depressive disorder, not elsewhere classified
- major depressive disorder, single episode, in part
- personal history of tobacco use
- migraine, unspecified without mention of intractab
- hemorrhoids, unspecified, w/o mention of complications
- spondylosis, lumbosacral without myelopathy
- family history of colonic polyps
- opiod type dependence, continuous use
- spinal enthesopathy
- osteoporosis, unspecified
- family history of other chronic respiratory condition
- family history of malignant neoplasm of gastrointestinal diverticulosis of colon (without mention of hemorrhoids)

constipation, unspecified

(Exhibit L). The Doctor prescribed several medications, including Effexor, Imitrex, Lexapro, Oxycontin and Prilosec. The Doctor continued treating Claimant through the last date of the records, April 28, 2011, sometimes changing medications.

Medical Records of Dr. Benecke

Claimant received treatment from Dr. Benecke for his hearing problems, beginning in 1999. (Exhibit F). He was diagnosed with chronic right otitis media, right mastoid cavity disease, and conductive hearing loss in the right ear. The Doctor performed surgery in the form of a revision of the right tympanoplasty with mastoidectomy, ossicular chain reconstruction, and ventilation tube placement. A second surgery was performed on June 2, 2000 in the form of a revision of the left tympanoplasty, mastoidectomy, ossicular chain reconstruction, facial nerve monitoring, and alloderm graft. A third surgery was performed on July 8, 2005 in the form of a right tympanoplasty, mastoidectomy, ossicular chain reconstruction, and AlloDerm graft. A fourth surgery was performed on December 9, 2005 in the form of a left tympanoplasty with ossicular chain reconstruction.

Dr. Benecke stated that Claimant had pre-existing hearing loss of 22%, and after the work accident of May 27, 2004 he had hearing loss of 32%. He stated that the work accident caused a fracture dislocation with the second bone of hearing known as the incus, as well as squamous epithelium deeply imbedded in the temporal bone.

Records of the Division of Workers' Compensation

Records from the Missouri Division of Workers' Compensation were admitted into evidence, showing that Claimant has had a variety of relatively minor injuries in his history. (Exhibit M). On February 15, 1990 Claimant strained his back while turning a resident. He lost no time from work. On September 24, 1996 Claimant slipped and fell at work, twisting his back. He was referred to Dr. Davis and treated conservatively. He had lower back complaints and radiating symptoms into his left leg, so an MRI was ordered, showing a bulging disc at L5-S1. Physical therapy was then performed. He was referred for an independent medical evaluation with Dr. Richard Covert, who felt that Claimant had no permanent disability. He eventually settled the claim, without counsel, for 2.5% permanent partial disability of the body as a whole, referable to the low back.

Dr. Volarich

Dr. David Volarich testified on Claimant's behalf, having evaluated Claimant on two occasions at his attorney's request. The initial evaluation was on December 15, 2006, and the second was on June 8, 2010. He testified that Claimant had disc protrusions which were putting pressure on the spinal cord. (Depo p. 9). He said that Claimant's fractured vertebrae has caused a change in the normal curve of his back. (Depo p. 10-11). He said Claimant has spinal stenosis, which is a narrowing of the spinal canal caused by a bulging disc. (Depo p. 11-12). Dr. Volarich testified that some of Claimant's back problems pre-existed the accident of May 27, 2004.

(Depo. 17). This includes the degenerative joint disease (facet arthritis), and the degenerative disc disease. (Depo. 17-18). He testified that the spinal stenosis was from the work injury. (Depo p. 18). He found trigger points in Claimant's back. (Depo p. 18). He felt Claimant was depressed. (Depo p. 19). On his second evaluation he found that Employee's lumbar motion had worsened due to chronic pain. (Depo p. 21). And the left calf circumference had gotten smaller, showing ongoing nerve pressure. (Depo p. 22-23). Dr. Volarich diagnosed Claimant with the following conditions due to the May 27, 2004 accident: compression fracture lumbar spine at L1 with resultant kyphosis at the T12-L1 junction; aggravation of degenerative disc disease and degenerative joint disease of the lumbar spine particularly at the lumbosacral junction causing intractable back pain with occasional lower extremity radicular symptoms; right ear injury, status-post tympanoplasty, mastoidectomy, and ossicular chain reconstruction; right elbow contusion, resolved; and concussion, resolved. (Depo p. 24-25). He explained that the degenerative conditions were aggravated by the work accident because when the accident occurred the facet joints were stressed, causing minor stress fractures and torn ligaments, which in turn caused further inflammation. (Depo p. 28).

Dr. Volarich testified that the May 27, 2004 accident caused a 50% permanent partial disability of the body as a whole, referable to the lumbar spine. (Depo p. 30). He also felt there was disability in the ears due to the accident, though he deferred to an ENT for that opinion. As far as pre-existing conditions are concerned, he found these: 12.5% of the body at the lumbar spine, due to the pain, lost motion, and prior disc bulge at L5-S1; 15% of the left hand due to the index finger amputation and lost grip strength; and disability in the ears. (Depo p. 31). He said that all of these disabilities would combine with each other to create a substantially greater disability than their simple sums. (Depo p. 32). He testified that Claimant needs to have restrictions placed upon his activities as a result of these injuries, including resting in a recumbent position. (Depo p. 33-35). And he finally stated that Claimant will need ongoing medical care due to the work injury in the form of pain management. (Depo p. 36).

Dr. Stillings

Dr. Wayne Stillings, a board-certified psychiatrist, testified on Claimant's behalf, having evaluated Claimant on two occasions at his attorney's request. The initial evaluation was on June 5, 2008, and the second was on December 1, 2010. Claimant complained of depression and stated that his depression began in approximately 1999. (6/5/08 Report, p. 4). Claimant said that when he was growing up his father was emotionally and physically abusive on a regular basis, often beating Claimant. (6/5/08 Report, p. 4). His father eventually ended up in prison for attempting to kill Claimant's mother and a doctor. (6/5/08 Report, p. 4). At the second evaluation Claimant's suicidal ideation had increased in frequency to a daily basis. (12/1/10 Report, p. 2). Dr. Stillings found Claimant to be depressed with many depressive symptoms and suicidal thinking. (Depo p. 8). Claimant reported his depression to be at a level "2" prior to the May 27, 2004 accident, and a level "8-9" since the accident. (Depo p. 8). He stated that since 1999 Claimant's depression has impaired his ability to be employed, because of poor concentration, reduced mental processing speed, a slow personal tempo, slow speech, a paucity of mental content, and little spontaneous speech. (Depo p. 9-10). He found that Claimant has a high level of anxiety, which he attributes to a post-traumatic stress disorder. (Depo p. 11-12). Dr. Stillings diagnosed Claimant with the following:

Dysfunctional Family of Origin, pre-existing the May 27, 2004 accident and causing 10% permanent partial disability of the body as a whole;

Abuse as a Child, pre-existing and 10% PPD;

Depressive Disorder, Not Otherwise Specified, pre-existing and 5% PPD;

Mood Disorder with a Major Depressive-like Episode Due to a General Medical Condition, caused by May 27, 2004 accident and causing 20% PPD;

Pain Disorder Associated with both Psychological Factors and a General Medical Condition, caused by May 27, 2004 accident and causing 20% PPD;

and Post-traumatic Stress Disorder, Chronic, caused by May 27, 2004 accident and causing 15% PPD.

(Depo p. 14-17). He testified that all of these psychiatric disabilities combine synergistically to create a disability that is greater than their simple sum. (Depo p. 17). He also stated that he did not believe Claimant could work at this time due to the psychiatric condition. (Depo p. 17).

Dr. Cantrell

Dr. Russell Cantrell, a physician board-certified in physical medicine and rehabilitation, testified on Employer's behalf, having evaluated Claimant on one occasion at Employer's request on April 3, 2007. He testified that Claimant had a 40% to 50% compression deformity at his L1 vertebrae, which he felt was stable. (Depo p. 8). He felt that Claimant had reached a state of maximum medical improvement, though he acknowledged that Claimant was still taking medications. (Depo p. 9). He stated that Claimant's medications were probably in excess of what he needed. (Depo p. 9). He stated that he believed Claimant to be employable in the open labor market, though the accident of May 27, 2004 caused permanent partial disability of 13% of the body as a whole. (Depo p. 12). He said that Claimant should have restrictions from the work injury of lifting no more than 35 pounds occasionally from floor to waist; 25 pounds from waist to shoulder; 30 pounds from shoulder overhead; and no repetitive bending. (Depo p. 12). Dr. Cantrell said that he had not seen any medical records since 2007. (Depo p. 19).

Stephen Dolan

Mr. John Stephen Dolan, a certified vocational rehabilitation counselor, testified on behalf of Claimant. He stated that Claimant stood during his evaluation on fourteen separate occasions, and was reading his lips during the interview. He said that Claimant did graduate from high school, after repeating one year and taking remedial classes. His grades were below average. Claimant thereafter took a three week class to become a nurse's aide and then classes once each week for several months to become a medical technician. He said that Claimant is computer illiterate. He said that Claimant understands conversation better than he understands writing or spelling, so:

he's not going to be able to do a job where reading and writing are critical to the job, and he's not going to be able to do a job where math is critical to the job. He just doesn't have good academic skills, which means that he's reduced to jobs that are basically physical in nature. (Depo p. 15-16).

Mr. Dolan also said in his report that Claimant's left hand injury (index finger) would further restrict his occupational base by preventing jobs requiring bilateral fine finger dexterity. He testified that Claimant's knowledge of repair and maintenance would transfer into jobs that are heavy-duty and construction related, but not into any jobs that are lighter in nature. (Depo p. 16-17). Nor would they allow Claimant to transfer into jobs such as sales in a hardware store because the person has to be able to stay on their feet all day, stock shelves, and communicate with the public (due to hearing problems). (Depo p. 17). Mr. Dolan concluded that Claimant has a very poorly controlled pain problem such that he's not able to tolerate protracted activity, and based upon his education, work experience and restrictions he's not able to maintain employment in the open labor market. (Depo p. 19-20).

Mr. Dolan indicated that Claimant was limited in the availability of jobs due to the fact that he lives in the rural area of Dixon, Missouri. (Depo p. 28). He said that Claimant was driven to the evaluation by his sister. (Depo p. 28).

James England, Jr.

Mr. James England, Jr., a certified vocational rehabilitation counselor, testified on behalf of Employer. He testified that he was asked to perform a vocational evaluation and to provide vocational services to Claimant. (Depo p. 6). He evaluated Claimant on one occasion, August 29, 2005. (Depo p. 6, 31). He said that Claimant was pleasant and cooperative, though uncomfortable. He said that Claimant put forth good effort. (Depo p. 8). He stated that he had determined that Claimant was not able to return to his former position. (Depo p. 9). However, he also stated that there are less physically demanding types of work that Claimant could do, and that he thinks there are such jobs that are available in the open labor market. (Depo p. 10). He said that it is important for a person to be able to hear accurately in these jobs because less physically demanding jobs involve dealing with customers and the public. (Depo p. 16). Mr. England said that he did not notice a hearing problem. Mr. England stated that Claimant could be employed as a non-working maintenance supervisor at an apartment complex. (Depo p. 18). He said that when this was raised with Claimant, Claimant showed interest. He said that he told Claimant that any available job would provide pay in the range of \$20,000.00 to \$25,000.00 per year, and that Claimant was interested in moving forward with such a search. (Depo p. 21). He said that after the evaluation he received a telephone call from Claimant's wife, stating that they wanted to move forward with job placement. (Depo p. 22). He said that in order for Claimant to be placed in a job as a building project estimator he would first have to be trained to operate a computer. (Depo p. 24). However, he said that computer training was never performed because Dr. Davis had put Claimant on a restriction of not working more than four hours per day. (Depo p. 26). He said that he saw nothing in the medical records that would indicate that Claimant might have a problem in operating a computer keyboard. (Depo p. 26). He stated that he was familiar with the work of being a gunsmith, and that it is sedentary. (Depo p. 27). He said that

persons can be trained either by going to a school in Colorado, or by working one-on-one with an employer who is willing to train. (Depo p. 27). He said that if he assumes that Claimant can only work four hours per day, then he could only look for part-time work. (Depo p. 34). He said that if he assumes the restrictions of Dr. Volarich, then Claimant would not be employable in the open labor market. (Depo p. 35).

FINDINGS OF FACT AND RULINGS OF LAW

Based on the competent and substantial evidence presented, including the testimony of Claimant and other witnesses, my personal observations, expert medical and vocational testimony, and all other exhibits received into evidence, I find:

Under Missouri law, it is well-settled that the employee bears the burden of proving all the essential elements of a workers' compensation claim, including the causal connection between the accident and the injury. *Grime v. Altec Indus.*, 83 S.W.3d 581, 583 (Mo.App. W.D.2002); see also *Davies v. Carter Carburetor*, 429 S.W.2d 738, 749 (Mo.1968); *McCoy v. Simpson*, 346 Mo. 72, 139 S.W.2d 950, 952 (1940). While the claimant is not required to prove the elements of his claim on the basis of "absolute certainty," he must at least establish the existence of those elements by "reasonable probability." *Sanderson v. Porta-Fab Corp.*, 989 S.W.2d 599, 603 (Mo.App. E.D.1999) (citing *Cook v. Sunnen Prods. Corp.*, 937 S.W.2d 221, 223 (Mo.App. E.D.1996)). However, the employee must prove the nature and extent of any disability by a reasonable degree of certainty. *Downing v. Willamette Industries, Inc.*, 895 S.W.2d 650, 655 (Mo. App. 1995); *Griggs v. A. B. Chance Company*, 503 S.W.2d 697, 703 (Mo. App. 1974).

Permanent Partial or Permanent Total Disability

Section 287.020.7 RSMo. (2000) defines total disability as the "inability to return to any employment and not merely . . . [the] inability to return to the employment in which the employee was engaged at the time of the accident." The words "inability to return to any employment" means "that the employee is unable 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. 1982). The words "any employment" mean "any reasonable or normal employment or occupation; it is not necessary that the employee be completely inactive or inert in order to meet this statutory definition." *Id.* at 922; *Brown v. Treasurer of Missouri*, 795 S.W.2d 479, 483 (Mo. App. 1990). The primary determination for permanent total disability is whether the claimant is able to compete in the open labor market given his physical condition and situation. *Messex v. Sachs Elec. Co.*, 989 S.W.2d 206, 210 (Mo.App. E.D. 1999).

Claimant has presented a prima facie case regarding permanent total disability. He suffered a work injury; he presented medical and psychiatric evidence that he is in fact permanently and totally disabled. The defense in this case is based on the fact that while Claimant is not able to return to his former type of work, he is able to perform work of a lighter

nature, so the evidence of permanent total disability is not credible. Employer has presented evidence and argument on a number of facts in order to advance this position.

Section 287 RSMo. underwent significant changes through legislative amendments which took effect August 28, 2005. Therefore, it must be determined which law applies to injuries sustained prior to August 28, 2005. *Article I, §13 of the Missouri Constitution* provides: That no ex post facto law, nor law impairing the obligation of contracts, or retrospective in its operation, or making any irrevocable grant of special privileges or immunities can be enacted.

There are two exceptions to the rule that a statute shall not be applied retrospectively. First, where the statute is only procedural and does not affect any substantive right of the parties and, second, where the legislature manifests a clear intent for retrospective application. *Gershman Investment Corp. v. Duckett Creek Sewer Dist.*, 851 S.W.2d 765 (Mo.App.1993). Section 287, as amended, does not contain a manifestation of legislative intent for retroactive application. Therefore, for any provision of §287 to apply retroactively, it must only be procedural in scope, as the retroactive application of statutory provisions which affects substantive rights violates the constitution. *Fletcher v. Second Injury Fund*, 922 S.W.2d 402, 406 (Mo.App.1996).

The distinction between substantive and procedural law is that substantive law relates to the rights and duties giving rise to the cause of action, while procedural law is the machinery used to effect the suit. *Wilkes v. Missouri Highway and Transp. Com'n*, 762 S.W.2d 27, (Mo. banc 1988). Substantive statutes take away or impair vested rights acquired under existing law, or create a new obligation or impose a new duty. *Brenneka v. Director of Revenue*, 855 S.W.2d 509, 511 (Mo.App.1993).

Prior to the 2005 amendments, §287.800 stated “All of the provisions of this chapter shall be liberally construed with a view to the public welfare, and a substantial compliance therewith shall be sufficient to give effect to rules, regulations, requirements, awards, orders or decisions of the division and the commission, and they shall not be declared inoperative, illegal or void for any omission of a technical nature in respect thereto.” The appellate courts have construed this to mean all doubts be resolved in favor of a claimant. All doubts must be resolved in favor of the employee and in favor of coverage. *Johnson v. City of Kirksville*, 855 S.W.2d 396, 398 (Mo. App. W.D. 1993). All provisions of the Workers’ Compensation Act must be liberally construed; accordingly we resolve all doubts in favor of employee. § 287.800 RSMo. *Hall v. Wagner Division-McGraw-Edison*, 755 S.W.2d 594, 596 (Mo.App.1988); *Fischer v. Archdiocese of St. Louis-Cardinal Ritter Institute*, 793 S.W.2d 195, 198 (Mo.App.1990). Yet, a liberal construction cannot be applied in order to excuse an element lacking in the claim. *Johnson* at 398.

A statutory provision which requires that doubts be resolved in favor of a particular party is a substantive statute, as the claim vests when the injury occurs. Applying the 2005 revision of § 287.800 would impair the cause of action itself; therefore, § 287.800 as it existed at the time of Claimant’s injury applies to this case.

As stated previously, Claimant has established a prima facie case, in that he is not lacking evidence on any essential element. There is little evidence contradicting Claimant's credibility, with information such as the functional capacity evaluation stressing his effort, consistency and reliability.

A. Analysis: Physical Disability

1. Spine

It is undisputed that Claimant suffered work-related injuries on May 27, 2004. The injury to his back resulted in a vertebrae being fractured to the extent that it lost 50% of its height. Surgery was discussed to correct this, but by the time Claimant was sent to a specialist, too much time had passed to allow for a successful surgery attempt. Several doctors commented upon Claimant's ability to work. The work restrictions of Dr. Cantrell render Claimant unable to return to his former employment, though they would not prevent him from performing lighter work.¹ Another physician chosen by Employer/Insurer was Dr. Dunteman, who also recommended restrictions which prevent Claimant from returning to his former work. Dr. Dunteman in fact stated that "Mr. Null is completely disabled from his employment". And Employer's company physician, Dr. Davis, stated on October 14, 2005:

based on the specialty consultations, his disability evaluation, and my close observation of him while he was employed in this building, and his documented pathology, he needs to be limited to four hours of work a day, no lifting greater than twenty pounds at most, and he should not sit in a car for more than ten to fifteen minutes at a time. Any of this will result in significant pain and disability.

A few months later Dr. Davis said "Mr. Null's work-related injuries have rendered him 100% disabled in a permanent and irrevocable way". (Exhibit F). He said "in my professional opinion of Mr. Null, there is no gray area; he is clearly and permanently disabled and should be viewed as such". These opinions alone are enough to find that Claimant is unemployable in the open labor market.

Claimant submitted the testimony of Dr. Volarich, whose restrictions limit Claimant to sedentary work. Among his restrictions was the recommendation that Claimant change positions frequently to maximize comfort and rest when needed, including resting in a recumbent fashion. Claimant confirmed that he requires such a restriction to make it through a normal day, especially if he has tried to be more active than usual. The vocational experts testified that if this is the case, then Claimant is unemployable in the open labor market, and the findings from the

¹ It is noted, as pointed out by vocational consultant Dolan, that Dr. Cantrell's restrictions were significantly different from the restrictions recommended by the functional capacity evaluation he relied upon. (Depo p. 25-26). Dr. Cantrell limited Claimant by advising no lifting more than 35 pounds from the floor level occasionally, no lifting more than 25 pounds from the waist level, no lifting more than 30 pounds overhead, and no repetitive bending. On the other hand, the functional capacity evaluation was more restrictive, finding that Claimant has numerous "positional deficits" which include decreased tolerance for sitting, walking, stairs and ladder climbing, repetitive and sustained stooping, pushing and pulling, getting to and from the floor, trunk twisting, and crouching. (Exhibit 7). The evaluation also indicated that Claimant cannot lift or carry frequently. And it stated that Claimant was negative in every Waddell test. (Exhibit 7).

functional capacity evaluation seem to support such a conclusion. For instance, the FCE showed that Claimant's heart rate exceeded 85% of his maximum heart rate when he attempted to walk on a treadmill at 2.5 miles per hour, such that the testing had to be stopped. (Exhibit 7). And when he performed the lifting test he had to frequently rest so that his heart rate would drop below his threshold. (Exhibit 7). When he tried to crouch, "he began to shake after 10 seconds and when he attempted to get up, he could not and lost his balance". (Exhibit 7). He walked flexed and bent to the right; he could not arise without using his hands; and he complained of pain increasing to the point that all testing had to be stopped. (Exhibit 7). Afterwards, the therapist stated "Mr. Null gave consistent and maximal effort throughout the evaluation today and this appears to be a true representation of his current physical abilities". (Exhibit 7).

2. Right Ear

The accident of May 27, 2004 also caused Claimant to need treatment for an injury to his right ear. Treatment was provided first by Dr. Davis, and then by Dr. Benecke, who performed surgery on July 8, 2005 in the form of a right tympanoplasty, mastoidectomy, ossicular chain reconstruction, and AlloDerm graft. He stated that the work accident caused a fracture dislocation in an inner ear bone known as the incus, and it also caused squamous epithelium to become deeply imbedded in the temporal bone. He acknowledged Claimant's prior hearing loss and rated it at 22%, but then stated his right ear hearing loss is 32% since the work accident of May 27, 2004.

No other physician commented upon disability from Claimant's right ear injury.

Vocational consultant Stephen Dolan stated that during his evaluation Claimant seemed to be having trouble hearing him as Claimant stared intently at Mr. Dolan. Claimant told Mr. Dolan that he was trying to read his lips. When Mr. Dolan turned his head away and asked a question, Claimant was unable to understand the question. (Depo p. 12-13). Mr. Dolan also stated that Claimant's hearing loss prevents him from obtaining many jobs that involve communicating with the public, so that Claimant would never be able to perform jobs such as that of a sales clerk, a cashier, a food service worker, or a job requiring use of the telephone. (Depo p. 18).

Vocational consultant England stated that being able to hear and communicate is much more important in less physically demanding work, since the worker is dealing with co-workers and the public. (Depo p. 16). However, he said that he did not notice that Claimant was hard of hearing. (Depo p. 17).

B. Analysis: Psychiatric Disability

Dr. Stillings was the only physician to testify concerning Claimant's mental state, so his medical opinions are uncontested.² He stated that since at least 1999 Claimant has had depression which has impaired his ability to be employed because of poor concentration, reduced

²Dr. Volarich also diagnosed Claimant with depression, though he did not perform psychological testing and he did not attempt to attribute the depression to a cause.

mental processing speed, a slow personal tempo, slow speech, a paucity of mental content, and little spontaneous speech. (Depo p. 9-10). He also found that Claimant has a high level of anxiety. (Depo p. 11-12). Dr. Stillings also provided the technical psychiatric diagnoses from which Claimant suffers: Dysfunctional Family of Origin, Abuse as a Child, Depressive Disorder, Mood Disorder with a Major Depressive-like Episode Due to a General Medical Condition, Pain Disorder, and Post-traumatic Stress Disorder. He testified that each of these psychiatric disorders causes partial disability, and together they combine in a synergistic fashion to create a disability that is greater than their simple sum. He ultimately concluded that Claimant is unemployable. (Depo p. 17).

C. Analysis: Education, Training and Experience

Claimant received a high school diploma. Mr. Dolan performed academic testing and concluded that Claimant would not be able to perform a job where reading and writing are critical to the job, nor where math is critical. (Depo p. 15-16). Mr. Dolan also stated that Claimant is computer illiterate. On the other hand, vocational consultant England stated that he also tested Claimant's academic abilities. He said that he felt Claimant would have the academic ability to undergo further training if he had an interest in something in particular. (Depo p. 12). He said that he believed Claimant could learn how to use e-mail and basic computer applications, (Depo p. 15), and that Claimant would have to first develop computer skills before he could consider a position such as that of a job estimator. (Depo p. 25-26). He said that based upon his review of the medical records there was nothing that would limit Claimant's capacity to use a keyboard or train on a keyboard.³ (Depo p. 26). Correspondence in Mr. England's file shows that attempts were made to find someone who could teach computer skills to Claimant, but apparently all of the potential teachers were too busy.

Claimant testified that he has had training in welding. Mr. Dolan stated that the welding and other maintenance experience has provided Claimant with a knowledge of tools that can transfer broadly to jobs where such tools are used, but it would not transfer into any jobs which Claimant can actually perform, because all jobs of this sort lie within the category of medium to heavy work. (Depo p. 17). The one exception would be a job where Claimant would work in sales at a hardware store, though these workers have to be able to be on their feet all day, and have to be able to stock shelves. (Depo p. 17). Most importantly, Mr. Dolan stated, the person has to be able to communicate with the public, which is a problem with Claimant because of his hearing problems. (Depo p. 17-18).

With regard to Claimant's previous experience as a nurse's aide, as well as that of a medical technician, Mr. Dolan indicated that Claimant's experience in these fields would transfer to jobs that involved taking care of people, but again, such jobs -- if they involved taking care of adults -- would fall into the medium to heavy exertion level.

One other possible area of employment was the occupation of gunsmithing, which Mr. England testified that Claimant would be capable of performing. (Depo p. 28). Mr. England has

³Mr. England was apparently unaware that Claimant has only nine fingers, despite the fact that this is laid out in the report of Dr. Volarich and the records of Dr. Davis.

not spoken to Claimant other than his first evaluation in 2005, though records from his staff show that there were job placement activities which took place after the initial evaluation. (Exhibit N). Two gunsmiths were identified for Claimant to contact concerning the possibility of an apprenticeship. (Exhibit N). Notes from a conversation with Claimant's wife, dated December 19, 2005, indicate that the first gunsmith was nearly an hour's drive from Claimant's home, which was too far for Claimant to handle because of back problems. (Exhibit N). Notes from a conversation with Claimant's wife, dated December 20, 2005, indicate that the second gunsmith was contacted, but that the training would take four years to complete. (Exhibit N). Claimant confirmed that he and his wife tried to make the trip to the first gunsmith, but they had to turn around before they got there due to the development of increased muscle spasms in his back. He therefore concluded that he would not be able to drive the distance required each day, simply to get to work. The second job involved a gunsmith who was closer to his home, though the man told him that there was no sense in him coming in if he was on a four hour restriction from Dr. Davis. The man also indicated that the training would take four years and that there was no way that Claimant could be trained in the three month period of time that was being approved by England & Company. The second job therefore was unworkable. Claimant's testimony was supported by his ex-wife, who confirmed Claimant's statements about not being able to attend the first one due to the distance, and not being able to take the second job due to being on part-time status and/or needing four years of schooling.

D. Analysis: Claimant's Location

Claimant lives in the town of Dixon, Missouri.⁴ Vocational consultant Dolan indicated that a person will be significantly limiting portions of the job market if they limit their job search to the area of Dixon, without considering the St. Louis metropolitan area. (Depo p. 28). He noted that Claimant would be restricted in his ability to drive because of the fact that he is still taking narcotic pain medications. (Depo p. 27). He said that Claimant was driven to his evaluation by Claimant's sister. (Depo p. 27). He said that he did not believe that Dr. Volarich put driving restrictions on Claimant (Depo p. 26), but that the Doctor had advised Claimant not to be in one position for more than 20 to 30 minutes. (Depo p. 39). Dr. Davis said to change positions every 15 minutes. (Depo p. 29).

Vocational consultant England testified that he identified one job for which Claimant might be qualified, which was that of a job estimator. (Depo p. 24). He testified that this job would require Claimant to drive to specific customers, and then drive back to an office. (Depo p. 24).

E. Conclusions Regarding Permanent Disability

Claimant and his ex-wife are found to be credible witnesses. Claimant established that he has tried to be more active in his life, but that the result of his activity is increased symptoms.

⁴Claimant testified that he does not drive long distances, limiting himself to twenty-five to thirty miles at the most. He did not drive to the hearing, but was driven by his sister, and he spent the night in a motel so that he did not have to drive on the morning of the trial. After he takes a trip such as that, it then takes him a day or so to recover. He said that based upon his experience he will be in bed for the entire day after the trial.

And his attempts at activity are made more difficult by the fact that his psychiatric illness causes him to avoid leaving his home. He has trouble even trying to clean his home or cook his meals, and driving is performed only for short distances. Claimant was viewed at trial, and it is noted that he ambulated with great difficulty, apparently in pain.

Based solely upon the restrictions placed on Claimant by Dr. Dunteman and Dr. Davis – doctors chosen by Employer – Claimant would be found to be unemployable in the open labor market. While Mr. England testified that he believed Claimant would be able to perform lighter duty work, Mr. England was never advised as to Claimant’s psychiatric illnesses. He therefore knew nothing about the debilitating effects of Claimant’s mental illness when he concluded that Claimant was able to work. Mr. Dolan, on the other hand, was aware of these problems, and his opinions are therefore found to be the more credible of the two. Likewise, Dr. Cantrell did not take into account Claimant’s psychiatric conditions in rendering his opinions on permanent disability. Based on the opinions of Dr. Dunteman, Dr. Davis, Dr. Volarich and Dr. Stillings, and taking into account Claimant’s educational and employment background, and the permanent restrictions, it is reasonably certain that Claimant was, and remains, unemployable in the open labor market, and is therefore permanently and totally disabled. Claimant’s permanent total disability is assessed against Employer/Insurer as it results from the last injury alone.

On March 4, 2005 Dr. Davis stated that he believes Claimant is at a point of maximum medical improvement. On June 16, 2005 Dr. Dunteman stated that Claimant had reached a point of “maximum medical improvement”. It is noted that Employer/Insurer paid temporary total/partial disability benefits to Claimant through January 18, 2006. Claimant became permanently and totally disabled as of January 19, 2006. The obligation to pay permanent disability compensation commences under Section 287.160.1 RSMo. (2000) on the date when the claimant's permanent disability begins. *Kramer v. Labor & Indus. Rel. Com'n*, 799 S.W.2d 142, 145 (Mo. App. 1990); *Hall v. Wagner Div.-McGraw-Edison*, 782 S.W.2d 441, 443-44 (Mo. App. 1989). The permanent total disability payments shall therefore commence effective January 19, 2006, which represents the first day after the last TPD payment, and shall continue to be paid in accordance with the provisions of this award and Section 287.200 RSMo. The applicable weekly rate for permanent total disability benefits is \$488.13 as determined by stipulation of the parties.

Past and Future Medical Care

It is sufficient to show that the need for additional medical treatment by reason of a compensable accident is a reasonable probability. *Mathia v. Contract Freighters, Inc.*, 929 S.W.2d 271, 277 (Mo.App.1996). Future medical care must flow from the accident, via evidence of a medical causal relationship between the condition and the compensable injury, if the employer is to be held responsible. *Mickey v. City Wide Maintenance*, 996 S.W.2d 144, 149 (Mo.App. W.D.1999). A claimant is not required to produce “conclusive” testimony or evidence to support a claim for future medical benefits; it is sufficient if the evidence shows by “reasonable probability” that he is in need of additional medical treatment by reason of the work-related accident. *Landers v. Chrysler Corp.*, 963 S.W.2d 275, 283 (Mo.App. E.D.1997). The type of treatment authorized can be for relief from the effects of the injury even if the condition is not

expected to improve. *Landman v. Ice Cream Specialties, Inc.*, 107 S.W.3d 240, 248 (Mo. banc 2003).

Claimant submitted Exhibit P into evidence without objection. He identified it as being medical bills he has incurred through the office of Dr. Davis since the workers' compensation insurance carrier stopped providing him with medical care. He also submitted Exhibit Q into evidence, which he identified as bills received from prescriptions that were ordered by Dr. Davis.

Employer's authorized treating physician, Dr. Dunteman, discharged Claimant from his care on June 16, 2005, stating that Claimant had reached a point of "maximum medical improvement". (Exhibit J). Dr. Dunteman did not say Claimant would not need further treatment. To the contrary, he said that Claimant should continue with Topamax, Lexapro, Cymbalta, Tizanidine, Fosamax and Lidoderm. He was also advised to purchase over-the-counter melatonin for sleep issues, and to obtain a smaller abdominal brace. Lastly, the Doctor provided Claimant with a "Patient Instructions" form on that date, advising him that he should "return to Dr. Davis". (Exhibit J).

The records of Dr. Davis show that he continues to treat Claimant for problems that are directly related to the work injury. For the most part, this includes medication and periodic follow-up appointments.

Dr. Volarich stated that Claimant will need ongoing medical care due to the work injury, in the form of pain management. (Depo p. 36).

Dr. Stillings testified that Claimant is in need of psychiatric care which he attributes to the work injury. (Depo p. 14). He said:

[w]ell, he's in dire need of psychiatric treatment. Treatment would consist of initially primarily with psychotropic medication, but he also needs some supportive psychotherapy. He will need at least one anxiolytic medication and two antidepressants on an open-ended basis most probably for the remainder [of] his life. Eighty percent of the need for treatment is related to the work injury and twenty percent preexisting.

Dr. Cantrell stated that Claimant was not in need of any further medical treatment that was related to the accident of May 27, 2004. (Depo p. 8).

The employer/insurer may be ordered to provide medical and hospital treatment to cure and relieve the employee from the effects of the injury even though some of such treatment may also give relief from pain caused by a preexisting condition. *Hall v. Spot Martin*, 304 S.W.2d 844, 854-55 (Mo. 1957). The existing case law at the time of the 2005 amendments to The Workers' Compensation Law instructs that in determining whether medical treatment is "reasonably required" to cure or relieve a compensable injury, it is immaterial that the treatment may have been required because of the complication of pre-existing conditions, or that the treatment will benefit both the compensable injury and a pre-existing condition. *Bowers v. Hiland Dairy Co.*, 188 S.W.3d 79, 83 (Mo.App. S.D.2006). Rather, once it is determined that

there has been a compensable accident, a claimant need only prove that the need for treatment and medication flow from the work injury. *Id.* The fact that the medication or treatment may also benefit a non-compensable or earlier injury or condition is irrelevant. *Id. Tillotson v. St. Joseph Medical Center*, (Mo.App.W.D.) June 14, 2011, --- S.W.3d ----, (2011 WL 2313691).

Claimant has provided sufficient evidence to establish that he is in need of further medical care as a result of his work injury of May 27, 2004. The opinion of Dr. Volarich is supported by the testimony of Employer's authorized treating physicians, with Dr. Dunteman specifically recommending ongoing medical care. It is therefore found that the opinion of Dr. Volarich is credible, while the opinion of Dr. Cantrell is not. Claimant is awarded reimbursement of his past medical expenses, in the amount of \$2,231.00 for those contained within Exhibit P, and \$3,408.99 for those contained within Exhibit Q.

Similarly, with regard to ongoing medical care, Claimant has established that he is in need of such care. It is found that Employer is liable for ongoing medical care to cure and relieve the effects of Claimant's injury of May 27, 2004, which includes injuries to his back, right ear and psychiatric condition, as well as their sequelae.

Dependency

In *Schoemehl v. Treasurer of Mo.*, 217 S.W.3d 900 (Mo. Banc 2007), the Missouri Supreme Court held an injured worker's right to compensation for both accrued and unaccrued permanent total disability (PTD) benefits survives to his or her dependents. *Id.* at 902. In other words, "when a claimant has been awarded PTD benefits and subsequently dies of a cause unrelated to the work injury, the claimant's dependents are entitled to receive the awarded benefits for their lifetime."

In this case, Claimant was married to Lori Null at the time of the injury. However, they have since divorced, during Claimant's lifetime, ending Lori Null's dependency. She would not be dependent on Claimant at the time of his death were he to predecease her. Lori Null is not found to be dependent for the possibility of future benefits per *Schoemehl*.

As liability has been determined against the Employer/Insurer for PTD benefits, the claim against the Second Injury Fund is denied.

Made by: /s/ GRANT C. GORMAN
GRANT C. GORMAN
Chief Administrative Law Judge
Division of Workers' Compensation