

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

Injury No.: 05-105014

Employee: Delbert Pruett
Employer: Federal Mogul Corporation
Insurer: Travelers Commercial Casualty
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 July 14, 2010. The award and decision of Chief Administrative Law Judge Lawrence C. Kasten, issued July 14, 2010, 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 27th day of April 2011.

LABOR AND INDUSTRIAL RELATIONS COMMISSION

William F. Ringer, Chairman

Alice A. Bartlett, Member

John J. Hickey, Member

Attest:

Secretary

ISSUED BY DIVISION OF WORKERS' COMPENSATION

FINAL AWARD

Employee: Delbert Pruett

Injury No. 05-105014

Dependents: N/A

Employer: Federal Mogul Corporation

Additional Party: Second Injury Fund

Insurer: Travelers Commercial Casualty

Appearances: James Guirl, attorney for employee, Sabrina Merritt, attorney for employer/insurer, and Cliff Verhines, attorney for Second Injury Fund.

Hearing Date: February 3, 2010

Checked by: LCK/rf

SUMMARY OF FINDINGS

1. Are any benefits awarded herein? Yes.
2. Was the injury or occupational disease compensable under Chapter 287? Yes.
3. Was there an accident or incident of occupational disease under the Law? Yes.
4. Date of accident or onset of occupational disease? On or about August 4, 2005.
5. State location where accident occurred or occupational disease contracted: Malden, 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 slipped and caught himself on a table and injured his low back and left leg.
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.
14. Nature and extent of any permanent disability: Permanent total disability.
15. Compensation paid to date for temporary total disability: None.
16. Value necessary medical aid paid to date by employer-insurer: \$4,064.90.
17. Value necessary medical aid not furnished by employer-insurer: \$1,786.11
18. Employee's average weekly wage: \$787.29
19. Weekly compensation rate: \$524.86 for temporary total and permanent partial disability. \$365.08 per week for permanent partial disability.
20. Method wages computation: By agreement.
21. Amount of compensation payable:

\$1,786.11 for previously incurred medical.
\$15,820.79 in temporary total disability.

Total: \$17,606.90.
22. Second Injury Fund liability: None.
23. Future requirements awarded: See Rulings of Law for permanent total disability benefits.

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: James Guirl.

FINDINGS OF FACT AND RULINGS OF LAW

On February 3, 2010, the employee, Delbert Pruett, appeared in person and with his attorney, James Guirl. The employer-insurer was represented at the hearing by its attorney, Sabrina Merritt. The Second Injury Fund was represented by Assistant Attorney General 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 findings of fact and rulings of law, are set forth below as follows:

UNDISPUTED FACTS

1. Federal Mogul Corporation was operating under and subject to the provisions of the Missouri Workers' Compensation Act, and its' liability was fully insured by Travelers Commercial Casualty.
2. On or about August 4, 2005, Delbert Pruett was an employee of Federal Mogul Corporation and was working under the Missouri Workers' Compensation Act.
3. The employer had notice of the employee's alleged accident.
4. The employee's claim was filed within the time allowed by law.
5. The employee's average weekly wage was \$787.29. The rate of compensation for temporary total disability and permanent total disability is \$524.86 per week. The rate of compensation for permanent partial disability is \$365.08 per week.
6. The employer-insurer furnished \$4,064.90 in medical aid.
7. The employer-insurer did not pay any temporary total disability.

ISSUES

1. Accident
2. Medical Causation
3. Previously Incurred Medical Expenses.
4. Additional Temporary Total Disability
5. Nature and Extent of Permanent Disability.
6. Liability of the Second Injury Fund for Permanent Partial or Permanent Total Disability.

EXHIBITS

The following exhibits were offered and admitted into evidence:

Employee's Exhibits

- A. Medical records of Malden Medical Center
- B. Medical records of Missouri Southern Healthcare
- C. Medical records of Poplar Bluff Regional Medical Center
- D. Medical records of Dr. Hatfield/Dexter Medical Center
- E. Medical records of St. Francis Medical Center
- F. Medical records of St. Francis Medical Center

- G. Medical records of Dr. Yingling
- H. Medical records of HealthSouth
- I. Deposition of Dr. Musich
- J. Deposition of James England
- K. Billing Statement from Poplar Bluff Regional Medical Center
- L. Billing Statement from St. Francis Medical Center
- M. Billing Statement from Missouri Southern Healthcare
- N. Billing Statement from Cape Neurosurgical Associates
- O. Billing Statement from HealthSouth

Employer-Insurer's Exhibits

- 1. Deposition of Dr. Lange
- 2. Deposition of Donna Abram
- 3. Payment History of Employer-Insurer
- 4. Medical Payment History of Employer-Insurer
- 5. Medical Records of Johns J. Pershing VA Medical Center
- 6. Medical Records of Dr. Ted Hatfield/Dexter Medical Center
- 7. Medical Records of Southeast Hospital
- 13. Medical Bill Spreadsheet

Employer-Insurer's Exhibits 8 through 12 were withdrawn. The employee objected to Employer-Insurer's Exhibit 14, certified business records of Federal Mogul, based on foundation and format. The objection was taken under advisement. Section 490.682.2 RSMO states that "No party shall be permitted to offer such business records into evidence pursuant to this section unless all other parties to the action have been served with copies of such records and such affidavit at least seven days prior to the day upon which trial of the cause commences." The employee and the Second Injury Fund were provided the business records on the day of the hearing. The employee's objection to Exhibit 14 is sustained and it is not admitted into evidence. Exhibit 14 shall be retained in the Division's file for purposes of appellate review.

The Second Injury Fund did not offer any exhibits into evidence. Judicial notice of the contents of the Division's file was taken.

WITNESS: Delbert Pruett, the employee.

BRIEFS: The employee and the employer-insurer's briefs were received on March 26, 2010. The Second Injury Fund's brief was received on April 7, 2010.

FINDINGS OF FACT: The employee is 64 years old and was born on September 26, 1945. He went to school until the 7th grade. When he was 13 years old he started working for his father on a farm. He went into the Army in 1968 and was an ammunition sergeant in an artillery unit. He served two tours of duty in Vietnam. After Vietnam he was stationed in Germany, Texas and Kentucky. In 1976, he received a GED. He took college classes at Elizabethtown Community College studied science and made all A's. The employee was honorably discharged.

The employee came back to Southeast Missouri and took a year off before starting to work at Federal Mogul on January 3, 1977. He worked there for 29 years. He received perfect attendance awards in 1990 and from 1994 through 1996. He was a grinder operator for a couple of years and became a machine operator. As a machine operator he made 1,000 pistons a day. He had knowledge of setting and reading gauges. He stood on his feet all day and did a lot of squatting, bending, twisting and lifting. The pistons were not heavy but he would have to frequently lift "chucks" which weighed 20-30 pounds. He worked a lot of overtime and worked a 12 hour shift 7 days a week. As part of the process, the floor around the machines got wet with cutting oil which is a mixture of water and oil. Prior to August 4, 2005, he was never hurt at Federal Mogul.

The employee testified that he was diagnosed with diabetes in 1996. From 1996 through August of 2005, he took oral medications and did not miss working due to that condition. It did not affect his ability to work. Prior to August of 2005, he had burning and numbness in his feet. He was diagnosed with a 30% hearing loss while in the military, which was confirmed by an audiologist in 2003. While in the Army, he did not injure his back but did have some back complaints and was treated once for it in 1972. He saw horrific things in the Vietnam War. When returned, he experienced flashbacks and had some trouble sleeping. While working at Federal Mogul, he left his station and went to the bathroom to take medication for his headaches but not for the flashbacks. He was diagnosed with post traumatic stress disorder due to Vietnam.

1997-2003:

In 1997, Dr. Hatfield noted the employee had just been diagnosed with diabetes. In February of 2001, the employee saw Dr. Boyd for an eye exam. He stated that the employee was doing quite well and showed no signs of diabetic eye disease. In September of 2001, the employee saw Dr. Hatfield. The employee was doing well and had been an excellent patient with all of his home glucose monitor readings basically acceptable except for a couple of times.

In April of 2003, the employee saw an audiologist for left ear tinnitus that has been present for the past two months. The employee had a hearing problem since 1970. The past 27 years he had worked in a manufacturing plant with occupational noise exposure. The audiogram showed a mild to moderate hearing loss through the 2000Hz and a moderately severe to severe hearing loss above 2000Hz in the right ear. The employee had a mild to moderate left-sided hearing loss through 3000Hz and a moderately severe to severe hearing loss above 3000Hz. The employee's word recognition was fair bilaterally. Due to tinnitus in his left ear, the employee should be referred to a doctor. The employee would benefit from hearing aids. In May of 2003, Dr. Hatfield stated that his home glucose readings were within normal limits. In July of 2003, Dr. Hatfield noted that the employee's home glucose readings were within normal limits.

2004:

On May 12, Dr. Hatfield noted the employee had been doing well except for complaints of low back pain with radiculopathy symptoms in the left lower extremity with no specific history of injury. The deep tendon reflexes were symmetrical in the patella and Achilles. The

straight leg raising was equivocal on the left at about 75 degrees. X-rays of the lumbar spine showed a fairly marked degenerative disc disease and some scoliosis and osteoarthritic changes. Dr. Hatfield gave him Celebrex samples and Darvocet for pain. Dr. Hatfield noted that he would monitor the back pain closely; and diagnosed degenerative disc disease. On May 24, the employee was seen for diabetes and back pain secondary to degenerative disc disease. The radiologist interpretation of the lumbar x-ray was degenerative disc disease and degenerative joint disease. Dr. Hatfield stated that he would see the employee in 6 months. On November 24, Dr. Hatfield noted that the employee's home glucose readings were acceptable. He diagnosed diabetes and degenerative joint disease.

2005:

On March 2, the employee saw Dr. Hatfield for diabetes and was doing well. The employee complained of a little burning and numbness in his feet, mostly at work. It did not bother him at night and was not painful. The employee had no edema. He had bilateral pulses in his feet and the monofilament test was within normal limits. The employee's feet appeared healthy. Dr. Hatfield diagnosed early peripheral neuropathy; and degenerative joint disease.

The employee testified that on August 4, 2005, he was moving from one machine to another. The rubber floor mat was wet underneath due to oil and water. The mat slipped which caused his feet to give out and he slipped. He reached out with his right hand so he would not fall and caught himself on a table. He did not fall all the way to the ground. His back felt like it slipped and his left leg went numb. The employee told his supervisor Tony Campbell that he had slipped and fell. He filled out an accident report. The employee thought his problem would go away and was not sent to a doctor.

The Report of Injury filed by the employer-insurer stated that the date of the injury was August 4, 2005 and the employer was notified that day. It stated that a rubber mat slipped in the employee's work area and he twisted his knee.

The employee testified that he finished his shift but had increasing problems with his back and left leg. Several days later, his left leg would not move and he was limping. He asked Tony Campbell about being sent to a doctor and was told to talk to Michelle Zimmerman at Human Resources. She made an appointment with Dr. Hunt. The employee cancelled the appointment and rescheduled it in order to get an appointment for both he and his wife. He continued to work and his back and leg became worse. When he saw Dr. Hatfield on August 30, it was for his diabetes and he would not have told him about his back.

On August 30, the employee was seen by Dr. Hatfield for evaluation and management of his diabetes. The employee was doing well and all of his home glucose monitorings were acceptable. His fasting blood sugar was 97. The employee told Dr. Hatfield that he needed Celebrex because if he did not take it, he was in quite a bit of pain. Dr. Hatfield diagnosed diabetes, degenerative joint disease, and osteoarthritis.

On October 5, the employee went to Malden Medical Center with back and hip pain. About two weeks ago he slipped on a mat at work and hurt his left knee and hip. His left leg slipped and he twisted his left hip and back. On exam, the employee had tenderness at L5-S1 and to the left hip. X-rays of the left hip and lumbar spine were taken. Dr. Hunt diagnosed disc pathology and ordered an MRI.

The employee testified that he spoke to Human Resources about the MRI. They did not say yes or no, but did not authorize the MRI. On October 27, the company sent to him to the emergency room because his left leg gave out and his back was hurting. As soon as he left the emergency room, he went to Dr. Hatfield who took him off work for 3 days.

The employee went to the emergency room at Missouri Southern on October 27 with a chief complaint of injury with pain to his back with the onset in August of 2005. The employee had severe pain in the lumbosacral region that radiated into his left buttocks, thigh, leg and foot. The cause of the injury was slipping on a mat in August of 2005 at work. Past medical history showed diabetes. The impression was lumbosacral radiculopathy in the left lower extremity and chronic lumbosacral instability.

The employee saw Dr. Hatfield on October 27 and gave a history that he sustained an injury on August 8 when he fell at work when a mat slipped out from under him. He hurt his back and was having left leg pain. He was sent to Dr. Hunt who thought he had a slipped disc and needed an MRI but workers' compensation refused. The employee continued to work and on October 27 his left leg "just gave out" and he started falling but co-workers broke his fall and caught him before he fell to the ground. He was taken to the emergency room and given Demerol. Dr. Hatfield prescribed Flexeril and Vicodin. He kept him off work and was going to try to get the MRI scheduled. Dr. Hatfield diagnosed a back injury and radiculopathy of the left lower extremity.

The employee testified that he went back and tried to work. On November 8, 2005 he could not finish his shift and that is the last day he worked. He received a call from workers' compensation and was told that they had rejected any more medical treatment including the MRI.

On November 9, the employee saw Dr. Hatfield and had severe pain. The employee had continued to try to work and had low back pain mostly on the left, with numbness, tingling, and weakness in the left lower extremity. Dr. Hatfield noted he would try to contact workers' comp to get an MRI. Dr. Hatfield diagnosed back pain secondary to an injury at work on August 8, rule out herniated disc, and left lower extremity radiculopathy.

On November 21, the employee had severe low back pain radiating into the left leg down into his foot. His left leg "gives out and goes numb". The left Achilles' reflex was absent with positive straight leg raising on the left. Dr. Hatfield ordered a lumbar MRI and diagnosed a history of an August work injury with low back pain and radiculopathy of the left lower extremity.

The November 28 MRI showed a disc bulge with a large central disc extrusion at L4-5. There was increased signal intensity in the L4-5 annulus representing a radial tear/fissure. At L5-S1 there was a diffuse disc bulge with mild central disc protrusion. The impression of the radiologist was a large central disc extrusion with evidence of radial tear/fissure at L4-5 narrowing the spinal canal.

The employee saw Dr. Hatfield on December 6 for back pain and left lower extremity radiculopathy. The Achilles' reflexes were absent on the left and the straight leg raising was positive on the left. Dr. Hatfield stated that the MRI showed a large central herniated disc at L4-5, and diagnosed back pain secondary to an injury at work in August with a herniated disc at L4-5 with radiculopathy in the left lower extremity. Dr. Hatfield referred the employee to Dr. Yingling, a neurosurgeon.

On December 20 Dr. Yingling stated that the employee was injured on August 8, 2005 when the mat he was standing on slipped, causing him to twist and fall; and he caught himself by grabbing a rail. He developed severe pain in his left lower back radiating down the left side of the left leg to the foot with numbness of the entire left foot. The employee was walking with a limp favoring the left lower extremity. His straight leg raising was positive on the left. He had some left sciatic tenderness as well as lumbosacral tenderness, left greater than right. An MRI showed left lateral disc protrusion with stenosis, left greater than right, at L4-5 and L5-S1 causing neural impingement on the left. His impression was lumbar stenosis and disc bulging/herniation at two levels which was causing pain and numbness in his left leg and hip. Dr. Yingling recommended an L4-5 and L5-S1 segmental decompression and discectomy.

2006:

On January 4, Dr. Yingling performed a L4-5 and L5-S1 segmental decompression and laminectomy with a left L4-L5 discectomy for a diagnosis of lumbar stenosis with disc rupture. The indication for surgery was severe back and leg pain with stenosis at L4-5 and L5-S1 with evidence of disc rupture on MRI. On examination of the nerve roots at L4-5 on the left side there was an extremely large disc protrusion in the axilla of the L5 nerve root displacing the nerve root tightly into the lateral recess. The extruded disc material and a large amount of degenerative disc were removed. At the L5-S1 level, the decompression was completed but no disc was removed. In the January 5, 2006 discharge summary it was noted that the employee was injured at work on August 8, 2005 when the mat he was standing on slipped, causing him to twist and fall. He caught himself by grabbing onto a railing. He developed severe pain in his left lower back radiating down the left side of the left leg to the foot with foot numbness. An MRI demonstrated a left lateral disc protrusion with stenosis at L4-5 and L5-S1 causing impingement on the left.

On February 28, the employee was having significant back pain and got a "catch" in his back when he first gets up. He cannot stand very long because his back hurts. His leg was much better with no pain or numbness in the leg or foot. Dr. Yingling noted that the employee had made a good recovery from his radiculopathy but continued to have significant pain and spasms in his back muscles, possibly relating to a sprain or strain from his original injury. Dr. Yingling prescribed therapy.

On March 28, Dr. Yingling sent the employee to St. Francis Medical Center Pain Clinic for trigger point injections for low back pain. He filled out a temporary handicap parking placard form. On April 6, the employee saw Dr. Brennan at the St. Francis Medical Center Pain Clinic due to left lower back and left leg pain. Prior to surgery the employee had 10/10 back pain and left leg pain. After surgery, the pain was better but he still had left lower back pain that would occasionally radiate into the left leg. Dr. Brennan diagnosed chronic muscle spasms of the left lumbar muscles. Dr. Brennan performed trigger point injections in the left lumbar paraspinous muscles and the left multifidus muscles.

On April 20, Dr. Yingling stated that the trigger point injections did not help. The employee had severe left lower back and left leg pain. The employee walked with a slight limp due to back pain. He had good strength in his legs with no foot drop. Dr. Yingling stated the employee continued to have severe pain and spasms in his left lower back which may be related to a strain or sprain at the time of his original injury. Dr. Yingling ordered therapy; prescribed a lumbosacral brace for muscle spasms; renewed his prescription for Lorcet Plus; and scheduled a repeat MRI with and without contrast.

On May 25, Dr. Yingling stated the employee's therapy did not help. He had left lower back and left leg pain. On exam there was moderately severe palpable spasms and tenderness of the left lumbar muscles and sciatic area. He walked with a limp favoring his left leg.

On June 8, the employee had a lumbar MRI for low back and left leg pain. The MRI showed the decompressive laminectomy at L5-S1 and the left microdiscectomy at L4-5. There was post-operative scar tissue within the canal at the operated level and at L4-5 surrounding the L5 nerve root. There was a left paramedian disc bulge at L5-S1 which appeared to abut the left S1 nerve root and displaced it against the facet resulting in moderate stenosis. If the employee's symptoms were in the S1 distribution on the left it was likely contributory. At L4-5, the study did not show evidence of comparable disc impression of the L5 nerve root or thecal sac.

On June 8, the employee saw Dr. Yingling for left lower back pain. His left leg "gives out" at times but he does not really have pain in the leg. Due to persistent pain he was applying for disability. The employee walked with a moderate limp favoring his left leg and had reasonably good strength with no evidence of foot drop. Dr. Yingling reviewed the MRI scan which showed post-operative changes at L4-5 and L5-S1. At L4-5 there appeared to be a soft tissue entity in the left lateral recess but on the post contrast image, the L5 nerve root is visualized and is in normal position and the surrounding soft tissue enhances indicating that it is scar tissue. The MRI did not show any evidence of any recurrent nerve root compression. Dr. Yingling did not recommend any further surgery; prescribed Naprosyn and the employee was to follow-up with Dr. Moyers.

The employee testified that the physical therapy and trigger point injections did not help with his back or leg. On June 8, Dr. Yingling released him and gave him restrictions of no lifting over 15 pounds with no bending or stretching; and stated that he could not work anymore. Dr. Yingling told him that he was disabled and would help him with getting disability. The employee went back to Federal Mogul with a cane and was told that there was no job.

In a physical therapy discharge dated June 20, it was noted that the employee had 19 visits. The employee's chief complaint was pain primarily radiating down the left leg with instability/giving way of the leg. The employee had minimal improvement with activities. The employee's subjective complaints matched the objective measures. The employee demonstrated minimal pain behaviors. The therapist stated that 10% of the goals were met and the plan was to discharge the employee to an independent home exercise program.

The employee testified that he started going to the VA in the summer of 2006 for treatment.

The employee went to the VA Clinic in Poplar Bluff on June 9, 2006. It was noted that the employee had not come into their facility for a few years. The employee had the sudden onset of left chest pain associated with shortness of breath and itchy skin rash. He was diagnosed with an allergic reaction to the I.V. contrast from the June 8 MRI. On September 11 the employee went to the VA to establish care. The employee was on disability. He was prescribed Tramadol for back pain and a muscle relaxant.

2007:

On January 5, the VA noted that the employee had been unemployed since November of 2005 due to a back injury. The employee was in Vietnam for two years and experienced severe combat. The employee had difficulties with anger, irritability and episodes of depression. Prior to his retirement in 2005 he had a lot of problems getting along with the people at work. While working at a machine, he suddenly couldn't remember what he was doing or how to run the machine. To keep others from knowing about it he would go to the bathroom to regroup. The employee was diagnosed with severe post-traumatic stress disorder.

In February, the employee had a psychiatric consultation at the VA and was diagnosed with chronic post-traumatic stress disorder with depression. He began participating in the post-traumatic stress disorder group and continued to have group therapy in 2007. In March, the employee had recently fallen because his legs were weak. The employee went to the VA clinic with a history of chronic back pain and post-traumatic stress disorder. The employee was prescribed medication for depression, nerves, muscle spasms and pain.

On May 22, the employee went to the VA clinic with a history of post-traumatic stress disorder and chronic low back pain. He had bilateral hand and foot numbness and a balance problem. He felt very weak in both legs and the assessment was possible peripheral neuropathy.

On May 31 the employee had a neurology consultation at the VA by Dr. Brenner. The employee had chronic low back pain and had been having episodes of falling for three to four months associated with left lower extremity weakness and dizziness. He first hurt his back at work when he slipped and twisted his back. After surgery he initially improved but had a reoccurrence of back pain and started falling several months thereafter. He was initially falling three to four times a week but was falling up to three times a day. He had a shuffling gait and positive Babinski's sign and clonus in the left lower extremity. The employee had a positive

Romberg sign and decreased sensation in both feet based on the monofilament test, and may be at early stages of diabetic sensory neuropathy. He was taking Tramadol and a muscle relaxant. Due to the falling episodes, the employee was scheduled for an MRI of the brain and ultrasound of the carotid arteries. For his back pain and left lower extremity, an MRI of the lumbar spine was ordered.

On June 6, the employee went to the VA. He had been very unsteady on his feet and fell several times. The employee used a cane to walk. He was taking a muscle relaxant and Tramadol for pain. The brain MRI showed cortical atrophy consistent with the employee's age, generalized aging changes, and a small focal lobe density region that appeared to represent an old CVA. The bilateral carotid ultrasound was normal without evidence of significant stenosis or abnormal Doppler flow.

On June 20, 2007 the VA noted with regard to his post-traumatic stress disorder, he had problems right after he returned from combat in Vietnam. He tried to cope with it through alcohol and drugs which he quit in 1975. He has had many years of stability up until February of 2006 when his brother, who was also a Vietnam veteran, passed away. That seemed to have triggered the reoccurrence of symptoms and he was now trying to cope more constructively through treatment. The employee had increased anxiety, sleep disturbance; felt slowed down and cannot function as well. The employee had not been employed since 2005 due to physical problems regarding back surgery.

The employee had an MRI of his cervical, thoracic, and lumbar spine on July 10 due to a history of falling and weakness of his leg. The MRI of the thoracic spine showed no acute soft tissue or boney change with degenerative arthritis and scoliosis. The MRI of the lumbar spine showed degenerative arthritis, mild bulging disc without definite signs of disc herniation at L4-5 and L5-S1. The MRI of the cervical spine showed posterior bulging of the disc particularly at C4-5. There was no evidence of disc herniation or acute process. On July 31 the employee was at the VA with chronic low back pain. He had been diagnosed with myelopathy and neuropathy. The employee had a history of falling and used an ambulatory aid. He continued to take muscle relaxants and his Tramadol was increased.

On September 6, the employee went to the VA with trouble staying asleep at night. He was using a cane to move around. On September 28 the employee was at the VA and was on Tramadol for pain, Trazodone for sleeping, and a muscle relaxant for spasms.

On December 13, the employee was using a cane due to back pain and it was difficult for him to walk. It was noted he was obviously disabled and unable to work. The diagnosis was chronic post-traumatic stress disorder with depression and chronic back pain. The Trazodone was increased due to difficulty sleeping. The employee went to the VA on December 18 with chronic low back pain. He injured his back on the job in November of 2005 and had been falling. Dr. Brenner diagnosed myelopathy and neuropathy secondary to diabetes. The employee stated he has not been able to work, is disabled, cannot lift more than ten to fifteen pounds of weight and has not been able to stand or sit more than one hour. He was taking a muscle relaxant, Tramadol for pain and a sleeping pill.

2008:

The employee had individual and group therapy at the VA clinic during 2008. In September the employee went to the VA with chronic low back pain. He was on a muscle relaxant, Hydrocodone for pain, and Trazodone for sleep. The doctor added Vicodin. In December, the employee could not lift more than ten to fifteen pounds of weight and has not been able to stand or sit longer than one hour. He was walking with a cane due to his low back. The employee was on a muscle relaxant, Hydrocodone, and Trazodone for sleep.

2009:

In 2009, the employee continued to go to group therapy. In April, the employee was on Hydrocodone, a muscle relaxant, and Trazodone for sleep. In May, the employee went to the VA for depression due to his son dying. In May and June the employee was on a muscle relaxant, Hydrocodone, and Trazodone for sleep.

Opinions:

The employee saw Dr. Lange on November 2, 2006. A supplemental report was issued on September 21, 2007. Dr. Lange's deposition was taken on December 9, 2008. The employee's exam in November of 2006 was normal objectively with symmetrical trace reflexes and no atrophy. It was not normal subjectively. The employee had decreased sensation to touch in the shin area and some interesting "weakness" in his lower extremities on manual testing. Everything appeared to be weak below the knees which would make it difficult to ambulate, but the employee's gait was normal and he could walk on his toes and heels. The employee bent forward somewhat and stood in an abnormal mild crouch which was consistent with a back problem. The employee suggested back pain with bending and extending in an unusual fashion and suggested discomfort with light palpitation of the back on passive hip rotation.

It was Dr. Lange's opinion that the work-related injury was the substantial factor in the development of his symptoms which was a new central herniation at the L4-5 level. It was Dr. Lange's opinion that the herniation at L4-5 was work related and the left L4-5 partial discectomy was performed to address the worked related disc herniation at L4-5. Dr. Lange stated that the employee had pre-existing degenerative changes at L4-5 and L5-S1 superimposed on congenital short pedicle stenosis. It was Dr. Lange's opinion that Dr. Yingling performed a decompression at L4-5 and L5-S1 to address essentially radiographic aging findings of stenosis or narrowing of the spinal canal. Dr. Lange stated that the left L5-S1 nerve root displacement and abutment was not a result of the August 4, 2005 injury but was pre-existing and part of aging. A discectomy was not performed at L5-S1. Dr. Lange believed that the August 4, 2005 incident was a substantial factor in the development of the employee's lumbar radiculopathy.

When asked if in May of 2004 the employee had low back pain with radicular symptoms in his lower extremities whether that would be consistent with the diagnosis of pre-existing degenerative disc disease, Dr. Lange stated that it would not be unusual for a patient to have some symptoms with an MRI like the employee had without the herniation at L4-5.

Dr. Lange stated that there was no evidence that the employee had any disability from employment as a result of having diabetes.

Based just on his work related low back injury, Dr. Lange did not consider him to be totally disabled. It was Dr. Lange's opinion that based purely on the central herniation at L4-5; the surgical treatment at that level; and taking even into consideration educational hurdles, the employee would not be totally disabled from all occupations. Dr. Lange stated that the injury and the relatively small spinal operation (two-level decompression) would in and of itself not prevent him from working. It was Dr. Lange's opinion that the employee had an approximate 20% permanent partial impairment of the whole person based on the herniation at L4-5. The 20% rating was for the August 4, 2005 injury and did not take into consideration his pre-existing degenerative changes including stenosis. Dr. Lange stated that the employee's prognosis was only fair due to a combination of the nature of the injury and his age. Just related to the August 4, 2005 work-related incident, the employee would be capable of performing sedentary employment. He was unable to perform his previous occupation; would require significant restrictions; would be at the sedentary physical demand level which is negligible lifting; but was unlikely totally disabled.

It was Dr. Lange's opinion that based on the injury as well as other social and physical factors, the employee would be permanently and totally disabled. He did not agree that the August 4, 2005 injury was the substantial cause in his permanent total disability. Dr. Lange stated that the employee's lack of education is a stumbling block and could impact his future employability. It was Dr. Lange's opinion that the employee's disability is the result of multiple factors, many that have nothing to do with his August 2005 injury. If the employee was totally disabled it would be from a combination of his work injury, his pre-existing injuries including diabetes, his back and his psychological issues.

The employee was seen by Donna Abram on July 26, 2009. A supplemental report was issued on September 9, 2009. Her deposition was taken October 30, 2009. The employee obtained a GED diploma on the first attempt and completed college level courses in science with significantly above average grades according to his account. After talking with the employee for almost two hours she reached a conclusion that any vocational testing would only confirm his background and the skill level associated with his past tasks. The employee got up and moved around but did not ask for breaks or ask to lie down during their interview. The employee is 63 years old which is close to retirement. He leads a very sedentary life style due to his pain. He lies down or reclines up to one-half of his waking hours that could prevent him from working. He has to lie down and sometimes sleep due to back pain and anxiety attacks. At times when his legs flare up from the combination of the skin problems and other forms of diabetic neuropathy, it contributes to his need to lie down. It is possible that the employee's significant left leg radiculopathy was related to the back injury and contributed or caused the need to lie down.

He had panic attacks and flash backs that occurred randomly and have interfered with his ability although he covered up the problems for the most part while working. One outlet was to talk to his brother. When his brother died in 2006 he lost his coping mechanisms and his difficulties increased. The employee's son died nine days prior to his appointment with Ms.

Abram. Due to his hearing problems, the employee was not able to hear instructions or information but was able to cover up his difficulty. All of the employee's medical conditions have impacted his ability to work in the open labor market. Even though the employee was able to successfully work at Federal Mogul without too many difficulties, Ms. Abram found the pre-accident limitations vocationally significant which impacted his ability to compete in the open labor market.

Using just Dr. Lange's sedentary restrictions, it was Ms. Abram's opinion that with a diligent job search the employee would be able to compete for sedentary jobs in the open labor market and would very likely be able to be employed in the open labor market. Considering Dr. Musich's assessment and the employee's appraisal of his ability to be active, the employee would be employable but not placeable in the open labor market. He would have a difficult time in locating and sustaining a job.

It was Ms. Abram's opinion that just the August 4, 2005 work injury alone did not prevent the employee from competing in the open labor market, and believed that the employee was employable and could be placed in the open labor market. The factors impacting the employee's employability and his ability to compete in the open labor market pre-dated and pre-existed his August 4, 2005 accident and included post-traumatic stress disorder, panic attacks, depression, diabetes, and hearing deficits. Based on a combination of the employee's pre-existing disabilities in conjunction with the August 4, 2005 back injuries, Ms. Abram thought he was employable but the combination of factors and the totality of disabilities would make it very difficult for the employee to get and maintain a job in the open labor market due to all his limitations and complaints.

Ms. Abram found the employee reliable and honest. What the employee told her was consistent with what was in the medical records. Ms. Abram believes that the employee has the physical limitations that he told her.

The employee was seen by Dr. Musich on April 24, 2007. His report and January 29, 2008 deposition were in evidence. Dr. Musich stated that on or about August 8, 2005 that the employee sustained an acute low back injury. A floor mat that the employee was standing on slipped which caused him to begin falling. He abruptly twisted his low back and caught himself on a nearby table. The employee developed severe low back pain and significant left lower extremity radicular symptoms. The medical records showed the employee continued to work at Federal Mogul and almost fell to the ground on October 27, 2005, when his left leg collapsed due to pain and weakness. Dr. Musich stated that the MRI in late November of 2005 documented a large central disc extrusion with evidence of a radial tear and fissure at L4-5 and a disc protrusion and disc pathology at L5-S1; and showed two separate level disc herniations. The pathology on the MRI was consistent with the type of injury described.

On exam, the employee's lumbar mobility was severely restricted and the employee could not extend or bend backwards due to his significant low back pain. There was atrophy of the left calf compared to the right calf and a diminished left ankle jerk reflex. The symptoms were consistent with lumbar radiculopathy and sciatic complaints from the low back into the left leg.

The left straight leg raising was positive. He ambulated with a limp and required the use of a cane for stability due to post-traumatic left leg weakness.

It was Dr. Musich's opinion in early August of 2005 during the course and scope of his employment with Federal Mogul that the employee suffered acute trauma. It was Dr. Musich's opinion that the incident that occurred in late October of 2005 was due to the low back trauma of August of 2005. It was his opinion that the work trauma of August of 2005 was the prevailing factor in the development of acute low back pain and left lower extremity radiculopathy that required multilevel surgical decompression at L4-5 and L5-S1 and a discectomy at L4-5. It was Dr. Musich's opinion that the work trauma in August 2005 was causally related to the employee's persistent low back pain and left lower extremity radiculopathy and resulted in a permanent partial disability of 60% of the man as a whole referable to his lumbosacral spine.

The employee told Dr. Musich that prior to August of 2005, he had no low back or radicular symptoms. Dr. Musich was asked about the May 12, 2004 visit to Dr. Hatfield where the employee complained of low back pain with radicular symptoms in his left lower extremity. The exam showed deep tendon reflexes were symmetrical and straight leg raising was equivocal on the left at 75 degrees. The x-rays showed degenerative disc disease and degenerative joint disease. Dr. Hatfield did not follow-up with any diagnostic testing, or physical therapy or refer him to a specialist. After the May 12, 2004 visit, the employee's follow-up visits were for diabetes, high cholesterol and the one notation regarding the tingling and burning of the feet.

Dr. Musich stated with regard to the March of 2005 burning and numbness in the feet, Dr. Hatfield did a monofilament test to determine abnormal sensation and didn't find anything. Since it was in both feet, it was Dr. Musich's opinion that the findings were consistent with the employee's history of diabetes. Dr. Musich stated that the medical records prior to August of 2005 did not indicate the employee's diabetes caused him to lose time from work or any limitations or restrictions at work or in any way industrially disabled him and none of the problems were a hindrance or obstacle to employment. Based on Dr. Hatfield's records, the employee had pre-existing degenerative disc disease. Dr. Musich did not believe the degenerative condition produced any significant disability before the August of 2005 work injury.

Dr. Musich did not believe the employee had any significant pre-existing disabilities. Dr. Musich stated that even with some back complaints in May of 2004 and some symptoms of numbness and tingling in March of 2005, he did not believe that constituted any permanent partial disability, nor a hindrance to his work. Dr. Musich did not believe the employee had any disability due to the low back prior to the August of 2005 injury. Dr. Musich did not find any permanent partial disability existing to any part of the employee's body prior to the injury date.

It was Dr. Musich's opinion that the employee would not be able to return to any type of job that he performed at Federal Mogul due to persistent post-traumatic symptomatology. Based upon the employee's advanced work age of 61, his limited GED education and his prior work history, it was his opinion that the employee was totally and permanently disabled due to the work trauma of August of 2005. It was Dr. Musich's opinion that the August of 2005 injury was the sole cause of the employee's permanent total disability.

The employee saw James England on June 25, 2007 for a vocational rehabilitation evaluation. His report was dated July 24, 2007, and his deposition was taken on February 26, 2008. On vocational testing, the employee scored quite well on reading with an end of high school level. His math skills were very poor at the third grade level and he would not likely pass the math test given to prospective cashiers. Mr. England stated that the employee had trouble just walking around, had an obvious limp, and was using a quad cane for support. He needed to shift around quite a bit when seated.

Mr. England did not believe that the employee would be able to compete successfully for employment or sustain it in the long run. The fact that he is hobbling around on a quad cane and looks so much older than his actual age, would cause an employer to pick virtually any other candidate over the employee. He has no skills to make him particularly attractive to an employer for any type of sedentary work and has very poor math skills. Mr. England did not believe that he would be a good candidate for any type of job placement or vocational rehabilitation. Mr. England did not see how the employee would be able to sustain any type of work on a consistent basis. He was likely to remain totally disabled from a vocational standpoint.

The employee had a stable work history but would not be able to go back to doing what he did before based on any of the doctor's restrictions, either with sedentary level or a 15 pound lifting limit. Mr. England did not think the employee could compete successfully for employment. It is going to make it very difficult for a 61 year-old man who is walking around with that kind of difficulty and who has trouble sitting and trouble getting up from a seated position to successfully compete for a job. He doesn't have any real skills that would make him particularly attractive to a sedentary employer. He doesn't have computer, bookkeeping or customer service skills. Considering his age, what he described as far as his day-to-day functioning, getting just a few hours of sleep at night and having to recline during the day, Mr. England did not see that the employee would be able to last in a regular job/work setting. There is no job, even at a sedentary level, where one can fall asleep or lie down periodically to get through the day. It was Mr. England's opinion that the employee was totally disabled from a vocational standpoint.

Mr. England did not see how the employee would be able to sustain any type of work on a consistent basis because of his pain and discomfort due to a combination of his physical problems. His conclusion included the employee's prior history of diabetes, his post-traumatic stress disorder, and his hearing difficulties. His post-traumatic stress disorder would affect his ability in concentrating and absorbing information. The burning sensations from his diabetes that caused him to have problems sleeping would have a negative effect on his ability to work. Mr. England stated that if, due to back pain, the employee had to lie down a good part of the day, had to walk with a quad cane, and had difficulty sitting and standing, that would be enough to prevent him from being able to successfully compete for alternative work activity or sustain it in the long run.

Based on his review of the medical records and the employee's history, Mr. England stated that prior to August of 2005, the employee was not diagnosed with nor had complaints of any mental health problems. Even with his diabetes and hearing difficulties, he was able to

handle his job duties. The employee did not give him any history of being unable to work or missing work due to his diabetes. The employee did not exhibit any mental health issues that affected his ability to be employed. It was Mr. England's opinion that even considering the diagnoses before August of 2005, that the low back difficulties since August of 2005 were enough to make him permanently and totally unemployable in the open labor market. Mr. England stated that it appeared that the injury on August 8, 2005 was in and of itself the reason for the employee's permanent total disability.

The employee testified that since June 8, 2006 he has been falling due to his left leg giving out. He has trouble getting into a car with left leg. He has excruciating low back pain daily with tingling in the leg. He can walk, stand or sit for about 30 minutes and can only walk about a block. He cannot squat but can kneel somewhat. He can lift 10 pounds once, and maybe lift two pounds repetitively. He has problems with sleep and gets 4-5 hours of sleep a night without taking sleeping pills. His back pain causes him to lose sleep. He has trouble staying awake during day due to pain pills. Other than taking a pain pill to help relieve pain, he will lie down during the day. The employee can drive and can travel back and forth to St. Louis. He can carry light groceries, lift a gallon of milk, and care for himself. He goes out to eat with friends and family. He can read, write, and make change. The cane he uses is not prescribed by a doctor. The employee has been getting pain pills for his back including Oxycodone and Tramadol and over the counter Aleve and Momentum. He was taking pain medication at least twice daily and sometimes more.

The employee received short term disability in the amount of \$295.00 a week from November 9, 2005 through May 31, 2006. The employee applied for his pension which was approved retroactive to June 1, 2006. The employee's medical bills were either paid through his health insurance, by himself, or are still outstanding. The employee paid \$962.60 in medical bills with an additional \$1,237.85 in still outstanding bills. The employee has applied for a job and listed his back problems. He applied at Emeron in Dexter which makes mufflers and tailpipes but was turned down. He checked about being a greeter at Wal-Mart but the job required him to stand all day.

Prior to August of 2005, the employee did not miss time from work due to his diabetes, back or headaches. The employee did not have any problems performing his job or miss any time from work due to his prior injuries or conditions. He had no work restrictions, was not reprimanded, and had no special accommodations. He was not taking any medication for any back condition at time of injury. He had no problems walking, bending, squatting or lifting. He was not having left leg problems including numbness or tingling. The employee stated that he would still be working if he did not have his 2005 work injury.

RULINGS OF LAW:

Issue 1. Accident

The employee's credible testimony was that on August 4, 2005, he stepped on a rubber mat that slipped and he started falling but caught himself which caused low back and left leg

pain. He testified that he reported the injury immediately to his supervisor. His testimony is corroborated by the Report of Injury that he reported the injury on August 4 and that a rubber mat slipped in his work area. The employee testified that at work on October 27, 2005 his left leg gave out and was sent to the emergency room. The history contained in the records of the various health care providers including Dr. Hunt, Missouri Southern Healthcare, Dr. Hatfield, Poplar Bluff Medical Center, Dr. Yingling, and St. Francis Medical Center are consistent with and corroborate the employee's testimony concerning the accident and injury. Based on a review of the evidence, I find that on or about August 4, 2005 the employee sustained an accident that arose out of and the course of his employment.

The employee, in its' brief argued that the employer-insurer filed its' answer late and therefore the statement of facts in the claim is deemed admitted. Based on my finding of accident as set forth above, said argument is moot shall not be addressed.

Issue. 2 Medical Causation

The employee's credible testimony was that at the time of his injury he was not taking any medication for his back; had no problems walking, bending, squatting or lifting; and was not having any left leg problems including numbness or tingling. During the accident on August 4, 2005, his back felt like it slipped and his left leg went numb. He finished his shift but had increasing problems with his back and left leg. Several days later, his left leg would not move and he was limping. He continued to work and his back and leg became worse.

The radiologist's interpretation of the MRI was a disc bulge with a large central disc extrusion at L4-5 with increased signal intensity in the L4-5 annulus representing a radial tear/fissure. At L5-S1 there was a diffuse disc bulge with mild central disc protrusion. Dr. Yingling stated that the MRI showed a left lateral disc protrusion with stenosis left greater than right at L4-5 and L5-S1 causing neural impingement on the left. Dr. Yingling's impression was lumbar stenosis and disc bulging/herniation at two levels which was causing pain and numbness in the left hip and leg. Dr. Yingling recommended a L4-5 and L5-S1 segmental decompression and discectomy. Dr. Yingling performed a L4-5 and L5-S1 segmental decompression and laminectomy with left L4-L5 discectomy for a diagnosis of lumbar stenosis with disc rupture. At L4-5 there was an extremely large disc protrusion displacing the L5 nerve root and the extruded disc material was removed. At L5-S1 a decompression was done but there was no disc removed.

It was Dr. Lange's opinion that the work-related injury was the substantial factor in the development of his symptoms which was a new central herniation at the L4-5 level. It was Dr. Lange's opinion that the herniation at L4-5 was work related and the left L4-5 partial discectomy was performed to address the work-related disc herniation at L4-5. It was Dr. Lange's opinion that Dr. Yingling performed a decompression at L4-5 and L5-S1 to address essentially radiographic aging findings of stenosis or narrowing of the spinal canal. Dr. Lange stated that the left L5-S1 nerve root displacement and abutment was not a result of the August 4, 2005 injury but was pre-existing and part of aging. Dr. Lange believed that the August 4, 2005 incident was a substantial factor in the development of the employee's lumbar radiculopathy.

Dr. Musich stated that the MRI documented a large central disc extrusion with evidence of a radial tear and fissure at L4-5 and a disc protrusion and disc pathology at L5-S1; and showed two separate level disc herniations. The pathology on the MRI was consistent with the type of injury that the employee described. It was Dr. Musich's opinion in early August of 2005, that the employee had suffered acute trauma and that the incident that occurred in late October of 2005 was due to the August low back trauma. It was his opinion that the work trauma of August of 2005 was the prevailing factor in the development of acute low back pain and left lower extremity radiculopathy that required a multilevel surgical decompression at L4-5 and L5-S1 and a discectomy at L4-5. It was Dr. Musich's opinion that the work trauma of August 2005 was causally related to the employee's persistent low back pain and left lower extremity radiculopathy.

Based upon a review of all the evidence, I find that the opinion of Dr. Musich is persuasive and is more credible than the opinion of Dr. Lange. I find that the employee's work accident on or about August 4, 2005, was a substantial factor in causing the employee's low back injury and need for medical treatment at the L4-5 and L5-S1 levels. I further find that the injury to the employee's low back and resulting medical condition and need for treatment including surgery is medically causally related to the work accident.

Issue 3. Previously Incurred Medical Expenses

The employee is claiming previously incurred medical costs in the amount of \$2,200.45. There is a dispute as to the authorization, reasonableness, necessity and causal relationship of those bills. The medical bills are contained in Employee Exhibits K, L, M, N and O. The employee is requesting the amounts he paid plus the amounts that are still due and owing.

With regard to the issue of authorization, under Section 287.140 RSMo, the employer has the right to select the treating physician but waives that right by failing or neglecting to provide necessary medical aid. See Banks v. Springfield Park Care Center, 981 S.W.2d 161 (Mo. App. 1998). The employer will be liable for medical expenses when the employer has unsuccessfully denied compensability of the claim. Denial of compensability is tantamount to a denial of liability for medical treatment. Beatty v. Chandeysson Elec. Co., 190 S.W.2d 648 (Mo. App. 1945). 1 Mo. Workers' Compensation Law Section 7.2 (Mo. Bar 3rd ed. 2004). In Wiedower v. ACF Industries, 657 S.W.2d 71 (Mo. App. 1983), medical bills were awarded when the employer chose to treat the injury as non-compensable and did not offer medical services.

The employee's credible testimony was that after November 8, 2005, he went to Dr. Hatfield who ordered an MRI. He received a call from workers' compensation and was told that they had rejected any more medical treatment including the MRI. I find that the employer-insurer waived its right to select the treating physician by denying medical treatment and denying the compensability of the case. The defense of authorization is not valid.

Exhibit K for Poplar Bluff Regional Medical Center contains two separate billing statements. The first statement is for services on October 5, 2005 and November 28, 2005. The total charges for those dates of service are \$2,049.50. The employee is requesting a total of

\$327.60 for that billing statement for the \$22.75 that he paid and for \$304.85 in outstanding bills. The second statement is for services provided between August 30, 2005 and December 7, 2005. The total charges for the second statement are \$1,127.75. The employee is requesting \$181.84 for the charges that he paid and \$217.50 in outstanding bills which total \$399.34. The charges for dates of service of August 30, 2005 and December 7, 2005, are for lab work, blood work, and vaccinations that are not related to the back. I find that those charges are not causally related to the accident. The charge for the date of service of October 5, 2005 is a duplicate charge that was contained in the first statement. The remaining services rendered on October 27, 2005, November 9, 2005, November 21, 2005, and December 6, 2005 were related to the low back injury. The charge for each of those visits was \$70.00 and total \$280.00. With regard to the \$280.00 in charges, it is impossible to determine what amount was paid by the employee or by health insurance; what amount was written off or adjusted; and what amount is still owed. I therefore find that none of the charges in the second statement are recoverable.

With regard to Exhibit N, Cape Neurological Associates, the employee paid \$75.00 and the balance owed was \$666.90. The total amount requested by the employee was \$741.90. The employee paid \$5.00 on February 28, 2006, April 20, 2006, and June 12, 2006 for disability insurance forms for a total of \$15.00. I find the \$15.00 in charges is not recoverable.

With regard to the remainder of the medical bills, based on review of the evidence and my ruling in Issue 2, I find they are medically causally related to the accident and are reasonable and necessary. I find that the employer-insurer is responsible for and is directed to pay the employee the sum of \$1,786.11 for the following previously incurred medical bills:

Exhibit K	Poplar Bluff Medical Center	\$327.60
Exhibit L	St. Francis Medical Center	\$577.68
Exhibit M	Missouri Southern Healthcare	\$67.23
Exhibit N	Cape Neurological Associates	\$726.90
Exhibit O	Health South	\$86.70

Issue 4. Temporary Total Disability.

The employee is claiming temporary total disability from November 8, 2005 through June 8, 2006. The employer-insurer is requesting credit in the amount of \$7,637.91 in short term disability paid in 2005 and 2006. Temporary total disability benefits are intended to cover healing periods and are payable until the employee is able to return to work or until the employee has reached the point where further progress is not expected. See Brookman v Henry Transportation, 924 S.W.2d 286 (Mo.App.1996).

On October 27, 2005, Dr. Hatfield diagnosed the employee with a low back injury and radiculopathy of the left lower extremity, wanted the employee to get an MRI and kept him off work. The employee testified that he went back to work but on November 8, 2005 could not finish his shift and that was the last day he worked. On November 9, Dr. Hatfield again ordered an MRI which was done on November 28. On December 6, Dr. Hatfield stated that the MRI showed a large central herniated disc at L4-5 and referred the employee to Dr. Yingling, a neurosurgeon. On December 20, 2005, Dr. Yingling recommended an L4-5 and L5-S1

segmental decompression and discectomy which was performed on January 4, 2006. Dr. Yingling continued to treat the employee with physical therapy, trigger point injections, a lumbosacral brace, pain medications, and a repeat MRI. On June 8, 2006 Dr. Yingling did not recommend any further surgery; prescribed Naprosyn; and noted that the employee should follow up with Dr. Moyers, a family doctor.

Based on a review of the evidence, I find that from November 9, 2005 through June 8, 2006 the employee was in his healing period and had not reached the point where further progress was not expected, and was entitled to temporary total disability. I find that the employee reached the point where further progress was not expected on June 8, 2006. The employer-insurer is ordered to pay the employee \$15,820.78 which represents 30 1/7 weeks of temporary total disability at the rate of \$524.86 per week.

Requested Credit:

Section 287.270 RSMo, states that “No savings or insurance of the injured employee, nor any benefits derived from any other source than the employer or the employer’s insurance for liability under this chapter, shall be considered in determining the compensation due hereunder; . . .”.

In Wilmeth v. TMI, Inc., 26 S.W. 3d 476 (Mo. App. 2000), the uninsured employer was not entitled to a credit under Section 287.270 RSMo, for an occupational-accident insurance policy that paid benefits since it was not a workers’ compensation policy. The Court of Appeals in Shaffer v. St. John’s Health Center, 943 S.W. 2d 803 (Mo. App. 1997) held that the employer was not entitled to credit for medical payments made by a health insurance carrier where the health insurance was provided to the employee as part of her employment benefits since the medical bills were not paid by the employer or its’ workers’ compensation carrier. In Homan v. American Can Company, 535 S.W. 2d 574 (Mo. App. 1976), the employee received payments from a disability policy carried by the employer. Since it was not a workers’ compensation policy, the Court of Appeals held that the employer was not entitled to a credit. Section 287.270 RSMo requires benefits to come from the employer or its’ insurer for Workers’ Compensation liability. Payments from any other source are not credited.

In Morris v. National Refractories & Minerals 21 S.W. 3rd 866 (Mo. App. 2000), the employer’s human resources manager described the health insurance coverage provided by the employer was the direct source of the funds for the payment of the employee’s medical bills. Therefore under Section 287.270 the employer-insurer were entitled to a credit on workers’ compensation benefits for all payment made by the employer on the employee’s medical bills. Payments from an insurance company or from any source other than the employer or the employer’s insurer for liability for workers’ compensation are not credited on workers’ compensation benefits. The burden of proving payment is on the party asserting it.

The employee received \$295.00 a week in short term disability payments from November 9, 2005 through May 31, 2006. There was no evidence whether the short term disability was directly paid by the employer or whether the payments were made from another source. I find

that the employer-insurer did not meet its' burden of proof that the direct source of the disability payments to the employee was from the employer. Based on a review of Section 287.270 RSMo, case law, and the evidence, I find that that employer-insurer is not entitled to a credit for the short term disability payments paid to the employee. The employer-insurer's request for a credit on the temporary total disability awarded is denied.

Issue 5. Nature and Extent of Permanent Disability against the Employer-Insurer and Issue 6. Liability of the Second Injury Fund for Permanent Partial or Permanent Total Disability.

The employee is claiming that he is permanently totally disabled. The term "total disability" is defined under Section 287.020.7 as follows:

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

The phrase "inability to return to any employment" has been interpreted as the inability of the employee to perform the usual duties of the employment under consideration in the manner that such duties are customarily performed by the average person engaged in such employment. See Kowalski v/ M-G Metals and Sales, Inc., 631 S.W.2d 919, 922 (Mo. App. 1992). The test for permanent total disability is whether; given the employee's situation and condition, he or she is competent to compete in the open labor market. See Reiner v. Treasurer of the State of Missouri, 837 S.W.2d 363, 367 (Mo. App. 1992). Total disability means the "inability to return to any reasonable or normal employment." An injured employee is not required, however, to be completely inactive or inert in order to be totally disabled. See Brown v. Treasurer of State of Missouri, 795 S.W.2d 479, 483 (Mo. App. 1990). The key question is whether any employer in the usual course of business would reasonably be expected to employ the employee in that person's present physical condition, reasonably expecting the employee to perform to work for which he or she entered. See Reiner at 367, Thornton v. Haas Bakery, 858 S.W.2d 831, 834 (Mo. App. 1993), and Garcia v. St. Louis County, 916 S.W.2d 263 (Mo. App. 1995).

The first question to be addressed is whether the employee is permanently and totally disabled. There is credible medical and vocational evidence to support his claim of permanent and total disability.

Dr. Lange stated that the employee's prognosis was only fair; the employee was unable to perform his previous occupation; would require significant restrictions; and was functioning at the sedentary physical demand level which is negligible lifting. It was his opinion that the employee would be permanently and totally disabled. Ms. Abram stated it would be very difficult for the employee to get and maintain a job in the open labor market. It was her opinion that that the employee was not able to be gainfully employed in the open labor market.

It was Dr. Musich's opinion that the employee would not be able to return to any type of job that he performed at Federal Mogul due to persistent post-traumatic symptoms; and that he was totally and permanently disabled. It was Mr. England's opinion that the employee would not

be able to compete successfully for or sustain employment in the long run. It was his opinion that the employee would not be able to sustain any type of work on a consistent basis; and that the employee was totally disabled from a vocational standpoint.

I find that the opinions of Dr. Musich, Dr. Lange, Ms. Abram, and Mr. England are credible and persuasive regarding whether the employee is permanently and totally disabled.

In addition to both the medical and vocational evidence, I find that the employee was a very credible witness on the issue of permanent total disability. The employee's testimony concerning the impact his injury has had on his daily ability to function either at home or in the work place is very credible and supports a conclusion that the employee will not be able to compete in the open labor market. Ms. Abram found the employee to be reliable and honest and believed that the employee has the physical limitations that he told her. I find that with his physical limitations, restrictions and pain it is extremely unlikely that any employer would reasonably be expected to hire the employee in his present physical condition.

The employee was observed prior to and during the course of the hearing. The employee walked with a cane and was moving slowly; requested a break during his testimony; and stood up and sat down during the hearing. The observations and opinions of the following physicians and vocational experts confirm my observations during the hearing. Dr. Yingling noted that the employee was using a cane and walked with a limp favoring his left leg. Dr. Musich noted that the employee ambulated with a limp and required the use of a cane for stability due to post-traumatic left leg weakness. Mr. England stated that the employee had trouble walking, had an obvious limp, and was using a quad cane for support. He needed to shift around quite a bit when seated. Ms. Abram stated that during her two hour interview the employee got up and moved around. These observations were important on the issue of permanent total disability.

I find that the employee is credible and is not exaggerating his complaints. Based on the credible testimony of the employee; the observed behavior of the employee; and the supporting medical and vocational rehabilitation evidence, I find that no employer in the usual course of business would reasonably be expected to employ the employee in his present physical condition and reasonably expect the employee to perform the work for which he is hired. I find that the employee is unable to compete in the open labor market and therefore is permanently and totally disabled.

Given the finding that the employee is permanently and totally disabled, the next issue is to determine whether the employer-insurer or the Second Injury Fund is liable for the employee's permanent total disability. Under Section 287.220.1 RSMo, the Second Injury Fund has no liability and the employer is responsible for full permanent total disability benefits if the last injury "considered alone and of itself," results in permanent total disability. See Roller v. Treasurer of the State of Missouri, 935 S.W. 2d 739 (Mo.App.1996), and Landman v. ICS, 107 S.W.3d 240, 248 (Mo. banc 2003). The Second Injury Fund is only liable for permanent total disability benefits if the permanent disability was caused by a combination of the pre-existing injuries and conditions and the employee's compensable work related accident and injury. Under

Section 287.220.1, the pre-existing injuries or conditions must have constituted a hindrance or obstacle to the employee's employment or re-employment.

The employee's credible testimony was that prior to August of 2005 he did not miss time from work and did not have any problems performing his job due to his prior injuries or conditions. He had no work restrictions, was not reprimanded, and had no special accommodations.

With regard to his low back, the employee testified that while he was in the Army in 1972 he had some back complaints and was treated once for it. The only medical records with regard to the back were two entries in May of 2004 by Dr. Hatfield. The employee had low back pain with symptoms in his left lower extremity, and was diagnosed with degenerative disc disease. These records were over a year and three months prior to the August of 2005 accident. The employee's credible testimony was that at the time of the August of 2005 accident he was not taking any medication for his back, and had no problems walking, bending, squatting or lifting. He was not having left leg problems including numbness or tingling. He stood on his feet all day and did a lot of squatting, bending, twisting and lifting; and worked a lot of overtime.

The employee testified that when he returned from Vietnam he experienced flashbacks and had some trouble sleeping. While working at Federal Mogul, he would leave his station and go to the bathroom. His post-traumatic stress disorder became worse later on. The medical records corroborate his testimony. The first mention in the medical records regarding post-traumatic stress disorder was in 2007. The VA records from June of 2007 showed that he had problems with post-traumatic stress disorder right after he returned from Vietnam. He tried to cope with it through alcohol and drugs which he quit in 1975. He had many years of stability until February of 2006 when his brother passed away which triggered the reoccurrence of symptoms in the employee.

The employee testified that from the time he was diagnosed with diabetes in 1996 through August of 2005, he took oral medications, did not miss any work, and his ability to work was not affected. His testimony is corroborated by the medical records of Dr. Hatfield. In 2001 there were no signs of diabetic eye disease. In 2003 and 2004, the home glucose readings were within normal limits and acceptable. In March of 2005, Dr. Hatfield noted that the employee was doing well but he had a little burning and numbness in his feet. The employee had no swelling of extremities, had bilateral foot pulses, and the monofilament test was normal. Dr. Hatfield stated that his feet appeared healthy and diagnosed early peripheral neuropathy.

The employee testified that he was diagnosed with a hearing loss while in the Army. The 2003 medical records show that an audiologist stated that the employee had left ear tinnitus, and had a hearing problem since 1970. The employee had fair bilateral word recognition.

Even though the employee was able to successfully work at Federal Mogul without too many difficulties, it was Ms. Abram's opinion that the pre-August of 2005 medical conditions were vocationally significant and impacted his ability to compete in the open labor market.

Dr. Lange stated that there was no evidence that the employee had any disability from employment as a result of diabetes. Mr. England stated that prior to August of 2005 the employee was not diagnosed with nor had complaints of any mental health problems, and did not exhibit any mental health issues that affected his ability to be employed. Mr. England stated that with his diabetes and hearing difficulties, he was able to handle his job duties and did not miss work. Dr. Musich did not believe that the diabetes, the back complaints of May of 2004 or the numbness in his feet in March of 2005 constituted any permanent partial disability, nor a hindrance to his work. It was Dr. Musich's opinion that the employee did not have any disability due to the low back prior to the August of 2005 injury. Dr. Musich did not find any disability existing to any part of the employee's body prior to the injury date and did not assign a permanent partial disability rating.

Based on the employee's credible testimony and a review of the medical records, I find the opinions of Dr. Musich and Mr. England persuasive and more credible than the opinions of Ms. Abram on whether the employee's pre-existing conditions were disabling and were a hindrance or obstacle to employment. I find that the employee's pre-existing conditions were not disabling, and were not a hindrance or obstacle to his employment or re-employment.

It was Dr. Lange's opinion that the employee had an approximate 20% permanent partial impairment of the whole person based solely on the August 4, 2005 injury. It was his opinion that the employee's permanent total disability is the result of a combination of his work injury and his pre-existing conditions including his diabetes, back and psychological issues. It was Ms. Abram's opinion that the August 4, 2005 work injury alone did not prevent the employee from competing in the open labor market. It was her opinion that the employee was not able to be gainfully employed in the open labor market based on a combination of the employee's pre-existing disabilities in conjunction with the August 4, 2005 back injuries.

It was Dr. Musich's opinion that the employee was totally and permanently disabled due to the work trauma of August of 2005. It was his opinion that the August of 2005 injury was the sole cause of the employee's permanent total disability. It was Mr. England's opinion that even considering the diagnoses before August of 2005, the low back difficulties since August of 2005 were enough to make him permanently and totally unemployable in the open labor market. Mr. England stated that the injury on August 8, 2005 was in and of itself the reason for the employee's permanent total disability.

Based on the evidence, I find that the opinions of Dr. Musich and Mr. England are more credible and more persuasive than the opinions of Dr. Lange and Ms. Abram on whether the employee's permanent and total disability was from the last injury alone and of itself.

Based on the credible testimony of the employee and the more credible medical and vocational evidence, I find that the employee's permanent total disability was caused solely by his August 4, 2005 accident and injury. The employee is not working due to the severe pain he is experiencing in his low back and left leg that resulted from the August 4, 2005 accident alone and of itself.

On June 8, 2006, Dr. Yingling did not recommend any further surgery; released the employee from his care and instructed the employee to follow-up with Dr. Moyers. I find that the employee was in his healing period through June 8, 2006. I find that as of June 9, 2006, no employer in the usual course of business would reasonably be expected to employ the employee in his physical condition and reasonably expect the employee to perform the work for which he is hired, and therefore was no longer able to compete in the open labor market and was permanently and totally disabled. I find that the employer-insurer is liable to the employee for permanent total disability benefits and is directed to pay the employee the sum of \$365.08 per week commencing on June 9, 2006, and continuing thereafter for the remainder of the employee's life or until suspended in accordance with Section 287.200 RSMo. I find that the Second Injury Fund has no liability in this case.

Since the employee has been awarded permanent total disability benefits against the employer, Section 287.200.2 RSMo mandates that the Division “shall keep the file open in the case during the lifetime of any injured employee who has received an award of permanent total disability”. Based on this section, the Division and Commission should maintain an open file in the employee’s case for purposes of reviewing the status of the employee’s permanent disability pursuant to Section 287.200 RSMo.

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

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

Date: _____

Made by:

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

A true copy: Attest:

Naomi Person
Division of Workers' Compensation