

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

Injury No.: 08-091302

Employee: Harold E. Reeves  
Employer: Master Pitching Machine, Inc.  
Insurer: Self-Insured  
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 amended 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 amended award and decision of the administrative law judge dated July 25, 2013. The amended award and decision of Administrative Law Judge Emily Fowler, issued July 25, 2013, 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 16<sup>th</sup> day of May 2014.

LABOR AND INDUSTRIAL RELATIONS COMMISSION

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John J. Larsen, Jr., Chairman

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James G. Avery, Jr., Member

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Curtis E. Chick, Jr., Member

Attest:

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Secretary

## **AMENDED AWARD**

EMPLOYEE: Harold E. Reeves Injury No. 08-091302  
DEPENDENTS: N/A  
EMPLOYER: Master Pitching Machine, Inc.  
INSURER: Self-Insured, c/o Missouri Merchants & MFG Assn.  
ADDITIONAL PARTY: Treasurer of Missouri, as Custodian of the Second Injury Fund  
HEARING DATE: April 18, 2013  
May 23, 2013 Checked by: ESF/lh

### **FINDINGS OF FACT AND CONCLUSIONS 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? Accident
4. Date of accident or onset of occupational disease: August 28, 2008
5. State location where accident occurred or occupational disease was contracted: 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? Employer was self-insured.

11. Describe work employee was doing and how accident occurred or occupational disease contracted: Claimant was carrying two pitching nets while descending a flight of stairs at work, when he tripped over a bucket of parts and fell down 4-5 stairs and landed on the floor
12. Did accident or occupational disease cause death? No                      Date of death? N/A
13. Part(s) of body injured by accident or occupational disease: body as a whole referable to employee's back and neck
14. Nature and extent of any permanent disability: Permanent total disability as to the employer
15. Compensation paid to-date for temporary disability: \$56,722.01
16. Value necessary medical aid paid to date by employer/insurer? \$163,188.74
17. Value necessary medical aid not furnished by employer/insurer? None
18. Employee's average weekly wages: \$935.04
19. Weekly compensation rate: \$623.46/\$404.66
20. Method wages computation: Stipulation of the parties
21. Amount of compensation payable: permanent total disability from the employer beginning October 5, 2010, in the amount of \$623.36 per week for as long as Employee remains permanently and totally disabled.
22. Second Injury Fund liability: N/A
23. Future requirements awarded: Pursuant to the parties' stipulation Employer shall provide such future medical care as may reasonably be required to cure and relieve the effects of Employee's injuries.

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

Attorney's lien is granted in favor of Mr. Kevin Rotert in the amount of 25% of the compensation payable.

## **FINDINGS OF FACT AND RULINGS OF LAW:**

EMPLOYEE: Harold E. Reeves Injury No. 08-091302

DEPENDENTS: N/A

EMPLOYER: Master Pitching Machine, Inc.

INSURER: Self-Insured, c/o Missouri Merchants & MFG Assn.

ADDITIONAL PARTY: Treasurer of Missouri, as Custodian of the Second Injury Fund

HEARING DATE: April 18, 2013  
May 23, 2013 Checked by: ESF/lh

The above Claim was heard on April 18, 2013 and May 23, 2013. Employee appeared in person and by Attorney Kevin P. Rotert, Employer and Insurer appeared by Attorney Brian J. Fowler, and the Second Injury Fund appeared by Attorney Kimberley Fournier.

### **STIPULATIONS**

Prior to the hearing, the parties stipulated to the following issues:

- (1) that on August 28, 2008, Master Pitching Machine, Inc. was an Employer operating under and subject to the provisions of the Missouri Workers' Compensation Law;
- (2) that their liability under said law was fully self-insured;
- (3) that on August 28, 2008, Harold E. Reeves was an employee of Master Pitching Machine, Inc. and was working under the provisions of the Missouri Workers' Compensation Law in Kansas City, Clay County, Missouri;
- (4) that on August 28, 2008, Harold E. Reeves sustained an injury by accident arising out of and in the course of his employment;
- (5) that the Employer had notice of the injury and that a Claim for Compensation was filed within the time prescribed by law;
- (6) that the average weekly wage was \$935.04 and that the applicable compensation rate is \$623.46/\$404.66 per week;
- (7) that compensation has been paid in the amount of \$56,722.01 for a total of 91 weeks, with the last payment made through October 4, 2010;
- (8) that medical aid has been furnished in the amount of \$163,188.74; and,
- (9) that Employee will require ongoing and future medical care as a result of injuries received in the accident on August 28, 2008, and medical care will remain open as to the

Employer/Insurer.

## **ISSUES**

The issues to be decided by the hearing are:

- (1) whether Employee suffered any disability and if so the nature and extent of permanent disability resulting from the August 28, 2008 accident;
- (2) If Employee is determined to be permanently and totally disabled whether such disability is due to the last accident alone or a combination of disability from his last accident and his prior disability combined.

Employee testified on his own behalf and offered the testimony of Claimant's neighbor, Sabrina Palmer and the testimony of Claimant's brother, Donald Reeves.

In addition, the employee presented the following exhibits, each of which were admitted into evidence without objection, or if deposition transcripts, subject to the objections contained therein:

- A. Deposition of P. Brent Koprivica, M.D., M.P.H. dated August 24, 2012
- B. Deposition of Allan D. Schmidt, Ph.D. dated August 7, 2012
- C. Deposition of Mary W. Titterington dated September 19, 2012
- D. Claimant's work history
- E. Paycheck stubs and summary of earnings of Claimant's after August 28, 2008 injury
- G. Claimant's Claim for Compensation filed with the Missouri Division of Workers' Compensation on October 14, 2008.

The Employer did not call any witnesses, it did present the following exhibits, which were admitted into evidence without objection, or if deposition transcripts, subject to the objections contained therein:

1. Medical report from Arthur B. Jenny, M.D. dated March 12, 2003
2. Stipulation for Compromise Settlement for prior Workers' Compensation Claim, Injury No. 02-156165,
3. Medical records from James V. Maturo, M.D.,
4. Medical records from Karladine Graves, D.O.,
5. Records from CVS Pharmacy
6. Medical records from Emergency Room at North Kansas City Hospital dated September 2, 2008
7. Medical records from Kam Fai Pang, M.D. dated September 1, 2008,

8. Amended Claim for Compensation filed with the Missouri Division of Workers' Compensation date January 5, 2010
9. Disability Rating Report from Robert M. Drisko, II, M.D. dated December 9, 2009, and his Curriculum Vitae and not admitted as to the Second Injury Fund;
10. Medical report from Ramic Medical Imaging for MRI dated September 10, 2008, and,
11. Medical records from James V. Maturo, M.D. dated July 25, 2012 and North Kansas City Hospital dated July 20, 2012.

The Second Injury Fund's did not offer any live testimony but offered the following exhibit which was admitted into evidence with no objections

1. Deposition of Harold Reeves dated March 9, 2010,

### **EVIDENCE PRESENTED**

Claimant had been working for Master Pitching Machine, Inc. since September 2000, assembling pitching machines, cages, and conveyors. On August 28, 2008, Claimant was carrying two pitching nets while descending a flight of stairs at work, when he tripped over a bucket of parts and fell down 4-5 stairs and landed on the floor. He was seen in the emergency room at North Kansas City Hospital on August 28, 2008, with complaints of pain in his back, neck, and right rib cage. The physician diagnosed a lumbar sprain, cervical sprain, and possible right rib fracture. On August 29, 2008, Claimant was seen in follow-up at North Kansas City Hospital Occupational Medicine with a diagnosis of cervical strain, lumbar strain, and right rib contusion. On September 2, 2008, Claimant was again seen in the emergency room at North Kansas City Hospital with complaints of acute neck and upper back pain, and low back pain which was as bad as his neck. Claimant was then referred to Kim Fai Pang, M.D. at Rockhill Orthopaedics.

On September 4, 2008, Claimant was seen by Dr. Pang with complaints of severe neck pain, thoracic pain, and low back pain, but he denied any radiation to his extremities. Claimant denied depression or anxiety, but did complain of sweat, malaise, appetite loss, light sensitivity and halos, and headaches. Dr. Pang diagnosed a lumbar strain, pain in the thoracic spine, chronic pain, spondylolistheis, low back pain, neck pain, and a cervical strain. The physician recommended physical therapy, prescribed medications, and ordered an MRI of the cervical, thoracic, and lumbar spine.

On September 18, 2008, Claimant was seen by Dr. Pang after the MRI's were obtained. Dr. Pang noted the MRI of the cervical spine showed postoperative changes at C5-6, mild degenerative disc disease, and foraminal stenosis, but no significant disc herniation. The MRI of the thoracic spine showed multiple levels of degenerative disc disease, but no significant disc herniation or central canal stenosis. The MRI of the lumbar spine showed an L5-S1 disc protrusion with facet arthritis affecting the left L5 neural foramina. Mr. Reeves reported severe

pain with a chronic aching and stabbing pain in the neck and thoracic area, and stabbing pain in the lumbar region which extended to his left buttocks. Dr. Pang diagnosed lumbar radiculopathy and degeneration of the lumbar/lumbrosacral disc. The physician recommended continued physical therapy and lumbar epidural steroid injections for the L5-S1 disc protrusion.

On September 22, 2008 and October 6, 2008, Claimant received lumbar epidural steroid injections from Sean Clinefelter, M.D. On September 22, 2008, Mr. Reeves informed the physician that he had continuing bilateral neck pain and bilateral low back pain. The low back pain radiated down the posterior aspect of his left leg just proximal to the left knee. The physician noted Claimant had a history of chronic neck pain and had a prior cervical fusion, but the level of pain in his neck had remained stable until he fell down the steps at work, and his neck and back pain had been worse since that time. Dr. Clinefelter diagnosed lumbar radiculitis and lumbar spinal stenosis.

Thereafter, Claimant was referred to Robert M. Drisko, II, M.D. for a second opinion. On October 7, 2008, Claimant informed Dr. Drisko that he injured his neck and back when he fell at work on August 28, 2008. Dr. Drisko diagnosed a trigger point in the right trapezius and performed an injection, which provided only temporary improvement. On October 22, 2008, Dr. Pang authored a letter stating that he was in agreement with Dr. Drisko that Claimant's headaches and neck pain were part of the result of the injury on August 28, 2008. On October 27, 2008, Claimant underwent a cervical epidural injection by Dr. Clinefelter, for a diagnosis of cervical radiculitis and cervical spinal stenosis.

Because Claimant's severe back pain with radiation into the left leg was not improving, Dr. Drisko recommended a spinal decompression and fusion using pedicle screw instrumentation and a bone stimulator. His diagnosis was spondylolisthesis with a disc protrusion at L5-S1. On March 2, 2009, Dr. Drisko performed the following procedures with the assistance of Arthur B. Jenny, M.D.:

1. Bilateral Gill decompression L5 vertebral level.
2. Bilateral medial facetectomies for stenosis with microscope inferior L4 and superior S1 vertebral levels.
3. Free fat transfer graft.
4. Pedicle screw instrumentation L4 through S1 (R. Drisko with A. Jenny assist).
5. Posterolateral fusion L4 through S1 (R. Drisko with A. Jenny assist).
6. Placement bone growth stimulator (R. Drisko with A. Jenny assist).

After the surgery, Claimant continued to see Dr. Drisko in follow-up, and underwent 33 sessions of physical therapy at Athletic and Rehabilitation Center (ARC) from 4/29/09 through 8/12/09. Claimant reported to Dr. Drisko and the physical therapist of general improvement, but he was still having severe low back pain, limited range of motion, and decreased general strength.

On September 14, 2009, a KEY Functional Assessment was performed at ARC. According to the assessment specialist who performed the testing, Claimant demonstrated the ability to parallel the job demands of a sedentary position, which required a person to be able to lift 10 pounds occasionally and/or a negligible amount of weight frequently.

When Claimant was seen by Dr. Drisko on September 17, 2009 to discuss the results of the FCE, the physician noted it was a valid test and results indicated Claimant could only function at a sedentary level, which did not parallel his job. Dr. Drisko noted Claimant understood that he could not return to his prior job, and was despondent over that fact. Claimant asked Dr. Drisko if there was anything else that could be done to help control his back pain, and the physician recommended a TENS unit.

On October 20, 2009, Dr. Drisko noted Claimant had not benefited from the TENS unit, had plateaued and reached MMI. Dr. Drisko noted the FCE was a valid test, and it indicated Claimant could only function at a sedentary level and he could only be up about 4 hours at a time. (Claimant's Ex. 4, pg 364).

Although Dr. Drisko released Claimant from his care on August 13, 2009, Mr. Reeves subsequently returned to the physician to discuss further treatment for his severe low back pain. On January 21, 2010, Dr. Drisko performed surgery to remove the bone growth stimulator which had been placed during surgery. The removal of the bone growth stimulator was not beneficial, and Dr. Drisko referred Claimant to Ann Y. Lee, M.D. for a physical medicine and rehabilitation pain consultant.

On March 25, 2010 and April 1, 2010, Dr. Lee performed two lumbar epidural steroid injections which provided minimal and temporary pain relief. Dr. Lee suggested consideration of a nerve stimulator.

On April 8, 2010, Dr. Drisko noted Claimant's back pain was significantly interfering with all of his activities. He could not work, was having difficulty with his normal daily activities, had been using a heating pad, and sleeping in a recliner. Dr. Drisko referred Claimant to Sean Clinefelter, M.D. for consultation regarding a dorsal column stimulator.

Dr. Clinefelter examined Claimant on April 30, 2010, and noted a spinal cord stimulator might be helpful for the buttocks and proximal leg component of his pain. Before that was performed, Dr. Clinefelter recommended a psychological evaluation and referred him to Robert P. Trombley, Ph.D., a clinical health psychologist.

At his initial examination by Dr. Trombley on June 2, 2010, Claimant reported that he did not have significant difficulties with anxiety or depression prior to his work-related injury on August 28, 2008. However, he was now having difficulties with his pain and not knowing if he

was going to get better. Dr. Trombley had Claimant perform objective psychological testing and made the following assessments:

- "I. Major Depressive Disorder, Single Episode, Moderate 296.22
- II. No Diagnosis on Axis II V71.09
- III. Chronic pain
- IV. Chronic pain, functional limits, limited social support
- V. GAF: Current: 55 - Highest Past Year: 58

#### Additional Diagnosis

- 1. Pain Disorder Associated With Both Psychological Factors and a General Medical Condition 307.89".

From a health psychologist perspective, Dr. Trombley believed Mr. Reeves was a reasonable candidate for a spinal cord stimulator (SCS) trial. In addition, Dr. Trombley recommended consideration of an anti-depressive medication to address his depression, and health psychology treatment with a focus on behavioral pain management. (Claimant's Ex. 4, pg 1239-1242).

On July 27, 2010, Dr. Clinefelter performed a phase I trial of a dorsal column/spinal cord stimulator. The preoperative and postoperative diagnosis were:

- 1. Persistent pain after lumbar fusion.
  - 2. Failed surgical back syndrome.
  - 3. Postlaminectomy pain syndrome.
  - 4. Lumbar spondylosis.
- (Claimant's Ex. 4, pg 1130).

The trial of the dorsal column/spinal cord stimulator was only mildly successful, and Claimant informed Dr. Clinefelter that it was not adequate enough in controlling his pain to justify putting in a permanent spinal cord stimulator. Dr. Clinefelter then removed the temporary SCS and advised Claimant to continue with conservative treatment options.

Mr. Reeves has not received any additional medical care for his injuries received on August 28, 2008, other than continuation of his prescription medications.

Claimant had a prior work-related injury to his neck and right shoulder on or about November 15, 2002 while employed by Master Pitching Machine, Inc. Claimant was lifting and carrying a metal basket which held baseballs and weighed approximately 65 pounds, to bolt it onto a pitching machine. While doing so, he felt a pop in his right shoulder and thereafter experienced severe pain with radiation in his parascapular area, into his right shoulder, and into his right arm.

An MRI of the cervical spine obtained on February 18, 2003. The MRI revealed a large central herniated disc at C5-6. A smaller anterior central herniated disc was noted at C4-5 with no anterior compression.

Claimant was subsequently referred by the Employer/Insurer to Robert M. Drisko, II, M.D., who recommended surgery. On May 2, 2003, Dr. Drisko performed an anterior C5-6 discectomy and anterior cervical fusion using a cadaver bone. For his right shoulder complaints, Dr. Drisko injected his acromial clavicular joint with a cortisone shot on July 9, 2003. While undergoing treatment by Dr. Drisko, the physician continued to prescribe pain medications. On November 6, 2003, Dr. Drisko released Claimant from his care

After settling his Workers' Compensation Claim in March 2004, Claimant had additional medical care as well as ongoing use of prescription medications for his work-related injury on or about November 15, 2002. James V. Maturo, M.D., his primary care physician, issued the prescriptions for pain medications including Hydrocodone and Diazepam.

On March 8, 2004, Claimant was examined by James A. Scowcroft, M.D. for pain management. He informed the physician he was approximately 70-80% better after the surgery, but did continue to have persistent pain. Claimant informed the physician that there had been changes in his mood as he was irritable. Dr. Scowcroft performed a cervical steroid injection at C6 and C7 on March 26, 2004 which was not beneficial.

Thereafter, Claimant continued to see Dr. Maturo for issuance of prescription medications for his neck pain. On June 8, 2004 and July 20, 2004, Claimant informed Dr. Maturo of ongoing insomnia and difficulty sleeping due to his chronic neck pain. Dr. Maturo prescribed Ambien and then Diazepam.

On March 31, 2005, Claimant advised Dr. Maturo that he was unwilling to go through another neck surgery after he ended up with continued persistent severe pain after his first surgery. Claimant advised the physician that because the previous epidural injection performed by Dr. Scowcroft on March 26, 2004 had not been beneficial, he was not interested in additional pain management. Claimant informed Dr. Maturo that the narcotic pain medications did not relieve his neck pain, but just took the edge off enough to be able to manage his daily life. Dr. Maturo counseled Mr. Reeves extensively about the risk of taking the medications at work or while driving, and stressed the importance of not doing so as he would be placing himself and others at risk.

When Claimant incurred his most recent work-related accident on August 28, 2008, he was taking Oxycodone 15 mg, one every 4-6 hours, and Diazepam 10 mg, three times per day.

On December 9, 2009, Robert M. Drisko, II, M.D. issued a rating report at the request of the Employer and Insurer. Dr. Drisko assigned a 20% permanent partial disability to the body as a whole as a result of the accident on August 28, 2008.

Claimant's expert, P. Brent Koprivica, M.D., M.P.H., conducted a physical examination of Claimant on January 5, 2010, and issued reports dated January 5, 2010, January 20, 2010 and December 24, 2011. As a result of the work injury on August 28, 2008, Dr. Koprivica diagnosed the development of symptomatic degenerative disk disease at the L4-L5 level along with the development of symptomatic spondylolisthesis and development of lumbar radiculopathy, and he now had a "failed back syndrome" as a consequence of this injury. Dr. Koprivica also diagnosed an aggravating injury in the cervical region with increase in regional myofascial pain as a result of the work injury on August 28, 2008. As a result of Claimant's low back injury, Dr. Koprivica recommended restrictions to a sedentary physical demand, with no lifting from floor level, squatting, crawling, kneeling or climbing. He should limit bending at the waist, push, pull, or twist to less than 5% of an 8 hour day on a cumulative basis. For the prior neck injury, Dr. Koprivica recommended permanent restrictions from repetitive or sustained activities above shoulder girdle level. He recommended limited overhead lifting to less than 20 pounds on an occasional basis, no frequent or constant lift overhead, avoidance of sustained or awkward postures of the cervical spine, and avoidance of jarring types of activities to the head and neck. It was Dr. Koprivica's belief that there was a psychological residual with a chronic pain syndrome as a result of both the low back injury on August 28, 2008 and the prior neck injury on November 15, 2002. Dr. Koprivica's opinion was that Claimant was permanently totally disabled. The physician noted that although there was a potential question as to whether or not Claimant would be permanently totally disabled based on the primary injury of August 28, 2008 in isolation, at that time it was his opinion that Claimant was permanently totally disabled as a result of the combination of pre-existent industrial disability from the accident on November 15, 2002 with the permanent disability resulting from the accident on August 28, 2008. Dr. Koprivica noted that his opinion of permanent total disability was made without input from a vocational expert.

Claimant's expert, Allan Schmidt, Ph.D., conducted a psychological evaluation of Claimant. After interviewing Claimant and conducting tests, Dr. Schmidt noted the following impressions:

- Axis I:           Depressive Disorder, NOS  
                  Pain Disorder associated with both Psychological Factors and a General Medical Condition
- Axis II:           Obsessive compulsive and avoidant personality traits
- Axis III:          See medical reports for details: chronic pain
- Axis IV:          Inability to work-disruption of financial plans

### Significant limitation on mobility and activities

Axis V: Global Assessment of Functioning-48  
(GAF is a measure of psychological, social, and occupational functioning on a 0-100 continuum of mental health-illness. A score of 50 or lower indicates serious symptoms or serious impairments in psychological, social or occupational functioning.)

Dr. Schmidt diagnosed major depression and a pain disorder associated with both psychological factors and a general medical condition which began as a result of the work-related accident on November 15, 2002 and was aggravated and increased as a result of the work-related accident on August 28, 2008. Dr. Schmidt assigned a psychological disability rating of 15% to the body as a whole prior to the accident of August 28, 2008, a 20% psychological disability to the body as a whole as a result of the accident on August 28, 2008, and a current total psychological disability rating of 35% to the body as a whole. It was his opinion that Claimant would be unable to successfully return to the workforce and obtain a full time job in the competitive job market based on his current psychological condition alone. On December 7, 2011, Dr. Schmidt prepared an Addendum Psychological Evaluation Report after reviewing additional records provided. In his Addendum Report, Dr. Schmidt's opinion was that Claimant was at MMI regarding his psychological condition, and none of his prior opinions regarding Claimant had changed.

On December 2, 2010, Claimant underwent a vocational evaluation by Mary Titterington, MS, CDMS. Ms. Titterington stated that Claimant was unable to perform the basic requirements of work including:

1. Report to work on a consistent basis.
2. Stay on task throughout the workday.
3. Meet production goals.
4. Accept supervision.
5. Work cooperatively with coworkers, supervisors, and customers.

Ms. Titterington testified that Claimant was unable to perform any work consistently, day in and day out. He was precluded from work both from a physical and a psychological perspective. His impairments and resultant limitations were too severe to allow him to perform the essential characteristics of work and he was unemployable. She further testified that Claimant was unemployable as a result of the residuals from the August 28, 2008 injury alone. Because Claimant reclined much of the day and when not reclining, alternated positions while attempting to relieve his pain with heating pads and stretching as a result of the August 28, 2008 injury, no Employer would be expected to hire Claimant.

On March 5, 2008, Dr. Koprivica performed his second medical examination of Claimant and prepared his final report, and his deposition was obtained on August 24, 2012. Prior to this

final examination, Dr. Koprivica had been provided the psychological report from Dr. Schmidt and the vocational evaluation report from Ms. Titterington. In his physical examination of Claimant on March 5, 2012, Dr. Koprivica again noted Mr. Reeves' presentation of overwhelming disability. He continued to demonstrate severe restrictions in his low back. He had severe postural limitations during the examination, and had to stand up and lean forward over the back of the chair and then sat supporting his weight on his hands on the end of the exam table. He could not lie supine in order to do supine straight leg raise testing. As a result of injuries received in the accident on August 28, 2008, Dr. Koprivica noted Claimant would need the opportunity to recline unpredictably, would need ad lib change in posture, would be restricted to a ten pound maximum on lifting or carrying, would be restricted from any lifting or carrying to only occasional activity, and he should not attempt to lift from floor level. Although Claimant had profound pre-existent industrial disability before August 28, 2008, it was Dr. Koprivica's opinion that Mr. Reeves was permanently totally disabled as a result of the residual physical and psychological disability attributed to the work injury of August 28, 2008, considered in isolation, in and of itself. It was also Dr. Koprivica's opinion that Claimant was permanently totally disabled from gainful employment solely from the physical residuals resulting from the accident on August 28, 2008, without considering any psychological contribution from that accident.

Claimant testified at trial that he was born on May 11, 1960, was 48 years old when the accident occurred on August 28, 2008, and was now 52. He had graduated from high school, but had no post high school education. He had worked as a laborer throughout his life, and had been trained to operate a fork lift and a sweeper. He was not proficient on a computer and rarely used one. He began working for Master Pitching Machines, Inc. in September 2000 assembling baseball pitching machines and cages. He would first assemble parts to make a subassembly. There were about 30 subassemblies which were made, weighing from a few ounces to 70 pounds. The subassemblers were then attached together to make the completed machine. Along with co-employees, he constructed all of the subassemblies using power tools, impact wrenches and hand tools.

As a result of the neck and shoulder injury on November 15, 2002, Claimant testified as to some limitations from that accident. It was difficult to hold or lift anything heavy out away from his body, he had difficulty working overhead because it resulted in more neck pain, and he had pain when working if he bent his neck in an awkward position. He therefore did things differently to avoid the increased pain. He built a wooden box about 8 inches tall so that he could stand on it when mounting a particular part on a pitching machine. He would not lower a pallet of parts on a forklift to the floor, but kept the pallet at waist height. He would recline in his car seat during lunch hour and breaks at work for relief of his neck pain and used a heating pad on his neck daily when he got off of work. He normally got 6 to 8 hours of sleep at night, but if he did things at work which aggravated his neck more than normal, he had difficulty sleeping or would wake up from neck pain that evening and sometimes the next day. When the accident occurred on August 28, 2008, Claimant was taking Hydrocodone and Diazepam prescribed by his physician. Despite his limitations from the neck and shoulder injury on

November 15, 2002, Claimant was able to perform all of his job duties. He completed his job duties in a timely manner, was never reprimanded for the work he performed, did not miss any time from work because of the neck injury and pain, and received raises. He lived in a raised ranch house with a 1 acre yard.

Prior to his accident in August 2008, he lived on the upper level, which was the main area of the house, and used the entrance stairs which were 10 to 12 steps. He had no problems going up and down the steps. He mowed his own yard with a riding mower which took about one hour, and would weed eat from 1 hour to 1 hour, 15 minutes. He did all of his own cooking, cleaning, and grocery shopping without any problems. He could perform his personal hygiene including shaving, showering, and cutting finger and toe nails. He engaged in several social activities including fishing, going to the lake with friends, camping, cooking out, and having dinner with friends and family. He owned a 19 foot boat and went fishing with it almost every week during the summer. He had no problems loading and unloading the boat at the lake and was able to operate the boat without difficulty. Hitting a rough wake while boating caused some neck pain, but he had no problems casting when fishing. He would cook on an outdoor grill without any problems, including standing by the grill and operating utensils. He went mushroom hunting on weekends and after work during the 2 - 2 1/2 week season. He had no problems walking or bending over to pick up mushrooms, and would cover five miles during a two hour period. He went camping 5-6 times during the summer, which included tent camping and renting a lodge, without any problems. He went canoeing at least one time per year on a family outing, although he would have neck pain at the end of a canoe trip. He played pool one or two times every two weeks for 1-2 hours at a time. It was sometimes a challenge to play pool depending upon where the ball was sitting, as he would have neck pain in certain positions when looking down the pool stick and turning his head. He slept in his bedroom on the upper floor of his house.

After the accident on August 28, 2008, Claimant returned to work from November 2008 to January 2009, and again from late June 2009 through mid July 2009, but was only able to work part-time. He averaged about 20 hours per week, with a minimum of 4 hours one week and a maximum of 32 hours another week. (Claimant's Ex. E) His supervisor informed Claimant that he would need to increase to full-time work or they could no longer employ him. He discussed the matter with his supervisor, and they agreed because Claimant could not work full-time, he would no longer be employed by the company. Mr. Reeves testified that because of his severe low and middle back pain from the accident on August 28, 2008, he could not work longer than 4 hours per day. He could not stand or sit in any one position for very long, could not lift medium or heavy weight, and had to recline.

Claimant testified that the low back surgery performed by Dr. Drisko relieved the radiculopathy in his leg, but he continued with severe pain in his low and mid back. On a scale of 0-10, his best average was a 5 and his worst average was a 10. 75-80% of the time his low back pain was 6-7 or above, and the rest of the time it was around a 5. His pain level and

limitations from the low back injury varied day to day and hour to hour. He stated his limitations were:

1. Standing: 10 minutes to 40 minutes.
2. He could not stand over 40 minutes without severe pain.
3. He bent forward when he stood and sat, as it was more comfortable.
4. Sitting: 30-40 minutes at a time with the use of a heat pad on his back.
5. On some days, he would sit with the heat pad on his back for 9-10 hours during the day.
6. Walking: Walking, using stairs, and standing for a period of time resulted in severe pain in his lower back. He would have severe pain after walking 1/2 block.
7. Sleeping: He could not remember the last time he slept 8 hours straight or through the night, and it was more like taking naps than sleeping. Sleeping 2 hours straight was an accomplishment.
8. He avoided lifting anything heavy, and limited himself to 20-25 pounds.

Claimant testified that he had incontinency after the accident on August 28, 2008, he had diarrhea which could occur every day for more than a week or one day in a week. It occurred without any warning and he would soil his clothes when it occurred.

After the accident on August 28, 2008, Claimant moved from the upper floor of his house to the downstairs, as he could enter that area through his garage where there were no steps. He no longer slept in a bed because it resulted in severe low back pain, but slept in a recliner or on the couch. He tried not to sleep during the day as it made it harder to sleep at night, and he would nap from 15-20 minutes per day to 1-1 1/2 hours. He now made microwave meals to eat, and if he made a regular meal, he tried to cook something that he could reheat and eat for 3-4 days. Claimant's brother Donald Reeves, moved in with him in approximately February 2010 to help him both physically and financially. Claimant tried to mow his lawn with the riding mower for 5 minutes, but had to stop because of severe low back pain. He tried to weed eat, but it was too painful because of his low back. Donald Reeves now does all of the yard work. He also cuts Claimant's toe nails because he is unable to bend over and sometimes helps him put on his socks. Before the accident on August 28, 2008, Claimant cleared his snow with a snow blower, but could no longer operate the machine after the accident as it was too big and hard to operate because of his back pain. Before the accident on August 28, 2008, Claimant did general maintenance work on his vehicles such as oil changes and regular maintenance. After the accident, Claimant is unable to change the oil because of his inability to bend or perform other vehicle maintenance which requires bending. On a normal day, Claimant got up between 7:00 and 7:30 a.m., took his medications, and sat on a heating pad. After about an hour, he would eat breakfast and take a shower every other day. The rest of the day was spent trying to manage his pain. He would alternate sitting and standing, sitting in a recliner with a heating pad and watching television. He would drive to his mother's residence which was about 10 miles away, and do the same thing. He had a heating pad for his low back and neck at his mother's house. He

had a TENS unit that was helpful for his low back pain if he was away from an area where he could not use his heating pad. He had a grabber to pick up low items or items overhead.

After the accident, Claimant and a friend took his boat out on two occasions, one time for about one hour and the second time for about two and a half hours. Because using the boat was too painful to his low back, and he had difficulty loading and unloading the boat from its trailer because of the physical strength required, Claimant sold his boat. Claimant has not gone mushroom hunting since the accident because he is unable to walk any distance and has difficulty bending over. He tried to go camping on one occasion but ended up going home because he couldn't make himself comfortable even though he brought a heating pad. Claimant testified that his personal hygiene had worsened after the accident. There were days he asked himself why he even tried to live because his pain was so bad. His low back injury had changed his whole life, and he was depressed because he was unable to do most of the things he did before his accident. Claimant was taking the following medications:

1. Diazepam-10 mg tablet, 4 times per day.
2. Oxycodone-10 mg tablet, 1 to 2 tablets every 4-6 hours as needed for pain. He usually took 3-4 tablets per day.
3. Oxycotton-10 mg tablet, 2 times per day
4. Celebrex-200 mg capsule, 1 time per day

Claimant had side effects from the medications including a loss of appetite, an inability to think clearly and process information, and a tremendous effect on his memory. He also believed the medications were causing his incontinency. It was Claimant's belief that he was unable to work because of his chronic low back pain.

Claimant testified that he had a heart attack in July 2012. He had no prior problems with his heart, and the attack occurred suddenly. He was not taking nitroglycerin because of his heart attack, and believed he had no limitations from the heart attack.

On cross-examination, Claimant was questioned concerning any problems he had to his low back prior to August 28, 2008. Records have been submitted from James D. Maturo, M.D., Claimant's primary care physician, beginning August 28, 2003. (Claimant's Ex. A, pg 912-955). In those records, Dr. Maturo first refers to lumbar spine pain on August 17, 2007, when Claimant complained of severe lumbar spine pain after a long car trip. The physician noted Claimant never had lumbar spine pain, and he was having no numbness, tingling, or weakness of the lower extremity. Dr. Mature diagnosed lumbar back pain. (Claimant's Ex. A, pg 923). On June 17, 2008, Dr. Maturo noted Claimant was still having a lot of neck and back pain, and his back became very painful while at work. However, Dr. Maturo did not state in what part of his back Claimant was complaining of pain. Mr. Reeves testified that he remembered talking to Dr. Maturo about low back pain on one occasion, although he could not remember what caused the low back pain and he thought it was from a new job at work. Claimant denied having any

ongoing low back pain or limitations therefrom, prior to the accident on August 28, 2008.

Sabrina Palmer, who lived across the street from Claimant, knew him after he moved into his house in early 2004. She had a romantic relationship with Claimant for six months to one year after her husband was killed in a vehicle accident on June 23, 2004. Claimant told her that he had surgery for a neck injury, and she noticed that he had occasional discomfort and pain in his neck area. She would see him rub his neck every once in a while, and he would occasionally put a heating pad on his neck, which she estimated at 5% of the time she saw him. She did not notice a big difference when he turned and moved his head. He mowed and weed-eated his yard every week. He took care of his landscaping and shrubs, and power washed his driveway. He lived in the upstairs of his house and slept in a bed, and he had no problem sleeping when she stayed with him on two occasions. She saw him working on his car including changing the oil. She knew that he got a boat, that he liked to go fishing, and the boat was gone at least one time per week. Ms. Palmer was aware that Claimant had another accident in 2008 injuring his low back, and he underwent surgery. About two months after the low back surgery, she noticed significant changes in Claimant. He walked slow, was hunched over and never stood upright, and kept his knees bent. Claimant's mailbox was approximately 25 yards from his house, and it took about 3 times as long for him to walk to his mailbox. It took about 4 times as long for him to climb the stairs to his house. He moved to the downstairs of his house where there was a couch but no bed. When she went to visit him, he was usually sitting in his recliner and always had a heating pad that went from his low back to his neck. She had not seen him perform any work on his vehicle since the accident. She had not seen him mow his yard, but did see him try to weed-eat one time. It looked like a strain for him to lift the weed-eater, which weighed 10 pounds at most. He no longer did any landscaping or other yard work. He sold his boat. She saw him power washing his driveway on one occasion for about 10 minutes, but he quit and it did not look like the job was finished. She would see him sitting in a chair outside for about 20 minutes. He would stand up 10-15 minutes and then sit back down. Ms. Palmer's present husband and Claimant purchased a snow blower, but Claimant was unable to use it. Claimant's brother moved in with Claimant, and he now did all of the yard work. Ms. Palmer stated that although Claimant was not a complainer, he did complain about his lower back. She thought his limitations had gotten worse over time. He spoke and thought slower since the accident on August 28, 2008. She also thought his attitude and demeanor had changed. She didn't see these problems prior to the accident on August 28, 2008. He no longer seemed happy with life. He complained because he couldn't do things. He stated that he wished he could go one day without pain. He was depressed and frustrated because he could no longer do the things he used to do. On cross-examination, Ms. Palmer testified Claimant had no heart problem or heart complaints before July 2012.

Claimant's brother, Donald Reeves, testified that they originally lived in town when they were children, but then moved to the country. Claimant had a very good work ethic, was hard working and dependable. He is aware that Claimant had a neck injury in 2002 and saw his brother 3-4 times per month after the neck surgery. He would see him holding his neck and often

saw him grimacing from neck pain. He did not know if his brother was taking any medications for his neck pain, and never saw him use a heating blanket on his neck although he did see one on his chair. Before the accident on August 28, 2008, he knew that his brother went fishing and he went with him on a canoe trip. He did all of his own yard work and did light mechanical work on his vehicle such as changing the oil and rotating his tires. After the accident on August 28, 2008, Donald began mowing Claimant's yard, cleaning up his yard, and doing whatever was needed. His brother could no longer mow or keep up his yard, and had trouble doing anything. It took about one hour to mow the yard with the riding mower, and thirty to forty minutes to weed eat. His brother tried to weed eat for about 15 minutes one or two times, but had to go and sit in a chair with his heating pad after doing so. Donald Reeves moved in with his brother 3 or 4 years prior to help him out. Claimant was living downstairs and sleeping on a sofa, and Donald lived upstairs. Claimant performed his household chores including cooking, but he cooked something which could be made quickly, or put something in a crock pot so that he would have leftovers for a few days. Donald cut his brother's toe nails. He testified Claimant spent the majority of his day sitting in a chair and watching TV using a heating pad. He would sometimes see his brother sitting in a chair outside. Claimant went over to their mother's house most days, where he also had a recliner and heating pad. He always kept his medications next to his recliner. Donald thought his brother was grouchy, depressed and in a bad mood. He thought his brother's condition was getting worse.

The first issue to be determined is whether the Claimant suffered any disability from his August 28 2008 injury and if so the nature and extent of Claimant's permanent disability. Employer contends that he has only permanent partial disability from that accident, and if he is permanently and totally disabled, this results from the combination of the disability from the accident on August 28, 2008 and permanent disability from the prior accident on November 15, 2002. The Second Injury Fund contends that if he is permanently and totally disabled, this is solely as a result of the disability arising from the accident on August 28, 2008. Section 287.020.7 RSMo 2005 defines total disability as an "inability to return to any employment and not merely mean inability to return to the employment in which the Employee was engaged at the time of the accident." The terms "any employment" mean "any reasonable or normal employment or occupation." , Brown vs. Treasurer of Missouri, 795 S.W.2d 479, 483 (Mo App. 1990). The Missouri Courts have repeatedly held that the test for determining permanent total disability is whether the individual is able to compete in the open labor market and whether the Employer in the usual course of business would reasonably be expected to employ the Employee in his present physical condition. See e.g. Faubion v. Swift Adhesives Co., 869 S.W.2d 839 (Mo App. 1994); Hines v. Conston of Missouri #852, 857 S.W.2d 546 (Mo App 1993) Lawrence v. R-VIII School District, 834 S.W.2d 789 (Mo App 1992); Carron v. St. Genevieve School District, 800 S.W.2d 64 (Mo. App. 1991); Fischer v Archdiocese of St. Louis, 793 S.W.2d 195 (Mo App. 1990). The critical question is whether Employer could reasonably be expected to hire the Claimant, considering her present physical condition, and reasonably expect her to successfully perform the work. Forshee v. Landmark Excavating and Equipment, et. al, No. 85582 (Mo App. E.D.2005); Sutton v. Vee Jay Cement Contracting Company, 37 S.W.3rd 803, 811 (Mo App. 2000). Total

disability means the inability to return to any reasonable or normal employment. It does not require that the employee be completely inactive or inert. Isaac v. Atlas Plastic Corporation, 793 S.W.2d 165 (Mo App. 1990); Kowalski v. M.G. Metals and Sales, Inc., 631 S.W.2d 919 (Mo App. 1982). The following factors are to be considered in determining whether an individual is permanently and totally disabled: the Claimant's physical condition, including his limitations and capabilities, his age, education and occupational background and skills. See generally Brown v. Treasurer of Missouri, 795 S.W.2d 479 (Mo App. 1990); Isaac, 793 S.W.2d 165 (Mo App. 1990); Reve v. Kindell's Mercantile Company, Inc., 793 S.W.2d 917 (Mo App. 1990); Laturno v. Carnahan, 640 S.W.2d 470 (Mo App. 1982); Patchin v. National Supermarkets, Inc., 738 S.W.2d 166 (Mo App. 1987).

In his medical report dated September 17, 2009, Dr. Drisko noted Claimant could only function at a sedentary level and could only be up about 4 hours at a time based on the valid FCE test. In the Physician's Residual Functional Capacity Form completed by Dr. Drisko on March 3, 2010, he noted Claimant could only sit one hour at a time, in an 8 hour workday he could sit a total of 3 hours, he could stand/walk at one time less than 1 hour, in an 8 hour workday he could stand/walk a total of 1 hour, during an 8 hour workday he would need to recline a total of 2 hours, he was never able to bend, squat, stoop, crouch, crawl, kneel, or climb, his degree of pain was debilitating, and the physician anticipated that his impairment would cause him to be absent from work more than 3 times a month.

Dr. Trombley, the clinical health psychologist who examined Claimant at the request of the Employer, diagnosed a pain disorder associated with both psychological factors and a general medical condition, major depression disorder, chronic pain and a current GAF of 55. Claimant's expert, Allan Schmidt, Ph.D., a psychologist, evaluated Claimant and had him undergo testing. Dr. Schmidt diagnosed major depression and a pain disorder associated with both psychological factors and a general medical condition which began as a result of the work-related accident on November 15, 2002 and was aggravated and increased as a result of the work-related accident on August 28, 2008. He noted Claimant's GAF was 48, and it was his opinion that Claimant would be unable to successfully return to the workforce and obtain a full time job in the competitive job market based on his psychological condition alone. Claimant's expert, Dr. Koprivica, conducted a physical examination of Claimant on two occasions, and found significantly limited ranges of motion of the lumbar spine. He was unable to perform a supine straight leg raise because of Claimant's low back pain. Dr. Koprivica diagnosed a "failed back syndrome" as a consequence of the accident on August 28, 2008. Dr. Koprivica described the syndrome as an individual who underwent surgical intervention on the lumbar spine and continued to have overwhelming disabling back pain that has been present for more than 12 months, and was an overwhelming situation regarding the low back. (Claimant's Ex. A, pg 18). It was his opinion that Claimant was permanently and totally disabled from gainful employment as a result of the physical injuries received in the accident on August 28, 2008 without even considering the psychological disability resulting from that accident. (Claimant's Ex. A, pg 24-25, 27). Dr. Koprivica recommended restrictions to a sedentary physical demand, with no lifting from floor level,

squatting, crawling, kneeling, or climbing. He limited bending at the waist, pushing, pulling, or twisting to less than 5% of an 8 hour day on a cumulative basis. Dr. Koprivica testified that the restrictions and limitations resulting from the accident on August 28, 2008 were so overwhelming that it was impossible and unrealistic to believe that an ordinary employer could accommodate them. Claimant was having to recline unpredictably, was on narcotic pain medications to manage his pain, had severe postural limitations that were unpredictable, and he was limited to a less than sedentary physical demand level of activity. He was unable to reliably present to work. (Claimant's Ex. A, pg 23-25).

As an occupational expert, Mary Titterington stated that Claimant was unable to perform the basic requirements of work including:

1. Report to work on a consistent basis.
2. Stay on task throughout the work day.
3. Meet production goals.
4. Accept supervision.
5. Work cooperatively with coworkers, supervisors, and customers.

Ms. Titterington testified that Claimant was unemployable because of his total inability to perform any work consistently, day in and day out. See generally Claimant's testimony and Claimant's Exhibit C. It was her opinion that Claimant was unemployable because of his limited physical capabilities and need to recline, without considering psychological restrictions. (Claimant's Ex. C, pg 35-36). She believed the residuals from the accident and injury received on August 28, 2008 resulted in him being unemployable. (Claimant's Ex. C, pg 37-38).

In summary, Claimant is clearly permanently and totally disabled from gainful employment. The overwhelming evidence is that Claimant is permanently and totally disabled from gainful employment.

The next issue to be determined is whether such disability is due to the last accident alone or a combination of disability from his last accident and his prior disability combined. If the permanent total disability found by this court is due to the last accident alone, the Employer shall be liable to Employee for permanent total disability benefits. If the disability is due to a combination of disability from his last accident combined with disability he suffered prior to the last accident then the Second Injury Fund shall be liable for such disability benefits.

The Second Injury Fund is liable for Employee's permanent total disability due to the combination of his prior disability with the disability attributable to this last accident. In determining the extent of disability attributable to the Second Injury Fund the extent of the compensable injury and compensation due from Employer must be determined first. *Roller v. Treasurer of the State of Missouri*, 935 S.W.2d 739, 742-43 (Mo. App. 1996). If the compensable injury results in permanent

total disability, no further inquiry into Second Injury Fund liability is made. *Id.* It is therefore necessary that Employee's last injury be closely evaluated and scrutinized to determine if it alone results in permanent total disability, not permanent partial disability, thereby alleviating any Second Injury Fund liability.

The substantial and credible evidence reflects that Mr. Reeves' condition following the work accident in 2008, when considered alone, supports a conclusion that Mr. Reeves is permanently and totally disabled. The only expert opinions regarding permanent and total disability come from Dr. Koprivica and Mary Titterington who both support the finding, as does Mr. Reeves' own testimony, that his permanent total disability is a result of his 2008 work accident alone. The vocational evidence from Mary Titterington addresses Mr. Reeves current inability to access the open labor market is a result of his 2008 work related injury.

Despite some ongoing physical problems before 2008, Mr. Reeves was able to work very heavy demand work on a full time/overtime basis, without missing work. He was able to participate in an active lifestyle which included camping, mushroom hunting, fishing and boating. Since his 2008 injury, Mr. Reeves suffers from severe pain in his low back, significantly disturbed sleep, incontinence, depression, loss of appetite and the inability to think clearly. He has to rotate postures between sitting and standing regularly. He also has the most significant limitation of needing to unpredictably lay down daily, numerous times per day.

The credible medical opinions of Dr. Koprivica and the credible vocational opinions of Mary Titterington concur with these limitations and restrictions. Both of these experts agreed that Mr. Reeves did have some pre-existing disability; however, after looking at the totality of the medical records and subjective complaints of Mr. Reeves, both opined Mr. Reeves' permanent and total disability as well as his unemployability on the open labor market is as a result of the residuals of this 2008 work accident considered alone and in isolation without considering the prior conditions.

Mr. Reeves testimony was credible. Mary Titterington and Dr. Koprivica both offered substantial and credible opinions to support Mr. Reeves's testimony.

Wherefore this Court finds the Employee is permanently totally disabled as a result of the injuries sustained in his August 28, 2008 accident alone. This court finds that the Employer is liable to Employee for permanent total disability benefits beginning October 5, 2010 in the amount of \$623.36 per week for as long as Employee remains permanently and totally disabled. Further, pursuant to the parties' stipulation, Employer shall provide such future medical care as may reasonably be required to cure and relieve the effects of Employee's injuries.

The Court awards to the Claimant's attorney, Mr. Kevin P. Rotert, 25% of all benefits awarded herein.

Issued by DIVISION OF WORKERS' COMPENSATION  
Employee: Harold E. Reeves

Injury No. 08-091302

Made by: \_\_\_\_\_  
Emily Fowler  
*Administrative Law Judge*  
*Division of Workers' Compensation*