

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

Injury No.: 06-048151

Employee: Chris Rigney
Employer: Overhead Door Company (Settled)
Insurer: Zurich American Insurance Co. (Settled)
Additional Party: Treasurer of Missouri as Custodian
of Second Injury Fund

The above-entitled workers' compensation case is submitted to the Labor and Industrial Relations Commission (Commission) for review as provided by section 287.480 RSMo. Having reviewed the evidence and considered the whole record, the Commission finds that the award of the administrative law judge is supported by competent and substantial evidence and was made in accordance with the Missouri Workers' Compensation Act. Pursuant to section 286.090 RSMo, the Commission affirms the award and decision of the administrative law judge dated April 24, 2008, and awards no compensation in the above-captioned case.

The award and decision of Administrative Law Judge John K. Ottenad, issued April 24, 2008, is attached and incorporated by this reference.

Given at Jefferson City, State of Missouri, this 13th day of February 2009.

LABOR AND INDUSTRIAL RELATIONS COMMISSION

William F. Ringer, Chairman

Alice A. Bartlett, Member

John J. Hickey, Member

Attest:

Secretary

AWARD

Employee: Chris Rigney

Injury No.: 06-048151

Before the
Division of Workers' Compensation
Department of Labor and Industrial Relations of Missouri
Jefferson City, Missouri

Dependents: N/A

Employer: Overhead Door Company (Settled)

Additional Party: Second Injury Fund

Insurer: Zurich American Insurance Co. (Settled)

Hearing Dates: December 3, 2007 and December 27, 2007

Checked by: JKO

FINDINGS OF FACT AND RULINGS OF LAW

1. Are any benefits awarded herein? No
 - Was the injury or occupational disease compensable under Chapter 287? No
3. Was there an accident or incident of occupational disease under the Law? No
 - Date of accident or onset of occupational disease: (allegedly) January 7, 2006
 - State location where accident occurred or occupational disease was contracted: St. Louis County
6. Was above employee in employ of above employer at time of alleged accident or occupational disease? Yes
7. Did employer receive proper notice? N/A
8. Did accident or occupational disease arise out of and in the course of the employment? No
 - Was claim for compensation filed within time required by Law? Yes
10. Was employer insured by above insurer? Yes
11. Describe work employee was doing and how accident occurred or occupational disease contracted: Claimant was a parts salesman for Employer who allegedly injured his thoracic spine from cutting springs.

- 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: (allegedly) Body as a Whole—Thoracic Spine
- 14. Nature and extent of any permanent disability: N/A
- 15. Compensation paid to-date for temporary disability: \$0.00
- 16. Value necessary medical aid paid to date by employer/insurer? \$2,734.25 as a part of the CLSS

Employee: Chris Rigney

Injury No.: 06-048151

- 17. Value necessary medical aid not furnished by employer/insurer? N/A

- Employee's average weekly wages: \$595.61

- 19. Weekly compensation rate: \$392.07 for TTD/\$365.08 for PPD
- 20. Method wages computation: By agreement (stipulation) of the parties

COMPENSATION PAYABLE

- 21. Amount of compensation payable:

Employer/Insurer previously settled their risk of liability in this case

- 22. Second Injury Fund liability:

None

\$0.00

Total:

\$0.00

- 23. Future requirements awarded: None

Said payments to begin immediately and to be payable and be subject to modification and review as provided by law.

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

FINDINGS OF FACT and RULINGS OF LAW:

| | | |
|-------------------|---|--|
| Employee: | Chris Rigney | Injury No.: 06-048151 |
| Dependents: | N/A | Before the Division of Workers' Compensation |
| Employer: | Overhead Door Company (Settled) | Department of Labor and Industrial Relations of Missouri |
| Additional Party: | Second Injury Fund | Jefferson City, Missouri |
| Insurer: | Zurich American Insurance Co. (Settled) | Checked by: JKO |

On December 3, 2007, the employee, Chris Rigney (Claimant), appeared in person and by his attorney, Mr. David J. Jerome, for a hearing for a final award on his claim against the Second Injury Fund. The employer, Overhead Door Company (Employer), and its insurer, Zurich American Insurance Co., were not present or represented at the hearing since they had previously settled their risk of liability in this Claim. The Second Injury Fund was represented at the hearing by Assistant Attorney General Kristin Frazier.

On the original hearing date, the Second Injury Fund requested that the record be left open so that the transcript of the deposition of Dr. Bernard Randolph, which the parties had not yet received from the Court Reporter, could be admitted into evidence. The Second Injury Fund was given up to 30 days to submit Dr. Randolph's deposition transcript. The Second Injury Fund subsequently submitted the deposition transcript, which was admitted into evidence on December 27, 2007. The record in this matter then closed as of the submission of that Exhibit on December 27, 2007. At the time of the hearing, the parties agreed on certain stipulated facts and identified the issues in dispute. These stipulations and the disputed issues, together with the findings of fact and rulings of law, are set forth below as follows:

STIPULATIONS:

- Claimant has alleged an accidental injury on or about January 7, 2006.

- Claimant was an employee of Employer.

- Venue is proper in the City of St. Louis.

- The Claim was filed within the time prescribed by law.

- At the relevant time, Claimant earned an average weekly wage of \$595.61, resulting in applicable rates of compensation of \$392.07 for total disability benefits and \$365.08 for permanent partial disability (PPD) benefits.

- Employer paid no temporary total disability (TTD) benefits.
- Employer paid medical benefits totaling \$2,734.25.
- Claimant reached the point of maximum medical improvement (MMI) from this injury on May 30, 2006.

ISSUES:

- Did Claimant sustain an accident?
- Did the accident arise out of and in the course of employment?
- Are Claimant's injuries and continuing complaints medically causally connected to his alleged accident at work on January 7, 2006?
- Did Claimant provide proper notice of the accident to Employer as required by law?
- What is the nature and extent of Claimant's permanent partial and/or permanent total disability attributable to this injury?
- What is the liability of the Second Injury Fund?

EXHIBITS:

The following exhibits were admitted into evidence:

Employee Exhibits:

- A) Deposition of Dr. Barry I. Feinberg, with attachments, dated April 26, 2007
- B) Deposition of Mr. Timothy G. Lalk, with attachments, dated October 4, 2007
- C) Certified medical treatment records of Missouri Baptist Medical Center
- D) Certified medical treatment records of O'Neal Family Practice Associates
- E) Certified medical treatment records of St. Elizabeth's Hospital

- F) Certified medical treatment records of Professional Imaging
- G) Certified medical treatment records of Dr. David G. Kennedy
- H) Walgreen's Prescription Profile for Claimant
- I) Claimant's Marriage Certificate
- J) Birth Certificates for Brittany Skye and Shannon Brooke Rigney
- K) Certified medical treatment records of Dr. Barry I. Feinberg
- L) Settlement stipulations resolving case between Claimant and Employer in Injury
Number 06-048151

Second Injury Fund Exhibits:

- I) Deposition of Ms. Delores E. Gonzalez, with attachments, dated November 28, 2007
- II) Deposition of Dr. Bernard C. Randolph, with attachments, dated November 30, 2007

Notes: 1) *Unless otherwise specifically noted below, any objections contained in these Exhibits are overruled and the testimony fully admitted into evidence.*

2) *Some of the records submitted at hearing contain handwritten remarks or other marks on the Exhibits. All of these marks were on these records at the time they were admitted into evidence and no other marks have been added since their admission on December 3, 2007 or December 27, 2007.*

EVIDENTIARY RULINGS:

In the deposition of Dr. Feinberg (Exhibit A), the Second Injury Fund objected on page 38 at lines 6-7 and on page 39 at lines 16-17, that Claimant's questions called for answers from the doctor that were beyond the scope of the doctor's report. Both of these objections are **OVERRULED**, and the testimony and answers are fully admitted into evidence. Similarly, without further detailed analysis, the rest of the objections contained in the deposition transcript are also **OVERRULED**, or else the objectionable questions were cured by the questioning party and rephrased prior to obtaining an answer from the witness.

In the deposition of Mr. Lalk (Exhibit B), the Second Injury Fund objected on page 33 at lines 9-12 and on page 34 at lines 2-7 and line 21, based on the Seven Day Rule. The Second Injury Fund, however, proceeded with cross-examination of the vocational expert on that date, and never asked for a continuance, or any other remedy for the alleged Seven Day Rule violation. Although I question whether the Seven Day Rule is even applicable in this instance when the testifying expert is not an examining or treating physician, since the Second Injury Fund never requested a continuance, or any other remedy for the alleged violation, and proceeded with cross-examination, I find that that the Fund effectively waived their Seven Day Rule objection. Accordingly, the objections listed above are **OVERRULED**. Similarly, without further detailed analysis, the rest of the objections contained in the deposition transcript are also **OVERRULED**, or else the objectionable questions were cured by the questioning party and rephrased prior to obtaining an answer from the witness.

In the deposition of Ms. Gonzalez (SIF Exhibit I), Claimant objected on page 90 at lines 7-8 based on leading, and at lines 13-14 based on speculation. Claimant also moved to strike the answer on line 8. Claimant's objections are **SUSTAINED**, and the motion to strike is granted. Without further detailed analysis, the rest of the objections contained in the deposition transcript are **OVERRULED**, or else the objectionable questions were cured by the questioning party and rephrased prior to obtaining an answer from the witness.

In the deposition of Dr. Randolph (SIF Exhibit II), Claimant objected to the doctor's testimony on page 7 at line 25 through page 8 at line 7, and on page 14 at lines 1-3, on the grounds that the doctor did not issue a complete medical report since he had no examination results. Claimant's objections are **OVERRULED**, and Dr. Randolph's

testimony is fully admissible into evidence. The fact that he did not examine Claimant could certainly go to the weight of the evidence, but there is no reason under the statute to completely exclude this evidence in its entirety. However, Claimant also objected to a question on page 17 at lines 23-24 based on leading, mischaracterization and speculation. Claimant's objection there is **SUSTAINED**.

FINDINGS OF FACT:

Based on a comprehensive review of the evidence, including Claimant's testimony, the expert medical opinions and depositions, the vocational expert opinions and depositions, the medical records, and the Stipulation for Compromise Settlement for the primary injury, as well as based on my personal observations of Claimant at hearing, I find:

- **Claimant** is a 45-year-old, currently unemployed individual, who worked for Overhead Door of St. Louis in the Parts Department as a salesman at or around the time of his alleged injury. Claimant testified that he has been married to Patricia Kaye Rigney for 25 years. His **Marriage Certificate** (Exhibit I) confirms that they were married on February 16, 1983. Claimant testified that his wife is disabled too and so their children have to help out at home. Claimant has 3 children: Chris, who is 22 years old and often stays to help out his parents; Brittany Skye who is 17 and Shannon Brooke who is 13. Claimant testified that his daughters, Brittany and Shannon, are still dependent upon him for support and living with him and his wife. The **Birth Certificates** for Brittany Skye Rigney and Shannon Brooke Rigney were admitted into evidence (Exhibit J).
- Claimant testified that he graduated from Belleville East High School in 1981. He noted that his grades were mostly B's and C's in high school. Claimant testified that prior to his job at Overhead Door of St. Louis he worked at Stagg Brewery cleaning tanks, as a pipefitter digging for irrigation systems, hanging doors and doing garage door installation. Claimant testified that all of his prior jobs involved manual labor requiring him to use his body.
- Claimant testified that he began working for Overhead Door of St. Louis in 1999, as an installer and service technician. He testified that in 2000 or 2001 he was promoted to the position of showroom manager. However, Claimant testified that he was better suited to a physical job and so he was eventually demoted from that manager position. By 2006, he was working as a parts salesman and he was stocking inventory in the parts department. He stated that he worked Monday through Friday in St. Louis and then Saturday in Collinsville, Illinois.
- At hearing, Claimant testified that sometime in 2004 his neck and low back began to bother him. He believed these complaints were the result of over-usage from the physical nature of his job lifting doors. Claimant said he received initial medical treatment for his neck and low back from his family doctor, Dr. O'Neal, and from Dr. Feinberg.
- Physical therapy records from **St. Elizabeth's Hospital** (Exhibit E), showed treatment that Claimant had at that facility from September 10, 2004 through September 27, 2004 for right shoulder pain. The records contain notations that at times Claimant would only tolerate minimal range of motion, that he had slow/deliberate movements with all activities and that he was painful and guarded with all activities. The St. Elizabeth's Hospital records also show a nerve conduction study of the right upper extremity that was performed on October

4, 2004 which showed no abnormalities and was termed "normal."

- The medical treatment records from **Injury Specialists (Dr. Barry Feinberg)** (Exhibit A) document Claimant's initial visit on October 26, 2004. Claimant was referred to Dr. Feinberg by his wife who apparently was also a patient. Claimant reported on the initial history form that his pain began in September 2004, from an accident at home. Claimant's main complaints were right arm swelling, numbness and pain, along with neck pain. The form indicates that he injured a muscle in his arm and the complaints progressed. Claimant reported he always feels neck pain, he feels right arm pain most of the time and he also has intermittent back pain. He reported his weight at 210 pounds and further noted that he had recently gained approximately 10 pounds. Claimant reported that he had been working with his family doctor for these complaints until he received the results of his MRI. He also noted that he was working full time in parts, sales, and stocking. Dr. Feinberg reports that the MRI of the cervical spine taken on October 13, 2004 showed an extruded disc at C5-C6 with a disc osteophyte complex at C4-C5 and right neural foraminal stenosis at C5-C6. He also recorded a left paracentral protrusion of the disc at C6-C7. Dr. Feinberg diagnosed cervical radiculopathy, cervicgia, and degenerative disc disease of the cervical spine. He administered a cervical epidural steroid injection at the C6-C7 level.
- By November 3, 2004, Claimant returned to Dr. Feinberg complaining of neck pain, shoulder pain and now left hand pain. Claimant stated at that time that it was "usually on the left side." He also stated that he was having "mirror image pain now on the left." He received another epidural steroid injection at the C7-T1 level. By Claimant's next visit with Dr. Feinberg on November 10, 2004, Claimant was now reporting interscapular pain as well as neck pain, and right leg and right gluteal pain. Dr. Feinberg suggested now an MRI of the lumbar spine and he performed another C7-T1 cervical epidural steroid injection. On December 6, 2004, Claimant was complaining again of neck pain and low back pain with radiation into the right gluteal region down to the leg and to the knee at times. Claimant reported being in so much pain that he took "3 Vicodins to relieve the pain." Dr. Feinberg again recommended an MRI of the lumbar spine.
- Medical treatment records from **St. Elizabeth's Hospital** (Exhibit E) document the lumbar MRI that was taken at that facility on December 8, 2004. On the admission forms prior to the MRI, Claimant reported right leg pain and right foot numbness and weakness. The MRI revealed slight narrowing of the left lateral recess at L4-5 without evidence of nerve compression. It also revealed no evidence of disc protrusion or central canal stenosis, and mild degeneration at the L3-4 disc.
- When Claimant returned to Dr. Feinberg on December 13, 2004, Claimant was complaining of neck, low back pain, and left leg pain. Claimant was ambulatory without assistance. Dr. Feinberg administered a left sacroiliac joint injection, which, according to the note, improved Claimant's pain level.
- The next office visit note from Dr. Feinberg is dated March 2, 2005. At that time, Claimant was complaining of right hip pain, right leg pain, and left neck pain. Claimant was again given a sacroiliac joint injection which apparently improved his pain level and improved his ability to weight bear. However, by May 25, 2005 Claimant continued to complain of right hip pain with radiation into the leg and foot. Claimant also complained of left neck pain and shoulder pain. He reported working 6 days a week for 12 hours each day. Claimant also reported numbness and tingling in the left arm and occasional paresthesias. Claimant was given a transforaminal epidural injection. In follow-up examinations with Dr. Feinberg dated June 8, 2005, and June 22, 2005, Claimant complained of neck pain on the left and pain into the shoulder as well as swelling in the right wrist. He also complained of right leg pain and right hip pain which was exacerbated by working all day. Claimant

was given 2 more cervical epidural steroid injections at those visits.

- By July 11, 2005, Claimant was then complaining of neck pain on the right side and also now scapular pain which the doctor noted was a new complaint. Claimant also reported spasms in his lower back. On physical examination, the doctor found a positive Spurling's maneuver at T6, T7 and T10 bilaterally. Claimant was given a median branch nerve block at this visit. Approximately a month later on August 18, 2005, Claimant still complained of neck pain, but his chief complaint was pain in the low back with radiation into the right leg. Claimant was given a lumbar epidural steroid injection on that date and then given a second one on September 6, 2005. On October 19, 2005, when Claimant was complaining again of low back pain with radiation into the right hip and groin as well as leg pain, foot pain, neck pain, spasms between the shoulder blades and daily headaches, Claimant was given another lumbar epidural steroid injection. A visit with Dr. Feinberg on December 7, 2005 revealed complaints of interscapular pain and right buttock pain. He was again given a sacroiliac joint injection.
- Claimant testified that as a result of his pre-existing neck condition, he had numbness down his left arm to his last two fingers, and he could not grasp real well. Claimant also described pain along the back side of his head and continued headaches. He testified that he still has these same problems with regard to his neck up to the present time. As a result of his low back condition that began in approximately 2004, Claimant described continued pain down his leg to his foot and continued right foot swelling. He said these problems also continue up to the present time.
- Claimant testified that both Dr. O'Neal and Dr. Feinberg told him to change jobs and to go to school to get a lighter job. He said he was given permanent restrictions prior to the January 2006 injury of no lifting over 30 pounds and limited overhead working. Claimant testified that he was able to return to work with these restrictions from his doctors and his Employer accommodated the restrictions as best they could. He said he would load boxes and a helper would then take them upstairs. Claimant admitted that sometimes he had to lift over 30 pounds to get the job done. He said because of his left leg, he had problems sitting and climbing the stairs. Claimant said that ladders were a problem for him because of his balance. He said that in 2004 and 2005 climbing ladders was a problem because of his low back and that activity continues to be a problem because of his leg pain, his fatigue, and the fact that he is not sure-footed. Prior to the primary injury Claimant testified that he received verbal warnings from Employer. He said a manager complained about him not lifting and he was also warned because of days he was missing from work. He testified that he missed at least two days a month prior to January of 2006, because the injections he received from Dr. Feinberg would cause him to be in bed for 24 to 48 hours. Prior to the January 2006 injury, Claimant said he was taking Vicodin and Lyrica for his pain. Despite taking pain medications and receiving multiple injections, he was still having problems with his back and neck.
- Claimant testified that on January 7, 2006, a Saturday, he was working at the Collinsville store cutting springs for a walk-in customer. He said the springs weighed 25 to 30 pounds apiece. In order to cut the springs, he would have to pull out a 10 foot length of spring that weighed approximately 100 pounds. He said he lifted this 100 pound spring by himself since no one else was there. He pulled the spring off the rack, sparked up the torch, and felt a twinge in his low back as he was cutting. Claimant described that he felt like he pulled a muscle. He also described a feeling of a spark of electricity in his lower to mid back. Claimant testified that initially he was not much worse than he was used to, but as the day went on, his complaints increased and he ended up laying on the ground for a period of time at work.

- Claimant said he called his wife and told her about his injury. The next day, Sunday, he woke up in extreme pain and lost control of his bowels. By Monday, he lost control of his bowels again and fell three or four times. He said he was in more pain. Because of these complaints, Claimant said he sought treatment with Dr. Feinberg that day. Claimant testified that his wife called work that day to say he would not be in. He testified that she did not originally report a work injury to his Employer, but about a week later she told Employer that it was work-related.
- Claimant was examined by **Dr. Barry Feinberg** next on January 9, 2006, on an emergency basis with the complaint of a pain level of 10+/10 in his low back and mid back. The note indicated that he "has been doing a lot of lifting at work in the past week and had increased pain." Claimant reported that he was unable to stand without shuffled gait and was standing in a forward-flexed position at the waist also with his knees flexed. Claimant also reported tremors with his significant pain level. He reported incontinence of bowel on a couple of occasions and felt like he constantly had to have a bowel movement. The doctor ordered an MRI of the lumbar spine on an emergency basis because of his complaints.
- An MRI of the lumbar spine was taken on January 9, 2006 at **Professional Imaging** (Exhibits F and C). The MRI revealed mild degenerative changes at L4-5 and L5-S1 without dominant disc herniation. There was neither canal stenosis nor any encroachment of the nerve roots.
- When Dr. Feinberg next saw Claimant on January 10, 2006, he confirmed the results of the MRI showing degenerative changes "as previously noted at the lower lumbar spine including L4-5." X-rays of the thoracic spine showed thoracic kyphosis with some minimal end plate degenerative changes and anterior wedging. There was no significant loss of disc space height noted. Claimant also had cervical spine x-rays taken which showed straightening of the normal cervical lordosis and some narrowing and degenerative changes primarily at C5-C6 as previously seen. The doctor noted no indication on the examination based on reflex, motor, or sensory testing to obtain an MRI of the cervical spine. The doctor commented that Claimant's problem was "primarily an exacerbation of his lumbar problems." Therefore, Dr. Feinberg provided another lumbar epidural steroid injection at that visit. The note does indicate that Claimant was ambulatory without assistance for that examination. By January 16, 2006, Claimant was again complaining of pain in the low back. He was slightly unstable, shaky, lethargic, and weak. Patient was ambulatory without assistance at that examination and was sent for an MRI of the thoracic spine.
- Claimant had his MRI of the thoracic spine at **Professional Imaging** (Exhibits F and C) on January 16, 2006. The MRI showed multi-level degenerative disc disease with a small herniation or focal protrusion noted at T7-T8 lateralizing to the left. The radiologist noted that "this abnormality is small but is focal and could efface the existing nerve root on the left." No other focal abnormalities or compression deformities were observed. Claimant was then discharged from Dr. Feinberg's office on January 16, 2006 by wheelchair to follow up later in the week for a thoracic epidural steroid injection at T8.
- When Claimant next saw Dr. Feinberg on January 18, 2006, he was complaining of pain at a level of 8/10 with additional complaints of dizziness and tingling in the top of his head. The Claimant stated that he was walking sideways and was unable to walk straight. He presented in a wheelchair on that date and stated he was able to walk but was slumped over. Dr. Feinberg characterized the MRI of the thoracic spine as showing T7-T8 discogenic disease with cord compression. Claimant also reported that when he reaches for something straight ahead, his hand goes to the side. Claimant was diagnosed with thoracic radiculopathy and was given an epidural

steroid injection at T7-T8. By January 23, 2006, Claimant was still complaining of tremors when he stands up and presented in a wheelchair, although he was able to walk without assistance from the wheelchair to the table without difficulty. He was given another thoracic epidural steroid injection and Dr. Feinberg now recommended an MRI of the cervical spine.

- The MRI of the cervical spine was taken at **Professional Imaging** (Exhibits F and C) on January 25, 2006. The MRI revealed findings compatible with mild cervical spinal spondylosis and disc changes at multiple levels from C3-C7. No definite soft tissue disc herniation was identified nor was there any significant spinal stenosis.
- On January 30, 2006, Claimant still reported tremors and also reported using a cane at times for stabilization. He was given another thoracic epidural steroid injection at T7-T8.
- As a result of his ongoing complaints, Claimant was admitted to **Missouri Baptist Medical Center** (Exhibit C) on February 2, 2006. Claimant provided a history upon admission to **Dr. David Kennedy** (Exhibits C and G) of pulling on heavy springs 2 weeks ago which caused a sudden onset of pain in his lower lumbar area, right thigh, and inguinal area. Claimant reported that he then began to have spasms in his trunk musculature. Claimant reported an initial episode of incontinence with the onset of this problem but no problems with incontinence since. He reported difficulty walking and said that he tends to veer to the right. He noted that he fell 2 or 3 times on February 2, 2006, while walking. Claimant reported prior treatment for cervical and lumbar pain but no clear-cut radicular symptoms. Dr. Kennedy's motor examination was normal. He found no atrophy or fasciculations. Dr. Kennedy reported that the sensory examination was grossly normal with "scattered sensory loss in the left fifth finger although the response to pinprick in this area is inconsistent." He also found that Claimant's reflexes were symmetric and his gait was fairly normal, although somewhat hesitant. Dr. Kennedy apparently reviewed the MRI's of the lumbar, cervical, and thoracic spines that were taken earlier in January 2006. He formed an impression of lumbar spondylosis with acute exacerbation of chronic pain and tremor with possible gait disturbance of an unclear etiology.
- Dr. David Kennedy recommended a neurology consult which was conducted on February 3, 2006 by **Dr. Dave Rengachary** (Exhibits C and G). Claimant gave Dr. Rengachary a history of prior neck and low back discomfort and chronic pain syndrome. Claimant reported that he was "doing reasonably well" until 2 weeks ago. He reported that he works installing garage doors and that since the onset of these problems he may have had some incontinence and he has had some gait difficulties. Claimant described tremor in both arms and his trunk. He also reported painful spasms in the low back and difficulty moving his right leg. Dr. Rengachary found a normal motor examination. He found no tremor while Claimant was at rest but found very fine postural tremor more so in the upper extremities. The doctor reported that Claimant was very unsteady about his trunk for unclear reasons. He said the strength testing was without clear focal weakness and the sensory examination revealed patchy dysesthesias over the right leg but no clear dermatomal distribution. The doctor found decreased pinprick over the left fourth and fifth fingers but noted this may be a long-standing problem. He found symmetric reflexes and no clonus. He reported that Claimant's gait was unsteady but not wide based. The doctor reported that there was no evidence from the imaging of compromise or other acute structural lesions to explain Claimant's symptoms. He found no clear unifying diagnosis for this constellation of symptoms. Instead he recommended further workup and testing, but noted that Claimant related that he wished to pursue this testing as an outpatient rather than staying in the hospital. He was therefore discharged from Missouri Baptist Medical Center on February 3, 2006. Claimant also had an MRI of the brain taken on February 2, 2006, at Missouri Baptist Medical Center which showed no abnormalities.

- When Claimant returned to the care of **Dr. Barry Feinberg** on February 8, 2006, he noted he was still getting thoracic spinal spasms in the paravertebral muscles and having tremors whenever he straightens up. He was started in a program of physical therapy which continued throughout February 2006. During that time, he also continued to complain of thoracic pain, low back pain, hip pain, groin pain, interscapular pain, and neck pain depending on the date of the examination.
- On March 6, 2006, Claimant was seen by **Dr. Rachel Feinberg** (Exhibit A) with his knees bent, flexed forward, and in extreme pain. It appears that Claimant was given four trigger point injections at that visit. There was also an indication in the March 6, 2006 note that Claimant is "very hypersensitive to touch" and so the doctor was suggesting an additional medication, Effexor, for that problem.
- When Claimant was next seen on March 13, 2006, he was then reporting sharp pains in his left arm which started the prior Wednesday. Claimant reported that this was the old pain he used to have with cervical radiculopathy. He also was having right leg pain down to the ankle as well as right hip and low back pain and chest pain. Claimant was ambulatory without assistance and reported that he still has thoracic pain that radiates from the posterior to the anterior end of the chest, even though the doctor noted that Claimant's tests were negative for thoracic radiculopathy at that time. At Claimant's next visit with Dr. Barry Feinberg on March 22, 2006, Claimant reported that he was no longer having pain referring anteriorly around the chest. He reported he was standing up better and his tremors were less but he woke up with a locked jaw on the right side on that date. He was again ambulatory without assistance. He was again given a median branch nerve block and told to continue in physical therapy and with his home exercise program.
- **Dr. Barry Feinberg** issued a summary report including his opinions on causation and ability to work dated April 15, 2006. Dr. Feinberg opined that based on his experience as Claimant's treating physician since October 2004, he believed Claimant suffered an injury to his thoracic spine and an acute exacerbation to his pre-existing lumbar and cervical degenerative disc disease "as a result of the increased lifting requirements at work in December, 2005 and early January, 2006." He further opined that the treatment he had provided to Claimant was medically necessary and reasonable to cure and relieve the injuries suffered by Claimant as a result of the work-related load placed on his lumbar, thoracic and cervical spine. He also opined that Claimant had been totally disabled from employment since his initial examination there on January 9, 2006 through the current date of April 15, 2006. He did not believe Claimant would be able to return to his work and perform any lifting for the foreseeable future. Dr. Feinberg also noted that as a result of Claimant's diffuse degenerative disease and the severity of his response to his injury from December 2005/January 2006, Claimant should have permanent restrictions of lifting no greater than 20 pounds, no bending, stooping, climbing, crawling, exposure to heights and extremes of temperature. He believed Claimant should be considered for vocational rehabilitation and training for a sedentary job position.
- Claimant next saw Dr. Feinberg on May 1, 2006 when he was complaining of interscapular pain as well as chest pain on the right side greater than the left and neck pain with some popping in the jaw. Dr. Feinberg's impression was lumbar radiculopathy and thoracic radiculopathy as well as resolving cervical radiculopathy status post cervical epidural steroid injection with marked improvement.
- Dr. Feinberg provided an addendum to his initial April 15, 2006 report, dated May 2, 2006. He noted that he spoke with Claimant on both May 1, 2006 and May 2, 2006 asking Claimant to clarify the events of late

December and January of 2006. Claimant reported that he spent all week lifting springs weighing anywhere from 30 to 100 pounds, pulling them off of a rack and cutting them. Claimant stated that he had pain on and off over the course of the week, but on the Saturday of the week of January 7, his pain significantly worsened and exacerbated to the point where he sought care. Claimant further described repetitively pulling springs out of the rack and cutting them into pieces weighing 30 pounds and then putting the springs away after they were cut. Claimant reported that the repetitive performance of this task "pushed him over the top."

- Claimant continued to follow-up with Drs. Barry and Rachel Feinberg receiving three trigger point injections and a manual release on May 23, 2006 for pain in the left side of his neck and some tingling and numbness in the left arm and left hand that had been present for the past 4-5 days. On May 30, 2006, Dr. Rachel Feinberg's note indicates that Claimant was describing pain at his disc in the thoracic spine. The doctor wrote that she had to explain to the patient that just because he was having pain in the middle of his back does not mean it was all from his disc. She explained that he had a thoracic epidural injection and the pain he was having now was more central and referred from torqued and rotated ribs and dysfunction. She performed additional trigger point injections on that date and also a compression/decompression of the rib cage. By June 7, 2006, she noted that Claimant was making progress. He described pain between his shoulder blades which she believed was consistent with the anterior rotation of the ribs along the left sternal border. She again performed trigger point injections and did a compression/decompression of the thorax.
- She performed additional trigger point injections on June 15, 2006, this time for referred pain down the right leg. By June 20, 2006, Dr. Feinberg noted that Claimant "looks amazing." He was using the Elliptical in the gym and she noted that while he did have difficulty sleeping, she thought a lot of it was "financial because he could not afford to pay for the Lyrica or the antidepressant medication." She again performed a series of trigger point injections.
- Claimant reached a settlement with Employer for the alleged January 7, 2006 injury (06-048151) by **Stipulation for Compromise Settlement** (Exhibit L) for \$30,000.00, representing approximately 18% permanent partial disability of the body as a whole referable to the thoracic spine. By the terms of the settlement, \$2,734.25 of the \$30,000.00 total was to be used to pay outstanding medical expenses. The Second Injury Fund was left open by the terms of that settlement. The settlement between Claimant and Employer was approved by ALJ Denigan on June 22, 2006. The document also noted that Employer paid no medical or temporary total disability benefits for this injury.
- Claimant testified that he received about eight months of physical therapy and he gets epidural steroid injections as often as possible. Claimant testified that he continues to see Dr. Feinberg and Dr. O'Neal for his pain complaints. He said he gets pain medications from Dr. Feinberg except for the Fentanyl patches that he receives from Dr. O'Neal. Claimant testified that he takes Valium for his tremors. He takes muscle relaxers to reduce the spasms in his low back. He takes Lyrica for nerve pain, and then also takes Vicodin and the Fentanyl patches for his pain.
- Despite having settled his case, Claimant continued to treat with **Dr. Barry Feinberg**, who next examined Claimant on July 18, 2006. Claimant was complaining of neck pain, interscapular pain, left thigh pain and numbness, and right foot pain. He was still reporting problems with equilibrium, but said he was not tripping as much. He stated that his right foot still drags but he has not fallen. He reported interscapular pain at the level of T8 which was activity related. He said he was driving more, but the medications he took caused him difficulty

with concentration. Dr. Feinberg noted that Claimant had progressed up to about 50% improvement overall in pain and functional capacity but he recommended continued strengthening. He did not believe Claimant was employable at the current time because of his difficulties with concentration, his poor sleep, his limitations including inability to drive, sit, stand, or lay for a prolonged period of time, et cetera.

- Just one week later on July 25, 2006, **Dr. Rachel Feinberg** wrote that Claimant was "doing phenomenally well." He reported that he still feels pain in the low back and a little bit at the base of the neck. She again performed trigger point injections and recommended continued strength and stabilization. Then, just two days later on July 27, 2006, Claimant reported right sacroiliac pain to Dr. Barry Feinberg. The doctor found that Claimant was ambulatory with a shuffled gait and was unable to fully weight bear on the right lower extremity. Dr. Feinberg performed a sacroiliac joint injection under fluoroscopic guidance on that date.
- Dr. Barry Feinberg then next saw Claimant on August 9, 2006 with a complaint of left thigh pain. Claimant's right sacroiliac joint pain was gone from the last session, but he felt like he had a ripping sensation in the left thigh. Dr. Feinberg, therefore, performed a trigger point injection and another sacroiliac joint injection under fluoroscopic guidance on that date.
- Claimant had another MRI of the lumbar spine taken on August 16, 2006, apparently at the request of his family doctor, **Dr. O'Neal**, because of his complaint of having left thigh burning when he saw Dr. O'Neal on August 14, 2006. The MRI report contained in Dr. O'Neal's records (Exhibit D) contains a history of low back pain, left leg and thigh pain, and sensitivity. The MRI revealed degenerative disc changes at L5-S1 with an annular tear, disc dehydration and posterior bulge. There was also disc dehydration and a mild bulge reported at L4-5. The radiologist found bilateral foraminal narrowing at both levels secondary to disc bulging.
- On August 24, 2006, Claimant's chief complaint was in the lower extremities and low back pain. He was unable to walk without severe pain. He noted that his primary care physician had given him Duragesic medication which was making him feel better. He reported left leg pain and left thigh pain "which has increased sensitivity to touch and to sunlight." Dr. Feinberg diagnosed lumbar radiculopathy and performed a lumbar epidural steroid injection on that date. He provided a second lumbar epidural steroid injection on August 28, 2006 when Claimant was found to have marked antalgia and was using a cane for ambulation. Finally, Dr. Feinberg performed the third lumbar epidural steroid injection on September 21, 2006. By November 7, 2006, Claimant was now complaining of severe pain in the mid back and associated tremors. He got a thoracic facet injection and a dorsal median nerve root injection on that date. With complaints of right thigh and leg pain, as well as neck pain and shoulder pain on November 30, 2006, Claimant was given another lumbar epidural steroid injection to treat his lumbar radiculopathy. On February 12, 2007, he reported low back pain on the left side and radiation into the left hip and thigh. He was, therefore, given a dorsal median nerve root block and a sacroiliac joint injection under fluoroscopic guidance.
- Dr. Feinberg wrote another report at the request of Claimant's attorney on October 4, 2006. On that date, the doctor noted that Claimant was complaining of bilateral thigh pain with hypersensitivity on the left side. He continued to have difficulty with walking and also reported facial pain associated with headaches. He reported back pain at a 9/10 but stated his lower back pain is about 80% better after the third epidural steroid injection. Dr. Feinberg noted that he has treated Claimant for his January 7, 2006 injury, which was an injury "primarily to his thoracic spine." He opined that as a result of that injury "in combination with patient's injuries to his cervical and to his lumbar region which pre-existed the thoracic injury,...Mr. Rigney is no longer employable in the open

labor market." Dr. Feinberg explained that Claimant was working full time prior to January 7, 2006 and although Claimant did have problems with his lumbar and cervical region which required treatment, now in combination with the thoracic injury, he did not believe he was employable.

- The last note in evidence from Dr. Feinberg is dated April 18, 2007. Claimant was now reporting neck pain with radiation into the right shoulder and low back pain with left lateral side pain down to the anterior aspect of the knee. He had yet another lumbar epidural steroid injection on that date.
- Claimant placed into evidence his **Walgreen's prescription profile** (Exhibit H) from November 28, 2005 through November 30, 2007. That document showed that Claimant had had 137 prescriptions filled during that two-year period of time. The records documented filled prescriptions for Duragesic, Fentanyl, multi-vitamin tablets, Levothyroxine, Lorazepam, Hydrocodone, Lyrica, Bupropion, Triamterene, Diazepam, Cyclobenzaprine, Tramadol, Nortriptyline, Hydrochlorothiazide, Amoxicillin, Penicillin, and Amitriptyline.
- The deposition of **Dr. Barry I. Feinberg** (Exhibit A) was taken by Claimant on April 26, 2007 to make his opinions in this case admissible at trial. Dr. Feinberg is a board certified anesthesiologist. He also specializes in pain management. Dr. Feinberg testified to his prior extensive treatment of Claimant before the primary injury, initially for neck and right arm complaints and then also for low back complaints and lower extremity problems. Dr. Feinberg testified that leading up to January of 2006, he did take Claimant off work occasionally for a day or two at a time, and then also in May, June, July, September, October, and December of 2005, he placed a 30-pound weightlifting restriction on Claimant's activities. Dr. Feinberg then testified regarding the history Claimant provided to him of an injury in January of 2006, and the extensive treatment he provided to Claimant following that injury. Dr. Feinberg testified that the main diagnosis he attributed to the work-related injury was thoracic radiculopathy from the bulging disc at T8 that was identified on the thoracic MRI.
- Dr. Feinberg was then questioned about his note from October 4, 2006, when Claimant was complaining of bilateral thigh pain and hypersensitivity on the left side with difficulty walking. Claimant also was complaining of pain in his face and headache pain. Dr. Feinberg opined that the bilateral thigh pain was most likely coming from his lumbar spine and that predated the accident of January 2006. He further opined that the cervical condition prior to the January 2006 injury and after that injury was essentially the same with no objective changes. He believed the same was true of the lumbar spine condition. He testified that the only change was that there was now a synergistic effect between the cervical, thoracic and lumbar regions affecting how the doctor could treat the complaints that Claimant had in those areas. Dr. Feinberg confirmed his opinion that Claimant was unemployable based on the combination of his lumbar, cervical and thoracic conditions. He did not believe the thoracic injury in and of itself was enough to make Claimant permanently and totally disabled.
- On cross-examination, Dr. Feinberg agreed that the December 8, 2004 lumbar MRI showed findings overall in the lumbar spine that were mild. Dr. Feinberg also agreed that after January 9, 2006, Claimant's primary complaints of pain were in the thoracic region but he was having bad problems with his legs as well, including radiating pain to his legs and tremors and weakness. He agreed that these findings represented a change in the status of his legs and new complaints in the thoracic region. He also admitted that the tremors were new. He admitted also that the tremors were mostly in the extremities but when Claimant was sitting the tremor would actually be noticeable in the head and neck. He also admitted Claimant had weakness in the neck and an abnormality of movement. He further admitted that the proprioceptive loss in the feet that Claimant reported after the January 9, 2006 examination was a new problem the doctor had not seen before in Claimant. Dr.

Feinberg agreed that the first notes he had regarding a new symptom of bilateral thigh pain was in August 2006 after the January 2006 injury. The doctor also agreed that the facial pain complaints were newer, occurring after the January of 2006 injury. Dr. Feinberg agreed that in comparing the MRI's of the lumbar and cervical spines from before and after the January 2006 injury, there were basically no changes in the degenerative conditions in the spine.

- However, Dr. Feinberg then also agreed that there was definitely a progression of his lumbar spine condition when comparing the 2004 MRI and the lumbar MRI from August of 2006. After noting these new symptoms and Claimant's described increases in his symptomology, Dr. Feinberg agreed that he changed his April 15, 2006 opinion that Claimant could do sedentary work, and found instead that he was no longer employable as a result of this evidence of worsening physical changes after his April 2006 report. Despite admitting that there was a progression of his lumbar spine condition based on the comparison of the MRI's and despite admitting that Claimant had newer findings of hypersensitivity and thigh pain that the doctor believed was coming from the lumbar region, he refused to finally admit that the progression of the cervical and lumbar spine conditions contributed to his opinion that Claimant was permanently and totally disabled. Dr. Feinberg finally admitted that the increased symptomology and additional problems noted in the lumbar spine after the January 2006 injury were part of the "normal progression of the degenerative process that's there."
- At no point in Dr. Feinberg's reports or deposition testimony did he ever provide his opinions on the nature and extent of Claimant's permanent partial disability in the thoracic spine attributable to the January 2006 injury, nor any specific amounts of permanent partial disability in the cervical or lumbar spines pre-existing the January 2006 injury. In light of the discussion of the deterioration of Claimant's lumbar spine condition as evidenced by his newer symptoms of hypersensitivity and pain in the thighs and the changes on the MRI, Dr. Feinberg also did not divide out any amount of disability due to the subsequent deterioration, unrelated to the primary thoracic injury, as opposed to any pre-existing disability that Claimant may have had in the lumbar spine.
- The deposition of **Timothy G. Lalk** (Exhibit B) was taken by Claimant on October 4, 2007 to make his opinions admissible at trial. Mr. Lalk met with Claimant on one occasion, February 28, 2007, at the request of Claimant's attorney. Claimant reported to Mr. Lalk at the time of his visit that he weighed approximately 200 pounds. He said he had gained 10 pounds since the time of his injury due to "how he is feeling" and due to lack of activity. Claimant reported that he uses a cane when he feels at his worst, approximately 3-4 days each month. Mr. Lalk observed Claimant walk with a limp favoring his right side which became more pronounced as the interview progressed. He ambulated with a shuffling gait and Mr. Lalk observed Claimant's upper body was stooped forward throughout the interview. He also noted that Claimant's upper body occasionally appeared to be shaking. He noted that Claimant grimaced and groaned while he was breathing heavy. Claimant stood up several times during the interview and also apparently resorted to kneeling while leaning against his chair and lying supine on the floor. Claimant reported to Mr. Lalk that he suffered a 2004 neck injury when he was diagnosed with "three herniated discs." He also reported that in 2004 he began to have low back and right lower extremity pain. He reported that his MRI showed two bulging discs in his low back. Claimant reported to Mr. Lalk that he was working for Employer six days per week or a total of 60 hours each week, but he was only able to do this by "toughing it out."
- In describing his injury on January 7, 2006, Claimant reported that he had cut some springs and returned them to a rack. After that he sat down and experienced sharp pain in the center of his shoulder blades going down his sternum. He said he immediately developed tremors and a gait disturbance. He reported to Mr. Lalk that over the next two days he fell five to six times at home and lost control of his bowels three times. Claimant described that his symptoms only decreased when he had epidural steroid injections, and if he "limits his activities to

almost a bedridden status." Claimant also indicated that after his January 7, 2006 injury, he developed symptoms of numbness and tingling in his left thigh which increased to a stabbing pain. It was after the left thigh symptoms that Claimant was prescribed a Fentanyl patch by Dr. O'Neal. According to Mr. Lalk's report, Claimant said it was the combination of all three areas of his back that left him nonfunctional and that limited his activities at different times. Claimant's wife suggested that he was most bothered by the pain in his mid back going into his sternum and the sensitivity of his left thigh. She told Mr. Lalk that Claimant would not let anyone touch or even get close to his left thigh and that he would instinctively brush away anyone who got close to it.

- Claimant reported complaints to Mr. Lalk including constant pain in the neck, numbness in the right arm with prolonged sitting or standing, numbness in the right hand which causes him to drop things, pain in the thoracic spine going from his back down into his chest that increases any time except when he is lying down, occasional hyperventilation because of his pain, tremors in his upper torso after sitting or standing more than one to two hours, low back pain from sitting or standing a long time, pain in the right leg down to his ankle with swelling, right foot drop causing him to have a shuffling gait, and a left thigh continuous stinging sensation which leads to unbearable stabbing, along with sensitivity in the left thigh to sunlight or to fabrics.
- In addition to taking a vocational history from Claimant, Mr. Lalk also administered vocational testing. Claimant scored at the post high school level in reading and at the 7th grade level in arithmetic on the Wide Range Achievement Test, Revision 3. Mr. Lalk also administered the reading comprehension portion of the Adult Basic Learning Examination, Level 3 and Claimant scored at the post high school level. Mr. Lalk opined that based on these test results, Claimant should be able to pursue post secondary training after taking a remedial arithmetic course.
- In his April 4, 2007 report, Mr. Lalk concluded that although Claimant told him it was a combination of his neck, thoracic and low back pain which limited his ability to work, when they discussed specific levels of activity, Claimant primarily described pain in his thoracic spine as the reason why he was unable to function. Mr. Lalk also noted that Claimant developed an increased severity of complaints in his low back and neck after the January 2006 thoracic spine injury which did not exist at that same level prior to that January 2006 injury. Mr. Lalk concluded that the complaints in the low back and the neck, and "these symptoms and limitations became worse after the injury in January of 2006." He noted that, "if there had been no change in the symptoms and limitations related to his neck and low back or even if these symptoms and limitations in his neck and low back had improved, Mr. Rigney would still be unemployable based upon his current symptoms and limitations related to his thoracic spine." Mr. Lalk went on to explain that "at the very least the injury in January 2006 appears to be related to his thoracic symptoms and limitations and that these in and of itself prevent him from working." Having provided those opinions, Mr. Lalk did opine that Claimant was unemployable in the open labor market and that he could not recommend any vocational rehabilitation services for Claimant unless he was better able to control his symptoms and improve his level of functioning.
- Mr. Lalk then issued a supplemental report dated May 16, 2007 at the request of Claimant's attorney. Mr. Lalk apparently reviewed the deposition of Dr. Barry Feinberg and then agreed with the doctor's analysis that Claimant's unemployability is due to the combination of his last injury involving the thoracic spine and his pre-existing cervical and lumbar injuries. Mr. Lalk explained that with his prior opinion, he was not providing a medical opinion and was only commenting that Claimant was able to work up until January 7, 2006 and then the thoracic symptoms prevented him from being able to work any further. He concluded after reviewing Dr. Feinberg's medical opinions that "it was the earlier injuries which combine with the work activity to make it an injury severe enough to cause the deconditioning which has increased the level of his current symptoms to the

point where he is unable to work.”

- In his deposition testimony, Mr. Lalk indicated that he believed it was very important to meet with an individual because he wanted to be able to see the individual the same way that a potential employer might be seeing the individual in a job interview. He agreed that he's able to see the individual's demeanor and also see firsthand whether any physical problems that an individual may have impacts their ability to be employed. It is clear based on Mr. Lalk's testimony that Claimant's personal interview and meeting with Mr. Lalk factored into his opinions in this case. In addition to the description above that was contained in Mr. Lalk's report of Claimant's presentation at the interview, in his deposition, Mr. Lalk also indicated that Claimant's face was often strained and he had difficulty talking. He noted that Claimant became tearful occasionally and he talked at length about his symptoms. Based on that presentation, Mr. Lalk did not believe Claimant would even be given any consideration by a potential employer because of the physical problems and difficulties that Claimant described during the interview.
- Mr. Lalk's deposition testimony also contained a specific timeline during the interview that documented Claimant's standing up, kneeling, and lying down on the floor throughout the course of a little over a two-hour interview. Mr. Lalk testified that Claimant did not have any skills from his prior work that would be transferable into other occupations. He did not believe Claimant would be able to perform any of his previous jobs based on his current physical condition. In his deposition, Mr. Lalk summarized his prior opinions and basically agreed with Dr. Feinberg that the combination of his pre-existing and primary injuries is the reason why Claimant is unemployable in the open labor market. Mr. Lalk further agreed that if he had an individual with the vocational and educational background of Claimant and he were limited exclusively to sedentary work, then Mr. Lalk would be able to find him a job in the sedentary work category.
- On cross-examination, Mr. Lalk explained that he wrote his first report dated April 4, 2007 after he met with the Claimant personally and reviewed all of the various medical records. He agreed that the only additional piece of information he had between that first report and his May 16, 2007 addendum, was the deposition testimony of Dr. Feinberg. He further agreed that he had Dr. Feinberg's records prior to writing the first report. Mr. Lalk agreed that his opinion in his first report that the neck and low back symptoms increased and prevented him from working even in a sedentary position was part of a vocational assessment and not a medical causation opinion. Mr. Lalk further agreed on cross-examination that the chronic and severe pain that Claimant had in his thoracic spine limited his ability to less than what would be expected by any employer. Mr. Lalk agreed that he wrote in his first report that the pain and symptoms in Claimant's neck and low back were not disabling until after the primary injury. He also confirmed that he wrote that even if there had been no change in Claimant's prior symptoms to his neck and low back or if those prior conditions had improved Claimant, Claimant would still be unemployable based on the current symptoms and limitations from the thoracic spine in and of themselves.
- On redirect examination, Mr. Lalk explained that the reason he changed his opinion between the first and second report on the cause of the permanent total disability was Dr. Feinberg's explanation of Claimant's medical condition and how the pre-existing conditions to the neck and low back affected the injury to Claimant's mid back.
- The Second Injury Fund took the deposition of **Delores E. Gonzalez** (SIF Exhibit I) on November 28, 2007 to make her opinions in this case admissible at hearing. Ms. Gonzalez is a certified rehabilitation counselor. Ms.

Gonzalez did not have the opportunity to meet personally with Claimant but she did provide an assessment of his employability based upon a review of the medical records and reports, as well as the depositions in this case. She indicated that she had experience doing these records reviews especially when she worked for Social Security Disability from 1975 to 1982.

- After her review of the records and depositions, Ms. Gonzalez offered one report dated November 26, 2007. After performing a transferability of work skills analysis, Ms. Gonzalez concluded that Claimant does not have transferable skills that could be used in other jobs within his residual functional capacity given the restrictions imposed by Dr. Rachel Feinberg. She noted that those restrictions limit Claimant to less than sedentary work which does not exist in the open labor market. In addition to reviewing Dr. Feinberg's restrictions though, Ms. Gonzalez also reviewed the report and opinions of Dr. Bernard Randolph, who noted that Claimant was not permanently and totally disabled primarily because Dr. Randolph could not find any objective neurological deficits that would lead to permanent and total disability. Ms. Gonzalez concluded from a vocational perspective that Claimant was able to work prior to his January 7, 2006 injury and "his pre-existing disabilities were not so serious as to constitute a hindrance or obstacle to employment." Ms. Gonzalez further concluded that while Dr. Rachel Feinberg's recommendations limit Claimant's residual functional capacity to less than sedentary work, Dr. Barry Feinberg's recommendations leave Claimant capable of performing sedentary work. Finally, she noted Dr. Randolph did not impose any restrictions and noted that mechanical pain in the cervical, thoracic and lumbar spines would not lead to permanent and total disability.
- Ms. Gonzalez concluded that although Claimant can no longer perform the duties of any of his previous jobs because of his overall physical limitations, "the evidence of record fails to show that he suffers from any exertional or nonexertional impairments or symptoms which would prevent him from performing unskilled, sedentary work." She noted that if he underwent vocational rehabilitation, he should be able to perform sedentary, semi-skilled to skilled work.
- On cross-examination, Ms. Gonzalez agreed that Dr. Barry Feinberg had changed his opinion by October of 2006 that Claimant was unemployable, even though he had initially believed Claimant would be able to return to a sedentary work status. She agreed that with that change, Dr. Barry Feinberg's opinion fell in line with Dr. Rachel Feinberg's opinion, who then both indicated Claimant's physical capabilities would be below a sedentary level. Ms. Gonzalez further admitted that despite providing the opinion that his pre-existing disabilities were not so serious as to constitute a hindrance or obstacle to employment, she did see where Claimant was working with lifting restrictions prior to the January 2006 injury, he was missing time from work, and he needed help to do his work activities. She also admitted that if Claimant had to lie down several times during the day because of his complaints, it would put him in a position where he would need to be accommodated and essentially he would be unemployable.
- The Second Injury Fund took the deposition of **Dr. Bernard C. Randolph** (SIF Exhibit II) on November 30, 2007, to make his opinions in this case admissible at trial. Dr. Randolph is a board certified physical medicine and rehabilitation specialist. He never personally examined Claimant, but instead performed a records review at the request of the Second Injury Fund. He issued his first report after review of the records on October 23, 2007, and then issued a supplemental report dated November 26, 2007. Dr. Randolph testified that he treats individuals with a variety of musculoskeletal problems including back or neck pain, or shoulder problems and knee problems. Dr. Randolph testified that there are times when he's asked to evaluate a person's medical diagnosis and abilities just based on a review of records. It is not always based on the personal observation of a patient. He testified that he believed he had sufficient information to assess Claimant's ability to work and his physical abilities in general, to a reasonable degree of medical certainty. He testified as to his methodology of

carefully reviewing the past treatment records and physical therapy records as well as notes from specialists to get their clinical impressions at that point in time, but also then to look at the chronology of the treatment to see how a person's complaints and problems progressed over a given period of time.

- Dr. Randolph confirmed that before the injury in January 2006, Dr. Feinberg had diagnosed Claimant with cervical radiculopathy and degenerative disc disease, as well as lumbar radiculopathy for which Dr. Feinberg provided cervical and lumbar epidural steroid injections and a sacroiliac joint injection. Dr. Randolph also confirmed that he saw off-work slips taking Claimant off work for one or two days at a time in the year prior to his January 2006 injury.
- Dr. Randolph ultimately concluded that based on his review of the records, Claimant developed an acute increase in cervical, thoracic and lumbar pain in January 2006 after a period of work in which Claimant was doing frequent bending and lifting of moderate-to-heavy weight. He opined that Claimant's condition represented an acute exacerbation of his pre-existing problems. He noted that the prevailing factor for the persistent pain appeared to be pre-existing since Claimant had been under Dr. Feinberg's care for lumbar and cervical radicular problems prior to the January 2006 incident. Dr. Randolph further opined that the thoracic symptoms were new based on his review of the information and that Claimant's work activities appeared to be the prevailing factor in the development of the acute pain in the thoracic spine in January of 2006.
- With regard to Claimant's complaints of tremors, ataxia, and problems with moving his legs, Dr. Randolph opined that these complaints were never clearly explained by objective medical findings and the neurologist was never able to identify an anatomical explanation for those complaints. Dr. Randolph further testified that he was unable to explain why Claimant did not improve after the conservative treatment that was provided to him. He said based on the objective information in the records, Claimant should have gotten better with the treatment that he was given. Dr. Randolph believed that there were psychosocial factors and nonorganic factors that were impacting Claimant's ability to improve.
- Dr. Randolph admitted that when he issued his first report, he did not specifically provide an opinion on whether or not Claimant was permanently and totally disabled. He admitted that he received a letter from the Second Injury Fund asking for that opinion, and so therefore, he issued his supplemental report. He opined in the supplemental report that based upon the objective information, Claimant was not permanently and totally disabled. He noted that he could only find evidence of cervical and lumbar degenerative disc disease for which he had undergone treatments for radicular problems. He also noted that Claimant had treatment for thoracic pain but there were no significant structural abnormalities at the thoracic level either. He explained that "thoracic disc herniations in the absence of myelopathy (spinal cord injury) have a good prognosis and generally respond well to time and noninvasive treatments." He explained that Claimant has no objective neurological deficits which would lead to permanent total disability. He agreed that Claimant does have findings which might lead to mechanical pain in the cervical, thoracic and lumbar spines, however, he concluded that these findings in and of themselves would not lead to permanent total disability in this case. Dr. Randolph testified that based on his review of the records, the lumbar and cervical degenerative conditions were not exacerbated by the primary injury. He testified that he was unable to draw any conclusions as to whether or not the disease process has progressed as a result of what happened in January of 2006, because he didn't see any evidence to that affect.
- With regard to his thoracic spine, Claimant testified that he has pain there on an average level of 5-6 on a scale of 10 being the worst. He said his pain goes as high as 9 at times. He described complaints that go straight

through the center of his chest to his sternum. He said he takes pain medications and lays on a heating pad for relief. He described that he must lay down 3-4 times a day because of the pain from his thoracic spine.

- Currently his low back complaints have leveled off back to where they were before, according to his testimony. He said they average a 5 to 6 on a scale of 1 to 10, with 10 being the worst. He said at times the low back complaints will go up to a 9 or 10. Claimant described that his leg hurts more than his low back. He said he has complaints down his left leg to his knee and down his right leg to his knee as well as sometimes down to the right ankle. The same treatment he receives for his thoracic spine also helps with the lumbar spine. He said he sometimes puts his feet up or lies on a noodle 2-3 times a day when his pain increases.
- With regard to his current complaints in his neck, Claimant testified that on average he has pain at a 3 to a 4 on a scale of 1 to 10, with 10 being the worst. He said at its worst, his pain in the neck might go up to a 7. He said his neck is the same now as it was prior to the January of 2006 injury. He described complaints in his left arm over the elbow down into the forearm and fingers more than the right arm. He said he simply lays down for relief of his pain and again described that he lays down 3-4 times a day to try to relieve that pain. Claimant testified that once one part of his back starts hurting, then the rest starts bothering him as well. He usually lays down for 15 to 20 minutes at a minimum, but sometimes is done for the day and just stays in bed the whole day.
- In terms of his current activities, Claimant said he can lift a gallon of milk, but he usually does not do it since he does not want to cause pain or further injure himself. Claimant said he has continued problems with sitting that causes him to either need to lie down or double-up on his pain medications. He said he cannot sit for more than 20 minutes without having an increase in complaints. Claimant also indicated he could not stand for more than 5-10 minutes, maybe 15 minutes, before his pain complaints increase, including low back pain, leg pain and tremors. Claimant testified that he uses a cane because it takes the strain off his left leg.
- Claimant testified he has never returned to work since 2006. He said he has the same symptoms today as he had in May 2006 when Dr. Rachel Feinberg put restrictions on his activities. Claimant said he does not believe he can work because of being a physical and emotional wreck, and because he has to lie down constantly during the day. He definitely believed he could not work eight hours a day because of lying down and he also could not tolerate working five days a week.
- On cross-examination, Claimant admitted that he did not have the cane at the deposition that he brought with him to the trial. He said that he only uses it during long walks or when he has to climb stairs. Claimant was also asked about the comment in Mr. Lalk's report that he was working 60 hours a week prior to his January 2006 injury. Claimant said that was not true at the end of his employment in 2005 going into 2006. He also denied that he told Mr. Lalk that missing work was not a problem for his Employer. Claimant said he was always under the gun about missing work. Claimant testified that he was not aware of Dr. Feinberg's report indicating that he was able to do sedentary retraining. He also admitted that no doctor has ever found a reason for his ataxia or tremors. He said he finds that those conditions are related to his fatigue.

RULINGS OF LAW:

Based on a comprehensive review of the evidence, and based upon the applicable laws of the State of Missouri, I find:

Issue 1: Did Claimant sustain an accident?

Issue 2: Did the accident arise out of and in the course of employment?

Issue 3: Are Claimant's injuries and continuing complaints medically causally connected to his alleged accident at work on January 7, 2006?

Given that these three issues are so inter-related in this Claim, I will address these three issues together.

Considering the date of the alleged injury, it is important to note that the new statutory provisions are in effect including, **Mo. Rev. Stat. § 287.800 (2005)**, which mandates that the Court “shall construe the provisions of this chapter strictly” and that “the division of workers’ compensation shall weigh the evidence impartially without giving the benefit of the doubt to any party when weighing evidence and resolving factual conflicts.” Additionally, **Mo. Rev. Stat. § 287.808 (2005)** establishes the burden of proof that must be met to maintain a claim under this chapter. That section states, “In asserting any claim or defense based on a factual proposition, the party asserting such claim or defense must establish that such proposition is more likely to be true than not true.”

Since this is a Second Injury Fund only case, it is also important to consider that under **Mo. Rev. Stat. § 287.220.1 (2005)**, in order to qualify for Second Injury Fund benefits, Claimant must prove the presence of pre-existing permanent partial disability, along with a “subsequent **compensable injury** resulting in additional permanent partial disability... [emphasis added].” In other words, if the primary injury against Employer is not a **compensable** injury, then the Second Injury Fund Claim fails.

Claimant bears the burden of proof on all essential elements of his Workers’ Compensation case. **Fischer v. Archdiocese of St. Louis-Cardinal Ritter Institute**, 793 S.W.2d 195 (Mo.App.E.D. 1990) *overruled on other grounds by Hampton v. Big Boy Steel Erection*, 121 S.W.3d 220 (Mo. 2003). The fact finder is charged with passing on the credibility of all witnesses and may disbelieve testimony absent contradictory evidence. **Id.** at 199.

Claimant alleges an accident, not an occupational disease, involving injury to his thoracic spine on January 7, 2006. At trial, Claimant testified that there was a specific incident that precipitated his increased mid and low back complaints, when on January 7, 2006, he pulled a 100-pound spring off the rack, sparked up a torch, cut a 25-30 pound length, and felt a twinge in his back as he was cutting. He described a spark of electricity feeling, increased complaints as the day went on, and having to lie down on the floor to try to get relief of those complaints. However, when Claimant first sees Dr. Feinberg, two days after the alleged accident, he does not describe this specific incident with cutting the springs. Instead, he reports that he "has been doing a lot of lifting at work in the past week and had increased pain." Claimant continues to see Dr. Feinberg numerous times in that month and never gives the history of a specific accident. The first time a specific accident with the springs is noted, is about a month later when Claimant seeks treatment at Missouri Baptist Medical Center. But even then, he reports that the incident with the springs happened only 2 weeks before that visit, which would still put the timeline off by about 2 weeks, if in fact the spring incident happened on January 7, 2006. Finally, when Dr. Feinberg issued his first summary report dated April 15, 2006, he still had no history of a specific accident, and causally connected Claimant's increased complaints to his increased lifting in late 2005 and early 2006. It is not until May 2, 2006, after the doctor admittedly spoke to Claimant on two successive days trying to clarify the events, that the doctor reports the one-time exacerbation on January 7, after Claimant had been doing heavy lifting all week.

Having thoroughly reviewed all of the evidence regarding Claimant's alleged accident involving his back, including Claimant's testimony, and the medical treatment records from Dr. Feinberg, Dr. Kennedy, Dr. Rengachary and Missouri Baptist Medical Center, I find that Claimant has failed to meet his burden of proving that an accident arose out of and in the course of his employment.

In reaching this conclusion, I must note that in addition to the absence of an accident described in the initial medical treatment records as noted above, I also more generally find that Claimant's testimony, both concerning the presence of an accident and concerning his overall physical complaints and abilities, is not credible or believable.

There is no dispute in the medical treatment records that in January 2006 when the MRI's of the cervical, lumbar and thoracic spines were taken, the only significant finding was a small focal protrusion or herniation at T7-8. Otherwise, the cervical and lumbar spines only showed evidence of mild degenerative changes at multiple levels of the spine. Yet Claimant reported complaints and sought treatment for a wide array of physical symptoms including tremors, bowel incontinence, dizziness, tingling on the top of his head, the inability to walk straight, falling, low back pain, neck pain, right thigh pain, spasms, difficulty moving the right leg, hypersensitivity to touch, popping in the jaw, chest pain, left thigh pain and numbness, and right foot pain, among others. Claimant received extensive treatment from Dr. Feinberg's office, including numerous pain medication prescriptions, and a number of injections in just about every part of his body. Yet the complaints continued, or more properly would simply shift to some other part of his body, which would be treated.

The truly incredible nature of Claimant's complaints was driven home clearly by a comparison of Claimant's demeanor at the trial setting as opposed to the way he presented himself at Mr. Lalk's office when he appeared for his vocational examination. Claimant knew that he had been sent to Mr. Lalk by his attorney to get an opinion on whether or not Mr. Lalk felt Claimant was capable of working. During that appointment, Mr. Lalk observed Claimant grimacing, groaning, walking with a shuffled gait, having a stooped over posture, shaking occasionally, and having difficulty talking, not to mention his standing, kneeling against a chair and lying down on the floor during an interview that lasted only a little over two hours. Claimant's presentation and demeanor at trial was nowhere near this incredible presentation as documented by Mr. Lalk. Claimant's presentation is even more incredible when you factor in the medical opinions of Dr. Kennedy and Dr. Rengachary, who can find no explanation for such a constellation of complaints. Mr. Lalk clearly testified that his opinions on employability were based in part on Claimant's presentation and the affect that such a presentation would have on a potential employer. To the extent then that Mr. Lalk relied on Claimant's incredible presentation in formulating his opinion on employability, I find that his opinion is not competent, credible or persuasive.

Dr. Kennedy, a neurosurgeon, and Dr. Rengachary, a neurologist, each independently examined Claimant at Missouri Baptist Medical Center when Claimant went there on his own for treatment for his complaints. Each of them found a normal motor examination, symmetric reflexes, no clonus, and no atrophy. Neither of them could find a clear unifying diagnosis for his constellation of symptoms, especially when the diagnostic MRI's revealed no compromise or other acute structural lesions. In essence, neither of them could find any reason to explain the wide array of complaints Claimant described, nor could they find anything specific that they could treat to deal with these alleged complaints. Given the totality of the evidence in this case, I find their opinions on the absence of any real explanation for the extent of Claimant's complaints to be competent, credible and persuasive.

On the other hand, Claimant relies on the treatment and opinions of Drs. Rachel and Barry Feinberg, to support his contention that his complaints are related to his alleged work injury and his pre-existing cervical and lumbar degenerative conditions. Essentially, they seem to just take his complaints at face value and continue providing injections and pain medications without any attempt to determine the validity or cause of these complaints. Despite the fact that Claimant's complaints seemingly jump from right to left arm, or from left to right leg, or from head to low back within days between appointments, there is no discussion of whether there is any validity to the complaints or any way to explain them. They simply provide more medication and more injections. At one point on May 30, 2006, when Claimant was complaining of pain at his disc in the thoracic spine, Dr. Rachel Feinberg even explained to Claimant that just because he had pain in his mid back, did not mean it was from the disc. It was one of the few times I saw in Dr. Feinberg's extensive records where they actually questioned the accuracy of Claimant's description of his complaints, but that did not stop the medication and injections that were being provided all along regardless of the nature of the complaints he voiced. Even when Claimant was described as "doing phenomenally well" or when the doctor noted that he "looks amazing," they still provided trigger point injections and continued his medications.

Given my prior findings on Claimant's lack of credibility or believability, to the extent that Dr. Feinberg relied on Claimant's incredible descriptions of his complaints and problems in formulating his opinions on medical causation and the nature and extent of Claimant's disability, I find that Dr. Feinberg's opinions in that regard thus also are not competent, credible or reliable. Therefore, Dr. Feinberg's opinions cannot serve as the basis for any award of compensation in this case.

Given Claimant's failure to provide credible testimony regarding any alleged accident or the nature and extent of his alleged continuing complaints, I find that he has failed to prove that there was an accident in the course and scope of his employment. Furthermore, given my findings that Dr. Feinberg's and Mr. Lalk's opinions are not competent, credible or persuasive, since they relied on Claimant's incredible testimony and assertions, Claimant has also then failed to meet his burden of proof on the medical causation issue.

Since Claimant has failed to prove the presence of a compensable underlying primary injury in this case, Claimant's Claim against the Second Injury Fund also then fails for that lack of proof. The Second Injury Fund Claim here is denied.

Although this ruling on these issues is dispositive of this case, I also wish to address some of the other remaining issues in this case to show other reasons why this would not be a compensable Claim against the Second Injury Fund, even if Claimant were able to get past these initial three issues of accident, arising out of and in the course of, and medical causation.

Even if Claimant were to get past these initial three issues, Claimant's Claim against the Second Injury Fund would fail because of Claimant's failure to provide any evidence of the extent of disability of Claimant's alleged primary thoracic injury. As noted above, Claimant bears the burden of proof on all the essential elements of his case, including the nature and extent of disability against Employer for the primary injury. In this case, even if Dr. Feinberg's opinions were found credible, he provides absolutely no opinion on the nature and extent of disability attributable to the primary thoracic injury. Dr. Feinberg simply opines that Claimant is permanently and totally disabled due to the combination of his various alleged injuries, but nowhere does he, or any other physician in evidence for that matter, break down how much of that disability is attributable to the alleged primary injury and how much is attributable to the alleged pre-existing conditions. In the absence of any medical evidence on the nature and extent of the alleged primary injury, separate and apart from the overall disability from the combination of his conditions, I find that Claimant has failed to meet his burden of proof on the nature and extent of the permanent partial disability attributable to the alleged primary thoracic injury.

Furthermore, I find Claimant's Claim against the Second Injury Fund would fail in this case because the medical records and opinions in evidence document a subsequent worsening of his pre-existing low back condition, unrelated to the primary injury. The statutes and case law in this area of the law have been clear that if a pre-existing condition deteriorates subsequent to the primary injury, and that subsequent deterioration is not related to the primary injury, then there is no valid claim against the Second Injury Fund for permanent total disability, if Claimant's inability to work is based in part on that unrelated subsequent deterioration.

In this case, Claimant had numerous pre-existing complaints allegedly related to his lumbar spine degenerative condition. He had MRI's of the lumbar spine on December 8, 2004 and January 9, 2006, which both showed mild degenerative changes, with no canal stenosis, no disc herniation, and no nerve root encroachment. Dr. Feinberg essentially testified that he did not see any change in the degenerative conditions in the spine from these MRI findings. Although Claimant continued to have complaints and receive treatment for his spine after the alleged January 2006 injury, by April 15, 2006, Dr. Barry Feinberg opined that Claimant had permanent restrictions as a result of his degenerative spine conditions and should receive vocational retraining for a sedentary job position.

After Dr. Feinberg offered this opinion and after Claimant settled his primary case against Employer on June 22, 2006, I find that the medical records reveal a frank worsening of Claimant's alleged lumbar spine condition. He began reporting a ripping sensation and pain in the left thigh, as well as sensitivity to touch and sunlight that he had not reported before. Dr. Feinberg admitted in his deposition that these left thigh complaints (pain and hypersensitivity), as well as the proprioceptive loss in the feet, were new complaints since the alleged January 2006 injury. Dr. Feinberg

also testified that the main diagnosis attributable to the alleged January 2006 injury was the thoracic radiculopathy from the bulging thoracic disc. He characterized the neck and low back problems as pre-existing and did not specifically attribute any problems with those parts of his back to the alleged primary injury.

Further, Claimant had a new MRI of the lumbar spine on August 16, 2006 because of the new complaints in his left thigh. This time the MRI showed posterior disc bulges at L4-5 and L5-S1, along with an annular tear at L5-S1. There was also bilateral foraminal narrowing at both levels secondary to disc bulging. Dr. Feinberg testified that there was definitely a progression of Claimant's spine condition when comparing the 2004 and the August 2006 lumbar MRI's. Dr. Feinberg also testified that the increased symptomology and additional problems noted in the lumbar spine after the January 2006 injury were part of the "normal progression of the degenerative process that's there."

Following this new MRI, and the new complaints in the left thigh, and difficulty walking, on October 4, 2006, Dr. Feinberg changed his opinion that Claimant could be retrained for sedentary work, and instead opined that Claimant was permanently and totally disabled. He explained in his deposition that he changed his opinion as a result of Claimant not getting any better and failing to progress with the treatment he was being provided.

Based on this evidence in the record, I find that comparing the MRI's of the lumbar spine from 2004 and August 2006 reveals a subsequent worsening of Claimant's degenerative lumbar spine condition. I further find that Claimant had increased symptomology as a result of his worsening low back condition that was not related to the alleged primary injury, but was instead part of the normal progression of his degenerative back condition. I further find that this increased symptomology and worsened MRI findings were responsible for Dr. Feinberg changing his opinion from Claimant being able to do sedentary work to Claimant being unable to work.

Therefore, I find that the subsequent deterioration of the pre-existing degenerative lumbar spine condition, unrelated to the alleged primary thoracic injury, is responsible for Dr. Feinberg's changed opinion on Claimant's ability to work. Since that unrelated subsequent deterioration was factored into the doctor's opinion on ability to work, even if Claimant could get past those initial four threshold issues described above, Claimant still would not have a valid Second Injury Fund Claim since the unrelated subsequent deterioration cannot be properly considered in an assessment of Second Injury Fund liability.

For all of the above described reasons, Claimant has failed to meet his burden of proof in this case, and his Second Injury Fund Claim is denied.

CONCLUSION:

Claimant has failed to prove that he sustained a compensable primary injury in this case. He failed to meet his burden of proving the presence of an accident that arose out of or in the course and scope of his employment for Employer, by failing to provide credible testimony or evidence in that regard. He also failed to provide competent, credible and persuasive medical or vocational evidence on the issues of medical causation or the nature and extent of disability connected to his alleged primary injury on January 7, 2006. Finally, even if Claimant were to get past these issues, the medical records and opinions clearly document a subsequent deterioration of the pre-existing lumbar spine condition that is unrelated to the alleged primary thoracic injury, and which caused Dr. Feinberg to change his opinion on Claimant's employability. Therefore, for all of the above stated reasons, the Second Injury Fund Claim is denied.

Date: _____

Made by: _____

JOHN K. OTTENAD

*Administrative Law Judge
Division of Workers' Compensation*

A true copy: Attest:

Jeffrey W. Buker
Director
Division of Workers' Compensation