

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

Injury No.: 02-157512

Employee: Donald K. Shelton  
Employer: Alliance Water Resources (Settled)  
Insurer: ACE American Insurance Company &  
Insurance Company of North America (Settled)  
Additional Party: Treasurer of Missouri as Custodian  
of Second Injury Fund

On January 10, 2012, the administrative law judge issued awards of compensation against employer/insurer and against the Second Injury Fund. Employee filed an application for review. While the matter was pending before us, employee and employer/insurer resolved employee's claim against employer/insurer. We approved a Stipulation for Compromise Settlement of the claim against employer/insurer on April 19, 2012.

We now consider employee's application as it pertains to the award against the Second Injury Fund. Having reviewed the evidence and considered the whole record, we find that the award of the administrative law judge is supported by competent and substantial evidence and was made in accordance with the Missouri Workers' Compensation Law. Pursuant to § 286.090 RSMo, we affirm the award and decision of the administrative law judge so far as it pertains to employee's claim against the Second Injury Fund. The award and decision of Administrative Law Judge Edwin J. Kohner issued January 10, 2012, is attached and incorporated to extent it determines the Second Injury Fund claim.

We further approve and affirm the administrative law judge's allowance of attorney's fees 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 August 2012.

LABOR AND INDUSTRIAL RELATIONS COMMISSION

V A C A N T  
Chairman

\_\_\_\_\_  
James Avery, Member

\_\_\_\_\_  
Curtis E. Chick, Jr., Member

Attest:

\_\_\_\_\_  
Secretary

## AWARD

Employee:	Donald K. Shelton	Injury No.:	02-157512
Dependents:	N/A		Before the
Employer:	Alliance Water Resources		<b>Division of Workers'</b>
			<b>Compensation</b>
Additional Party:	Second Injury Fund		Department of Labor and Industrial
			Relations of Missouri
			Jefferson City, Missouri
Insurer:	ACE American Insurance Company & Insurance Company of North America		
Hearing Date:	November 8, 2011	Checked by:	EJK/lsn

### FINDINGS OF FACT AND RULINGS OF LAW

1. Are any benefits awarded herein? Yes
2. Was the injury or occupational disease compensable under Chapter 287? Yes
3. Was there an accident or incident of occupational disease under the Law? Yes
4. Date of accident or onset of occupational disease: December 6, 2002
5. State location where accident occurred or occupational disease was contracted: Franklin County, Missouri
6. Was above employee in employ of above employer at time of alleged accident or occupational disease? Yes
7. Did employer receive proper notice? Yes
8. Did accident or occupational disease arise out of and in the course of the employment? Yes
9. Was claim for compensation filed within time required by Law? Yes
10. Was employer insured by above insurer? Yes
11. Describe work employee was doing and how accident occurred or occupational disease contracted:  
The claimant, a field maintenance operator for a water company, suffered a severe right shoulder right clavicle non-union and hardware failure while turning off a fire hydrant.
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: Right clavicle
14. Nature and extent of any permanent disability: 50% permanent partial disability of the right shoulder
15. Compensation paid to-date for temporary disability: \$36,961.85
16. Value necessary medical aid paid to date by employer/insurer: \$94,211.28

- 17. Value necessary medical aid not furnished by employer/insurer? None
- 18. Employee's average weekly wages: \$557.48
- 19. Weekly compensation rate: \$371.65/\$340.12
- 20. Method wages computation: By agreement

**COMPENSATION PAYABLE**

- 21. Amount of compensation payable:

116 weeks of permanent partial disability from Employer	\$39,453.92
---------------------------------------------------------	-------------

- 22. Second Injury Fund liability: Yes

45.6 weeks of permanent partial disability from Second Injury Fund	\$15,509.47
--------------------------------------------------------------------	-------------

TOTAL:	\$54,963.39
--------	-------------

- 23. Future requirements awarded: See Additional Findings of Fact and Rulings of Law.

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: Preston E. Roskin, Esq.

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

Employee:	Donald K. Shelton	Injury No.: 02-157512
Dependents:	N/A	Before the <b>Division of Workers' Compensation</b>
Employer:	Alliance Water Resources	Department of Labor and Industrial Relations of Missouri
Additional Party:	Second Injury Fund	Jefferson City, Missouri
Insurer:	ACE American Insurance Company & Insurance Company of North America	Checked by: EJK/lsn

This workers' compensation case raises several issues arising out of a work related injury in which the claimant, a field maintenance operator for a water company, suffered a severe right shoulder right clavicle non-union and hardware failure while turning off a fire hydrant. The issues for determination are (1) Future medical care, (2) Temporary Disability, (3) Permanent disability, and (4) Second Injury Fund liability. The evidence compels an award for the claimant for permanent partial disability benefits and future medical care.

At the hearing, the claimant testified in person and offered depositions of David T. Volarich, D.O., and Timothy G. Lalk, and voluminous medical records. The claimant also offered medical reports from John A. Garcia, M.D., but objections were sustained based on the rule against hearsay. The defense offered depositions of Michael P. Nogalski, M.D., and Karen Kane-Thaler and medical records from Robert L. Pierron, M.D.

All objections not previously sustained are overruled as waived. Jurisdiction in the forum is authorized under Sections 287.110, 287.450, and 287.460, RSMo 2000, because the accident occurred in Missouri. Any markings on the exhibits were present when offered into evidence.

### **SUMMARY OF FACTS**

On December 6, 2002, this 46 year old claimant injured his right shoulder while attempting to close off a water hydrant. As he pulled forcefully on the wrench, the claimant felt a "pop" and severe pain in his right mid-clavicle with pain, numbness, and tingling radiating into his hands and fingers. The claimant's wife drove him home from work where he rested for the weekend while applying heat and ice to the painful area. The pain worsened however, and he reported his injury when he returned to work.

The claimant went to Unity Corporate Health, and on December 9, 2002, x-rays revealed a fracture of multiple screws holding the stabilization bar of his right shoulder and a united fracture of the mid aspect of the right clavicle. He consulted Dr. Pierron, an orthopedic surgeon, who put the claimant on light duty due to a failure of the internal fixation of his non-union right clavicle. On January 14, 2003, Dr. Pierron performed an open reduction internal fixation with Flexon bone graft to the right clavicle non-union. See Exhibit A. Dr. Pierron ordered physical

therapy. On May 6, 2003, Dr. Pierron recommended applying an Exogen bone stimulator to try to boost the amount of new bone formation at the interface and that the claimant delay unrestricted heavy physical labor until he developed better bone. On June 16, 2003, Dr. Pierron ordered an exercise program with a one to two pound progression per week. On August 4, 2003, Dr. Pierron found that the claimant had pain when trying to lift more than three pounds due to the persistent non-union fracture. On August 18, 2003 Dr. Pierron performed a bone marrow and bone-void filler ignite injection to the right clavicle non-union. On September 22, 2003, the claimant still had pain lifting over five pounds, popping around the shoulder blade and straining and pulling on the muscles around the shoulder, and Dr. Pierron ordered additional physical therapy. On January 12, 2004, x-rays showed persistent non-union, and Dr. Pierron opined that additional surgical intervention was indicated. On February 16, 2004 Dr. Pierron performed an open bone grafting with autograft, both cancellous and corticocancellous bone from the right pelvis. The claimant had additional physical therapy after the surgical procedure.

On August 2, 2004, Dr. Pierron examined the claimant and found shoulder instability and persistent pain. The claimant reported shooting pains and numbness in his arm and Dr. Pierron opined that further surgery was only indicated in the event of failure of the plate and/or screws. On August 10, 2004, an EMG revealed bilateral carpal tunnel syndrome with loss of the sensory nerve function with the maintenance of the other nerves involved in the brachial plexus. On August 30, 2004, Dr. Pierron examined the claimant and found that the claimant had a 30% weaker shoulder in the right compared to the left. He had significant pain and limitation of motion and radiographic incomplete healing of the clavicle non-union and needed to continue with physical therapy. On September 27, 2004, the claimant had increased swelling around the right clavicle and shoulder and residual weakness of the right scapula. X-rays revealed loosening around two of the three lateral screws without failure of the plates. The claimant continued the ultrasound stimulation and physical therapy. On November 29, 2004, Dr. Pierron examined the claimant and found that the claimant had more pain with increased shoulder activity, radiating pain around the shoulder itself, and clicking behind the shoulder blade. There was snapping of the scapula not directly related to his clavicle other than the residual weakness and change in the muscular balance of the shoulder after prolonged limitation of use of the right upper extremity. On November 29, 2004 Dr. Pierron opined that no further surgical intervention was indicated, because the claimant had not had complete failure of the hardware. Dr. Pierron opined that the claimant had reached maximum medical improvement "to date."

On March 7, 2005, Dr. Pierron examined the claimant and found loosening and continued motion of the screws. The claimant could not return to physical labor activities that require forceful use of the right arm. On July 25, 2005, the claimant reported increasing pain during a long drive. On March 20, 2006, Dr. Pierron indicated that if the x-rays showed complete failure or fracture of the screws, then the claimant would need surgery for the revision of the internal fixation hardware. On April 12, 2006, the claimant had a nerve conduction study of the right arm which showed chronic degeneration in the C6-7 and 8 innervated muscles consistent with mild, early median neuropathy at the wrist/carpal tunnel and suggestive of chronic mild middle cervical radiculopathy. On May 3, 2006, Dr. Pierron took x-rays that revealed a failure of the plate with distal screws pulling up allowing the plate to disassociate from the distal clavicle. Dr. Pierron, at that time, suggested repeat surgery. Dr. Pierron also indicated that the chronic nerve degeneration from the neck was probably causing numbness. The claimant did not want to consider cervical surgery at that time. On May 23, 2006, Dr. Pierron performed a surgical

procedure removing the hardware, reducing the fractured clavicle allograft intercalary bone graft, replating the clavicle, and applying a Grafton Flex demineralized bone matrix. At this point, the claimant was released at maximum medical improvement and temporary total disability benefits payments were stopped. Dr. Pierron followed the claimant until August 21, 2006, and turned the claimant over to Dr. Garcia.

On November 29, 2006, x-rays revealed no evidence of healing of the clavicle fracture. On December 19, 2006, a CT revealed an incomplete union of about 10% to 20% of the anterior portion of the clavicle. Dr. Garcia examined the claimant on December 29, 2006, for chronic pain in the right clavicle area. On April 25, 2007, Dr. Garcia found tenderness to palpation around the incision and significant pain around the clavicle. X-rays revealed that some of the screws were starting to back out of the plate, and the claimant still had a non-union fracture. On April 25, 2007, Dr. Garcia referred the claimant to Dr. Watson. See Exhibit A.

On May 31, 2007, Dr. Watson examined the claimant and diagnosed a chronic non-union of the right clavicle fracture. X-rays revealed that three screws were broken and that his diagnosis was the same as before, a non-united clavicular fracture with hardware failure. On July 11, 2007, Dr. Watson performed a complex hardware removal with irrigation and debridement of the infected right clavicular non-union with application of five antibiotic beads. On July 26, 2007, x-rays revealed that the clavicular fracture was unchanged. On August 30, 2007, Dr. Watson found an infected hardware status post right clavicular non-union and that there was no change from the previous x-rays. On November 1, 2007, Dr. Watson examined the claimant, and the x-rays demonstrated an increase in the space between the two distal and proximal clavicular segments. There was some weakness of the biceps and triceps and paresthesia in the ulnar nerve distribution suggestive of a traction-type phenomenon. He recommended physical therapy.

#### Pre-existing Conditions

#### Pre-existing Right Shoulder Condition

Dr. Volarich reviewed and summarized voluminous medical records regarding the claimant's pre-existing right shoulder condition that were not submitted into evidence. His findings were not challenged or the source of any objection by any party. On February 6, 1995, Dr. Mishkin examined the claimant for pain and discomfort in his neck. The claimant had slipped and fallen on ice in the parking lot at his place of employment on January 24, 1995. Dr. Mishkin diagnosed mild cervical myositis.

On April 18, 1992, the claimant was involved in an automobile accident and right shoulder x-rays revealed a fracture of the middle portion of the shaft of the clavicle, with moderate superior displacement of the lateral fragment; small intermediate fragments at the fracture site, with the fragments in satisfactory position. No dislocation of the lateral end of the clavicle, or head of the humerus; fracture, right clavicle. The claimant was placed in a clavicle strap. Dr. Johnston treated the claimant's mid clavicle fracture from April 20, 1992, through October 26, 1992. On August 27, 1992, Dr. Johnston excised a fragment from the claimant's right clavicle. On October 26, 1992, x-rays revealed no fracture at that area and the claimant was to return on an as needed basis. On May 23, 2000, Dr. Matthews examined the claimant for

increasing arm and shoulder pain and occasional numbness in his hands. See Exhibit L. X-rays confirmed a hypertrophic area of the clavicle non-union site. On May 23, 2000, a CT scan revealed a non-union of right clavicle fracture. On July 24, 2000, Dr. Matthews performed an open reduction internal fixation of right clavicle fracture for non-union with allograft fibular strut graft. On October 26, 2000, x-rays confirmed more consolidation of his fracture. On February 5, 2001, evaluation showed increasing swelling around the mid-clavicle area indicative of a breakdown of a non-union fixation. On February 7, 2001 Dr. Matthews opined that the claimant could return to work on limited duty. On February 23, 2001, Dr. Pierron examined the claimant regarding plate removal. See Exhibit 3. On March 26, 2001 Dr. Pierron performed an open reduction and internal fixation of the right clavicle fracture with bone grafting at St. Louis University Hospital. On April 6, 2001, and May 4, 2001, Dr. Pierron opined that there was excellent alignment and that the plate was in place; there was no evidence of hardware failure. On June 15, 2001, Dr. Pierron allowed the claimant to return to work on light duty. On July 31, 2001, Dr. Pierron found excellent alignment and no failure of hardware with bone that seemed to be filling in without difficulty. Dr. Pierron opined it would be safe to give the claimant a release to return to work as long as he can be restricted from lifting over ten pounds with his right arm. See Exhibit L.

#### Pre-existing Low Back Condition

The claimant first injured his back when he was about thirteen years old and involved in a bicycle accident. The back pain progressed throughout his adolescent and early adult years, to the present. He was treated by Dr. Haywood, a chiropractor, three times a week for a year.

On March 5, 1991, while working at Paramount Cap Manufacturers, Claimant was picking up a carton of copy paper to put on a conveyor belt when he hurt his back. He received treatment for this injury at Missouri Baptist Hospital in Sullivan, Missouri and by Dr. Johnston. In the early 1990's, the claimant was treated by Dr. Sampson and Dr. Anderson. On April 18, 1992, the claimant was involved in an automobile accident and x-rays of the thoracic spine revealed an irregularity at the anterior and inferior margins at T4 and of the anterior and superior margins at T5 suspicious of a slightly compressed fracture, with fragments in good position. X-rays of the lumbar spine revealed an old juvenile epiphysitis, L1. On January 25, 1993, Dr. Johnston, an orthopedic surgeon, examined the claimant for further evaluation of exacerbation of low pack pain and treated the claimant from January 25, 1993 through June 4, 1993. See Exhibit D. On June 4, 1993 an MRI revealed focal disc degeneration at L5-S1 with a disc protrusion at the midline and lateralizing towards the left and touching the dural space on the left S1 nerve root; moderate degenerative disc bulge at L4-5; degenerative disc bulge at L3-4; some evidence of anterior disc herniation at L3-4. Dr. Johnston ordered physical therapy. Dr. Johnston referred the claimant to Dr. Cynthia Guy for steroid injections.

On September 30, 1999, the claimant began treatment with Dr. Lawrence Tyler, a chiropractor in Washington, Missouri, for cervical brachial syndrome, muscle spasms, thoracic/lumbosacral neuritis/radiculitis. The claimant received treatment from Dr. Tyler from September 30, 1999 through December 29, 2000. See Exhibit E. On February 26, 2001, the claimant returned to Dr. Lawrence Tyler for treatment for lower back pain radiating to both legs, numbness in the right arm, and shoulder pain. The claimant received treatment from Dr. Tyler from February 26, 2001 through September 30, 2002. See Exhibit F. On September 24, 2002,

the claimant was seen by Jerry Fitzgerald, his family doctor for low back pain radiating to both legs. See Exhibit G. Dr. Fitzgerald ordered a CT scan of the lumbar spine. The CT scan showed grossly midline degenerative disc changes mainly L4-5 and L5-S1 causing mild extradural compression. The claimant followed up with Dr. Fitzgerald on October 1, 2002, and the claimant indicated that he felt better as long as he takes medication. Dr. Fitzgerald referred the claimant to Dr. Place, who examined the claimant on October 18, 2002, for back pain. See Exhibit H. Dr. Place discussed non-operable treatment with Claimant.

On October 18, 2002, less than two months before the accident, Dr. Place evaluated the claimant for longstanding episodes of back pain for at least twenty years. See Exhibit H. The claimant gave a medical history:

“His last episode began ... three weeks ago and is now essentially resolved. He ... gets an episode of severe back pain at least once a year and when this occurs, it lasts for several weeks up to a month. He will intermittently lose a day or two at work because of his back. The patient ... on a regular basis adjusts the way he does things and avoids certain activities. He does know proactive preventative exercises or activities for his back.” See Exhibit H.

A CT scan revealed no spondylosis and no degenerative changes in his lumbar spine. The scan also revealed slight decreased disc space height with some mild sclerosis. “Dr. Place concluded that the claimant had mechanical low back pain with probable early degenerative disc disease, peripheral vascular disease, manifested by aortic calcifications, nicotine abuse, and a history of chronic GI upset. See Exhibit H.

#### Back Condition 2002 to Date

After the December 6, 2002, accident, Dr. Weidle treated the claimant for worsening back pain. See Exhibit I. Dr. Weidle ordered an MRI of the lumbar spine which indicated mild to moderate L4-L5 central spinal canal stenosis secondary to a lobular central disc herniation combined with modest facet hypertrophy; Left L4-L5 foraminal disc herniation causing moderate foraminal stenosis and contacts the exiting left L4 nerve root; Central and right paracentral disc herniation at L5-S1 causing right inferolateral recess stenosis and minor mass effect upon the right S1 nerve root. The right paracentral extruded component extends just below the intervertebral disc level; Mild right L3-L4, mild right L4-L5 and mild bilateral L5-S1 foraminal stenosis; Colonic diverticulitis. See Exhibit I.

By 2009, the claimant's condition had significantly changed. On March 20, 2009, Dr. Weidle examined the claimant's low back, based on the claimant's report that his low back condition had “gotten worse” with onset in December 2008. He reported that the “left foot gets tingling and pain will go down let (sic) and cause more of the same.” See Exhibit I. On March 23, 2009, an MRI revealed herniated discs at L4-L5 and L5-S1 and foraminal stenosis at L3-L4, L4-L5, and L5-S1. See Exhibit I.

On April 8, 2009, Dr. Merenda examined the claimant and found multiple levels of degenerative disc disease with varying disc herniations both centrally and to the right and to the

left between L4 and S1. He had mild to moderate stenosis as well. See Exhibit K. Dr. Merenda's medical history reflected:

“[A]cute onset of back pain on top of chronic back pain about two months ago. At that time, there was no specific event that brought the pain on. He has had no right-sided complaints at this time. His biggest problem is pain down the left leg when he sits. If he gets up and walks he feels a little bit better. Again, he has had back pain for greater than thirty years time. In fact, he is on disability for his low back and shoulder.” See Exhibit J.

Dr. Merenda prescribed epidural steroid injections and a limited amount of narcotics. See Exhibit J. Dr. Smith treated the claimant from May 14, 2009, through June 10, 2009, and performed an L4-5 selective epidural steroid injection with fluoroscopy on May 21, 2009 and June 10, 2009. See Exhibit K. The claimant reported that he was totally disabled based on his low back and shoulder conditions. See Exhibit K. Dr. Smith's impressions were left lumbar radiculitis, suspected left L4 radiculitis with left L4-5 foraminal disc herniation, and multilevel lumbar degenerative disc disease.

#### Dr. Volarich

Dr. Volarich examined the claimant and took a medical history from the claimant about his activities before December 6, 2002, that the claimant had tenderness and deformity at the surgery site and had some numbness and tingling in his hand. He returned to his prior employer performing heavy lifting and repair of water pumps and water meters but not as heavy as earlier demolition work. The claimant was able to lift 50 pounds, swim, play softball with his daughter, take float trips, go camping with the family, and ride a motorcycle and off-road vehicles. He could wash his back and dress without difficulty prior to his injury of 2002. See Dr. Volarich deposition, page 19.

After the 2002 injury, the claimant was able to perform personal care with greater difficulty. Bathing and dressing moved very slowly and with greater difficulty forcing the claimant to rely mostly on his left arm. He had to ask his wife to wash his back or areas he was unable to reach. When dressing, he had to put his right arm in first. As far as his leisure activity, he is no longer able to swim, play basketball, baseball, volleyball, or throw balls to his daughter. Fishing is very difficult and he has to use his left hand. When he tried to return to riding a motorcycle, the vibration was too painful for him. See Dr. Volarich deposition, page 18. He lives on two acres and was able to push a power mower until 2002 and now has to use a riding lawn mower with his left hand. He also has to use his left arm to drive his motor vehicle. He can no longer take long trips because of the pain. Even sitting as a passenger is more painful than driving. He tries to help around the house performing household chores but found sweeping, mopping, washing dishes and anything that required him to use the weight of his arms hanging down resulted in pain for three to four days. See Dr. Volarich deposition, pages 18-19.

With regard to the claimant's past medical history, his low back problems began at age 11 when he was involved in a bicycle accident. The claimant had been treated in the past by Dr. Haywood, a chiropractor three days a week for a year. The claimant's symptoms resolved except for some intermittent pain at the waist and he was able to play ball and be active as a youngster.

See Dr. Volarich deposition, page 20. On March 5, 1991, while working at Paramount Headwear, he bent over and picked up a carton of copy paper and his back became exacerbated and he returned for conservative management because of his back pain. See Dr. Volarich deposition, page 20. Sometime in 1992 Claimant's flare-ups of his low back pain became accompanied by pain radiating down both lower extremities, left greater than right. He was seen by Dr. Richard Johnston (Exhibit D) who reviewed the CT scan and opined that it demonstrated a bulging disc at L5-S1. He was diagnosed with discogenic low back pain and recommended the use of a lumbosacral corset, work restrictions, physical therapy, and anti-inflammatory medications. He gradually improved and then on May 13, 1993 returned to Dr. Johnston because of an exacerbation of low back pain. See Dr. Volarich deposition, page 20. On June 2, 1993, Claimant underwent an MRI and returned to Dr. Johnston on June 4, 1993, and Dr. Johnston opined that it demonstrated focal degenerative disc changes at L5-S1 with disc protrusion at the midline lateralizing toward the left and touching the dural space on the left S1 nerve root. Also a moderate degenerative bulge was seen at L4-5 without focal lateralization and degenerative bulging at L3-4 without lateralization. There was evidence of an anterior disc herniation at L3-4. Dr. Johnston recommended epidural steroid injections and no work for three weeks. This helped relieve the claimant's pain and he was able to do well and work regularly with only occasional flare-ups until the exacerbation of pain radiating down both legs in 2002. A CT scan of the lumbar spine on 9/27/02 revealed grossly midline degenerative disc changes mainly at L4-L5 and L5-S1 causing mild extradural compression of both S1 nerve root sheaths. See Dr. Volarich deposition, page 21. Up to the date of the accident, the claimant continued to experience annual episodes of severe aching across his low back at the belt line, radiating down both lower extremities, left greater than right. The claimant occasionally missed a day at times because of severe flare-ups that could last a week and were treated by a chiropractor. See Dr. Volarich deposition, page 22.

Dr. Volarich noted that the claimant had weakness of the right shoulder. Testing of the deltoid and rotator cuff was 3/5 which is about a 40% loss of power. See Dr. Volarich deposition, page 24. The left shoulder was strong at 5/5. The claimant had problems walking heel to toe because of weakness in the left leg as well as back discomfort. See Dr. Volarich deposition, page 25. The neck and cervical spinal motion was restricted. Dr. Volarich found a 20% loss in flexion, 13% loss in extension, 7% loss in side bending to the right, 16% loss in side bending to the left, 35% loss in rotation to the right and 32% to the left. See Dr. Volarich deposition, page 25. Examination of the right shoulder revealed there was at least a 35% loss in motion as evaluated by the Apley Scratch test. See Dr. Volarich deposition, page 26. Significant deformity was noted over the clavicle with at least a three to four centimeter soft tissue and bony defect at approximately mid shaft. There was a 15 centimeter scar traversing the length of the clavicle (pg. 26). Pain occurred when palpating the central bony defect consistent with the history of recurrent nonunion. See Dr. Volarich deposition, pages 26 and 27. Dr. Volarich checked the hand grip strength and pinch strength using the Jamar device. In the right hand settings 1 through 5 his grip strength measured 40, 70, 75, 55, and 50 foot pounds. The left measured 50, 85, 90, 65, and 60 foot pounds.

Dr. Volarich diagnosed an aggravation of the right clavicle nonunion with hardware failure after five separate surgical repairs including repeat open reduction internal fixation and bone grafting procedures culminating in placement of antibiotic beads because of chronic infection of the right clavicle and persistent nonunion. See Dr. Volarich deposition, page 28. Dr.

Volarich also opined regarding the previous status was that there were three surgical repairs including open reduction internal fixation with bone grafting and chronic lumbar syndrome secondary to degenerative disc disease and degenerative joint disease with disc bulges at L4-5 and L5-S1 along with chronic cervical strain syndrome. See Dr. Volarich deposition, pages 28 and 29.

Dr. Volarich opined that the work accident that occurred on December 6, 2002, while turning off a fire hydrant pulling with a two foot wrench was the substantial contributing factor as well as the prevailing or primary factor causing the aggravation of his right clavicle nonunion and hardware failure that required a series of five surgical repairs from which he continued to experience significant difficulties from the nonunion and loss of function. See Dr. Volarich deposition, page 29. Dr. Volarich opined that the claimant had a 60% permanent partial disability of the right shoulder due to the aggravation of his right clavicle fracture nonunion and hardware failure that required a series of five surgical repairs, pain, lost motion, weakness, crepitus and atrophy in the dominant arm. See Dr. Volarich deposition, page 30.

Dr. Volarich opined that the claimant suffered from a 25% pre-existing permanent partial disability of his right upper shoulder due to the fracture that required three surgical repairs including two open reductions and bone grafting, pain, lost motion, weakness, crepitus and atrophy in the dominant arm. See Dr. Volarich deposition, page 30. Dr. Volarich opined that the claimant had a 20% permanent/partial disability of the body as a whole rated at the lumbosacral spine due to the chronic lumbar syndrome secondary to the bulging disc at L4-L5 and L5-S1. The rating accounted for back pain and lost motion and occasional lower extremity paresthesias. See Dr. Volarich deposition, pages 30 and 31. Dr. Volarich opined that the claimant had a 12.5% permanent/partial disability of the body as a whole rated at the cervical spine due to his chronic cervical syndrome causing neck pain and lost motion. See Dr. Volarich deposition, page 31. Dr. Volarich recommended that the claimant undergo vocational assessment to determine if he is able to work in the open labor market in any capacity in the mid Missouri region. See Dr. Volarich deposition, page 31. The claimant's education was limited to the 10th grade and he has never earned a GED and has worked as a laborer the majority of his working career and has not been able to work since January 14, 2003 and has received Social Security benefits. See Dr. Volarich deposition, page 31.

Dr. Volarich opined that the claimant is permanently and totally disabled as a direct result of the December 2002 accident in combination with the pre-existing medical conditions if the vocational assessment is unable to identify a job for which he is suited. See Dr. Volarich deposition, page 32.

Dr. Volarich opined that the claimant needed to continue on medical care in order to maintain his current state and will require ongoing care for his pain syndrome using narcotics, non-narcotic medications, muscle relaxants, physical therapy, and similar treatments. See Dr. Volarich deposition, page 33. Dr. Volarich also opined that the claimant will require periodic right shoulder x-rays and/or MRI scans to assess the ongoing difficulties with the non-union and infection. See Dr. Volarich deposition, page 33.

Dr. Volarich recommended that the claimant should not use his right arm for anything other than activities of daily living because of the severity of the non-union and infection of the

right clavicle and cannot use his arm above the chest level. See Dr. Volarich deposition, page 34. Dr. Volarich limited him to not use his right arm overhead or prolonged use of his arm any way from his body above chest level and limit him pushing, pulling and particularly traction maneuvers with the right upper extremity. See Dr. Volarich deposition, page 34. Dr. Volarich testified that the claimant was to be careful about heavy lifting and to restrict his bending, pushing, and pulling as much as possible due to his low back. See Dr. Volarich deposition, page 50.

Dr. Volarich testified that the claimant's low back symptoms worsened between December 2002 and sometime in 2008 or 2009. See Dr. Volarich deposition, page 56. Dr. Volarich testified that he didn't think the claimant was able to work and "I think the disabilities and his inability to get back to work is a combination of all of his conditions as they were up to 12/6/02 in combination with the 12/6/02 accident." See Dr. Volarich deposition, page 59.

#### Karen Kane

Karen Kane, a vocational rehabilitation counselor, who relied heavily on Mr. Lalk's testing, evaluated the claimant on August 21, 2011, and opined that the claimant would be able to return to the workforce. See Kane deposition, pages 10, 29. Ms. Kane opined that the claimant was employable based on his right clavicle injury alone or based on his right clavicle injury in combination with his pre-existing low back complaints. See Kane deposition, page 24. Ms. Kane opined that the claimant is employable in several positions, none of which involved any type of labor, such as greeter, cashier, desk clerk, housekeeping, and counter person.

Ms. Kane testified that the claimant could be employed as a service writer in a dealership or work in a parts department at a store because of his skills and interest in mechanical knowledge. See Kane deposition, page 17. Ms. Kane testified that the claimant has the academic skills necessary to continue with his education if he wishes. See Kane deposition, page 18. Ms. Kane testified that the claimant could work in sedentary positions with regards to the right arm restrictions, but that these restrictions did not impact the use of the left arm or body as a whole. See Kane deposition, page 22. Ms. Kane testified that when the claimant's entire body was taken into account, he would be able to perform in excess of a sedentary position and would be considered in a light work category. See Kane deposition, page 22. Ms. Kane opined that based on the claimant's education, work history, medical records, and physical abilities he would be able to seek, be hired and maintain full time gainful employment. See Kane deposition, page 23. Ms. Kane further testified that the claimant could go back to school and obtain a new set of skills that would further aid in his employability. See Kane deposition, page 23.

#### Dr. Nogalski

Dr. Nogalski, an orthopedic surgeon, examined the claimant on August 30, 2011, and diagnosed a painful non-union clavicle fracture since 1992. See Dr. Nogalski deposition, page 10. He testified that the claimant's right clavicle never fused solidly and that the claimant's smoking habit hindered his ability to recover, in that smoking minimizes some of the conditions that are favorable for the formation of small blood vessels and coordination of nutrition to the healing environment. See Dr. Nogalski deposition, pages 11-12. Dr. Nogalski testified that the claimant suffered from an infection in his right clavicle, which would also decrease blood supply

and nutrition and thwart the normal biological processes that make bone healing favorable. See Dr. Nogalski deposition, page 12. Dr. Nogalski testified that the claimant lost a significant amount of normal tissue around the area where his collar bone broke and where he had multiple surgeries. See Dr. Nogalski deposition, pages 15-16. Dr. Nogalski testified the effect of this was there would be less and less healthy tissue in the surrounding area of the injury where blood and nutrients would help the bone fractures or surgical procedures heal. See Dr. Nogalski deposition, page 16. Dr. Nogalski opined that the claimant could not expect a great chance of healing and defending against infection due to the unfavorable condition of the claimant's tissue bed. See Dr. Nogalski deposition, page 16. Dr. Nogalski testified the claimant had a horrible time healing bone and defending against infection dating back to the claimant's initial clavicle injury in 1992. See Dr. Nogalski deposition, page 16.

Dr. Nogalski testified the claimant sustained a thirty eight percent disability to his right upper extremity at the level of the shoulder as a result of the December 6, 2002 injury. See Dr. Nogalski deposition, page 17. He further testified the claimant had a ten percent disability to his right upper extremity at the level of the shoulder related to his pre-existing clavicle fractures and nonunion. See Dr. Nogalski deposition, page 17. Dr. Nogalski opined that further treatment was not reasonable given the previous infection and significant wound bed or loss of normal tissues around the claimant's shoulder and the claimant's inability to stop smoking. See Dr. Nogalski deposition, page 32. Dr. Nogalski testified he would strongly recommend against any additional surgical procedures. See Dr. Nogalski deposition, page 32.

Dr. Nogalski testified that taking hydrocodone and Tylenol 4 should not be used while driving a vehicle, making any decisions, or operating any motor vehicles. See Dr. Nogalski deposition, page 37-38. Dr. Nogalski testified that the claimant probably will require further medical attention for pain medication, but did not specify whether the medication was required due to the claimant's shoulder condition or his low back condition. See Dr. Nogalski deposition, pages 41, 42. Dr. Nogalski testified that if the claimant was back on hydrocodone he would have the same limitations of driving, operating machinery, thinking, or making decisions. See Dr. Nogalski deposition, pages 51, 52.

#### Timothy G. Lalk

Mr. Lalk, a vocational rehabilitation counselor, interviewed the claimant on June 29, 2005 and January 21, 2010. Mr. Lalk summarized the claimant's educational and vocational background. The claimant completed the 10<sup>th</sup> grade and later obtained his GED sometime around 1985 – 1987, but tested at the 7<sup>th</sup> grade level for reading and the high-school level for arithmetic. After high school, he worked in a factory, and then worked on demolishing buildings, doing interior work, and performing manual labor. He worked for the Bourbon city public works department budgeting and operating heavy equipment such as backhoes and dozers. He received a certification to manage public drinking water and began working for this employer in May 2002 as a field maintenance operator responsible for reading water meters and maintaining water and sewer facilities. The job could require him to drive 5 hours in a day and perform 5 hours of paperwork per day which required sitting. The heaviest lifting consisted of items weighing 150 pounds, and he had to bend, kneel, squat, reach overhead, and climb a ladder. After the claimant's first surgery following this accident, he was unable to return to any other employment. He was terminated from employment in 2003 and was told he could return if

he did not have the restrictions that were placed on him and if there was a job opening. Dr. Pierron never released the claimant to return to that employment.

The claimant never learned to type, but can use the internet. He has skills with a variety of manual equipment. The claimant stated that he is now unable to stand, sit, or drive for a long time. When required to do tasks for any extended period, he now requires a recliner or a spot on the floor where he could lay down to recover from pain. The claimant is able to sweep and mop during the day, but only in 15 minute increments. He can cut the grass, but only on a riding lawn mower and only for 30 minutes at a time. He is able to prepare a dinner as long as there is not much prep in doing so. Standing to cut or chop food causes pain. He is only able to go to the store for 30 minutes and this includes time that he is sitting down. The majority of his day is spent in his recliner watching television. He does not visit people much.

Mr. Lalk opined that the claimant is unable to secure and maintain employment in the open labor market and that the claimant would not be able to effectively work in even a sedentary position through a full work day because of his need to repeatedly rest to relieve the symptoms in his low back and right upper extremity. He also has to support his right arm on most occasions with only limited movement for short periods of time and he needs to recline using heat and cold packs to relieve his low back symptoms. Mr. Lalk opined that the need to rest throughout the day precludes him from any gainful employment. Mr. Lalk opined that the claimant is not a candidate for vocational rehabilitation services unless he can better control his symptoms and is able to function at a sedentary level or greater through a full work shift on a regular basis.

### **FUTURE MEDICAL CARE**

The Workers' Compensation Act requires employers “to furnish compensation under the provisions of this chapter for personal injury or death of the employee by accident arising out of and in the course of the employee's employment[.]” § 287.120.1. This compensation often includes an allowance for future medical expenses, which is governed by Section 287.140.1. Rana v. Landstar TLC, 46 S.W.3d 614, 622 (Mo.App.2001). Section 287.140.1 states:

In addition to all other compensation paid to the employee under this section, the employee shall receive and the employer shall provide such medical, surgical, chiropractic, and hospital treatment, including nursing, custodial, ambulance, and medicines, as may reasonably be required after the injury or disability, to cure and relieve from the effects of the injury.

Section 287.140.1 places on the claimant the burden of proving entitlement to benefits for future medical expenses. Rana, 46 S.W.3d at 622. The claimant satisfies this burden, however, merely by establishing a reasonable probability that he will need future medical treatment. Smith v. Tiger Coaches, Inc., 73 S.W.3d 756, 764 (Mo.App.2002). Nonetheless, to be awarded future medical benefits, the claimant must show that the medical care “flow [s] from the accident.” Crowell v. Hawkins, 68 S.W.3d 432, 437 (Mo.App.2001) (quoting Landers v. Chrysler Corp. 963 S.W.2d 275, 283 (Mo.App.1997)).

In this case, none of the physicians found that the claimant required any additional surgery relating to his right shoulder. However, Dr. Volarich opined that the claimant needed to

continue on medical care in order to maintain his current state and will require ongoing care for his pain syndrome using narcotics, non-narcotic medications, muscle relaxants, physical therapy, and similar treatments. See Dr. Volarich deposition, page 33. Dr. Nogalski opined, "It's probable he will require some medication." See Dr. Nogalski deposition, page 42. Both experts were unclear whether these medical requirements flowed from the claimant's pre-existing shoulder condition, the claimant's right shoulder injury in December 2002, or the claimant's severe low back condition. Dr. Volarich also opined that the claimant will require periodic right shoulder x-rays and/or MRI scans to assess the ongoing difficulties with the non-union and infection. See Dr. Volarich deposition, page 33. Dr. Nogalski made no contrary findings. The chronic infection that resulted from the claimant's condition appears to compel medical assessment to treat the condition and appears to flow from the claimant's 2002 shoulder injury.

Based on the record of evidence, the claimant is entitled to additional medical treatment as may reasonably be required after the injury or disability, to cure and relieve from the effects of the injury to be administered by a medical provider selected by the employer.

### **TEMPORARY DISABILITY**

When an employee is injured in an accident arising out of and in the course of his employment and is unable to work as a result of his or her injury, Section 287.170, RSMo 2000, sets forth the TTD benefits an employer must provide to the injured employee. Section 287.020.7, RSMo 2000, defines the term "total disability" as used in workers' compensation matters as meaning the "inability to return to any employment and not merely mean[ing the] inability to return to the employment in which the employee was engaged at the time of the accident." The test for entitlement to TTD "is not whether an employee is able to do some work, but whether the employee is able to compete in the open labor market under his physical condition." Thorsen v. Sachs Electric Co., 52 S.W.3d 611, 621 (Mo.App. W.D. 2001). Thus, TTD benefits are intended to cover the employee's healing period from a work-related accident until he or she can find employment or his condition has reached a level of maximum medical improvement. Id. Once further medical progress is no longer expected, a temporary award is no longer warranted. Id. The claimant bears the burden of proving his entitlement to TTD benefits by a reasonable probability. Id.

Temporary total disability awards are designed to cover the employee's healing period, and they are owed until the claimant can find employment or the condition has reached the point of maximum medical progress. When further medical progress is not expected, a temporary award is not warranted. Any further benefits should be based on the employee's stabilized condition upon a finding of permanent partial or total disability. Shaw v. Scott, 49 S.W.3d 720, 728 (Mo.App. W.D. 2001).

In this case, the claimant has been unable to work since the January 14, 2003, surgery and received temporary total disability benefits for 95 6/7 weeks (January 14, 2003 – February 9, 2004, and February 23, 2004 – November 29, 2004) when he was released at maximum medical improvement. The claimant received \$36,961.85 for temporary total disability benefits based on the parties' stipulation at the beginning of the hearing. The stipulated rate for temporary total disability benefits was \$371.65. That sum equates to 99 4/7 weeks for benefits at the stipulated rate.

The parties also stipulated that the claimant was temporarily totally disabled for 96 1/7 weeks. The claimant was entitled to receive \$35,731.49. The claimant is entitled to no additional temporary total disability benefits.

### **PERMANENT DISABILITY**

Workers' compensation awards for permanent partial disability are authorized pursuant to section 287.190. "The reason for [an] award of permanent partial disability benefits is to compensate an injured party for lost earnings." Rana v. Landstar TLC, 46 S.W.3d 614, 626 (Mo. App. W.D. 2001). The amount of compensation to be awarded for a PPD is determined pursuant to the "SCHEDULE OF LOSSES" found in section 287.190.1. "Permanent partial disability" is defined in section 287.190.6 as being permanent in nature and partial in degree. Further, "[a]n actual loss of earnings is not an essential element of a claim for permanent partial disability." Id. A permanent partial disability can be awarded notwithstanding the fact the claimant returns to work, if the claimant's injury impairs his efficiency in the ordinary pursuits of life. Id. "[T]he Labor and Industrial Relations Commission has discretion as to the amount of the award and how it is to be calculated." Id. "It is the duty of the Commission to weigh that evidence as well as all the other testimony and reach its own conclusion as to the percentage of the disability suffered." Id. In a workers' compensation case in which an employee is seeking benefits for PPD, the employee has the burden of not only proving a work-related injury, but that the injury resulted in the disability claimed. Id.

In a workers' compensation case, in which the employee is seeking benefits for PPD, the employee has the burden of proving, inter alia, that his or her work-related injury caused the disability claimed. Rana, 46 S.W.3d at 629. As to the employee's burden of proof with respect to the cause of the disability in a case where there is evidence of a pre-existing condition, the employee can show entitlement to PPD benefits, without any reduction for the pre-existing condition, by showing that it was non-disabling and that the "injury cause[d] the condition to escalate to the level of [a] disability." Id. See also, Lawton v. Trans World Airlines, Inc., 885 S.W.2d 768, 771 (Mo. App. 1994) (holding that there is no apportionment for pre-existing non-disabling arthritic condition aggravated by work-related injury); Indelicato v. Mo. Baptist Hosp., 690 S.W.2d 183, 186-87 (Mo. App. 1985) (holding that there was no apportionment for pre-existing degenerative back condition, which was asymptomatic prior to the work-related accident and may never have been symptomatic except for the accident). To satisfy this burden, the employee must present substantial evidence from which the Commission can "determine that the claimant's preexisting condition did not constitute an impediment to performance of claimant's duties." Rana, 46 S.W.3d at 629. Thus, the law is, as the appellant contends, that a reduction in a PPD rating cannot be based on a finding of a pre-existing non-disabling condition, but requires a finding of a pre-existing disabling condition. Id. at 629, 630. The issue is the extent of the appellant's disability that was caused by such injuries. Id. at 630.

Missouri courts have routinely required that the permanent nature of an injury be shown to a reasonable certainty, and that such proof may not rest on surmise and speculation. Sanders v. St. Clair Corp., 943 S.W.2d 12, 16 (Mo.App. S.D. 1997). A disability is "permanent" if "shown to be of indefinite duration in recovery or substantial improvement is not expected." Tiller v. 166 Auto Auction, 941 S.W.2d 863, 865 (Mo.App. S.D. 1997).

None of the forensic experts opined that the claimant was permanently and totally disabled solely as a result of the December 2002 accidental injury to the claimant's right shoulder. Dr. Volarich rated the claimant's permanent partial disability from the occurrence at 60% of the right shoulder, and Dr. Nogalski rated the claimant's permanent partial disability from the occurrence at 38% of the right shoulder. Dr. Garcia rated the claimant's overall impairment to his right shoulder at 8%, but did not break the rating down to the extent of the pre-existing condition and the extent of disability from the December 2002 accidental injury. Based on the record as a whole, the claimant suffered a 50% permanent partial disability to his right shoulder from the occurrence. Therefore, the claimant is awarded a 50% permanent partial disability to his right shoulder.

### **SECOND INJURY FUND**

"Section 287.220 creates the Second Injury Fund and sets forth when and in what amounts compensation shall be paid from the [F]und in [a]ll cases of permanent disability where there has been previous disability." For the Fund to be liable for permanent, total disability benefits, the claimant must establish that: (1) he suffered from a permanent *partial* disability as a result of the *last* compensable injury, and (2) that disability has combined with a *prior* permanent *partial* disability to result in total permanent disability. Section 287.220.1. The Fund is liable for the permanent total disability only *after* the employer has paid the compensation due for the disability resulting from the later work-related injury. Section 287.220.1 ("After the compensation liability of the employer for the last injury, considered alone, has been determined ..., the degree or percentage of ... disability that is attributable to all injuries or conditions existing at the time the last injury was sustained shall then be determined..."). Thus, in deciding whether the Fund is liable, the first assessment is the degree of disability from *the last injury considered alone*. Any prior partial disabilities are irrelevant until the employer's liability for the last injury is determined. If the last injury in and of itself resulted in the employee's permanent, total disability, then the Fund has no liability, and the employer is responsible for the entire amount of compensation. ABB Power T & D Company v. William Kempker and Treasurer of the State of Missouri, 263 S.W.3d 43, 50 (Mo.App. W.D. 2007).

Section 287.220.1, RSMo 1994, contains four distinct steps in calculating the compensation due an employee, and from what source:

1. The employer's liability is considered in isolation- "the employer at the time of the last injury shall be liable only for the degree or percentage of disability which would have resulted from the last injury had there been no preexisting disability."
2. Next, the degree or percentage of the employee's disability attributable to all injuries existing at the time of the accident is considered;
3. The degree or percentage of disability existing prior to the last injury, combined with the disability resulting from the last injury, considered alone, is deducted from the combined disability; and

4. The balance becomes the responsibility of the Second Injury Fund. Nance v. Treasurer of Missouri, 85 S.W.3d 767, 772 (Mo.App. W.D. 2002).

Missouri courts have routinely required that the permanent nature of an injury be shown to a reasonable certainty, and that such proof may not rest on surmise and speculation. Sanders v. St. Clair Corp., 943 S.W.2d 12, 16 (Mo.App. S.D. 1997). A disability is “permanent” if “shown to be of indefinite duration in recovery or substantial improvement is not expected.” Tiller v. 166 Auto Auction, 941 S.W.2d 863, 865 (Mo.App. S.D. 1997). The standard for determining whether Claimant was permanently and totally disabled is whether the person is able to compete on the open job market, and the key test to be answered is whether an employer, in the usual course of business, would reasonably be expected to employ the person in his present physical condition. Joulzhouser v. Central Carrier Corp., 936 S.W.2d 908, 912 (Mo.App. S.D. 1997). Generally, where two events, one compensable and the other non-compensable, contribute to the claimant’s alleged disabilities, the claimant has the burden to prove the nature and extent of disability attributed to the job related injury. Strate v. Al Baker’s Restaurant, 864 S.W.2d 417, 420 (Mo.App. E.D. 1993); Bersett v. National Super Markets, Inc., 808 S.W.2d 34, 36 (Mo.App. E.D. 1991).

This is so, because our law is, “If the employee's last injury in and of itself rendered the employee permanently and totally disabled, the Fund has no liability; the employer is responsible for the entire amount of compensation.” Landman v. Ice Cream Specialties, Inc., 107 S.W.3d 240, 248 (Mo. banc 2003); Paul Birdsong v. Waste Management and Insurance Company of the State of Pennsylvania, et al., Slip Op. Case No. 25996 (Mo.App. S.D. October 26, 2004). “For this reason, pre-existing disabilities are irrelevant” if the last injury in and of itself rendered the claimant unemployable in the open labor market without regard to his preexisting permanent partial disabilities. Id.

Based on the findings above, the claimant suffered a 50% permanent partial disability to his right shoulder from the occurrence.

The claimant clearly had pre-existing permanent partial disabilities relating to his right shoulder and his spine. Dr. Volarich diagnosed a pre-existing right clavicle fracture, status post three surgical repairs including open reductions fixation and bone grafting, chronic lumbar syndrome secondary to degenerative disc disease and degenerative joint disease with disc bulges at L4-5 and L5-S1, and a chronic cervical strain syndrome. He opined that the claimant’s pre-existing permanent partial disabilities from these conditions were 25% of the right shoulder, 20% of the lumbar spine, and 12 ½% of the cervical spine. Dr. Nogalski opined that the claimant had a 10% pre-existing permanent partial disability to his right shoulder. The record has no other forensic evaluations of the claimant’s pre-existing conditions. Based on the evidence as a whole, the claimant had pre-existing permanent partial disabilities of 25% of the right shoulder, 20% of the lumbar spine, and 12 ½% of the cervical spine. The pre-existing permanent partial disabilities in this case are those that a cautious employer could reasonably perceive as having the potential to combine with a work related injury so as to produce a greater degree of disability than would occur in the absence of such condition, and, therefore, constitute a hindrance or obstacle to employment or reemployment if the employee became unemployed. Based on this, the simple sum of the claimant’s overall permanent partial disability is 76% or 304 weeks.

The evidence as a whole compels a finding that the claimant is unemployable in the open labor market as of the date of the hearing in this case due to his need to sleep during the day. The evidence supports a finding that his need to sleep at intervals during the day results from pain medications that the claimant now consumes due to a deteriorating low back condition. The claimant argues in his brief:

Dr. Volarich believes that Claimant is permanently and totally disabled as a result of the combination of his work-related and pre-existing disabilities. Mr. Lalk is reasonably certain that the limitations of Claimant render him unable to compete for work in the open labor market, or to be re-trained.

On the other hand, the Second Injury Fund argues in its brief that those forensic experts have serious flaws that limit their ability to prove that the claimant's total disability resulted from the combination of the permanent partial disability from his December 2002 accident, his pre-existing permanent partial disabilities, his education, and past relevant work history:

Dr. Volarich saw the claimant on December 7, 2009. (Volarich 6) At that time Dr. Volarich offered opinions as to the extent of claimant's disability as well as suggested restrictions. (Volarich. 29 – 35). He also stated that he would defer to a vocational expert as to whether or not any jobs would be available to claimant within his suggested restrictions. (Volarich.31-32, 51, 58, 60) Dr. Volarich was later sent a copy of Tim Lalk's report, and based on his review of that offered his own addendum report. (Depo 32) In the addendum he stated that Mr. Lalk found the claimant unemployable in the open labor market because he needed to lie down several times during the day, and therefore he [Dr. Volarich] found that he was PTD due to a combination of his primary and preexisting disabilities. (Volarich 32 – 33, 60 - 61) The problems with this PTD opinion are numerous. First of all, Dr. Volarich deferred to a vocational expert as to whether or not any jobs were available within his restrictions – however, Tim Lalk never saw, or obviously considered, Dr. Volarich's restrictions when he prepared his February 16, 2010 report. (Lalk Depo. 59 – 60; Volarich depo 51 – 52) [Dr.] Volarich agreed that the reason Tim Lalk found the claimant unemployable was because of his purported need to lie down several times a day. (Volarich 52) Dr. Volarich did not know when the need to lie down several times a day arose. (Volarich 52) Dr. Volarich had taken no history from the claimant during his examination of the need to lie down during the day because of either his shoulder or his back. (Volarich 53) Dr. Volarich was not aware of any worsening of the claimant's low back problems subsequent to his 2002 work injury. (Volarich 52) He did not have the subsequent low back medical records. (Volarich 54) Dr. Volarich agreed, after the records were pointed out to him, that they did indicate a worsening in the claimant's low back complaints between 2002 and 2009. (Volarich 53 – 56) Claimant himself testified at hearing that his low back problems have worsened since December 2002.

Dr. Volarich agreed that his opinion, in his addendum report, was based at least in part of (sic) Mr. Lalk's opinion that claimant was unemployable – which in turn relied on the purported fact that the claimant needed to lie down several

times a day. (Volarich 57 – 58) Volarich agreed that as of December 6, 2002 the claimant did not need to lie down during the day because of low back pain, that his back pain worsened between December 2002 and sometime in 2008 or 2009 – and it was this worsening of the low back that was causing him to need to lie down during the day. (Volarich 57 – 58)

Mixed in with all this are the weaknesses in Mr. Lalk's opinion. Mr. Lalk agreed that he would defer to a medical physician as to what restrictions claimant should be operating under. (Lalk 64) But Mr. Lalk did not base his opinion of employability on doctor's restrictions – instead, he based it on claimant's assertion that he needed to lie down during the day. (Lalk 51 – 53). No doctor has imposed the restriction of needing to lie down during the day to relieve pain complaints. Dr. Volarich did not take a history from the claimant of needing to lie down to relieve pain complaints. Finally, the claimant himself did not testify that he needs to lie down due to pain complaints. Mr. Lalk's opinion of employability is therefore also not supported by the record.

The defense position that the claimant's requirement to rest during the day was not present before the accident and that it appears to result from the deterioration in the claimant's low back condition after the 2002 accident appears to be well taken and firmly documented in the record. The claimant's medical records relating to his low back condition from October 2002 sharply contrast with the claimant's medical records from 2009 to the present.

On October 18, 2002, less than two months before the accident, Dr. Place evaluated the claimant for longstanding episodes of back pain for at least twenty years. See Exhibit H. The claimant gave a medical history:

“His last episode began ... three weeks ago and is now essentially resolved. He ... gets an episode of severe back pain at least once a year and when this occurs, it lasts for several weeks up to a month. He will intermittently lose a day or two at work because of his back. The patient ... on a regular basis adjusts the way he does things and avoids certain activities. He does know proactive preventative exercises or activities for his back.” See Exhibit H.

A CT scan revealed no spondylosis and no degenerative changes in his lumbar spine. The scan also revealed slight decreased disc space height with some mild sclerosis. “Dr. Place concluded that the claimant had mechanical low back pain with probable early degenerative disc disease, peripheral vascular disease, manifested by aortic calcifications, nicotine abuse, and a history of chronic GI upset.” See Exhibit H.

After the December 6, 2002, accident, Dr. Weidle treated the claimant for worsening back pain. See Exhibit I. Dr. Weidle ordered an MRI of the lumbar spine which indicated mild to moderate L4-L5 central spinal canal stenosis secondary to a lobular central disc herniation combined with modest facet hypertrophy; Left L4-L5 foraminal disc herniation causing moderate foraminal stenosis and contacts the exiting left L4 nerve root; Central and right paracentral disc herniation at L5-S1 causing right inferolateral recess stenosis and minor mass effect upon the right S1 nerve root. The right paracentral extruded component extends just below the

intervertebral disc level; Mild right L3-L4, mild right L4-L5 and mild bilateral L5-S1 foraminal stenosis; Colonic diverticulitis. See Exhibit I.

By 2009, the claimant's condition had significantly changed. On March 20, 2009, Dr. Weidle examined the claimant's low back, based on the claimant's report that his low back condition had "gotten worse" with onset in December 2008. He reported that the "left foot gets tingling and pain will go down let (sic) and cause more of the same." See Exhibit I. On March 23, 2009, an MRI revealed herniated discs at L4-L5 and L5-S1 and foraminal stenosis at L3-L4, L4-L5, and L5-S1. See Exhibit I.

On April 8, 2009, Dr. Merenda examined the claimant and found multiple levels of degenerative disc disease with varying disc herniations both centrally and to the right and to the left between L4 and S1. He had mild to moderate stenosis as well. See Exhibit K. Dr. Merenda's medical history reflected:

"[A]cute onset of back pain on top of chronic back pain about two months ago. At that time, there was no specific event that brought the pain on. He has had no right-sided complaints at this time. His biggest problem is pain down the left leg when he sits. If he gets up and walks he feels a little bit better. Again, he has had back pain for greater than thirty years time. In fact, he is on disability for his low back and shoulder." See Exhibit J.

Dr. Merenda prescribed epidural steroid injections and a limited amount of narcotics. See Exhibit J. Dr. Smith treated the claimant from May 14, 2009, through June 10, 2009, and performed an L4-5 selective epidural steroid injection with fluoroscopy on May 21, 2009 and June 10, 2009. See Exhibit K. The claimant reported that he was totally disabled based on his low back and shoulder conditions. See Exhibit K. Dr. Smith's impressions were left lumbar radiculitis with suspected left L4 radiculitis with left L4-5 foraminal disc herniation, and multilevel lumbar degenerative disc disease.

Based on this medical history, the claimant's permanent total disability resulted from the combination of his limitations and restrictions from his work related accident, his pre-existing permanent partial disabilities, his educational background, his past relevant work history, and the subsequent deterioration of his low back condition requiring more potent pain relief medication with sedative qualities.

Notwithstanding, the claimant is entitled to an award of additional permanent partial disability benefits based on the record. Dr. Volarich credibly opined that the claimant's overall disability exceeds the simple sum of the claimant's individual disabilities (76% or 304 weeks). The claimant's overall disability exceeds the simple sum of the claimant's individual permanent partial disability by 15% resulting in an overall permanent partial disability of 87.4%. The claimant's award of benefits can be summarized as follows:

Permanent partial disability	Weeks	Load	Weeks Awarded
50% Right Shoulder	116	15%	17.4
25% Right Shoulder	58	15%	8.7
20% Lumbar Spine	80	15%	12.0
12 ½% Cervical Spine	50	15%	7.5
Totals	304	15%	45.6

The claimant's pre-existing right shoulder non-union differs significantly from his 2002 right shoulder injury due to the chronic infection that now characterizes the claimant's right shoulder non-union. Based on the above, the claimant is awarded an additional 45.6 weeks of permanent partial disability from the Second Injury Fund.

Made by: /s/ EDWIN J. KOHNER  
EDWIN J. KOHNER  
*Administrative Law Judge*  
*Division of Workers' Compensation*