

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

Injury No.: 02-137410

Employee: David Tippen
Employer: Ken Barbee d/b/a KMB Construction
Insurer: Truck Insurance Exchange
Additional Party: Treasurer of Missouri as Custodian
of Second Injury Fund

The above-entitled workers' compensation case is submitted to the Labor and Industrial Relations Commission (Commission) for review as provided by § 287.480 RSMo.¹ Having reviewed the evidence, read the briefs, and considered the whole record, the Commission finds that the award of the administrative law judge (ALJ) is supported by competent and substantial evidence and was made in accordance with the Missouri Workers' Compensation Law. Pursuant to § 286.090 RSMo, the Commission affirms the award and decision of the ALJ dated September 15, 2011, as supplemented herein.

Applications for Review were filed by the Second Injury Fund, employee, and employer/insurer. The Commission decided to hold review of this matter in abeyance pending the ruling by the Missouri Supreme Court (Court) in *Gervich v. Condaire*, 370 S.W.3d 617 (Mo. banc 2012). The Court issued its decision in *Gervich* on July 31, 2012. The parties subsequently filed briefs.

We provide this supplemental opinion solely to clarify the dependency issue involving employee's wife and only dependent, Mary Tippen.

The ALJ found that Mary Tippen "was a conclusively presumed total dependent at the time of the employee's accident and injury and has remained in the same capacity since then." The ALJ went on to conclude that "[a]lthough the employee is not deceased, I find that Mary Tippen would be entitled to the employee's permanent total disability payments in the event that Mary Tippen survives the employee." We find, based upon the subsequent rulings in *Gervich* and *White v. University of Missouri, Kansas City*, 375 S.W.3d 908 (Mo. App. 2012), that the issue of Mary Tippen's entitlement to said benefits requires further analysis.

Before discussing the holdings in *Gervich* and *White*, it is helpful to review the history of the *Schoemehl* holding. The Court in *Gervich* summarized *Schoemehl's* history, as follows:

In *Schoemehl*, [the] Court addressed whether the workers' compensation statutes in effect at that time required that an employee's dependents have the right to continuing permanent total disability benefits. [The] Court found that the language of the workers' compensation statutes, when reading the relevant statutory sections together, provided that the dependents of an injured employee who died from causes unrelated to the work-related injury had a right to continuing permanent total disability benefits.

...

¹ Statutory references are to the Revised Statutes of Missouri 2002 unless otherwise indicated.

Employee: David Tippen

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In 2008, the legislature amended sections 287.010.1, 287.200, and 287.230, the statutes interpreted by *Schoemehl* to make clear that compensation for a permanent total disability is payable only during the lifetime of the injured employee and is not payable to dependents after the employee's death when the employee dies from causes unrelated to the work injury. The legislature expressly stated its intent to 'reject and abrogate the holding' in *Schoemehl*.

...

In *Bennett [v. Treasurer of State of Missouri, 271 S.W.3d 49 (Mo. App. 2009)]*, the court of appeals noted the 2008 amendments to the relevant statutes and stated that application of the holding in *Schoemehl* 'is limited to claims of permanent total disability that were pending between January 9, 2007, the date the Missouri Supreme Court issued its decision in *Schoemehl*, and June 26, 2008, the effective date of [the 2008 amendments].'¹ This holding in *Bennett* was quoted by the court of appeals in *Tilley v. USF Holland Inc., 325 S.W.3d 487, 494 [(Mo. App. 2010)]*.... *Tilley* further stated that the amendment to section 287.230.3, expressly abrogating *Schoemehl*, 'is not retroactive and will only apply to claims initiated after the effective date of the amendment.'

Gervich, 370 S.W.3d at 620-21 (citations omitted).

In *Gervich*, the Commission denied Deborah Gervich, the wife of Gary Gervich (the injured worker), her workers' compensation benefits as a dependent of her deceased husband. *Id.* at 618.² The Commission found that Deborah's right to receive her husband's permanent total disability benefits had not "vested" prior to the 2008 statutory amendments that eliminated dependents from the definition of "employee" in § 287.020.1 RSMo. *Id.* On appeal, the Court found that contrary to the Commission's finding, the statutes in effect at the time of the worker's injury governed whether his or her dependent was entitled to receive disability benefits, not the statutes on the date of death. Thus, the Court found that *Schoemehl* and that decision's interpretation of three statutes, §§ 287.020, 287.200, and 287.230, controlled.

In *White*, the Missouri Court of Appeals for the Western District was faced with a set of facts distinguishable from *Schoemehl* and *Gervich* in that the injured employee was still alive when the court ruled on the issue of dependency.³ The *White* court pointed out that because the injured employees were already deceased in *Schoemehl* and *Gervich*, there was "at stake ... an immediate right to receive benefits; there were no remaining contingencies in the nature of conditions precedent." *White*, 375 S.W.3d at 912-13. The court noted that in their case, because the injured employee is still alive, and his wife cannot be substituted as "employee" for him at that stage, she was *not* entitled to receive benefits under *Schoemehl* at that time. *Id.* at 913.

In accordance with *Gervich*, the *White* court held that the employee's wife's dependent status was established and determined as a matter of law at the time of the injury. However, the court held that the adjudication of her claim to entitlement of successor benefits was simply not ripe for review because the injured employee was still alive.

² Gary Gervich's claim for permanent total disability benefits was pending between January 9, 2007, and June 26, 2008.

³ In *White*, the injured employee's claim for permanent total disability benefits was pending between January 9, 2007, and June 26, 2008.

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In this case, employee's claim for permanent total disability benefits was pending during the *Schoemehl* window, January 9, 2007, to June 26, 2008. However, similar to *White*, the injured employee is still alive. Employee testified that as of the time of the injury and of the hearing, he was married to and living with Mary Tippen. Dependent status is determined at the time of the injury, not at the time of the employee's death. *Gervich*, 370 S.W.3d at 622. Consequently, we conclude that, as of the time of employee's injury, Mary Tippen satisfied the definition of dependent set forth in § 287.240.4 RSMo.

While we find that as a matter of law, Mary Tippen is currently employee's dependent, the adjudication of her claim to entitlement to successor benefits is simply not ripe for review because employee is still alive. Therefore, we only find that Mary Tippen is entitled to receive employee's permanent total disability benefits so long as at the time of employee's death, all subsequent conditions applicable under the Missouri Workers' Compensation Law and under *Schoemehl* and its progeny are satisfied.

The Commission affirms the award and decision of the ALJ, as supplemented herein.

The award and decision of Chief Administrative Law Judge Lawrence C. Kasten, issued September 15, 2011, is attached hereto and incorporated herein to the extent it is not inconsistent with this decision and award.

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

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

Given at Jefferson City, State of Missouri, this 14th day of December 2012.

LABOR AND INDUSTRIAL RELATIONS COMMISSION

V A C A N T
Chairman

James Avery, Member

Curtis E. Chick, Jr., Member

Attest:

Secretary

ISSUED BY DIVISION OF WORKERS' COMPENSATION

FINAL AWARD

Employee: David Tippen Injury No. 02-137410
Dependents: N/A
Employer: Ken Barbee d/b/a KMB Construction
Additional Party: Second Injury Fund
Insurer: Truck Insurance Exchange
Appearances: Ronald Little and Sheila Blaylock, attorneys for employee.
Catherine Salmon, attorney for the employer-insurer.
Jonathan Lintner, Assistant Attorney General for the Second Injury Fund.
Hearing Date: March 11, 2011 Checked by: LCK/rf

SUMMARY OF FINDINGS

1. Are any benefits awarded herein? Yes.
2. Was the injury or occupational disease compensable under Chapter 287? Yes.
3. Was there an accident or incident of occupational disease under the Law? Yes.
4. Date of accident or onset of occupational disease? November 22, 2002.
5. State location where accident occurred or occupational disease contracted: Ripley 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 happened or occupational disease contracted: The employee fell and injured his neck and shoulders.
12. Did accident or occupational disease cause death? No.
13. Parts of body injured by accident or occupational disease: Right shoulder, left shoulder and body as a whole referable to the neck.
14. Nature and extent of any permanent disability: 25% of the right shoulder; 25% of the left shoulder; and 30% of the body as whole referable to the neck.
15. Compensation paid to date for temporary total disability: \$5,504.06.
16. Value necessary medical aid paid to date by employer-insurer: \$11,193.93.
17. Value necessary medical aid not furnished by employer-insurer: \$26,536.02.
18. Employee's average weekly wage: \$546.00
19. Weekly compensation rate: \$364.00/\$340.12
20. Method wages computation: By agreement.
21. Amount of compensation payable:
 - \$26,536.02 in previously incurred medical.
 - \$ 4,408.96 in medical mileage.
 - \$46,540.00 in temporary total disability.
 - \$ 1,204.03 in temporary total disability for underpayment.
 - \$80,268.32 in permanent partial disability.

 - Total: \$158,957.33.
22. Second Injury Fund liability: Permanent total disability.
23. Future requirements awarded: See Rulings of Law.

Said payments shall be payable as provided in the findings of fact and rulings of law, and shall be subject to modification and review as provided by law.

The Compensation awarded to the claimant shall be subject to a lien in the amount of 25% of all payments hereunder in favor of the following attorney for necessary legal services rendered to the claimant: Ronald Little & Sheila Blaylock.

FINDINGS OF FACT AND RULINGS OF LAW

On March 11, 2011, the employee, David Tippen, appeared in person and with his attorneys, Ron Little and Shelia Blaylock for a hearing for a final award. The employer-insurer was represented by its' attorney, Catherine Salmon. The Second Injury Fund was represented by Assistant Attorney General Jon Lintner. The parties agreed on certain undisputed facts and identified the issues that were in dispute. These undisputed facts and issues together with the findings of fact and rulings of law, are set forth below as follows:

UNDISPUTED FACTS

1. Ken Barbee d/b/a KMB Construction was operating under and subject to the provisions of the Workers' Compensation Act and was fully insured by Truck Insurance Exchange.
2. On November 22, 2002, David Tippen was an employee of Ken Barbee d/b/a KMB Construction and was working under the Workers' Compensation Act.
3. The employer had notice of the employee's alleged accident.
4. The employee's original claim was filed within the time allowed by law.
5. The employee's average weekly wage was \$546.00. The rate of compensation for temporary total disability and permanent total disability is \$364.00 per week. The rate of compensation for permanent partial disability is \$340.12 per week.
6. The employer-insurer paid \$11,193.93 in medical aid.
7. The employer-insurer paid \$5,504.06 in temporary disability benefits for 18 3/7 weeks from November 23, 2002 to March 31, 2003.
8. The employer-insurer paid temporary disability benefits at the rate of \$298.67 per week and not \$364.00 per week. The employer-insurer owes and shall pay to the employee \$1,204.03 in additional temporary total disability for underpayment from November 23, 2002 to March 31, 2003.
9. The date of maximum medical improvement for the employee is September 12, 2005.
10. The employer-insurer has paid all medical expenses in this matter except the following:

Dr. Davis/Advanced Healthcare	\$14,234.10
Cape Neurosurgical Associates	\$268.00
Poplar Bluff Regional Medical Center	\$7,480.25
University Hospital/University Physicians	\$44,902.17
Advanced Healthcare Pharmacy	\$688.51

The foregoing charges of \$67,573.03 have not been paid by the employer-insurer.

ISSUES

1. Accident
2. Medical Causation
3. Previously Incurred Medical Aid
4. Claim for Mileage Expenses under Section 287.140
5. Claim for Future Medical Aid

6. Additional Temporary Benefits
7. Nature & Extent of Permanent Disability.
8. Liability of the Second Injury Fund for either permanent partial disability or permanent total disability.
9. Medicaid Lien in the amount of \$17,749.70
10. Dependency under Schoemehl v. Treasurer of the State of Missouri, 217 S.W.3d 900 (Mo. 2007.)

EXHIBITS

The following exhibits were offered and admitted into evidence:

Employee's Exhibits

- A. Deposition of Dr. Cohen including his CV and report
- B. Deposition of James England including his report
- D. Medical records of Chung Medical Clinic
- E. Medical records and bills from HealthSouth Rehab
- F. Medical records and bills from Dr. Davis/Advanced Healthcare
- G. Medical records and bills from Dr. August Ritter/Orthopaedic Associates
- H. Medical records and bills from Cape Imaging
- I. Medical records and bills from Dr. Peeples
- J. Medical records and bills from University Hospital/University Physicians
- K. Medical records and bills from Poplar Bluff Regional Medical Center
- L. Medical record and bill from Cape Neurosurgical Associates
- M. Medical bills from Advanced Healthcare Pharmacy
- N. Mileage
- O. Wage Statement
- P. Attorney Contracts
- Q. Missouri Dept of Social Services lien of March 2, 2011

Employer-Insurer's Exhibits

1. Deposition of Dr. Odegard including his CV and report.
2. Deposition of Dr. Kennedy including his CV and report.

The following exhibit was offered but was not admitted into evidence:

- C. Medical records from Methodist Hospital of Memphis from 1982 to 1987. An offer of proof was made.

The Second Injury Fund did not offer any exhibits.

The parties agreed for the hearing to be in Cape Girardeau County but the venue remains in Ripley County, Missouri.

Judicial notice of the contents of the Divisions' files for the employee was taken. (The Second Injury Fund objected to any portions of the Division file that were not open, not relevant, and whose probative value was substantially outweighed by prejudice, and which the Division was not a party to. The objection included uncertified medical records based on hearsay. The ruling on this exhibit was taken under advisement. The objection to uncertified medical records is sustained. All other objections are overruled.)

WITNESS: David Tippen, the employee.

BRIEFS: The Second Injury Fund filed its' brief on April 11, 2011. The employer-insurer filed its' brief on April 14, 2011. The employee filed his brief on May 2, 2011.

FINDINGS OF FACT

The employee was born in 1944 and is 66 years old. He has been married to his wife Mary Lou Ann for 41 years. He has lived with her for all that time and has never been divorced. He has four children that are all adults. He graduated from Fisk High School, can read and write and does mathematics pretty well. He does not know how to use computers. He last worked on November 22, 2002, and was working for KMB Construction which involved performing dry wall and painting for commercial and residential construction.

The employee testified that during high school, he worked on a farm which included driving a tractor, and picking and chopping cotton. After high school, he did factory work and then worked on a riverboat for five years. Since 1971 he has hung and finished sheetrock and did painting. He has done nothing other than physical labor jobs.

The employee testified that in 1982 he had back surgery in Memphis where part of a lumbar disc was taken out. He continued to have problems and around 1986-1987 went back to the doctor and was admitted to the hospital but did not have a second surgery. He had testing including a myelogram and MRI. His low back continued to bother him and once or twice a year he missed work for a couple of weeks to a month due to his back going out and not being able to walk. All of his work has been hard physical jobs which he was able to perform.

The employee filed a claim in Injury Number 87-132765 after injuring his low back while working at B & G Lathing and Plaster. The employee was off work 26 1/7 weeks. In April of 1988, the employee settled his claim against the employer-insurer for 22% permanent partial disability to the body as a whole.

In December of 1989, the employee saw Dr. Chung for low back pain with the left leg giving way. Dr. Chung prescribed medication.

The employee testified that prior to November 22, 2002, he had arthritis in his left index finger and pain in his left hand which affected his work. He changed the way he used his other fingers but was able to work as well as before.

2002:

The employee testified that on Friday, November 22, 2002, he sustained a work accident around 9:00 a.m. He fell down steps and fell backwards onto his elbows as he was leaving a job. He started hurting in his shoulder and neck but continued working. He went to a different job site to finish dry wall. By the time he left that day, he had more pain in his neck and shoulders. Over the weekend, he had a lot of pain in his neck and shoulders. The employee did not go into work on Monday and told the employer about the accident. The employer gave him permission to go to the doctor; and he went to Dr. Chung, his family doctor.

On November 27, the employee saw Dr. Chung after a fall six days ago on Friday where he hurt his left shoulder and low back. Dr. Chung diagnosed left shoulder and low back pain. Medications were prescribed. X-rays of the lumbar spine and left shoulder were ordered. On December 10 the employee had left shoulder pain and occasional headaches. Dr. Chung diagnosed painful bilateral shoulders and referred him to an orthopedist. The employee testified that the employer-insurer sent him to Dr. Ritter.

2003:

The employee saw Dr. Ritter on January 23 for bilateral shoulder pain after sustaining a November 22, 2002 injury. The employee fell backwards onto stairs as he was going down and landed on his elbows. Since then, both shoulders have hurt and he has radiating sensations and a cold feeling in all digits of the left hand. He has not returned to work. In 1982, the employee had lumbar surgery including an apparent fusion in Memphis. Dr. Ritter diagnosed bilateral shoulder strains with radiating left arm pain; and thought it was primarily a muscular strain of the shoulders with possible cervical radiculopathy. Dr. Ritter recommended medication and physical therapy; and noted that it appeared related historically and would match nicely with his history of the injury. Dr. Ritter thought he could work at least sedentary activity with no work over the shoulder.

On January 23, Dr. Chung noted that the employee's left shoulder was painful and his left hand got numb and cold. The employee had an initial evaluation for physical therapy on January 28 for a bilateral shoulder sprain/strain. On February 14, the employee was not working secondary to restrictions for his bilateral upper extremities. The employee saw Dr. Ritter on February 18 with unchanged symptoms and radiating left arm complaints. Dr. Ritter diagnosed bilateral shoulder and radiating left arm pain which he thought was primarily due to cervical spine degenerative changes with a super imposed strain/sprain. Dr. Ritter continued light duty with no work over shoulder high and ordered an MRI.

The employee was discharged from therapy on February 27, 2003 after nine visits. The cervical MRI was done on March 5. The employee had been having worsening pain in his neck and shoulders since the November 22, 2002 fall. The employee had back surgery in November of 1982 at L2-3. The MRI findings showed multi-level degenerative discs at C3-C4, C5-C6 and C6-C7. At C3-C4, there was a broad-based low signal intensity lesion with encroachment on both neural canals with no significant cord impingement. At C4-C5, the extradural defect was

minimal. At C5-C6, there was an asymmetric broad-based extradural defect with minimal cord impingement. At C6-C7, there was a broad-based lesion with effacement of the anterior dural sac and some displacement of the cord. The impression of the radiologist was multiple extradural defects most prominent at C3-C4, C5-C6 and C6-C7.

The employee saw Dr. Ritter on March 13, 2003 with occasional headaches. The MRI showed advanced degenerative disc disease, especially C3-4, C4-5, C5-6 and C6-7. The employee had persistent pain and Dr. Ritter diagnosed degenerative disc disease and bilateral shoulder pain. Dr. Ritter performed a left shoulder injection and ordered therapy. He restricted the employee from working over shoulder high. Dr. Ritter stated there was no evidence of nerve encroachment but the significant degenerative changes would likely explain his headaches and radiating arm symptom which did not appear to be related to the work injury.

The employee had three physical therapy sessions from March 24 through March 27. On March 28, Dr. Ritter noted persistent neck pain, headaches and bilateral shoulder rotator cuff pain. Dr. Ritter recommended a neurosurgical evaluation and ordered no work over shoulder high. Dr. Ritter was to see him back if his shoulder pain persisted. Therapy was stopped.

On April 3, it was Dr. Ritter's opinion that the cervical disc disorders were not due to his work related injury and were not related to his occupation. Dr. Ritter believed that he was likely to be symptomatic with or without any work related injury, and did not believe his injury alone was any significant part of the neck and headache symptoms, but was due in part to his shoulder complaints, which may be separate from his neck.

On April 3, the employee spoke to Dr. Ritter and stated that he had worked three hours the day before painting hand rails and had worsening headaches from bending over and twisting. Dr. Ritter give restrictions of avoiding bending and twisting, and no work over shoulder height. The employee would be seen on an as needed basis.

On April 15 Dr. Ritter stated that the employee's shoulder pain was work related and at that point would require a sedentary activity level with no overhead work. The inability to look underneath hand rails while painting is related to his non-work related neck disorder.

The employee testified that after Dr. Ritter released him from treatment, he saw Dr. Kennedy with the approval of the employer-insurer. After seeing Dr. Kennedy, the employer-insurer did not offer any additional treatment.

On May 22, 2003 the employee saw Dr. Kennedy. On exam, the employee had pain in his bilateral trapezius areas; and a positive Tinel's sign bilaterally at the elbows; diffuse sensory loss in both arms and hands in no clear cut radicular distribution. The March 5, 2003 MRI showed mild degenerative changes at C3-4 and C4-5, a slightly more prominent disc prolapse at C5-6 without cord impingement and minimal neuroforaminal narrowing and similar findings at C6-7. Dr. Kennedy ordered an EMG/NCV.

The employee saw Dr. Peeples on May 22, 2003 for upper extremity EMG and nerve conduction studies. The employee had neck and bilateral shoulder pain and at times numbness in his arms which does not follow a characteristic pattern; and bilateral shoulder impingement signs with reduced range of movement. The EMG and nerve conduction study was normal with no evidence of cervical radiculopathy or neuropathy affecting his upper extremities.

On May 29 Dr. Kennedy noted that the EMG/NCV study was normal with no evidence of cervical radiculopathy. Dr. Kennedy diagnosed a cervical strain; and did not see any findings on the MRI or EMG that would contraindicate a return to normal duty. He recommended non-steroidal medication on an as needed basis.

On June 19, the employee saw Dr. Ritter. The employee has not been allowed to return to work due to his restrictions of no bending or twisting which was not work related. The employee had persistent bilateral neck, shoulder, arm and hand pain radiating on the left side into the long, ring and small fingers. Dr. Ritter thought the bilateral shoulder pain was related to the cervical spine, which is a non-work related degenerative condition. The employee was released to full activities with regard to his shoulders. Dr. Ritter ordered an FCE to determine his capacity due to cervical degenerative disc disease.

On July 7, Dr. Ritter stated that on the FCE, the employee showed consistency of effort in lifting and was able to lift up to 30-35 pounds. He had primarily anterior shoulder and neck pain and with rotation of the neck, a popping sensation that caused pain radiating through the top of his head down into his left hand with persistent numbness along the ulnar border of his left hand. Dr. Ritter diagnosed cervical spine degenerative changes with radiating pain. With regard to his shoulder, the employee can return to full activities. The lifting limitations of 35 pounds are due to radiating neck pain from the degenerative disk disease. On July 22, Dr. Ritter noted that the employee's persistent bilateral shoulder pain was due to a cervical degenerative condition which is non-work related. The employee appeared to have significant persistent limitations which were due to his pre-existing condition.

The employee saw Dr. Davis on November 21, 2003 for a general checkup. It was noted that he fell last November and hurt his neck and shoulders. On December 5 the employee saw Dr. Davis for back pain and an appointment was made with Dr. Soeter.

2004:

On January 12 Dr. Davis noted that a left shoulder x-ray showed degenerative arthritis, most significant in the acromioclavicular joint and to a lesser degree in the glenohumeral joint. Dr. Soeter performed two back injections with little results. Dr. Davis ordered an left shoulder MRI that was done on January 20 which showed no evidence of a rotator cuff tear but showed degenerative arthritis in the acromioclavicular and glenohumeral joints; and possible mild tenosynovitis of the supraspinatus tendon.

Due to neck pain, Dr. Davis ordered a cervical MRI which was done on January 27, and showed bulging discs at C5-6, C6-7, C7-T1 and T2-3; degenerative arthritis; narrowing of the

neural foramina bilaterally at C3-4, C5-6 and C6-7 and on the right at C4-5, probably due to degenerative changes; and degenerative endplate changes at C6-7. In February, Dr. Davis wanted to refer the employee to a neurosurgeon, and in March contacted Dr. Oro for an evaluation for neck pain and neuropathy.

The employee testified that he continued to get neck and shoulder treatment; and tried to work light duty but could not due to neck and shoulder pain. He sought treatment at University of Missouri hospital. He had neck surgery by Dr. Oro and shoulder surgeries by Dr. Kane which helped for about a month but went back to the way it was.

Dr. Oro, a neurosurgeon saw the employee on June 16, 2004. In November of 2002, the employee fell, landed on his elbows, and had onset of left shoulder pain which has steadily progressed. The employee had pain at the base of his neck, in the left shoulder, and down into his arm to the fingers. The employee's past surgical history included low back surgery in 1982 and left leg surgery in 1950. The employee was currently on disability from low back pain. The employee had decreased light touch sensation from C5 to C8 on the left. The range of motion in the neck was limited in flexion and extension which caused an aching discomfort. The employee has left shoulder pain with rotation, elevation and palpation. X-rays of the left shoulder showed mild degenerative changes. Dr. Oro stated that the cervical MRI showed degenerative disc disease and foraminal narrowing at C3-4, C5-6 and C6-7. Dr. Oro's impression was left shoulder injury and cervical spondylosis. Dr. Oro stated that the left shoulder should be evaluated and if it significantly improves, he would not need further cervical workup.

The employee saw Dr. Bal, an orthopedist on June 16 for left shoulder pain. He had chronic subacromial impingement and degenerative changes of the acromioclavicular joint. Dr. Bal performed a subacromial injection and referred the employee to Dr. Kane.

On June 16 the employee saw Dr. Greenberg for left shoulder pain and left hand numbness. His past surgical history has been an open reduction and internal fixation of left femur many years ago, and discectomy in the low back. Dr. Greenberg diagnosed left shoulder pain and ulnar neuropathy. The left shoulder pain was likely due to a combination of impingement with degenerative joint disease; and the left ulnar neuropathy was possibly due to cubital tunnel or cervical stenosis.

The employee saw Dr. Kane on July 27 for his left shoulder and related his shoulder pain to an injury on November 22, 2002. The employee was disabled for secondary reasons of lumbar surgery. Dr. Kane recommended a non-operative rotator cuff protocol; and to follow up after neurosurgery evaluation of the cervical spine by Dr. Oro.

On August 4 Dr. Oro noted that the primary pain was to both shoulders with deep aching neck pain. Dr. Oro diagnosed spondylosis and bilateral shoulder disease. He ordered a cervical myelogram to more clearly define the nerve root compression. The myelogram and post myelogram CT was done on August 19, 2004. At C3-4, there was moderate to severe bilateral foraminal stenosis. At C4-5, a mild disc bulge compatible with mild central canal stenosis. At C5-6, the disc height was moderately to severely shortened and a moderate disc bulge was

asymmetrically worse on the left. The cord was borderline compressed and compatible with mild to moderate central canal stenosis. At C6-7, the disc height is moderately to severely shortened; and there was a moderate disc bulge. The cord is borderline compressed compatible with mild to moderate central canal stenosis. The impression was moderate to severe cervical spondylosis that resulted in mild-moderate central canal and moderate-severe foraminal stenosis

On September 27, 2004, the employee saw Dr. Kane. The injection did not help much; and the left shoulder MRI showed signs of tears, but no gross atrophy. Dr. Kane ordered a MRI of the right shoulder and injected the shoulder. The right shoulder MRI was performed on September 28. The impression was thickening of the biceps tendon with fluids suspicious for a tenosynovitis; degenerative arthritis of the acromioclavicular and glenohumeral joints; and degenerative changes in the acromioclavicular joint causing mild impingement upon the supraspinatus muscle and tendon.

On October 7, Dr. Oro noted that the employee's neck and shoulder pain had temporary short term relief with epidural steroid injections. Dr. Oro diagnosed cervical spondylosis; and scheduled surgery due to increasing cervical radicular symptoms with diagnostic testing showing neural foraminal encroachment at several levels. On October 11, Dr. Oro performed bilateral C3-4 laminectomies and foraminotomies; a right C4-5 laminotomy and foraminotomy; a C5-6 bilateral laminotomy and foraminotomy; and a bilateral C6-7 laminotomy and foraminotomy. On December 22, the employee had the same symptoms. Dr. Oro diagnosed persistent neck and arm pain and ordered a cervical MRI.

2005:

On January 4, the employee saw Dr. Davis. The employee stated he had fallen last week, and thought he might have re-injured his neck. Dr. Davis ordered a cervical MRI which showed bulging discs at C5-6, C6-7 and C7-T1; narrowing of the neural foramen bilaterally at C3-4 and C6-7 and on the right at C4-5 and on the left at C5-6 due to degenerative changes; degenerative arthritis; degenerative endplate changes at C5-6 and C6-7; post-operative changes; and small amount of fluid in the soft tissues at C3-4 through C7-T1 probably due to the prior surgery.

On February 2, the employee saw Dr. Oro and reported no real benefits from the procedure. Dr. Oro stated that the follow-up MRI showed that overall the nerve root decompressions looked good with some lower nerve root fibrosis. Dr. Oro suggested a cervical epidural block; and recommended a night splint due to left hand numbness that may be secondary to carpal tunnel syndrome in addition to cervical spondylosis.

On March 21, Dr. Kane noted that the left shoulder was worse. Physical therapy and an injection did not help. The employee appeared to be developing atrophy at the left supraspinatus/infraspinatus area. Dr. Kane did not believe the problems were from his neck; and recommended surgery for a possible rotator cuff tear.

On April 26, 2005, Dr. Kane noted that the employee has had bilateral shoulder pain since a fall in November 2002. A left shoulder MRI apparently showed a rotator cuff tear. The

employee was retired and disabled from his back injuries. The left shoulder showed mild atrophy of the infraspinatus; with pain around the anterior shoulder and the biceps; and with overhead motion. Dr. Kane scheduled a left shoulder arthroscopy, rotator cuff repair and debridement.

On May 11, 2005 Dr. Kane performed a left shoulder diagnostic arthroscopy; a debridement, intra-articular synovitis and biceps tendon stump; and an open subacromial decompression, and exploration of the biceps tendon. The postoperative diagnosis was a rotator cuff tear; and a biceps tendon long head rupture of the left shoulder which was irreparable. On May 26, the employee saw a nurse practitioner with improved left shoulder pain. On June 21, the employee told Dr. Kane that he was quite pleased with the left shoulder. The right shoulder had discomfort and pain; with clinical signs of a rotator cuff tear and subacromial impingement. On August 2, the employee saw Dr. Smith with continued right shoulder pain with positive impingement signs with tenderness over the biceps tendon. Dr. Smith recommended surgery.

On August 5, Dr. Kane performed a diagnostic arthroscopy of the right shoulder with subacromial decompression by resection of partial-thickness of the coracoacromial ligament; and an open biceps tenodesis. The post operative diagnosis was a greater than 50% thickness injury to the biceps tendon and subacromial impingement by the coracoacromial ligament. On August 22, Dr. Smith noted that the employee had some mild pain and therapy was scheduled. The employee had eleven physical therapy visits from August 9, 2005 through September 12, 2005.

2007:

On September 4, the employee saw Dr. Davis for left shoulder pain and left arm numbness; neck pain; and headaches. Dr. Davis prescribed Naprosyn. X-rays of the neck showed moderate to severe degenerative arthritis at C3-4, C5-6 and C6-7. A left shoulder x-ray showed mild degenerative arthritis involving the acromioclavicular and glenohumeral joints. A September 5 cervical MRI showed no significant bulging or herniated disc; post-operative changes; degenerative arthritis; degenerative endplate changes at C5-6 and C6-7; degenerative disc disease from C2-3 through T2-3; and stenosis of the neural foramen bilaterally at C3-4, on the right at C4-5 and on the left at C5-6. On September 12, Dr. Davis recommended a consultation with Dr. Yingling for neck pain.

The employee saw Dr. Yingling a neurosurgeon on November 6 for left neck, shoulder and arm pain. The multi-level posterior cervical operation in 2004 helped for some time but the pain gradually returned. The employee had left-sided neck pain traveling up to the head and occasionally causing headaches as well as pain in the interscapular area and pain radiating down the arm and forearm with decreased sensation of the medial two to three digits of the left hand. On examination, there was mild give away weakness in all muscle groups in the left upper extremity due to pain. Sensation is diminished to pinprick in the medial three digits of the left hand compared to the right. There was tenderness to palpation of the left cervical and interscapular muscles and moderately diminished range of motion of his neck. A September 2007 cervical MRI showed moderately severe degenerative disc disease in the mid and lower cervical spine; and mild foraminal stenosis but nothing severe enough to cause his symptoms. Dr. Yingling stated that the employee had chronic pain in his neck and left shoulder and arm after the

fall. Dr. Yingling thought the symptoms were related to degenerative disease, muscle spasm, and scar tissue; did not recommend surgery; and prescribed therapy.

The employee saw Dr. Davis on November 19, 2007 with continued neck pain. Medications were prescribed. The employee continued to treat with Dr. Davis for neck pain the rest of 2007 and during 2008.

The employee saw Dr. Kennedy on November 25, 2008 with pain in the neck and both shoulders. The employee had trouble sleeping and his cervical range of motion was significantly reduced. Dr. Kennedy reviewed the January 4, 2005 cervical MRI which demonstrated post-operative changes at C4-5 and C5-6. Dr. Kennedy diagnosed on-going cervical spondylosis; thought the employee was at maximum medical improvement; and did not think he would be able to work at anything other than a sedentary capacity.

The employee continued to see Dr. Davis in 2009 for various matters including his neck. In October of 2009, Dr. Davis noted that the employee had quite a bit of neck pain and hand numbness; and diagnosed chronic neck pain. In February 2010, the employee saw Dr. Davis for several things including quite a bit of neck and bilateral shoulder pain left more than right. The employee had decreased shoulder motion, left greater than right. Dr. Davis prescribed Ultram.

Opinions:

On January 15, 2009, Dr. Kennedy addressed the cervical spine and not the shoulders since he did not treat or have any specific experience treating shoulders. The employee had been functioning in a satisfactory capacity as a painter and drywall installer and developed cervical pain with radicular symptoms in immediate relationship to the November 22, 2002 fall. It was Dr. Kennedy's opinion that the prevailing factor in the injury, care and treatment of the cervical spine was the November 22, 2002 work accident and injury. The employee had degenerative changes in his neck but did not need treatment until the work injury. It was his opinion that the employee's work was a substantial factor in his resultant condition and disability; and that the employee sustained a 20% permanent partial disability with respect to the cervical spine only.

On August 25, 2010 Dr. Kennedy's deposition was taken. Dr. Kennedy reviewed the March 5, 2003 cervical MRI which showed some degenerative changes at C3-4 and C4-5; a disc prolapse at C5-6 without cord impingement; some minimal foraminal narrowing at C5-6 and C6-7. Dr. Kennedy stated that a disc prolapse is some weakening and bulging of the disc with some degree of injury but not to the point where it is necessarily causing spinal cord impingement. In November of 2008 Dr. Kennedy diagnosed on-going cervical spondylosis which is degenerative wear and tear type changes. In January of 2009, Dr. Kennedy diagnosed a cervical strain and cervical spondylosis. It was Dr. Kennedy's opinion that the employee's pre-existing condition of degeneration or deterioration played a role in the employee's current condition; but the dominant factor in his current condition is the work injury. The employee ultimately required an operation and never fully recovered. It was Dr. Kennedy's opinion that the employee cannot work at anything other than in a sedentary capacity; and his work is a substantial factor in his resultant condition and disability.

The employee saw Dr. Odegard, an orthopedic surgeon, on November 17, 2009 to be evaluated his shoulders and neck. His deposition was taken on November 5, 2010. Dr. Odegard diagnosed chronic cervical arthritis status-post decompressions with persistent subjective neurologic symptoms; secondary bilateral chronic shoulder pain status post arthroscopic subacromial decompressions; and biceps tenodesis on the left and open subacromial decompression and arthroscopic debridement on the left, with persistent left greater than right shoulder pain. Dr. Odegard stated that the employee's current condition was predominately attributable to ordinary deterioration and progressive degeneration associated with his age, activity level, work experience, and life activities. Dr. Odegard stated that it was impossible to say how much of his current problems are related specifically to his job, as opposed to the normal process of aging which he encountered hanging drywall for thirty one years. It was Dr. Odegard's opinion that a lot of his problems were related to his age and to his long work history of heavy work throughout his life that has a wear and tear effect on the body. Dr. Odegard stated that the employee's activity level and life activities caused more of these problems of degeneration than the specific 2002 work injury.

It was Dr. Odegard's opinion that the injury of November 22, 2002 was not the prevailing factor causing his current medical condition. The injury sounded like a minor problem which contributed in a minor way to his current symptoms. The employee had a specific traumatic injury but subsequent evaluations did not show any condition for which the fall was the prevailing factor. When asked if the alleged work injury was a substantial factor in causing the employee's current condition, Dr. Odegard stated that he did not believe that the injury was the primary cause of his symptoms; and the employee's conditions were not clearly caused by the 2002 fall. It was Dr. Odegard's opinion that the employee had 10% permanent partial impairment to his shoulder related to the November 22, 2002 injury.

The employee continued to have pain and functional limitations in his arms but the exact cause of his problems was less clear due to neck surgery. The persistent symptoms seemed to be neurologic in nature. Dr. Odegard did not have any indication that the employee had prior complaints or treatment to his neck or shoulders. Dr. Odegard stated that degenerative disc disease can be aggravated by trauma and trauma can cause injuries to soft tissue, muscles and tendons. Dr. Odegard does not treat spines and deferred any opinions on the neck to Dr. Kennedy, a neurosurgeon. If Dr. Kennedy found that the neck and cervical problems were caused by the accident, Dr. Odegard would not have any reason to disagree with that or his opinion that the spine injury alone limited the employee to sedentary work.

The employee saw Dr. Cohen on July 24, 2006. In 1950, when he was six, the employee fell off the back of a truck which ran over his leg and fractured his femur just below the left hip. He had surgery with wires and screws; and due to that received a 4-F military classification and has pain at the surgical site. In 1982, the employee picked up a bucket of drywall mix; injured his low back; and had a partial discectomy at L6. After the surgery, he was out of work on several occasions because of his low back. He cannot lift as much as he could before. There are times when he would bend over and his back would go out and cause extreme pain which would last from three to fourteen days. He had to modify his bending, had difficulty stooping; and would frequently have to take breaks because of the back pain. He took aspirin for his back pain.

Since 1988, the employee has had left hand arthritis. He had to hold down the drywall knife to flatten out drywall with his left index finger. As the years went by, he began to have a deformity of the left index finger including aching and cramping. He eventually had to use his middle finger to do the work due to extreme pain and swelling in the index finger.

The employee had marked osseous changes in the left index finger at the DIP joint. He was tender to palpation and there was a marked loss of flexion. The employee had loss of cervical range of motion and there were several distinct trigger points noted along the right lower cervical paraspinal muscles and right upper trapezius muscle. The employee had right shoulder pain with range of motion testing and was diffusely tender to palpation. The rotator cuff muscles were weak and had a loss of range of motion. The employee had left shoulder pain with abduction and forward flexion. There was loss of motion and the impingement sign was borderline positive. The left bicep and triceps muscles were weak. He had mild discomfort with left hip flexion and extension as well as with internal and external rotation. There was a loss of hip motion. The lumbar spine revealed a well healed surgical scar. Tender segments were noted from approximately L3 down through L5.

The employee spends a significant part of the day in a recliner which does help with the neck pain. He has daily headaches where the pain starts in his neck and radiates up to the front of his head. He has to lie down when he gets the headaches. He has numbness in his left upper extremity that goes all the way down to the hand and fingers. His hands will go to sleep when he drives; has difficulty grasping objects; and frequently drops things from both hands. He can no longer hunt or fish as he cannot hold on to the rod or gun. It is difficult for him to look up or down except for an extremely brief period of time. He generally wakes up at night after approximately three hours because of pain and cannot go back to sleep and will get up around 4:00 a.m. He is constantly tired during the day.

It was Dr. Cohen's opinion that as a direct result of the November 22, 2002 work-related injury that the employee had the following diagnoses:

1. Status-post extensive cervical surgery for bilateral radicular symptoms from trauma at work due to aggravation of cervical spondylosis.
2. Status-post right shoulder surgery for right shoulder biceps tendon tear and impingement syndrome; and status-post left shoulder surgery for rotator cuff tear and biceps tendon rupture.

It was Dr. Cohen's opinion that work accident was the substantial factor in the disability and the treatment he has received was medically necessary and was reasonable. It was his opinion that the employee sustained a 45% whole person disability at the level of the cervical spine, of which 5% was pre-existing and 40% was a direct result of the primary work-related injury. It was his opinion that the employee sustained a 40% permanent partial disability of the right shoulder and a 40% permanent partial disability at the left shoulder. Due to the significant involvement of both upper extremities it was his opinion that there was an additional loading factor of 15% permanent partial disability.

It was Dr. Cohen's opinion that due to the primary work-related injury, the employee needed to be restricted from any activities in which he does any overhead motions or movements with his arms. He should not lift the arms past the shoulder level and should not do any lifting greater than five pounds with either arm. He should not do any repetitive activities with his arms including pushing or pulling with either arm in a repetitive manner. He should not keep his head and neck in any type of sustained or awkward position.

It was Dr. Cohen's opinion that the employee had pre-existing conditions or disabilities for the left femur fracture surgery; status-post lumbar surgery for a partial discectomy at L6; and arthritis of the left index finger which has affected the hand level. It was his opinion that the employee had a whole person disability of 30% at the lumbar spine, a 25% permanent partial disability at the left hip, and a 20% disability at the left hand. In regard to his pre-existing conditions or disabilities, he needs to be restricted from any activity in which he does any prolonged sitting, standing, climbing, lifting, ladder work, or walking on uneven surfaces. He should not do any repetitive work with the left hand.

It was his opinion that the pre-existing conditions or disabilities were a hindrance or obstacle to employment or re-employment. It was his opinion that the pre-existing conditions or disabilities to the lumbar spine, left hip and left finger and hand combined with the primary work-related injury to create a greater overall disability than their simple sum and that due to this combination of disabilities, the employee is permanently and totally disabled.

It was Dr. Cohen's opinion that it was reasonably probable that the employee will need to be followed by a physician for the remainder of his life to prescribe medications for the pain in his cervical spine and shoulders to help relieve the pain and to help him sleep. There is some disability from his pulmonary condition but that would only add to his permanent total disability.

Dr. Cohen's deposition was taken on November 7, 2006. It was Dr. Cohen's opinion that the employee had cervical spondylosis which is degenerative changes prior to his primary injury but was not symptomatic. It was his opinion that the November 22, 2002 accident and injury caused the necessity for the neck surgery and the reason for that opinion is the employee had no prior history of any neck problems. The injury caused the onset of neck pain. The pain in his shoulders and arms is from pulling or stretching or entrapment of the nerves. When someone has a violent or serious injury in which the neck is stressed or pulled, they don't have as much flexibility and the nerve is encroached or trapped, Swelling and inflammation of the nerve roots cause the symptoms. Due to nerve root encroachment if conservative treatment does not work, neck surgery has to be performed. The medical treatment that the employee had was reasonable and necessary; and was caused and made necessary by his injury. The injury and surgery was a substantial factor in causing the headaches. It was Dr. Cohen's opinion that the treatment including the surgeries for the shoulders was necessary and reasonable and was due to the injury.

Dr. Cohen thought there might be some overlap but he tried to divide his restrictions between the primary injuries and the pre-existing injuries. It was his opinion that the employee was permanently disabled before the lungs were involved and it was his understanding that was diagnosed in 2005. It was his opinion that the employee was permanently and totally disabled

due to the primary injury in combination with the pre-existing disability even though he worked for 32 years as a dry waller; and the only time he lost time due to his pre-existing disability was several occasions due to the low back.

The employee saw James England for a Vocational Rehabilitation Evaluation on January 2, 2007. His deposition was taken on May 9, 2007. The employee appeared rather stiff and admitted that he was having difficulty looking down while doing the testing. The employee graduated from high school; and learned drywall finishing through a two year apprenticeship. From 1971 on he has done nothing other than drywall hanging, finishing, and painting which was medium exertion but at times heavy. The employee has not operated farm equipment for a number of years. He has done some bookkeeping while operating his own business and supervised five to six workers. The employee did not appear to have any transferable skills outside of drywall work. The employee scored at a high school level on reading and at a sixth grade level on math. His academics were good enough for some alternative employment.

Dr. Ritter had recommended a 35 pound lifting limit at the time of his discharge. Dr. Cohen had restrictions which would limit the employee to less than even sedentary employment. His restrictions included not being on his feet or seated for long periods of time and included no repetitive use of the upper extremities and in the left hand in particular. The employee told Mr. England that he changes position often during the day and will spend an average of at least a third of a the day reclining to help with neck and shoulder as well as some low back pain. The employee is 62 years old and he worked as a drywall finisher and painter and has done some drywall hanging since 1971. It is much more difficult for someone without transferable skills to re-enter the work force at 62 compared to someone who is younger; and for someone who has done one kind of work for a number of years to return to the work force in an alternative capacity. Considering the employee's combination of physical problems, Mr. England did not see how the employee would be able to compete for employment successfully or to sustain it in the long run. Even sedentary employment normally involves repetitive use of the upper extremities and requires a person to be awake and alert. An employee who is not resting well at night, has to recline up to a third of the day and who has difficulty using his upper extremities effectively for more than brief amounts of time would not, in Mr. England's opinion, be a good candidate for alternative work activity. Assuming the combination of impairments, it appeared to Mr. England that the employee was totally disabled from a vocational standpoint.

Mr. England stated that if the employee had only Dr. Ritter's restriction of the 35 pound lifting limit then the employee would be a candidate for employment in the work force. He could perform jobs such as retail sales, security work, cashiering, and just about anything in the sedentary to light range as far as entry level work. Mr. England stated with the restrictions that the employee described he was functioning at less than a sedentary level. He could perform sedentary to light activities on an occasional basis but would not be able to doing something eight hours a day, five days a week over the long run. With Dr. Cohen's restrictions alone, Mr. England did not think that he would be able to find jobs for the employee.

When asked if the bulk of the reason that he is unable to work in the open labor market is due to all the restrictions on his upper extremities; Mr. England stated that the combination of

things limits what is left, especially in unskilled, entry level kind of work. Mr. England stated that even though he did not have any pre-existing medically imposed restrictions, the employee told him that his low back went out occasionally. He had difficulty with using the upper extremities in repetitive fashion; he had trouble with his hands locking up at times and had to change how he used a trowel. He had difficulties with day to day work function prior to the primary injury. During cross examination by the Second Injury Fund, Mr. England was asked with regard to his employability, whether the restrictions that Dr. Cohen gave due to the primary injury alone are enough to keep him out of work. Mr. England answered "I think that is true."

The employee testified that he had no prior neck or shoulder problems. After the accident, he had neck pain and a limited range of motion. He had more left shoulder pain than right, and is left-handed. After the injury he was very limited in his daily activities. Cloudy and damp weather; and movement causes more pain in his neck and shoulders. He can work with his hands for about 20 minutes and then his shoulders hurt worse. He cannot lift more than about 10 pounds. He is not as active and does not get out as much as he used to. He now has to mow his yard in 10-20 minute stages due to pain in his neck and shoulders. He does limited things such as taking out the trash and other minor things. Prior to the injury he fished a lot. The employee now goes fishing about once month and only for an hour or two which is not as long as he used to. He fishes for crappie using a pole and a line and does not use a rod and reel. He no longer hunts due to the injury. Prior to his accident, he had no limits in walking. Now he limits his walking to maybe a quarter of a mile due to neck and shoulder pain.

The employee testified that to help with the pain, he takes pain pills and uses a heating pad across his neck and shoulders almost every day. He is seeing Dr. Davis for pain medication for his neck and shoulders. Most of the day he rests in a recliner which helps with his neck and shoulders. When he is not in his recliner he walks and moves around. He gets up and down from the recliner, and stays in the recliner half the time. He has to sleep on his side but still has problems sleeping for more than about three to four hours due to pain. Once he awakens, he cannot go back to sleep. He has trouble staying awake during the day, and sometimes the pain pills cause drowsiness.

The employee testified that he enjoyed working and would still be working if not for the accident. He stated that he cannot work due to severe pain in his neck and shoulders. If he just had the neck and shoulder injury, he would not be able to work. For a day, he might be able to a job that required lifting or repetitive use of the upper extremities, and had the option of standing up and sitting down, but the he could not work the next day due to neck and shoulder pain.

RULINGS OF LAW:

Issue 1. Accident and Issue 2. Medical Causation

It is disputed that on or about November 22, 2002 the employee sustained an accident arising out of and in the course of his employment and that the employee's injuries are medically causally related to the alleged November 22, 2002 accident. In 2002, Section 287.020.2 RSMo defined accident as an unexpected or unforeseen identifiable event or series of events happening

suddenly and violently, with or without human fault and producing at the time objective symptoms of an injury. An injury is compensable if it is clearly work related. An injury is clearly work related if work was a substantial factor in the cause of the resulting medical condition or disability. An injury is not compensable merely because work was a triggering or precipitating factor.

Under Missouri law, the employer can be held responsible for accidents that aggravate pre-existing conditions which were asymptomatic prior to the date of the accident. See Indelicatio v. Missouri Baptist Hospital, 690 S.W.2d 183 (Mo. App. 1983). A pre-existing but non-disabling condition does not bar recovery under the Workers' Compensation Act if a work-related accident causes a pre-existing condition to escalate to the level of disability. See Weinbauer v. Gray Eagle Distributions, 661 S.W.2d 652, 654 (Mo. App. 1983) and Miller v. Wefemeyer, 890 S.W.2d 372 (Mo. App. 1994). The worsening of a pre-existing condition is a change in pathology needed to show a compensable injury. See Windsor v. Lee Johnson Const. Co., 950 S.W. 2d 504,509 (Mo. App. 1997). The aggravation of a pre-existing symptomatic condition is compensable. See Rector v. City of Springfield, 820 S.W.2d 639 (Mo. App. 1991) and Parker v. Mueller Pipeline, 807 S.W. 2d 518 (Mo. App. 1991). In Kelly v. Banta and Stude Construction Company, Inc., 1 S.W.3d 43 (Mo. App. 1999), the Court of Appeals held that the employer-insurer was liable for hip replacements based on a finding that the employee's work activity aggravated the employee's pre-existing osteoarthritis.

It is sufficient that causation be supported only by reasonable probability. See Davis v. Brezner, 380 S.W.2d 523 (Mo. App. 1964) and Downing v. Willamette Industries, Inc., 895 S.W.2d 658 (Mo. App. 1995). The Court of Appeals in Bloss v. Plastic Enterprises, 32 S.W.3d 666 (Mo. App. 2000), held that if work is a substantial factor in the cause of the injury, it can be compensable even if the injuries were triggered or precipitated by the work. The Court of Appeals in Cahall v. Cahall, 963 S.W.2d 368 (Mo. App. 1998), held that a work-related accident can be both a triggering event and a substantial factor. There is no bright line test or minimum percentage defining a substantial factor. A causative factor may be substantial even if it is not the primary or most significant factor. The Court held that one-third of a cause is sufficient to be a substantial factor.

Prior to November 22, 2002, the employee had pre-existing conditions in his cervical spine and shoulders. The employee's credible testimony was that on Friday, November 22, 2002, as he was going down steps he fell backwards onto his elbows and shoulders and started having pain in his neck and shoulders. His pain increased and by Monday he was unable to work. The history in the various medical records is consistent with and corroborates the employee's testimony concerning the accident and injury.

In his initial visit to Dr. Ritter for bilateral shoulder pain in late January of 2003, Dr. Ritter noted that his condition appeared related historically and would match nicely with his history of the injury. It was Dr. Ritter's subsequent opinion that the cervical disk disorders were not due to the work related injury. In April of 2003, Dr. Ritter stated that the employee's shoulder pain was work related but the neck disorder was non-work related. Dr. Ritter's final opinion in June and July of 2003, was that the bilateral shoulder pain was due to a cervical degenerative

condition which was not work related, and that his significant limitations were due to his pre-existing condition.

Dr. Kennedy diagnosed a cervical strain and cervical spondylosis. It was Dr. Kennedy's opinion that the employee had been functioning in a satisfactory capacity as a painter and drywall installer and developed cervical pain with radicular symptoms in immediate relationship to the November 22, 2002 fall. It was Dr. Kennedy's opinion that the prevailing factor in the injury, care and treatment of the cervical spine was the November 22, 2002 work accident and injury. The employee had degenerative changes in his neck but he did not need treatment until the work injury. It was his opinion that the employee's work was a substantial factor in his resultant condition and disability. It was Dr. Kennedy's opinion that the employee's pre-existing condition played a role in the employee's current condition; but the dominant factor is the work injury.

It was Dr. Odegard's opinion that the employee's current condition was predominately attributable to ordinary deterioration and progressive degeneration associated with his age, activity level, work experience, and life activities. Dr. Odegard stated that the employee's activity level and life activities caused more degeneration than the 2002 work injury. It was Dr. Odegard's opinion that the injury of November 22, 2002 was not the prevailing factor causing his current medical condition; and contributed in a minor way to his current symptoms. When asked if the alleged work injury was a substantial factor in causing the employee's current condition, Dr. Odegard did not believe that the injury was the primary cause of his continuing symptoms; and the employee's conditions were not clearly caused by the 2002 fall. Dr. Odegard did state that degenerative disc disease can be aggravated by trauma and trauma can cause injuries to soft tissue muscles and tendons. Dr. Odegard deferred any opinions on the neck to Dr. Kennedy or other spine surgeons.

It was Dr. Cohen's opinion that as a direct result of the November 22, 2002 work-related injury that the employee was status-post extensive cervical surgery for bilateral radicular symptoms from trauma at work due to aggravation of cervical spondylosis; status-post right shoulder surgery for right shoulder biceps tendon tear and impingement syndrome; and status-post left shoulder surgery for rotator cuff tear and biceps tendon rupture. Dr. Cohen stated that prior to the accident, the employee had cervical spondylosis which was not symptomatic. It was his opinion that the November 22, 2002 accident and injury caused the neck pain and the necessity for the neck surgery. It was Dr. Cohen's opinion that the treatment including the surgeries for both shoulders was necessary and reasonable and was the result of the injury. It was Dr. Cohen's opinion that work accident was the substantial factor in the disability and the treatment and was medically necessary and reasonable.

Based upon a review of all the evidence, I find that the opinions of Dr. Kennedy and Dr. Cohen are persuasive and are more credible than the opinions of Dr. Ritter and Dr. Odegard on the issues of accident and medical causation and whether the accident was a substantial factor in causing the injury and need for treatment.

Based on the credible testimony of the employee, the medical records and the credible and persuasive medical testimony of Dr. Kennedy and Dr. Cohen, I find the following: On November 22, 2002, the employee sustained an accident arising out of and in the course of his employment; the work accident either caused a new injury and/or aggravated a pre-existing condition to the employee's cervical spine, right shoulder, and left shoulder which caused the employee's cervical spine, right shoulder and left shoulder to become symptomatic and disabling; the accident was a substantial factor in causing the employee's cervical, right shoulder and left shoulder injuries, resulting medical conditions, and the resulting medical treatment including surgeries; the accident caused the need for the employee's medical treatment; and the employee's cervical, right shoulder and left shoulder conditions and need for medical treatment were medically causally related to the November 22, 2002 work accident.

Issue 3. Previously Incurred Medical Aid and Issue 9. Medicaid Lien in the amount of \$17,749.70

The employee is claiming previously incurred medical in the amount of \$67,583.03 from the following medical providers:

Dr. Davis/Advanced Healthcare	\$14,234.10
University Hospital/University Physicians	\$44,902.17
Poplar Bluff Regional Medical Center	\$7,480.25
Cape Neurosurgical Associates	\$268.00
Advanced Healthcare Pharmacy	\$688.51

The correct total is \$67,573.03. The employer-insurer is disputing the authorization, reasonableness, necessity and causal relationship of those medical bills.

With regard to authorization, Section 287.140 RSMo gives the employer the right to select the treating physician. The employer waives that right by failing or neglecting to provide necessary medical aid. See Herring v. Yellow Freight System, 914 S.W. 2d 816 (Mo. App. 1995) and Banks v. Springfield Park Care Center, 981 S.W.2d 161 (Mo. App. 1998). In Wiedower v. ACF Industries, 657 S.W.2d 71 (Mo. App. 1983), medical bills were awarded to the employee when the employer had notice of the injury but chose to treat the injury as non-compensable and did not offer medical services.

The employer will be liable for medical expenses incurred by the employee when the employer has unsuccessfully denied compensability of the claim. Denial of compensability is tantamount to a denial of liability for medical treatment. An Award can be entered for medical expenses of a employee through the selection of his own medical treatment. *Beatty v. Chandeysson Elec. Co.*, 190 S.W.2d 648 (Mo. App. 1945). I Mo. Workers' Compensation Law Section 7.2 (Mo. Bar 3rd ed. 2004)

The employer initially offered treatment by Dr. Chung, Dr. Kennedy and Dr. Ritter. At the end of July of 2003, Dr. Ritter opined that the employee's symptoms were due to a pre-existing condition and not work related. After that the employer-insurer did not offer any

additional treatment; and denied the compensability of the claim. The employee went to physicians on his own starting with Dr. Davis in late November of 2003. Based upon the case law and a review of the evidence, I find that the employer-insurer waived its right to select the treating physician by denying the compensability of the case and by failing or neglecting to provide necessary medical aid. The alleged defense of authorization is not valid.

Based on my ruling on accident and medical causation, I find that the medical bills are medically causally related to the accident and injury that the employee sustained on November 22, 2002. It was Dr. Cohen's credible and persuasive opinion that the medical treatment including the surgeries was reasonable and necessary; and was caused and made necessary by the injury. I find that the medical bills were reasonable and necessary.

Most of the submitted bills were paid by Missouri Medicaid. When health care providers agree to accept payment from Medicaid, they are legally prohibited from collecting the remaining balance due from the Medicaid patient. In this case, the bills confirm that the health care providers who received Medicaid payments have adjusted their bills, and the employee is no longer legally liable for the amount of those adjustments. Based on this evidence and Farmer-Cummings v. Personnel Pool of Platte County, 110 S.W.3d 818 (Mo. 2003) and Mann v. Varney Construction, 23 S.W.3d 231 (Mo. App. 2000), all of the bills must be reduced by the amount of the Medicaid adjustments.

The Missouri Department of Social Services, MO HealthNet Division filed a Medicaid lien in the amount of \$17,749.70. A Notice of Amended Lien for MO HealthNet Payment was filed along with a printout of a billing statement for payments made to Advanced Healthcare including Dr. McVey and Dr. Davis; University of Missouri Hospital/University Physicians; Poplar Bluff Regional Medical Center; D & S Drugs; and Advanced Healthcare Pharmacy. A copy of the lien was filed as Employee Exhibit Q. Exhibit Q was missing the first two pages of the billing statement; but a copy of the entire billing statement was part of the Division file.

With regard to the previously incurred medical bills of Dr. Davis/Advanced Healthcare in the claimed amount of \$14,234.10, those bills are contained in Employee Exhibit F. The employee testified that not all of the bills in that exhibit are related to the November 22, 2002 accident. The treatment from Dr. Davis for his neck and shoulders that he is requesting are for the following dates of service: November 21, 2003; December 5, 2003; January 12, 2004; January 27, 2004; February 2, 2004; September 28, 2004; October 20, 2004; January 4, 2005; January 7, 2005; May 17, 2005; June 28, 2006; September 4, 2007; September 12, 2007; November 19, 2007; December 17, 2007; and February 8, 2010. There are other bills from other providers at Advanced Health Care that are related to the November 22, 2002 accident. Based on a review of the medical bills I find that the \$14,234.10 claimed includes bills that are clearly not related. With regard to the June 28, 2006 medical bill in the amount of \$133.00, I find that the employee went to Dr. Davis mainly for conditions not related to his neck, and that the employer-insurer is not responsible for the payment of that bill. The accurate amount of related medical bills is \$13,108.10. Based on a review of the Medicaid Lien in conjunction with a review of the medical bills, I find that a substantial amount of the medical bills have been paid by Medicaid and the remaining amounts have been adjusted to a zero balance and must be reduced by the

amount of adjustments. I find that \$8,989.49 was clearly paid by Medicaid. There are several bills where it was not sufficiently clear that Medicaid paid and therefore cannot be reduced. The total amount of those bills is \$555.00, which are for dates of service of November 21, 2002; January 12, 2004; January 27, 2004; February 2, 2004; and January 4, 2005. The employer-insurer is therefore responsible for and is ordered to pay the employee \$9,544.49 for previously incurred medical bills contained in Exhibit F

With regard to the previously incurred medical bills of University Hospital/University Physicians in the claimed amount of \$44,902.17, those bills are contained in Employee Exhibit J. Based on a review of the Medicaid Lien in conjunction with a review of the medical bills, I find that a portion of all of the medical bills have been paid by Medicaid. I find that Medicaid paid \$15,799.08, the employee paid \$12.00 and the remaining amount was adjusted to a zero balance. The employer-insurer is therefore responsible for and is ordered to pay to the employee \$15,811.08 for the previously incurred medical bills contained in Exhibit J.

With regard to the previously incurred medical bills from Poplar Bluff Regional Medical Center in the claimed amount of \$7,480.25, those bills are contained in Exhibit K. The bills are for physical therapy in the months of May, June, July, August and September of 2005. I find that the medical bills for the months of May, June, and July of 2005 are not recoverable by the employee because the corresponding medical records are not in evidence. See Martin v. Mid-America Farm Lines, Inc. 769 S.W. 2d 105 (Mo. Banc 1989). The medical bills for August were \$841.75 and for September were \$264.00. I find that Medicaid paid \$55.74 for the August bills and the remaining amount was adjusted to a zero balance. With regard to the September bill, there is no record that Medicaid paid any part of the bill. \$78.15 was paid by someone and the rest was adjusted. I find that there is not sufficient evidence that Medicaid paid the bill. I therefore find that the employer-insurer is liable for all of the \$264.00 bill for September. The employer-insurer is therefore responsible and is ordered to pay the employee \$319.74 for the medical bills contained in Exhibit K.

With regard to the previously incurred medical bill from Cape Neurosurgical Associates in the amount of \$268.00, that bill is contained in Exhibit L. I find that Medicare paid \$132.05 and the employee paid \$33.00. The remaining balance was adjusted and written off. The employer-insurer is therefore responsible for and is ordered to pay to the employee \$165.05 for the previously incurred medical bill contained in Exhibit L.

With regard to Advanced Healthcare Pharmacy bills, those are contained in Employee Exhibit M. The amount of the bills contained in the exhibit is substantial. The employee is claiming \$688.51 for prescription medication of Naproxen, Neurontin, Ultracet, Tramadol, Propoxyphene, and Endocet for neck and shoulder pain. Based on a review of the medical bills, I find that the total amount for the claimed medications is \$698.66. Based on a review of the Medicaid lien, I find Medicaid paid \$81.71 for 5 prescriptions for dates of service of January 12, 2004; February 16, 2004; October 14, 2004; and May 12, 2005; and there was a total adjustment of \$3.00. Based on a review of the bills, it was not clear whether Medicaid paid the remaining bills, and I find that the employer-insurer is responsible for these medical bills. The employer-

insurer is therefore responsible for and is ordered to pay the employee \$695.66 for the medical bills contained in Exhibit M.

I find that the employer-insurer is responsible for and is directed to pay the employee the sum of \$26,536.02 for the following previously incurred medical bills:

Employee Exhibit F-Dr. Davis/Advanced Healthcare	\$9,544.49
Employee Exhibit J-University Hospital/University Physician	\$15,811.08
Employee Exhibit K-Poplar Bluff Regional Med. Ctr.	\$319.74
Employee Exhibit L-Cape Neurosurgical Assoc.	\$165.05
Employee Exhibit N-Advanced Healthcare Pharmacy	\$695.66

Section 287.266 RSMo provides that the State shall have a lien for the payment of medical benefits, if those payments were made for a compensable injury. The administrative law judge shall apportion the debt due the state between the employee and the employer-insurer when an agreement cannot be reached regarding their respective liability.

Based on a review of the Medicaid Lien filed, I find that all payments made by the Department of Social Services are recoverable except for the \$346.62 in bills paid to Poplar Bluff Regional Medical Center for physical therapy in May, June and July of 2005. Since there was no corresponding medical records for the medical bills that were paid for those dates of service, I find there was no sufficient medical evidence to show that it was medically causally related to the compensable work related accident. I find that portion of the lien is not recoverable. The total amount of the recoverable lien is \$17,403.08. I find that the compensation awarded to the employee is subject to a lien in favor of the Department of Social Services, MO HealthNet Division for \$17,403.08. As set forth in Section 287.266.7 RSMo, this debt due the state shall be subordinate only to the fee right of the injured employee's attorney pursuant to this chapter.

Issue 4. Claim for Mileage Reimbursement.

The employee is claiming mileage under Section 287.140 RSMo. in the amount of \$4,065.03 as set forth as Exhibit N after a credit for mileage paid by the employer-insurer of \$740.92. The employee testified that he drove for medical treatment in Cape Girardeau, St. Louis, Columbia, and Dexter. Under Section 287.140 RSMO, the employer-insurer is responsible for all necessary and reasonable mileage for medical treatment outside the local area.

Based on a review of the medical records and Exhibit N, I find that three of the claimed mileage trips are not recoverable. The May 13, 2003 record from Health South in Dexter, was a discharge but there was no actual visit. The October 14, 2004 record from University of Missouri Hospital in Columbia was the date the employee was discharged after being in the hospital since the October 11, 2004 surgery. The May 12, 2005 record from University of Missouri Hospital in Columbia was the date the employee was discharged after being in the hospital since the May 11, 2005 surgery.

Based on a review of the medical records and Exhibit N, I find that the employer-insurer is responsible and liable for the following mileage:

1. 2,090 miles from January 21, 2003 through June 19, 2003 at the rate of .335 cents per mile for a total of \$700.15.
2. 800 miles from July 7, 2003 through June 16, 2004 at the rate of .33 cents per mile for a total of \$264.00.
3. 7,228 miles from July 28, 2004 through June 21, 2005 at the rate of .345 cents per mile for a total of \$2,493.66.
4. 1,668 miles from August 2, 2005 through August 22, 2005 at the rate of .375 cents per mile for a total of \$625.50.
5. 334 miles on November 25, 2008 at the rate of .475 cents per mile for a total of \$158.65.
6. 334 miles on November 19, 2009 at the rate of .50 cents per mile for a total of \$167.00

The employer-insurer is therefore ordered to pay the employee a total of \$4,408.96 for the 12,454 medical miles incurred. The employer-insurer is entitled to credit for any amount previously paid for these medical miles.

Issue 5. Claim for additional or future medical aid.

The employee is claiming additional or future medical aid. Under Section 287.140 RSMo the employee is entitled to receive all medical treatment that is reasonably required to cure and relieve him from the effects of the injury. In Landers v. Chrysler Corporation, 963 S.W.2d 275 (Mo. App. 1997), the Court held that it is sufficient to award medical benefits if the employee shows by “reasonable probability” that he is in need of additional medical treatment by reason of his work related accident.

The employee’s credible testimony was that taking pain medication helps with his pain in the neck and shoulders; and he has been seeing Dr. Davis for pain medication. Dr. Davis’ medical records show that he has been treating the employee with pain medications up through 2010 for neck and shoulder pain. It was Dr. Cohen’s opinion that it was reasonably probable that the employee will need to be followed by a physician for the remainder of his life to prescribe medications for his cervical spine and shoulders to help relieve the pain and to help him sleep. I find that the opinion of Dr. Cohen is credible and persuasive with regard to the issue of additional medical treatment.

I find that the employee is in need of additional medical treatment to cure and relieve him from the effects of his November 22, 2002 work related injury. The employer-insurer is therefore ordered to provide the employee with all of the medical care that is reasonable and necessary to cure and relieve the employee from the effects of his work related injury pursuant to Section 287.140 RSMo including but not limited to the treatment and medications recommended by Dr. Cohen.

Issue 6. Additional Temporary Total Disability

The employee is claiming an additional \$46,540.00 in temporary total disability benefits from April 1, 2003 through September 12, 2005 which is an additional 127 6/7 weeks of compensation. Temporary total disability benefits are intended to cover healing periods and are payable until the employee is able to return to work or until the employee has reached the point where further progress is not expected. See Brookman v Henry Transportation, 924 S.W.2d 286 (Mo.App.1996).

The employer-insurer last paid temporary total disability on March 31, 2003. Starting on April 1, 2003 the employee continued to receive treatment from multiple physicians that included diagnostic testing for his cervical spine and shoulders; injections; cervical surgery in October of 2004; left shoulder surgery in May of 2005; and right shoulder surgery on August 5, 2005; and therapy that ended on September 12, 2005. The parties stipulated that the employee had reached maximum medical improvement on September 12, 2005.

Based on a review of the evidence, I find that from April 1, 2003 through September 12, 2005, the employee was in his healing period and had not reached the point where further progress was not expected, and was entitled to temporary total disability. I find that the employee reached the point where further progress was not expected on September 12, 2005. The employer-insurer is ordered to pay the employee \$46,540.00 which represents 127 6/7 weeks of temporary total disability at the rate of \$364.00 per week.

Issue 7. Nature and extent of permanent disability and Issue 8. Liability of the Second Injury Fund for either permanent partial disability or permanent total disability.

This is an alleged permanent total disability case. In their briefs, it is the employee and the Second Injury Fund's position that the employee was permanently and totally disabled due to the November 22, 2002 accident in and of itself. It is the employer-insurer's position that if the employee is permanently and totally disabled it is from a combination of the November 22, 2002 accident and the conditions that pre-existed the 2004 accident.

The term "total disability" in Section 287.020.7 RSMo, means inability to return to any employment and not merely inability to return to the employment in which the employee was engaged at the time of the accident. The phrase "inability to return to any employment" has been interpreted as the inability of the employee to perform the usual duties of the employment under consideration in the manner that such duties are customarily performed by the average person engaged in such employment. See Kowalski v. M-G Metals and Sales, Inc., 631 S.W.2d 919, 922 (Mo. App. 1992). The test for permanent total disability is whether, given the employee's situation and condition, he or she is competent to compete in the open labor market. See Reiner v. Treasurer of the State of Missouri, 837 S.W.2d 363, 367 (Mo. App. 1992). Total disability means the "inability to return to any reasonable or normal employment." An injured employee is not required, however, to be completely inactive or inert in order to be totally disabled. See Brown v. Treasurer of State of Missouri, 795 S.W.2d 479, 483 (Mo. App. 1990).

The question is whether any employer in the usual course of business would reasonably be expected to employ the employee in that person's present physical condition, reasonably expecting the employee to perform the work for which he or she entered. See Reiner at 367, Thornton v. Haas Bakery, 858 S.W.2d 831, 834 (Mo. App. 1993), and Garcia v. St. Louis County, 916 S.W.2d 263 (Mo. App. 1995).

The first question that must be addressed is whether the employee is permanently and totally disabled.

I find that the employee was a very credible and persuasive witness on the issue of permanent total disability. The employee offered detailed testimony concerning the impact his condition has had on his daily ability to function in the work place or at home. His testimony supports a conclusion that the employee will not be able to compete in the open labor market.

The employee was observed during the hearing. After about 30 minutes the employee moved around in his chair frequently for the remainder of the hearing which supports a finding that the employee was suffering from pain and discomfort. The observations and opinions of Mr. England confirm my observations. Mr. England stated that during his evaluation, the employee appeared rather stiff and was having difficulty looking down during testing. The testimony and observed behavior of the employee were important on the issue of permanent total disability.

There is both medical and vocational evidence that addresses whether the employee is permanently and totally disabled.

Dr. Ritter restricted the employee to lifting limitations of 35 pounds and stated that the employee appeared to have significant persistent limitations. It was Dr. Kennedy's opinion that the employee cannot work at anything other than in a sedentary capacity.

It was Dr. Cohen's opinion that the employee needed to be restricted from any activities in which he does any overhead motions or movements with his arms; he should not lift the arms past the shoulder level and should not do any lifting greater than 5 pounds with either arm; should not do any repetitive activities with his arms including pushing or pulling in a repetitive manner; should not keep his head and neck in any type of sustained or awkward position; should not do any repetitive work with the left hand; and needs to be restricted from any activity in which he does any prolonged sitting, standing, climbing, lifting, ladder work, or walking on uneven surfaces. It was Dr. Cohen's opinion that the employee was permanently and totally disabled.

Mr. England stated that Dr. Cohen's restrictions would limit the employee to less than even sedentary employment. The employee is 62 years old and does not have transferable skills to reenter the work force. Mr. England did not see how the employee would be able to compete for employment successfully or to sustain it in the long run. It was Mr. England's opinion that the employee was totally disabled from a vocational standpoint.

Based on a review of all the evidence, I find that the opinions of Dr. Cohen and Mr. England are more credible and persuasive than Dr. Ritter and Dr. Kennedy on whether the employee is permanently and totally disabled.

Based on the credible testimony of the employee and the supporting medical and vocational rehabilitation evidence, I find that no employer in the usual course of business would reasonably be expected to employ the employee in his present condition and reasonably expect the employee to perform the work for which he is hired. I find that the employee is unable to compete in the open labor market and is permanently and totally disabled.

Given the finding that the employee is permanently and totally disabled, it must be determined whether the November 22, 2002 accident alone and of itself or that accident in combination with the pre-existing conditions resulted in permanent total disability.

As a result of the neck condition, Dr. Ritter put lifting restrictions of 35 pounds due to the neck condition. With regard to his shoulders, he was released to full activities. This was prior to the neck and shoulder surgeries.

It was Dr. Kennedy's opinion that the employee sustained a 20% permanent partial disability with respect to the cervical spine only; and that the pre-existing condition of degeneration or deterioration played a role in his current condition. It was Dr. Odegard's opinion that due to the November 22, 2002 accident alone that the employee had 10% permanent partial impairment of the shoulders.

It was Dr. Cohen's opinion that the employee had a 40% whole person disability at the level of the cervical spine of which 5% was pre-existing and 40% was a direct result of the November 22, 2002 injury. It was his opinion that as a result of the November 22, 2002 accident that the employee sustained a 40% permanent partial disability of the right shoulder and a 40% permanent partial disability of the left shoulder. Dr. Cohen gave restrictions for both the primary work-related injury and the pre-existing conditions or disabilities; and stated that there was some overlap in the restrictions. It was his opinion that the employee was permanently and totally disabled due to the primary injury in combination with the pre-existing disabilities.

Dr. Oro and Dr. Kane noted when they saw the employee in June and July of 2004 that the employee was currently disabled for secondary reasons of lumbar surgery and low back pain.

Mr. England stated that the employee told him that he changed positions often during the day and will spend an average of at least a third of a the day reclining due to neck, shoulder and low back pain. Mr. England noted that the employee had pre-existing low back problem and had difficulty with using the upper extremities in repetitive fashion; he had trouble with his hands locking up at times and had to change how he used a trowel. He had difficulties with day to day work functions prior to the primary injury. Mr. England stated that considering the employee's combination of physical problems, he did not see how the employee would be able to compete successfully for or sustain employment in the long run. It was his opinion assuming the combination of impairments that it appeared that the employee was totally disabled from a

vocational standpoint. During cross examination by the Second Injury Fund, Mr. England was asked whether the restrictions that Dr. Cohen gave due to the primary injury alone are enough to keep him out of work. Mr. England answered "I think that is true."

The lion's share of Mr. England's opinion was that it was not the primary injury that caused the employee's permanent and total disability but was due to a combination of the primary injuries and the pre-existing conditions and disabilities. I find that the report and the testimony of Mr. England to be credible and persuasive with the exception of the answer to the Second Injury Fund's cross examination question of whether the Dr. Cohen's restrictions due to the primary injury alone are enough to keep him out of work.

The employee testified that he cannot work due to severe constant pain in his neck and shoulders; and if he just had the neck and shoulder injury, he would not be able to work. Based on a review of all the evidence including the overwhelming medical and vocational evidence, I find that the testimony of the employee as to the basis of his permanent and total disability is neither credible nor persuasive.

I find that the opinions of Dr. Ritter, Dr. Kennedy, Dr. Odegard, Dr. Cohen and Mr. England that the November 22, 2002 accident alone did not cause the employee to be permanently and totally disabled are credible and persuasive.

The overwhelming, persuasive and credible evidence was that the employee was permanently and totally disabled from a combination of injuries and conditions including the November 22, 2002 accident. There is no persuasive or credible evidence that the primary November 22, 2002 injury alone caused the employee to be permanently and totally disabled.

I find that as a result of the November 22, 2002 accident and injury alone that the employee sustained permanent partial disability. Based upon the evidence, I find that as a direct result of the November 22, 2002 accident and injury alone, the employee sustained a permanent partial disability of 30% of the body as a whole referable to the neck, a permanent partial disability of 25% to the right shoulder and a permanent partial disability of 25% to the left shoulder. I find that the employee's November 22, 2002 injury alone did not cause the employee to be permanently and totally disabled. The employer-insurer is therefore ordered to pay to the employee 236 weeks of compensation at the rate of \$340.12 per week for a total award of permanent partial disability of \$80,268.32.

The next issue to be addressed is whether the employee's pre-existing conditions were a hindrance or obstacle to his employment or re-employment.

As a result of his 1950 left lower extremity injury, the employee had an open reduction and internal fixation of his left femur just below the hip. He received a 4-F military classification due to the injury. He continued to have pain; and on exam had mild discomfort with left hip flexion and extension as well as with internal and external rotation; with a loss of hip motion.

As a result of a 1982 low back injury, the employee had a lumbar discectomy, and after that continued to have problems. In 1987, the employee sustained a second low back injury that was work related. The employee was admitted to the hospital and had diagnostic testing including a myelogram and MRI but did not have a second surgery. He was off work for 26 weeks. In 1988, he settled his claim against the employer-insurer for 22% permanent partial disability to the body as a whole. His low back continued to bother him and he sought treatment for his left leg going out. He could not lift as much, had to modify his bending; had difficulty stooping; and would frequently have to take breaks due to back pain. He took over the counter medications for his back pain. Once or twice a year he would bend over and his back would go out and he could not walk. He would have extreme pain which lasted for up to 2 weeks; and missed work for a couple of weeks to a month.

As a result of the arthritis that developed in 1988 to his left index finger, his work was affected. He used his index finger in the drywall process; and he began to have aching, cramping, extreme pain and swelling. He started using his middle finger to do the work but could not work as well. On exam, the employee had marked osseous changes in the left index finger at the DIP joint; with tenderness and marked loss of flexion.

Mr. England stated that prior to the primary injury the employee had difficulty using his upper extremities in repetitive fashion; had trouble with his hands locking up at times; had to change how he used a trowel; and had difficulties with day to day work functions. It was Dr. Cohen's credible opinion that the pre-existing conditions or disabilities were a hindrance or obstacle to employment or reemployment. Based on a review of the evidence, I find that the employee's pre-existing conditions to his low back, left lower extremity; and left upper extremity constituted a hindrance or obstacle to his employment or to obtaining re-employment.

It was Dr. Cohen's credible opinion that the pre-existing conditions or disabilities to the lumbar spine, left hip and left finger and hand combined with the primary work-related injury to create a greater overall disability than their simple sum. It was his credible opinion that due to the combination of disabilities, the employee is permanently and totally disabled.

Mr. England stated that the reason that the employee reclined a lot during the day was due to the neck, shoulder and low back pain. It was Mr. England's credible opinion that considering the employee's combination of physical problems, he did not see how the employee would be able to compete successfully for or sustain employment in the long run; and that due to the combination of impairments the employee was totally disabled from a vocational standpoint.

I find that the employee's pre-existing injuries and conditions to his low back and body as a whole; left lower extremity; and left index finger and hand combined synergistically with the primary injury to the neck and body as a whole; left shoulder; and right shoulder to cause the employee's overall condition and symptoms. Based on the evidence, I find that the employee is permanently and totally disabled as a result of the combination of his pre-existing injuries/conditions and the conditions caused by the November 22, 2002 accident and injury.

The parties stipulated and agreed that the date of maximum medical improvement for the employee was September 12, 2005. I find that the employee was in his healing period and had not reached the point where further progress was not expected until September 12, 2005. I find that for the purpose of determining liability of the Second Injury Fund, the 30% permanent partial disability of the body as a whole referable to the neck, the 25% permanent partial disability of the right shoulder and the 25% permanent partial disability of the left shoulder would have been payable in 236 weekly installments commencing on September 13, 2005, the end of the healing period; and continuing through March 23, 2010. Since the compensation rate for permanent partial disability is less than the rate for permanent total disability; the Second Injury Fund is liable for the difference between what the employee is receiving for permanent partial disability and what he is entitled to receive for permanent total disability under Section 287.220.1 RSMo. The difference between the permanent total disability rate of \$364.00 per week and the permanent partial disability rate of \$340.12 per week is \$23.88 per week. The Second Injury Fund is therefore ordered to pay to the employee the sum of \$23.88 per week for 236 weeks commencing on September 13, 2005 and ending on March 23, 2010. Commencing on March 24, 2010 the Second Injury Fund is responsible for paying the full permanent total disability benefit to the employee at the rate of \$364.00 per week.

These payments for permanent total disability shall continue for the remainder of the employee's lifetime or until suspended if the employee is restored to his regular work or its equivalent as provided in Section 287.200 RSMO.

Issue 10. Dependency under Schoemehl v. Treasurer of the State of Missouri, 217 S.W.3d 900 (Mo. 2007)

The employee is requesting a determination of dependency and a contingent award of benefits for any dependent(s) against either the employer-insurer or the Second Injury Fund.

The employee filed his original claim on February 3, 2003 alleging that he was permanently and totally disabled. An amended claim was filed on February 4, 2011. In the amended claim, Mary Tippen was added as a claimant and as a dependent of the employee. In the additional statements section, it alleged that Mary Tippen is now and was at the time of the November 22, 2002 work injury a total dependent of the employee; and was potentially entitled to benefits and have her dependency status determined and confirmed. The Second Injury Fund and the employer-insurer raised the statute of limitations as an affirmative defense on the filing of the amended claim only to the issue of dependency and potential benefits under Schoemehl. The Second Injury Fund and employer-insurer are not raising the defense of the statute of limitations for the original claim for compensation.

The Court of Appeals in Tilley v. USF Holland, Inc. 325 S.W. 3d 487, (Mo. App. 2010), held that recovery under Schoemehl is limited to claims for permanent total disability benefits that were pending between January 9, 2007 and June 26, 2008. The original claim for permanent total disability was filed on February 3, 2003 and was pending between January 9, 2007 and June 26, 2008. The amended claim joined the employee's spouse as an additional party to the workers' compensation claim. I find that the amended claim was not a new claim for compensation and related back to the original claim and the amended claim was filed within the

statute of limitations. The claim for permanent total disability was therefore pending within the time recognized for Schoemehl to be applicable.

Under Section 287.240 RSMo, a dependent is defined as a relative by blood or marriage of a deceased employee, who is actually dependent for support, in whole or in part, upon his wages at the time of the injury. Under Section 287.240 RSMo, a wife upon a husband with whom she lives or who is legally liable for her support is conclusively presumed to be totally dependent for support. I find that Mary Tippen, the wife of the employee, was a conclusively presumed total dependent at the time of the employee's accident and injury and has remained in the same capacity since then.

Although the employee is not deceased, I find that Mary Tippen would be entitled to the employee's permanent total disability payments in the event that Mary Tippen survives the employee.

Underpayment of Temporary Total Disability:

The parties stipulated that the employer-insurer owes and shall pay to the employee \$1,204.03 in additional temporary total disability for underpayment from November 23, 2002 to March 31, 2003. Based on the stipulation, the employer-insurer is ordered to pay the employee \$1,204.03 for underpayment of temporary total disability.

Since the employee has been awarded permanent total disability benefits, Section 287.200.2 RSMo mandates that the Division "shall keep the file open in the case during the lifetime of any injured employee who has received an award of permanent total disability". Based on this section and the provisions of 287.140 RSMo., the Division and Commission should maintain an open file in the employee's case for purposes of resolving medical treatment issues and reviewing the status of the employee's permanent disability pursuant to Sections 287.140 and 287.200 RSMo.

ATTORNEY'S FEE: Ron Little and Shelia Blaylock, attorneys at law, are allowed a fee of 25% of all sums awarded under the provisions of this award for necessary legal services rendered to the employee. The amount of this attorney's fee shall constitute a lien on the compensation awarded herein.

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

Made by:

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