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

Injury No.: 07-130828

Employee: Lamont Cooper

Employer: Mid-Missouri Mental Health Center

Insurer: Self-Insured

Additional Party: Treasurer of Missouri as Custodian of Second Injury Fund

This workers' compensation case is submitted to the Labor and Industrial Relations Commission (Commission) for review as provided by § 287.480 RSMo. We have reviewed the evidence, read the parties' briefs, and considered the whole record. Pursuant to § 286.090 RSMo, we modify the award and decision of the administrative law judge. We adopt the findings, conclusions, decision, and award of the administrative law judge to the extent that they are not inconsistent with the findings, conclusions, decision, and modifications set forth below.

Preliminaries

The parties asked the administrative law judge to determine the following issues: (1) whether employee sustained an accident or occupational disease arising out of and in the course of his employment; (2) if so, whether the work-related accident or occupational disease is the prevailing factor in the cause of any or all of the injuries and/or conditions alleged in the evidence; (3) whether employer is liable for permanent partial or permanent total disability; (4) whether employer is liable for temporary total disability benefits; (5) employer's liability, if any, for past medical expenses; (6) employer's liability, if any, for future medical expenses; (7) the liability of the Second Injury Fund, if any; (8) whether a 15% penalty shall be applied to claimant's benefits for employer's alleged violation of § 287.120.4 RSMo; (9) whether costs and attorney's fees shall be ordered under § 287.560 RSMo relative to employer's defense of these proceedings; and (10) potential dependency issues.

The administrative law judge determined as follows: (1) employee sustained an occupational disease (hypersensitivity pneumonitis) arising out of and in the course of his employment on or about July 8, 2007; (2) the prevailing factor in the cause of the occupational disease was the exposure to dust in the work environment beginning on or about July 8, 2007 and continuing through early September 2007; (3) employee is permanently and totally disabled as a result of the occupational disease; (4) employee is not entitled to temporary total disability benefits; (5) employer is ordered to reimburse employee the amount of $232,627.63 for reasonable medical charges for necessary medical treatment; (6) employer is responsible for future medical treatment to cure and relieve employee from the effects of his occupational disease; (7) there is no liability on behalf of the Second Injury Fund; (8) employee's weekly compensation rate ($254.31) and all benefits to which the employee is entitled are to be increased by 15% under

§ 287.120; (9) employer has not defended these proceedings without reasonable ground in violation of § 287.560 RSMo.

In evaluating the reasonable medical charges for reimbursement, the administrative law judge (ALJ) identified those conditions which resulted from the treatment of hypersensitivity pneumonitis. Certain medical bills were disallowed for reimbursement. Specifically, treatment for lung/breathing problems, diabetic retinopathy, fatigue, diabetes and avascular necrosis of the left hip were found compensable on the basis that large doses of prednisone on a consistent basis is a recommended treatment for hypersensitivity pneumonitis. A known side effect of that treatment are the conditions cited by the ALJ. On that basis, the ALJ found the occupational disease to be the prevailing factor causing these conditions.

The ALJ also addressed potential dependency issues as follows: Angelique Smith and the employee were married in August 1997; were married at the time of the onset of the disease on July 8, 2007; and continued to be married up to and including the time of final hearing.

Employer filed a timely application for review with the Commission alleging the administrative law judge erred as follows:

(1) in concluding that employee met his burden of proof that he sustained an occupational disease;
(2) that the alleged exposure caused hypersensitivity pneumonitis and employee's problems with lungs, breathing and fatigue;
(3) that the employee's use of prednisone was caused by the alleged occupational disease and was the prevailing factor causing employee's diabetes, diabetic retinopathy and avascular necrosis of the left hip;
(4) in awarding past medical bills;
(5) in finding that employee was permanently and totally disabled as a result of his last injury alone;
(6) in finding that employer violated §§ 292.300 and 292.320 RSMo[1] and thereby awarding a 15% enhancement of all benefits awarded.

The Second Injury Fund filed a brief objecting to Second Injury Fund liability. Employee filed a brief urging the ALJ's Award be upheld.

Oral argument was heard before the Commission on January 24, 2018, with counsel for employer, employee and the Second Injury Fund participating.

For the reasons stated below, we modify the award and decision of the administrative law judge only with regard to the 15% enhancement of all benefits awarded under the provisions of §§ 287.120.4, 292.300 and 292.320 RSMo.

[1] The ALJ specifically found § 292.310 RSMo was not applicable because there was no evidence that any of the specifically named substances of that section were present. (See Award, page 26, footnote 11)

Discussion

Applicability of §§ 287.120.4, 292.300 and 292.320 RSMo

At issue is whether the provisions of §§ 287.120.4, 292.300 and 292.320 apply to the employer's conduct.

> § 287.120.4 RSMo:
> **Liability of Employer Set Out – Compensation Increased or Reduced**
>
> Where the injury is caused by the failure of the employer to comply with any statute in this state or any lawful order of the division or the commission, the compensation and death benefit provided for under this chapter shall be increased fifteen percent.
>
> §292.300 RSMo:
> **Employer to provide protection to employees from diseases.**
>
> That every employer of labor in this state engaged in carrying on any work, trade or process which may produce any illness or disease peculiar to the work or process carried on, or which subjects the employee to the danger of illness or disease incident to such work, trade or process, to which employees are exposed, shall for the protection of all employees engaged in such work, trade or process, adopt and provide approved and effective devices, means or methods for the prevention of such industrial or occupational diseases as are incident to such work, trade or process. (Emphasis ours.)
>
> §292.320 RSMo:
> **Employees to be furnished with clothing – respirators to be used while at work.**
>
> Every employer in this state to which sections 292.300 to 292.440 apply shall provide for and place at the disposal of the employees so engaged, and shall maintain in good condition without cost to the employees, working clothes to be kept and used exclusively by such employees while at work and all employees therein shall be required at all times while they are at work to use and wear such clothing; and in all processes of manufacture or labor referred to in this section which are productive of noxious or poisonous dusts, adequate and approved respirators shall be furnished and maintained by the employer in good condition and without cost to the employees, and such employees shall use such respirators at all times while engaged in any work productive of noxious or poisonous dusts.

The Administrative Law Judge noted that with regard to employer's failure to comply with § 292.300 and/or § 292.320, there was no expert testimony on the causation issue.[2] (Award, page 26), and then continued:

> Nevertheless, § 292.320 requires Employer to provide effective devices, means or methods for the prevention of such industrial or occupational diseases. If Employer would have provided effective devices, means or methods (as required by the statute) then the occupational disease, by definition, would have been prevented. The wording of the statute itself appears to satisfy the causation requirement of § 287.120.4. (Emphasis in original)

We find that claimant's hypersensitivity pneumonitis was caused by conditions in the employer's workplace and exposure occurred relative to employee's work duties. However, there is an absence of evidence demonstrating the existence of approved and effective devices, means or methods for the prevention of employee's injury; nor is there evidence demonstrating employer's failure to provide such caused employee's injury. Therefore, we are not prepared to conclude if employer had provided a device, means or methods (as required by the statute), then the occupational disease could have been prevented.[3] A cause of hypersensitivity pneumonitis is exposure to organic dusts.[4] Employee has not proven that an approved and effective device, means or method existed for the prevention of such occupational disease. Furthermore, the evidence is insufficient to establish that employee's hypersensitivity pneumonitis is "*incident to* [*the*] *work, trade or process,"* routinely engaged in by this employer, a mental health center.

In sum, we conclude that employee's injuries were not caused by employer's failure to comply with §§ 293.300-320. Accordingly, we decline to apply § 287.120.4 to increase the compensation awarded herein.

Conclusion

We modify the award of the administrative law judge. The compensation awarded hereto is not subject to increase by 15% under § 287.120.4 RSMo.

Employee is entitled to, and employer is hereby ordered to pay, past medical expenses in the amount of $232,627.63.

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[2] Obviously, the ALJ found earlier in his Award that Dr. Parmet credibly testified as to a link between the exposure in employee's "workplace to large amounts of biological dust and particles" as a causal agent for the hypersensitivity pneumonitis. (Award, page 17) The ALJ's meaning behind the statement on page 26 of the Award which might seem to contradict the earlier conclusion on page 17, was clearly directed to the proof of causation necessary to apply the safety penalty under § 287.120.4 RSMo. Considering the language of §§ 287.120.4 and 292.300-320 together, the issue appears to us to be whether a protective measure could have prevented the causal agent from affecting the employee's health.

[3] Employer's witness, Dennis Elmore, a Certified Industrial Hygienist, testified regarding safeguards against asbestos exposure and that asbestos exposure is not a known cause of hypersensitivity pneumonitis (H. P.), although he conceded there may be other causes for H. P. than microbes. (Tr. page 224) Employee did not provide any expert testimony on the effective means of prevention of hypersensitivity pneumonitis.

[4] Employer's own expert, Dennis Elmore, testified that hypersensitivity pneumonitis is typically caused by an organic dust and asbestos isn't an organic dust. (Tr. page 213, 224)

Employee is entitled to, and employer is hereby ordered to pay permanent total disability benefits at the weekly compensation rate $254.31 since January 11, 2008.

The award and decision of Chief Administrative Law Judge Robert Dierkes, issued June 5, 2017, is attached hereto and incorporated herein to the extent not inconsistent with this decision and award.

The Commission approves and affirms the administrative law judge's allowance of an 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 23rd day of February 2018.

LABOR AND INDUSTRIAL RELATIONS COMMISSION

John J. Larsen, Jr., Chairman

VACANT
Member

Curtis E. Chick, Jr., Member

Attest:

Secretary

AWARD

Employee: Lamont Cooper

Injury No. 07-130828

Dependents:

Employer: Mid-Missouri Mental Health Center

Additional Party: Second Injury Fund

Insurer: Self-Insured

Hearing Date: March 29, 2017

Before the
DIVISION OF WORKERS' COMPENSATION
Department of Labor and Industrial Relations of Missouri
Jefferson City, Missouri

Checked by: RJD/cs

FINDINGS OF FACT AND RULINGS OF LAW

1. Are any benefits awarded herein? Yes.
2. Was the injury or occupational disease compensable under Chapter 287? Yes.
3. Was there an accident or incident of occupational disease under the Law? Yes.
4. Date of accident or onset of occupational disease: July 8, 2007.
5. State location where accident occurred or occupational disease was contracted: Boone 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? Employer is self-insured.
11. Describe work employee was doing and how accident occurred or occupational disease contracted: Employee, a custodian, was exposed to dust from an elevator project, an asbestos abatement project, and a sewage abatement project.
12. Did accident or occupational disease cause death? No. Date of death? N/A.
13. Part(s) of body injured by accident or occupational disease:
14. Nature and extent of any permanent disability: Permanent total disability.
15. Compensation paid to-date for temporary disability: None.
16. Value necessary medical aid paid to date by employer/insurer? None.
17. Value necessary medical aid not furnished by employer/insurer? $232,627.63.

18. Employee's average weekly wages: $381.47.

19. Weekly compensation rate: $254.31, increased 15% to $292.46.

20. Method wages computation: Stipulation.

COMPENSATION PAYABLE

Employer is ordered to pay Claimant the sum of $267,521.77 for medical benefits. Employer is ordered to pay Claimant permanent total disability benefits of $292.46 per week, beginning January 11, 2008, for Claimant's lifetime.

Employer is also ordered to provide Claimant with future medical care and treatment as is reasonable and necessary to cure and relieve Claimant from the effects of the occupational disease.

The claim against the Second Injury Fund is denied in full.

Claimant's attorney, William Rotts, is allowed 25% of all benefits awarded as and for necessary attorney's fees, including future weekly benefits, and the amount of such fees shall constitute a lien thereon.

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

Employee: Lamont Cooper Injury No. 07-130828

FINDINGS OF FACT AND RULINGS OF LAW:

Employee: Lamont Cooper Injury No. 07-130828

Dependents:

Employer: Mid-Missouri Mental Health Center

Additional Party: Second Injury Fund

Insurer: Self-Insured

Hearing Date: March 29, 2017

Before the
DIVISION OF WORKERS' COMPENSATION
Department of Labor and Industrial Relations of Missouri
Jefferson City, Missouri

ISSUES DECIDED

An evidentiary hearing was held in this case on March 29, 2017 in Columbia. Lamont Cooper ("Claimant") appeared personally and by counsel, William Rotts. Mid-Missouri Mental Health Center ("Employer") appeared by counsel, Maggie Ahrenbach and Kirsten Dunham, Assistant Attorneys General. The Treasurer of the State of Missouri, as Custodian of the Second Injury Fund, appeared by counsel, Shelly Hinson, Assistant Attorney General. The parties requested leave to file post-hearing briefs, which leave was granted, and the case was submitted on May 12, 2017. The hearing was held to determine the following issues:

1. Whether Employee sustained a compensable accident or occupational disease arising out of and in the course of his employment with Mid-Missouri Mental Health Center;

2. If found to have been sustained, whether the work-related accident or occupational disease is the prevailing factor in the cause of any or all of the injuries and/or conditions alleged in the evidence;

3. Employer's liability, if any, for permanent partial disability benefits or permanent total disability benefits;

4. Employer's liability, if any, for temporary total disability benefits;

5. Employer's liability, if any, to reimburse Claimant for past medical expenses;

6. Employer's liability, if any, to provide Claimant with future medical benefits pursuant to §287.140, RSMo;

7. The liability of the Second Injury Fund, if any, for permanent partial disability benefits or permanent total disability benefits;

8. Whether a 15% penalty shall be applied to Claimant's benefits for Employer's alleged violation of §287.120.4, RSMo;

9. Whether costs and attorney's fees shall be ordered for Employer's alleged defense of these proceedings without reasonable cause; and

10. Potential dependency issues pursuant to *Schoemehl v. Treasurer*, 217 S.W.3d 900 (Mo. banc 2007).

STIPULATIONS

The parties stipulated as follows:

1. That the Missouri Division of Workers' Compensation has jurisdiction over this case;

2. That venue for the evidentiary hearing is proper in Boone County;

3. That the claim for compensation was filed within the time allowed by the statute of limitations, Section 287.430;

4. That both Employer and Employee were covered under the Missouri Workers' Compensation Law at all relevant times;

5. That the average weekly wage is $381.47, with compensation rates of $254.31 for temporary total disability and permanent total disability and $254.31 for permanent partial disability;

6. That Employer has paid no benefits under Chapter 287, RSMo;

7. That the notice requirement of Section 287.420 is not a bar to Claimant's Claim for Compensation herein; and

8. That Mid-Missouri Mental Health Center, Inc. was an authorized self-insurer for Missouri Workers' Compensation purposes at all relevant times.

EVIDENCE

The evidence consisted of the testimony of Claimant, Lamont Cooper; the deposition testimony of Claimant, Lamont Cooper; the testimony of Madeline Rolley; the testimony of Angelique Smith, Claimant's wife; the testimony of Dennis Elmore, an industrial hygienist; the testimony of Mark Grannemann, Facilities Operations Manager for the Missouri Office of Administration; the deposition testimony and report of Gary Weimholt, a vocational rehabilitation counselor; medical records; the deposition testimony and narrative reports of Dr. Allen J. Parmet; the deposition testimony of Robert M. Reitz, regional executive officer for the Central Region, Division of Comprehensive Psychiatric Services, Missouri Department of Mental Health; narrative report of Dr. Michael Graham; narrative report and deposition

testimony of Dr. Myron Jacobs; narrative report and deposition testimony of Dr. Thomas B. Kibby; Award on Hearing in Injury No. 01-127074; extensive medical records; extensive medical bills; copy of Claimant's personnel file; copies of Claimant's leave documents and correspondence related thereto.

Claimant offered Exhibit 15 (medical bill summary); the objection thereto was sustained and Exhibit 15 was not admitted into evidence.

Claimant offered Exhibit 16 (correspondence); the objection thereto was sustained and Exhibit 16 was not admitted into evidence.

Claimant offered Exhibit 17 (documents from the Social Security Administration); the objection thereto was sustained. Claimant withdrew Exhibit 17.

Exhibits 21, 23 and 24 were marked and later withdrawn by Claimant.

Claimant offered Exhibit 8 (records and correspondence from the Mayo Clinic). Hearsay objection was made. I agreed to reserve ruling on admissibility of Exhibit 8 and allow the parties to brief the issue. After consideration, the hearsay objection is sustained, and Exhibit 8 is not admitted into evidence.

Exhibit 6, Dr. Allen Parmet's June 23, 2016 report was admitted into evidence; however, articles attached to the report were not admitted into evidence upon timely hearsay objection.

Exhibit D, the transcript of the deposition testimony of Dr. Thomas Kibby, was admitted into evidence; however, the attached article was not admitted into evidence upon timely hearsay objection.

DISCUSSION

Claimant, Lamont Cooper, was born on September 25, 1967. In 1998, Claimant married Angelique Smith. Claimant and Angelique Smith have lived together as husband and wife continuously since 1998. Angelique has been employed at the University of Missouri-Columbia Hospital as a nurse for twenty years. Claimant and Angelique's children are all emancipated.

Claimant graduated from Hickman High School in Columbia in 1986. During high school, he worked in a grocery store and worked in maintenance at a hotel. After high school, Claimant worked as a janitor, and as a cook at fast food restaurants; Claimant also worked for the City of Columbia Parks and Recreation Department, for a meat packing company, for a wine distributor as a driver, for a medical equipment company as a driver, and for an airport shuttle service as a driver. In 2001, while working for a wine distributor, Claimant sustained a back injury. After recovering from the back injury, Claimant went to work for Employer (Mid-Missouri Mental Health Center) as a janitor.

Claimant worked as a janitor for most of his tenure with Employer. Claimant did work for a period of time as a psychiatric aide. Claimant testified in his September 2008 deposition

that he worked as a psychiatric aide for "like six, eight months". He also testified in his September 2008 deposition that June 30, 2007 was the date he returned to work as a janitor (after his stint as a psychiatric aide). Claimant's personnel records show that Claimant began as a psychiatric aide on October 18, 2006 and returned to janitorial duties on July 8, 2007.[1]

The claimed occupational disease involves exposures allegedly occurring on and after Claimant's return to janitorial service at the end of June or the beginning of July in 2007. Claimant and Ms. Rolley testified that, beginning on the date of Claimant's return to janitorial service. Claimant was continuously exposed to large amounts of construction and/or demolition dust for approximately two months. The testimony of Claimant's wife, Angelique Smith, corroborates Claimant's and Rolley's testimony in this regard. Claimant testified that the dust consisted of a "heavy" white powder "every day" "for two months during the summertime". Claimant testified that the white powder was all over the ground floor, even on shelves that he had to clean daily. He testified that "people were tracking" the white powder, and thus there was powder in the elevator and on the floor outside the elevator on the second floor. (Claimant was responsible for cleaning all of the ground floor and parts of the second floor.) In his 2008 deposition testimony, Claimant testified: "I observed them taking out plaster, a white powdery substance on the floors, hard to mop up, made my water milky. I had to get new water every time I mopped." Claimant testified that he was also required to dump "trash carts" full of construction/demolition debris. He testified that he had to spray the powder out of the trash carts after he dumped the debris. He testified the powder was in the air, and on his pants and his arms. Claimant was not given a dust mask, nor was he given any type of protective gear.

Madeline Rolley testified that Claimant "worked in that stuff a good three weeks" before the staff was informed that the demolition project included "asbestos".[2] Claimant testified that after he had been working with the dust for several days, he saw someone come out of the "boiler room" wearing a white hazmat suit and mask.

Robert Reitz testified in his deposition that construction work on the elevators at Mid-Missouri Mental Health Center began "as late as fall 2006 but most of the work was done spring 2007 through the summer of 2007." As the elevator project was proceeding, asbestos was discovered and asbestos abatement became part of the elevator project. Mr. Reitz said that the asbestos abatement projects were supposed to be "relatively short in length" in terms of completion but as the projects commenced, "they found more asbestos that they had to do something about." Originally, Employer anticipated the abatement projects would take 6 months

[1] In his February 2016 deposition, Claimant testified that he worked as a psychiatric aide in "oh-four or five"; in his hearing testimony, Claimant testified that he worked as a psychiatric aide for "only a couple weeks" in 2005 or 2006. Employer argues that these discrepancies irrevocably damage Claimant's credibility, not only on this issue, but on every issue. I cannot agree with Employer's argument. Claimant's 2008 testimony is very much in line with the information from his personnel file. Claimant testified in 2008 that he worked as a psychiatric aide for "six or eight months"; the personnel records indicate it was eight and a half months. Claimant testified in 2008 that he returned to work as a janitor on June 30, 2007; the personnel records indicate it was eight days later. Claimant's "conflicting" testimony in 2016 and 2017 was given after the passage of many years AND after Claimant's condition had deteriorated.

[2] A portion of the project was asbestos abatement. While the parties have spent a considerable amount of time and effort focusing on "asbestos", this is simply a red herring. As discussed below, Claimant's claim for the alleged occupational disease of hypersensitivity pneumonitis has absolutely nothing to do with asbestosis exposure.

to complete, but "it wound up to be a quite long project." Mr. Reitz also testified that there was a sewage abatement project being done at the same time as the elevator project and that this involved the sub-basement. A document entitled: "State of Missouri Office of Administration Division of Design and Construction CONTRACT CHANGE", signed by a representative of "Division of Design and Construction" on 12/8/07[3], states that the project titled "Replace Elevators and Miscellaneous Repairs" at "Mid Mo Mental Health, Columbia, MO" had an "original completion date" of 7/30/2007 and a "revised completion date" of 9/11/2007.

In the summer of 2007, Claimant began having night sweats, headaches, dizziness, blurry vision, and eye pain in sunlight which caused him to require dark glasses while outside. He developed a persistent, dry cough. Claimant's wife noticed he started to have problems breathing and memory issues around that time Claimant initially attributed his symptoms to a common cold, but the symptoms persisted.

Claimant testified that on or about November 6, 2007, a coworker noticed Claimant's eyes looked extremely red and was concerned that Claimant had a contagious condition known as "pink-eye" (conjunctivitis). Claimant went to the eye clinic at University of Missouri Hospital where he was diagnosed with bacterial versus viral conjunctivitis and prescribed sodium sulfacetamide drops to cure the condition. Days later his symptoms continued despite use of the eye drops, and he returned to the eye clinic. Dr. Erickson diagnosed Claimant with anterior uveitis and iritis and started him on prednisone eye drops.

Claimant testified that he suffered progressive fatigue. He began noticing he was moving slower and felt compelled to rest intermittently. Work duties he normally could have done quickly in half a day began taking a full day for him to complete. Eventually he found he needed to rest every 15 minutes.

Claimant sought disability through his employment benefits and until his condition improved to where he could return to work. His last day of physical work with Employer was January 10, 2008. Claimant subsequently used up the sick leave and vacation time he had accrued.

Although Claimant's initial diagnosis was an eye condition, believed treatable with eye drops, by the time he was taken off work by Dr. Wen, it was clear Claimant also had diffuse interstitial lung disease, a significant and serious lung condition. Initial thoughts were that his condition was sarcoidosis. A lung biopsy was taken on 02/13/08 which confirmed a diagnosis of hypersensitivity pneumonitis.[4]

On February 20, 2008, pulmonologist Dr. Vamsi Guntur wrote:

> (A)lthough my clinical suspicion for sarcoidosis was high initially, based on the CD-4 to CD-8 ratio, the surgical lung biopsies, the direct correlation to his job and environment

[3] The signature appears to be "Harry Clampett for Mark Grannemann"; the date is hand-written and appears to be "12/8/07", but could be "12/6/07".

[4] Interstitial lung disease is a general description covering several different conditions, including pulmonary sarcoidosis and hypersensitivity pneumonitis.

> and onset of worsening symptoms over the past 5 years [sic], are all supportive of the clinical and objective diagnosis of hypersensitivity pneumonitis at this time. We will again personally review the pathology slides at a future date. However, at this time I will be treating him as a patient with hypersensitivity pneumonitis.

Also on February 20, 2008, Dr. Guntur began Claimant on oral prednisone, 60 mg. daily. Claimant continued on oral prednisone daily through May 2008.

On March 17, 2008, Claimant was advised by his primary care physician, Dr. Dennis Wen, to remain off work due to his declining physical health and the possible additional exposures he would have while working. Dr. Wen wrote Employer a note stating, "Due to medical condition, [Claimant] will not be able to work at present job indefinitely, likely permanently." Soon thereafter, Dr. Vigdorchik of the cardiothoracic clinic discussed with Claimant the possibility of changing his work environment given the work exposure related to his diagnosis.

Claimant began his official leave of absence with Employer on 05/01/2008. This was scheduled to end on 06/15/08. Dr. Wen filled out long term disability insurance paperwork for Claimant on May 8, 2008, noting Claimant's primary diagnosis was "hypersensitivity pneumonitis" with symptoms of "dyspnea" and "fatigue", adding that Claimant's condition was "possibly permanent".

On 05/15/08, Claimant was admitted to the hospital for 5 days with severe hyperglycemia. His blood sugar was measured at 1243. On May 23, 2008, Dr. Wen stated: "(n)ew diagnosis of diabetes, probably as a result of prednisone that he was on for hypersensitivity pneumonitis."

On June 11, 2008, Drs. Thameem and Guntur, the pulmonologists, decreased Claimant's daily oral prednisone to 20 mg. On September 3, 2008, the daily oral prednisone was reduced to 15 mg. Dr. Thameem's assessment was "chronic hypersensitivity pneumonitis by (open lung biopsy) secondary to parakeet and cleaning supplies".

Claimant saw Dr. Thameem again on March 25, 2009. It was noted by Dr. Thameem that Claimant "did go for a second opinion to Mayo and was told that his diagnosis is consistent with hypersensitivity pneumonitis and did not give him any new therapeutic options." Claimant's daily oral prednisone was reduced to 10 mg. On July 23, 2009, Dr. Thameem noted fatigue, possibly caused by chronic prednisone use. On November 18, 2009, again noted fatigue and noted: "at this time, we will decrease his prednisone dose to 5 mg. once daily for one month, and then patient is advised to stop his prednisone after that."

Claimant saw Dr. Rachel Kingree, pulmonologist (of the same clinic as Drs. Thameem and Guntur) on January 20, 2010. Claimant noted increased breathing problems when off the prednisone entirely. Dr. Kingree continued Claimant on 5 mg. prednisone daily. Dr. Kingree saw Claimant again on April 7, 2010, and put Claimant on 5 mg. of prednisone every other day.

Claimant saw Dr. Harjyot Sohal, pulmonologist (of the same clinic as Drs. Thameem, Guntur and Kingree) on August 31, 2010. Dr. Sohal assessed hypersensitivity pneumonitis and anterior uveitis with granulomatous disease, possibility of sarcoidosis. He ordered a chest CT scan with IV contrast. On September 10, 2010, Dr. Sohal noted "CT scan shows same amount of interstitial infiltrate as previous." Dr. Sohal's assessment was:

> Sarcoidosis of the eye. Looking back, it could be that the interstitial infiltrates that were present on his CAT scan and open lung biopsies showed noncaseating granulomas. This could be sarcoid instead of hypersensitivity pneumonitis, so my suggestion at this time was to go ahead and continue this as sarcoid with lung involvement.

In September of 2010, Claimant reported to Dr. Wen progressively worsening aches and pains, peeling skin on his shins, edema, decreased appetite, fatigue, poor sleep along with night sweats, and lower extremity weakness. Dr. Wen suggested the swelling and pain symptoms in Claimant's legs could be related to the discontinuation of prednisone. Dr. Wen ordered a three phase bone scan. Findings of the September 20, 2010 bone scan were consistent with degenerative joint disease of lower extremities.

Claimant began treatment with the Rheumatology Clinic on October 11, 2010 with Dr. Emily Larson on referral from the Ophthalmology Clinic. At that time, Claimant's muscle pain and weakness had subsided, but he complained of a rash with peeling skin on his arms and legs. Dr. Larson questioned sarcoid myopathy versus normal aches and pains related to withdrawal from steroids after prolonged use of prednisone. She noted Claimant's medical history was significant for hypersensitivity pneumonitis with a past history of anterior uveitis and possible systemic disease. Dr. Larson referred Claimant for a dermatological consult. A skin biopsy revealed cutaneous sarcoidosis. Given the results of the biopsy and the family history of sarcoidosis, Dr. Larson thought the most likely diagnosis was sarcoidosis. Dr. Larson ordered a muscle biopsy. On December 1, 2010, Claimant underwent a biopsy of his quadriceps muscle which showed inflammatory changes consistent with sarcoidosis.

On December 14, 2010, Claimant had a follow-up with Dr. Celso Velasquez and Dr. Larson. Claimant refused to resume taking prednisone to treat his conditions. Dr. Larson later prescribed Cellcept as an alternative to prednisone. As reported to Dr. Wen on January 19, 2011, Cellcept caused Claimant to have nose bleeds. Claimant discontinued taking Cellcept on his own on January 20, 2011. He restarted prednisone that he had at home in February 2011.

A repeat CT of the chest was done on January 25, 2011. It showed grossly unchanged honeycombing and traction bronchiectasis, consistent with chronic changes of hypersensitivity pneumonitis. Dr. Sohal ordered blood work.

In his March 22, 2011 follow-up with the Rheumatology Clinic, Claimant's rash and strength were noted to be much improved. Claimant was continued on Azathioprine at 50 mg (an immunosuppressant) and prednisone at 10 mg by Dr. Velazquez and Dr. Larson. As Claimant's skin symptoms were brought under control by mediations managed by Rheumatology, further dermatological consultations were not required.

Claimant returned to Rheumatology approximately every 2 to 3 months to monitor his condition. On May 3, 2011, Claimant reported weakness in his legs that cause him to fall. He had stopped taking prednisone on his own, but Dr. Larson recommended he remain on a low dose of 10 mg daily. Claimant decreased his dosage to 5 mg of prednisone by his next follow-up on September 26, 2011. He complained of generalized aches in his entire body, mostly in his knees and ankles. He was anxious about going off prednisone and restarting immunosuppressants due to adverse side effects.

Repeat diagnostic testing was completed on September 14, 2011. Chest CT results were unchanged from previous scan, with findings of apical fibrotic/cystic changes. A pulmonary function test revealed improved lung capacity from 2010 studies. Claimant advised Drs. Jason Goodin, and Rajiv Dhand, pulomonologists, that he was unable to climb flight of stairs without having to stop. He was referred for an echocardiogram to consider cardiac involvement with sarcoid. Results of the echocardiogram were unremarkable.

On October 11, 2011, Dr. Wen noted Claimant was started on Prozac due to chronic stress and depression, partly related to his debilitated state with sarcoidosis and hypersensitivity pneumonitis.

On November 14, 2011, Claimant underwent a pulmonary function test, which showed improvement of a restrictive defect, as compared to previous studies.

On March 20, 2012, Claimant was seen by Drs. Yuji Oba, Dennis Chairman, and Ramez Sunna, pulmonologists, for progressive shortness of breath with significant increase in coughing. He had been off prednisone since January, as ordered by Rheumatology, but sarcoid skin rashes had been recurring since that time and he had experienced a significant increase in coughing with progressive shortness of breath. A new pulmonary function test showed mild lung restriction. A new chest CT showed increased septal thickening in bilateral apices with increased air trapping in bases; honeycombing appeared unchanged. Treatment options were discussed with Rheumatology and Claimant resumed taking prednisone for sarcoidosis.

On August 23, 2012, Claimant was treated in the emergency department for diabetic hyperglycemia symptoms. He exhibited elevated blood sugars brought on by prednisone use. His situation was discussed with the Family Medicine Clinic and a sliding scale of insulin and Metformin was recommended.

In September 2012, Claimant reported that his shortness of breath and fatigue were both significantly improved. Dr. Chairman saw no evidence of significant ongoing pulmonary involvement and recommended repeat diagnostic testing in 4 months. On January 4, 2013, Claimant was doing fairly well since his last visit, but complained of fatigue and tiredness. He did have a nonproductive cough and occasional episodes of nasal congestion, but no chest pain, wheezing, orthopnea or paroxysmal nocturnal dyspnea (PND). An x-ray of his chest showed that he was stable, and pulmonary function test revealed “significant improvement in flows and lung volumes and DLCO.”

On April 15, 2013, Claimant reported to Dr. Guntur and Dr. Chairman significant improvement. Claimant's cough had resolved, but he had occasional clear sputum. His shortness of breath was at baseline. He had occasional episodes of night sweats. A review of the chest CT from April 4, 2013 showed chronic, stable fibrotic changes. That chest CT was ordered by the Employer's expert, Dr. Myron Jacobs, for the purpose of an independent medical examination.

On June 24, 2013, Claimant was seen in the emergency room for constant, severe left leg and hip pain. He then was evaluated by Dr. Ajay Aggarwal who thought Claimant's issue was low back pain with radicular symptoms. Claimant continued to experience severe left hip pain and swelling. He was seen in the emergency room on November 17, 2013 and admitted to the hospital for testing and observation. An MRI of Claimant's left hip showed: 1) anterior superior femoral head avascular necrosis with early cortical flattening; 2) anterior superior labral tear; and 3) tendinosis of gluteus minimus insertion. On November 20, 2013, Dr. Aggarwal reviewed the left hip MRI. He noted Claimant had a history of chronic steroid use due to sarcoidosis, with left hip pain likely resulting from avascular necrosis or an atypical presentation of sarcoidosis. Left hip surgery for a total left hip replacement was discussed and planned.

On December 6, 2013, Claimant underwent a left hip arthroplasty with femoral head biopsy performed by Dr. Aggarwal for a diagnosis of avascular necrosis of left hip. It was an in-patient procedure. The surgical pathology of the hip biopsy revealed malignant lymphoma most consistent with follicular lymphoma, small degenerative joint disease, and avascular necrosis.

Claimant consulted with the Hematology/Oncology Clinic on December 16, 2013 with Dr. Uladzislau Naidzionak and Dr. Donald Doll regarding possible treatment for follicular lymphoma. Claimant underwent a PET scan/CT fusion on 12/23/13. The impression was as follows:

> "1) FDG avid left internal iliac/pelvic wall lymph node suspicious for metastic lesion.
> 2) Prominent right paratracheal, inferior diaphragmatic and para-aortic lymph nodes with mild FDG uptake could be inflammatory, infectious vs. neoplastic lesions. Recommended follow-up.
> 3) Left mid femoral FDG uptake distal to recently placed femoral component of hip prosthesis could be due to inflammation.
> 4) Non-FDG avid left lung upper lobe nodule unchanged compared to CT: Chest 04/04/13."

After reviewing the PET scan results, Dr. Gautam Kale and Dr. Doll determined that no treatment for lymphoma would be done at that time. Claimant has returned to the Hematology/Oncology Clinic approximately once every 6 months for continued monitoring for lymphoma.

On January 22, 2014, Claimant reported no new pulmonary symptoms, and his joint pain and muscle aches were at baseline. Though his symptoms appeared stable, Dr. Ramez Sunna and Dr. Raed Al-Suyyagh reviewed a new pulmonary function test, in which the spirometry revealed results suggestive of a mild restrictive defect, worse compared to 2013. His total lung capacity was measured at 3.95 liters, 58% of the predicted capacity, or a moderate lung volume

restriction. His cough continued and he experienced dyspnea when walking upstairs and reflux-type symptoms, as reported to the Rheumatology Clinic during a routine follow-up on May 22, 2014.

On September 29, 2014, Claimant saw Dr. Lenard Politte and Dr. Sivakumar Ardhanari in the Cardiology Clinic. He reported a "grabbing" sensation and heaviness in his chest, not specifically related to exertion, as Claimant was not physically active relative to his pulmonary condition. Claimant had shortness of breath related to sarcoid. Claimant was unable to perform a treadmill stress test due to a recent hip replacement and his lung condition, and instead underwent a stress echocardiograph test on October 1, 2014. Dr. Toprak reviewed the test showing normal results, and opined that Claimant's diffuse chest pain and heaviness could be explained by diffuse pulmonary disease.

Claimant was again seen in the emergency room on November 4, 2014 for worsening diabetes symptoms. He was admitted for two day testing. He reported a fourteen pound weight loss over a 2 ½ week period, an increase in chest pain, and some nausea. Recent stress echo test results were negative and no etiology for elevated blood sugar was identified other than prednisone use. He was diagnosed with uncontrolled non-insulin dependent diabetes, originally diagnosed in 2008. He had continuously been taking prednisone since 2008 with the last burst in 2012. He had been off anti-diabetic meds since May 2014. Dr. Wen increased his dosages of insulin medications soon thereafter. Approximately a month later, Dr. Wen noted this was Claimant's second time with significant hyperglycemia followed shortly by an inability to get completely off insulin.

On December 10, 2014, Claimant saw Dr. Al-Suyyagh and Dr. Sunna with reports of an increased cough for weeks, with night sweats and weight loss. The cough was productive with orange sputum. He also reported a recent history of chest pain. An x-ray of his chest showed unchanged reticular opacities in upper and lower lobes consistent with known fibrosis, likely related to a history of sarcoidosis.

Dr. Guntur and Dr. Al-Suyyagh noted Claimant was at baseline with shortness of breath as well as general aches and pains during their follow-up on January 15, 2015. A new pulmonary function test and chest CT results did not show significant changes compared to the previous studies. Their diagnosis remained sarcoidosis. Claimant continued to be afflicted with an intermittent dry, nonproductive cough.

Dr. Aggarwal continued to follow Claimant post-operatively in the Orthopaedic Clinic regarding the total left hip replacement. Periodic x-rays showed no complications with the left hip. On March 18, 2015, Dr. Aggarwal advised Claimant to return in three years for follow-up of his left hip, as x-rays showed well-fixed surgical components with no interval changes.

On May 11, 2015, Claimant was treated in the emergency department at University of Missouri Hospital for hyperglycemia and uncontrolled diabetes. On August 19, 2015, Claimant saw Dr. Prasad Bichu. at the Nephrology IM Clinic for management of chronic kidney disease from diabetes. A renal ultrasound was unremarkable. Dr. Bichu's overall impression was Stage 2 chronic kidney disease, hypertension, sarcoidosis, diabetes and follicular lymphoma.

On August 14, 2015, Claimant felt fairly well, though he still had shortness of breath on exertion. His prednisone dose had been increased by the Rheumatology Clinic in January. Dr. Chairman and Dr. Mario Fadila opined that Claimant's restrictive lung disease was stable. Claimant expressed concern about being on chronic steroids and was advised to discuss "steroid-sparing" therapy with rheumatology.

On September 15, 2015 Claimant began regular visits to the Endocrinology Clinic to monitor diabetes. His treatment is overseen by Dr. Cameron Herr. He periodically follows up with the Eye Clinic for diabetic retinopathy exams. As of the hearing date, Claimant's condition of diabetes was considered to be "under control".

On January 20, 2016, Claimant consulted with Dr. Robert Zitsch, III and Dr. Lauren Umstarttd in the Otolaryngology Clinic regarding growing masses on both sides of his neck and "tingling" of his left jaw. A diagnostic CT of the soft tissue of the neck confirmed a diagnosis of bilateral parotid fullness, most likely secondary to systemic sarcoidosis. Symptoms were likely to recur or become persistent.

On June 22, 2016, Claimant was seen for a routine follow-up by Dr. Chairman and Dr. Fadila, His activity level was at baseline and his pulmonary disease was stable based on symptoms. He was continued on leflunomide and prednisone prescriptions, per rheumatology. A follow-up was ordered in one year.

Whether Claimant sustained a compensable occupational disease. Claimant clearly has interstitial lung disease. It was originally diagnosed as hypersensitivity pneumonitis; later that diagnosis was changed to sarcoidosis.[5]

Employer's medical experts were Dr. Michael Graham, a forensic pathologist, and Dr. Myron Jacobs, a pulmonogist.

Dr. Graham did not examine Claimant, but reviewed records and microscopic slides with tissue from the lung biopsy, lymph node biopsy, and muscle biopsy, and authored a report which is in evidence. Based on his review of the slides and medical information, Dr. Graham opined that Claimant has sarcoidosis and that his lung disease is related to the sarcoidosis. Dr. Graham opined that the non-caseating granulomas in the lymph node and muscle tissue are consistent with sarcoidosis. Dr. Graham believed the "extent of the fibrosis, bronchiectasis, remodeling and chronic inflammation in the lung tissue exceeds the changes typically seen in cases of chronic hypersensitivity pneumonitis."

Dr. Jacobs performed a medical examination of Claimant, authored a report and testified by deposition. Dr. Jacobs also opined that Claimant has sarcoidosis. Dr. Jacobs testified that the cause of sarcoidosis is unknown and is characterized by an immune system attacking the body. Dr. Jacobs stated that the disease can attack any organ and "virtually always" attacks the lungs.

[5] I note here that the change in the diagnosis had no significance in the treatment of Claimant's interstitial lung disease, as the treatment for hypersensitivity pneumonitis and (pulmonary) sarcoidosis are the same; however, in making the determination as to whether Claimant sustained an occupational disease, the distinction is crucial.

Dr. Jacobs testified that Claimant's sarcoidosis affects his lung, eyes, skin, muscle and maybe joints. Dr. Jacobs testified that hypersensitivity pneumonitis does not affect the eyes, skin, muscle or joints. Dr. Jacobs noted that over the last several years the variety of treating physicians treated Claimant for sarcoidosis and opined that the hypersensitivity pneumonitis was considered "early in the course of his illness."

Dr. Allen Parmet was Claimant's medical expert. Dr. Parmet practices in the area of occupational medicine and aerospace medicine. Dr. Parmet reviewed Claimant's medical records and examined Claimant on two occasions. He authored four reports and was deposed twice. Dr. Parmet testified that Claimant's interstitial lung disease was hypersensitivity pneumonitis and not sarcoidosis. Dr. Parmet explained that there was no reason that hypersensitivity pneumonitis and sarcoidosis couldn't coexist. Dr. Parmet also pointed out that Claimant's lab work shows highly positive ANA and RF titers, which are consistent with hypersensitivity pneumonitis but not sarcoidosis. He pointed out that Claimant's normal angiotensin-converting enzyme ("ACE") level is also consistent with hypersensitivity pneumonitis but not sarcoidosis. He also noted that Claimant's vitamin D3 levels should be elevated with sarcoidosis and his CD4 to CD8 ratio should be elevated, and they are not elevated.[6]

Dr. Parmet and Dr. Jacobs agreed that the cause of hypersensitivity pneumonitis is inhalation of organic dusts. They also both agreed that the cause of sarcoidosis is "unknown".[7]

On the issue as to whether Claimant's interstitial lung disease is hypersensitivity pneumonitis or sarcoidosis, I find Dr. Parmet's opinion to be more credible and persuasive than those of Dr. Graham or Dr. Jacobs. First of all, Dr. Parmet's opinion was made upon the examination of all the evidence. Second, Dr. Parmet's opinions are consistent with the laboratory results. Third, Dr. Parmet's opinion is consistent with the chronology of the case. While correlation is not causation, Claimant's lung symptoms did correspond temporally to significant dust exposure. The lung symptoms were not initially accompanied by any other symptoms related to sarcoidosis, and in February 2008 hypersensitivity pneumonitis was diagnosed, and Claimant was treated with prednisone (which is the proper treatment for hypersensitivity pneumonitis and is also the proper treatment for sarcoidosis), and Claimant's lung symptoms responded positively to the prednisone. It was not until September 2010 (two and a half years later) after evidence of sarcoidosis was found in other body systems, that Dr. Sohal "changed" Claimant's lung diagnosis to sarcoidosis.

Having found that Claimant's lung condition is hypersensitivity pneumonitis, I will now address whether Claimant sustained an occupational disease.

[6] This is consistent with Dr. Guntur's 2-20-08 note: "although my clinical suspicion for sarcoidosis was high initially … the CD-4 to CD-8 ratio, the surgical lung biopsies, the direct correlation to his job and environment … are all supportive of the clinical and objective diagnosis of hypersensitivity pneumonitis".

[7] Dr. Parmet testified that it has long been suspected that sarcoidosis is caused by environmental factors, such as dust exposure, but that he could not so testify to a reasonable degree of medical certainty.

There are certain obvious similarities between this case and *Lankford v. Newton County*, 2017 WL 167582 (Mo. App. S.D. Jan. 17, 2017). As stated by the Southern District in *Lankford*, Section 287.067 (subsections 1 and 2) govern occupational diseases such as alleged in this case. Those subsections read as follows:

> 287.067. 1. In this chapter the term "occupational disease" is hereby defined to mean, unless a different meaning is clearly indicated by the context, an identifiable disease arising with or without human fault out of and in the course of the employment. Ordinary diseases of life to which the general public is exposed outside of the employment shall not be compensable, except where the diseases follow as an incident of an occupational disease as defined in this section. The disease need not to have been foreseen or expected but after its contraction it must appear to have had its origin in a risk connected with the employment and to have flowed from that source as a rational consequence.
>
> 2. An injury or death by occupational disease is compensable only if the occupational exposure was the prevailing factor in causing both the resulting medical condition and disability. The "prevailing factor" is defined to be the primary factor, in relation to any other factor, causing both the resulting medical condition and disability. Ordinary, gradual deterioration, or progressive degeneration of the body caused by aging or by the normal activities of day-to-day living shall not be compensable.

It is noted here that the *Lankford* court found that Mr. Lankford's respiratory illness (mycobacterium avium intracellulare) was not an "ordinary disease of life to which the general public is exposed outside of the employment". Although Employer has not argued that hypersensitivity pneumonitis is an "ordinary disease", I find that the evidence clearly established that hypersensitivity pneumonitis is not an "ordinary disease of life to which the general public is exposed outside of the employment".

Nor has Employer argued that workers are "equally exposed" to the hazard or risk of contracting hypersensitivity pneumonitis outside of and unrelated to the employment in normal nonemployment life.[8] *Lankford* held that the "unequal exposure" requirement in section 287.020.3 is not applicable to a claim alleging an injury by occupational disease, and thus that issue need not be addressed.

The next issue that must be considered is whether the occupational exposure was the prevailing factor in causing both the resulting medical condition and disability.

At pages 22-23 of his 2012 deposition (Exhibit 11), Dr. Parmet testified:

> Q. Now, doctor, I would like to take you back to the exposure itself. You were provided the records that were generated by the independent testing service for Sircal Contracting, were you not?
>
> A. Correct.

[8] See Section 287.020.3(2)(b).

Q. And those records went through and – I attempted to identify the particulates that were gleaned from their samplings. Do you remember going through those?

A. Yes.

Q. I believe the service that provided this for Mid-Missouri Mental Health was a company by the name of Tetra Tech. Are you familiar with that company?

A. Only by their report here.

Q. Did you have occasion to look over that report and see if there were any biological agents that you suggested would be the cause of hypersensitivity pheumonitis?

A. Yes.

Q. And what did you see?

A. Tetra Tech did an environmental sampling on the building where Mr. Cooper was working. They did find quite a bit of dust and particulates composed of many things, including metals and rust and sand. There's fungi and biological particles compromising as much as 20 percent of the dust. They did not do an identification of the specific biological particles. In other words, they weren't trying to culture them or do any specific mold and bacterial growth to determine what agents were actually present. They just noted they were there.

At pages 28 and 29 of Exhibit 11, Dr. Parmet testified:

Q. But from an epidemiological perspective, it's clear that biological agents are the cause of the hypersensitivity pneumonitis?

A. Yes. There are many, many different kinds, and there are typical workplaces that will produce hypersensitivity pneumonitis. The classic people who would handle sugar cane. Handle sugar cane and you get moldy. You get a disease called byssinosis, which is caused by the biological agents that would grow in the moldy sugar cane and all the workers would get it. As I have said, they have seen it in people who had bird fanciers. They have lots and lots and lots of birds, so they have very high exposures to large amounts of these bacteria or fungi. One of the hallmarks here is it's a large amount. You get lots of particles in the air, more than the average lung can clean. Because your lungs are perfectly capable of cleaning out routine amounts of fungi and bacteria. We do so on a daily basis, unless the lung has been injured either by smoking or genetic diseases like cystic fibrosis, they can clean themselves. But when you get very large amounts of these in the air, it overwhelms the body's defenses, and that's where we see hypersensitivity pneumonitis.

And at pages 30 and 31, Dr. Parmet testified:

Q. Now, if I might, I would like, then, to explore some of the things that we just talked about, but on a level of certainty, what we call a reasonable degree of medical certainty. And I would ask you first: Do you perceive a recognizable link between his exposure to the dust and particulate that was in the air during the abatement in the spring of 2007 and the onset of his hypersensitivity pneumonitis later in that year?

A. Yes.

Q. And what would be that link?

A. There is an exposure in his workplace to large amounts of biological dust and particles that could be reasonably expected to contain a causal agent for hypersensitivity pneumonitis.

Q. And you see that direct causation to a reasonable degree of medical certainty?

A. Correct.

Q. Do you believe that the exposure was the predominant factor that led to his condition of hypersensitivity pneumonitis?

A. Yes.

Q. And that, again, is to a reasonable degree of medical certainty?

A. Yes.

Q. The condition itself, as I understand, and is it your opinion to a reasonable degree of medical certainty, irreversible?

A. Yes.

Q. How so?

A. He is physically limited to exerting himself at the sedentary level of labor. He might even require oxygen in a normal workplace, but his ability to maintain his concentration and wakefulness, he may, even with the aches and pains he is having, need to take rest breaks during the day. All this is going to impact on his employability, and I have not addressed his vocation capabilities because that is getting outside my area of specialty.

Employer argues in its brief: "Employee did not prove with a reasonable probability that he was exposed to a substance that is linked to Employee's condition. Employee did not prove what he was likely exposed to, and even Employee's expert admits that no one has identified a

causal agent of Employee's lung condition." Employer is correct that Dr. Parmet testified that he had not identified a specific agent that caused Claimant's hypersensitivity pneumonitis.

In *Vickers v. Department of Public Safety*, 283 S.W.3d 287 (Mo. App. W.D. 2009), Ms. Vickers contracted a bacterium, *clostridium difficile* ("c-diff"). Ms. Vickers alleges that she contracted c-diff while working in the laundry at a Missouri Veterans' Home. There was no direct proof that Vickers was actually exposed to the c-diff bacterium at work. The Administrative Law Judge and the Labor and Industrial Relations Commission denied Vickers' claim for occupational disease. In reversing the Commission's decision, the appellate court stated (at page 295):

> Chapter 287 does not require a claimant to establish, by a *medical certainty*, that his or her injury was caused by an occupational disease in order to be eligible for compensation. In fact, the medical experts for both sides in this case agreed that determining exactly when Vickers contracted C diff would be impossible. Under 287.067, however, a single medical expert's opinion may be competent and substantial evidence in support of an award of benefits, even where the causes of the occupational disease are indeterminate.

In *Smith v. Capital Region Medical Center*, 412 S.W.3d 252 (Mo. App. W.D. 2013), Mr. Smith contracted hepatitis C and died. Mrs. Smith filed a claim for death benefits, alleging that Mr. Smith contracted hepatitis C during his many years of work as a phlebotomist/laboratory technician at the hospital. There was no direct evidence that Mr. Smith was ever exposed to blood containing the hepatitis C virus. The Administrative Law Judge and the Labor and Industrial Relations Commission denied Smith's claim for occupational disease. In reversing the Commission's decision, the appellate court, citing *Vickers*, stated (at pages 261-262):

> The claimant in our case offered the testimony of Dr. Parmet to establish the probability that Smith's working conditions caused the hepatitis C. Dr. Parmet testified that Smith's work at Capital Region and his daily exposure to blood put him at a greater risk of contracting hepatitis C. Dr. Parmet further testified that there is a recognizable link between hepatitis C and the distinctive features of Smith's position as a laboratory technologist. Dr. Parmet categorized Smith's job as posing the greatest risk of acquiring hepatitis C due to the high number of needle sticks sustained by those in Smith's profession. According to Dr. Parmet, blood samples taken in hospitals are more likely to contain hepatitis C because of the simple fact that hospitals treat people with illnesses. Further, Dr. Parmet said that the likelihood of hepatitis C infected blood increases for hospitals in urban settings, such as Capital Region located in Jefferson City. Dr. Parmet also explained that the risk factor for contracting hepatitis C for phlebotomists like Smith was especially high before the implementation of OSHA regulations.
>
> Based upon these facts, Dr. Parmet concluded that it was "more likely than not that ... Smith acquired his hepatitis C infection due to his occupational exposure at Capital Region Medical Center, either by a needle stick or by handling blood and body products." Dr. Parmet said that Smith's exposure to needle sticks and Smith's handling blood and body products was the prevailing factor in Smith's developing hepatitis C. Dr. Parmet stated that Smith's work was "clearly the largest risk factor and the most probable source"

> of his hepatitis C. Further, Dr. Parmet said that, to a reasonable degree of medical certainty, it was "more probable than not that the 1991 recorded symptoms of Stephen Smith [were] the medically competent producing cause of the hepatitis C."
>
> Such evidence from Dr. Parmet established **a probability** that Smith's working conditions caused his hepatitis C, and under *Vickers,* **such evidence was sufficient to meet the claimant's burden of production on the issue of causation**. (Emphasis added.)

And in *Lankford v. Newton County (supra),* Mr. Lankford died due to complications of pneumonia and COPD, allegedly caused by exposure to a bacterium called Mycobacterium avium intracellulare ("MAI"). While there was evidence that Lankford was exposed to pigeon droppings on the courthouse roof while taking his smoke breaks, there was no direct evidence that he was exposed to MAI. The Commission affirmed the Administrative Law Judge's finding that Claimant did sustain an compensable occupational disease. The ALJ stated:

> A claimant does not have the burden of proof in an occupational disease case such as this to pinpoint the specific exposure. (Citing *Smith v. Capital Region).* The totality of the evidence clearly establishes a probability that Lankford's occupational activities at Employer caused the MAI. It is clear that he experienced a greater risk of exposure to contracting MAI during his employment with Employer than in his non-work activities. I find Dr. Parmet's opinion regarding exposure and causation to be more persuasive than the opinions of Dr. Jost and Dr. Hofmann.

The appellate court affirmed the Commission's finding of a compensable occupational disease.

The instant case is quite similar to *Vickers, Smith* and *Lankford* on the issue of whether a compensable occupational disease was sustained. While Dr. Parmet admits that he cannot identify the specific causal agent, he testified that "there is an exposure in his workplace to large amounts of biological dust and particles that could be reasonably expected to contain a causal agent for hypersensitivity pneumonitis." In so finding, Dr. Parmet relied, in part, on environmental testing performed which showed that fungi and other biological particles formed 20% of the dust. That 20% number is certainly not surprising, considering that a sewage abatement project was also being performed at the same time, and in the same area as the elevator project.

I find that Claimant did indeed sustain a compensable occupational disease, said occupational disease being hypersensitivity pneumonitis.

Whether the occupational disease is the prevailing factor in the cause of any or all of the injuries and/or conditions alleged in the evidence. The injuries and conditions alleged in the evidence are the following:

- Hypersensitivity pneumonitis
- Lung/breathing problems
- Sarcoidosis

- Lymphoma
- Eye problems
- Rash/skin problems
- Fatigue
- Diabetes
- Avascular necrosis of the left hip
- Depression

Hypersensitivity pneumonitis. Consistent with the above finding of occupational disease of hypersensitivity pneumonitis, I find that the occupational disease is the prevailing factor in the cause of hypersensitivity pneumonitis.

Lung/breathing problems. Hypersensitivity pneumonitis is an interstitial lung disease. Consistent with Dr. Parmet's findings, which I find to be persuasive, I find that the occupational disease is the prevailing factor in the cause of Claimant's lung problems and breathing problems.

Sarcoidosis. The evidence is clear that the occupational disease of hypersensitivity pneumonitis is NOT the prevailing factor in the cause of Claimant's sarcoidosis. Claimant's occupational disease was caused by dust exposure in the work environment. Although Dr. Parmet testified that it has long been *suspected* that sarcoidosis may also be caused by environmental factors, such as dust exposure, he could not so testify to a reasonable degree of medical certainty.

Lymphoma. The evidence was that Claimant's lymphoma was caused by his use of the drug azathioprine, or that the cause was unknown. The evidence was also clear that Claimant was prescribed azathioprine for his (non-work-related) sarcoidosis, and not for his (work-related) hypersensitivity pneumonitis. Therefore, I must conclude that the occupational disease of hypersensitivity pneumonitis is NOT the prevailing factor in the cause of Claimant's lymphoma.

Eye problems. The evidence was that most of Claimant's eye problems were caused by sarcoidosis. There is no evidence that Claimant's eye problems were caused directly by hypersensitivity pneumonitis. However, in addition to the eye problems caused by sarcoidosis, Claimant has also developed diabetic retinopathy. As discussed below, the occupational disease of hypersensitivity pneumonitis was treated with prolonged use of oral prednisone which caused Claimant to develop diabetes. Therefore, I find that the occupational disease is the prevailing factor in the cause of Claimant's diabetic retinopathy only.

Rash/skin problems. The evidence was clear that Claimant's rash and skin problems were caused by sarcoidosis. Therefore, I must conclude that the occupational disease of hypersensitivity pneumonitis is NOT the prevailing factor in the cause of Claimant's skin problems.

Fatigue. Dr. Parmet testified:

Q. Given his condition of, would it be fair to call it oxygen deficiency?

A. He's chronically hypoxic, so we could call it that.

> Q. And the multiple effects that you described from everything from joints to brain to kidney function, would you expect this person to have periods of profound disability?
>
> A. You would -- you would anticipate that somebody like this would be -- would spend much of his time being extremely fatigued, and any exertion would increase that fatigue.
> (Exhibit 12, pages 44-45.)

Regarding the cause of Claimant's fatigue, there was no evidence to the contrary. While Dr. Parmet did not expressly use the term "prevailing factor", the unmistakable inference from Dr. Parmet's testimony is that the occupational disease of hypersensitivity pneumonitis is the prevailing factor in the cause of Claimant's fatigue, and I so find.

Diabetes. Dr. Parmet testified: "Well, when I saw him back in 2011, he had diabetes, of course, and he'd been placed on significant doses of a steroid, prednisone. And unfortunately a side effect of prednisone is causing diabetes. And whether it's a primary cause or whether he was pushed over the edge by it, regardless, he didn't have diabetes before he was begun on prednisone, and he certainly has it now." As Claimant's prednisone was prescribed for the hypersensitivity pneumonitis, there is a direct cause and effect relationship between the hypersensitivity pneumonitis and the development of diabetes. "Injuries sustained during authorized medical treatment of a prior compensable injury are the natural and probable consequence of the compensable injury and the employer is liable for all resulting disability." *Lahue v. Treasurer*, 820 S.W.2d 561, 563 (Mo. App. W.D. 1991).[9] As there was no testimony to the contrary regarding the cause of the diabetes, I find that the occupational disease is the prevailing factor in the cause of Claimant's diabetes.

Avascular necrosis of the left hip. Claimant sustained avascular necrosis of the left hip which resulted in the need for a (successful) left hip replacement surgery. In this regard, Dr. Parmet testified: "they originally thought it was just a degenerative disease of the – or what we call avascular necrosis. That means the blood supply to a bone has failed to adequately keep the bone alive and the bone dies due to loss of blood supply, avacular. And that's unfortunately another side effect you see with prednisone because of its secondary effect on the blood vessels." As Claimant's prednisone was prescribed for the hypersensitivity pneumonitis, there is a direct cause and effect relationship between the hypersensitivity pneumonitis and the development of avascular necrosis. See references to *Lahue*, above, and footnote 9. As there was no testimony to the contrary regarding the cause of the avascular necrosis, I find that the occupational disease is the prevailing factor in the cause of Claimant's avascular necrosis of the left hip.

Depression. Claimant has been diagnosed with depression and treated with medication by his primary care physician. There was no expert medical testimony regarding the cause of the

[9] In *Lahue*, the court cited, with approval, the following language from a Kansas case: "The law is well settled, that where a claimant sustains an injury arising out of and in the course of her employment, every natural consequence that flows from the injury, including a distinct disability in another area of the body is compensable as a direct and natural result of the primary or original injury."

depression. As the employee has the burden of proof on this issue, I find that that the occupational disease is NOT the prevailing factor in the cause of Claimant's depression.

Employer's liability, if any, for permanent partial disability benefits or permanent total disability benefits. Claimant alleges that he is permanently and totally disabled and is seeking permanent total disability benefits from Employer or from the Second Injury Fund.

Under section 287.020.7, "total disability" is defined as the inability to return to any employment and not merely the inability to return to the employment in which the employee was engaged at the time of the accident. *Fletcher v. Second Injury Fund,* 922 S.W.2d 402, 404 (Mo.App. W.D.1996). The test for permanent and total disability is the worker's ability to compete in the open labor market in that it measures the worker's potential for returning to employment. *Knisley v. Charleswood Corp.,* 211 S.W.3d 629, 635 (Mo.App. E.D. 2007). The primary inquiry is whether an employer can reasonably be expected to hire the claimant, given his present physical condition, and reasonably expect the claimant to successfully perform the work. *Id.*

Second Injury Fund liability exists only if Employee suffers from a pre-existing permanent partial disability that constitutes a hindrance or obstacle to employment or re-employment, that combines with a compensable injury to create a disability greater than the simple sums of disabilities. § 287.220.1 RSMo 2000; *Anderson v. Emerson Elec. Co.,* 698 S.W.2d 574, 576, (Mo.App.E.D. 1985). When such proof is made, the Second Injury Fund is liable only for the difference between the combined disability and the simple sum of the disabilities. *Brown v. Treasurer of Missouri,* 795 S.W.2d 479, 482 (Mo.App. 1990). In order to find permanent total disability against the Second Injury Fund, it is necessary that Employee suffer from a permanent partial disability as a result of the last compensable injury, and that disability has combined with prior permanent partial disability(ies) to result in total disability. 287.220.1 RSMo 1994, *Brown v. Treasurer of Missouri,* 795 S.W.2d 479, 482 (Mo.App. 1990), *Anderson v. Emerson Elec. Co.,* 698 S.W.2d 574, 576 (Mo.App. 1985). Where preexisting permanent partial disability combines with a work-related permanent partial disability to cause permanent total disability, the Second Injury Fund is liable for compensation due the employee for the permanent total disability **after** the employer has paid the compensation due the employee for the disability resulting from the work related injury. *Reiner v. Treasurer of State of Mo.,* 837 S.W.2d 363, 366 (Mo.App. 1992) (emphasis added). In determining the extent of disability attributable to the employer and the Second Injury Fund, an Administrative Law Judge must determine the extent of the compensable injury first. *Roller v. Treasurer of the State of Mo.,* 935 S.W.2d 739, 742-43 (Mo.App. 1996). If the compensable injury results in permanent total disability, no further inquiry into Second Injury Fund liability is made. *Id.* It is, therefore, necessary that the Employee's last injury be closely evaluated and scrutinized to determine if it alone results in permanent total disability and not permanent partial disability, thereby alleviating any Second Injury Fund liability.

Gary Weimholt evaluated Claimant and formed conclusions based on "first-hand knowledge of [Claimant] obtained through this vocational assessment and evaluation, the medical opinions and [Mr. Weimholt's] professional experiences in the field of vocational rehabilitation and disability management access." Mr. Weimholt found that Claimant "has a total

loss of access to the open competitive labor market." He further found that there "is no reasonable expectation that an employer, in the normal course of business, would hire [Claimant] for any position, or that he would be able to perform the usual duties of any job that he is qualified to perform." Mr. Weimholt based his conclusions on the fact that Claimant's limitations from "his pulmonary/lung problems, combined with a low grade level of education, low academic abilities for reading, sentence completion, math, and spelling, and absence of any skills for Sedentary work, has resulted in [Claimant's] total loss of labor market." Mr. Weimholt found that because of Claimant's "ongoing symptoms and the severity of his symptoms, [Claimant] is not a candidate for further vocational rehabilitation training or job placement."

Similarly, Dr. Parmet concluded that Claimant was permanently and totally disabled as a result of his workplace exposure. Dr. Parmet also opined that "[Claimant] is physically limited to exerting himself at the sedentary level of labor" and "might even require oxygen in a normal workplace, but his ability to maintain his concentration and wakefulness, he may, even with the aches and pains he is having, need to take rest breaks during the day." Therefore, Dr. Parmet stated that Claimant would not be "capable of functioning full-time even at a sedentary level of labor because all of [his] limitations imposed upon him would place him at permanent total disability." Dr. Parmet maintained this opinion throughout the duration of Claimant's case. In his second deposition, Dr. Parmet stated that Claimant is permanently totally disabled and "functionally he is below sedentary level of labor . . . I don't see that he could do any gainful employment with that degree of physical limitation."

There were no other expert opinions regarding Claimant's ability to compete in the open labor market. The opinions of Mr. Weimholt and Dr. Parmet are totally consistent with the remaining evidence in the case and thus I find them to be credible. Thus, I find that Claimant cannot compete in the open labor market and is permanently and totally disabled.

I further find that Claimant was rendered permanently and totally disabled by the 2007 occupational disease considered alone and of itself, and not taking into account any prior disabilities or conditions. I find that Claimant's only preexisting condition was a back injury which did not affect his work for Employer. I also have taken into consideration the following testimony of Gary Weimholt:

> Q. Okay. So it's your opinion that it's the restrictions and the functional limitations stemming from the June '07 workplace exposure and the problems that he has from his pulmonary lung problems combined with his basically lack of transferable job skills is what is taking him out of the open labor market, correct?
>
> A. Yes.
>
> Q. So it's this last injury, so to speak, of the exposure in June 2007 and the restrictions of Dr. Parmet which were imposed therefrom along with the pain, the functional limitations, the fact that he has breathing problems, that he also testified that his hands and feet swell, and he can't grip things, he has headaches, he has neck pain since the June '07 injury, all of those things are -- those things

are -- is what taking him out of the open labor market and rendering him permanently and totally disabled in isolation, correct?

A. Yes.

Q. Without any consideration of the prior back condition, correct?

A. Correct, yes.

I further find that Claimant was permanently and totally disabled, due to his occupational disease of hypersensitivity pneumonitis, on or before his last day of actual work for Employer, which was January 10, 2008. Therefore, Employer's liability for the payment of permanent total disability benefits began on January 11, 2008.

Due to the above finding, the issues of permanent partial disability, temporary total disability and Second Injury Fund liability are all moot.

Employer's responsibility for past medical expenses. Employer has proffered no medical treatment. Employer had denied this case from the beginning. Claimant was forced to seek his medical treatment on his own. Medical expenses incurred by a claimant to cure and relieve a compensable injury, when the employer has denied the claim and abandoned the claimant to independently obtain medical treatment, must be paid by the employer. An award to a claimant for the cost of medical services shall only be paid to the claimant and to no one else other than the claimant, such as a hospital, health insurer or other institution. *Maness v. City of Desoto*, 421 SW 3d 532 (Mo. App. 2014); *Wiedower v. ACF Industries, Inc.*, 657 SW2d 71, 75 (Mo. App. 1983); *Strohmeyer v. Southwestern Bell Telephone Co.*, 396 S.W.2d 1, 5 (Mo. App. 1965).

A sufficient factual basis exists for the Commission to award compensation for past medical expenses when: (1) the claimant introduced his medical bills into evidence; (2) the claimant testifies that the bills are related to and the product of his work injury; and (3) "the bills relate to the professional services rendered as shown by the medical records in evidence." *Martin v. Mid–America Farm Lines, Inc.,* 769 S.W.2d 105, 111-12 (Mo. banc 1989).

Claimant submitted over $266,000 in medical charges; there are medical records in evidence corresponding to all of the bills. Some of those bills were for treatment of conditions which I found not to be related to the occupational disease (i.e., sarcoidosis[10], lymphoma, eye treatment other than for diabetic retinopathy, rash, depression/anxiety), have been excluded. After excluding those bills, I find that Employer is responsible to reimburse Claimant for $232,627.63 for past medical charges.

[10] Some of the treatment records for Claimant's lung condition give a diagnosis of sarcoidosis, which diagnosis I have found to be incorrect. Therefore, Employer is being ordered to pay for all of the lung treatment, irrespective of the diagnosis.

Employer's responsibility for future medical treatment. It is quite clear from the evidence that Claimant is in need of continuing and future medical treatment for hypersensitivity pneumonitis, breathing problems, diabetes, diabetic retinopathy, fatigue, and a left hip replacement due to avascular necrosis of the left hip; an extended discussion of Section 287.140 and case law is not necessary in this case. Employer is responsible for future medical treatment pursuant to Section 287.140.

Safety penalty. Claimant is alleging a 15% enhancement of all benefits awarded, pursuant to Section 287.120.4, which states:

> Where the injury is caused by the failure of the employer to comply with any statute in this state or any lawful order of the division or the commission, the compensation and death benefit provided for under this chapter shall be increased fifteen percent.

Claimant argues that Employer has violated the following statutes: §292.300, §292.310 and §292.320, RSMo. They provide, as follows:

> §292.300. That every employer of labor in this state engaged in carrying on any work, trade or process which may produce any illness or disease peculiar to the work or process carried on, or which subjects the employee to the danger or illness or disease incident to such work, trade or process to which employees are exposed shall for the protection of all employees engaged in such work, trade or process adopt and provide approved and effective devices, means or methods for the prevention of such industrial or occupational diseases are incident to such work, trade or process.
>
> §292.310. The carrying on of any process or manufacture or labor in this state in which antimony, arsenic, brass, copper, lead, mercury, phosphorus, zinc, alloys or salts or any poisonous chemicals, minerals, acids, fumes, vapors, gases or other substances are generated or used, employed or handled by the employees in harmful quantities or under harmful conditions or come into contact with in a harmful way are hereby declared to be especially dangerous to the health of the employee.
>
> §292.320. Every employer in this state to which sections 292.300 to 292.440 apply shall provide for and place at the disposal of the employees so engaged, and shall maintain in good condition without cost to the employees, working clothes to be kept and used exclusively by such employees while at work and all employees therein shall be required at all times while they are at work to use and wear such clothing; and in all processes of manufacture or labor referred to in this section which are productive of noxious or poisonous dusts, adequate and approved respirators shall be furnished and maintained by the employer in good condition and without cost to the employees, and such employees shall use such respirators at all times while engaged in any work productive of noxious or poisonous dusts.

I find that Employer has violated §292.300 in that the dust from the abatement process, to which dust Claimant was exposed, subjected Claimant to disease incident thereto, and no means

or methods for the prevention of such industrial or occupational diseases were adopted or provided.

As I find that Employer has violated §292.300, I must also find that Employer has violated §292.320 as no "working clothing" was provided, nor were respirators provided for "noxious" … "dusts".[11]

The question, then, is whether Claimant's "injury" (i.e., the occupational disease of hypersensitivity pneumonitis) was "caused" by Employer's failure to comply with §292.300 and/or §292.320. There was no expert testimony on the causation issue. Nevertheless, §292.300 requires Employer to provide effective devices, means or methods for the prevention of such industrial or occupational diseases. If Employer would have provided effective devices, means or methods (as required by the statute) then the occupational disease, by definition, would have been prevented. The wording of the statute itself appears to satisfy the causation requirement of §287.120.4. I find, therefore, that the requirements of §287.120.4 have been met, and thus the compensation benefit shall be increased fifteen percent. The "compensation benefit" subject to the penalty includes the cost of medical aid. *Martin v. Star Cooler Corp.*, 484 S.W.2d 32 (Mo.App. St. L. 1972).

Costs and attorneys' fees for alleged violation of Section 287.560. Section 287.560, RSMo, states (in part):

> All costs under this section shall be approved by the division and paid out of the state treasury from the fund for the support of the Missouri division of workers'compensation; provided, *however, that if the division or the commission determines that any proceedings have been brought, prosecuted or defended without reasonable ground, it may assess the whole cost of the proceedings upon the party who so brought, prosecuted or defended them*. (Emphasis added.)

The term "whole cost of the proceedings" as used in Section 287.560 includes attorney's fees. *Landman v. Ice Cream Specialties*, 107 S.W.3d 240 (Mo. 2003).

Claimant is asking that the whole cost of the proceedings, including attorney's fees and litigation costs, be assessed against the employer, alleging that Employer has defended these proceedings "without reasonable ground". This case presents extremely complicated issues of medical causation. The issues have been complicated by the apparent change in diagnosis of Claimant's lung disease from hypersensitivity pneumonitis to sarcoidosis. The issues have been further complicated by Claimant's subsequent health issues, some related to the hypersensitivity pneumonitis and treatment therefor, others unrelated. Employer proffered expert medical

[11] I find that Employer has not violated §292.310, as there was no evidence that any of the named substances (i.e., antimony, arsenic, etc.) were generated, used, employed or handled; nor was there any evidence that poisonous chemicals, minerals, acids, fumes, vapors, gases or other substances were generated, used, employed or handled. The adjective "poisonous" clearly describes each of the several nouns following it. While the "other substance" (dust) which was generated by the abatement process and handled and inhaled by Claimant was "noxious", it was not "poisonous".

testimony on the issue of diagnosis, occupational disease and medical causation. A finding that Employer has "defended without reasonable ground" does not appear to be warranted in this case. Claimant's request is denied.

Potential dependency issues. On January 9, 2007, the Supreme Court of Missouri issued its decision in the case of *Schoemehl v. Treasurer of State*, 217 S.W.3d 900 (Mo. 2007), holding that when a permanently and totally disabled employee dies of a cause unrelated to the work injury, the employee's surviving dependent(s) become the "employee" entitled to the award of lifetime permanent total disability benefits. Although the holding was abrogated by section 287.230 in 2008, *Schoemehl* continues to apply to claims for permanent total disability benefits that were pending between January 9, 2007, and June 26, 2008. *Estate of Dunkin v. Treasurer of Mo.*, No. WD80035, 2017 WL 965650 (Mo. App. WD Mar. 14, 2017).

Claimant filed his original claim for compensation in this case on March 17, 2008; his claim was pending on June 26, 2008, and has remained pending since that time.

As I have found that Claimant is entitled to permanent total disability benefits, I make the following findings concerning Claimant's wife, Angelique Smith:

1. Claimant and Angelique Smith were married in August 1997.
2. At the time of the occupational hazard exposure and the onset of his disease on or about July 8, 2007, Claimant and Angelique Smith remained married.
3. Up to and including the time of final hearing, Claimant and Angelique Smith remained married.

FINDINGS OF FACT AND RULINGS OF LAW

In addition to those facts and legal conclusions to which the parties stipulated, I find the following:

1. Claimant sustained an occupational disease arising out of and in the course of his employment on or about July 8, 2007.
2. The occupational disease is hypersensitivity pneumonitis.
3. The testimony of Dr. Allen Parmet was credible and persuasive on all issues, including the diagnosis of hypersensitivity pneumonitis and the cause thereof.
4. The report of Dr. Michael Graham was not persuasive on the issue of the diagnosis of pulmonary sarcoidosis.
5. The testimony of Dr. Myron Jacobs was not persuasive on the issue of the diagnosis of pulmonary sarcoidosis.
6. Claimant's continued exposure to dust from an elevator project, an asbestos abatement project, and a sewage abatement project, beginning on or about July 8, 2007 and continuing through early September 2007 was the prevailing factor in the cause of the occupational disease.

7. Although the specific causative agent of the occupational disease has not been identified, Claimant was exposed in his workplace to large amounts of biological dust and particles that could be reasonably expected to contain a causal agent for hypersensitivity pneumonitis.
8. In an attempt to cure and relieve Claimant from the effects of hypersensitivity pneumonitis, Claimant was prescribed prednisone over a long period of time.
9. Chapter 287 does not require a claimant to establish, by a medical certainty, that his or her injury was caused by an occupational disease in order to be eligible for compensation. *Vickers v. Department of Public Safety*, 283 S.W.3d 287, 295 (Mo. App. W.D. 2009).
10. Under Section 287.067, RSMo, a single medical expert's opinion may be competent and substantial evidence in support of an award of benefits, even where the causes of the occupational disease are indeterminate. *Vickers v. Department of Public Safety*, 283 S.W.3d 287, 295 (Mo. App. W.D. 2009).
11. A claimant does not have the burden of proof in an occupational disease case such as this to pinpoint the specific exposure. *Lankford v. Newton County*, 2017 WL 167582 (Mo. App. S.D. Jan. 17, 2017).
12. The totality of the evidence in this case clearly establishes a probability that Claimant's occupational activities at Employer caused the hypersensitivity pneumonitis.
13. Claimant's occupational disease of hypersensitivity pneumonitis is the prevailing factor in the cause of Claimant's lung problems, breathing problems, and fatigue.
14. Claimant's prolonged use of prednisone, necessitated by the hypersensitivity pneumonitis, is the prevailing factor in the cause of Claimant's diabetes, diabetic retinopathy, and avascular necrosis of the left hip.
15. "Injuries sustained during authorized medical treatment of a prior compensable injury are the natural and probable consequence of the compensable injury and the employer is liable for all resulting disability." *Lahue v. Treasurer*, 820 S.W.2d 561, 563 (Mo. App. W.D. 1991). Therefore, the occupational disease is the prevailing factor in the cause of Claimant's diabetes, diabetic retinopathy, and avascular necrosis of the left hip.
16. Claimant's occupational disease of hypersensitivity pneumonitis is not the prevailing factor in the cause of Claimant's sarcoidosis, lymphoma, rash, skin problems, and eye problems other than diabetic retinopathy.
17. Prior to July 8, 2007, Claimant was working with a preexisting back injury which did not affect his work for Employer.
18. Claimant is unable to compete in the open market for employment.
19. Claimant is permanently and totally disabled.
20. The injuries and conditions Claimant sustained as a result of the July 8, 2007 occupational disease were sufficient to render Claimant permanently and totally disabled.
21. Employer is responsible for payment of permanent total disability benefits beginning January 11, 2008.
22. Employer has no responsibility for payment of permanent partial disability benefits.
23. Employer has no responsibility for payment of temporary total disability benefits.

24. The Second Injury Fund has no responsibility for payment of permanent total disability benefits or permanent partial disability benefits.
25. Employer has denied this case from the outset and has provided no medical treatment for Claimant. Medical expenses incurred by a claimant to cure and relieve a compensable injury, when the employer has denied the claim and abandoned the claimant to independently obtain medical treatment, must be paid by the employer. An award to a claimant for the cost of medical services shall only be paid to the claimant and to no one else other than the claimant, such as a hospital, health insurer or other institution. *Maness v. City of Desoto*, 421 SW 3d 532 (Mo. App. 2014); *Wiedower v. ACF Industries, Inc.*, 657 SW2d 71, 75 (Mo. App. 1983); *Strohmeyer v. Southwestern Bell Telephone Co.*, 396 S.W.2d 1, 5 (Mo. App. 1965).
26. Employer is responsible for reimbursing Claimant the amount of $232,627.63 for reasonable medical charges for necessary medical treatment.
27. Claimant is in need of continuing and future medical treatment to cure and relieve Claimant from the effects of his occupational disease.
28. "Where the injury is caused by the failure of the employer to comply with any statute in this state or any lawful order of the division or the commission, the compensation and death benefit provided for under this chapter shall be increased fifteen percent." Section 287.120.4, RSMo.
29. "That every employer of labor in this state engaged in carrying on any work, trade or process which may produce any illness or disease peculiar to the work or process carried on, or which subjects the employee to the danger or illness or disease incident to such work, trade or process to which employees are exposed shall for the protection of all employees engaged in such work, trade or process adopt and provide approved and effective devices, means or methods for the prevention of such industrial or occupational diseases are incident to such work, trade or process." Section 292.300, RSMo.
30. Claimant's occupational disease of hypersensitivity pneumonitis was caused by the failure of Employer to comply with §292.300.
31. The compensation due to Claimant hereunder shall be increased by 15%, per the mandate of §287.120.4, due to Employer's failure to comply with §292.300.
32. The "compensation benefit" subject to the penalty of §287.120.4 includes the cost of medical aid. *Martin v. Star Cooler Corp.*, 484 S.W.2d 32 (Mo.App. St. L. 1972).
33. The cost of medical aid due to Claimant by Employer ($232,627.63) is ordered increased by 15%, resulting in the total sum of $267,521.77.
34. The stipulated weekly compensation amount for permanent total disability ($254.31) is ordered increased by 15%, resulting in a weekly compensation rate of $292.46.
35. Employer has not defended these proceedings without reasonable ground.
36. Claimant and Angelique Smith were married in August 1997.
37. At the time of the occupational hazard exposure and the onset of his disease on or about July 8, 2007, Claimant and Angelique Smith remained married.
38. Up to and including the time of final hearing, Claimant and Angelique Smith remained married.
39. Claimant's attorney, William Rotts, is entitled to attorney's fees for necessary legal services rendered to Claimant in this matter.

ORDER

Employer is ordered to pay Claimant the sum of $267,521.77 for medical benefits. Employer is ordered to pay Claimant permanent total disability benefits of $292.46 per week, beginning January 11, 2008, for Claimant's lifetime.

Employer is also ordered to provide Claimant with future medical care and treatment as is reasonable and necessary to cure and relieve Claimant from the effects of the occupational disease.

The claim against the Second Injury Fund is denied in full.

Claimant's attorney, William Rotts, is allowed 25% of all benefits awarded as and for necessary attorney's fees, including future weekly benefits, and the amount of such fees shall constitute a lien thereon.

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

Made by _____
/s/ Robert J. Dierkes – 6-5-2017
Chief Administrative Law Judge
Division of Workers' Compensation