

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

Injury No.: 15-031122

Employee: James Allen
Employer: State of Missouri Fulton State Hospital
Insurer: Missouri Office of Administration
Central Accident Reporting Office

The above-entitled workers' compensation case is submitted to the Labor and Industrial Relations Commission (Commission) for review as provided by § 287.480 RSMo. Having reviewed the evidence and considered the whole record, the Commission finds that the award of the administrative law judge is supported by competent and substantial evidence and was made in accordance with the Missouri Workers' Compensation Law. Pursuant to § 286.090 RSMo, the Commission affirms the award and decision of the administrative law judge dated October 11, 2018. The award and decision of Administrative Law Judge Bruce Farmer, issued October 11, 2018, is attached and incorporated by this reference.

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

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

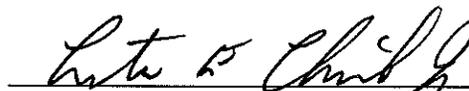
Given at Jefferson City, State of Missouri, this 13th day of June 2019.

LABOR AND INDUSTRIAL RELATIONS COMMISSION

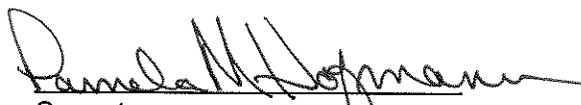



Robert W. Cornejo, Chairman


Reid K. Forrester, Member


Curtis E. Chick, Jr., Member

Attest:


Secretary

AWARD

Employee:	James Allen	Injury No.:	15-031122
Dependents:	N/A		Before the
Employer:	State of Missouri Fulton State Hospital		DIVISION OF WORKERS'
Insurer:	Missouri Office of Administration Central Accident Reporting Office		COMPENSATION
			Department of Labor and Industrial Relations of Missouri Jefferson City, Missouri
Hearing Date:	July 11, 2018	Checked by:	

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: May 5, 2015
5. State location where accident occurred or occupational disease was contracted: Callaway County, Missouri
6. Was above employee in employ of above employer at time of alleged accident or occupational disease? Yes.
7. Did employer receive proper notice? Yes.
8. Did accident or occupational disease arise out of and in the course of the employment? Yes.
9. Was claim for compensation filed within time required by Law? Yes.
10. Was employer insured by above insurer? Yes.
11. Describe work employee was doing and how accident occurred or occupational disease contracted:
.See award.
12. Did accident or occupational disease cause death? No. Date of death? N/A
13. Part(s) of body injured by accident or occupational disease: right shoulder, head, cervical spine, thoracic spine.
14. Nature and extent of any permanent disability: See award.
15. Compensation paid to-date for temporary disability: \$0
16. Value necessary medical aid paid to date by employer/insurer: \$57,814.59

Issued by DIVISION OF WORKERS' COMPENSATION

17. Value necessary medical aid not furnished by employer/insurer? None.
18. Employee's average weekly wages: Not submitted.
19. Weekly compensation rate: \$451.02
20. Method wages computation: Stipulation

COMPENSATION PAYABLE

21. Amount of compensation payable: See award.

169 weeks of permanent partial disability from Employer

6 weeks of disfigurement from Employer

22. Second Injury Fund liability: N/A

TOTAL: \$78,928.50

23. Future requirements awarded: See award.

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

The compensation awarded to the claimant shall be subject to a lien in the amount of 25% of all payments hereunder in favor of the following attorney for necessary legal services rendered to the claimant:
Van Camp Law Firm LLC.

FINDINGS OF FACT and RULINGS OF LAW:

Employee:	James Allen	Injury No.: 15-031122
Dependents:	N/A	Before the
Employer:	State of Missouri Fulton State Hospital	DIVISION OF WORKERS'
Insurer:	Missouri Office of Administration Central Accident Reporting Office	COMPENSATION Department of Labor and Industrial Relations of Missouri Jefferson City, Missouri

The above-referenced matter was heard for a final award hearing on July 11, 2018. The employee, James Allen, appeared in person and through his attorney, Tammy Kearns. The employer, State of Missouri Fulton State Hospital, and its insurer, the Missouri Office of Administration c/o Central Accident Reporting Office (CARO), appeared through their attorney, Erika Eliason.

This was a consolidated hearing involving four separate accidents. The parties agreed that four accidents occurred, the first on January 12, 2015 (Injury No. 15-000919), the second on February 1, 2015 (Injury No. 15-005001), the third on May 5, 2015 (Injury No. 15-031122), and the fourth on December 20, 2016 (Injury No. 16-099060). The parties agreed on certain undisputed facts and identified the issues that were in dispute. Unless otherwise indicated, the following undisputed facts and issues apply to all four claims.

UNDISPUTED FACTS

1. The employment and accidents occurred in Fulton, Callaway County, Missouri. The hearing was held in Jefferson City, Cole County, Missouri. Venue for the hearing was therefore proper.
2. The State of Missouri Fulton State Hospital was operating under and subject to the provisions of the Missouri Workers' Compensation Act and was duly qualified as a self-insured employer through the Missouri Office of Administration.

3. On the four accident dates set forth above, James Allen was an employee of the State of Missouri Fulton State Hospital and was working under the Workers' Compensation Act.
4. On the four accident dates set forth above, the employee sustained accidents arising out of and in the course of his employment.
5. The employer had notice of each accidents.
6. The employee's claims were each filed within the time allowed by law.
7. The employer-insurer paid medical benefits as follows:

Jan. 12, 2015 injury:	\$ 1,216.22
Feb. 1, 2015 injury:	\$28,393.02
May 5, 2015 injury:	\$57,814.59
Dec. 20, 2016 injury:	\$ 59.47
8. The employer-insurer paid temporary disability benefits only for the February 1, 2015 injury in the amount of \$13,179.17.
9. The employee is entitled to the maximum permanent partial disability rate of \$451.02 for the three 2015 injuries and \$477.33 for the 2016 injury.

ISSUES

1. The nature and extent of any permanent disabilities.
2. Whether the employee has sustained injuries that will require future medical care in order to cure and relieve the employee of the effects of the injuries.
3. Disfigurement related to the May 5, 2015 accident.

The findings and conclusions will address all four claims. Separate awards will be issued for each injury number and date of injury. This award addresses Injury No. 15-031122, date of injury May 5, 2015.

FACTS

Mr. Allen has been employed at Fulton State Hospital since 2012. At the time of all four injuries discussed, Mr. Allen worked as a forensic rehabilitation specialist (FRS II). His job duties included scheduling staff for shifts and breaks, charting, meeting with treatment teams, and responding to staff supports. Mr. Allen still holds this position.

Injuries and Treatment

On January 12, 2015, Mr. Allen responded to a staff support on a different ward than the one he worked in and encountered a very large male client that was in crisis. The client had barricaded himself into his room with his bed pushed against his door. The nurse that was present directed Mr. Allen and other staff members to restrain the client. Approximately ten staff members pushed the door open and Mr. Allen was the first person in the room. The client immediately charged at him and Mr. Allen and another staff member each grabbed onto the client's arms. During the altercation, a different staff member grabbed Mr. Allen's legs, causing the client and another staff member to fall directly on top of Mr. Allen thereby forcefully shoving his head, neck, and shoulder into a brick column. Mr. Allen testified that client rooms are very small and the staff members are not equipped with protective gear, body armor, or helmets.

Mr. Allen went to the Callaway Community Hospital Emergency Room, where he was diagnosed with a contusion to the right temporal area. (Exhibit 2) Mr. Allen was instructed to follow up with his primary care physician in a week. Mr. Allen testified that he missed two days of work related to the January 12, 2015 accident. Mr. Allen did not see his primary care physician or schedule a follow-up appointment.

On February 1, 2015, Mr. Allen responded to a staff support involving the same large male client that charged him on January 12, 2015. This time, the client was tearing apart his mattress and trying to choke himself. When Mr. Allen entered the client's room to remove the mattress, the client clawed Mr. Allen's face and punched him several times on the right side of his head before Mr. Allen could get the client into restraints.

Mr. Allen received treatment the same day at the Callaway Community Hospital Emergency Room. He was diagnosed with contusions to his left face, mouth, and cheek. (Exhibit 2) Three days later, Mr. Allen was seen by Dr. Runde for both injuries. Regarding the January

12, 2015 injury, Dr. Runde noted pain on the right side of Mr. Allen's head and neck, a constant headache, an earache, difficulty hearing in the right ear, decreased memory, and concentration issues. Dr. Runde ordered an audiogram, which showed decreased hearing in the right ear. However, a follow-up audiogram showed normal hearing bilaterally. Dr. Runde diagnosed Mr. Allen with a head contusion, neck pain, and decreased hearing in the right ear. He also recommended a cervical spine x-ray and physical therapy to treat Mr. Allen's neck. (Exhibit 5)

With regard to the February 1, 2015 injury, Dr. Runde noted pain to the right side of Mr. Allen's head, neck, face, and right ear, mild photophobia, and decreased short-term memory. Dr. Runde diagnosed neck pain, headache possibly due to concussion, right shoulder pain, and facial abrasions. Dr. Runde recommended physical therapy to treat Mr. Allen's neck and right shoulder. Dr. Runde eventually ordered an MRI of Mr. Allen's right shoulder to evaluate the anterior serratus muscle and an electrodiagnostic study to rule out a long thoracic nerve injury. The MRI revealed suspected labral tears anteriorly and posteriorly with a paralabral cyst, tendinopathy with subacromial impingement of the supraspinatus and infraspinatus tendons, edema in the acromioclavicular joint, and edema along the serratus anterior in the lateral chest wall. Dr. Runde referred Mr. Allen to an orthopedic surgeon on March 20, 2015. (Exhibit 5)

While treating with Dr. Runde, Mr. Allen was also seen by Dr. Peebles for a neurologic evaluation and treatment. Dr. Peebles' records indicate that Mr. Allen continued to suffer from daily headaches, decreased concentration, decreased short-term memory, and right shoulder pain. Dr. Peebles' records further note that Mr. Allen's headaches were exacerbated by loud noises, concentration, and pushing or pulling with his right arm. Dr. Peebles diagnosed concussions without loss of consciousness on January 12, 2015 and February 1, 2015, post-concussive headaches, subjective memory and concentration problems, and right scapular winging.

Dr. Peeples recommended an EMG/NCS for right scapular winging and prescribed Depakote to treat Mr. Allen's headaches. (Exhibit 6)

Before Mr. Allen could be seen by an orthopedic surgeon as recommended by Dr. Runde or obtain his nerve studies as recommended by Dr. Peeples, he was injured a third time. On May 5, 2015, a client had become very aggressive and was running around the ward without any clothes on. A staff support was called, and the client went back into his room. Mr. Allen was instructed to restrain the client. When Mr. Allen entered the client's room, the client fixated on him and charged at him. Mr. Allen grabbed the client's legs and they rolled over the client's bed, trapping Mr. Allen between the bed and the wall. The client was able to get one leg loose and then kicked Mr. Allen on the right side of his head.

Mr. Allen initially received treatment at Fulton Medical Clinic. He was diagnosed with right shoulder strain, neck strain, head contusion, concussion, and back pain. A CT scan of Mr. Allen's brain was performed and showed slight asymmetry with the right frontal horn greater than the left, but no other acute intracranial process. An x-ray of Mr. Allen's right shoulder showed no abnormalities and an x-ray of his cervical spine revealed mild degenerative disk disease at C6-C7. Mr. Allen was referred to an orthopedic surgeon. (Exhibit 11)

Mr. Allen was sent to Dr. Runde again. Dr. Runde documented complaints of neck pain, right shoulder pain, and pain in the inferior and superior right scapular area. Dr. Runde diagnosed right shoulder pain, headache, and neck pain with recent exacerbation. Dr. Runde recommended that Mr. Allen follow-up and continue treatment with Dr. Peeples as scheduled for his headaches and that Mr. Allen be seen by Dr. Gross, an orthopedic surgeon, to evaluate Mr. Allen's shoulder injury from February 1, 2015 and May 5, 2015. (Exhibit 5)

Dr. Peeples ordered an EMG/NCS. The findings were consistent with incomplete acute/subacute right long thoracic neuropathy. A repeat test done almost three months later

revealed the same findings. Mr. Allen's headaches improved with medication, so Dr. Peeples attempted to wean him off the prescription. The headaches quickly returned, and Mr. Allen had to resume the use of his prescription medication. He was instructed to taper off the medications again before being released by Dr. Peeples in August 2015 and has since used Tramadol as prescribed by the VA Hospital. To treat his persistent right scapular winging, Dr. Peeples recommended further physical therapy or a shoulder stabilization procedure, both of which Dr. Peeples opined would result in some degree of functional limitation. (Exhibit 6)

On May 25, 2016, Mr. Allen was seen by Dr. Gross to evaluate his shoulder injury. Dr. Gross diagnosed right long thoracic neuropathy and an injury to the long thoracic nerve. Dr. Gross recommended the use of non-steroidal anti-inflammatories and physical therapy. Mr. Allen's symptoms persisted, and Dr. Gross ordered another EMG/NCS which again showed incomplete right long thoracic neuropathy. Dr. Gross recommended continued physical therapy, a posture shirt, and referred Mr. Allen to Dr. Hagan to determine if he was a candidate for nerve decompression or a nerve transfer. (Exhibit 9)

Dr. Hagan's records document continued right shoulder pain and winging, upper extremity numbness and weakness, reduced range of motion in the right shoulder, neck pain, anterior chest wall pain, scapular pain, pain that radiates into the bicep, pressure in the clavicular region, ear pain, and occipital headache. Upon examination, Dr. Hagan noted tenderness over the scalene muscles, reproducible Tinel, supraclavicular pressure test resulting in numbness in the right hand, and positive Wright's test, Adson's test, elevated arm stress test, and modified upper limb tension test. Dr. Hagan recommended an MRI, MRA, injections, and a diagnostic visit with Patricia Zorn, a physical therapist that specializes in neurological injuries. Dr. Hagan diagnosed neurogenic thoracic outlet syndrome, pectoralis minor syndrome, and traumatic contracture of the anterior and middle scalene muscles. On October 5, 2015, Dr. Hagan performed site specific ultrasound guided

diagnostic injections into the upper, middle, and lower trunks and nerves of the brachial plexus with independent ultrasound guided hydrodissection of each of the three trunks. During the same procedure, Dr. Hagan also performed ultrasound guided injections into the anterior and middle scalene muscles at multiple levels, as well as ultrasound guided injections into the pectoralis minor muscle and its tendinous insertion. Mr. Allen testified that he did not get any lasting symptom relief from the injections, but experienced paralysis on the right side of his body while the block was in effect. (Exhibit 7)

Because Mr. Allen had been cleared from a structural shoulder injury standpoint by Dr. Gross, Dr. Hagan opined that Mr. Allen's symptoms instead relate to the neurogenic findings and recommended surgery. On October 27, 2015, Dr. Hagan performed neurolysis of the brachial plexus including all five nerve roots and all three trunks, subtotal resection of the anterior scalene muscle, release of the middle scalene muscle, release of the pectoralis minor muscle insertion, decompression of the subclavian artery, and decompression and neurolysis of the dorsal scapular nerve, long thoracic nerve, and suprascapular nerve. Dr. Hagan's post-operative diagnoses consisted of the following: neurogenic thoracic outlet syndrome/scalene triangle syndrome, brachial plexus compression, anterior and middle scalene contracture, pectoralis minor contracture/syndrome, compression and scarring of the subclavian artery, and injury to the dorsal scapular nerve, long thoracic nerve, and the supra-scapular nerve. Mr. Allen testified as to the location of the surgical incisions, noting that one incision was made at the base of his neck on the right side and the second incision was made through his pectoral muscle. Dr. Hagan's report notes that the surgical procedure provided some improvement of Mr. Allen's numbness and tingling, but his scapular winging increased and persisted following his return to full duty employment. Mr. Allen testified that the surgical procedure slightly improved his cervical range of motion and

relieved some pressure from his neck, but that he did not regain any use of the serratus anterior muscle. (Exhibit 7)

While treating with Dr. Hagan, Mr. Allen attended seven therapy sessions with Patricia Zorn, as recommended by Dr. Hagan, between September 2015 and April 2016. During the initial evaluation, Ms. Zorn noted that Mr. Allen's diagnosis is consistent with neural thoracic outlet syndrome and that Mr. Allen has some impingement signs but that they are likely due to the severe weakness of the serratus anterior muscle which allows the acromion to compress the subacromial space with every arm motion. Ms. Zorn opined that her examination findings support the hypothesis that the anterior shoulder pain is not just from the local shoulder joint issues, but rather neural glide issues. In a later therapy session, Ms. Zorn reported that Mr. Allen's serratus anterior muscle has an unusual pattern in that the muscle showed improved strength when in a shortened position but remained weak in its long position, which allows the scapula to wing when the glenohumeral joint is in certain flexed positions. At Mr. Allen's last session, Ms. Zorn noted continued soreness on the top of his right trapezius, pain where his shoulder blade protrudes, right ear pain, head pain, and numbness and tingling in the fingers on his right hand. Ms. Zorn provided Mr. Allen with a home exercise program upon release. (Exhibit 10)

Mr. Allen also completed eighty-nine physical therapy sessions between February 2015 and January 2016. During his sessions, he received treatment for cervicalgia, headache, injury to the nerves in the upper right limb, right shoulder pain, and brachial plexus disorders. Upon discharge, the physical therapy records report pain that has only improved to six out of ten on the ten-point pain scale, decreased cervical range of motion, weakness in the right shoulder, and continued issues with the scapula hiking up with any arm use, thereby causing increased pain. (Exhibit 4)

On December 20, 2016, while responding to a staff support, Mr. Allen approached six female staff members trying to restrain one male client. Mr. Allen reached across the other staff members involved to put a waist belt on the client and, in the process, the client head butted Mr. Allen directly on his forehead. Mr. Allen did not seek treatment following this injury.

Mr. Allen returned to Dr. Hagan on January 19, 2017 for evaluation due to continued complaints of headaches. Dr. Hagan diagnosed chronic daily headaches, cervicalgia, and occipital neuralgia and recommended injections. On February 3, 2017, Dr. Hagan did diagnostic and therapeutic block injections under fluoroscopic guidance into the C2 nerve root, C3 nerve root, and the lesser occipital nerves. Following the procedure, Mr. Allen had some improvement in his headaches, but continued to suffer from tenderness over his right greater third and lesser occipital nerves and discomfort in his shoulder with palpation of the occipital nerves. Because of his continued symptoms, Dr. Hagan recommended repeat injections. On May 5, 2017, Dr. Hagan did diagnostic and therapeutic block injections under fluoroscopic guidance into the C2 nerve root, C3 nerve root, and the lesser occipital nerves. Mr. Allen testified that both sets of injections were placed into the base of his skull on the right side.

Mr. Allen reported relief from his symptoms while the diagnostic block was in effect, but his headaches returned as soon as the block wore off. Dr. Hagan's report notes that Mr. Allen did not receive any significant long-lasting relief from the steroid portion of the injection. Dr. Hagan also noted that Mr. Allen's pain associated with his headaches ranges between four and seven on a ten-point pain scale and that his right arm symptoms vary depending on how active he is. Following the injections, the only treatment options Dr. Hagan offered was surgery. Mr. Allen testified that he was not interested in undergoing another procedure due to the minimal improvement achieved with his previous surgery and his lack of response to the injections.

Dr. Hagan released Mr. Allen noting that Mr. Allen should return for re-evaluation if his symptoms deteriorate or worsen over time. (Exhibit 8)

Current Symptoms and Limitations

Mr. Allen testified that he never has a headache free day and that he has a headache every morning when he wakes. Because of this, Mr. Allen wakes up thirty minutes early every day to take headache medication and then goes back to bed to give his medication time to take effect. Mr. Allen explained that his headaches start behind his right ear and move outward, with more severe headaches wrapping around to his temple. When Mr. Allen wakes the first time each morning, he rated his pain between seven and eight on the ten-point pain scale. At his second wake up, after his medication has dulled his headache, Mr. Allen testified that he has an aching, throbbing pain that he rated between one and two on the ten-point pain scale. On a good day, Mr. Allen's headache pain will remain between one and two, but on a bad day Mr. Allen's headache pain will reach eight to nine and he suffers from sensitivity to touch on his head and throbbing pain that is so bad that he can feel his heartbeat in his head. Mr. Allen's headaches are increased by stress, lights, noise, and any use of his right shoulder.

Mr. Allen also testified that he has constant pain at the base of his skull and constant tenderness on the back of his head. His pain ranges between one and two on a good day, and seven and eight on a bad day. Mr. Allen's pain is increased with any use of his right arm, pushing or pulling with his right arm, or if his arm hangs unsupported. Mr. Allen also finds it difficult to concentrate and described occasional decreased hearing in his right ear, explaining that he has trouble distinguishing conversations if there is background noise and must turn toward the person speaking in order to hear.

Regarding his neck, Mr. Allen testified that he has pain from the base of his skull down to his shoulder that limits his ability to turn his head. Mr. Allen's pain is increased if he tilts his head

toward his shoulder or stretches the muscles or ligaments. His neck pain is constant, but ranges between one to two out of ten on a good day, and seven to eight out of ten on a bad day. On a good day, Mr. Allen describes the pain as neck stiffness. On a bad day, Mr. Allen describes excruciating and burning pain that feels like muscle tissues are being ripped apart from the base of his skull outward toward his shoulder.

Mr. Allen also continues to suffer from pain in his thoracic spine. If his right shoulder is unsupported or if he is lifting his arm up and down, he explained that it feels like his top right rib is being pulled out of socket and as though the muscles on the left side of his thoracic spine are pulling in the opposite direction to compensate. These actions cause Mr. Allen's shoulder blade to shove upward because he lacks musculature to control his shoulder area. Mr. Allen also suffers from a constant burning pain in the muscles directly to the right of his thoracic spine that range between one and two on a good day, and between seven and eight out of ten on a bad day. In addition, Mr. Allen explained that the outer edge of his scapula has a constant dull achy pain deep in the muscle tissue that ranges between one and two on a good day, and between eight and nine on a bad day. This pain is made worse with pushing or pulling movements. Mr. Allen described the location of his pain as being along his right shoulder blade near the center of his back, in the muscles located on the right side of his spine, inside his shoulder blade, and on his upper back to the right of the base of his neck. At best, Mr. Allen describes the pain as dull and achy in nature that ranges between one and two on the pain scale. On bad days, Mr. Allen suffers from ripping and burning pain that he rates between eight and nine out of ten.

As for his right shoulder, Mr. Allen testified that he has constant pinching and grinding pain in the front of his shoulder joint that radiates into his hand and increases with any use of his shoulder or when reaching across his body. Mr. Allen's right shoulder also hangs approximately four inches lower than his left shoulder and tilts forward, which causes him to experience loud

popping and grinding noises with use. In addition, he has pain that shoots from the top of his bicep down the back of the muscle, nerve sensations or numbness and tingling in the bottom of his hand and in his forearm, and weakness in his right arm and hand due to lack of use.

Because of his injuries, Mr. Allen testified that he cannot use his right arm to brush his daughters hair or play catch with his kids because the repetitive motion causes his pain to increase. He has to sit on the floor to tie his shoes because reaching down to do so forces his scapula upward which causes pain. He cannot pick his children up with his right arm because of his shoulder pain and testified that when he takes his children to the park, he no longer plays with them and instead just watches them from a bench because of his constant pain. Mr. Allen also explained that he must use his left hand to wash his body, shave, brush his teeth, get dressed, and fasten his belt. He also described how his injuries have affected his sleep, explaining that he wakes every two to four hours with numbness in his right arm, cannot lay on his right side, and has to sleep with a pillow tucked under his arm to hold him in place while he sleeps.

Mr. Allen testified that he is responsible for all household chores and finds it difficult to vacuum, do laundry, or cook a large meal and cannot move any furniture. He is unable to use a push mower and instead uses a zero-turn mower since it requires less strength and minimal movement in the upper extremities. In order to use his weed eater, Mr. Allen has modified a tactical sling and drapes it over his left shoulder to support the weight of the weed eater. Since his injuries, Mr. Allen has given up several hobbies because he is either unable to do them or unable to do them without a significant increase in his pain, including drawing, airbrushing, riding his motorcycle, riding ATVs, driving vehicles with manual transmissions, and driving his dune buggy. Mr. Allen also testified that he avoids long road trips, and that even the drive from Fulton, Missouri to Jefferson City, Missouri for the hearing caused his pain to increase.

To accommodate for his injuries, Mr. Allen favors his left hand and arm despite being right handed. He also has to keep his right arm supported at all times to avoid an increase in pain. To do so, he drives with his left arm only and puts a pillow on top of the center console to prop his right arm up, uses chairs with arm rests, props his right arm on his desk while he is typing, or rests his hand in his pocket. If he does not keep his right arm supported, he experiences extreme pain where the first rib goes into the spine, pain at the base of his neck, pain on the outside of his shoulder, and his headaches become more severe.

Mr. Allen testified that he has only been able to maintain full time employment because of the position he holds as an FRS II. He has an office with a door that he can close when necessary and a large portion of his job duties include paperwork, scheduling, charting, and meetings, all of which can be done at a desk. This allows Mr. Allen to keep his right arm supported throughout the day and self-accommodate his pain and his bad days by taking breaks in his office or leaving his ward if necessary. He is also one of the last people that is required to respond to staff supports. Because Mr. Allen is able to self-accommodate at work, he testified that he rarely uses sick days but estimates that he has still called in sick three or four times since his 2016 injury due to pain. Mr. Allen also explained that while it is difficult for him to make it through twelve-hour shifts, he can do so because he spends his three days off work recovering.

To treat his symptoms, Mr. Allen testified that he takes 50 milligrams of Tramadol three times per day for pain, 1000 milligrams of Tylenol three times per day for pain and inflammation (was originally using Ibuprofen), Effexor for pain, 10 milligrams of Ambien to help him sleep, and a prescription topical lidocaine cream for pain. Mr. Allen also uses a heating pad, a massage tool, and does home exercise stretches four to five times per day that focus specifically on the muscles that run from the base of his neck through the outside of his shoulder. Mr. Allen explained that he was not using Tramadol, Tylenol, or the lidocaine cream prior to his work injuries, but he

was using Effexor and Ambien. Mr. Allen testified that prior to his injuries, he was on a lower dose of Effexor to treat depression and the dosage was increased following his injuries because the medication is also used to treat pain. Mr. Allen also testified that leading up to his work injuries, he was on 5 milligrams of Ambien per night because he had difficulty falling asleep. Following his injuries, his dosage doubled and he now takes 10 milligrams every night to help him stay asleep for longer stretches throughout the night. Mr. Allen explained that he has tried to go without taking Tramadol but was unable to make it through a day due to the increase in his pain. Mr. Allen sees a primary care physician through the VA Hospital who writes these prescriptions for him.

Mr. Allen testified that he was not experiencing any headaches or pain in his head, neck thoracic spine, or right shoulder prior to his four work-related injuries. He did testify that he had a prior work injury in 2012 in which he was kicked in his upper back but was not experiencing any symptoms leading up to his 2015 and 2016 injuries and has not reinjured these body parts after 2016. Mr. Allen further testified that he has not experienced any improvement in his symptoms since being released by the authorized treating physicians.

Experts

Mr. Allen was evaluated by Dr. Cohen on October 4, 2016. Mr. Allen testified that Dr. Cohen spent approximately two to three hours with him at his appointment. Dr. Cohen reported that Mr. Allen continued to suffer from daily headaches, more severe headaches, difficulty hearing, constant pain in the back of the right shoulder area, pain in the shoulder blade area that radiates up into the muscles along the right side of his neck with any use of his right arm, shooting pain that goes from the supraclavicular area to the base of his skull on the right side, numbness and tingling in his right arm, constant pinching pain from the right arm down to the right hand, and weakness in his right upper extremity. Dr. Cohen also noted that Mr. Allen has difficulty

brushing his teeth or his daughter's hair, opening doors, and can no longer ride his motorcycle, shift a manual transmission, carry his kids or lift groceries with his right arm, and has to keep his right arm propped up at all times.

Upon examination of the cervical spine, Dr. Cohen noted increased tissue tension along the right para spinous muscles from C4 through C7, distinct trigger points in the mid and upper right trapezius muscle, pain up to the scalp on the right and to the right lateral shoulder, and decreased range of motion with associated discomfort and pain. Examination of the thoracic spine revealed distinct trigger points over the rhomboid and upper thoracic para spinous muscles, reduced range of motion, and discomfort with flexion and extension. Examination of the right shoulder revealed reduced range of motion, posterior scapula winging when reaching forward to flex the arm at the shoulder, significant and persistent winging of the right scapula with standing pushups against the wall, positive impingement signs, positive O'Brien's test causing pain and a popping noise in the shoulder, popping with circumduction, numbness and tingling to the long, ring, and small finger on the right hand with Adson's testing, weakness of the deltoid and rotator cuff, and atrophy of the deltoid and rotator cuff. Dr. Cohen also noted surgical scars over the supraclavicular area and right pectoral region. In addition, Dr. Cohen reported that with visual inspection, the right shoulder is significantly lower than the left shoulder. Examination of the right hand revealed a dusky colored hand with a cool temperature as compared to the uninvolved left hand.

Dr. Cohen concluded that Mr. Allen's January 12, 2015, February 1, 2015, and May 5, 2015 injuries are the "prevailing factor in causing his symptoms and the need for medical care and treatment." For the January 12, 2015 injury, Dr. Cohen diagnosed Mr. Allen with a closed head injury with mild traumatic brain injury, post-traumatic headaches, right shoulder sprain/strain, and cervical sprain/strain. He assigned the following permanent partial disability ratings: 10% of the

body as a whole at the head, 5% of the body as a whole at the cervical spine, 10% at the right shoulder, and 10% of the body as a whole at the thoracic spine.

With regard to the February 1, 2015 injury, Dr. Cohen diagnosed a closed head injury with mild traumatic brain injury, post-traumatic headaches, right long thoracic nerve neuropathy, and right shoulder impingement syndrome. He assigned permanent partial disability ratings as follows: 10% of the body as a whole at the head, 5% of the body as a whole at the cervical spine, 20% of the right shoulder, and 15% of the body as a whole at the thoracic spine.

Due to the May 5, 2015 injury, Dr. Cohen diagnosed a closed head injury with mild traumatic brain injury, aggravation of post-traumatic headaches (now exhibiting migraine headaches), cervical sprain/strain, right shoulder internal derangement (impingement with labral tear), right shoulder girdle neurogenic thoracic outlet syndrome, brachial plexus compression, and injury to the dorsal scapular nerve, long thoracic nerve, and suprascapular nerve. Dr. Cohen also diagnosed status post-surgery for neurogenic thoracic outlet syndrome/scalene triangle syndrome, brachial plexus compression, anterior and middle scalene contracture, pectoralis minor contracture/syndrome, compression and scarring of the subclavian artery, and injuries to the dorsal scapular nerve, long thoracic nerve, and supra scapular nerve. Dr. Cohen assigned the following permanent partial disability ratings: 10% of the body as a whole at the head, 10% of the body as a whole at the cervical spine, 20% at the right shoulder, and 20% of the body as a whole at the thoracic spine.

Dr. Cohen explained that he provided ratings at the right shoulder level due to the diagnostic studies and abnormal findings on clinical exam, and at the chest level/thoracic spine level due to the neurogenic thoracic outlet surgery since it has affected him at more than just the shoulder level. He further explained that thoracic outlet syndrome surgery affects the patient at the chest level based on the anatomical structures involved, and the clinical exam involves both

the thoracic structures as well as the right upper extremity. Dr. Cohen placed Mr. Allen at self-limiting restrictions to tolerance.

Dr. Cohen recommended treatment with an orthopedic surgeon to see if Mr. Allen would benefit from any surgical procedures for diagnostic or therapeutic purposes. Dr. Cohen also opined that Mr. Allen would need ongoing treatment for his post-traumatic headaches for an indefinite period of time, including medications. Dr. Cohen further noted that Mr. Allen continues to use ibuprofen and Tramadol for his right shoulder pain, which Dr. Cohen opined is appropriate due to his multiple injuries. Dr. Cohen concluded that the treatment recommended does reasonably flow from the primary work-related injuries of January 12, 2015, February 1, 2015, and May 5, 2015. (Exhibit 1)

Mr. Allen was evaluated by Dr. Cohen a second time on March 9, 2018, with the main focus being on his December 20, 2016 injury. Dr. Cohen did not assign a permanent partial disability rating for the December 20, 2016 injury and noted that his opinions and ratings contained within his October 4, 2016 remain unchanged. (Exhibit 1)

Dr. Hagan also provided permanent partial disability ratings with regard to Mr. Allen's right shoulder and headaches. In his report dated May 24, 2017, Dr. Hagan noted his diagnosis of long thoracic nerve injury and neurogenic thoracic outlet syndrome with scalene triangle syndrome. Dr. Hagan outlined the treatment he provided to Mr. Allen, including a diagnostic evaluation, diagnostic injections, and decompression surgery. Dr. Hagan assigned a 5% permanent partial disability rating to Mr. Allen's right shoulder because of his nerve injury and persistent weakness. (Exhibit 8)

In Dr. Hagan's July 7, 2017 report regarding Mr. Allen's headaches, he noted that he diagnosed Mr. Allen with post-traumatic right sided occipital nerve syndrome involving the greater, third, and lesser occipital nerves. Dr. Hagan further noted that he performed injections on

February 3, 2017 and again on May 3, 2017. Dr. Hagan reported that Mr. Allen continues to suffer from ongoing significant headaches despite the injections provided and concluded that Mr. Allen should be allowed to return for re-evaluation or treatment should he have recurrence, decompensation of symptoms, or if he fails to improve further. Dr. Hagan assigned a permanent partial disability rating of 8% of the body as a whole relating to Mr. Allen's head. (Exhibit A)

RULINGS OF LAW

Permanent Partial Disability

Section 287.190.6(1) defines permanent partial disability as "a disability that is permanent in nature and partial in degree." The determination of disability is not purely a medical question: "The testimony of the claimant or other lay witnesses as to facts within the realm of lay understanding can constitute substantial evidence of the nature, cause, and extent of the disability, especially when taken in connection with, or where supported by, some medical evidence." *Grauberger v. Atlas Van Lines, Inc.*, 419 S.W.3d 795 (Mo. App. 2013).

Mr. Allen was diagnosed by his various authorized treating physicians with right occipital headaches, chronic daily headaches, occipital neuralgia, concussion, post-concussive headaches, mild subjective memory loss, concentration problems, head contusion, neck strain, cervicalgia, decreased hearing in the right ear, right shoulder strain, right scapular winging, right long thoracic neuropathy, neurogenic thoracic outlet syndrome/scalene triangle syndrome, brachial plexus compression, anterior and middle scalene contracture, pectoralis minor contracture/syndrome, compression and scarring of the subclavian artery, injuries to the dorsal scapular nerve, long thoracic nerve, and the supra-scapular nerve, and contusions to the right temporal area, left face, mouth, and cheek.

Mr. Allen underwent multiple injections into the brachial plexus, scalene muscles, and pectoralis minor muscle and insertion, all of which are at the 400-week level. Mr. Allen also

underwent surgical repair of the brachial plexus and the nerves arising from the brachial plexus, scalene muscles, pectoralis minor muscle, and subclavian artery. The injuries that were surgically repaired are all at the 400-week level, which is consistent with the medical records and Mr. Allen's testimony regarding the location of the incisions and his understanding of the procedure. Further, Mr. Allen received two separate sets of injections, totaling six injections in all, in the occipital nerves. Once again, the treatment received was at the 400-week level.

Mr. Allen testified that because of his injuries, he continues to suffer from daily headaches and constant pain in his head, neck, right shoulder, and thoracic spine. He also testified that he continues to experience severe pain if his shoulder hangs without support, weakness in his right arm, and decreased hearing. Mr. Allen tries to maintain his symptoms throughout the day by self-accommodating and favoring his non-dominant hand and testified that he would not be employed still if he held any other position than the one he currently holds. Further, Mr. Allen continues to take several prescription medications every day to control his headaches and pain.

Dr. Cohen reported that Mr. Allen has continued headaches, difficulty hearing, constant pain in the back of the right shoulder area, pain in the shoulder blade area that radiates up into the muscles along the right side of his neck with any use of his right arm, shooting pain that goes from the supraclavicular area to the base of his skull on the right side, numbness and tingling in his right arm, constant pinching pain from the right arm down to the right hand, and weakness in his right upper extremity. In addition, Dr. Hagan reported that Mr. Allen continues to suffer from significant headaches, nerve injury, and persistent weakness in his right arm.

Dr. Cohen's report also documents his findings upon examination of the cervical spine and thoracic spine, including tissue tension, distinct trigger points, pain up to the scalp on the right and to the right lateral shoulder, and decreased range of motion with discomfort and pain. Examination of the right shoulder revealed reduced range of motion, significant posterior scapula winging,

positive impingement signs, positive O'Brien's testing, pain and a popping noise in the shoulder, numbness and tingling down into the fingers, and weakness and atrophy of the deltoid and rotator cuff.

May 5, 2015 Accident

Claimant has met his burden of proof with regard to permanent partial disability to the head, right shoulder, cervical spine and thoracic spine. The undersigned notes that it is difficult to determine the disability associated between the February 1, 2015 accident and the May 5, 2015 accident as both accidents involve the same parts of the body and similar complaints. Nevertheless, based on the reports of Dr. Cohen and Dr. Hagan, separate disability awards will be assigned for each date of accident.

Based on consideration of all the evidence in this case, the following PPD awards are entered for the May 5, 2015 accident:

10% body as a whole related to the head	40 weeks
5% body as a whole cervical spine	20 weeks
12.5% of the right shoulder	29 weeks
20% body as a whole thoracic spine	80 weeks
Total	169 weeks.

Claimant has not met his burden of proof regarding alleged hearing loss. The follow-up audiogram showed normal hearing bilaterally. Therefore, there is no PPD award for hearing loss.

Future Medical

Missouri Law requires that employers provide injured employees with medical treatment. Specifically, § 287.140.1 reads:

In addition to all other compensation paid to the employee under this section, the employee shall receive and the employer shall provide such medical, surgical, chiropractic, and hospital treatment, including nursing, custodial, ambulance and

medicines, as may reasonably be required after the injury or disability, to cure and relieve from the effects of the injury.

Treatment must be provided even if while comforting and relieving the claimant's pain, the underlying condition cannot be cured. *Mathia v. Contract Freighters, Inc.*, 929 S.W.2d 271 (Mo.App. 1996).

The threshold for determining if additional treatment is needed is reasonable probability. *Downing v. Willamette Industries, Inc.*, 895 S.W.2d 650, 655 (Mo.App. 1995). "Probable means founded on reason and experience which inclines the mind to believe but leaves room to doubt." *Tate v. Southwestern Bell Telephone Co.*, 715 S.W.2d 326, 329 (Mo.App. 1986). Section 287.140.1 RSMo. does not require that the medical evidence identify particular procedures or treatments to be performed or administered. *Talley v. Runny Meade Estates, Ltd.*, 831 S.W.2d 692, 695 (Mo.App. 1992). Further, the employer/insurer may be ordered to provide medical treatment to cure and relieve a claimant from the effects of the injury even though some of such treatment may also give relief from pain caused by a preexisting condition. *Hall v. Spot Martin*, 304 S.W.2d 844, 854-55 (Mo. 1957).

Here, it is clear that additional medical treatment is required to continue to cure and relieve the effects of the injury. Dr. Cohen recommended continued treatment for post-traumatic headaches, including medications, for an indefinite period of time. Dr. Cohen also noted Mr. Allen's use of Tramadol and Ibuprofen/Tylenol for pain and opined that such medications are appropriate due to Mr. Allen's multiple injuries. Mr. Allen testified that he has attempted to go without medication but was unable to make it through a day because of the pain. Further, Dr. Cohen recommended treatment with an orthopedic surgeon to see if Mr. Allen would benefit from any surgical procedures for diagnostic or therapeutic purposes. While Mr. Allen does not wish to undergo any procedures at this time, his opinion may change in the future if his symptoms

decline. Dr. Cohen opined that the treatment he recommended does reasonably flow from the primary work-related injuries of February 1, 2015 and May 5, 2015.

In addition, Dr. Hagan, who evaluated Mr. Allen at the request of the Employer and Insurer, noted ongoing significant headaches when he released Mr. Allen and concluded that Mr. Allen should be allowed to return for re-evaluation or treatment should he have recurrence or decompensation of symptoms or fails to improve.

Therefore, given that the evaluating physician and an authorized treating physician agree that future medical treatment is needed, the Employer should be ordered to provide future treatment necessary to cure and relieve the employee of the effects of the injuries suffered in the May 5, 2015 accident.

Disfigurement

Pursuant to section 287.190.4, “[i]f an employee is seriously and permanently disfigured about the head, neck, hands or arms, the division or commission may allow such additional sum for the compensation on account thereof as it may deem just, but the sum shall not exceed forty weeks of compensation.” Mr. Allen has scarring on his right arm and neck. Therefore, Mr. Allen is entitled to an additional six weeks of compensation for disfigurement as a result of the May 5, 2015 injury.

CONCLUSION

Mr. Allen is a credible witness who reports significant ongoing complaints of headache as well as pain in his head, neck, thoracic spine, and right shoulder. Mr. Allen’s complaints are consistent with the examination and treatment of the authorized treating physicians as well as the examination and opinion of Dr. Cohen. Mr. Allen has met his burden of establishing that the work injuries are the prevailing factor in leading to the diagnosis given and has sustained his burden of establishing that he is in need of additional medical treatment as set forth by the treating and

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evaluating physicians in this case. Therefore, an Award should be entered ordering the Employer to pay permanent partial disability benefits and disfigurement to Mr. Allen as set forth above. The Employer should also be ordered to provide future medical benefits.

The compensation awarded to the claimant shall be subject to a lien in the amount of 25% of all payments hereunder in favor of the Van Camp Law Firm LLC for necessary legal services rendered to the claimant.

I certify that on 10-11-18, I delivered a copy of the foregoing award to the parties to the case. A complete record of the method of delivery and date of service upon each party is retained with the executed award in the Division's case file.

By [Signature]

Made by: [Signature]
Bruce Farner
Administrative Law Judge
Division of Workers' Compensation

