

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

Injury No.: 02-001001

Employee: Karla Barnes  
Employer: Insituform Technologies, Inc.  
Insurer: Liberty Mutual Fire Insurance Co.  
Date of Accident: January 9, 2002  
Place and County of Accident: St. Louis, Missouri

The above-entitled workers' compensation case is submitted to the Labor and Industrial Relations Commission (Commission) for review as provided by section 287.480 RSMo. Having reviewed the evidence and considered the whole record, the Commission finds that the award of the administrative law judge is supported by competent and substantial evidence and was made in accordance with the Missouri Workers' Compensation Act. Pursuant to section 286.090 RSMo, the Commission affirms the award and decision of the administrative law judge dated April 25, 2007. The award and decision of Administrative Law Judge Margaret D. Landolt, issued April 25, 2007, 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 10<sup>th</sup> day of September 2007.

LABOR AND INDUSTRIAL RELATIONS COMMISSION

\_\_\_\_\_  
William F. Ringer, Chairman

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Alice A. Bartlett, Member

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John J. Hickey, Member

Attest:

\_\_\_\_\_  
Secretary

**AWARD**

Employee: Karla Barnes

Injury No.: 02-001001

Dependents: N/A  
Employer: Insituform Technologies, Inc.  
Additional Party: N/A  
Insurer: Liberty Mutual Fire Insurance Co.  
Hearing Date: February 2, 2007

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

Checked by: MDL:tr

### 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: January 9, 2002
5. State location where accident occurred or occupational disease was contracted: St. Louis, Mo.
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:  
Employee was moving a telephone extension when a cabinet fell on her.
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 wrist, cervical spine
14. Nature and extent of any permanent disability: 25% of the right wrist, and 5% of the body as a whole referable to the cervical spine
15. Compensation paid to-date for temporary disability: -0-
16. Value necessary medical aid paid to date by employer/insurer? \$8,501.98

Employee: Karla Barnes Injury No.: 02-001001

17. Value necessary medical aid not furnished by employer/insurer? \$64,443.49
18. Employee's average weekly wages: \$769.23
19. Weekly compensation rate: \$512.81/\$329.42
20. Method wages computation: Stipulation

### COMPENSATION PAYABLE

21. Amount of compensation payable:

63.75 weeks of permanent partial disability from Employer

\$21,000.53

22. Second Injury Fund liability: No

TOTAL: \$21,000.53

23. Future requirements awarded: None

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

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

Mr. Andrew Mandel

## FINDINGS OF FACT and RULINGS OF LAW:

Employee:	Karla Barnes	Injury No.: 02-001001
Dependents:	N/A	Before the
Employer:	Insituform Technologies, Inc.	<b>Division of Workers'</b>
Additional Party:	N/A	<b>Compensation</b>
Insurer:	Liberty Mutual Fire Insurance Co.	Department of Labor and Industrial
		Relations of Missouri
		Jefferson City, Missouri
		Checked by: MDL:tr

### PRELIMINARIES

A hearing was held on February 2, 2007, at the Division of Workers' Compensation in the City of St. Louis. Karla Barnes (Claimant) was represented by Mr. Andrew Mandel. Insituform Technologies, Inc. (Employer) and its Insurer, Liberty Mutual Fire Insurance Company, were represented by Mr. John Sander. Mr. Mandel requested a fee of 25% of Claimant's award.

The parties stipulated that on or about January 9, 2002, Claimant sustained an accidental injury arising out of and in the course of employment; Claimant was an employee of Employer; venue is proper in the City of St. Louis; Employer received proper notice of the injury; and the claim was timely filed. The parties further stipulated

Claimant was earning an average weekly wage of \$769.23 resulting in applicable rates of compensation of \$512.81 for total disability benefits and \$329.42 for permanent partial disability benefits. Employer paid medical benefits of \$8,501.98.

The issues for resolution by hearing are medical causation; liability of Employer for past medical benefits in the amount of \$64,443.49; liability of Employer for future medical care; whether Claimant is entitled to temporary total disability benefits from March 6, 2003 to the present; whether Claimant is permanently and totally disabled; and nature of extent of permanent partial disability sustained by Claimant.

## SUMMARY OF EVIDENCE

### ***Claimant's Testimony***

Claimant is a 51 year old woman with an Associate of Arts Degree in Applied Sciences. Claimant has been working since she was 15 years old. Claimant worked for Steak N' Shake, then for Credit Systems, Inc. as an authorization operator, and then went to work for MasterCard as a product support analyst. Claimant next moved to Chicago and worked in telecommunications where she was responsible for stacking units for computers and telephone equipment. Claimant moved back to St. Louis in 1981 or 1982, and went to work for Management Systems, Inc. as a consultant. While traveling for them, she injured her neck in a car accident in 1983. After some medical treatment for her neck, her symptoms resolved and she had no other problems with her neck leading up to January 9, 2002.

Claimant also testified she had an injection in her back from Dr. Pierron in 1983, but had no other problems with her back until her pregnancy in 1986. Claimant testified she had a myelogram, which was negative, and she continued working.

Claimant testified that in 1986 she started working for a management company as a consultant responsible for telephone and fax equipment. The job was physical, and required heavy lifting, bending, and climbing ladders.

In 1999, Claimant went to work for Employer. She was hired as a communications engineer. Her duties involved lifting fax machines, moving and lifting furniture, bending, and getting down on her knees. Until 2002, Claimant never missed time from work because of her neck, back or right hand. Claimant testified that she strained a muscle in her neck before 2002, had one doctor's visit where she received muscle relaxants, and never received a settlement for that injury.

Claimant testified that in 1991 she went to her internist about her back. He referred her to Dr. Bridwell. Claimant testified she had no treatment in her back from 1991, until the date of injury and had no back problems during that time. She also testified she had some hip problems that subsided after she saw her internist.

On January 9, 2002, Claimant was at work moving a telephone extension for an employee when a cabinet fell on her. Her hand was on the desk and she fell back on her buttocks. When the cabinet hit her hand she felt severe pain and it cut her knuckles. Her neck also began to hurt. She didn't feel anything in her back at that time. Claimant received medical treatment that day. She first went to Dr. Gelfand, and told him that a hutch fell on top of her. Claimant testified her hand, neck, and shoulder were bothering her, but she didn't say anything about her back that day. Claimant testified Dr. Gelfand took her off work, and told her she had a cyst on her finger. Claimant testified on her second office visit on January 11, 2002, Dr. Gelfand injected her hand. Her complaints at that time were to her hand and head. Dr. Gelfand returned her to light duty on January 11, 2002, and she went back to work. Claimant testified she returned to the doctor on January 16, 2002, and told him about numbness in her foot and leg. Claimant testified Dr. Gelfand put her on Vicodin for her hand and neck. Claimant testified she saw Dr. Gelfand again on February 5, 2002, complaining about her leg, continued hand and neck pain, and tingling down her leg. On February 19, 2002, Claimant began physical therapy for her hand and neck.

Claimant testified her back was bothering her up through April 30, 2002, but it wasn't severe until she started going off her medications. Claimant testified that on May 15, 2002, she saw Dr. Gelfand and complained of chronic severe back pain. When she saw Dr. Gelfand she couldn't even get out of bed. Dr. Gelfand gave her an injection in her back and prescribed medications. According to Claimant, Dr. Gelfand sent her for an MRI on

May 21, 2002, which, to her knowledge, showed a ruptured disc at L4-5 and problems at L5-S1. Claimant testified Dr. Gelfand did not send her to anyone because he did not consider it part of her workers' compensation claim. Claimant testified she informed Employer, and was told her back problems were not considered workers' compensation, and she should pursue treatment under her personal insurance.

Claimant continued to treat with Dr. Gelfand for her hand, and she was referred to Dr. Kaplan in March 2002. She was also prescribed physical therapy for her neck complaints. Eventually, Employer sent her to Dr. Coin who referred her to Dr. Tate.

Claimant testified she saw Dr. Mollman for her back in July 2002. At that time, she was still working for Employer at light duty. Eventually, Dr. Mollman ordered a myelogram and MRI which revealed problems with L3-4, L4-5, and L5-S1. Dr. Mollman referred her to Dr. Metzler who did some injections, which worked for a short period of time. On September 27, 2002, Dr. Mollman performed surgery. Following her surgery, her pain persisted and she asked for another myelogram and MRI, which led to another surgery in December 2002.

Claimant treated with Dr. Mollman through March of 2003, at which time he did another myelogram, and then released her to go back to work. After being released to return to work, Claimant continued to have pain and wasn't getting any better. She was fired by Employer in March 2003, and she doesn't know why she was fired.

In April of 2003, Claimant went to see Dr. Taylor who did a myelogram, MRI, and x-rays. He recommended physical therapy, but did not do surgery.

After seeing Dr. Taylor, she continued to have problems. In October 2003, Claimant went to Dr. Bernardi complaining of pain across her back down her legs, in her neck, shoulder, and hand, and tingling feet. He referred her to Dr. Anwar who did injections. In June 2004, Dr. Bernardi did another surgery, which helped relieve a little bit of pain. Claimant was unable to get up in the morning and was in severe, chronic pain. Claimant has received no treatment for her back since seeing Drs. Bernardi and Anwar.

Claimant testified that before her injury in 2002 she liked to water-ski and skied all summer. She liked to sew, type, and swing dance. She bowled, swam, played softball, mowed the lawn, washed the dogs, cleaned gutters, and painted. Since her injuries, she is no longer able to perform these activities.

Currently, with respect to her right hand, she has severe pain in her hand from her left ring finger and experiences decreased sensation. It has a continuous quiver and is sore. She can't flex her index finger fully. With regard to her neck, Claimant cannot turn like she used to, has headaches, and has pain going down her right and left side with severe pain in her neck. Currently, Claimant's back problems consist of severe pain starting in the middle of her back going into both legs. She has no feeling in her right foot. Her left leg pain goes down the side of her calf into her foot. Her toes draw and cramp. She has trouble sleeping and pain shoots down her leg. She also has numbness and tingling. Claimant testified to numerous medical bills she incurred as a result of her injury. Claimant is asking for TTD benefits since March 28, 2003, future medical benefits and permanent total disability benefits. She is also asking for permanent partial disability benefits for her hand and neck, reimbursement for her medical expenses, and future medical treatment.

### ***Medical Evidence***

In 1983, Claimant underwent a chemonucleolysis of L4-5 by Dr. Pierron for a presumed herniated disc. Eventually, her left lower extremity symptoms disappeared until a car accident on June 19, 1985, when she was riding in a taxicab and was rear-ended.

Claimant was treated by Dr. Marchosky on September 11, 1985, complaining of neck pain, headaches, and cervical pain into the intrascapular area. Claimant also reported discomfort in her lower back with extension into the left lower extremity. She also noticed cramps in her left lower extremity. The low back and left lower extremity symptoms resembled what she had in 1983. Following some physical therapy, her low back symptoms subsided and she continued to have cervical pain. Claimant found out she was pregnant in July 1985, and waited until after she delivered her baby to follow up with her neck complaints.

Claimant returned to Dr. Marchosky on May 13, 1986. She reported continued neck symptoms with neck pain extending into the left shoulder and left upper extremity, with intermittent episodes of numbness and tingling involving the thumb and index finger. Dr. Marchosky started over the door cervical traction, and ordered a cervical x-ray with an MRI of the brain. In June 1986, Dr. Marchosky recommended a myelogram to rule out cervical radiculopathy. The cervical myelogram and post myelogram CT were entirely within normal limits.

On August 13, 1991, Claimant saw Dr. Saltman for the first time complaining of a flare up of her chronic low back problems. Claimant reported swelling of the left hip which resulted in back pain in the extreme lower back with radiating pain usually down the right leg. She reported several episodes of this, but in the previous two days, she reported being incapacitated by pain due to these symptoms. Dr. Saltman referred Claimant to Dr. Bridwell.

Following Claimant's work accident on January 9, 2002, Claimant was examined by Dr. Gelfand. Dr. Gelfand ordered x-rays of Claimant's cervical spine and right hand. Claimant had no low back complaints at that time. He provided conservative treatment. Dr. Gelfand diagnosed a cervical strain and contusion of the right index finger. Dr. Gelfand's records reflect that following some conservative treatment, Claimant's neck problems resolved. From March to May 2002, Claimant continued to receive conservative treatment for her hand including cortisone injections into her knuckles.

Dr. Richard Coin examined Claimant on July 9, 2002. After examining Claimant, Dr. Coin diagnosed tenosynovitis versus arthritis versus possible carpal tunnel syndrome. Dr. Coin stated the arthritis was a non work related diagnosis, but the tenosynovitis and possible carpal tunnel syndrome were work related. Dr. Coin recommended a nerve conduction study as well as a bone scan to determine if Claimant's complaints of pain were degenerative in nature versus inflammatory. In the interim, he recommended conservative treatment. Dr. Coin then reviewed a nerve conduction study performed by Dr. Tate in September 2002. The results of the study were negative for absolute carpal tunnel syndrome; however, Dr. Tate stated the study may represent early findings, and may require a repeat study in three to six months. Based upon the results of the nerve conduction study, Dr. Coin recommended Claimant pursue conservative treatment for right hand tenosynovitis. He stated she also has arthritis, which is non work related. He recommended a bone scan. In the interim, he recommended conservative treatment such as warm soaks, anti-inflammatory medications, and possible physical therapy. He stated Claimant would need to be re-evaluated in four to six weeks to determine if the conservative treatment had been helpful. He stated that if Claimant's numbness persisted, a repeat nerve conduction study at the end of 2002 remained another option.

Dr. Coin provided an independent medical evaluation on July 24, 2002. Dr. Coin performed a physical examination, and took x-rays which revealed evidence for a healing fracture at the radial distal aspect of the distal middle phalanx. There were also diffuse degenerative changes noted throughout the interphalangeal joint of the thumb. There were low grade degenerative changes noted at the first metacarpal joint, and a decreased joint space ratio in the distal interphalangeal joint of the index finger and thumb. Dr. Coin diagnosed tenosynovitis versus arthritis versus possible carpal tunnel syndrome. He stated the arthritis was not work related. The diagnosis of tenosynovitis and possible carpal tunnel syndrome were work related. Claimant complained that she was having numbness in her index and middle fingers, which Dr. Coin felt may have represented post traumatic carpal tunnel syndrome. Dr. Coin stated Claimant needed a nerve conduction study to delineate any nerve entrapment in the upper extremity. He reiterated Claimant may also need a bone scan to determine if her complaints of pain are degenerative in nature versus inflammatory.

On May 15, 2002, Claimant saw Dr. Gelfand for "AM back pain, unable to tolerate". Claimant had bilateral lumbar pain and a positive straight leg raising. Dr. Gelfand ordered an x-ray which revealed arthritic degenerative changes of L5-S1. Prior to May 15, 2002, Claimant did not make any complaints to Dr. Gelfand for lumbar discomfort. Dr. Gelfand injected Claimant with Toradol. Dr. Gelfand saw Claimant again on May 21, 2002, and Dr. Gelfand referred Claimant for an MRI that revealed disc desiccation at L1-L2, L4-L5, and L5-S1. She had a disc bulge at L3-L4 and severe arthritic changes in L3-L4, and L4-L5. Dr. Gelfand testified Claimant's lumbar pain was not related to her work injury. Dr. Gelfand testified his opinion was based upon the MRI which had revealed a lot of degenerative changes, as well as the fact that Claimant never complained about her low back before May 15, 2002.

Claimant first saw Dr. Mollman on July 25, 2002. Claimant's chief complaints were back pain, pain down her left leg and left hip, and numbness in both feet. The diagnosis was herniated nucleus pulposus at L4-L5 on the left. Following her myelogram, Dr. Mollman performed a lumbar microdiscectomy at L4-5 on the left on September 27, 2002. The postoperative diagnosis was herniated nucleus pulposus on L4-5 on the left. Following her surgery, Claimant continued to have significant problems. On December 20, 2002, Dr. Mollman performed a lumbar microdiscectomy at L4-L5 on the left with external neurolysis, L5 nerve root, and foraminotomy at L4-L5 on the left. The postoperative diagnosis was herniated nucleus pulposus at L4-L5 on the left.

Following her second surgery, Claimant continued to have significant problems which prompted Dr. Mollman to recommend another MRI, which was performed on February 3, 2003. That MRI revealed a posterior lateral herniation of the L3-4 intervertebral disc to the left, with a small extruded fragment extending into the anterolateral recess, and foraminal bulge narrowing of the L3-4 foramen on the left. There was also marked degenerative thinning of the L4-L5 and L5-S1 intervertebral discs. Postoperative change at the L4-L5 level on the left was noted. Dr. Mollman last examined Claimant on March 18, 2003, and released her to return to work on March 24, 2003.

Following Dr. Mollman's work release, Claimant was fired by Employer. Beginning on April 10, 2003, Claimant began treating with Dr. Taylor, an orthopedic surgeon at Washington University. After examining Claimant on April 17, 2003, Claimant was diagnosed with postoperative radiculopathy/failed back syndrome. Claimant was referred for EMG studies as well as pain management. Claimant was encouraged to pursue pain management and non-operative treatment. Following a course of conservative treatment and diagnostics on September 9, 2003, Dr. Taylor discouraged Claimant from considering another surgical procedure. He encouraged her to exhaust a non-operative treatment before considering surgery, because the chances of a failed third procedure were highly likely. Dr. Taylor expressed the opinion that Claimant's quality of life could be decreased or made worse by surgical intervention. Dr. Taylor also gave Claimant a list of other physicians who might be able to help her.

Claimant saw Dr. Bernardi, a spine surgeon, on October 24, 2003. Dr. Bernardi felt Claimant's symptoms primarily reflect underlying degenerative disc disease at the L4-5 and L5-S1 segments. He stated that to surgically address these problems would require a lumbar fusion and he was hesitant to recommend this to Claimant because of her preexisting multilevel degenerative disease. Dr. Bernardi referred Claimant to Dr. Anwar to explore other non-surgical alternatives. Claimant treated with Dr. Anwar between November 14, 2003, and February 10, 2004. Dr. Anwar ordered a repeat MRI which was performed on December 29, 2003. The impression was recurrent or residual L4-5 disc herniation, and L3-4 and L5-S1 bulging discs. On June 14, 2004, Dr. Bernardi performed a repeat L4-5 discectomy on the left. Following her surgery, Claimant continued to have problems and underwent physical therapy and injections. Eventually, Dr. Anwar recommended against any additional injections. Dr. Anwar released Claimant from treatment on May 2, 2004.

Dr. Dennis Mollman, a board-certified neurosurgeon, testified on behalf of Employer. Dr. Mollman testified Claimant's herniated disc at L4-5 was at the same level as the chemonucleolysis which she had in 1983. Dr. Mollman testified when he last examined Claimant on March 18, 2003, he did not believe Claimant required any additional surgery. Dr. Mollman testified the cause of the surgery that he performed in July 2002 was progressive degenerative disc disease of the lumbar spine. He placed the onset of this degenerative disc disease as far back as the chemonucleolysis in 1983. Dr. Mollman testified that the reason Claimant needed surgery in July 2003 was due to degenerative disc disease of her lumbar spine which predated 2002. Dr. Mollman testified 86% of the people who underwent chemonucleolysis were re-operated on within 5 to 10 years, and probably close to 100% of those people were re-operated on within 15 or 20 years. Dr. Mollman testified the chemonucleolysis treatment is no longer used in the United States because the mortality rate for the procedure was 10% and the procedure didn't treat the disease, and in fact aggravated it by forming calcifications which resulted in spinal stenosis.

Dr. Raymond Cohen, also a board-certified neurologist, testified on behalf of Claimant. Dr. Cohen first examined Claimant on March 14, 2005. Dr. Cohen diagnosed status post three lumbar surgeries for disc herniation on the left at L4-5; failed lumbar laminectomy syndrome; cervical myofascial pain disorder; and crush injury to the right hand with posttraumatic right carpal tunnel syndrome and exterior tenosynovitis; and a history of fracture to the right index finger. Dr. Cohen opined Claimant's diagnoses are a direct result of injuries she sustained at work on or about January 9, 2002, and work is the substantial factor in her injury, and the treatment

she received was medically necessary and reasonable. Dr. Cohen stated Claimant would need pain management for the remainder of her life. Dr. Cohen rated Claimant's disability at 10% of the body as a whole at the level of the cervical spine, a 30% permanent partial disability at the right hand, and a 60% permanent partial disability at the lumbar spine. He also assessed an additional 25% at the left ankle due to her foot drop. Dr. Cohen also testified Claimant is permanently and totally disabled.

Dr. Cohen provided an additional medical rating on October 26, 2006, after reviewing additional records. Dr. Cohen diagnosed status post three lumbar surgeries for disc herniation on the left at L4-5, left lumbar radiculopathy, left foot drop, failed lumbar laminectomy syndrome, cervical myofascial pain disorder, and crush injury to the right hand with posttraumatic right carpal tunnel syndrome and extensor tenosynovitis, and history of fracture to the right index finger. Dr. Cohen stated the above diagnoses were a direct result of injuries she sustained at work on or about January 9, 2002, her work injury was the substantial factor in her injury and disability, and the treatment she received was medically necessary and reasonable. He assessed a 60% PPD at the level of the lumbar spine, 5% of which was preexisting, and the remaining 55% is the direct result of the primary work related injury. He also assessed a 10% body as a whole disability at the cervical spine and 30% PPD at the right hand. He also assessed an additional 25% of the left ankle due to her foot drop. It remained his opinion Claimant was permanently and totally disabled. Dr. Cohen testified Claimant failed to tell him she had previously been diagnosed and treated for a herniated disc in her low back as far as 1983, and that she underwent a chemonucleolysis.

#### FINDINGS OF FACT AND RULINGS OF LAW

Based upon my observations of Claimant at hearing, an extensive review of the evidence, and the application of Missouri law, I find:

Claimant failed to meet her burden of proving that her accident of January 9, 2002, was the medical cause of her need for surgery and her current medical condition. I find the testimony of Dr. Mollman to be more persuasive and consistent with all of the medical evidence in this case than that of Dr. Cohen. Claimant had a longstanding history of degenerative disc disease in her spine which dates back to her 1983 chemonucleolysis procedure. In 1991, Claimant had another flare up of her low back symptoms. Claimant's degenerative condition of her spine continued to deteriorate. Claimant first reported low back symptoms following her January 9, 2002, injury in May of 2002. On May 21, 2002, her MRI revealed a significant degenerative disc disease in her back.

I did not find Claimant to be entirely credible. She was evasive and argumentative, and had difficulty answering questions upon cross-examination that she felt did not help her case.

Claimant sustained a cervical strain and a crush injury to her right hand as a result of her January 9, 2002, accident. Her accident did not cause her herniated disc, and did not necessitate the multiple surgeries she has undergone since that time.

Claimant sustained permanent partial disability of 25% of her right hand as a result of her work related accident. Claimant's neck symptoms for the most part improved following a course of conservative treatment. Claimant is entitled to 5% body as a whole disability at the level of the cervical spine.

Because Claimant has failed to meet her burden of proving her accident caused her current disability in her lumbar spine, the remaining issues are moot.

This award is subject to an attorney's lien in the amount of 25% in favor of Claimant's attorney, Mr. Andrew Mandel.

Date: \_\_\_\_\_

Made by: \_\_\_\_\_

Margaret D. Landolt  
*Administrative Law Judge*

A true copy: Attest:

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Patricia "Pat" Secret  
*Director*  
*Division of Workers' Compensation*