

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

Injury No.: 96-438230

Employee: Laura Belmar
Employer: Dial Corporation (Settled)
Insurer: Self-Insured (Settled)
Additional Party: Treasurer of Missouri as Custodian
of Second Injury Fund
Date of Accident: December 31, 1996
Place and County of Accident: St. Louis City, 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 December 22, 2006, and awards no compensation in the above-captioned case.

The award and decision of Administrative Law Judge Linda J. Wenman, issued December 22, 2006, is attached and incorporated by this reference.

Given at Jefferson City, State of Missouri, this 10th day of August 2007.

LABOR AND INDUSTRIAL RELATIONS COMMISSION

NOT SITTING

William F. Ringer, Chairman

Alice A. Bartlett, Member

John J. Hickey, Member

Attest:

Secretary

AWARD

Employee: Laura Belmar

Injury No.: 96-438230

Dependents: N/A
Employer: Dial Corporation - settled
Additional Party: Second Injury Fund
Insurer: Self-insured - settled
Hearing Date: November 1, 2006

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

Checked by: LJW:tr

FINDINGS OF FACT AND RULINGS OF LAW

1. Are any benefits awarded herein? No
 2. Was the injury or occupational disease compensable under Chapter 287? Yes
 3. Was there an accident or incident of occupational disease under the Law? Yes
 4. Date of accident or onset of occupational disease: December 31, 1996 (corrected date)
 5. State location where accident occurred or occupational disease was contracted: St. Louis City, 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: Claimant fell while walking down stairs at work.
 12. Did accident or occupational disease cause death? No
 13. Part(s) of body injured by accident or occupational disease: Left foot/ankle and left 4th finger
 14. Nature and extent of any permanent disability: Disputed by Employer, but 20% BAW permanent partial disability referable to the cervical spine paid as a compromise settlement.
 15. Compensation paid to-date for temporary disability: None
 16. Value necessary medical aid paid to date by employer/insurer? None
- Employee: Laura Belmar Injury No.: 96-438230
17. Value necessary medical aid not furnished by employer/insurer? N/A
 18. Employee's average weekly wages: \$800.00
 19. Weekly compensation rate: \$513.01 / \$268.72
 20. Method wages computation: Stipulated

COMPENSATION PAYABLE

21. Second Injury Fund liability: No

TOTAL:

NONE

22. Future requirements awarded: N/A

FINDINGS OF FACT and RULINGS OF LAW:

Employee:	Laura Belmar	Injury No.: 96-438230
Dependents:	N/A	Before the
Employer:	Dial Corporation - settled	Division of Workers'
Additional Party:	Second Injury Fund	Compensation
Insurer:	Self-insured - settled	Department of Labor and Industrial
		Relations of Missouri
		Jefferson City, Missouri
		Checked by: LJW:tr

PRELIMINARIES

The above referenced Workers' Compensation claim was heard by the undersigned Administrative Law Judge on November 1, 2006. Briefs were received and the case was formally submitted on December 12, 2006. ^[1] Attorney Harry Nichols represented Laura Belmar (Claimant). Assistant Attorney General Kay Osborne represented the Second Injury Fund (SIF).

Prior to hearing, Dial Corporation (Employer) disputed all issues regarding the primary injury. On December 19, 2005, Employer compromised the disputed issues, and agreed to pay the equivalent of 20% BAW permanent partial disability (PPD) referable to Claimant's cervical spine to settle all issues in the primary case.

Prior to the start of the hearing the parties identified the following issues for disposition: accident; arising out of and

in the course and scope of employment; notice; medical causation; date of maximum medical improvement (MMI); and liability of SIF for permanent total or permanent partial disability. Hearing venue is correct, and jurisdiction properly lies with the Missouri Division of Workers' Compensation.

Claimant offered Exhibits A-T. Claimant withdrew Exhibit H. SIF's objection to Exhibit K was sustained, and the remaining exhibits were admitted into the record without objection. SIF offered no exhibits. Any markings contained within any exhibit were present when received, and the markings did not influence the evidentiary weight given the exhibit. Any objections not expressly ruled on in this award are overruled.

SUMMARY OF EVIDENCE

All evidence presented has been reviewed. Only testimony necessary to support this award will be summarized.

Testimony

Claimant: Claimant is sixty-four years old, and began working full-time at age sixteen as a waitress. Claimant next became a factory worker, and worked with various employers until 1975. Between 1975 and 1980, Claimant left employment to raise her children. Claimant returned to factory work during 1980, and worked until September 1997.

When Claimant returned to work in 1980, she obtained employment with Employer as a fork-lift driver. [2] As a fork-lift driver, Claimant moved materials from the manufacturing line to the loading dock. Claimant was required to hand lift pallets containing an average of thirty-five cases per pallet. Each case weighed approximately fifty-nine pounds, and needed to be loaded by hand. Claimant was scheduled to work a forty hour week, but was required to work mandatory over-time and frequently worked sixty hours or more per week.

In 1982, Claimant injured her low back at work, and underwent a lumbar fusion. She returned to work as a fork-lift driver until 1990, when she successfully bid for a job as a shipping clerk. Claimant sought the shipping clerk position as it was physically less demanding, and provided greater mental stimulus. Although Claimant's work still involved physical lifting, it also required her to use a computer, calculate shipping weights, and make sure shipments were loaded correctly. Claimant continued to work as a shipping clerk until she left her employment in 1997.

On December 31, 1996, Claimant was descending stairs at work when she slipped and fell six to seven steps. As a result of the fall, Claimant testified she injured her head, neck, shoulders, left ring finger, and left foot. She was assisted from the floor by co-workers, and Employer arranged to have Claimant taken to Barnes Care by taxi. Following treatment, Claimant lost no time from work, and Employer did not pay TTD or medical benefits. Claimant did file a report of incident/accident with Employer.

Barnes Care provided care to Claimant for her injuries until January 1997, and Claimant also sought treatment with her personal physician, Dr. Carmody. The injuries to her foot, head, neck, and shoulders never healed, and Claimant sought treatment with neurosurgeons, Dr. Kitchens and Dr. Albana. During her initial visit on October 17, 1997, Claimant was informed she had a herniated disc in her neck, and on January 8, 1998, Claimant underwent a cervical fusion at St. Anthony's Hospital. Post-operatively, Claimant continued to experience cervical pain, and she was provided pain management treatment. She never returned to work.

As of the date of hearing, Claimant complained of constant neck and shoulder pain, and she takes Celebrex for her discomfort. She experiences frequent headaches that she attributes to tension and stress. She avoids any activity involving bending, doesn't vacuum, mop floors, or dust at low levels. She is able to do laundry as long as she does not bend down. She spends her day reading, doing cross-word puzzles, and enjoys performing family research. Claimant lives in a rural area of south-central Missouri. Claimant receives a monthly union pension, has not looked for further employment, and does not believe she is capable of employment. Claimant considers her low back and neck condition as the main factors in her inability to work.

In addition to her lumbar fusion, Claimant listed eight additional medical conditions that predated the January 1996 fall. At age three, Claimant was struck by a car, she remembered not being able to go out and play, but testified she "healed well" from that incident. In 1976, Claimant fractured a bone in her right hand while at work, has full range of motion, but experiences arthritis in the hand. During 1984, Claimant was diagnosed with narrow angle glaucoma, underwent surgery for the condition after her January 1996 work injury, and now uses eye drops every day that cause headaches. She underwent mastoid surgery in 1985, was in the hospital overnight, but "healed fairly well." Claimant fractured her left wrist in 1994, has pain with wrist rotation, and was told the bone didn't heal correctly. Claimant underwent a hernia repair in 1975, and "healed fine." She fractured her left foot in 1995, but didn't pursue it as a workers' compensation case. In 1972, she was diagnosed with cancer of the cervix, but has not suffered a reoccurrence. Finally, in 2000 and 2001, Claimant was diagnosed and underwent right knee surgery.

Upon cross-examination, Claimant disputed September 19, 1997 was the first time she told Dr. Carmody about her

neck pain, and also disputed a Barnes Care record listing her complaints on the date of injury to be to her left foot and finger. Claimant verified Dr. Kitchen performed a single level fusion of her cervical spine, and she has not had treatment for her neck since May 1999. In regard to her preexisting conditions, Claimant has not had treatment for her low back since 1982, and prior to 1996 had no permanent work restrictions. Claimant verified she uses a TENS unit for her cervical spine symptoms, and not for her low back, and her recent right knee surgeries are part of the reason she is unable to work. Finally, Claimant denied telling Dr. Bernstein she fell in 1998 injuring her right shoulder.

Pertinent Medical Records

Barnes Care: Claimant's first visit occurred on August 30, 1995, after she slipped on a wet work floor and injured her left foot.^[31] The initial x-rays were negative, and Claimant was diagnosed with a hyperextension injury, and strained left foot. The next day, repeat x-rays were obtained of Claimant's left foot, which showed a questionable cortex crack in her 3rd metatarsal bone, and Claimant was placed in a "post-op" shoe. Claimant was discharged from care on October 20, 1995.

Claimant was next seen on December 31, 1996, after she twisted her left foot while descending stairs at work. Claimant reported she had struck her left foot and left 4th finger as she fell. Upon examination, Claimant was noted to display slight soft tissue swelling over the dorsal lateral aspect of her left foot. X-rays of her left foot were reported as negative. Claimant was diagnosed with a left foot sprain, and acute sprain of the DIP joint of her left 4th finger. By January 10, 1997, Claimant had normal range of motion in her left foot and 4th finger, and she was discharged from care.

Dr. Carmody: Claimant was first examined on January 21, 1991. Other pertinent visits were recorded as follows:

11/29/93 – Claimant fractured her left arm, and was referred to an orthopedist, Dr. Dusek, for further treatment.

1/18/95 – Claimant fractured her left wrist, and was referred to Dr. Hauelsen for further treatment.

4/7/95 – Claimant underwent pulmonary function testing (PFT), which demonstrated very mild obstructive changes. It was noted Claimant was a pack per day cigarette smoker.

11/94 – Claimant provided a preliminary diagnosis of bilateral carpal tunnel syndrome (CTS).

12/94 – Claimant was noted to have undergone nerve conduction velocity (NCV) studies on September 9, 1994, which were found to be normal. The NCV studies found no evidence of neuropathy, plexopathy, or radiculopathy in either arm. NCV studies were repeated on December 7, 1994, and found to be normal.

9/19/97 – Claimant complained of cervical spine pain with radiation into her right arm that had worsened in the past three weeks. Claimant told Dr. Carmody "she attributed her symptoms to an incidence that occurred at work." Claimant's diagnosis was possible herniated cervical disc, and an x-ray and cervical MRI was ordered.

9/24/97 – Cervical MRI demonstrated degenerative changes at C5-6, and a spur complex at that level that attenuated the cervical subarachnoid space in front of Claimant's spinal cord and barely abutted the surface of the spinal cord.

12/3/97 – Claimant was scheduled for cervical disc surgery due to an "injury at work."

1/28/98 – Claimant is seen post-operatively with complaints of neck pain and hip pain at the bone donor site.

3/18/98 – Claimant is diagnosed with depressive reaction, and started on the medication Zoloft.

9/24/98 – X-ray of Claimant's left foot demonstrated degenerative changes at her great toe interphalangeal joint.

Dr. Kitchens: Claimant was first examined on October 17, 1997, and Dr. Kitchens noted Claimant's cervical and arm pain began six months prior to her visit, but had worsened in the last month. Physical therapy is started. Pertinent visits were recorded as follows:

1/8/98 – Claimant underwent a C5-6 cervical fusion with a left iliac crest graft.

3/4/98 – Claimant reported increased shoulder and right arm pain after falling on a gravel road.

4/1/98 – Claimant complained of intra-scapular pain, without evidence of neurological changes.

7/22/98 – Cervical x-rays demonstrated complete bony bridging anteriorly, and also demonstrated preservation of the sagittal diameter of her spinal canal. Claimant's cervical fixation hardware remained in good position.

7/30/98 – An MRI of Claimant's cervical spine demonstrated no evidence of disc herniation or foraminal stenosis.

4/15/99 – Claimant continued to complain of neck pain, and also complained of low back pain. Dr. Kitchens noted Claimant had improvement after receiving cervical epidural steroid injections. Claimant was to be seen on an as-needed basis.

Dr. Feinberg: Claimant was referred to Dr. Feinberg for cervical pain management. Claimant was provided three cervical epidural steroid injections between October 15, 1998 and October 29, 1998.

St. Anthony's Hospital: Pertinent records indicated Claimant underwent a discectomy with laminectomy and fusion at L4-5 on March 11, 1982. On January 21, 1999, an MRI of Claimant's lumbar spine demonstrated spondylolisthesis L4-5 with degenerative disc disease throughout her lumbar spine, and a disc bulge at L4-5.

Dr. Coleman: Claimant was referred by Dr. Kitchens for lumbar pain management. Pertinent visits were recorded as follows:

3/17/99 – Claimant was administered a lumbar epidural steroid injection, and two trigger point injections into the right upper thoracic paraspinous region due to myofascial pain complaints.

3/25/99 – Claimant reported improvement in her back pain, and was using a muscle stimulator.

4/6/99 – Claimant reported “has much less pain.” Claimant was provided another epidural steroid injection.

Dr. Dusek: Claimant was seen on November 30, 1993, after she fell on the ice, and sustained an angulated distal radius fracture of her left arm. Dr. Dusek performed a closed reduction, and Claimant's arm was placed in a cast. Claimant continued to complain of left wrist pain, and tingling of the anterior surface of her hand. Claimant was then referred to Dr. Wilkerson, who referred Claimant to Dr. Haueisen, and an MRI was obtained on January 24, 1995. The MRI demonstrated a partially healed comminuted fracture of her left wrist, and un-united fracture of her ulnar styloid.^[4] Claimant's repeat NCV studies were reported as normal, and Dr. Haueisen concluded a surgery to correct Claimant's mal-alignment might leave Claimant with more symptoms than she was currently experiencing.

Medical Deposition Testimony

Dr. Hanaway: Dr. Hanaway first examined Claimant on March 19, 2001, and issued his final report on January 6, 2003. Upon examination, Dr. Hanaway noted Claimant had limited cervical range of motion upon side-to-side rotation, and with flexion and extension. Claimant had full range of motion and voiced no complaints regarding her left shoulder. Claimant complained of left hand pain with hyper-flexion of her MP joint, but possessed full range of motion. Dr. Hanaway noted a three millimeter bump at the cuboid and tuberosity of Claimant's 5th metatarsal junction, and left ankle hypermobility. Dr. Hanaway diagnosed a neck injury, left shoulder sprain, left MP ring finger sprain, grade III left ankle sprain all due to Claimant's December 1996 injury. Dr. Hanaway rated Claimant's cervical spine at 20% PPD BAW due to the C5-6 cervical fusion; 15% PPD referable to her left ankle sprain; and 20% PPD BAW referable to a disc herniation at C3-4, although Dr. Hanaway could not relate this herniation to Claimant's December 1996 injury. Dr. Hanaway did not provide a rating regarding Claimant's left shoulder or left ring finger.

Dr. Hanaway identified Claimant's preexisting conditions as a 1993 left wrist fracture, but noted Claimant had “no problems or complaints there,” and a 1995 left ankle injury^[5] that Dr. Hanaway rated at 5% PPD. Dr. Hanaway also noted Claimant had undergone lumbar surgery in 1982, but he did not examine or rate Claimant's low back. Dr. Hanaway opined Claimant remained permanently and totally disabled due to the combination of her December 1996 injuries and her preexisting conditions, and should be evaluated by a vocational expert to determine her employability.

Upon cross-examination by Employer, Dr. Hanaway acknowledged he first examined Claimant 4 ½ years after her 1996 work injury, and 3 years after she stopped working. Dr. Hanaway confirmed the history he related in his report regarding the severity of Claimant's left ankle injury came from Claimant. He also acknowledged the medical report from Barnes Care regarding Claimant's left ankle demonstrated only slight soft tissue swelling, no description of gross swelling or bruising, and Claimant was noted to be able to stand and walk on her left ankle. Further, Dr. Hanaway affirmed other than the two visits to Barnes Care, no other medical records demonstrate Claimant's left ankle was unstable, and Claimant returned to working sixteen hour days. Dr. Hanaway supported his diagnosis of a Grade III ankle sprain by explaining an ankle can only be hypermobile if an injury to a ligament has occurred. Regarding Claimant's right knee condition, Dr. Hanaway confirmed medical records from Claimant's treating physician demonstrated Claimant's knee problems began six months prior to the start of treatment in 2000. Dr. Hanaway also confirmed the medical records indicated a first notation of cervical complaints by Claimant occurred on September 19, 1997, and his diagnosis of traumatic neck injury was based on the history Claimant provided.

Upon cross-examination by SIF, Dr. Hanaway also acknowledged no other physician involved in Claimant's care had casually linked Claimant's cervical condition to the December 31, 1996 fall, and any notation made by treating physicians regarding how the injury occurred simply recited Claimant's history. Dr. Hanaway confirmed Claimant's current cervical complaints may now be originating from C3-4, and he can't say if her discomfort is coming from a combination of C5-6 and

C3-4, or from either level standing by itself. Dr. Hanaway further verified Claimant's cervical complaints were a significant component in his determination of PTD, because she had chronic cervical problems and an un-operated herniated disc at C3-4. Dr. Hanaway also acknowledged Claimant returned to un-restricted work following her lumbar surgery, and continued to work for the next fifteen to sixteen years. Dr. Hanaway was unaware of the type of work Claimant performed after her lumbar surgery. Dr. Hanaway confirmed his PTD determination was due to Claimant's un-operated C3-4 disc, chronic neck pain, and chronic left ankle problem. Finally, Dr. Hanaway verified he had not placed any restrictions on Claimant's activities.

Vocational Deposition Testimony

Samuel Bernstein, Ph.D.: Dr. Bernstein is a licensed psychologist and vocational rehabilitation counselor. Dr. Bernstein interviewed Claimant on September 29, 2005, and noted Claimant displayed anxiety and difficulty concentrating during the interview. Dr. Bernstein observed Claimant walked with a limp favoring her left leg, and appeared to have difficulty getting in and out of a chair. On the day of interview, Claimant complained of a headache, pain in her left hip, back, legs, and neck. Claimant told Dr. Bernstein she experienced difficulty falling asleep due to discomfort, is able to sit or stand for approximately 30 minutes before needing to alternate her position, is able to walk approximately 1 block, and has difficulty with overhead lifting due to her neck discomfort. Claimant told Dr. Bernstein she spends most of her day in a reclining position. Claimant informed Dr. Bernstein she had a 9th grade education, but later obtained a GED and attended junior college.

After considering Claimant's age, employment background, and impairments, Dr. Bernstein concluded Claimant was unemployable in the open labor market. Specifically, Dr. Bernstein considered Claimant's severe residuals from her medical and psychological history in addition to her incapacitating headaches, right and left shoulder pain, and left foot swelling. Dr. Bernstein opined Claimant could not be hired or perform substantial work activities in a concentrated and persistent manner.

Upon cross-examination, Dr. Bernstein believed Dr. Kitchens had discharged Claimant with permanent lifting restrictions of twenty pounds on occasion, and ten pounds frequently, but acknowledged he could not find this restriction in Claimant's medical records. Dr. Bernstein also believed Claimant's headaches and left shoulder pain were caused by her 1996 neck injury, and acknowledged Claimant's right shoulder pain is developing and unrelated. Dr. Bernstein conceded Claimant worked in heavy to sedentary work until 1997. Further, Dr. Bernstein confirmed Claimant worked without restrictions, without assistance, and did not miss work after her lumbar surgery. Finally, Dr. Bernstein acknowledged at the time of Claimant's 1996 injury, she was fifty-four years old, which would be considered approaching advanced age.

FINDINGS OF FACT & RULINGS OF LAW

Having given careful consideration to the entire record, based upon the above testimony, the competent and substantial evidence presented, and the applicable law of the State of Missouri, I find the following:

Issues relating to accident and arising out of, course/scope of employment

Section 287.020 RSMo., defines accident as an unexpected or unforeseen event or series of events that occur suddenly, without fault, and produce objective symptoms of an injury. The injury must be "clearly work related", and that term is defined as work being a substantial factor in the resulting medical condition. Further, an injury is not compensable merely because work was a triggering or precipitating factor. Section 287.020.3(1) defines injury as that which has arisen out of and in the course of employment. Section 287.020.3(2) instructs that to arise out of and in the course of employment an injury must meet four requirements; (a) the employment is a substantial factor causing the injury, (b) the injury is a natural incident of the work/employment, (c) the employment was a proximate cause of the injury, and (d) the injury is not from risk unrelated to the employment to which other workers would be equally exposed outside of employment in normal life. A substantial factor is a factor that has a larger contributory effect in producing an injury. *Kasl v. Bristol Care, Inc.*, 984 S.W.2d 852 (Mo.App.1999). To satisfy subparagraphs (a) and (c) of §287.020.3 RSMo., a causal connection must exist between the conditions of the work and the resulting injury. *Cook v. St. Mary's Hospital*, 939 S.W.2d 934 (Mo.App.1997) (overruled in part). A cause is proximate if it is a substantial factor in bringing about the result. *McCutcheon v. Tri-County Group XV, Inc.*, 920 S.W.2d 627 (Mo.App.1996).

Although identified as a disputed issue, no evidence was produced to question Claimant's assertion that she fell down several stairs while she was working on December 31, 1996. I find Claimant did sustain an accident on December 31, 1996, that arose while she was in the course and scope of her employment.

Issues relating to medical causation

The true dispute in this case involves the extent to which Claimant was injured in the December 31, 1996 fall. As a result of that fall, Claimant alleges she injured her left foot/ankle, left 4th finger, neck, head, and shoulders. As a result of the December 31, 1996 fall, Dr. Hanaway diagnosed and rated injuries only to Claimant's C5-6 cervical spine, and her left ankle.

Medical causation not within lay understanding or experience requires expert medical evidence. *Wright v. Sports*

Associated, Inc., 887 S.W.2d 596 (Mo.banc 1994) (overruled on other grounds). The weight to be accorded an expert's testimony should be determined by the testimony as a whole and less than direct statements of reasonable medical certainty will be sufficient. *Choate v. Lily Tulip, Inc.*, 809 S.W.2d 102 (Mo.App. 1991) (overruled on other grounds). Medical causation must be established within a reasonable degree of medical probability. *Fisher v. Archdiocese of St. Louis*, 793 S.W.2d 195 (Mo.App. 1990) (overruled on other grounds). Reasonable probability is based on reason and experience that inclines the mind to believe, but leaves room for doubt. *Tate v. Southwestern Bell Telephone Co.*, 715 S.W.2d 326, 320 (Mo.App. 1986).

Claimant's ability to accurately portray the extent and severity of her injuries has seriously placed her credibility at issue. The medical records simply do not support Claimant's contention that her fall on December 31, 1996 caused her cervical disc herniation at C5-6. The Barnes Care records make no mention Claimant reported any injury to her neck, head or shoulders, either on the date of accident or follow-up care provided approximately 10 days later. The first mention of cervical complaints appeared 9 ½ months after the December 31, 1996 fall, and was made to her personal physician. Between the Barnes Care discharge and when cervical symptoms appear in her medical records, Claimant sought no medical treatment regarding her left foot, left 4th finger, neck or shoulders.^[6] Her testimony alleging she informed Dr. Carmody sooner about her cervical complaints is not credible.

Further, regarding her left ankle, Claimant reported to Dr. Hanaway her ankle when seen at Barnes Care was black and blue, and swollen. As a result of this history, Dr. Hanaway concluded there was "no treatment offered by this organization" [Barnes Care], "despite her grossly swollen ankle." This assessment of the condition of Claimant's left ankle on the date of injury is in stark contrast to the Barnes Care records indicating Claimant was able to walk on her left foot, had "slight" soft tissue swelling over the "dorsal lateral aspect" of her left foot, and "no ecchymotic skin changes." Ten days later, Barnes Care noted Claimant's left foot had "no swelling or ecchymotic skin changes," and Claimant was able to stand and walk without difficulty. After Claimant was discharged from Barnes Care, she never sought additional treatment for her left ankle. Again, Claimant's testimony that as a result of the December 31, 1996 injury her left ankle never healed is not credible.

Dr. Hanaway's reliance on Claimant's ability to be an accurate historian places his diagnoses in jeopardy, and further damages an already flawed opinion. Dr. Hanaway confirmed he relied on the history Claimant provided when relating her herniated disc at C5-6, and her left ankle instability to the December 31, 1996 fall. Yet, Dr. Hanaway conceded Claimant's medical records do not support the history Claimant provided. Further, Dr. Hanaway conceded Claimant's current cervical complaints may be the result of pathology now occurring at C3-4, which he cannot relate to Claimant's December 31, 1996 fall. As Dr. Hanaway stated in his deposition:

Q. So it could be entirely C3-4?

A. It could be. There's no way in the world I could stand on saying that it was C5-6. I just don't know.

Q. Okay. And you don't know - - I mean, you said earlier that you cannot link up any pathology referable to C3-4 with the injury of 12/30/96, right?^[7]

A. Because it didn't come out - - yeah. It didn't come out until '98. I mean, it's just speculation. One way, it could be. One, it could be the other. I don't know.

Q. Okay. But, I mean, no doubt in your mind all the present symptoms that she presented to you with could have been coming from the C3-4 injury?

A. I can't deny that. It's possible.

Q. Okay. That was a significant component, was it not, in your determination that this woman was unable to work?

A. Yes, because she had chronic neck problems and an un-operated herniated disc in her neck.
(Exhibit G, pgs. 58, 59)

I do not find Dr. Hanaway's opinion of medical causation regarding Claimant's C5-6 disc herniation was established within a reasonable degree of medical probability. It is based on questionable history and speculation. Further, Dr. Hanaway's assessment of the severity of Claimant's left ankle/foot injury is unsupported by competent medical evidence.

Although Claimant settled her case against Employer and was paid 20% BAW PPD referable to her cervical spine, the settlement is not dispositive of any permanency associated with this injury.^[8] Settlement agreements with third parties are generally not admissible in evidence for the purpose of establishing the validity of a claim or as an admission against interest. *Joice v. Missouri-Kansas-Texas R. Co.*, 189 S.W.2d 568, 575 (Mo. 1945); *State ex rel. Malan v. Huesemann*, 942 S.W.2d 424, 27-28 (Mo. App. 1997); *Massman Const. v. Highway & Transp. Com'n*, 835 S.W.2d 465, 468 (Mo. App. 1992); *Taylor v. Associated Elec. Co-Op Inc.*, 818 S.W.2d 669, 672 (Mo. App. 1991). As the Second Injury Fund is not a party to the settlement, any agreements concluded therein are not binding on the Second Injury Fund. *Employers Ins. of Wausau v.*

Crane Co., 904 S.W.2d 460, 462 (Mo. App. 1995); *Erslon v. Vee-Jay Cement Contr. Co.*, 728 S.W.2d 711, 714 (Mo. App. 1987). When Employer settled the alleged primary injury, it disputed all issues. By settling the case, Employer may have simply made a business decision to avoid further litigation exposure. Second Injury Fund was not a party to the primary settlement, and retains its right of defense.

In a hearing in which Second Injury Fund is the only defendant, Claimant still must establish the essential elements of her claim. Medical causation is an essential element Claimant must establish. I find Claimant has failed to meet her burden regarding a cervical injury allegedly caused by the December 31, 1996 fall. The medical evidence does establish Claimant sustained strain injuries to her left ankle/foot, and her left 4th finger as a result of the December 31, 1996 fall, but both injuries resolved by January 10, 1997, and Claimant suffered no permanent disability associated with either injury.

Conclusion

As there was no permanent disability associated with the primary injury, there can be no Second Injury Fund liability for permanent total disability or permanent partial disability, and all remaining issues are moot.

Date: _____

Made by: _____

LINDA J. WENMAN
Administrative Law Judge
Division of Workers' Compensation

A true copy: Attest:

Patricia "Pat" Secrest
Director
Division of Workers' Compensation

- _____
[\[1\]](#) Post-hearing briefs were due on December 1, 2006, but due to extreme weather conditions both parties were granted continuances to file late briefs.
[\[2\]](#) Claimant was initially hired by Purex Corporation, which was later acquired by Dial Corporation.
[\[3\]](#) This injury preceded the December 31, 1996 injury.
[\[4\]](#) The MRI of January 24, 1995 references a right wrist MRI, but this appears to be a typographical error as all treatment was to Claimant's left wrist.
[\[5\]](#) During deposition testimony, Dr. Hanaway conceded Claimant's 1995 alleged left ankle fracture was actually a metatarsal fracture.
[\[6\]](#) During August 1997, the only medical treatment directed toward Claimant's head was due to ear and sinus infections.
[\[7\]](#) The medical evidence reflected Claimant's date of injury to be December 31, 1996.
[\[8\]](#) Administrative Judicial Notice taken of the December 19, 2005 settlement.