

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

Injury No.: 06-125189

Employee: Teresa Carkeek  
Employer: Hallmark Cards, Inc. (Settled)  
Insurer: Hallmark Cards, Inc. (Settled)  
Additional Party: Treasurer of Missouri as Custodian  
of Second Injury Fund

The above-entitled workers' compensation case is submitted to the Labor and Industrial Relations Commission (Commission) for review as provided by 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 Law. Pursuant to section 286.090 RSMo, the Commission affirms the award and decision of the administrative law judge dated March 26, 2010. The award and decision of Administrative Law Judge Kenneth J. Cain, issued March 26, 2010, 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 17<sup>th</sup> day of December 2010.

LABOR AND INDUSTRIAL RELATIONS COMMISSION

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William F. Ringer, Chairman

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Alice A. Bartlett, Member

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John J. Hickey, Member

Attest:

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Secretary

## **FINAL AWARD**

Employee: Teresa Carkeek Injury No: 06-125189  
Employer: Hallmark Cards, Inc. (previously settled)  
Additional Party: Missouri State Treasurer, Custodian of the Second Injury Fund  
Insurer: Hallmark Cards, Inc.  
Hearing Date: February 1, 2010  
Final Briefs filed: March 9, 2010 Checked by: KJC/cy

### **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: December 13, 2006
5. State location where accident occurred or occupational disease was contracted: Liberty, Clay County, Missouri, an adjoining county to Jackson County.
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, in the course and scope of her employment for Hallmark Cards, Inc., was pushing a buggy when she tripped on some debris on the floor and stumbled forward. Employee alleged a cervical spine injury.
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: Neck

14. Nature and extent of any permanent disability: 12.5 percent permanent partial disability per settlement on January 5, 2010
15. Compensation paid to-date for temporary disability: None
16. Value necessary medical aid paid to date by employer/insurer? \$2,827.21
17. Value necessary medical aid not furnished by employer/insurer? N/A
18. Employee's average weekly wages: \$744.30
19. Weekly compensation rate: \$496.20/376.55
20. Method wages computation: By Agreement

**COMPENSATION PAYABLE**

21. Amount of compensation payable:

Unpaid medical expenses: N/A  
N/A weeks for permanent partial disability from employer  
N/A temporary total or temporary partial disability  
N/A weeks for disfigurement

22. Second Injury Fund liability: 20 weeks @ \$376.55 per week = \$7,531.
23. Future requirements awarded: None

**TOTAL: \$7,531.**

Said payments to begin as of date of Award 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 percent of all payments hereunder in favor of the following attorney for necessary legal services rendered to the Claimant: Mr. Mark Kelly.

## **FINDINGS OF FACT and RULINGS OF LAW:**

Employee: Teresa Carkeek Injury No: 06-125189  
Employer: Hallmark Cards, Inc. (previously settled)  
Additional Party: Missouri State Treasurer, Custodian of the Second Injury Fund  
Insurer: Hallmark Cards, Inc.  
Hearing Date: February 1, 2010  
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The Employee settled her claim arising out of the alleged December 13, 2006 accident, Injury No. 06-125189, against her Employer, Hallmark Cards, Inc. on January 5, 2010 based on a permanent partial disability of 12.5 percent to the body as a whole due to an injury to her neck. The settlement stipulation showed that no temporary total disability benefits were paid and that \$2,827.21 was paid in medical aid.

The Employee also had another case heard at the hearing on February 1, 2010. That claim was under Injury Number 06-125432, injury date June 5, 2006. The Employee alleged in the June 2006 case that she was rendered permanently and totally disabled due to a combination of the disability she sustained in the June 2006 accident and her preexisting disability. The Employee did not prevail on that argument. Claimant allegedly injured her shoulder in the June 2006 accident. She continued working until August 2007. She quit working of her own volition. She alleged a subsequent accident at work on December 13, 2006. She settled that claim as noted above on January 5, 2010. She did not prove the Second Injury Fund's liability for permanent total disability benefits in the June 2006 case.

The Employee and the State Treasurer as Custodian of the Second Injury Fund entered into various admissions and stipulations in the December 2006 case. The remaining issues were as follows:

1. Whether the employee sustained an accident arising out of and in the course and scope of her employment; and
2. Liability of the Second Injury Fund for Compensation.

At the hearing on her December 2006 case, Ms. Teresa Carkeek (hereinafter referred to as Claimant) testified that she was born on March 25, 1952 and that she had a high school education. She stated that she had no post-high school education or vocational training. She stated that she had no computer training.

Claimant testified that her first job was at a fast food restaurant. She stated that she next worked in day care at a fitness facility for about 5 years. She stated that in addition to her day care duties, she scheduled and fired employees. She stated that she was "pretty" much the manager.

Claimant testified that afterwards she worked in the cafeteria for the Liberty School District. She stated that she worked as a cashier, on the line and in the salad department. She stated that she was in charge of the salad bar department for the last two years of her employment with the district.

Claimant testified that her job at Hallmark Cards, Inc. was retail order processor. She stated that she had to pick up and fill orders. She stated that she had to do a lot standing, lifting and walking. She stated that she had to pack, tape and ship boxes. She stated that the boxes generally weighed 10 to 15 pounds. She stated that occasionally a box weighed 35 to 60 pounds. She stated that she pushed a buggy to the various stations to pick up products for shipping.

Claimant testified that her alleged injury at work occurred on December 13, 2006. She stated that she injured her neck and upper back in the alleged accident. She stated that the injury occurred when she slipped on some boxes, packing foam and cables on the floor. She stated that she began to fall forward and at the same time she was trying to keep from dropping the cards in her hands. She stated that as she fell forward, she jerked her whole body in a forward direction and that she felt as though an electric shock had gone through her back. She stated that she experienced stiffness and soreness in her back. She admitted that she did not fall to the floor. She admitted that she did not fall into a wall. She admitted that her head, neck, back and hip did not strike any object.

Claimant admitted that she worked the remainder of the month of December. She stated that on January 7, 2007, she had an MRI of her left shoulder which she had injured at work in June 2006. She stated that she had arthroscopic shoulder surgery on February 20, 2007. She stated that Dr. Lingenfelter, who performed the surgery, wanted to treat her neck and recommended an MRI, which Hallmark refused to authorize. She stated that Hallmark also refused to authorize an injection in her neck as prescribed by Dr. Griffith in pain management.

Claimant admitted that she returned to work following the arthroscopic shoulder surgery and that she worked light duty during the summer of 2007. She stated that she worked the light duty for 90 days.

Claimant testified that she was re-examined by Dr. Lingenfelter in March 2008. She also stated that in 2008 she was referred to Dr. Reintjes for her neck complaints. She stated that he told her that he would not do any neck surgery on her due to her obesity. She stated that he told her to come back after she had lost 100 pounds.

Claimant complained that she was still experiencing numerous problems as a result of her June and December 2006 injuries at work. She stated that she could not lift her left arm past

chest level. She stated that she did not have a lot of pain in her shoulder. She stated that she had numbness and tingling in her left hand. She stated that she had pain in the biceps area of her left arm. She stated that she had a loss of strength in her left arm. She stated that she did not have much grip strength in her left hand.

Claimant testified that she still had upper back and neck pain. She stated that she had occasional numbness. She stated that she could not turn her head. She stated that she could not look up. She stated that she had a lot of pain between her shoulder blades. She stated that it was difficult to sleep at night. She stated that she could not lie on her side for very long due to her back pain. She stated that she had numbness going down both arms to her fingertips. She stated that she had shooting pains.

Claimant testified that she was on pain medication for her neck and upper back. She stated that the pain medication had affected her concentration. She stated that the medication had affected her driving. She also stated that her driving was affected by her inability to fully turn her head to the side. She stated that her injuries had affected her ability to engage in recreational activities. She stated that she could no longer decorate cakes. She stated that on camping trips, her husband now had to do all the work to set up the camp. She stated that she could no longer sew due to her problems in sitting and standing. She stated that it now takes her two weeks to sew what she used to do in one day.

Claimant also testified to several injuries and medical problems which occurred prior to December 2006. She alleged a shoulder injury at work in June 2006 which, according to her, occurred after she had placed a 40 to 60 pound box on the conveyor. She stated that the conveyor belt caught the box and it jerked her left arm. She stated that she felt a pop in her shoulder.

Claimant admitted that she continued working after the June 2006 shoulder injury until the following year when she had the arthroscopic shoulder surgery. She admitted that she initially declined treatment for her shoulder when her employer offered it. She also stated that during the period June 2006 to February 2007 she took a three week vacation, had gall bladder surgery, a hemorrhoidectomy, and that she was hospitalized for complaints of chest pains, which her doctor determined was caused by her gallbladder problems.

Claimant testified that prior to her alleged June and December 2006 accidents she had experienced back pain and problems. She stated that prior to both accidents, she had problems with deep vein thrombosis (DVT's) or blood clots in her left leg. She stated that she could not work when she experienced a flare up in her DVT problems. She stated that her DVT problems caused pain and the veins in her left knee and calf to swell. She stated that she was hospitalized on three occasions for blood clots in her leg. She also stated that prior to 2006, she had right carpal tunnel and right shoulder surgery, left thumb problems and a tremor in her right hand.

Claimant admitted that she had not applied for work since she left Hallmark. She stated that she could not do any of her past jobs. She stated that she was not aware of any job that she could do.

On cross-examination by the Second Injury Fund Claimant testified that she had a tremor in her right hand of unknown cause for about 10 years. She admitted that it had gotten worse since 2006. She admitted that it had never affected her ability to work.

Claimant testified that Dr. Haas had told her prior to 2006 that she was too young for a left knee replacement. She admitted that her left knee had gotten worse since 2006. She admitted that her back pain had gotten worse since 2006.

Claimant testified that her DVT problems had affected her at work. She stated that her DVT problems caused swelling in her leg and knee and caused her to slow down at work. She stated that she did not recall Dr. Reintjes telling her that degenerative problems were the source of her neck pain.

Claimant testified that she was currently receiving \$900 per month in Social Security Disability benefits and \$1,100 per month in long-term disability.

### **Medical Evidence**

Claimant offered a medical deposition and numerous medical reports and records into evidence. Claimant's Exhibit K was the deposition testimony of P. Brent Koprivica, M.D. Dr. Koprivica testified that he received his M.D. degree in 1980 and that he had practiced occupational medicine since 1992.

Dr. Koprivica testified that he examined Claimant on March 31, 2009. He stated that the examination took approximately four hours and 45 minutes. He stated that he spent an additional hour reviewing her records and writing his report.

Dr. Koprivica testified that Claimant provided a history of injuring her neck and upper back at work on December 13, 2006 when she allegedly tripped on some empty cubes and foam on the floor. He noted that Claimant's medical records showed that Dr. Reintjes had evaluated Claimant for her neck complaints and suggested non-operative management. He noted that the MRI of Claimant's cervical spine showed stenosis and other degenerative changes.

Dr. Koprivica also testified that Claimant provided a history of injuring her left shoulder at work on June 5, 2006 when she awkwardly lifted a box and felt a pop in her left shoulder. That history differed from her testimony at the hearing where she alleged that she placed a box on a conveyor belt where it was caught and jerked her shoulder.

In addition, Dr. Koprivica noted Claimant's injuries and impairments which preexisted her alleged June and December 2006 injuries at work. He stated that only two of her preexisting injuries or impairments, a low back condition and her DVT problems, had resulted in any

permanent partial disability and which were also an obstacle or hindrance to her employment or reemployment.<sup>1</sup>

Dr. Koprivica testified that Claimant's preexisting low back impairment had resulted in a permanent partial disability of 15 percent to the body as a whole. He stated that her preexisting DVT problem had resulted in a permanent partial disability of 25 percent of the left lower extremity at the 207 week level. He stated that he rated her injuries from the June 2006 accident at 50 percent of the left upper extremity at the 232 week level. Claimant, however, settled her case against her employer involving the left upper extremity injuries on January 5, 2010, based on a permanent partial disability of 35 percent at the 232 week level. See Claimant's Exhibit B.

Dr. Koprivica testified that he rated Claimant's neck injury from the alleged December 2006 accident at 15 percent to the body as a whole. Claimant settled her case against her employer involving the alleged neck injury on January 5, 2010, based on a permanent partial disability of 12.5 percent to the body as a whole. See Claimant's Exhibit O.

Dr. Koprivica also testified that on examination Claimant had a reduced range of motion of her cervical spine. He admitted that she had spondylosis of the cervical spine or a degenerative process. He admitted that she had stenosis or narrowing of the spinal canal, a degenerative condition. He stated, however, that she did not have disabling symptoms prior to the December 2006 accident. He stated that her neck was asymptomatic prior to December 2006. He diagnosed her injury from the alleged December accident as a sprain or strain to her cervical spine. He stated that the sprain or strain led to an increase in the preexisting narrowing of her cervical spine, traumatized her ligaments and caused a greater bulging of the already degenerated disks.

The evidence showed that Dr. Koprivica may not have read the numerous medical records Claimant offered into evidence. Claimant's medical records showed that on April 29, 2002 she complained to her family doctor at the Seaport Family Practice Clinic that she had neck pain that was getting worse. That contradicted Dr. Koprivica's conclusion that Claimant's neck was asymptomatic prior to the alleged December 2006 accident. It contradicted his conclusion that Claimant did not have disabling symptoms prior to the alleged December 2006 accident.

Claimant also complained in April 2002 that her neck pain was made worse by just standing. She complained in 2002 that her neck pain was made worse by looking in a downward direction. She complained that her neck pain was made worse by any type of jarring motion. Claimant clearly had degenerative problems in her cervical spine prior to December 2006 and, contrary to Dr. Koprivica's assertion, her neck was symptomatic prior to December 2006.

In addition to the evidence referred to above which contradicted his opinion, Dr. Koprivica also admitted that he believed that there were psychological issues involved in

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<sup>1</sup> The statute provides that the Second Injury Fund is only liable for benefits if the preexisting impairments result in permanent partial disability and if the preexisting impairments are a hindrance or obstacle to the employee's employment or reemployment. See § 287.220 RSMo. 2005.

Claimant's presentation. He stated that Claimant came to tears during the interview. He stated that she was "very tremulous" during the examination, which he attributed to anxiety. He did state that he believed that Claimant was genuine in her presentation and that her scores on the Waddell's testing were appropriate.

Finally, Dr. Koprivica testified that none of Claimant's four "significant" impairments, the neck strain from the alleged December 2006 accident, the left upper extremity injury from the June 2006 accident, the preexisting low back impairment and the preexisting DVT problem in isolation were sufficient to render Claimant permanently and totally disabled.

When asked whether Claimant was rendered permanently and totally disabled due to the combined effect of the disability Claimant sustained as a result of what he termed the four "significant" impairments, Dr. Koprivica refused to answer the question. Dr. Koprivica admitted that he had answered questions in other cases about whether a person was permanently and totally disabled. He stated that in Claimant's case he was going to defer to a vocational expert to answer the question.

Claimant's Exhibit A contained the records of Erich J. Lingenfelter, M.D. of Northland Bone & Joint Orthopedic Surgery. Dr. Lingenfelter noted on September 12, 2007 that Claimant was now complaining of chronic cervical trapezius and scapular pain. He noted that he had performed a rotator cuff repair on Claimant in February 2007. He stated that Claimant's pain was "way out of proportion to what I would expect with rotator cuff pathology." He stated that "I think there are other issues that need to be addressed."

On August 10, 2007, Dr. Lingenfelter, in a letter to Patrick Griffith, M.D. of a pain management clinic, noted that Claimant complained of pain with neck rotation and lateral bending. He stated that her CT scan did not show any "concerning" findings. He stated that on examination, Claimant's complaints seemed out of proportion to what he would expect for someone even with severe scapular bursitis and scapular dyskinesis. He stated that Claimant's shoulder pain had essentially resolved since her surgery. He stated that he did not believe that Claimant's neck complaints were related to her shoulder surgery.

On June 8, 2007, Dr. Lingenfelter noted that Claimant was complaining of chronic neck, posterior scapular and thoracic-cervical pain. He stated that I do not think "this" is related to her shoulder. He stated that "she keeps relating this back to an injury." He stated that he believed it was reasonable to proceed with a trigger point injection as well as possible cervical epidurals.

On February 4, 2009, Dr. Lingenfelter noted that Claimant's complaints of pain were out of proportion to the findings from his examination of her. He stated that she complained of almost hypersensitivity. He stated that although she complained of problems in raising her left shoulder, when he passively performed range of motion exercises on her shoulder, she had a full functional range of motion of her left shoulder and equal to that of her right shoulder.

Dr. Lingenfelter concluded that no further intervention was needed. He stated that Claimant had a healed rotator cuff. He stated that her pain was way out of proportion to the

small tear she had in her shoulder. He stated that nothing on the examination suggested that her cuff had re-ruptured. He stated that Claimant had a significant amount of kyphosis (curvature) in her spine and that her body habitus could definitely be contributing to her complaints. He stated that he had no treatment recommendations for Claimant.

Claimant's Exhibit B contained the records of Stephen Reintjes, M.D. of the Kansas City Neurosurgery Group, LLC. In September 2008, Dr. Reintjes noted that a bone scan showed a significant uptake in Claimant's left AC joint consistent with degenerative changes. He also stated that there was an uptake associated with Claimant's feet and knees, greater on the left than the right. Dr. Reintjes indicated that although Claimant complained of neck pain, "I think that her primary complaints of pain and restriction of motion are related to her left shoulder. Coincidentally, she has some foraminal stenosis which is degenerative in nature at C6-7 on the left." He did not recommend any specific treatment other than weight loss.

Subsequently, Dr. Reintjes stated that Claimant continued to complain of pain, numbness and tingling across her left shoulder blade and around the left scapula and chronic neck pain. He stated that Claimant's continuing left shoulder problems were due to degenerative changes. He stated that radiographic studies of her cervical spine showed foraminal stenosis (narrowing) on the left at C6-7. He stated that he would not consider her a surgical candidate for the foraminal stenosis due to her size and body habitus. He did not even mention her alleged neck strain from the alleged December 2006 accident as a cause for any need for surgery, or any other treatment.

Dr. Reintjes stated that Claimant was not having a true C7 radicular pain, numbness or tingling. He stated that he would reassess her radicular complaints after her weight loss. In his June 2008 notes, Dr. Reintjes noted that although Claimant complained of injuring her neck in a fall at work in December 2006, that she did not "hit her neck or her low back" in the accident. He stated that she complained that her neck felt stiff and sore the day after the alleged incident at work. He stated that she stood 5 foot 4 inches tall and weighed 285 pounds.

Claimant's Exhibit C contained physical therapy records. Exhibit D contained Claimant's records from Northland Family Care. On November 8, 2006 Claimant complained of left leg pain. On May 17, 2006 she complained of ankle and heel pain.

On February 17, 2006 Claimant complained of left shoulder and calf pain. Dr. Roney's diagnosis was left shoulder pain with an impingement syndrome. He indicated that an orthopedic consultation might be necessary. He noted that Claimant had indicated that her shoulder was better since she resumed the use of Celebrex. That was less than four months prior to the alleged June 2006 left shoulder injury at work where one of the diagnoses was impingement syndrome.

There were several notations in the records from 2005 showing that Claimant complained of left knee pain. There were records showing that she had a Baker's cyst and right middle finger trigger pain. In November 2004, Claimant complained of ankle pain, hand numbness and dizziness. Her doctor noted that findings were suggestive of carpal tunnel syndrome.

In September 2004 Claimant complained of dizziness. In May 2004 she complained of persistent low back pain. She complained of excessive perspiration. She complained of a sharp shooting pain into her right hip and buttock area. In April 2004 she complained of back and left hip pain. In January 2004 she complained of heart palpitations. It was noted that she had a tremor. She complained of hand numbness. She alleged that her job had aggravated her hand problems and numbness.

There were numerous notations where Claimant was complaining of colds and flu-type symptoms. She complained of ingrown toenails. She complained of discoloration of her toenail.

On May 6, 2003 Claimant had a lesion removed from her shoulder. In March 2003 she complained of back pain. In November 2002 she complained of Bell's palsy and facial pain. She was taking Percocet and Neurontin. In August 2002 Claimant complained of back pain and wrist tendonitis. An MRI showed a broad base disk bulge slightly symmetric to the left. In April and July 2002 Claimant complained of back pain.

Claimant's medical records also contained 2006 and later notations. A June 2007 imaging of her lumbar spine showed mild degenerative spurring at L4-L5. A January 2007 MRI of her left shoulder showed a small rotator cuff tear. She also had a mild impingement. A December 20, 2006 CT scan in three views of her cervical spine showed no acute abnormalities.

On December 16, 2007, Claimant saw Dr. Roney, her family physician with complaints of cold type symptoms. She did not mention any neck pain. The alleged injury at work allegedly occurred three days earlier. On September 24, 2007 she saw Dr. Roney for upper respiratory complaints. She told Dr. Roney at that that she had injured her left 5<sup>th</sup> finger in a fall a week earlier.

On January 3, 2007 Claimant saw Dr. Pritchett. She described an injury at work a few weeks earlier. He diagnosed an acute myofascial strain based on the history she provided to him. He offered no test results or any evidence to support the diagnosis other than Claimant's subjective complaints.

Claimant's records from Seaport Family Practice showed that on April 29, 2002, she complained of back pain, toenail discoloration and pain in her neck and upper and mid back. She told the doctor that she noticed the pain when she looked in a downward direction. She told the doctor that her neck was becoming increasingly painful by just standing. She told the doctor that her neck pain was made worse by any kind of jarring-type motion such as riding in a vehicle when it rolled over a bump in the road.

Claimant's Exhibit E also contained medical records. The records noted that she had significant osteoarthritis. She had knee surgery in 2008. She complained of ankle pain and right foot pain. Of note was that on September 6, 2006, prior to the alleged December 2006 accident at work, Claimant complained of right hip pain of several months duration increased with lying on her hip. Also of note was that in 1999 Claimant had a right rotator cuff repair.

Claimant's Exhibit I contained records showing that she had a right carpal tunnel release in January 2005. Exhibit P contained her Hallmark personnel records. The records were primarily medical and they were cumulative and duplicative of the other medical records.

### **Vocational Testimony**

Mr. Terry Cordray, a vocational rehabilitation counselor, testified at the hearing on Claimant's behalf. He stated that he had worked in the field for 35 years. He stated that about 65 percent of his referrals were from the defense in workers' compensation, personal injury and FELA cases and that about 35 percent of his cases were from plaintiffs' law firms. He stated that he evaluated Claimant on November 24, 2009.

Mr. Cordray testified that his evaluation of Claimant lasted four hours. He stated that he reviewed Claimant's medical records and considered her education, age, employment history, and her lack of any transferrable job skills. He stated that her age was significant because it became more difficult to learn new skills past the age of 50 to 55. He stated that Claimant had no schooling since she graduated from high school in 1970.

Mr. Cordray outlined Claimant's work history. He stated that she scored in the average range on intelligence testing in reading, spelling and arithmetic. He stated that she scored slightly below average on the Wonderlic Intelligence Test, but noted that in taking the test she had a slight tremor in her right hand.

Mr. Cordray testified that due to Claimant's age she was not a candidate for retraining to do sedentary work. He stated that based on her restrictions she was limited to sedentary work which required a sit/stand option. He stated that Claimant was unemployable. He stated that no employer would hire Claimant.

Mr. Cordray did not mention whether he had considered the restrictions given by Dr. Lingenfelter, Claimant's treating orthopedic surgeon, in August 2007. Dr. Lingenfelter did not restrict Claimant to sedentary work. Dr. Lingenfelter noted in August 2007 that Claimant could do waist-level activities. He stated that she could do chest-level activities with her elbows flexed. He stated that she should not do overhead activities. He stated that she could push and pull up to 25 pounds.

Finally, Mr. Cordray concluded that Claimant was permanently and totally disabled due to her June 2006 shoulder injury combining with her prior impairments. He stated that her December 2006 neck injury at work was just "icing" on the cake.

On cross-examination by the Second Injury Fund, Mr. Cordray admitted that Claimant had some supervisory experience due to her job at the day care center. He stated that Claimant could be retrained to operate a cash register. He stated that she could not do dispatcher work due to her neck injury which would preclude her from constantly looking down at a monitor.

Mr. Cordray testified that he was unaware that Claimant was a cake decorator. He stated that she could not work as a baker due to the bending required to do the job and the tremor in her right hand. He stated that the light-duty program at Hallmark was not a "real job." Claimant had testified earlier that her salary on what she termed the light-duty job remained the same as in her previous position. She stated that in the job she characterized as light duty there was less pressure to work as quickly as in other jobs.

## LAW

After considering all the evidence, including the testimony at the hearing, Dr. Koprivica's deposition, Dr. Lingenfelter's reports, Dr. Reintjes' reports, the other medical reports and records, the other exhibits, and observing Claimant's appearance and demeanor, I find and believe that Claimant did prove that she sustained a job-related accident as defined by Missouri law. She did not prove that she was rendered permanently and totally disabled due to the disability she sustained in the December 2006 accident at work combining with her preexisting disability. She did not prove the Second Injury Fund's liability for permanent total disability benefits. She did prove the Second Injury Fund's liability for compensation. She proved the Second Injury Fund's liability for 20 weeks of compensation. At a rate of \$376.55 per week for 20 weeks, the Second Injury Fund is liable for \$7,531. The Second Injury Fund is ordered to pay that amount to Claimant.

## Burden of Proof

Claimant had the burden of proving all material elements of her claim. Fischer v. Arch Diocese of St. Louis – Cardinal Richter Inst., 703 SW 2<sup>nd</sup> 196 (Mo. App. E.D. 1990); overruled on other grounds by Hampton vs. Big Boy Steel Erections, 121 SW 3<sup>rd</sup> 220 (Mo. Banc 2003); Griggs v. A.B. Chance Company, 503 S.W. 2d 697 (Mo. App. W.D. 1973); Hall v. Country Kitchen Restaurant, 935 S.W. 2d 917 (Mo. App. S.D. 1997); overruled on other grounds by Hampton. Claimant, as noted above, did prove that she sustained a job-related accident as defined by Missouri law. She did not prove that the disability she sustained in the accident combined with her preexisting disability to render her permanently and totally disabled.

## Accident

The applicable statute pertaining to accident provides as follows:

2. The word "accident" as used in this chapter shall mean an unexpected traumatic event or unusual strain identifiable by time and place of occurrence and producing at the time objective symptoms of an injury caused by a specific event during a single work shift. An injury is not compensable because work was a triggering or precipitating factor.

3.(1) In this chapter the term "injury" is hereby defined to be an injury which has arisen out of and in the course of employment.

An injury by accident is compensable only if the accident was the prevailing factor in causing both the resulting medical condition and disability. "The prevailing factor" is defined to be the primary factor, in relation to any other factor, causing both the resulting medical condition and disability.

287.020 RSMo. 2005

As noted above, Claimant had the burden of proving all material elements of her claim. The Second Injury Fund, however, chose to make accident an issue in the case. The Second Injury Fund did not explain the basis for its position or why it believed that Claimant had not sustained an accident under Missouri Law.

Both parties were requested to and allowed to file briefs to explain their position on the various issues. Claimant filed a brief in both pending cases and addressed all the issues. The Second Injury Fund only filed a brief in the December 2006 case. The Second Injury Fund's brief was four pages in length and did not address the issue of accident. The Second Injury Fund offered no evidence at the hearing on the issue of accident. The Second Injury Fund produced no evidence on cross-examination of Claimant on the issue of accident. Thus, the Second Injury Fund left it to the Court to try to ascertain the basis for the Second Injury Fund's position.

Claimant did allege a traumatic event identifiable by time and place of occurrence. She complained shortly after the alleged accident of neck pain. Her alleged injury was diagnosed as a neck strain three weeks after the alleged accident by Dr. Pritchett. His opinion was conclusory and appeared to be based entirely on Claimant's history. No doctor testified that the alleged December 2006 accident was merely a triggering or precipitating factor. There was no evidence to that effect.

Claimant proved that the alleged December 2006 accident was the prevailing factor in causing her resulting medical condition, the strain. She also proved that the alleged December 2006 accident was the prevailing factor in causing the disability resulting from the strain. Clearly, however, Claimant had preexisting medical conditions in her cervical spine. Claimant clearly had preexisting degenerative problems in her cervical spine, including foraminal stenosis at C6-7. The alleged December 2006 accident was not the cause of most of the disability in Claimant's cervical spine. Most of the disability in Claimant's cervical spine was caused by her degenerative problems, which were present throughout her body. Claimant is morbidly obese. The question was whether the alleged December 2006 accident was the prevailing factor in causing the strain and the disability caused by the strain.

For example, an employee could be bone-on-bone in the knee. The employee could fall down the stairs at work and fracture her knee cap. Clearly, the fall at work would not be the cause of most of the disability in the employee's knee. The accident, however, would be the prevailing factor in causing the fractured knee cap. The accident would be the prevailing factor in causing the disability resulting from the fractured knee cap.

In Claimant's case, the Second Injury Fund chose not to offer any medical evidence or any other evidence. Claimant offered the opinion of Dr. Koprivica who testified that Claimant's alleged December 2006 accident was the prevailing factor in causing her neck strain and the disability resulting from the neck strain. Based on the evidence presented, Claimant proved that she sustained a compensable accident as set out in § 287.020 RSMo. 2005. She proved that the alleged December 2006 accident was the prevailing factor in causing her neck strain and the disability resulting from the neck strain. She proved a compensable claim.

### **Permanent Total Disability**

Section 287.020 (6) RSMo. 2005 defines total disability as an inability to return to any employment and not merely . . . inability to return to the employment in which the employee was engaged at the time of the accident. The terms "any employment" means "any reasonable or normal employment or occupation." Fletcher v. Second Injury Fund, 922 S.W.2d 402 (Mo. App. 1995); Crums v. Sachs Electric, 768 S.W.2d 131 (Mo. App. 1989).

Claimant did not prove that she was rendered permanently and totally disabled due to the combined effect of the disability she sustained in the alleged December 2006 accident at work and her preexisting disability. Therefore, she did not prove the Second Injury Fund's liability for permanent total disability benefits.

Claimant's testimony and her complaints were not credible. In many instances her testimony was almost incomprehensible. She appeared to have great difficulty in providing a straight answer to any question.

When first asked on direct examination what happened at work on December 13, 2006, she became tearful and a recess was taken. Upon resumption of the hearing and after a two-page rambling response she eventually stated that, "So I was going to my buggy and I started trying to get my footing through all of the cubes and foam pieces on the floor, and I all of a sudden felt myself falling forward and my thought was to save my cards. And so I was falling forward pretty fast pace, as I remember, and I hit my cards, my arm, my midsection, everything. And it kind of threw me forward. And I remember feeling like electrical shocks going down my back and my arms."

Claimant's attorney then asked, "And one of those pieces of cardboard or Styrofoam caught your foot as you were walking and you fell forward striking your cart with your side, your left shoulder?" Claimant responded, "Yeah. I remember that I hit my midsection, my arm, my cards went flying. That's mostly all I can remember. It happened so fast, I just..." At that point her attorney asked another question.

Thus, it appeared that Claimant did not know exactly what happened on December 13, 2006. That was understandable due to how quickly the alleged events transpired. As best can be determined, however, it appeared that she was pushing her buggy or cart and tripped on some debris on the floor and stumbled or fell forward. It is clear that she did not fall to the floor. She

did not fall into the wall. Her midsection may have struck the buggy or cart. She did not strike her head, neck, back or hip on any object.

Dr. Reintjes, a neurosurgeon whom Claimant consulted for her neck complaints, specifically noted that Claimant did not strike her head or low back in the accident. He apparently thought it was significant that those parts of her body were not impacted in the alleged accident when she was alleging a neck injury.

Claimant did not prove that the alleged injury she sustained in December 2006 by merely stumbling in a forward direction resulted in a severe enough injury and sufficient disability to combine with her prior impairments to render her permanently and totally disabled. She settled the alleged December 2006 injury with her employer based on a permanent partial disability of 12.5 percent to the body as a whole. The settlement stipulation specifically provided that all issues were being settled including liability for past temporary total disability and past medical benefits.

Although Dr. Koprivica indicated that Claimant was temporarily and totally disabled for more than two years after the alleged December 2006 accident, her employer paid no temporary total disability benefits and the settlement of 12.5 percent encompassed its liability for such benefits. The settlement of 12.5 percent permanent partial disability to the body as a whole was also based on the minimum amount of disability the legislature deemed as even possible to establish Second Injury Fund liability in permanent partial disability cases. See §287.220 RSMo. 2005.

Claimant had prior neck complaints from 2002. She stated that her neck pain was getting worse in 2002. Dr. Koprivica, her rating physician was not aware of her prior neck complaints. He was of the opinion that she was asymptomatic until the alleged December 2006 accident at work. Claimant clearly failed to prove that she sustained a severe injury in the alleged December 2006 accident.

In addition, Claimant's subjective complaints of severe pain and disability were not credible. The objective evidence clearly did not support her subjective complaints. Her complaints were grossly exaggerated.

Dr. Lingenfelter, the orthopedic surgeon whom Claimant admitted that her employer allowed her to choose to provide treatment, noted on several occasions subsequent to the alleged December 2006 accident that Claimant's subjective complaints were not supported by the objective evidence. In August 2007, Dr. Lingenfelter observed that "when I barely touch her scapula, she about comes off the table with significant hypersensitivity to minimal palpation." In an August 2007 letter to Dr. Griffith, Dr. Lingenfelter noted that Claimant complained of pain with neck rotation and lateral bending. He stated that her CT scan did not show any "concerning" findings. He again stated that Claimant's complaints during the examination were out of proportion to the findings.

In September 2007, Dr. Lingenfelter stated that Claimant's complaints of pain were "way out of proportion to what I would expect." On February 4, 2009, Dr. Lingenfelter again observed that Claimant's complaints of pain were out of proportion to the findings from his examination of her. He indicated that she was almost hypersensitive. He stated that although on active range of motion testing she complained of pain in raising her left shoulder; when he passively performed range of motion exercises on her left shoulder, she had a full functional range of motion equivocal to the other non-injured shoulder.

Thus, when Claimant knew that her range of motion was being tested, she complained of severe pain and problems. When she did not know that her range of motion was being tested, she did not complain of severe pain and problems and she had an appropriate range of motion. Dr. Lingenfelter in his report following the February 2009 examination reiterated that while Claimant did have a small rotator cuff tear; "This was a small tear and this pain is way out of proportion to this size of tear." At no point did Dr. Lingenfelter indicate any belief that he considered Claimant's complaints of neck or shoulder pain as valid.

Similarly, Dr. Reintjes' records did not support Claimant's allegation of severe and disabling pain. Dr. Reintjes noted in June 2008 that Claimant provided a history of falling at work in December 2006 and injuring her neck. He specifically noted that she did not "hit her neck or her low back." He noted that she had degenerative changes. He found no explanation for Claimant's subjective complaints other than foraminal stenosis, a degenerative condition.

Drs. Lingenfelter and Reintjes were credible. The evidence clearly supported their opinions. In fact, Claimant's medical history during the period essentially 2002 to 2006 supported Dr. Lingenfelter's opinion about Claimant's hypersensitivity. During that period, Claimant sought medical treatment on numerous occasions and often with very minor type complaints.

The record showed that from essentially 2002 to 2006 Claimant sought treatment on numerous occasions for colds and respiratory problems, alleged back pain on numerous occasions, neck pain, hip pain on numerous occasions, ankle pain on numerous occasions, bilateral shoulder problems on numerous occasions, thumb problems, finger problems, tremors, excessive perspiration, heel pain, bilateral knee problems on numerous occasions, carpal tunnel syndrome, toenail discoloration, ingrown toenails, bunions, foot pain, facial numbness and pain, hemorrhoids, dizziness on several occasions, heart palpitations, a "racing" heart, chest pains, digestive problems, DVT problems, numbness, tingling, gallbladder problems, rashes, excessive bleeding, and a finger injury from a non-work related fall which occurred subsequent to her December 2006 accident.

Dr. Koprivica, Claimant's rating physician, admitted that there was a psychological component to Claimant's complaints. The evidence clearly supported that opinion. Dr. Koprivica also concluded that only Claimant's pre-2006 low back and DVT problems had resulted in permanent partial disability and were a hindrance and obstacle to her employment and reemployment. He did not conclude that any other complaint listed above met that test.

Claimant's preexisting low back impairment involved degenerative conditions. At one point she was diagnosed with a bulging disk. More recent MRI findings from 2007 did not show a bulging disk. She was never diagnosed with a herniated disk. She was never diagnosed with any fractures or tears. She did not have any back surgery. No doctor recommended any such surgery.

Claimant's preexisting DVT problems had resulted in three blood clots in her left lower leg. Her problems were being controlled with medication. The DVT problems had not resulted in any internal derangement to her hip, knee or ankle. There was no credible evidence that Claimant's minor neck strain resulting from an incident where she stumbled forward at work had combined with her preexisting low back, June 2006 small rotator cuff tear and left upper extremity injury and DVT problems to render her permanently and totally disabled.

No doctor told Claimant to stop working after the alleged December 2006 accident. Her employer did not terminate her employment. She offered no evidence showing that after the alleged December 2006 accident that her employer ever disciplined her or took any type of job action against her due to performance problems. Claimant clearly stopped working of her own volition.

In fact, Dr. Lingenfelter, the orthopedic surgeon, who treated Claimant from February to August 2007, released her to return to work with minor restrictions in August 2007. Claimant chose not to abide by the doctor's instructions. She chose to discontinue her employment with Hallmark Cards.

Finally, Claimant offered no definitive medical or vocational opinions which supported her allegation that the Second Injury Fund was liable for permanent total disability benefits in the December 2006 case. Dr. Koprivica was asked whether the disability from Claimant's two accidents at work, June and December 2006, combined with her preexisting disability to render her permanently and totally disabled. He refused to answer the question. He admitted that he had answered questions in other cases about whether other individuals were permanently and totally disabled. He stated that he was going to defer to a vocational expert to answer that question in Claimant's case. That Dr. Koprivica had answered that question in other cases, but would not answer it in Claimant's case was telling.

Similarly, Claimant's vocational expert concluded that Claimant was permanently and totally disabled due to the disability from her June 2006 accident combining with her preexisting disability. He did not conclude that her alleged injuries from the alleged December 2006 accident had anything to do with her alleged permanent total disability. He stated that the December 2006 accident was just "icing" on the cake.

The statute, however, provides that the Second Injury Fund is only liable for permanent total disability benefits if the disability from the last injury or accident combines with the preexisting disability to render the employee permanently and totally disabled. See § 287.220 RSMo. 2005. In Claimant's case, her last accident and injury was not the June 2006 injury.

Claimant's last accident and injury occurred in December 2006. The statute must be strictly construed. See §287.800 RSMo. 2005.

Claimant clearly failed to prove the Second Injury Fund's liability for permanent total disability benefits in the December 2006 case. She failed to prove that she could not work. She failed to prove that the minor neck strain she allegedly sustained by merely stumbling forward at work in December 2006, combined with her preexisting impairments, to render her permanently and totally disabled.

### **Second Injury Fund's liability for compensation**

Claimant did prove the Second Injury Fund's liability for compensation. As per the award in Injury No. 06-125432, she proved that preexisting the December 2006 accident, she had sustained a permanent partial disability of 55 percent to her body as a whole. Her preexisting impairments, according to her own expert, which met the test for establishing Second Injury Fund liability were the low back, DVT problems and June 2006 left upper extremity injury.

Claimant settled her December 2006 case based on a permanent partial disability of 12.5 percent to her body as a whole.<sup>2</sup> The Second Injury Fund offered no medical evidence and did not challenge whether the settlement properly reflected the amount of disability Claimant sustained in the accident.

Based on the evidence presented and because the Second Injury Fund did not challenge the validity of the settlement, Claimant proved that she sustained a permanent partial disability of 12.5 percent to her body as a whole as a result of the injury she allegedly sustained in the alleged December 2006 accident at work. Dr. Koprivica testified that the disability Claimant sustained in the alleged December 2006 accident combined with her preexisting disability to result in an overall disability to Claimant's body as whole which was greater than the simple sum of the disability from the impairments considered individually. Dr. Koprivica was credible in that opinion.

Claimant proved that the 12.5 percent permanent partial disability from her alleged December 2006 accident combined with her preexisting 55 percent permanent partial disability to result in a permanent partial disability greater than 67.5 percent to her body as a whole, which represented the simple sum of the disability from her impairments considered individually. Claimant proved that her disability from the alleged December 2006 accident combined with her preexisting disability to result in a permanent partial disability of 72.5 percent to her body as a whole.

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<sup>2</sup> The statute provides that 12.5 percent permanent partial disability to the body as a whole is the minimum amount of disability possible to establish Second Injury Fund liability in permanent partial cases. See § 287.220 RSMo. 2005. Claimant's medical expert testified that Claimant remained temporarily and totally disabled until February 4, 2009. Claimant's employer paid no temporary total disability benefits. Claimant's employer paid only \$2,827.21 in medical aid. The settlement based on a permanent partial disability of 12.5 percent to the body as a whole was in compromise of all the issues in the case including past due temporary total disability benefits and past medical aid.

Thus, the Second Injury Fund was liable for the difference between the 67.5 percent to the body as a whole disability and the 72.5 percent disability to the body as a whole, or 20 weeks of compensation. See § 287.220 RSMo. 2005. (67.5 percent permanent partial disability to the body as a whole equals 270 weeks of compensation; 72.5 percent permanent partial disability to the body as a whole equals 290 weeks of compensation). At a rate of \$376.55 per week for 20 weeks, the Second Injury Fund is liable for \$7,531. The Second Injury Fund is ordered to pay that amount to Claimant.

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

**Kenneth J. Cain**  
*Administrative Law Judge*  
*Division of Workers' Compensation*

This award is dated, attested to and transmitted to the parties this \_\_\_\_\_ day of \_\_\_\_\_, 2010 by:

\_\_\_\_\_  
Naomi Pearson