

FINAL AWARD ALLOWING COMPENSATION

Injury No.: 08-091923

Employee: Mark Cerutti
Employer: Missouri Department of Corrections
Insurer: C A R O

The above-entitled workers' compensation case is submitted to the Labor and Industrial Relations Commission (Commission) for review as provided by § 287.480 RSMo. Having reviewed the evidence and considered the whole record, the Commission finds that the award of the administrative law judge is supported by competent and substantial evidence and was made in accordance with the Missouri Workers' Compensation Law. Pursuant to § 286.090 RSMo, the Commission affirms the award and decision of the administrative law judge dated September 28, 2012, as corrected herein. The award and decision of Chief Administrative Law Judge Lawrence C. Kasten, issued September 28, 2012, is attached and incorporated by this reference to the extent it is not modified by this award.

The administrative law judge inadvertently referred to employee's left hand instead of employee's right hand on two occasions. We correct those errors.

The paragraph beginning at the bottom of page 10 of the administrative law judge's award is corrected to read:

Based on a review of the evidence, I find that as a direct result of the work related left carpal tunnel syndrome and left long trigger finger including surgery the employee sustained a 18% permanent partial disability of the left hand and wrist at the 175 week level (31.5 weeks) and as a direct result of the right carpal tunnel syndrome including surgery the employee sustained a 15% permanent partial disability of the **right** hand and wrist at the 175 week level (26.25 weeks). The employee is therefore entitled to 57.75 weeks of compensation for permanent partial disability.

The fifth paragraph on page 14 of the administrative law judge's award is corrected to read:

I find that the employee's pre-existing bilateral hand condition was of such seriousness as to constitute a hindrance or obstacle to employment or obtaining re-employment. I find that the pre-existing bilateral hand condition resulted in an 18% permanent partial disability of the left hand and wrist at the 175 week level and 15% permanent partial disability of the **right** hand and wrist at the 175 week level for a total of 57.75 weeks of compensation.

In all other respects, we affirm the administrative law judge award.

Employee: Mark Cerutti

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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 28th day of March 2013.

LABOR AND INDUSTRIAL RELATIONS COMMISSION

V A C A N T

Chairman

James Avery, Member

Curtis E. Chick, Jr., Member

Attest:

Secretary

ISSUED BY DIVISION OF WORKERS' COMPENSATION

FINAL AWARD

Employee: Mark Cerutti Injury No. 08-091923 and 10-063790
Dependents: N/A
Employer: Missouri Department of Corrections
Additional Party: Second Injury Fund
Insurer: Self c/o CARO
Appearances: Doug VanCamp, attorney for employee.
Gregg Johnson, attorney for the employer-insurer.
Kevin Nelson, attorney for Second Injury Fund.
Hearing Date: June 27, 2012 Checked by: LCK/rmm

SUMMARY OF FINDINGS

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? On or about September 28, 2008 and July 20, 2010.
5. State location where accident occurred or occupational disease contracted: St. Francois County, Missouri.
6. Was above employee in employ of above employer at time of alleged accident or occupational disease? Yes.
7. Did employer receive proper notice? Yes.
8. Did accident or occupational disease arise out of and in the course of the employment? Yes.
9. Was claim for compensation filed within time required by law? Yes.

10. Was employer insured by above insurer? Yes.
11. Describe work employee was doing and how accident happened or occupational disease contracted: 2008: Repetitive use of bilateral hands. 2010: Injured low back in altercation with inmate.
12. Did accident or occupational disease cause death? No.
13. Parts of body injured by accident or occupational disease: 2008: Bilateral Hands. 2010: Low Back.
14. Nature and extent of any permanent disability: 2008 case: 18% of the left wrist, 15% of right wrist, 15% multiplicity and 3 weeks of disfigurement. 2010 case: 12.5% permanent partial disability of the body as a whole referable to the low back.
15. Compensation paid to date for temporary total disability: \$52.68.
16. Value necessary medical aid paid to date by employer-insurer: \$20,341.04 for 2008 injury \$5,737.88 for 2010 injury.
17. Value necessary medical aid not furnished by employer-insurer: N/A.
18. Employee's average weekly wage: Undetermined.
19. Weekly compensation rate: \$368.74 for the 2008 case and \$376.46 for the 2010 case.
20. Method wages computation: Rate determined by agreement.
21. Amount of compensation payable:

\$25,594.24 against the employer in the 2008 case.
\$18,823.00 against employer in 2010 case.
22. Second Injury Fund liability: \$4,056.36 in 2010 case. No Second Injury Fund Claim in 2008 case.
23. Future requirements awarded: None.

Said payments shall be payable as provided in the findings of fact and rulings of law, and shall 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: Doug VanCamp.

FINDINGS OF FACT AND RULINGS OF LAW

On June 27, 2012, the employee, Mark Cerutti, appeared in person and with his attorney, Doug VanCamp for a hearing for a final award. The employer was represented by Assistant Attorney General Gregg Johnson. Representing the Second Injury Fund in the 2010 case was Assistant Attorney General Kevin Nelson. The parties agreed on certain undisputed facts and identified the issues that were in dispute. These undisputed facts and issues, together with a summary of the evidence and the findings of fact and rulings of law, are set forth below as follows:

UNDISPUTED FACTS:

1. The Missouri Department of Corrections was operating under and subject to the provisions of the Missouri Workers' Compensation Act, and was duly qualified as a self-insured employer.
2. On September 28, 2008 and July 20, 2010 Mark Cerutti was an employee of the Missouri Department of Corrections and was working under the Workers' Compensation Act.
3. On July 20, 2010 the employee sustained an accident arising out of and in the course of his employment.
4. The employer had notice of the employee's alleged accident or occupational disease in Injury Number 08-091923 and the accident in Injury Number 10-063790.
5. The employee's claims were filed within the time allowed by law.
6. The rate of compensation in Injury Number 08-091923 is \$368.74 per week and in Injury Number 10-063790 is \$376.46.
7. In Injury Number 10-063790, the employee's injury was medically causally related to the July 20, 2010 accident.
8. The employer paid medical aid in the amount of \$20,341.04 in the 2008 case and \$5,737.88 in the 2010 case.
9. The employer paid \$52.68 in temporary disability benefits for 1/7 of a week in the 2008 case. The employer did not pay any medical aid in the 2010 case.

ISSUES:

1. Accident or Occupational Disease in Injury Number 08-091923.
2. Medical Causation in Injury Number 08-091923.
3. Permanent Partial Disability in Injury Number 08-091923.
4. Permanent Partial Disability in Injury Number 10-063790.
5. Liability of the Second Injury Fund for Permanent Partial Disability in Injury Number 10-063790.

EXHIBITS:

Employees Exhibits:

- A. Report of Dr. Schlafly dated February 23, 2010.
- B. Report of Dr. Schlafly dated August 24, 2011.

- C. Report of Dr. Schlafly dated June 25, 2012.
- D. Medical records of Mid Missouri Hand & Orthopedic Surgery, Inc.
- E. Medical records of Parkland Health Center.
- F. Medical records of Medical Center.
- G. Medical records of Orthopedic Associates, LLC.
- H. Medical records of Jefferson City Medical Group.
- I. Medical records of Orthopedic Associates LLC.
- J. Medical records of David M. Brown, M.D.
- K. Medical records of Neurological and Electrodiagnostic Institute.
- L. Medical records of Midwest Imaging Center.
- M. Medical records of Pro Rehab.
- N. Medical records of Farmington Hand & Physical Therapy.
- O. Medical records of St. Louis Orthopedic, Inc.
- P. Medical records of Orthopedic Associates, LLC.
- Q. Medical records of Farmington Hand & Physical Therapy.
- R. Medical records of Midwest Spine Surgeons.
- S. Medical records of Midwest Imaging Center.
- T. Medical records of Parkland Health Clinic.
- U. Photograph of keys.
- V. Van Camp Law Firm expenses.
- W. Report of David Robson, M.D. dated March 2, 2011.

The Employer and the Second Injury Fund did not offer any exhibits.

Judicial notice of the contents of the Divisions' files for the employee was taken.

WITNESS: Mark Cerutti.

BRIEFS: The employee filed his Proposed Award on July 27, 2012. The employer and the Second Injury Fund filed their Briefs on July 30, 2012.

FINDINGS OF FACT IN 08-091923:

The employee testified that lives in Farmington and has worked at the Department of Corrections as a Correctional Officer I since 2001. He is responsible for maintaining security which includes the accountability of offenders; securing and unlocking doors; policing; and observing offenders.

The employee testified that he thought in November of 2006 he started working in the B dining hall but it was possible that he could have started in September of 2006. The B dining hall is 40-50 yards long and is wide as a football field. It contains a lot of doors with locks. When he starts his shift he will search the dining hall before anyone comes in. As he is searching the area he is opening, unlocking, and locking each of the doors. He has to perform paperwork and also pulls brooms, mops, and parts to hold trays for the inmates to use. He is supposed to have a partner but 80% of time he does not because they assign his partner somewhere else. He is usually without his partner 3 or 4 days out of a 5 day work week. As he is going through the

building, he is on a continuous basis locking and unlocking the doors. The locks and keys are varied from small to large. Exhibit U is a picture of keys he is using on a daily basis. The small keys are for master locks and the larger keys are for big metal doors and closets. Some turn quickly but most are hard to manipulate and he has to twist the doors because the locks catch. The minimum number of times he is putting a key and turning a lock on an easy day is 75-100 times. On a busy day 150-200 times he will have to insert keys into locks and apply force to unlock. Sometimes the force used is substantial and sometimes it is not. He is right handed and he used his right hand to lock and unlock the locks.

On September 5, 2006, the employee saw Dr. Hoff for hand numbness and tingling. The history showed swelling and tight muscles in his right hand with an onset of three to four weeks. It was noted the employee was cutting firewood with a chain saw and splitter. There was no loss of sensation; the right hand and forearm was a bit swollen; and there was crepitus with finger flexion and extension which was felt in the forearm muscles. Dr. Hoff diagnosed tenosynovitis of the right forearm and paresthesia of the right hand and prescribed Prednisone.

The employee saw Dr. Folz on March 6, 2007 after being referred by Dr. Baskett for an EMG/NCS. The employee had pain in the right forearm and hand with a sub acute onset occurring in an intermittent pattern for 6 months. The aching and cramping pain was aggravated by physical activity. The pain is associated with paresthesias into the right hand and he wakes up at night with symptoms. Dr. Folz stated that the electrodiagnostic study was consistent with a mild right median neuropathy (carpal tunnel syndrome) at the wrist.

The employee testified that the 6 month history in Dr. Folz's record would be around September of 2006 when he approximately started having problems with his right hand. He thought within a month or two of going to work in the B dining hall he started having problems with his right hand.

The employee saw Dr. Cameron on March 30, 2007 for pain and problems to his right hand and forearm. The history noted difficulty with his hand including intermittent numbness and tingling for the past several months. He denied any injury or trauma but worked as a Correctional Officer and does a lot of work using his arm. He gets numbness and tingling in the ulnar three fingers and occasionally at the median nerve distribution. He has been on steroid pills in the past but it has not improved. Dr. Cameron stated that the March 6 EMG revealed some slowing of the right median sensory nerve. Dr. Cameron diagnosed mild right carpal tunnel syndrome and lateral epicondylitis of the right elbow and prescribed Aleve and exercises.

On February 7, 2008 the employee saw Dr. Hoff for his right arm and hand. It was painful and swollen for three weeks and getting worse. He had a nerve test a year ago and was told that he had carpal tunnel syndrome. All of his fingers and thumb were numb and painful; and there was no definite positive Tinel's or Phalen's. Dr. Hoffman diagnosed right arm pain with a history of a positive test for nerve impingement and prescribed Prednisone.

The employee testified that on September 28, 2008 he was unlocking a door, and as he was turning the key, his right wrist and hand popped. He felt a lot of pain and started going numb all the time and hurting more.

The employee went to Parkland Health Clinic on September 30, 2008. The employee had pain and numbness in the right wrist up to the elbow. The wrist had sharp pain after it popped when he was unlocking a door. An x-ray of the right wrist and elbow were negative except for a tiny osteophyte in the trapezium of the wrist.

The employee saw Dr. Strecker on October 28, 2008. The employee stated that on September 28 he was turning a key to unlock a door when he felt something pop in his hand. He had pain and marked swelling of the hand and forearm and pain radiating to the elbow. The swelling and pain decreased. His hand occasionally popped and with use developed numbness and swelling mostly over the thumb, index and long fingers. The employee had positive median nerve compression and positive Phalen's. Dr. Strecker diagnosed acute tenosynovitis and mild right carpal tunnel syndrome. It was Dr. Strecker's opinion that based on the acute traumatic episode the work was the primary and prevailing factor in his symptoms. He continued the employee on full duty; and recommended anti-inflammatories, physical therapy and vitamin B6.

On May 13, 2009 Dr. Strecker prescribed physical therapy and medication. On June 24, Dr. Strecker noted a positive Phalen's and tenderness with median nerve compression; ordered an EMG/nerve conduction study; and continued therapy.

The employee saw Dr. Phillips on July 2 for an EMG/nerve conduction study. The employee had progressive right hand numbness since September of 2008 with pain and swelling in the hand. The studies showed moderate carpal tunnel syndrome in the right wrist. On July 22, Dr. Strecker noted that the electrical studies were consistent with a moderate carpal tunnel of the right wrist and recommended surgery. On September 25, Dr. Strecker performed a right carpal tunnel release. After surgery the employee had physical therapy.

The employee testified that after his right hand popped he favored his right hand and started using his left hand to turn all the keys. He started having problems with his left hand including tingling and numbness. There was not a certain date or time he started having problems but it started gradually. He started having problems with his left middle finger becoming stuck. After he went back to work after the right carpal tunnel surgery, his left hand was numb constantly.

On October 23, 2009, the employee saw Dr. Strecker. He no longer had paresthesias in his radial digits, but was experiencing intermittent numbness of the right ring and small fingers. The employee had similar symptoms occurring in his left hand which he attributed to overusing his left hand to compensate for his right. Dr. Strecker noted the employee was doing well following his right carpal tunnel release and continued physical therapy. It was his opinion that the employee's new symptoms in his right hand were from cubital tunnel syndrome but did not believe those symptoms were work-related. Dr. Strecker diagnosed the employee with symptoms of left carpal tunnel syndrome and cubital tunnel syndrome. It was Dr. Strecker's opinion that there was no evidence that his job activities were a significant or contributing factor to the cubital tunnel syndrome; and there was no evidence that over compensation activities were a significant or primary causative event for the carpal tunnel syndrome.

On November 17, 2009, Dr. Strecker put the employee at maximum medical improvement for his right carpal tunnel syndrome. In a letter dated December 13, Dr. Strecker

rated 5% permanent partial disability of the right wrist due to the September of 2008 accident and injury.

The employee saw Dr. Schlafly on February 23, 2010 who diagnosed right carpal tunnel syndrome with release and left carpal tunnel syndrome. Dr. Schlafly recommended a left carpal tunnel release. It was Dr. Schlafly's opinion that the employee's repetitive work with his hands, opening and closing and locking and unlocking the heavy prison doors is the prevailing factor in the cause of his bilateral carpal tunnel syndrome; and in the need for bilateral carpal tunnel releases. The work injury of September 28, 2008 was an additional aggravating factor in the development of the right carpal tunnel syndrome. Dr. Schlafly opined that the employee had a 25% permanent partial disability of the right wrist due to the work related right carpal tunnel syndrome and release. If the employee did not have any further left hand treatment then there was a 30% percent permanent partial disability of the left wrist due to the work related carpal tunnel syndrome. Due to the disability in both hands, a condition of multiplicity exists and a loading factor should be added.

On August 3, 2010, the employee saw Dr. Brown. The employee gave Dr. Brown a job description about opening and closing cell doors; cuffing and uncuffing inmates; computer work; and paper work. In September of 2008, he was turning a key to unlock a door when he felt his right hand pop. About 6 weeks after that injury the employee noticed numbness and tingling in his left hand. After the right carpal tunnel release by Dr. Strecker in September of 2009, his symptoms improved in his right hand. The employee continued to have numbness in his left hand and occasionally his left middle finger would lock up. Dr. Brown stated that the employee had symptoms and findings consistent with left carpal tunnel syndrome and recommended an EMG/nerve conduction study on the left; and prescribed a wrist splint and anti-inflammatory medications. It was Dr. Brown's opinion that the employee's job activities were not the prevailing causative factor of carpal tunnel syndrome. Dr. Brown noted that the employee weighed 235 pounds, was 5'10" tall, and had an increased body mass index. Dr. Brown stated it was well established in medical and hand surgical literature that an increased body mass is associated with a high incidence of carpal tunnel syndrome. One study noted it was four times the incidence of patients without an increased body mass index.

The employee saw Dr. Strecker on November 16, 2010, with continued numbness and tingling to his left hand as well as triggering to his long finger. Dr. Strecker noted signs of both carpal and cubital tunnel syndromes; and recommended an EMG/nerve conduction study. On November 23, Dr. Philips performed an EMG/Nerve Conduction Study due to a history of sharp throbbing and aching of the left hand and arm pain with intermittent numbness mainly in the index and middle fingers since September or October of 2008. The findings were mild left carpal tunnel syndrome. On November 30, Dr. Strecker noted that the electrical studies were consistent with left carpal tunnel syndrome; and recommended left carpal tunnel and A1 pulley releases.

On February 7, 2011, Dr. Strecker performed a left carpal tunnel release and a release of the A1 pulley of the left long finger. After surgery the employee had physical therapy. On March 18, the employee stated that the paresthesias in his left hand resolved and his long finger no longer triggered; but he did have stiffness in the long finger. Dr. Strecker prescribed a Medrol Dosepak and diagnosed tenosynovitis. On April 1, 2011, the employee told Dr. Strecker

that when he was on the Medrol Dosepak his hand was fine but since then has had some recurrence of his stiffness. Dr. Strecker diagnosed residual tenosynovitis; prescribed Celebrex; and put the employee on full duty work.

The employee saw Dr. Schlafly on June 28, 2011 with his report dated August 24. Dr. Schlafly noted that the employee had undergone a surgical release for his left carpal tunnel syndrome and a trigger finger release of his left long finger. Dr. Schlafly diagnosed bilateral carpal tunnel syndrome with releases and left long trigger finger treated with trigger finger release with residual stiffness and pain. Due to the unusual amount of tenderness in the distal palm associated with the left long trigger finger releases with reduced range of motion, Dr. Schlafly noted it would be reasonable to repeat the trigger finger release. It was his opinion that the employee had a 25% permanent partial disability of each wrist for the work related bilateral carpal tunnel syndrome with releases and a 35% permanent partial disability of the left long finger at the 35-week level due to the work related left long trigger finger and release. It was his opinion that a multiplicity loading factor be added.

On June 25, 2012, it was Dr. Schlafly's opinion that the September 28, 2008 work injury was the prevailing factor in the cause of the disability of his hands which is 25% permanent partial disability of each wrist and 35% permanent partial disability of the left long finger at the 35 week level. It was his opinion that since the employee has disability in both hands that a condition of multiplicity exists which should be compensated by a loading factor of 15%.

The employee testified the tingling and numbness in his right hand resolved after surgery; however, he has diminished strength in his right hand leaving it difficult for him to open jars or restrain inmates. He uses both hands to secure inmates and put on wrist restraints. He has lost 30% of his grip strength in his right hand, and is unable to sustain a tight grip on things for very long. He will occasionally have a flash of pain of 7-8 out of 10 from his wrist into his palm to his thumb. He has trouble handling inmates, has a slower reaction and response, and takes longer to restrain them. The employee has to use his arms and not his hands to restrain inmates. He has difficulty with fatigue in his right hand when he holds onto the steering wheel, or when using keys to unlock and lock the doors. The employee has the same complaints in his left hand as his right hand, but had additional pain and problems related to his left index and long fingers. When he puts any pressure on the left index finger it causes pain and will collapse. He is not able to make a complete fist, nor will his long finger completely lay down flat without manually pushing it down with his other fingers, which is painful. His left hand is worse than his right hand due to the finger problems. His problems are worse due to having problems with both hands. Due to his hands he bid for, and is now a Utility Officer which has less hand repetitive activity.

The employee has an approximate 1½ inch scar on the right hand from the surgery and a 1½ inch scar on the left hand and a small scar from the trigger finger release.

RULINGS OF LAW IN NUMBER 08-091923:

Issue 1. Accident and/or Occupational Disease and Issue 2. Medical Causation.

The employer is disputing that on or about September 28, 2008 that the employee sustained an accident and/or occupational disease arising out of and in the course of his employment and that the employee's injuries were medically causally related to the alleged accident and/or occupational disease on or about September 28, 2008.

Section 287.020.2 RSMO defines accident as "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."

Under Section 287.020.3 (1) RSMo, "injury" is defined to be an injury which has arisen out of and in the course of employment.

287.020.3(2) RSMo, states:

An injury shall be deemed to arise out of and in the course of the employment only if: a) It is reasonably apparent, upon consideration of all the circumstances, that the accident is the prevailing factor in causing the injury; and b) It does not come from a hazard or risk unrelated to the employment to which workers would have been equally exposed outside of and unrelated to the employment in normal non-employment life.

Under Section 287.067.2 and 287.067.3 RSMo, an injury by occupational disease is compensable only if the occupational exposure was the prevailing factor in causing both the resulting medical condition and disability. An injury due to repetitive motion is recognized as an occupational disease. An occupational disease due to repetitive motion is compensable only if the occupational exposure was the prevailing factor in causing both the resulting medical condition and disability. The "prevailing factor" is defined to be the primary factor, in relation to any other factor, causing both the resulting medical condition and disability. In order to be a compensable injury under a repetitive motion occupational disease, the employee has the burden to prove that the occupational exposure was the prevailing factor in causing the resulting medical condition and disability.

The employee's testimony regarding the repetitive work activities and job duties was very credible and uncontradicted. It was his credible testimony that sometime in the fall of 2006 he started working in the B dining hall. Within a month or two of going to work in the B dining hall he started having problems with his right hand. On September 28, 2008 he was unlocking a door, and as he was turning the key, his right hand and wrist popped. He developed constant numbness and more pain. He favored his right hand, started using his left hand to turn all the keys, and gradually started having problems with his left hand including tingling and numbness; and his left middle finger becoming stuck.

Dr. Strecker diagnosed acute tenosynovitis and mild right carpal tunnel syndrome. It was Dr. Strecker's opinion that the acute traumatic work episode was the primary and prevailing factor in his symptoms. Dr. Strecker diagnosed left carpal tunnel syndrome; and it was his opinion there was no evidence that over compensation activities were a significant or primary causative event for the carpal tunnel syndrome.

Dr. Brown diagnosed left carpal tunnel syndrome. It was his opinion that the employee's job activities were not the prevailing causative factor of his left carpal tunnel syndrome. Dr. Brown stated that the employee had an increased body mass index; and it was well established in the medical literature that is associated with a high incidence of carpal tunnel syndrome.

Dr. Schlafly diagnosed the employee with bilateral carpal tunnel syndrome and left long trigger finger. It was Dr. Schlafly's opinion that the employee's repetitive work with his hands, opening and closing and locking and unlocking the heavy prison doors is the prevailing factor in the cause of his bilateral carpal tunnel syndrome; and need for bilateral carpal tunnel releases; and the September 28, 2008 work injury was an additional aggravating factor in the development of the right carpal tunnel syndrome. It was his opinion that the work injury was the prevailing factor in the cause of the disability of his hands, wrists and left long finger.

I find that the opinions of Dr. Schlafly and Dr. Strecker are very persuasive and are credible regarding the right wrist and hand. I find that the opinion of Dr. Schlafly is very persuasive and is more credible than the opinions of Dr. Strecker and Dr. Brown regarding the left wrist, hand and long finger.

Based on all the evidence, I find that the employee's work activities and job duties were the prevailing factor in causing the resulting medical condition and disability of bilateral carpal tunnel syndrome and left long trigger finger; which did not come from a hazard or risk unrelated to the employment to which workers would have been equally exposed outside of and unrelated to the employment in normal non-employment life. I find that the employee sustained a compensable work-related occupational disease and injury; and compensable work-related accident and injury that arose out of and in the course of his employment. I find that the employee's bilateral carpal tunnel syndrome and left trigger finger and the need for medical treatment are medically causally related to the employee's occupational disease and accident.

Issue 3. Permanent Partial Disability

It was Dr. Strecker's opinion that the employee had a 5% permanent partial disability of the right wrist. It was Dr. Schlafly's opinion that the employee had a 25% permanent partial disability of each wrist for the bilateral carpal tunnel syndrome and a 35% permanent partial disability of the left long finger at the 35-week level for the trigger finger and release. It was his opinion that due to the disability in both hands that a condition of multiplicity existed and that a loading factor of 15% be applied.

Based on a review of the evidence, I find that as a direct result of the work related left carpal tunnel syndrome and left long trigger finger including surgery the employee sustained a

18% permanent partial disability of the left hand and wrist at the 175 week level (31.5 weeks) and as a direct result of the right carpal tunnel syndrome including surgery the employee sustained a 15% permanent partial disability of the left hand and wrist at the 175 week level (26.25 weeks). The employee is therefore entitled to 57.75 weeks of compensation for permanent partial disability.

Based upon the evidence, I find that the employee is entitled to an additional 15% for multiplicity which is an additional 8.66 weeks of compensation (57.75 weeks x 15% equals 8.66 weeks). I further find that as a result of the surgical scars that the employee is entitled to an additional 3 weeks of disfigurement.

The employer is therefore ordered to pay to the employee a total of 69.41 weeks of compensation at the rate of \$368.74 per week for a total award of permanent partial disability of \$25,594.24.

FINDINGS OF FACT IN INJURY NUMBER 10-963790:

The employee testified that on July 20, 2010 he injured his back in an altercation with an inmate. He had to subdue an inmate, was bouncing off tables and machines; and the inmate was ultimately tackled. The employee developed severe pain in his low back.

On August 16, 2010, the employee went to Parkland Health Clinic after being attacked by an inmate and when restraining him went to the ground. X-rays of the lumbar back and right hip were performed. Therapy and medications including a muscle relaxer were prescribed. The employee had point tenderness in the low back; right hip; and down to the right knee. The employee continued to treat with Parkland Health.

On October 4, 2010, the employee had low back, right buttock and pain down the right leg to the foot. A Medrol Dose Pak was prescribed. On October 12 the employee went back to Parkland Health Clinic. The Medrol Dose Pak helped decrease the pain for the right hip and lumbar strain. Mediations and therapy was continued. On October 13, the lumbar MRI showed at L4-5 diffuse disc bulging extending far laterally to the left with what appeared to be an annular fissure along the lateral aspect of the disc. There was no definite evidence of mass effect on the exiting nerve root. There was some encroachment on the left neuroforamin. At L5-S1 there was diffuse disc bulging toward the right which encroaches on the neuroforamin and appears to impinge on the L5 nerve root. On October 19, the employee went to Parkland Health Clinic and was referred to a back specialist.

The employee saw Dr. Coyle on November 3, 2010 for back, right hip and right lower extremity pain. Dr. Coyle noted that the October MRI showed evidence of a left-sided annular tear at L4-5 and a far right disc protrusion at L5-S1. Dr. Coyle's impression was lumbar radiculopathy and right trochanteric bursitis. He referred the employee for an extraforaminal block at L5-S1 on the right as well as a steroid injection over the right greater trochanter. The employee did not have any motor deficits and felt he could fulfill his full-duty position. Dr. Coyle returned the employee to full duty work with no restrictions; continued therapy; prescribed medications; and to follow up with a physiatrist for conservative management.

The employee saw Dr. Randolph on November 16, 2010 for right-sided low back and gluteal pain, and pain radiating down the posterior and lateral aspects of his leg. His symptoms increased with bending, twisting, transitional movements, prolonged sitting and prolonged walking. The October MRI showed a high-intensity zone in the left of the L4-5 disc and a minimal lateral bulge to the right at L5-S1. Dr. Randolph stated that the employee had a contusion and sprain of the lumbar spine and right hip contusion; and developed mild radicular symptoms into her right lower extremity and right trochanteric bursitis. The findings reflect a combination of mechanical and mild radicular pain at the lumbar level and trochanteric bursitis. Dr. Randolph performed an epidural steroid injection in the right hip and prescribed additional physical therapy.

On December 7, Dr. Randolph noted that the employee was doing significantly better and treatments have been helpful for pain control and strength. The employee had some soreness in the low back and right gluteal area. Physical therapy was continued.

On December 28, 2010, the employee reported to Dr. Randolph a flare-up of his low back pain with vague numbness in his right lower extremity. Dr. Randolph prescribed a tapering course of prednisone. His symptoms were improved on January 18, 2011; and Dr. Randolph noted that the straight leg raising was negative and the examination was normal. The employee was placed at maximum medical improvement and he was continued at full duty work.

On January 20, 2011, the employee went to Parkland Health Clinic for a sore chest and muscle spasms in the lower back after falling on his chest. On exam, there were muscle spasms in the thoracic spine; and Soma was prescribed.

The employee saw Dr. Robson on March 2, 2011 with continued problem in his low back and right leg. He had 5-6 out of 10 pain that was made worse during and after exercise, with sitting, damp weather, twisting, lying in bed and driving. His symptoms improved with walking, ultrasound treatment and heat. After physical examination and review of diagnostic studies, Dr. Robson's impression was spinal stenosis L4-5, disc dehydration at L5-S1 and right greater trochanteric bursitis. Dr. Robson recommended a right greater trochanteric bursa injection. If this injection did not give relief, Dr. Robson thought a CT-myelogram should be completed to consider surgical options.

The employee testified that Dr. Robson discussed the possible need for surgery but he does not want to have surgery.

On April 25, 2011, the employee saw Dr. Coyle. The employee reported that he had not received the right sided extraforaminal block at L5-S1. The employee was working full duty, was experiencing no difficulty and his symptoms had essentially gone away; but had occasional right sided pain. On examination Dr. Coyle found no evidence of focal motor or sensory deficits and no tenderness over the trochanteric bursa. Dr. Coyle released the employee at maximum medical improvement and it was his opinion that the employee had no permanent disability from the July 20, 2010, work injury.

The employee saw Dr. Schlafly on June 28, 2011 with his report dated August 24, 2011. Dr. Schlafly diagnosed a low back strain associated with bulging and protruding discs but without clear cut radiculopathy. It was his opinion that the work injury of July 20, 2010 resulted in a 15% permanent partial disability to the body as a whole referable to the lumbar spine.

On June 25, 2012, it was Dr. Schlafly's opinion that the employee has a combination of disabilities that created a synergistic effect between the disabilities of his hands and low back giving a combined effect greater than the simple sum of the components. These disabilities create an obstacles or hindrance to employment. It was his opinion that the employee had a 15% load due to the synergistic effect between the disabilities of his hand and his low back.

The employee testified that after sitting for 10-15 minutes he develops a burning sensation in his low back and right buttock. He must keep moving throughout the day to try to stay comfortable. Cold and rainy weather make his back more painful. It feels as if there is a bulge or knot below his belt area. At night he might sleep for an hour to hour and 15 minutes before he must get up and walk around to ease his pain. The more active he is the more pain he has. He has good days and bad days. On a good day he experiences a constant dull or burning pain of 4 or 5 out of 10 in the right upper buttock and hip. In a typical week, he has at least one bad day but it varies depending on the weather and activity. On a bad day his low back pain is 7 or 8 out of 10; and he will have trouble walking stairs and has to get help out of a couch and chair. His condition makes him slower. He has difficulty escorting inmates due to his low back pain and is afraid of altercations with inmates. The employee is having a harder time due to combination of two bad hands and a bad back. He can complete activities but it takes him longer, and sometimes he has to get assistance which hinders him at work. He has missed work due to his low back and hands.

RULINGS OF LAW IN INJURY NUMBER 10-063790:

Issue 4. Permanent Partial Disability

Dr. Schlafly diagnosed a low back strain associated with bulging and protruding discs without clear cut radiculopathy. Dr. Coyle stated that the October of 2010 MRI showed a left-sided annular tear at L4-5 and a right sided disc protrusion at L5-S1. Dr. Coyle diagnosed lumbar radiculopathy and right trochanteric bursitis, and recommended an extraforaminal block at L5-S1 and a steroid injection over the right greater trochanter. Dr. Randolph stated that the October MRI showed a left sided high-intensity zone of the L4-5 disc and a right sided disc bulge at L5-S1; diagnosed mild radicular symptoms into the right lower extremity and right trochanteric bursitis; performed an epidural steroid injection in the right hip; and prescribed physical therapy. Dr. Robson diagnosed spinal stenosis at L4-5, disc dehydration at L5-S1 and right greater trochanteric bursitis; and recommended a right greater trochanteric bursa injection.

It was Dr. Coyle's opinion that the employee had no permanent disability from the July 20, 2010 work injury. It was Dr. Schlafly's opinion that the work injury of July 20, 2010 resulted in a 15% permanent partial disability to the body as a whole referable to the lumbar spine.

The employee was observed during the hearing and appeared to be uncomfortable and in pain. He was frequently moving around in his chair, stood up and sat down several times, and at the end of direct examination requested a break to move around and stretch.

Based on the medical evidence, my observations, and the credible testimony of the employee, I find that the employee has sustained permanent partial disability as a result of the July 20, 2010 accident. I find that as a direct result of the July 20, 2010 accident the employee sustained a 12.5% permanent partial disability of the body as a whole referable to his low back. The employer is ordered to pay the employee 50 weeks of compensation at the rate of \$376.46 per week for a total award of permanent partial disability of \$18,823.00.

Issue 5. Liability of the Second Injury Fund for Permanent Partial Disability

Based on the credible testimony of the employee and the medical evidence, including the credible opinion of Dr. Schlafly, I make the following rulings:

Primary Injury:

I find that the primary injury to the employee's low back resulted in a 12.5% permanent partial disability of the body as a whole at the 400 week level for a total of 50 weeks of compensation.

Pre-existing bilateral hand conditions:

I find that the employee's pre-existing bilateral hand condition was of such seriousness as to constitute a hindrance or obstacle to employment or obtaining re-employment. I find that the pre-existing bilateral hand condition resulted in an 18% permanent partial disability of the left hand and wrist at the 175 week level and 15% permanent partial disability of the left hand and wrist at the 175 week level for a total of 57.75 weeks of compensation.

Conclusion:

I find that the employee's pre-existing bilateral hand conditions and the last injury to the low back combined synergistically to create a total disability of 118.525 weeks. This total disability is based on a loading factor of 10%. After deducting the percent of disability that existed prior to the last injury (57.75 weeks) and the disability resulting from the last injury alone (50 weeks) from the total disability attributable to all injuries or conditions existing at the time of the last injury (118.525 weeks), the remaining balance to be paid by the Second Injury Fund is equal to 10.775 weeks. The Second Injury Fund is therefore directed to pay to the employee the sum of \$376.46 per week for 10.775 weeks for a total award of permanent partial disability of \$4,056.36.

ATTORNEY'S FEE:

Doug VanCamp, attorney at law, is allowed a fee of 25% of all sums awarded under the provisions of this award for necessary legal services rendered to the employee. The amount of this attorney's fee shall constitute a lien on the compensation awarded herein

INTEREST:

Interest on all sums awarded hereunder shall be paid as provided by law.

Made by:

Lawrence C. Kasten
Chief Administrative Law Judge
Division of Workers' Compensation

ISSUED BY DIVISION OF WORKERS' COMPENSATION

FINAL AWARD

Employee: Mark Cerutti Injury No. 08-091923 and 10-063790
Dependents: N/A
Employer: Missouri Department of Corrections
Additional Party: Second Injury Fund
Insurer: Self c/o CARO
Appearances: Doug VanCamp, attorney for employee.
Gregg Johnson, attorney for the employer-insurer.
Kevin Nelson, attorney for Second Injury Fund.
Hearing Date: June 27, 2012 Checked by: LCK/rmm

SUMMARY OF FINDINGS

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? On or about September 28, 2008 and July 20, 2010.
5. State location where accident occurred or occupational disease contracted: St. Francois County, Missouri.
6. Was above employee in employ of above employer at time of alleged accident or occupational disease? Yes.
7. Did employer receive proper notice? Yes.
8. Did accident or occupational disease arise out of and in the course of the employment? Yes.
9. Was claim for compensation filed within time required by law? Yes.

10. Was employer insured by above insurer? Yes.
11. Describe work employee was doing and how accident happened or occupational disease contracted: 2008: Repetitive use of bilateral hands. 2010: Injured low back in altercation with inmate.
12. Did accident or occupational disease cause death? No.
13. Parts of body injured by accident or occupational disease: 2008: Bilateral Hands. 2010: Low Back.
14. Nature and extent of any permanent disability: 2008 case: 18% of the left wrist, 15% of right wrist, 15% multiplicity and 3 weeks of disfigurement. 2010 case: 12.5% permanent partial disability of the body as a whole referable to the low back.
15. Compensation paid to date for temporary total disability: \$52.68.
16. Value necessary medical aid paid to date by employer-insurer: \$20,341.04 for 2008 injury \$5,737.88 for 2010 injury.
17. Value necessary medical aid not furnished by employer-insurer: N/A.
18. Employee's average weekly wage: Undetermined.
19. Weekly compensation rate: \$368.74 for the 2008 case and \$376.46 for the 2010 case.
20. Method wages computation: Rate determined by agreement.
21. Amount of compensation payable:

\$25,594.24 against the employer in the 2008 case.
\$18,823.00 against employer in 2010 case.
22. Second Injury Fund liability: \$4,056.36 in 2010 case. No Second Injury Fund Claim in 2008 case.
23. Future requirements awarded: None.

Said payments shall be payable as provided in the findings of fact and rulings of law, and shall 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: Doug VanCamp.

FINDINGS OF FACT AND RULINGS OF LAW

On June 27, 2012, the employee, Mark Cerutti, appeared in person and with his attorney, Doug VanCamp for a hearing for a final award. The employer was represented by Assistant Attorney General Gregg Johnson. Representing the Second Injury Fund in the 2010 case was Assistant Attorney General Kevin Nelson. The parties agreed on certain undisputed facts and identified the issues that were in dispute. These undisputed facts and issues, together with a summary of the evidence and the findings of fact and rulings of law, are set forth below as follows:

UNDISPUTED FACTS:

1. The Missouri Department of Corrections was operating under and subject to the provisions of the Missouri Workers' Compensation Act, and was duly qualified as a self-insured employer.
2. On September 28, 2008 and July 20, 2010 Mark Cerutti was an employee of the Missouri Department of Corrections and was working under the Workers' Compensation Act.
3. On July 20, 2010 the employee sustained an accident arising out of and in the course of his employment.
4. The employer had notice of the employee's alleged accident or occupational disease in Injury Number 08-091923 and the accident in Injury Number 10-063790.
5. The employee's claims were filed within the time allowed by law.
6. The rate of compensation in Injury Number 08-091923 is \$368.74 per week and in Injury Number 10-063790 is \$376.46.
7. In Injury Number 10-063790, the employee's injury was medically causally related to the July 20, 2010 accident.
8. The employer paid medical aid in the amount of \$20,341.04 in the 2008 case and \$5,737.88 in the 2010 case.
9. The employer paid \$52.68 in temporary disability benefits for 1/7 of a week in the 2008 case. The employer did not pay any medical aid in the 2010 case.

ISSUES:

1. Accident or Occupational Disease in Injury Number 08-091923.
2. Medical Causation in Injury Number 08-091923.
3. Permanent Partial Disability in Injury Number 08-091923.
4. Permanent Partial Disability in Injury Number 10-063790.
5. Liability of the Second Injury Fund for Permanent Partial Disability in Injury Number 10-063790.

EXHIBITS:

Employees Exhibits:

- A. Report of Dr. Schlafly dated February 23, 2010.
- B. Report of Dr. Schlafly dated August 24, 2011.

- C. Report of Dr. Schlafly dated June 25, 2012.
- D. Medical records of Mid Missouri Hand & Orthopedic Surgery, Inc.
- E. Medical records of Parkland Health Center.
- F. Medical records of Medical Center.
- G. Medical records of Orthopedic Associates, LLC.
- H. Medical records of Jefferson City Medical Group.
- I. Medical records of Orthopedic Associates LLC.
- J. Medical records of David M. Brown, M.D.
- K. Medical records of Neurological and Electrodiagnostic Institute.
- L. Medical records of Midwest Imaging Center.
- M. Medical records of Pro Rehab.
- N. Medical records of Farmington Hand & Physical Therapy.
- O. Medical records of St. Louis Orthopedic, Inc.
- P. Medical records of Orthopedic Associates, LLC.
- Q. Medical records of Farmington Hand & Physical Therapy.
- R. Medical records of Midwest Spine Surgeons.
- S. Medical records of Midwest Imaging Center.
- T. Medical records of Parkland Health Clinic.
- U. Photograph of keys.
- V. Van Camp Law Firm expenses.
- W. Report of David Robson, M.D. dated March 2, 2011.

The Employer and the Second Injury Fund did not offer any exhibits.

Judicial notice of the contents of the Divisions' files for the employee was taken.

WITNESS: Mark Cerutti.

BRIEFS: The employee filed his Proposed Award on July 27, 2012. The employer and the Second Injury Fund filed their Briefs on July 30, 2012.

FINDINGS OF FACT IN 08-091923:

The employee testified that lives in Farmington and has worked at the Department of Corrections as a Correctional Officer I since 2001. He is responsible for maintaining security which includes the accountability of offenders; securing and unlocking doors; policing; and observing offenders.

The employee testified that he thought in November of 2006 he started working in the B dining hall but it was possible that he could have started in September of 2006. The B dining hall is 40-50 yards long and is wide as a football field. It contains a lot of doors with locks. When he starts his shift he will search the dining hall before anyone comes in. As he is searching the area he is opening, unlocking, and locking each of the doors. He has to perform paperwork and also pulls brooms, mops, and parts to hold trays for the inmates to use. He is supposed to have a partner but 80% of time he does not because they assign his partner somewhere else. He is usually without his partner 3 or 4 days out of a 5 day work week. As he is going through the

building, he is on a continuous basis locking and unlocking the doors. The locks and keys are varied from small to large. Exhibit U is a picture of keys he is using on a daily basis. The small keys are for master locks and the larger keys are for big metal doors and closets. Some turn quickly but most are hard to manipulate and he has to twist the doors because the locks catch. The minimum number of times he is putting a key and turning a lock on an easy day is 75-100 times. On a busy day 150-200 times he will have to insert keys into locks and apply force to unlock. Sometimes the force used is substantial and sometimes it is not. He is right handed and he used his right hand to lock and unlock the locks.

On September 5, 2006, the employee saw Dr. Hoff for hand numbness and tingling. The history showed swelling and tight muscles in his right hand with an onset of three to four weeks. It was noted the employee was cutting firewood with a chain saw and splitter. There was no loss of sensation; the right hand and forearm was a bit swollen; and there was crepitus with finger flexion and extension which was felt in the forearm muscles. Dr. Hoff diagnosed tenosynovitis of the right forearm and paresthesia of the right hand and prescribed Prednisone.

The employee saw Dr. Folz on March 6, 2007 after being referred by Dr. Baskett for an EMG/NCS. The employee had pain in the right forearm and hand with a sub acute onset occurring in an intermittent pattern for 6 months. The aching and cramping pain was aggravated by physical activity. The pain is associated with paresthesias into the right hand and he wakes up at night with symptoms. Dr. Folz stated that the electrodiagnostic study was consistent with a mild right median neuropathy (carpal tunnel syndrome) at the wrist.

The employee testified that the 6 month history in Dr. Folz's record would be around September of 2006 when he approximately started having problems with his right hand. He thought within a month or two of going to work in the B dining hall he started having problems with his right hand.

The employee saw Dr. Cameron on March 30, 2007 for pain and problems to his right hand and forearm. The history noted difficulty with his hand including intermittent numbness and tingling for the past several months. He denied any injury or trauma but worked as a Correctional Officer and does a lot of work using his arm. He gets numbness and tingling in the ulnar three fingers and occasionally at the median nerve distribution. He has been on steroid pills in the past but it has not improved. Dr. Cameron stated that the March 6 EMG revealed some slowing of the right median sensory nerve. Dr. Cameron diagnosed mild right carpal tunnel syndrome and lateral epicondylitis of the right elbow and prescribed Aleve and exercises.

On February 7, 2008 the employee saw Dr. Hoff for his right arm and hand. It was painful and swollen for three weeks and getting worse. He had a nerve test a year ago and was told that he had carpal tunnel syndrome. All of his fingers and thumb were numb and painful; and there was no definite positive Tinel's or Phalen's. Dr. Hoffman diagnosed right arm pain with a history of a positive test for nerve impingement and prescribed Prednisone.

The employee testified that on September 28, 2008 he was unlocking a door, and as he was turning the key, his right wrist and hand popped. He felt a lot of pain and started going numb all the time and hurting more.

The employee went to Parkland Health Clinic on September 30, 2008. The employee had pain and numbness in the right wrist up to the elbow. The wrist had sharp pain after it popped when he was unlocking a door. An x-ray of the right wrist and elbow were negative except for a tiny osteophyte in the trapezium of the wrist.

The employee saw Dr. Strecker on October 28, 2008. The employee stated that on September 28 he was turning a key to unlock a door when he felt something pop in his hand. He had pain and marked swelling of the hand and forearm and pain radiating to the elbow. The swelling and pain decreased. His hand occasionally popped and with use developed numbness and swelling mostly over the thumb, index and long fingers. The employee had positive median nerve compression and positive Phalen's. Dr. Strecker diagnosed acute tenosynovitis and mild right carpal tunnel syndrome. It was Dr. Strecker's opinion that based on the acute traumatic episode the work was the primary and prevailing factor in his symptoms. He continued the employee on full duty; and recommended anti-inflammatories, physical therapy and vitamin B6.

On May 13, 2009 Dr. Strecker prescribed physical therapy and medication. On June 24, Dr. Strecker noted a positive Phalen's and tenderness with median nerve compression; ordered an EMG/nerve conduction study; and continued therapy.

The employee saw Dr. Phillips on July 2 for an EMG/nerve conduction study. The employee had progressive right hand numbness since September of 2008 with pain and swelling in the hand. The studies showed moderate carpal tunnel syndrome in the right wrist. On July 22, Dr. Strecker noted that the electrical studies were consistent with a moderate carpal tunnel of the right wrist and recommended surgery. On September 25, Dr. Strecker performed a right carpal tunnel release. After surgery the employee had physical therapy.

The employee testified that after his right hand popped he favored his right hand and started using his left hand to turn all the keys. He started having problems with his left hand including tingling and numbness. There was not a certain date or time he started having problems but it started gradually. He started having problems with his left middle finger becoming stuck. After he went back to work after the right carpal tunnel surgery, his left hand was numb constantly.

On October 23, 2009, the employee saw Dr. Strecker. He no longer had paresthesias in his radial digits, but was experiencing intermittent numbness of the right ring and small fingers. The employee had similar symptoms occurring in his left hand which he attributed to overusing his left hand to compensate for his right. Dr. Strecker noted the employee was doing well following his right carpal tunnel release and continued physical therapy. It was his opinion that the employee's new symptoms in his right hand were from cubital tunnel syndrome but did not believe those symptoms were work-related. Dr. Strecker diagnosed the employee with symptoms of left carpal tunnel syndrome and cubital tunnel syndrome. It was Dr. Strecker's opinion that there was no evidence that his job activities were a significant or contributing factor to the cubital tunnel syndrome; and there was no evidence that over compensation activities were a significant or primary causative event for the carpal tunnel syndrome.

On November 17, 2009, Dr. Strecker put the employee at maximum medical improvement for his right carpal tunnel syndrome. In a letter dated December 13, Dr. Strecker

rated 5% permanent partial disability of the right wrist due to the September of 2008 accident and injury.

The employee saw Dr. Schlafly on February 23, 2010 who diagnosed right carpal tunnel syndrome with release and left carpal tunnel syndrome. Dr. Schlafly recommended a left carpal tunnel release. It was Dr. Schlafly's opinion that the employee's repetitive work with his hands, opening and closing and locking and unlocking the heavy prison doors is the prevailing factor in the cause of his bilateral carpal tunnel syndrome; and in the need for bilateral carpal tunnel releases. The work injury of September 28, 2008 was an additional aggravating factor in the development of the right carpal tunnel syndrome. Dr. Schlafly opined that the employee had a 25% permanent partial disability of the right wrist due to the work related right carpal tunnel syndrome and release. If the employee did not have any further left hand treatment then there was a 30% percent permanent partial disability of the left wrist due to the work related carpal tunnel syndrome. Due to the disability in both hands, a condition of multiplicity exists and a loading factor should be added.

On August 3, 2010, the employee saw Dr. Brown. The employee gave Dr. Brown a job description about opening and closing cell doors; cuffing and uncuffing inmates; computer work; and paper work. In September of 2008, he was turning a key to unlock a door when he felt his right hand pop. About 6 weeks after that injury the employee noticed numbness and tingling in his left hand. After the right carpal tunnel release by Dr. Strecker in September of 2009, his symptoms improved in his right hand. The employee continued to have numbness in his left hand and occasionally his left middle finger would lock up. Dr. Brown stated that the employee had symptoms and findings consistent with left carpal tunnel syndrome and recommended an EMG/nerve conduction study on the left; and prescribed a wrist splint and anti-inflammatory medications. It was Dr. Brown's opinion that the employee's job activities were not the prevailing causative factor of carpal tunnel syndrome. Dr. Brown noted that the employee weighed 235 pounds, was 5'10" tall, and had an increased body mass index. Dr. Brown stated it was well established in medical and hand surgical literature that an increased body mass is associated with a high incidence of carpal tunnel syndrome. One study noted it was four times the incidence of patients without an increased body mass index.

The employee saw Dr. Strecker on November 16, 2010, with continued numbness and tingling to his left hand as well as triggering to his long finger. Dr. Strecker noted signs of both carpal and cubital tunnel syndromes; and recommended an EMG/nerve conduction study. On November 23, Dr. Philips performed an EMG/Nerve Conduction Study due to a history of sharp throbbing and aching of the left hand and arm pain with intermittent numbness mainly in the index and middle fingers since September or October of 2008. The findings were mild left carpal tunnel syndrome. On November 30, Dr. Strecker noted that the electrical studies were consistent with left carpal tunnel syndrome; and recommended left carpal tunnel and A1 pulley releases.

On February 7, 2011, Dr. Strecker performed a left carpal tunnel release and a release of the A1 pulley of the left long finger. After surgery the employee had physical therapy. On March 18, the employee stated that the paresthesias in his left hand resolved and his long finger no longer triggered; but he did have stiffness in the long finger. Dr. Strecker prescribed a Medrol Dosepak and diagnosed tenosynovitis. On April 1, 2011, the employee told Dr. Strecker

that when he was on the Medrol Dosepak his hand was fine but since then has had some recurrence of his stiffness. Dr. Strecker diagnosed residual tenosynovitis; prescribed Celebrex; and put the employee on full duty work.

The employee saw Dr. Schlafly on June 28, 2011 with his report dated August 24. Dr. Schlafly noted that the employee had undergone a surgical release for his left carpal tunnel syndrome and a trigger finger release of his left long finger. Dr. Schlafly diagnosed bilateral carpal tunnel syndrome with releases and left long trigger finger treated with trigger finger release with residual stiffness and pain. Due to the unusual amount of tenderness in the distal palm associated with the left long trigger finger releases with reduced range of motion, Dr. Schlafly noted it would be reasonable to repeat the trigger finger release. It was his opinion that the employee had a 25% permanent partial disability of each wrist for the work related bilateral carpal tunnel syndrome with releases and a 35% permanent partial disability of the left long finger at the 35-week level due to the work related left long trigger finger and release. It was his opinion that a multiplicity loading factor be added.

On June 25, 2012, it was Dr. Schlafly's opinion that the September 28, 2008 work injury was the prevailing factor in the cause of the disability of his hands which is 25% permanent partial disability of each wrist and 35% permanent partial disability of the left long finger at the 35 week level. It was his opinion that since the employee has disability in both hands that a condition of multiplicity exists which should be compensated by a loading factor of 15%.

The employee testified the tingling and numbness in his right hand resolved after surgery; however, he has diminished strength in his right hand leaving it difficult for him to open jars or restrain inmates. He uses both hands to secure inmates and put on wrist restraints. He has lost 30% of his grip strength in his right hand, and is unable to sustain a tight grip on things for very long. He will occasionally have a flash of pain of 7-8 out of 10 from his wrist into his palm to his thumb. He has trouble handling inmates, has a slower reaction and response, and takes longer to restrain them. The employee has to use his arms and not his hands to restrain inmates. He has difficulty with fatigue in his right hand when he holds onto the steering wheel, or when using keys to unlock and lock the doors. The employee has the same complaints in his left hand as his right hand, but had additional pain and problems related to his left index and long fingers. When he puts any pressure on the left index finger it causes pain and will collapse. He is not able to make a complete fist, nor will his long finger completely lay down flat without manually pushing it down with his other fingers, which is painful. His left hand is worse than his right hand due to the finger problems. His problems are worse due to having problems with both hands. Due to his hands he bid for, and is now a Utility Officer which has less hand repetitive activity.

The employee has an approximate 1½ inch scar on the right hand from the surgery and a 1½ inch scar on the left hand and a small scar from the trigger finger release.

RULINGS OF LAW IN NUMBER 08-091923:

Issue 1. Accident and/or Occupational Disease and Issue 2. Medical Causation.

The employer is disputing that on or about September 28, 2008 that the employee sustained an accident and/or occupational disease arising out of and in the course of his employment and that the employee's injuries were medically causally related to the alleged accident and/or occupational disease on or about September 28, 2008.

Section 287.020.2 RSMO defines accident as "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."

Under Section 287.020.3 (1) RSMo, "injury" is defined to be an injury which has arisen out of and in the course of employment.

287.020.3(2) RSMo, states:

An injury shall be deemed to arise out of and in the course of the employment only if: a) It is reasonably apparent, upon consideration of all the circumstances, that the accident is the prevailing factor in causing the injury; and b) It does not come from a hazard or risk unrelated to the employment to which workers would have been equally exposed outside of and unrelated to the employment in normal non-employment life.

Under Section 287.067.2 and 287.067.3 RSMo, an injury by occupational disease is compensable only if the occupational exposure was the prevailing factor in causing both the resulting medical condition and disability. An injury due to repetitive motion is recognized as an occupational disease. An occupational disease due to repetitive motion is compensable only if the occupational exposure was the prevailing factor in causing both the resulting medical condition and disability. The "prevailing factor" is defined to be the primary factor, in relation to any other factor, causing both the resulting medical condition and disability. In order to be a compensable injury under a repetitive motion occupational disease, the employee has the burden to prove that the occupational exposure was the prevailing factor in causing the resulting medical condition and disability.

The employee's testimony regarding the repetitive work activities and job duties was very credible and uncontradicted. It was his credible testimony that sometime in the fall of 2006 he started working in the B dining hall. Within a month or two of going to work in the B dining hall he started having problems with his right hand. On September 28, 2008 he was unlocking a door, and as he was turning the key, his right hand and wrist popped. He developed constant numbness and more pain. He favored his right hand, started using his left hand to turn all the keys, and gradually started having problems with his left hand including tingling and numbness; and his left middle finger becoming stuck.

Dr. Strecker diagnosed acute tenosynovitis and mild right carpal tunnel syndrome. It was Dr. Strecker's opinion that the acute traumatic work episode was the primary and prevailing factor in his symptoms. Dr. Strecker diagnosed left carpal tunnel syndrome; and it was his opinion there was no evidence that over compensation activities were a significant or primary causative event for the carpal tunnel syndrome.

Dr. Brown diagnosed left carpal tunnel syndrome. It was his opinion that the employee's job activities were not the prevailing causative factor of his left carpal tunnel syndrome. Dr. Brown stated that the employee had an increased body mass index; and it was well established in the medical literature that is associated with a high incidence of carpal tunnel syndrome.

Dr. Schlafly diagnosed the employee with bilateral carpal tunnel syndrome and left long trigger finger. It was Dr. Schlafly's opinion that the employee's repetitive work with his hands, opening and closing and locking and unlocking the heavy prison doors is the prevailing factor in the cause of his bilateral carpal tunnel syndrome; and need for bilateral carpal tunnel releases; and the September 28, 2008 work injury was an additional aggravating factor in the development of the right carpal tunnel syndrome. It was his opinion that the work injury was the prevailing factor in the cause of the disability of his hands, wrists and left long finger.

I find that the opinions of Dr. Schlafly and Dr. Strecker are very persuasive and are credible regarding the right wrist and hand. I find that the opinion of Dr. Schlafly is very persuasive and is more credible than the opinions of Dr. Strecker and Dr. Brown regarding the left wrist, hand and long finger.

Based on all the evidence, I find that the employee's work activities and job duties were the prevailing factor in causing the resulting medical condition and disability of bilateral carpal tunnel syndrome and left long trigger finger; which did not come from a hazard or risk unrelated to the employment to which workers would have been equally exposed outside of and unrelated to the employment in normal non-employment life. I find that the employee sustained a compensable work-related occupational disease and injury; and compensable work-related accident and injury that arose out of and in the course of his employment. I find that the employee's bilateral carpal tunnel syndrome and left trigger finger and the need for medical treatment are medically causally related to the employee's occupational disease and accident.

Issue 3. Permanent Partial Disability

It was Dr. Strecker's opinion that the employee had a 5% permanent partial disability of the right wrist. It was Dr. Schlafly's opinion that the employee had a 25% permanent partial disability of each wrist for the bilateral carpal tunnel syndrome and a 35% permanent partial disability of the left long finger at the 35-week level for the trigger finger and release. It was his opinion that due to the disability in both hands that a condition of multiplicity existed and that a loading factor of 15% be applied.

Based on a review of the evidence, I find that as a direct result of the work related left carpal tunnel syndrome and left long trigger finger including surgery the employee sustained a

18% permanent partial disability of the left hand and wrist at the 175 week level (31.5 weeks) and as a direct result of the right carpal tunnel syndrome including surgery the employee sustained a 15% permanent partial disability of the left hand and wrist at the 175 week level (26.25 weeks). The employee is therefore entitled to 57.75 weeks of compensation for permanent partial disability.

Based upon the evidence, I find that the employee is entitled to an additional 15% for multiplicity which is an additional 8.66 weeks of compensation (57.75 weeks x 15% equals 8.66 weeks). I further find that as a result of the surgical scars that the employee is entitled to an additional 3 weeks of disfigurement.

The employer is therefore ordered to pay to the employee a total of 69.41 weeks of compensation at the rate of \$368.74 per week for a total award of permanent partial disability of \$25,594.24.

FINDINGS OF FACT IN INJURY NUMBER 10-963790:

The employee testified that on July 20, 2010 he injured his back in an altercation with an inmate. He had to subdue an inmate, was bouncing off tables and machines; and the inmate was ultimately tackled. The employee developed severe pain in his low back.

On August 16, 2010, the employee went to Parkland Health Clinic after being attacked by an inmate and when restraining him went to the ground. X-rays of the lumbar back and right hip were performed. Therapy and medications including a muscle relaxer were prescribed. The employee had point tenderness in the low back; right hip; and down to the right knee. The employee continued to treat with Parkland Health.

On October 4, 2010, the employee had low back, right buttock and pain down the right leg to the foot. A Medrol Dose Pak was prescribed. On October 12 the employee went back to Parkland Health Clinic. The Medrol Dose Pak helped decrease the pain for the right hip and lumbar strain. Mediations and therapy was continued. On October 13, the lumbar MRI showed at L4-5 diffuse disc bulging extending far laterally to the left with what appeared to be an annular fissure along the lateral aspect of the disc. There was no definite evidence of mass effect on the exiting nerve root. There was some encroachment on the left neuroforamin. At L5-S1 there was diffuse disc bulging toward the right which encroaches on the neuroforamin and appears to impinge on the L5 nerve root. On October 19, the employee went to Parkland Health Clinic and was referred to a back specialist.

The employee saw Dr. Coyle on November 3, 2010 for back, right hip and right lower extremity pain. Dr. Coyle noted that the October MRI showed evidence of a left-sided annular tear at L4-5 and a far right disc protrusion at L5-S1. Dr. Coyle's impression was lumbar radiculopathy and right trochanteric bursitis. He referred the employee for an extraforaminal block at L5-S1 on the right as well as a steroid injection over the right greater trochanter. The employee did not have any motor deficits and felt he could fulfill his full-duty position. Dr. Coyle returned the employee to full duty work with no restrictions; continued therapy; prescribed medications; and to follow up with a physiatrist for conservative management.

The employee saw Dr. Randolph on November 16, 2010 for right-sided low back and gluteal pain, and pain radiating down the posterior and lateral aspects of his leg. His symptoms increased with bending, twisting, transitional movements, prolonged sitting and prolonged walking. The October MRI showed a high-intensity zone in the left of the L4-5 disc and a minimal lateral bulge to the right at L5-S1. Dr. Randolph stated that the employee had a contusion and sprain of the lumbar spine and right hip contusion; and developed mild radicular symptoms into her right lower extremity and right trochanteric bursitis. The findings reflect a combination of mechanical and mild radicular pain at the lumbar level and trochanteric bursitis. Dr. Randolph performed an epidural steroid injection in the right hip and prescribed additional physical therapy.

On December 7, Dr. Randolph noted that the employee was doing significantly better and treatments have been helpful for pain control and strength. The employee had some soreness in the low back and right gluteal area. Physical therapy was continued.

On December 28, 2010, the employee reported to Dr. Randolph a flare-up of his low back pain with vague numbness in his right lower extremity. Dr. Randolph prescribed a tapering course of prednisone. His symptoms were improved on January 18, 2011; and Dr. Randolph noted that the straight leg raising was negative and the examination was normal. The employee was placed at maximum medical improvement and he was continued at full duty work.

On January 20, 2011, the employee went to Parkland Health Clinic for a sore chest and muscle spasms in the lower back after falling on his chest. On exam, there were muscle spasms in the thoracic spine; and Soma was prescribed.

The employee saw Dr. Robson on March 2, 2011 with continued problem in his low back and right leg. He had 5-6 out of 10 pain that was made worse during and after exercise, with sitting, damp weather, twisting, lying in bed and driving. His symptoms improved with walking, ultrasound treatment and heat. After physical examination and review of diagnostic studies, Dr. Robson's impression was spinal stenosis L4-5, disc dehydration at L5-S1 and right greater trochanteric bursitis. Dr. Robson recommended a right greater trochanteric bursa injection. If this injection did not give relief, Dr. Robson thought a CT-myelogram should be completed to consider surgical options.

The employee testified that Dr. Robson discussed the possible need for surgery but he does not want to have surgery.

On April 25, 2011, the employee saw Dr. Coyle. The employee reported that he had not received the right sided extraforaminal block at L5-S1. The employee was working full duty, was experiencing no difficulty and his symptoms had essentially gone away; but had occasional right sided pain. On examination Dr. Coyle found no evidence of focal motor or sensory deficits and no tenderness over the trochanteric bursa. Dr. Coyle released the employee at maximum medical improvement and it was his opinion that the employee had no permanent disability from the July 20, 2010, work injury.

The employee saw Dr. Schlafly on June 28, 2011 with his report dated August 24, 2011. Dr. Schlafly diagnosed a low back strain associated with bulging and protruding discs but without clear cut radiculopathy. It was his opinion that the work injury of July 20, 2010 resulted in a 15% permanent partial disability to the body as a whole referable to the lumbar spine.

On June 25, 2012, it was Dr. Schlafly's opinion that the employee has a combination of disabilities that created a synergistic effect between the disabilities of his hands and low back giving a combined effect greater than the simple sum of the components. These disabilities create an obstacles or hindrance to employment. It was his opinion that the employee had a 15% load due to the synergistic effect between the disabilities of his hand and his low back.

The employee testified that after sitting for 10-15 minutes he develops a burning sensation in his low back and right buttock. He must keep moving throughout the day to try to stay comfortable. Cold and rainy weather make his back more painful. It feels as if there is a bulge or knot below his belt area. At night he might sleep for an hour to hour and 15 minutes before he must get up and walk around to ease his pain. The more active he is the more pain he has. He has good days and bad days. On a good day he experiences a constant dull or burning pain of 4 or 5 out of 10 in the right upper buttock and hip. In a typical week, he has at least one bad day but it varies depending on the weather and activity. On a bad day his low back pain is 7 or 8 out of 10; and he will have trouble walking stairs and has to get help out of a couch and chair. His condition makes him slower. He has difficulty escorting inmates due to his low back pain and is afraid of altercations with inmates. The employee is having a harder time due to combination of two bad hands and a bad back. He can complete activities but it takes him longer, and sometimes he has to get assistance which hinders him at work. He has missed work due to his low back and hands.

RULINGS OF LAW IN INJURY NUMBER 10-063790:

Issue 4. Permanent Partial Disability

Dr. Schlafly diagnosed a low back strain associated with bulging and protruding discs without clear cut radiculopathy. Dr. Coyle stated that the October of 2010 MRI showed a left-sided annular tear at L4-5 and a right sided disc protrusion at L5-S1. Dr. Coyle diagnosed lumbar radiculopathy and right trochanteric bursitis, and recommended an extraforaminal block at L5-S1 and a steroid injection over the right greater trochanter. Dr. Randolph stated that the October MRI showed a left sided high-intensity zone of the L4-5 disc and a right sided disc bulge at L5-S1; diagnosed mild radicular symptoms into the right lower extremity and right trochanteric bursitis; performed an epidural steroid injection in the right hip; and prescribed physical therapy. Dr. Robson diagnosed spinal stenosis at L4-5, disc dehydration at L5-S1 and right greater trochanteric bursitis; and recommended a right greater trochanteric bursa injection.

It was Dr. Coyle's opinion that the employee had no permanent disability from the July 20, 2010 work injury. It was Dr. Schlafly's opinion that the work injury of July 20, 2010 resulted in a 15% permanent partial disability to the body as a whole referable to the lumbar spine.

The employee was observed during the hearing and appeared to be uncomfortable and in pain. He was frequently moving around in his chair, stood up and sat down several times, and at the end of direct examination requested a break to move around and stretch.

Based on the medical evidence, my observations, and the credible testimony of the employee, I find that the employee has sustained permanent partial disability as a result of the July 20, 2010 accident. I find that as a direct result of the July 20, 2010 accident the employee sustained a 12.5% permanent partial disability of the body as a whole referable to his low back. The employer is ordered to pay the employee 50 weeks of compensation at the rate of \$376.46 per week for a total award of permanent partial disability of \$18,823.00.

Issue 5. Liability of the Second Injury Fund for Permanent Partial Disability

Based on the credible testimony of the employee and the medical evidence, including the credible opinion of Dr. Schlafly, I make the following rulings:

Primary Injury:

I find that the primary injury to the employee's low back resulted in a 12.5% permanent partial disability of the body as a whole at the 400 week level for a total of 50 weeks of compensation.

Pre-existing bilateral hand conditions:

I find that the employee's pre-existing bilateral hand condition was of such seriousness as to constitute a hindrance or obstacle to employment or obtaining re-employment. I find that the pre-existing bilateral hand condition resulted in an 18% permanent partial disability of the left hand and wrist at the 175 week level and 15% permanent partial disability of the left hand and wrist at the 175 week level for a total of 57.75 weeks of compensation.

Conclusion:

I find that the employee's pre-existing bilateral hand conditions and the last injury to the low back combined synergistically to create a total disability of 118.525 weeks. This total disability is based on a loading factor of 10%. After deducting the percent of disability that existed prior to the last injury (57.75 weeks) and the disability resulting from the last injury alone (50 weeks) from the total disability attributable to all injuries or conditions existing at the time of the last injury (118.525 weeks), the remaining balance to be paid by the Second Injury Fund is equal to 10.775 weeks. The Second Injury Fund is therefore directed to pay to the employee the sum of \$376.46 per week for 10.775 weeks for a total award of permanent partial disability of \$4,056.36.

ATTORNEY'S FEE:

Doug VanCamp, attorney at law, is allowed a fee of 25% of all sums awarded under the provisions of this award for necessary legal services rendered to the employee. The amount of this attorney's fee shall constitute a lien on the compensation awarded herein

INTEREST:

Interest on all sums awarded hereunder shall be paid as provided by law.

Made by:

Lawrence C. Kasten
Chief Administrative Law Judge
Division of Workers' Compensation

