

TEMPORARY OR PARTIAL AWARD
(Affirming Award and Decision of Administrative Law Judge)

Injury No. 13-051044

Employee: Felicia S. Clutter
Employer: Conagra Foods, Inc.
Insurer: Old Republic Insurance Company

The above-entitled workers' compensation case is submitted to the Labor and Industrial Relations Commission for review as provided by § 287.480 RSMo, which provides for review concerning the issue of liability only. Having reviewed the evidence and considered the whole record concerning the issue of liability, the Commission finds that the award of the administrative law judge in this regard 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 and adopts the award and decision of the administrative law judge dated February 6, 2015.

This award is only temporary or partial, is subject to further order and the proceedings are hereby continued and kept open until a final award can be made. All parties should be aware of the provisions of § 287.510 RSMo.

The award and decision of Administrative Law Judge Robert B. Miner, issued February 6, 2015, is attached and incorporated by this reference.

Given at Jefferson City, State of Missouri, this 14th day of May 2015.

LABOR AND INDUSTRIAL RELATIONS COMMISSION

John J. Larsen, Jr., Chairman

James G. Avery, Jr., Member

Curtis E. Chick, Jr., Member

Attest:

Secretary

TEMPORARY OR PARTIAL AWARD

Employee: Felicia S. Clutter

Injury No.: 13-051044

Employer: Conagra Foods, Inc.

Additional Party: None

Insurer: Old Republic Insurance Company, c/o
Sedgwick Claims Management Services

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

Hearing Date: November 7, 2014

Date Record Closed: November 26, 2014

Checked by: RBM

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: July 15, 2013.
5. State location where accident occurred or occupational disease was contracted:
Trenton, Grundy, Missouri.
6. Was above employee in employ of above employer at time of alleged accident or occupational disease? Yes.
7. Did employer receive proper notice? Yes.
8. Did accident or occupational disease arise out of and in the course of the employment? Yes.
9. Was claim for compensation filed within time required by Law? Yes.
10. Was employer insured by above insurer? Yes.
11. Describe work employee was doing and how accident occurred or occupational disease contracted: While working for Employer, Employee lifted a door weighing about

two hundred pounds and while she held the door above her head she felt a pop in her left shoulder, had pain in her left shoulder, and she injured her left shoulder.

12. Did accident or occupational disease cause death? No.
13. Part(s) of body injured by accident or occupational disease: Left shoulder.
14. Compensation paid to-date for temporary disability: \$638.35.
15. Value necessary medical aid paid to date by employer/insurer? \$6,781.05.
16. Value necessary medical aid not furnished by employer/insurer?
17. Employee's average weekly wages: \$1,117.93.
18. Weekly compensation rate: \$745.29 for temporary total disability and \$446.85 for permanent partial disability.
19. Method wages computation: By agreement of the parties.

COMPENSATION PAYABLE

20. Amount of compensation payable:

Employer is directed to authorize and furnish additional medical treatment to cure and relieve Claimant from the effects of her July 15, 2013 work injury, in accordance with section 287.140, RSMo.

Each of said payments to begin immediately and be subject to modification and review as provided by law. This award is only temporary or partial, is subject to further order, and the proceedings are hereby continued and the case kept open until a final award can be made.

IF THIS AWARD IS NOT COMPLIED WITH, THE AMOUNT AWARDED HEREIN MAY BE DOUBLED IN THE FINAL AWARD, IF SUCH FINAL AWARD IS IN ACCORDANCE WITH THIS TEMPORARY AWARD.

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: Michael J. Joshi.

FINDINGS OF FACT and RULINGS OF LAW:

Employee: Felicia S. Clutter

Injury No.: 13-051044

Employer: Conagra Foods, Inc.

Additional Party: None

Insurer: Old Republic Insurance Company, c/o
Sedgwick Claims Management Services

Before the
**Division of Workers'
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Department of Labor and Industrial
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PRELIMINARIES

A hardship hearing (non-section 287.203, RSMo) was held in this case on Employee's claim against Employer on November 7, 2014 in St. Joseph, Missouri. Employee, Felicia S. Clutter, appeared in person and by her attorney, Michael J. Joshi. Employer, Conagra Foods, Inc., and Insurer, Old Republic Insurance Company, c/o Sedgwick Claims Management Services appeared by their attorney, Anton C. Andersen. The Second Injury Fund is not a party in this case. Michael J. Joshi requested an attorney's fee of 25% from all amounts awarded.

STIPULATIONS

At the time of the hearing, the parties stipulated to the following:

1. On or about July 15, 2013, Felicia S. Clutter ("Claimant") was an employee of Conagra Foods, Inc. ("Employer") and was working under the provisions of the Missouri Workers' Compensation Law.
2. On or about July 15, 2013, Employer was an employer operating under the provisions of the Missouri Workers' Compensation Law and was insured by Old Republic Insurance Company, c/o Sedgwick Claims Management Services ("Insurer").
3. Employer had notice of Claimant's alleged injury.
4. Claimant's Claim for Compensation was filed within the time allowed by law.

5. The average weekly wage was \$1,117.93, the rate of compensation for temporary total disability is \$745.29 per week, and the rate of compensation for permanent partial disability is \$446.85 per week.
6. Employer/Insurer has paid \$638.35 in temporary total disability.
7. Employer/Insurer has paid \$6,781.05 in medical aid.
8. Venue is proper in St. Joseph, Missouri for the November 7, 2014 hearing.
9. The issue of permanent partial disability is not to be determined in connection with the November 7, 2014 hearing.

ISSUES

The parties agreed that there are disputes on the following issues:

1. Did Claimant sustain an injury by accident on or about July 15, 2013 arising out of and in the course of her employment for Employer?
2. If Claimant had an accident on or about July 15, 2013, is the accident the prevailing factor in the medical condition and any disability she sustained?
3. What is Employer's liability, if any, for additional medical aid?

Claimant testified in person. Angie Bruyer testified on behalf of Claimant.

Employer offered the following exhibits which were admitted in evidence without objection:

- 1—Deposition of Dr. Alexandra Strong taken October 31, 2014 with Deposition Exhibits
- 2—MRI Report dated November 11, 2013
- 3—Records of St. Luke's Health System
- 4—Pay Records
- 5—Records of Dr. Salvatore Miceli
- 6—Deposition of Claimant taken September 4, 2014

It was agreed at the November 7, 2014 hearing that the record would be left open to permit the deposition of Dr. James Hopkins with deposition exhibits to be admitted in evidence as Joint Exhibit 7, subject to any objections contained in the deposition. The deposition of Dr. James Hopkins with deposition exhibits was received by the Division of

Workers' Compensation St. Joseph office on November 26, 2014 and was admitted in evidence on November 26, 2014 as Joint Exhibit 7, subject to any objections contained in the deposition. The record was closed in this case on November 26, 2014.

Any objections not expressly ruled on during the hearing or in this award are now overruled. To the extent there are marks or highlights contained in the exhibits, those markings were made prior to being made part of this record, and were not placed thereon by the Administrative Law Judge.

The Post-Hearing Briefs have been considered.

Findings of Fact

Claimant is 26-years-old. She works for Employer in Trenton, Missouri. Her job title is Fourth Lead. Her prior title was General Laborer.

Claimant was working for Employer as a general laborer on July 15, 2013. She was working on a machine that wrapped cans that were put into boxes. She worked on the warehouse side. She helped package product to be shipped when she worked in general labor. Her duties included loading boxes and keeping the machine running. She checked the machine every thirty minutes. If the machine stopped, she opened doors to fix it. The machine stopped if boxes were feeding in the wrong way or flaps were not gluing.

The machine that she worked on is surrounded by metal and heavy Plexiglas doors. There are ten doors on the machine. They go the length of the machine and are different sizes. The doors protect employees from moving parts within the machine. The doors are tight. The machine shuts off when a door opens.

Claimant does not know the exact weight of the doors. She knows that they are heavy and that is the reason the doors have air locks. Air holds the doors down. Switches need to be pushed to open the doors. Pushing a switch helps raise the doors and makes it easier to open the doors.

Claimant was working around Door 8 on July 15, 2013. Door 8 is about eight or nine feet tall and nine or ten feet long. The door is like a garage door. It is a bi-fold door. The door has a handle on the bottom and on the middle.

Door 8 was not operating properly on July 15, 2013. The switch was broken and did not work. Air did not help push the door. It was harder to open Door 8 that day because the switch was not working.

Claimant was injured at work on July 15, 2013. She picked up Door 8 in the middle using the higher handle. She pulled and lifted the door up with both hands and then grabbed the next handle and lifted more. When the door was overhead, she released her right hand and held the door handle with her left arm while her left arm was outstretched. She used her right hand to reach. Her left arm was up in the air while she reached out with her right hand. While she was reaching with her right hand and holding the door with her left arm, she felt a pop in her left shoulder. She pushed the door up a little when she felt a pop and let go. The door did not come down.

Claimant's left arm started throbbing right after that. She had pain on the top outside of her left shoulder and in the scapula under her left shoulder blade. The pain that Claimant felt in her left shoulder at that time was an eight on a scale of one to ten.

Claimant also testified she was not in the process of lifting at the time of the pop even though records at Wright Memorial Hospital said that she was lifting. The pop happened when she was holding the door. The door was not stuck, even though Dr. Miceli's records say it was. The door weighed a couple of hundred pounds, not five hundred pounds as reflected in Dr. Strong's records.

Claimant had lifted Door 8 about forty times on July 15, 2013 before she felt the pop in her left shoulder. She was holding the door up because it had moved a couple of times before. The door had started to come back down one time before. Claimant had also lifted other doors on July 15, 2013 before she was injured.

Claimant continued to work for about an hour after her left shoulder popped. She had another pop when she was pulling during that hour. She went to her supervisor and told him she was hurting and that the machine was not working right.

Claimant went home about 9:00 p.m. that evening after she reported her injury to her supervisor. She had started work at 6:15 p.m. on July 15, 2013. She would have normally worked until between 5:00 a.m. and 6:15 a.m. She normally worked ten to twelve hours per day.

Claimant took Ibuprofen and put ice on her shoulder when she got home on July 15, 2013.

On July 16, 2013, Claimant went to work and reported the injury. Employer sent her for medical treatment at Wright Memorial Hospital on July 17, 2013. She saw Nancy, a nurse practitioner, at Wright Memorial Hospital. Her shoulder was swollen at that time. She got medication and had an x-ray. She was put on light-duty with restrictions and was prescribed physical therapy at Wright Memorial Hospital. Her job at Employer was changed due to her restrictions. Employer provided light-duty work for her.

Claimant had physical therapy and took medication. She also saw Dr. Miceli on referral from Nancy. Dr. Miceli looked at her left shoulder and ordered an MRI. Dr. Miceli did not prescribe physical therapy. Dr. Miceli examined Claimant three times and had her do motions. Claimant did not get relief from the treatment provided by Dr. Miceli, except the injections she received relieved her symptoms a little. She last saw Dr. Miceli on July 21, 2013.

Employer sent Claimant to Dr. Alexandra Strong who saw Claimant on February 14, 2014. Claimant had seen no one else for treatment between the times she saw Dr. Miceli and Dr. Strong. She saw Dr. Strong on one occasion. Dr. Strong looked at Claimant's left shoulder, got an x-ray, and looked at the MRI. She examined Claimant for about ten minutes and had her do motions with her left arm.

Claimant still had problems with her shoulder when she saw Dr. Strong. She had throbbing pain. Activity increased her pain.

Claimant saw Dr. Hopkins on April 5, 2014. He took Claimant's history and examined her for between forty-five and sixty minutes. Dr. Hopkins moved Claimant's left arm more than Dr. Strong did.

Claimant's pain has been constant up from the time of her July 15, 2013 injury until the day of the November 7, 2014 hearing. Her lowest pain has been a three. Her pain is six to seven most of the time when she uses her left arm.

Claimant had never had problems with her left shoulder before July 15, 2013. She had never had medical treatment for her left shoulder before July 15, 2013. She had never injured her left shoulder before July 15, 2013.

It has bothered Claimant after July 15, 2013 when she pushes and pulls. It bothers her to lift her child. Her child was age six at the time of the injury. She usually holds her child in her right arm when she picks her up.

Claimant had an automobile accident in December, 2012. Her vehicle was totaled in the accident. She was restrained and the air bag was deployed. She went to the emergency room after the accident.

Claimant was broad-sided in 2009 when she was driving twenty miles an hour. The other vehicle hit Claimant's car behind the driver's door. Claimant's left shoulder was the closest point of impact. Claimant's air bag deployed.

Claimant did not receive any treatment for her left shoulder from either motor vehicle accident. Her left shoulder had not been x-rayed before July 15, 2013.

Claimant returned to work after July 15, 2013. She was working for Employer full-time at the time of the November 7, 2014 hearing.

Claimant is still having trouble with her left shoulder. She wants further medical treatment for her left shoulder.

Claimant's deposition taken on September 4, 2014 was admitted as Exhibit 6. Claimant was asked the following questions and gave the following answers at Claimant deposition, pages 21-32:

Q. Okay. So on that day, July 15, 2013, how did you hurt yourself?

A. I was lifting on the door 8 and that is the stacking area door and the door was broke. The air switch wasn't working and it's an air ride door and I lifted it and I felt a pop.

Q. Okay. Lifting door No. 8. What type of door is that? Is it like a door like we have in an office or what kind of door is it?

A. It's kind of like a folding door. You turn a switch and you push a button and the air helps lift it. Well, the air wasn't working. The switch was broke. So you had to literally hold it up there to make sure it stays and then get in there and fix whatever.

Q. Okay. So the door is – is that on a machine or is it in the wall of the building?

A. On the machine.

Q. Okay. And what machine is it?

A. The Kister.

Q. The Kister. How high – how big is the door? And if we're estimating, I mean, is it as tall as you are or is it shorter than you are?

A. It's taller.

Q. Okay. And how tall are you?

A. 5-6.

Q. Okay. How much taller than you is it?

A. About 3 feet.

Q. Okay. So it's 8 foot, 9 foot high; is that correct?

A. Yes.

Q. So does the door operate on – like a garage door that rolls up into the machine?

A. It bends – like it bends – like when you lift it, it kind of comes out in the middle. It folds kind of.

Q. All right. So is it kind of a bifold door where you – where the top kicks out and the bottom kicks out as well and then they meet together, but it goes towards the top of the machine?

A. The door is like this and then when you lift it up, it goes like this. So it kind of comes out toward you, but up.

Q. Okay. So as I understand it, there's two pieces to the door; is that correct?

A. Yes.

Q. There's a top piece and there's a bottom piece, correct?

A. Uh-huh. Yes.

Q. And the top piece and the bottom piece meet at – there's a hinge there, correct?

A. Yes.

Q. And when you operate the door, the top piece goes up and the bottom piece folds up underneath and matches the top piece at some point; is that correct?

A. Yes.

Q. And there's an air assist to that door, correct?

A. Yes.

Q. And that door, when you open it, it – you said there's a key?

A. It's a switch.

Q. A switch?

A. It's on and off – turns on the air and off the air.

Q. Okay.

A. And there's also a button to push to help lift the door.

Q. What's the door made out of?

A. I'm not sure on the middle, but then it's Plexiglass. So it's see-through. So you can see inside the machine.

Q. So it has a metal frame and a Plexiglass interior?

A. Uh-huh.

Q. Is that a yes?

A. Yes.

Q. So do you know how much that door weighs?

A. About 200 pounds.

Q. When you lift on the door, are there handles at the bottom or are there handles in the middle or handles at the top?

A. There's a bar where the bend – the middle – the top and bottom and then there's a lever – there's two holders. There's a bottom and the top you can hold to lift.

Q. Okay. So there's a bar. Is that like a long open bar?

A. It's about a foot-long bar and it's about – there's a bar that comes down, up and down, and then there's two across. One is at the middle of the top and bottom where the top and bottom meets and then there's one at the bottom so you can –

Q. Okay. Let me make sure I understand. There's a vertical bar. Is that mounted on the top piece?

A. No. It's on the bottom.

Q. It's mounted on the bottom piece?

A. Yeah.

Q. Okay. And then there's two horizontal bars or hand pieces, correct?

A. Yes.

Q. And one is at the very top of the bottom piece, this other one is at the very bottom of the top and bottom piece, correct?

A. Yes.

Q. And so when you were doing this, what were you grabbing when you felt this pop in your shoulder?

A. I was – I was grabbing the middle to lift up so I could grab the bottom and I lift up and I went up all the way to lift the door all the way up and make sure it wasn't going to come down, lift it, and that's when I felt the pop.

Q. So you pick – of the three bars we're talking about, the top, middle vertical one, and the bottom horizontal one, you pick the top horizontal bar or handhold and you use that to push the door up; is that correct?

A. Yes.

Q. Okay. And you're pushing that up with one hand or both?

A. Both.

Q. Okay. And as you're pushing that, you're – where does it start when you're –

A. When I turn the switch –

Q. Right.

A. – for the air and at this time, that switch was not working. So I push up a little bit and then I let go to pull, you know – bend down to pull up --

Q. Okay.

A. – on the bottom, because I got it so far and then I have to lift up.

Q. And then you try to get to the bottom bar to help lift it the rest of the way; is that correct?

A. Yes.

Q. All right. And when is it when you're pushing on the top bar or the bottom bar that you feel the pop in your shoulder? What are you holding onto?

A. I was holding it – lifting it up over my head.

Q. The entire – the door?

A. Yes.

Q. All right. So let me make sure. So you have used the top bar and you lift it up a little bit of the way, correct?

A. Yes.

Q. And then you release from that grip and you grab the bottom bar, correct?

A. Yes.

Q. And you pull it up the rest of the way, correct?

A. Yes.

Q. And you now have it overhead, correct?

A. Yes.

Q. At that point have you had a pop in your shoulder?

A. Yes.

Q. Okay. So –

A. Right there is where I had the pop.

Q. Okay. So are you holding onto the bottom bar at that point?

A. Yes.

Q. Okay. And have you got it all the way to the very top?

A. No.

Q. Okay. How far from the top?

A. I just got it – it was all the way up and now it's just trying to hold it to make sure it's not going to –

Q. Come back?

A. – come back. I was just holding. And then I let go to reach in and I just kind of kept my hand right there just to make sure and that's when I started the popping.

Q. Okay. So let me make sure I understand. So you had it up, both hands. When you initially got it up there, you didn't have a pop in your shoulder yet, correct?

A. Right.

Q. Okay. And then you released which hand?

A. I released my right.

Q. Your right hand. And you're holding it up with your left hand?

A. Yes. Just for reassurance that the door was not going to –

Q. Right.

A. And I was holding it up there.

Q. And you were going to do something inside the machine, correct?

A. Yes.

Q. And then you felt a pop where?

A. In the shoulder.

Q. In your left shoulder?

A. Yes.

Q. All right. And that's while you're holding the door up, correct?

A. Yes.

Q. Had the door moved?

A. No.

Q. So you had it in place –

A. Yes.

Q. – and you were just holding it in place, correct?

A. Yes.

Q. And you felt a pop?

A. Yes.

Q. Ma'am, are you right-hand or left-hand dominant?

A. Right hand.

Q. Okay. So I want to make sure I go through this and make sure. So at the point that you have both hands on the door holding it up, the door is all the way to the top where it's supposed to be; is that correct?

A. Yes.

Q. And then, as we talked about, you release with your right hand and hold it up with your left hand, correct?

A. Yes.

Q. And as you're holding it up with your left hand, you feel a pop in your shoulder, correct?

A. Yes.

Q. Did the door move at all?

A. No.

Q. Okay. So you were just holding it in place, correct?

A. Yeah, I –

Q. Is that correct?

A. Yes.

Q. Okay. And were you trying to pull back on the door or push it back farther?

A. No. I was just holding it there just for a little bit and then I did release my arm to go work with both hands. I just wanted to make sure the door wasn't going to – just make sure that it didn't move.

Q. Okay. And when you felt the pop in your shoulder, did you immediately release the door?

A. Yes.

Q. And did the door move?

A. No.

Q. So the door was still in place?

A. Yes.

Q. All right. And then was it – was your hand on the door when you felt the pop or had you already released it at that point when you were going to work with both hands?

A. I felt it when I was still on the door.

Q. Okay. And not to put too fine a point on this, but just to make sure. When you had it held up, did you – was your arm in a locked position or did you have your elbow bent?

A. Locked.

Q. Okay. All right. And you had – you said you had a pop in your shoulder. What did you do next after – when you felt the pop?

A. Rubbed my shoulder.

Q. You released the door I assume?

A. Yeah.

Q. You rubbed your shoulder, correct?

A. Uh-huh.

MR. JOSHI: Is that a yes?

A. Yes.

I find Claimant's testimony to be credible.

Angie Bruyer

Claimant's mother, Angie Bruyer, testified. Claimant does not live with her mother. She lives one-quarter mile away. Ms. Bruyer recalled the night Claimant was injured at work. She was babysitting for Claimant at the time. Ms. Bruyer received a phone call from Claimant who was crying. Claimant told her she had hurt her arm at work. Ms. Bruyer told Claimant to get home. Claimant was holding her left shoulder when she arrived at the house. She was in excruciating pain and said her shoulder hurt. Ms. Bruyer told Claimant to take 600 milligrams of Ibuprofen and gave Claimant ice for her shoulder.

Ms. Bruyer does not recall Claimant ever hurting her left shoulder before she had this work injury. Claimant never complained about her left shoulder while she was in high school. Ms. Bruyer never took Claimant for treatment of her left shoulder before the work injury. Claimant never complained of her left shoulder after the automobile accidents.

I find Angie Bruyer's testimony to be credible.

Medical Evidence

A July 23, 2013 note of Nancy Guthrie of St. Luke's Health System (Strong deposition Exhibit 3) states in part: "On 7/16/13, was at work at Conagra, pulling on a piece of equipment when she heard a pop in her left shoulder, a little pain, which got worse rapidly. It has been quite painful ever since." Bicipital tendonitis and upper back pain, muscle spasm, left side were assessed.

Dr. Salvatore J. Miceli's records were admitted as Strong deposition Exhibit 5. Dr. Miceli's September 26, 2013 report states in part:

IMPRESSION: Left shoulder strain, I do not think there is a significant rotator cuff tear present. She may have a bit of bicipital tendinitis as well but the multiple locations of pain suggest that this is not one focal tendon injury.

PLAN/RECOMMENDATIONS: Education regarding her injury was provided. It sounds as though she has slowly improved and she estimates she is at least 50% better than at the time of her original injury. I suggested a corticosteroid injection from posterior approach would be reasonable to try to provide her more complete relief. This

will need insurance preauthorization. In the meantime I have written to continue with her current work restrictions of no lifting more than 10 pounds with the left arm above chest level. I will travel to Wright Memorial Hospital in Trenton for clinic on 10/03/2013 and we will try to do her injection there. Her restrictions will remain in place until I see her for a follow-up.

Dr. Miceli examined Claimant on October 24, 2013. Dr. Miceli's October 24, 2013 report states in part:

CHIEF COMPLAINT/HISTORY OF PRESENT ILLNESS: Felicia returns today for follow-up of left shoulder pain. She reports that the recent injection hurt quite a bit for a few days and then seemed to provide some relief. Overall, she feels like it is better, but indicates she still has pain. When I asked her to explain what types of things bother it, she had quite a bit of difficulty coming up with any specific functions. She does report that it bothers her to lift her child. She denied any new difficulties currently.

PHYSICAL EXAMINATION: Demonstrates a well developed, well nourished appearing 25-year-old female. She has normal range of motion through all left shoulder movements. She has good strength with all rotator cuff functions. She has grossly intact sensation. She has some mild generalized tenderness about the trapezius and deltoid.

IMPRESSION: Left shoulder pain/strain.

PLAN: I have referred Felicia back to physical therapy for some work conditioning 3 times weekly for 2 weeks. I also suggested continuing with her current work restrictions until she follows up with me on November 5th. I am hopeful she will be able to return to work at that time.

A Northland Imaging Report dated 11/11/2013 states in part:

Prominent glenohumeral osteoarthritis for age with cartilage loss and subchondral cystic and reactive changes within the mid to inferior glenoid.

7 mm loose body within the subscapular recess.

Degeneration and probable tear of the anteroinferior labrum with tiny paralabral cyst. This can be confirmed with MR arthrography as indicated.

Dr. Miceli examined Claimant on November 21, 2013. Dr. Miceli's November 21, 2013 report notes he had reviewed the November 11, 2013 MRI, and that the impression in the MRI was: "Prominent glenohumeral osteoarthritis for age with cartilage loss and subchondral cystic and reactive changes within the mid to inferior glenoid. A 7 mm loose body within the subscapular recess. Degeneration and probable tear of the anterior/inferior labrum with tiny paralabral cyst."

Dr. Miceli's Impression on November 21, 2013 was: "Persistent left shoulder pain with MRI findings suggesting prominent glenohumeral osteoarthritis, loose body within the subscapular recess, and probable degeneration and probable tear of the anterior/inferior labrum with tiny paralabral cyst." Dr. Miceli suggested an orthopedic consult for further evaluation of her shoulder pathology.

Dr. Alexandra Strong Evaluation

Exhibit 1 is the deposition of Dr. Alexandra Strong dated October 31, 2014 with deposition exhibits. Dr. Strong is a medical doctor with Drisko, Fee & Parkins. (Strong deposition, page 4). She is board certified by the American Board of Orthopedic Surgery and Orthopedic Sports Medicine. She has hospital affiliations with North Kansas City and Centerpoint Hospitals. She is licensed in Kansas and Missouri. She has been practicing since 1992. She has specialization primarily in shoulders and knees. (Strong deposition, page 5).

Dr. Strong saw Claimant on February 14, 2014. Dr. Strong prepared her report, Deposition Exhibit 2, pertaining to that evaluation.

Dr. Strong saw Claimant for an independent medical examination. Claimant was complaining of her left shoulder. Claimant told Dr. Strong that she injured her shoulder at work on July 15, 2013.

Dr. Strong was asked the following questions and gave the following answers at Strong deposition, pages 6-9:

Q. Did she indicate what she was doing at work that caused this problem?

A. Yes.

Q. What did she say?

A. She said that she had a 500 pound door that was supposed to have some sort of air valve mechanism on it that helped it go up, and it wasn't working. She was lifting that up in front of her and pushing it up overhead. While she was pushing it up she felt a pop in her shoulder, and she pointed to the back of her shoulder toward the scapula.

Q. Did she demonstrate the mechanism to you in your examination?

A. I believe so.

Q. I'm going to ask you if you could review for me a few pages of deposition testimony. Ms. Clutter was deposed on September 4, 2014. And prior to today's deposition I think you looked at pages 27 through 33. I'll hand that to you. Did you review those pages?

A. I think 26 through 30 maybe. But yeah, a couple pages in here.

Q. Also on the next page. Is there a description of the injury as listed in her testimony that you reviewed?

A. Yes.

Q. Did the mechanism of injury that she described in the deposition, did that match what she told you at your evaluation?

A. It doesn't seem to exactly.

Q. In her deposition I think what she said on Page 29 through 33 she talks about having the door overhead with both hands on it, does she not?

A. Yes.

Q. And then she removed her right hand and held on to the door with her left hand, correct?

A. Yes.

Q. And she talked about having her elbow locked I believe. I think she said that a little bit later. Do you see that?

A. I don't see it yet.

Q. She said that when she – she was going to do something inside – this is on Page 29 at line 19. And that then she felt a pop in her left shoulder. Do you see where she says that?

A. Yes.

Q. So if I'm understanding the biomechanics, doctor, she has her left hand out-stretched over her arm holding a door in place, is that how you understand that?

A. Yes.

Q. The biomechanics of that, Doctor, is there some sort of a stress or strain on the shoulder when you do that? What is involved in the shoulder when you're in that position (indicating)?

A. It would depend on how heavy it was.

Q. She describes later that the door – while she held on it that the door did not move at all when she released the door I think is what she said. Do you see that on page 31? She was holding it in place?

A. Yes.

Q. When you evaluated the claimant on February the 14th, 2014 what condition did you see she had in her shoulder?

A. What did I think she had in her shoulder?

Q. Yes.

A. I thought she had degenerative changes and a possible loose body.

Q. The degenerative changes, how do you diagnose that from your evaluation of Ms. Clutter?

A. Her x-rays and MRI.

Q. What do they reveal? What did you see in the MRI?

A. The MRI showed glenohumeral osteoarthritis and cartilage loss, some subchondral cystic and reactive changes in the med to inferior glenoid, and what appeared to be a loose body in the subscapular recess, and degeneration of her interior and inferior labrum.

Dr. Strong was asked the following questions and gave the following answers at Strong deposition, pages 10-11:

Q. In her case did you believe she had degenerative issues in her shoulder?

A. Yes.

Q. When you diagnosed her did you believe that the problem in her left shoulder was the result of this event that she had at work back on July 15th, 2013?

A. No.

Q. Did you believe that the event as she described it to you, lifting the door, was the prevailing factor in the medical condition for her left shoulder and any treatment that would be needed for that?

A. No.

Q. Given the description that you read in her deposition transcript which was different, kind of a different mechanism of injury, would that change your opinion as to whether or not that event of holding the door over her head with her left arm would be the prevailing factor in causing the problems with her left shoulder?

A. No.

Q. In short, Doctor, do you believe that the prevailing factor in this case was the work injury of July 15, 2013?

A. No.

Q. Is that within a reasonable degree of medical certainty?

A. Yes.

Claimant did not complain of any paresthesia with regard to her left upper extremity when Dr. Strong saw her. (Strong deposition, page 12). Dr. Strong did not see any diminished size in Claimant's left deltoid or in her supraspinatus or any diminished size in her anterior pectoral muscle. (Strong deposition, page 12). There was no reduction in range of motion in Claimant's shoulder. (Strong deposition, page 13). Impingement sign was mildly positive – the result was mild discomfort. (Strong deposition, page 13).

The file that Dr. Strong had in this case consisted of thirteen pages. They included six pages from a nurse practitioner, a note about continued work restrictions dated October 22, 2013, and an office note from Dr. Miceli dated November 21, 2013. (Strong deposition, pages 15-16).

Dr. Strong had reviewed the MRI. (Strong deposition, page 17). A thirteenth page in her records was the November 11, 2013 MRI report. (Strong deposition, page 18).

Dr. Strong testified that holding a weighted object weighing 200 pounds above the shoulder level would put some compression and sheer stresses across the humeral, glenohumeral socket of the shoulder. (Strong deposition, pages 17-19).

Claimant indicated to Dr. Strong that she experienced a pop in her arm. Dr. Strong stated there are multiple possibilities of something happening to the shoulder when one hears something go pop in the shoulder. (Strong deposition, page 19).

Dr. Strong was asked the following questions and gave the following answers at Strong deposition, pages 19 – 21:

Q. Tell me what they are.

A. It could be a simple fold of bursa snapping, could be just a simple people's joints pop, biceps could have a problem, the labrum could have a problem, the rotator cuff could have a problem, the articular cartilage could have a problem. There's lots of possibilities.

Q. You said the articular cartilage could have a problem. What do you mean by that?

A. It means that you could have damage to the surface of the joint.

Q. When someone hears a pop in their shoulder, is that correct?

A. It's possible.

Q. What were some of the other things that you mentioned?

A. Bursa, rotator cuff, biceps, labrum, cartilage. There's many possibilities. Sometimes joints just pop.

Q. In reviewing the MRI or any of the other information did you see that there was any sort of a biceps problem that she had?

A. I do not recall a biceps problem.

Q. What about a bursa problem?

A. That can be difficult to image, but no.

Q. What about a labrum problem?

A. That is very difficult to image and – I take that back. Probable tear of the anterior inferior labrum.

Q. What about the cartilage, is that the degenerative changes that are found in the glenohumeral joint?

A. Yes.

Q. At least possible problems that a pop could indicate would be a problem with the labrum and a problem with the cartilage is that correct?

A. Yes.

Q. When you say a possible labrum problem if you're describing something that's occurring to the labrum when the shoulder pops, what is that?

A. Could get a tear of the labrum. She has degenerative changes, and labrum often have degeneration and tearing along with that.

Q. So that pop could be the labrum tearing, is that correct?

A. Perhaps.

Q. What would happen and you heard a pop and you say it's related to the cartilage, what's going on there with the cartilage?

A. It just means that the surface is uneven. You don't know more than that from just a pop.

Dr. Strong was asked the following questions and gave the following answers at Strong deposition, pages 22-24:

Q. He [Dr. Hopkins] says in here that Dr. Strong does not feel that the process of lifting with the shoulder could cause exfoliation or direct damage to the articular surface of her shoulder joint. Does that correctly state your opinion?

A. Yes and no.

Q. Explain.

A. I think she has underlying degenerative changes that predated the date of her injury. Whether she caused more damage to her articular surface at the moment she had the pop, you can't tell.

Q. You don't know?

A. You don't know.

Q. Would you agree that exfoliation and shedding of the articular surface of joints is usually caused by joint compression in association with motion which can provide sheer stresses that can separate the articular surface from the underlying skeleton?

A. I would take exception to the word usually.

Q. Would you agree outside of the word usually if we took that out?

A. I would have to read it.

Q. It's actually highlighted there at the bottom.

A. (Examines document.) Without the word usually I would agree.

Q. He's actually talking about exfoliation and shedding of the articular surface which can provide shear [*sic*] stresses that can separate the articular surface from the underlying skeleton. Isn't that what you're also saying when you told me that holding a weighted object above shoulder level could cause compression and sheer stress on the joint?

A. I did say that. Your sentence started so long ago. You have to start over.

Q. What he's saying, outside of usually, is not inconsistent of what you told me in terms of a type of stress of a weighted object above shoulder level could place on the shoulder, is that correct?

A. Yes.

Dr. Strong stated she was not saying that four months was not long enough for someone for degenerative changes to occur in a joint, particularly on a post-traumatic basis. (Strong deposition, page 25). She was not able to rule out the accident that Claimant described is the cause of the seven millimeter loose body noted in her report. (Strong deposition, page 25). She was not able to rule out that the accident was the cause of the labral tear. (Strong deposition, page 25-26).

Dr. Strong agreed that Claimant denied prior symptoms in her left shoulder, that her symptoms began on July 15, 2013, that she has had symptoms in her shoulder since that time, and that Claimant has testified to functional difficulty since that time period. (Strong deposition, pages 26-27).

Dr. Strong was not saying that the accident was not the prevailing factor in the loose body or the labral tear. (Strong deposition, page 29-30).

Dr. Strong did not think arthroscopy was appropriate to remove the loose body or remove the labral tear or repair the labral tear because Claimant was not symptomatic from it. Claimant had no instability findings. Dr. Strong recommended she start with anti-inflammatories and physical therapy, and perhaps an intra-articular injection. (Strong deposition, page 30). Arthroscopy would be the last resort. (Strong deposition, page 31). If conservative therapy, injections and anti-inflammatories fail to relieve the symptoms, arthroscopy would not be unreasonable. (Strong deposition, page 31).

Dr. Strong stated that the degenerative changes in Claimant's shoulder could have been made worse from the pop in her shoulder as Claimant described. (Strong deposition, page 32).

Dr. Strong stated that a pop in the shoulder is not always an indication of injury. (Strong deposition, page 33).

In this case, the description Claimant gave Dr. Strong did not give Dr. Strong an indication that a loose body was causing problems for Claimant. (Strong deposition, page 34).

Dr. Strong was asked the following questions and gave the following answers at Strong deposition, pages 34-36:

Q. For the purposes of a description to the court, what degenerative changes did you see on the MRI within the shoulder joint? How would you describe that to the court?

A. It seemed that most of them were on the glenoid or the socket side, and cartilage lost and subchondral cystic changes. She had a good size cyst in the lower posterior part of her glenoid.

Q. What is a cyst caused by?

A. Degenerative changes. It's the body's reaction.

Q. And a cyst is like a little growth in there?

A. It's like a hole, a vacant hole that might have fluid or something in it, but there's no bone. It's kind of an empty pocket under the joint surface.

Q. Is that something that develops over time?

A. Yes.

Q. Is that something that was caused by this popping episode that she's described?

A. I don't believe so.

Q. Do you believe that cyst is explanatory of the symptoms she now complains of in her shoulder?

A. Not the cyst itself.

Q. The reaction to the cyst within the shoulder?

A. I think the cyst is indicative of the overlying arthritis changes she has. It's the body's reaction to arthritis, subchondral cysts.

Q. The loose body that's in the shoulder, Doctor, is there any way you can tell when that was created?

A. No.

Q. In your best medical expertise do you believe that loose body was caused when she was holding up that door with her left arm?

A. I can't be certain.

Dr. Strong's medical report dated February 19, 2014 was admitted as Strong deposition Exhibit 2. Dr. Strong examined Claimant on February 14, 2104. Dr. Strong's report notes that Claimant:

. . . states that on 7/15/13, she was lifting a door on a machine. She states that it wasn't working. She demonstrates lifting in front of her and then pushing up overhead to raise the door in front of her. She states that while pushing up overhead, she felt a 'pop' in her shoulder and she points towards the back of her shoulder toward her scapula. She states that whole shoulder and arm had pain.

Dr. Strong noted that Claimant stated that her shoulder still hurts. Claimant denied ever having a problem with this shoulder.

Dr. Strong's report further states in part:

Her MMI report and images were reviewed from 11/11/13. The MRI report indicates prominent glenohumeral osteoarthritis for the age with cartilage loss and subchondral cystic and reactive changes within the mid to inferior glenoid, a 7mm loose body in the subscapular recess and degeneration and probably tear of the anteroinferior labrum with

tiny paralabral cyst. I looked at her images and agree. I do think her glenoid changes are more inferior and posterior.

Dr. Strong's report contains the results of her physical examination of Claimant. She noted that there was no obvious atrophy or deformity of her shoulders. Claimant was tender in her parascapular area, over her trapezius, AC joint and over the anterior acromial area. Dr. Strong noted that Claimant had full ROM of her shoulder and consistent with the other side. She noted that strength testing was five plus and equal. Neer's test gave Claimant mild discomfort. Hawkins was noted to be negative. O'Brien's test gave Claimant mild pain that was not localized well. SLAP test was negative. Apprehension test was negative. Dr. Strong noted that one time with range of motion, she thought she felt some crepitus in her shoulder, but did not feel it throughout any other times.

Dr. Strong's report states in part:

Impression: Left shoulder pain.

Comment: By MRI and x-ray, it appears that she has degenerative changes of her shoulder. It seems somewhat unusual for a person of this age to have that. Further medical work-up may be indicated. However, I do not believe that this is related to a work injury from 7/15/13. From her description of the injury and the mechanism, I do not believe that work episode could have caused her symptoms and her MRI and x-ray findings. Therefore, I believe that within a reasonable degree of medical certainty, her work episode in 2013 is not the prevailing factor or cause of her current shoulder symptoms. Since I do not believe that work is the prevailing factor in the cause of her shoulder symptoms, I do not believe that MMI or permanent partial disability apply in her situation.

Dr. William Hopkins Evaluation

The deposition of Dr. William Hopkins taken November 5, 2014 with deposition exhibits was admitted as Joint Exhibit 7. Dr. Hopkins's current practice consists of doing independent medical examinations. He also has a small non-surgical orthopedic practice. He does not operate any more. (Hopkins deposition, page 3). He has been an orthopedic surgeon for almost 50 years. (Hopkins deposition, page 4). He identified his Curriculum Vitae, Deposition Exhibit 1. He is board certified by the American Board of Orthopedic Surgeons.

Dr. Hopkins examined Claimant on April 5, 2014. He reviewed medical records, examined films, and performed an examination of her on that date. (Hopkins deposition, page 5). He prepared a report dated April 5, 2014. After that, he reviewed some additional records and prepared a subsequent report dated September 15, 2014. (Hopkins deposition, page 5). His findings and conclusions and opinions expressed in those reports remain the same.

Dr. Hopkins has reviewed the report of Dr. Alexander Strong who concluded Claimant's accident was not the prevailing factor in causing the conditions Claimant complained about and the findings on the MRI. (Hopkins deposition, page 6).

Dr. Hopkins was asked the following questions and gave the following answers at Hopkins deposition, pages 6-9:

Q. Now, Doctor, you stated in your September 15, 2014, report that to develop unilateral damage to the articular surface of the shoulder joint was uncommon for someone of Ms. Clutter's age; is that correct?

A. Not only is it uncommon because of her age, but I don't believe she could have performed her work for a period of years for this company in the same manner with those changes pre-existing in her shoulder, so it's not just the type of changes that she had. The uniqueness for her age with the damage that she had, again, it would be obvious at least to me that she would not have been able to perform her job.

Q. Without significant complaints of pain?

A. Without some form of complaints or inability to function.

Q. Now, you further indicated when one sees the extent and severity of the damage to a shoulder in someone her age, the most common factor would be trauma. Is that true?

A. That is true.

Q. How so is that, Doctor?

A. That is correct. At the age of 26 to have idiopathic nontraumatic arthritis in the shoulder joint would be highly unusual. There is one discrepancy and that is in men even in an early age state we can we can [*sic*] find degenerative changes in the acromial clavicular joint.

Those changes don't have to be symptomatic. It's much more frequent in men than in women, but it can be seen in females.

Q. Now you also stated that the type of injury Ms. Clutter sustained and the MRI four months later could produce the type of damage that was seen on that MRI; is that correct?

A. That is correct.

Q. Now, Doctor, you talked about the process of lifting of the shoulder, how it could cause I believe you used the word exfoliation and direct damage to the articular surface of the shoulder joint; is that correct?

A. Yes.

Q. Now, in Ms. Clutter's deposition, she testified she was not actually lifting the door of the packing machine, rather that she was holding the door above her head with her left arm and reaching into the machine with her right hand. Is it your opinion that that mechanism of injury could cause the same type of force and stress exfoliation on the shoulder joint?

MR. ANDERSEN: Leading and suggestive.

A. With the description of her injury versus however it occurred, damage by removal of articular surface in joints is usually a combination of compression and forced motion or motion, but usually the motion is forced, so it's joint surface compression in association with a force or pressure that forces the joint out of position and so it's that compressive sheer forces that can have a direct damage to the joint surface.

BY MR. JOSHI:

Q. Would that be inconsistent holding a weighted object above one's head?

MR. ANDERSEN: Objection. It's leading and suggestive and also it assumes facts not in evidence.

A. I think that is very compatible with it. In addition, the type of force that she sustained had to have caused at least a partial subluxation or displacement of her shoulder joint and that in itself is another type of injury that can cause joint surface injuries and also to the labrum.

Dr. Hopkins noted that Dr. Strong did not feel that the process of lifting with the shoulder could cause exfoliation direct damage to the shoulder joint. (Hopkins deposition, page 10). Dr. Hopkins believed “that in contradistinction to that, that that is the case and that is a frequent mechanism of injury.” (Hopkins deposition, page 10).

Dr. Hopkins was asked the following question and gave the following answer at Hopkins deposition, page 11:

Q. But in describing Ms. Clutter’s mechanism of injury, the pop followed by the pain, would that be consistent with a tearing of labrum or sheering of cartilage in the shoulder joint?

A. I believe so, yes.

Dr. Hopkins was asked the following questions at Hopkins deposition, pages 11-13:

Q. Now, with respect to your exam findings, Doctor, and I think they are on page 4 of your first report, the April 5, 2014, report, okay, could you describe these findings and their significance for us?

A. First of all, externally she had a diminution in the muscle mass of her left shoulder. She was right-hand dominant, but I thought that that disparity and muscle mass, which I described as atrophy or for which I felt was atrophy, would be more than one would expect normally. Most of the time people’s shoulder muscles are fairly symmetrical even though their arm or forearm sizes may be different.

Q. Between the dominant and the nondominant hand or arm?

A. Yes. Usually shoulder musculature is fairly symmetrical, and so she had diminished size in her deltoid, the supraspinatus, also in the front chest muscles on the left side. She had painful impingement tests. I describe a Neer and Hawkins impingement tests that were painful, which are very common tests to describe or determine whether tendinopathy is present in the shoulder joint. She had pain

and tenderness over the acromioclavicular and also over the shoulder joint on the left side. I did not find tenderness elsewhere. I described a painful jerk test which is just a nonspecific, abrupt downward distraction of the shoulder which is normally not painful in an average individual, but it's a nonspecific test saying, yes, there is probably something wrong in the shoulder. This girl is in pain.

She had a history of numbness and tingling in her left arm. I looked for that. I looked for the possibility of brachial plexopathy. I could not find it at the shoulder by direct compression of the brachial plexus as it exited over the first rib. She did have loss of significant motion of the left shoulder which I measured in the routine fashion and felt that she had significant loss of motion in the left shoulder and also she had weakness in her shoulder girdle musculature. In association with that, very frequently people will lose grip strength which she also had on the left side, a very significant loss of grip strength.

Q. What about her range of motion?

A. Range of motion was very limited in the left shoulder, yeah.

Dr. Hopkins testified that by the history Claimant gave him and the medical information he had, Claimant did not have any prior shoulder problems. (Hopkins deposition, page 14). He understood her symptoms began on July 15, 2013. (Hopkins deposition, page 14). Claimant indicated to him that her symptoms had been ongoing since the event of July 15, 2013. (Hopkins deposition, page 15). Dr. Hopkins believed that Claimant's symptoms and his findings were consistent with her holding the door above her head. Dr. Hopkins believed that produced a compression and sheer force on her shoulder. (Hopkins deposition, page 15).

Dr. Hopkins did not find any inconsistencies in her examination and findings and in her symptoms and the history she gave him. (Hopkins deposition, page 15). Dr. Hopkins noted that none of Claimant's responses were anatomically inappropriate. (Hopkins deposition, page 16).

Dr. Hopkins was asked the following questions and gave the following answers at Hopkins deposition, pages 17-19:

Q. Now, Doctor, based upon your review of the records, films, findings, your history taken from the claimant, your examination of the claimant, do you have an opinion to a reasonable degree of

medical probability as to whether the event of July 15, 2013, was prevailing factor in causing her condition as it was presented to you on that day and her disability?

A. Yes, I do.

Q. What's your opinion?

A. That the injury that she described to me during her occupation on that date, I believe it was the cause - - the direct and prevailing cause of her left shoulder injury and her current condition.

Q. Now, Doctor, you indicated in your September 15th report that she will likely have to require a shoulder arthroplasty in the future; is that correct?

A. Yes. As a very young person, even though she is right-hand dominant, she has a profoundly injured joint surface in the shoulder. I can't perceive that that shoulder is going to last with any type of reasonable use for the next 40, 50, 60 years.

Q. Doctor, what would your recommendations be for treatment excluding the extreme remedy of a shoulder replacement at this particular time?

A. Give me the question again while I'm looking.

Q. If she's currently symptomatic and she's obviously too young for a shoulder replacement at this time, what would be your recommendation for additional treatment at this time, physical therapy, arthroscopy, injections?

MR. ANDERSEN: Leading and suggestive.

A. Certainly I would agree with you and I think any medical professional would agree with you she's too young for joint replacement at this time. I think physical therapy may have something to offer, but I think first of all she should have another evaluation with an MRI with the possibility of yet an arthroscopic examination to make sure she has no more loose bodies to be removed and that the exercise program, that would be beneficial rather than potentially injurious. Steroid injections are sometimes helpful for a brief period

of time. In addition, even though it's not FDA approved, physical supplementation injections have been performed into the shoulder. In some instances those can provide temporary improvement in shoulder motion and pain, but she is always going to have limited function with that shoulder.

BY MR. JOSHI:

Q. Doctor, we discussed the possibility of arthroscopy with Dr. Strong and she indicated that was a last resort, but if you've gone through noninvasive conservative measures, therapy, cortisone injection without improvement, would it be reasonable to do a diagnostic arthroscopy under anesthesia to remove the loose body, repair the torn labrum at this point in time?

A. I think that would be very beneficial. First of all, loose bodies in a joint can produce additional articular surface damage. They can also block motion. They can also provide instability to the shoulder itself which she already has a result of her labral tear and her joint injury, so I think that would be very beneficial and it has the possibility of delaying progressive joint surface damage.

Dr. Hopkins was asked the following question and gave the following answer at Hopkins deposition, page 21:

Q. I appreciate that, but back to what I said. Is this something that you would have thought that based upon Dr. Strong noting cystic and increased calcifications and irregularities in the four views of the shoulder taken when she saw her on February 14th of 2014, that had those been present, they would have been noted or seen on x-rays on July 17, 2013, two days afterwards?

MR. ANDERSEN: Same objection.

A. I believe that they would be noticeable and go on to comment that when you have exfoliated large pieces of joint surface, that those cystic changes in the shoulder joint can occur in a very short period of time, so the combination of that serious of an abnormality in the shoulder, including loose bodies in the shoulder joint, I have no concept as to how those could have been missed on routine x-rays. I just don't think it would happen.

Dr. Hopkins does not actively operate. (Hopkins deposition, page 22). Ninety to ninety-five percent of his time is spent on doing evaluations for legal purposes. He last did shoulder surgery about 7 years before. (Hopkins deposition, page 23). He normally did open shoulder surgery. (Hopkins deposition, page 24).

Dr. Hopkins saw Claimant on April 5, 2013. The date "April 3" in his report is a typographical error. (Hopkins deposition, page 25).

Claimant reported the history of the mechanism of injury as follows at Hopkins deposition, page 26:

A. She was working on a machine called a Kister which is a machine that boxes and wraps hams. The machine was malfunctioning, and as she was working on an air valve lifting the machine door about the size of a garage door made of plexiglass and metal, she felt a popping sensation in the left shoulder with an onset of pain.

Dr. Hopkins had reviewed records of St. Luke's Health System and reports dated 7/17, 7/23, 7/30, 8/13, and 8/28. He also had the reports of Dr. Miceli of September 24, 2013, October 22, 2013, and November 21, 2013. (Hopkins deposition, page 29). Dr. Hopkins did not have the MRI. He at first testified he had the MRI report. (Hopkins deposition, page 29-30). He later testified that he did not find a radiologist's report of Claimant's left shoulder, only Dr. Miceli's summary. (Hopkins deposition, page 32). He did not have the MRI to review the evaluation. (Hopkins deposition, page 33). Dr. Hopkins testified at pages 31-32 regarding the MRI:

A. I have in my medical record November 21, 2013, that Ms. Clutter had a follow-up visit with Dr. Miceli, that she was forced to have a massage therapist for treatment which made her pain worse. He, Dr. Miceli, described her MRI of the left shoulder. The impression was prominent glenohumeral osteoarthritis for age with cartilage loss, subchondral cystic and reactive changes in the mid inferior glenoid, a 7 millimeter loose body within the suprascapular recess with a probable tear of the anterior/inferior labrum with tiny paralabral cyst described, so that's the information I got on the MRI. Now - -

Claimant gave Dr. Hopkins a history that she sustained an injury on or about July 15, 2013 lifting a door. (Hopkins deposition, page 41).

Dr. Hopkins was asked the following questions and gave the following answers at Hopkins deposition, pages 45-47:

Q. What force is required to make the shoulder move?

A. God, how many can there be?

Q. Just tell me what it was in this lady's case.

A. In this case she had a pressure on the shoulder joint that caused joint compression and obviously the shoulder went out of place where she would not have had labral tear, so the labral tear is caused by displacement of the shoulder joint up to the margin of the socket.

Q. How do you know the labral tear occurred at that moment when she was holding the door overhead with her left arm?

A. Because she had no prior symptoms and labral tears are typically symptomatic and usually due to a traumatic event.

Q. Can they become asymptomatic?

A. I'm sure they can.

Q. What was the size of her labral tear?

A. I don't know. It was never described.

Q. Could you have described it if you saw the MRI?

A. Maybe yes, maybe no. The labral tear is best defined by the person who does the arthroscopy.

Q. Doctor, do you believe the claimant has glenohumeral osteoarthritis, that Ms. Clutter has glenohumeral osteoarthritis?

A. Yes, I do.

Q. Doctor, you mention on page 2 of your September 15, 2014, report that there's no evidence of generalized arthritic condition to suggest there's a medical reason for her left shoulder incapacities and abnormalities on her studies. Are you talking about a systemic arthritic condition?

A. Yes, that was my - -

Q. But people can have arthritis without it being systemic; is that correct?

A. What I'm saying is there was no history or suggestion that for instance she had changes in her left shoulder - - I mean, right shoulder compared to the left, and I had no history of evidence of a generalized arthritic condition that would cause arthritic changes in a joint in general.

Q. Doctor, you mentioned some treatment recommendations for her. Are you recommending a major reconstruction of her left shoulder right now?

A. No. I already answered that question.

Q. Doctor, she's had physical therapy in the past; is that correct?

A. Yes.

Q. The type of treatment for physical therapy you would recommend would be like a home exercise program for her left shoulder?

A. I think one has to be very careful with an exercise program with loose bodies in the joint. I would recommend physical therapy if the loose bodies were removed because motion and stress and lifting and exercises with loose bodies in the joint can be damaging, so at the moment I think that physical therapy is more likely to be a negative approach to her problem with potentially increasing her problem because of the loose bodies.

Q. Doctor, do people have loose bodies in their shoulder that are asymptomatic?

A. Yes. That can happen.

Dr. Hopkins was asked the following questions and gave the following answers at Hopkins deposition, pages 49-50:

Q. Now, Doctor, there's been a bunch of back and forth about when the injury occurred whether she was lifting the door or whether she was holding the door above her head. You agree with me?

A. To me the answer is very clear. It speaks for itself. She had no shoulder problems and during the work of managing some type of door she had an onset of pain in her shoulder, it was immediate, it was abrupt, and at that point in time she had an abnormal shoulder.

Q. Doctor, is it significant to you from a mechanism of injury standpoint, okay, whether the injury occurs while she is actually in the process of lifting the door or whether she is actually holding the door above her head?

A. Again, the mechanism of injury that we just discussed was joint compression. With motion, that motion can be forced or it can be active motion while there's joint compression.

Q. Just so we know, we really don't know how heavy that door was. It was actually an air compression door. I asked what type of stress does holding a weighted object weighing 200 pounds above the shoulder level place on the shoulder and Dr. Strong's report was, I would think some compression and sheer stresses. Is that consistent with what you're saying?

A. That's consistent with my opinion, yes.

Dr. Hopkins's April 5, 2014 report was admitted as Deposition Exhibit 2. Dr. Hopkins examined Claimant on April 5, 2014. His report notes she continued to have shoulder pain. His report describes Claimant's treatment. He notes Claimant's complaints as follows:

The residuals from her left shoulder injury are listed below:

1. The left shoulder hurts and it is sore to use it.
2. Lately (within the last two months), she has been getting numbness and tingling in the left hand indicating the dorsal aspect of her left wrist and hand.
3. "I don't think my shoulder motion is normal."
4. "I don't have much strength in my arm."

With her injury, she has difficulty lifting and carrying or pushing, pulling, or reaching, grasping or grabbing with her left upper extremity. This interferes with her activities of daily living such as doing laundry, putting up clothing or making her bed and at work she

has difficulty lifting and pushing or pulling, holding or reaching with her left arm.

Dr. Hopkins's April 5, 2014 report summarizes the records he reviewed. The report describes results of his physical examination of Claimant.

Dr. Hopkins's April 5, 2014 report sets forth the following Summary and Conclusion:

In summary, based on information available to me, I believe with reasonable degree of medical certainty that Ms. Clutter did sustain an injury to her left upper extremity as a direct and prevailing factor of her injury on or about July 15, 2013, lifting a machine door about the size of a garage door. She has persistent left shoulder pain and with a history given to me of paresthesias into her left arm down to the hand. The symptoms were not commented upon by Dr. Strong.

Ms. Clutter's medical records did not reflect prior left shoulder or left upper extremity injuries or disabilities and she gives me no history of such. Therefore, I believe that it is reasonable that her injury to her left shoulder and left arm are work incurred.

On her physical examination of her shoulder, she has visible atrophy of her shoulder girdle musculature with positive impingement tests with pain and tenderness about the shoulder joint with loss of motion and with loss of shoulder and arm strength. This is not uncommon for shoulder injuries.

In addition, she has a sensory loss in her left arm down to the hand with weakness in her biceps as well as the intrinsic musculature of her left hand suggesting a neurological impairment at the shoulder or above. I cannot with reasonable certainty determine whether her symptoms are coming from associated cervical impingement radiculopathy or a brachial plexus stretch injury, however her symptoms and physical losses began after her injury and treatment for her injury on or about July 15, 2013, without a prior history or left arm losses. Based on this I believe her neurological losses in her left arm are also a direct and prevailing factor of her July 15, 2013 injury.

With these considerations, I believe that Ms. Clutter deserves additional considerations. I believe she should have an examination by an independent orthopedic surgeon in association with an

additional MRI of the left shoulder and I would suggest a contrast MRI. In addition, she should have an electromyographic examination of her left upper extremity to see if additional information can be obtained as to the level of causation of her neurological losses in her left upper extremity.

I believe that her additional evaluations or treatment would depend upon the results of her additional evaluations and testing and the ordering physician's recommendations.

This evaluation is based on information available to me as well as my training and experience as a board certified orthopedic surgeon (see curriculum vitae).

Dr. Hopkins's September 15, 2014 report states as follows:

Subsequent to my examination and report to you on April 5, 2014, I have additionally reviewed the independent medical examination performed by Dr. Alexandra Strong, an orthopedic surgeon. In her report, she discusses various factors regarding Ms. Clutter and renders an opinion that the work-incurred lifting incident that Ms. Clutter sustained on the job on July 15, 2013, was not the cause of the injuries of Ms. Clutter's shoulder. Dr. Strong based this on the description and the mechanism of her lifting injury and felt that it could not cause the symptoms demonstrated on her MRI and X-ray findings.

With all due respect to Dr. Strong, whom I hold in good regard, I respectfully disagree.

I believe there are other considerations that need to be discussed. First of all, Ms. Clutter is 26 years of age and to develop unilateral damage to the articular surface of a shoulder joint at her age is uncommon, and when one sees the extent and severity of the damage to the shoulder, again at her age, the most common factor for causation is trauma.

In addition, Ms. Clutter had no history of prior shoulder difficulties or injuries. In addition, she had been employed by the ConAgra Food Company for approximately three years in the same capacity. I do not believe that a three-year work history in her capacity would be compatible with a preexisting shoulder injury.

The MRI of her shoulder was performed on November 11, 2013, approximately four months after her injury. With the type of injury that Ms. Clutter sustained with a four-month history of physical therapy and an exercise program, this is certainly sufficient time for so-called degenerative changes to occur, but on a posttraumatic basis.

Dr. Strong does not feel that the process of lifting with the shoulder could cause exfoliation and direct damage to the articular surface of her shoulder joint. However, exfoliation and shedding of articular surfaces of joints is usually caused by joint compression in association with motion, which can provide sheer stresses that can separate the articular surface from the underlying skeleton. Certainly, forcibly lifting something with the arm in my opinion can cause this type of injury.

In addition, in her history and on her physical examination, I find no evidence of a generalized arthritic condition to suggest there is a medical reason for her left shoulder incapacities and abnormalities on her studies.

Dr. Strong did not approach the numbness and tingling in Ms. Clutter's right [*sic*] upper extremity.

There are differences in my examination as opposed to Dr. Strong's report in regards to the presence of pain, atrophy, and loss of motion and arm strength.

With all of these considerations, I continue to believe that Ms. Clutter should have additional evaluations. On her physical examination, I could not with accuracy determine the cause of her arm paresthesias. Certainly, a brachial plexopathy is a high suspicion with a cervical impingement radiculopathy less of a consideration. However, on my examination, I could not determine, which were causative. Electromyographic examinations can only differentiate this condition occasionally as the accuracy of the study in this situation is certainly less than 100%.

I believe with a reasonable medical certainty also that Ms. Clutter at some point in time in her life is going to require a major reconstruction of her left shoulder. I believe at the present time that this ultimately will be a left shoulder joint replacement, and because of her age, additional secondary replacements will probably be

required and that this requirement is a direct and prevailing result of her work-incurred injury on or about July 15, 2013.

The statements I have made have been within reasonable medical certainty unless otherwise indicated.

I certify this report is pursuant to Missouri Law.

Rulings of Law

Based on the substantial and competent evidence, the stipulations of the parties, and the application of the Workers' Compensation Law, I make the following Rulings of Law:

1. Did Claimant sustain an injury by accident arising out of and in the course of her employment for Employer on or about July 15, 2013, and 2. Is Claimant's current condition medically causally related to the alleged work accident of July 15, 2013?

Section 287.800, RSMo¹ provides in part that administrative law judges shall construe the provisions of this chapter strictly and shall weigh the evidence impartially without giving the benefit of the doubt to any party when weighing evidence and resolving factual conflicts.

Section 287.808, RSMo provides:

The burden of establishing any affirmative defense is on the employer. The burden of proving an entitlement to compensation under this chapter is on the employee or dependent. In asserting any claim or defense based on a factual proposition, the party asserting such claim or defense must establish that such proposition is more likely to be true than not true.

Section 287.020.2, RSMo provides:

¹ All statutory references are to RSMo 2006 unless otherwise indicated. In a workers' compensation case, the statute in effect at the time of the injury is generally the applicable version. *Chouteau v. Netco Construction*, 132 S.W.3d 328, 336 (Mo.App. 2004); *Tillman v. Cam's Trucking Inc.*, 20 S.W.3d 579, 585-86 (Mo.App. 2000). See also *Lawson v. Ford Motor Co.*, 217 S.W.3d 345 (Mo.App. 2007).

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.

Section 287.020.3, RSMo provides in part:

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.

(2) 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 nonemployment life.

(3) An injury resulting directly or indirectly from idiopathic causes is not compensable.

(5) The terms 'injury' and 'personal injuries' shall mean violence to the physical structure of the body. . . .

Section 287.020.10, RSMo provides:

In applying the provisions of this chapter, it is the intent of the legislature to reject and abrogate earlier case law interpretations on the meaning of or definition of 'accident', 'occupational disease', 'arising out of', and 'in the course of the employment' to include, but not be limited to, holdings in: *Bennett v. Columbia Health Care and Rehabilitation*, 80 S.W.3d 524 (Mo.App. W.D. 2002); *Kasl v. Bristol Care, Inc.*, 984 S.W.2d 852 (Mo.banc 1999); and *Drewes v. TWA*, 984 S.W.2d 512 (Mo.banc 1999) and all cases citing, interpreting, applying, or following those cases.

The workers' compensation claimant bears the burden of proof to show that her injury was compensable in workers' compensation. *Johme v. St. John's Mercy Healthcare*, 366 S.W.3d 504, 2012 WL 1931223 (Mo. banc 2012) (citing *Sanderson v. Producers Comm'n Ass'n*, 360 Mo. 571, 229 S.W.2d 563, 566 (Mo. 1950)).

“In a workers' compensation case, the claimant carries the burden of proving all essential elements of the claim.” *Fischer v. Archdiocese of St. Louis*, 793 S.W.2d 195, 198 (Mo.App. 1990).

Where there are conflicting medical opinions, the fact finder may reject all or part of one party's expert testimony which it does not consider credible and accept as true the contrary testimony given by the other litigant's expert. *Kelley v. Banta & Stude Constr. Co. Inc.*, 1 S.W.3d 43, 48 (Mo.App. 1999); *Webber v. Chrysler Corp.*, 826 S.W.2d 51, 54 (Mo.App. 1992); *Hutchinson v. Tri-State Motor Transit Co.*, 721 S.W.2d 158, 162 (Mo.App. 1986). The Commission's decision will generally be upheld if it is consistent with either of two conflicting medical opinions. *Smith v. Donco Const.*, 182 S.W.3d 693, 701 (Mo.App. 2006). The acceptance or rejection of medical evidence is for the Commission. *Smith*, 182 S.W.3d at 701; *Bowers v. Hiland Dairy Co.*, 132 S.W.3d 260, 263 (Mo.App. 2004).

The testimony of Claimant or other lay witnesses as to facts within the realm of lay understanding can constitute substantial evidence of the nature, cause, and extent of disability when taken in connection with or where supported by some medical evidence. *Pruteanu v. Electro Core, Inc.*, 847 S.W.2d 203, 206 (Mo.App. 1993), 29; *Reiner v. Treasurer of State of Mo.*, 837 S.W.2d 363, 367 (Mo.App. 1992); *Fischer*, 793 S.W.2d at 199. The trier of facts may also disbelieve the testimony of a witness even if no contradictory or impeaching testimony appears. *Hutchinson*, 721 S.W.2d at 161-2; *Barrett v. Bentzinger Brothers, Inc.*, 595 S.W.2d 441, 443 (Mo.App. 1980). The testimony of the employee may be believed or disbelieved even if uncontradicted. *Weeks v. Maple Lawn Nursing Home*, 848 S.W.2d 515, 516 (Mo.App. 1993).

The Commission may not arbitrarily disregard and ignore competent, substantial, and undisputed evidence of witnesses who are not shown by the record to have been impeached and the Commission may not base its findings upon conjecture or its own mere personal opinion unsupported by sufficient and competent evidence. *Cardwell v. Treasurer of State of Missouri*, 249 S.W.3d 902, 907 (Mo.App. 2008), citing *Copeland v. Thurman Stout, Inc.*, 204 S.W.3d 737, 743 (Mo.App. 2006).

8 CSR 50–2.010(14) states in part, “Prior to hearing, the parties shall stipulate uncontested facts and present evidence only on contested issues.” Such stipulations “are controlling and conclusive, and the courts are bound to enforce them.” *Hutson v.*

Treasurer of Missouri as Custodian of Second Injury Fund, 2012 WL 1319428 (Mo.App. 2012) (citing *Boyer v. Nat'l Express Co.*, 29 S.W.3d 700, 705 (Mo.App. 2001)).

I find Claimant credibly testified that while she was working for Employer on July 15, 2013, she lifted a door weighing about two hundred pounds, and while she held the door above her head she felt a pop in her left shoulder. She had pain in her left shoulder that was an eight out of ten immediately after this happened. She reported the injury to her supervisor about an hour later. Claimant's mother was at Claimant's home when she got home from work, and Claimant's mother observed Claimant's expression of left shoulder pain. She gave Claimant ice for her shoulder.

Claimant reported the injury at work the next day, and Employer sent her for treatment at Wright Memorial Hospital. A July 23, 2013 treatment record notes Claimant was at work at Employer, was pulling on a piece of equipment when she heard a pop in her left shoulder, had pain which got worse rapidly, and it had been quite painful ever since.

Claimant was put on light duty work due to restrictions. Claimant saw Dr. Miceli because of continuing shoulder complaints. He ordered an MRI on November 11, 2013 that revealed, "Prominent glenohumeral osteoarthritis for age with cartilage loss and subchondral cystic and reactive changes within the mid to inferior glenoid. 7 mm loose body within the subscapular recess. Degeneration and probable tear of the anteroinferior labrum with tiny paralabral cyst."

Claimant has had continuous left shoulder pain since July 15, 2013. She has difficulty lifting with her left arm.

Claimant was evaluated by Dr. Strong at Employer's request on February 14, 2014. Dr. Strong's February 19, 2014 report states in part:

By MRI and x-ray, it appears that she has degenerative changes of her shoulder. It seems somewhat unusual for a person of this age to have that. Further medical work-up may be indicated. However, I do not believe that this is related to a work injury from 7/15/13. From her description of the injury and the mechanism, I do not believe that work episode could have caused her symptoms and her MRI and x-ray findings. Therefore, I believe that within a reasonable degree of medical certainty, her work episode in 2013 is not the prevailing factor or cause of her current shoulder symptoms.

Dr. Strong testified that she did not believe Claimant's either lifting the door or holding the door over her head with her left arm would be the prevailing

factor in causing the problems with her left shoulder. I find this opinion of Dr. Strong is not credible or persuasive.

Dr. Strong testified that holding a weighted object weighing 200 pounds above the shoulder level would put some compression and sheer stresses across the humeral, glenohumeral socket of the shoulder.

Dr. Strong testified that Claimant's pop in her left shoulder could be the labrum tearing. Although Dr. Strong thought Claimant has underlying degenerative changes that predated the date of her injury, she did not know whether Claimant caused more damage to her articular surface at the moment she had the pop.

Dr. Strong stated she was not saying that four months was not long enough for someone for degenerative changes to occur in a joint, particularly on a post-traumatic basis. She stated that the degenerative changes in Claimant's shoulder could have been made worse from the pop in her shoulder as Claimant described.

Dr. Strong was not able to rule out the accident that Claimant described is the cause of the seven millimeter loose body noted in her report. She was not saying that the accident was not the prevailing factor in the loose body or the labral tear. She was not able to rule out that the accident was the cause of the labral tear. She could not be certain that the loose body was caused when Claimant was holding up the door with her left arm.

Dr. Strong agreed that Claimant denied prior symptoms in her left shoulder, that her symptoms began on July 15, 2013, that she has had symptoms in her shoulder since that time, and that Claimant has testified to functional difficulty since that time period.

Dr. Hopkins believed the injury that Claimant described to him during her occupation on July 15, 2013 was the direct and prevailing cause of her left shoulder injury and her current condition. I find this opinion of Dr. Hopkins is credible and persuasive.

Dr. Hopkins noted Claimant externally had a diminution in the muscle mass of her left shoulder. She had painful impingement tests. He noted she had loss of motion of the left shoulder and weakness in her shoulder girdle musculature. He noted Claimant did not have any prior shoulder problems.

Dr. Hopkins testified that by the history Claimant gave him and the medical information he had, Claimant did not have any prior shoulder problems. He understood her symptoms began on July 15, 2013. Claimant indicated to him that her symptoms had been ongoing since the event of July 15, 2013. Dr. Hopkins believed that Claimant's symptoms and his findings were consistent with her holding the door above her head. Dr.

Hopkins believed that produced a compression and sheer force on her shoulder. I find this opinion of Dr. Hopkins is credible and persuasive.

Dr. Hopkins testified damage by removal of articular surface in joints is usually a combination of compression and forced motion or motion and would be very compatible with holding a weighted object above one's head. He believed Claimant's description of the mechanism of injury, the pop followed by the pain, would be consistent with a tearing of labrum or sheering of cartilage in the shoulder joint. He stated he knew the labral tear occurred at the moment when Claimant was holding the door overhead with her left arm because she had no prior symptoms and labral tears are typically symptomatic and are usually due to a traumatic event. I find these opinions of Dr. Hopkins are credible and persuasive.

Dr. Hopkins stated exfoliation and shedding of articular surfaces of joints is usually caused by joint compression in association with motion, which can provide sheer stresses that can separate the articular surface from the underlying skeleton. He stated forcibly lifting something with the arm can cause this type of injury. He also noted in Claimant's history and on her physical examination, he found no evidence of a generalized arthritic condition to suggest there is a medical reason for her left shoulder incapacities and abnormalities on her studies.

Employer argues Dr. Hopkins's opinions are less credible than Dr. Strong's because they are allegedly premised on Claimant's inconsistent testimony regarding the mechanism of injury. I disagree. It was not significant to Dr. Hopkins from a mechanism of injury standpoint whether Claimant's injury occurred while she was actually in the process of lifting the door or whether she was actually holding the door above her head, because the mechanism of injury was joint compression.

Employer argues that Dr. Hopkins's findings and opinions are questionable because he did not review the MRI or MRI report. I disagree. Dr. Hopkins did review the results of the MRI report as noted in page 36 of this Award. He reviewed Dr. Miceli's November 21, 2013 record that contains the results of the MRI.

I find the opinions of Dr. Hopkins are more credible and persuasive than the opinions of Dr. Strong regarding whether Claimant's work for Employer was the prevailing factor in causing her left shoulder condition.

I find and conclude that on July 15, 2013, while working for Employer, Claimant lifted a door weighing about two hundred pounds and while she held the door above her head she felt a pop in her left shoulder, had pain in her left shoulder, and she injured her left shoulder. I find and conclude that this was an unexpected traumatic event 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.

I find and conclude that Claimant's current left shoulder condition is medically causally related to the alleged work accident of July 15, 2013.

I find and conclude that on July 15, 2013, Claimant sustained a compensable injury to her left shoulder by accident arising out of and in the course of her employment for Employer and that the accident was the prevailing factor in causing both the resulting medical condition and disability.

3. *What is Employer's liability, if any, for additional medical aid?*

Claimant is requesting an award of additional medical aid. Section 287.140, RSMo requires that the employer/insurer provide "such medical, surgical, chiropractic, and hospital treatment ... as may reasonably be required ... to cure and relieve [the employee] from the effects of the injury." This has been held to mean that the worker is entitled to treatment that gives comfort or relieves even though restoration to soundness [a cure] is beyond avail. *Bowers v. Hiland Dairy Co.*, 132 S.W.3d 260, 266 (Mo.App. 2004). Medical aid is a component of the compensation due an injured worker under Section 287.140.1, RSMo. *Bowers*, 132 S.W.3d at 266; *Mathia v. Contract Freighters, Inc.*, 929 S.W.2d 271, 277 (Mo.App. 1996). The employee must prove beyond speculation and by competent and substantial evidence that his or her work related injury is in need of treatment. *Williams v. A.B. Chance Co.*, 676 S.W.2d 1 (Mo.App. 1984). Conclusive evidence is not required. *Farmer v. Advanced Circuitry Division of Litton*, 257 S.W.3d 192, 197 (Mo. App. 2008); *Bowers*, 132 S.W.3d at 270; *Landers v. Chrysler Corp.*, 963 S.W.2d 275, 283 (Mo.App. 1997).

It is sufficient if Claimant shows by reasonable probability that he or she is in need of additional medical treatment. *Tillotson v. St. Joseph Medical Center*, 347 S.W.3d 511, 524 (Mo.App. 2011); *Farmer*, 257 S.W.3d at 197; *ABB Power T & D Co. v. Kempker*, 236 S.W.3d 43, 53 (Mo. App. 2007); *Bowers*, 132 S.W.3d at 270; *Mathia*, 929 S.W.2d at 277; *Downing v. Willamette Industries, Inc.*, 895 S.W.2d 650, 655 (Mo.App. 1995); *Sifferman v. Sears, Roebuck and Co.*, 906 S.W.2d 823, 828 (Mo.App. 1995). "Probable means founded on reason and experience which inclines the mind to believe but leaves room to doubt." *Tate v. Southwestern Bell Telephone Co.*, 715 S.W.2d 326, 329 (Mo.App. 1986); *Sifferman* at 828. Section 287.140.1, RSMo does not require that the medical evidence identify particular procedures or treatments to be performed or administered. *Tillotson*, 347 S.W.3d 525; *Forshee v. Landmark Excavating & Equipment*, 165 S.W.3d 533, 538 (Mo. App. 2005); *Talley v. Runny Meade Estates, Ltd.*, 831 S.W.2d 692, 695 (Mo.App. 1992); *Bradshaw v. Brown Shoe Co.*, 660 S.W.2d 390, 394 (Mo.App. 1983).

The type of treatment authorized can be for relief from the effects of the injury even if the condition is not expected to improve. *Farmer*, 257 S.W.3d at 197; *Bowers*, 132 S.W.3d at 266; *Landman v. Ice Cream Specialties, Inc.*, 107 S.W.3d 240, 248 (Mo.banc 2003). Future medical care must flow from the accident, via evidence of a medical causal relationship between the condition and the compensable injury, if the employer is to be held responsible. *Bowers v. Hiland Dairy Co.*, 188 S.W.3d 79, 83 (Mo.App. 2006). Once it is determined that there has been a compensable accident, a claimant need only prove that the need for treatment and medication flow from the work injury. *Id*; *Tillotson*, 47 S.W.3d 519.

The court in *Tillotson v. St. Joseph Medical Center*, 347 S.W.3d 511, 2011 WL 2313691 (Mo.App. 2011) states at 524:

To receive an award of future medical benefits, a claimant need not show ‘conclusive evidence’ of a need for future medical treatment.” *Stevens*, 244 S.W.3d at 237 (quoting *ABB Power T & D Co. v. Kempker*, 236 S.W.3d 43, 52 (Mo.App.W.D.2007)). “Instead, a claimant need only show a ‘reasonable probability’ that, because of her work-related injury, future medical treatment will be necessary. A claimant need not show evidence of the specific nature of the treatment required. *Id*.

The court in *Tillotson* also states at 525:

In summary, we conclude that once the Commission found that Tillotson suffered a compensable injury, the Commission was required to award her compensation for medical care and treatment reasonably required to cure and relieve her compensable injury, and for the disabilities and future medical care naturally flowing from the reasonably required medical treatment.

Claimant continues to have left shoulder pain. She wants further medical treatment for her left shoulder.

Dr. Strong stated that further medical work-up may be indicated. I find this opinion of Dr. Strong is credible and persuasive. Dr. Strong recommended Claimant start with anti-inflammatories and physical therapy, and perhaps an intra-articular injection. She stated arthroscopy would be the last resort. She also testified if conservative therapy, injections, and anti-inflammatories fail to relieve the symptoms, arthroscopy would not be unreasonable.

Dr. Strong does not believe that the indication for further medical work-up is related to a work injury from July 15, 2013. I find this opinion of Dr. Strong is not credible or persuasive. I have previously found and concluded that Claimant's current left shoulder condition is medically causally related to the alleged work accident of July 15, 2013 and that the accident was the prevailing factor in causing the resulting medical condition.

Dr. Hopkins believes that Claimant should have additional evaluations. He testified physical therapy may have something to offer Claimant, but first of all Claimant should have another evaluation with an MRI with the possibility of an arthroscopic examination to make sure she has no more loose bodies to be removed, and that the exercise program, would be beneficial rather than potentially injurious. He noted steroid injections are sometimes helpful for a brief period of time. He stated Claimant is too young for joint replacement at this time. I find these opinions of Dr. Hopkins are credible and persuasive.

Dr. Hopkins testified if you have gone through noninvasive conservative measures, therapy, cortisone injection without improvement, it would be very beneficial to do a diagnostic arthroscopy under anesthesia to remove the loose body, repair the torn labrum at this point in time because loose bodies in a joint can produce additional articular surface damage, they can also block motion, and they can also provide instability to the shoulder. I find this opinion of Dr. Hopkins is credible and persuasive.

I find the opinions of Dr. Hopkins are more credible and persuasive than the opinions of Dr. Strong regarding whether Claimant needs additional treatment for her July 15, 2013 left shoulder injury.

Based on competent and substantial evidence and the application of the Missouri Workers' Compensation Law, I find Claimant will need additional medical aid to cure and relieve her from the effects of her July 15, 2013 compensable injury.

Employer is directed to authorize and furnish additional medical treatment to cure and relieve Claimant from the effects of her July 15, 2013 injury, in accordance with section 287.140, RSMo.

Attorneys Fees

Claimant's attorney is entitled to a fair and reasonable fee in accordance with Section 287.260, RSMo. An attorney's fee may be based on all parts of an award, including the award of medical expenses. *Page v. Green*, 758 S.W.2d 173, 176 (Mo.App. 1988). During the hearing, and in Claimant's presence, Claimant's attorney requested a fee of 25% of all benefits to be awarded. Claimant did not object to that request. I find

Claimant's attorney is entitled to and is awarded an attorney's fee of 25% of all amounts awarded for necessary legal services rendered to Claimant. The compensation awarded to 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 Claimant: Michael J. Joshi.

The parties stipulated the issue of Employer's liability for partial disability benefits was not to be determined in connection with the November 7, 2014 hearing, and that issue has not been determined.

This award is only temporary or partial, is subject to further order, and the proceedings are hereby continued and the case kept open until a final award can be made.

Made by: /s/ Robert B. Miner
Robert B. Miner
Administrative Law Judge
Division of Workers' Compensation