

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

Injury No.: 01-036727

Employee: Lana Cooper
Employer: Scott County Ambulance District
Insurer: Missouri Employer's Mutual
Additional Party: Treasurer of Missouri as Custodian
of Second Injury Fund (Open)
Date of Accident: Alleged April 2, 2001
Place and County of Accident: Alleged Scott County, Missouri

The above-entitled workers' compensation case is submitted to the Labor and Industrial Relations Commission for review as provided by section 287.480 RSMo. Having reviewed the evidence and considered the whole record, the Commission finds that the award of the administrative law judge is supported by competent and substantial evidence and was made in accordance with the Missouri Workers' Compensation Act. Pursuant to section 286.090 RSMo, the Commission affirms the award and decision of the administrative law judge dated December 9, 2005, and awards no compensation in the above-captioned case.

The award and decision of Associate Administrative Law Judge Lawrence C. Kasten, issued December 9, 2005, is attached and incorporated by this reference.

Given at Jefferson City, State of Missouri, this _____13th_____ day of June 2006.

LABOR AND INDUSTRIAL RELATIONS COMMISSION

William F. Ringer, Chairman

Alice A. Bartlett, Member

John J. Hickey, Member

Attest:

Secretary

ISSUED BY DIVISION OF WORKERS' COMPENSATION

AWARD

Employee: Lana Cooper

Injury No. 01-036727

Employer: Scott County Ambulance District.

Additional Party: Second Injury Fund

Insurer: Missouri Employer's Mutual

Hearing Date: June 20, 2005.

SUMMARY OF FINDINGS

1. Are any benefits awarded herein? No.
2. Was the injury or occupational disease compensable under Chapter 287? Yes.
3. Was there an accident or incident of occupational disease under the Law? Yes.
4. Date of accident or onset of occupational disease? On April 2, 2001
5. State location where accident occurred or occupational disease contracted: Scott County, Missouri.
6. Was above employee in employ of above employer at time of alleged accident or occupational disease? Yes.
7. Did employer receive proper notice? Yes.
8. Did accident or occupational disease arise out of and in the course of the employment? Yes.
9. Was claim for compensation filed within time required by Law? Yes.
10. Was employer insured by above insurer? Yes.

11. Describe work employee was doing and how accident happened or occupational disease contracted: Lifting Patient.
11. Did accident or occupational disease cause death?. No.
12. Parts of body injured by accident or occupational disease: Mid and Low back.
13. Nature and extent of any permanent disability: None.
14. Compensation paid to date for temporary total disability: \$262.43
15. Value necessary medical aid paid to date by employer-insurer? \$996.53.
16. Value necessary medical aid not furnished by employer-insurer? N/A
17. Employee's average weekly wage: \$393.70
18. Weekly compensation rate: \$262.47
19. Method wages computation: By agreement.
20. Amount of compensation payable: None.

TOTAL: None.

Second Injury Fund liability: N/A Future requirements awarded: None.

Said payments to begin (see findings) and be payable and be subject to modification and review as provided by law.

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

FINDINGS OF FACT AND RULINGS OF LAW

On, June 20, 2005, the employee, appeared in person and by her attorney, Kim Heckemeyer for a hearing for a final award. The employer-insurer was represented at the hearing by its attorney, Mark Lanzotti. The employee had filed a claim against the Second Injury Fund but the claim was left open and was not part of the hearing. At the time of the hearing, the parties agreed on certain undisputed facts and identified the issues that were in dispute. These undisputed facts and issues, together with a summary of the evidence and the findings of fact and rulings of law, are set forth below as follows:

UNDISPUTED FACTS:

1. On or about April 2, 2001, Scott County Ambulance District was a covered employer operating under and subject to the provisions of the Missouri Workers' Compensation Act and its liability was fully insured by Missouri Employer's Mutual.
2. On or about April 2, 2001, Lana Cooper was an employee of Scott County Ambulance District and was working under the Missouri Workers' Compensation Act.
3. On or about April 2, 2001, the employee sustained an accident arising out of and in the course of her employment.
4. The employer had notice of the employee's accident as required by law.
5. The employee's average weekly wage \$393.70. The employee's rate of compensation for temporary total disability and permanent partial disability is \$262.47.
6. The employee is not making any claim for temporary total disability. All of the temporary total disability has been paid but there is a dispute as to which files the payments were for.

The parties agreed that all of the medical bills are paid. There is a dispute as to how much was paid for the April 2, 2001 injury. The employee is not making a claim for any previously incurred medical. The court took judicial notice of the contents of this file. The court took judicial notice of the contents of file No. 01-046494 where a report of injury was filed with a date of injury listed of May 7, 2001 and file No. 01-080159 where a report of injury with an injury date of July 29, 2001. The Division administratively closed those two files.

ISSUES:

1. Statute of Limitations
2. Medical causation
3. Permanent partial disability

EXHIBITS:

Employee's Exhibits

- A. Medical records
- B. Medical payments received by Harrison Chiropractic Center
- C. Report of Dr. James Palen

Employer-Insurer Exhibits

1. Wage statement of employee
2. Reports of injury and payments made by the employer-insurer in this case and also in the files with the date of injury of May 7, 2001 and July 29, 2001.
3. Medical Records of Health Facilities Rehab Service
4. Medical records of Dr. Sampson
5. Medical records of Restart Physical Therapy
6. Medical records of Orthopedic Associates
7. Medical records of Dr. Harrison
8. Medical records of Dr. Wayne
9. Medical records of Dr. Stone in 2001 and medical records of Dr. Stone in 2002

SUMMARY OF THE EVIDENCE:

Testimony of the Employee:

The employee is 35 years old. Prior to becoming an EMT she worked in residential care and at Wal-Mart. She starting working at South Scott Ambulance beginning in November of 1997 and worked until November of 2003. She has had several prior work related injuries. In 1991, she broke her ankle at Wal-Mart. In 1999 she injured her left knee lifting a heavy patient at Scott County Ambulance. She ultimately had three surgeries to her knee.

On April 2, 2001, she had a work related injury when she was called to Haywood City to assist a heavy male. She and her partner lifted him into an ambulance. As soon as they lifted the stretcher, she felt extreme pain in her low back and left leg. She was in excruciating pain. The employee was treated in the emergency room. She had pain in her low back that was shooting down her left leg into her foot. She was ordered off work, and to follow-up with Dr. Stone.

The follow-up visit was with Dr. Stone's nurse practitioner, Lisa Colwick. The employee had low back pain radiating down the left leg into her foot. She was continued off work, was prescribed pain medication, muscle relaxers and physical therapy. She then saw Dr. Stone on April 12. On that day, the employee lied to Dr. Stone and told him she was fine, so she could go back to work. She was still in pain. Dr. Stone released her to full duty. After her return to work she continued to take pain medications and applied heat and ice. When she worked a 24-hour shift, she would lie down in her room when she was not on a call. During the month of April 2001, she had a hard time doing her job. She still had severe low back pain, numbness and pain down her left leg. From April 12 until May 7, she did not miss any time from work.

On May 7, 2001, there was an incident. She and her partner responded to a large patient who weighed over 400 pounds. It happened at a Sikeston nursing home. While trying to lift the patient from the floor she was again in excruciating pain and felt a pop. They moved the patient onto a backboard and lifted the backboard to a stretcher. She had the same pain as she had since April, but at that moment it was unbearable and worsened. The patient was taken to Missouri Delta Medical Center. She did not assist in moving the patient from the ambulance to the hospital. She reported the injury to her supervisor who was Herman Sadler. She was treated at Missouri Delta due to severe pain in her low back and down her left leg. She was provided pain relief and x-rays were taken.

Dr. Stone then treated her due to continued severe pain in her low back, which radiated down her left leg. Her complaints were the same as the April of 2001 incident. Dr. Stone prescribed pain medication, muscle relaxers, therapy, and an MRI. Dr. Stone took her off work and referred her to Dr. Kapp, an orthopedic surgeon. She told Dr. Kapp that she had previously injured her back the month before and it was the same ongoing symptoms that she had aggravated, and it was the same pain in the same area. She told him that she had pain in her low back, which radiated down her left leg. Dr. Kapp ordered therapy. When she returned to Dr. Kapp, he released her to full duty with no restrictions. On the day she was released she still had the same pain in her low back and left leg. She did not tell him the truth about her complaints and told him that her back was better.

She had a subsequent injury on July 28, 2001, when she responded to a very large patient. The patient was in the floor at a residence in Sikeston. She and her partner rolled the patient to a backboard and lifted. When they lifted the patient from the floor to a cot she had severe pain down her left leg and sharp tingling. It was the same pain as in April of 2001, which was made worse. They drove the patient to Missouri Delta, but she did not assist moving the patient from the ambulance to the hospital. The employee was treated the same date at Missouri Delta. She had severe low back pain radiating down her left leg. She was given pain management, had x-rays, and was taken off work.

She was referred to Dr. Trueblood an orthopedic surgeon. Before her appointment, she had a lot of problems. She called her office manager who sent an ambulance to her house and she was taken to St. Francis Medical Center. She was admitted with severe low back pain, numbness and pain down her left leg. She had pain medication and was given a pain block while under Dr. Trueblood's care. She was in the hospital for 5 days. After she was discharged, she had physical therapy and continued to be off work.

Her employee sent her for treatment in St. Louis. She had x-rays and a myelogram. She also saw Dr. Harrison a chiropractor due to severe pain down her low back and leg, which were the same complaints as she had in April of 2001.

Prior to April of 2001, she had no low back or leg pain. Her current complaints are the same, which is low back pain numbness and tingling down her left leg. Her low back pain is at least 7 out of 10. To get relief, she lies down and alternates heat and ice, and takes Tylenol P.M. at night and regular Tylenol through the day. She has trouble doing laundry, keeping her house clean, and playing with her 10-year old daughter. She no longer participates in swimming, camping, fishing, or volleyball. She only sleeps for about three hours a night due to pain in low back and leg. Her low back interferes with her sitting, and after driving for a short period she is in excruciating pain in low back and left leg to foot.

During cross-examination, the employee testified that she has not worked since 2002. She is not relating any neck pain, right shoulder, or knee pain to this claim. They are from prior claims. She recalled her deposition being taken on August 11, 2003. On Page 31 of the deposition, she was asked if her back claim had resolved itself, and she answered yes.

The employee testified in direct that she lied to Dr. Stone and Dr. Kapp when she said her back was better. When asked during cross, if she lied to any other health care providers, she testified that if it concerned going back to work before she was supposed to, she is sure that she did. She would lie to the doctors so she could go to work but she really was not better. Other than those incidents with Dr. Stone and Dr. Kapp, she makes a habit of fully disclosing all information to her treating physicians and tells them what is wrong and how she feels.

With regard to what Dr. Stone wrote on April 12, 2001, "patient presents today with complete improvement of the discomfort in her lower spine, she has no persisting symptoms or discomfort. Patient indicates she is ready to return to her normal duties." This is in Employer-Insurer Exhibit 9-A. She stated that is the lie she is talking about. That is what she told Dr. Stone that day, and he discharged her from care and returned her to normal duties.

The employee testified in direct that her pain has been consistent and ongoing from the April injury to the present. During cross, the employee reviewed, Employer-Insurer Exhibit 7, which are the records of Dr. Harrison. She stated that she signed the accident and injury report, which shows the date of accident as July 28, 2001. She also signed the Confidential Patient Injury, which also shows that the date of accident as July 28. She testified that nothing in the records that she filled out that shows her problems have been going on since April of 2001.

The employee testified that she informed Dr. Kapp of the April injury. She agreed that in his June 1, 2001 record that there is no mention of the April incident. The employee testified that her lie to Dr. Kapp is in his June 19, 2001 record that says the employee had no further pain except occasional pain in the SI joint. He stopped physical therapy and released her to full duty.

During redirect, the employee testified that she told Dr. Stone and Dr. Trueblood that the problems completely resolved, and when asked why she lied, she stated that she was a single mother, and that her job was her only income and she had to support her child. During recross, the employee testified that due to her prior knee surgeries, she was off work and received temporary total disability benefits but it was not enough to pay her bills.

Medical Records:

On April 4, 2001, the employee went to the emergency room at Missouri Delta Medical Center due to middle and lower back pain after lifting a patient. The employee had spasms in the lumbar spinal region with no radiation and negative straight leg raises. The employee's pain was 10 out of 10. Dr. Reese diagnosed a lumbar strain. The employee was kept off work. She was to follow up with the company physician. (Employee Exhibit A-4 and Employer-Insurer Exhibit 10)

On April 6, the employee saw nurse practitioner Lisa Colwick. The employee stated that she was pulling up on a patient and hurt her back. The employee had muscle spasms of the paravertebral muscles of the lower

thoracic and lumbar regions. The straight leg raises were negative and the heel and toe walking was within normal limits. The assessment was thoracic and lumbar strain. The employee was put on light duty. The injury report shows a date of injury of April 2, 2001. Dr. Stone saw the employee on April 12. He noted that the employee presented with a complete improvement of the discomfort in her lower spine. She had no persisting stiffness or discomfort. The employee indicated that she was ready to return to her normal duties. Dr. Stone noted that the employee had full range of motion of her lumbar spine with no tenderness. The deep tendon reflexes were brisk, her sensation intact and she had normal strength. His assessment was lumbar strain resolved. Dr. Stone discharged the employee and returned her to normal duties. (Employee Exhibit A-2 and Employer-Insurer Exhibit 9-A)

The next treatment for the employee's low back was at the emergency room at Missouri Delta Medical Center on May 7, 2001. The record showed that it was a workers' compensation injury. The employee had pain in her buttocks and down her left leg from going down steps with a patient on a stretcher. The pain scale was 10 out of 10 with tingling in the left leg. The nurse's narrative note stated that the accident had happened approximately 45 minutes ago. Dr. Angelos took the employee off work and assessed a lumbar strain. (Employee Exhibit A-4 and Employer-Insurer Exhibit 10)

On May 11 the employee saw nurse practitioner Colwick for a work related injury. The employee stated that as she was moving a patient she heard something pop in her back. After that she had excruciating pain to her lower back and left buttocks which had been radiating down the back of her leg and at times felt tingly. She has been unable to stand or sit for very long periods of time. The employee had extreme tenderness of the muscles of the lower lumbar region on the left. The straight leg raises were positive. Heel walking was extremely difficult. The range of motion was only approximately 25% with forward lateral bending due to pain. The diagnosis was lumbar strain and radiculopathy. She was scheduled for an MRI of the lumbar spine and taken off work. She was prescribed Vicodin, Motrin and Soma. The employee injury report has May 7 as the date of injury. (Employee Exhibit A-2 and Employer-Insurer Exhibit 9-A)

The employee saw Dr. Stone on May 18 with continued severe discomfort in the left lower back radiating into the left leg. Dr. Stone noted that the MRI was essentially negative. The employee had numbness along the lateral aspect of the thigh, calf and foot. Dr. Stone's impression was nerve compression and piriformis syndrome. He ordered therapy, a medrol dose pack, continued Lorcet, and continued the employee off work. (Employee Exhibit A-2 and Employer-Insurer Exhibit 9-A)

The employee went to physical therapy at Restart beginning May 21. It was noted that the employee injured her back on May 7 when she felt a pop when carrying a stretcher downstairs. The employee had pain and tingling in her leg that was worse at night. In the evaluation summary, it shows that the onset date as May 7. The employee had low back pain with radiculopathy. (Employer-Insurer Exhibit 5).

On May 31, Dr. Stone noted that the employee continued to have radicular symptoms down her left leg to the left foot. Dr. Stone thought she was having radicular symptoms from nerve compression and recommended an injection of Cortisone. The employee was sent to Dr. Kapp. (Employee Exhibit A-2 and Employer-Insurer Exhibit 9-A)

The employee saw Dr. Kapp on June 1 with pain in her left SI joint, which radiated down to her left buttock. The employee stated that on May 7, she was lifting a patient going down steps while working as an EMT, when she felt a pop in her low back. The MRI evaluation of her lumbar spine showed no evidence of internal disc disruption. Dr. Kapp's assessment was left SI joint dysfunction with mild left lower extremity radiculopathy. He placed her on Neurotin and Voltaren and ordered therapy. (Employee Exhibit A-3 and Employer-Insurer Exhibit 6)

The physical therapy visit on June 11 showed that the employee was feeling better, but still felt like she would get a catch in her left back and hip when she bent too far forward. (Employer-Insurer Exhibit 5). On June 19 Kapp noted the employee had no further pain except for an occasional pain in her SI joint. Her SI joint appeared to be well aligned. He stopped physical therapy and released her to full duty without restrictions and scheduled a return visit in one month. On July 17, the employee did not appear for her follow up appointment. (Employee Exhibit A-3 and Employer-Insurer Exhibit 6)

On July 28, 2001, the employee went to the Missouri Delta Medical Center emergency room. It was noted that she has had problems with sacroiliitis and has had recurrent spasms. While moving a patient that day the employee had severe pain and spasms in her left lower back. After moving the patient in the emergency room she was unable to move initially. Her pain was 10 out of 10. The physical exam showed that the employee was quite uncomfortable and had marked discomfort with range of motion problems in her left leg due to pain. She had marked spasms and the doctor could not completely examine her due to her inability to move. The initial plan was to admit her to the hospital for pain control but since the employee did not want that, she was discharged to follow up with her primary care physician. The workers' compensation employee work status report showed an injury date of July 28. The cause of injury was lifting a patient. (Employee Exhibit A-4 and Employer-Insurer Exhibit 10)

The employee saw Dr. Trueblood on July 30 with acute low back and left lower extremity pain and constant tingling in her left foot. The date of injury was shown as July 28, the duration of the symptoms was 2 days, and the mechanism of the injury was on the job. The employee squatted down to release the wheels of a stretcher and when she stood up she felt a pop in her low back. She went back to the ambulance station and laid down to rest. There was then a call for an ambulance run. While she was moving the patient from the ER stretcher to the ambulance stretcher, she twisted and had immediate and severe pain in her lower lumbar sacral area. It was noted that on May 1, 2001, she was lifting a large patient and hurt her back, and had been seeing Dr. Kapp. The employee had been back to work for a little over a month when this current episode happened. Dr. Trueblood's assessment was acute back sprain with muscle spasm and truncal deviation and a re-injury of a previous injury. Dr. Trueblood took her off work and prescribed OxyContin. (Employee Exhibit A-3 and Employer-Insurer Exhibit 6)

The employee was admitted to St. Francis Medical Center on July 30, for pain management due to severe low back pain with radiation to the left hip and left lower extremity. The employee was injured on July 28, when she squatted down to release the wheels on a stretcher and experienced a pop in her low back. A repeat MRI was performed due to the severity of her symptoms but it showed no evidence of a herniated disk or significant pathology. Dr. Trueblood stated that the employee had no evidence of nerve root impingement or major structural damage, and would not require surgical treatment. Due to her excruciating pain she was given an epidural infusion. On August 3, Dr. Trueblood released her from the hospital, continued physical therapy and kept her off work. (Employer-Insurer Exhibit 6).

On August 7, Dr. Trueblood noted that the employee was doing considerably better and had corrected much of her truncal shift and was able to straighten up to a neutral position. The employee had resolving low back spasms. He returned her to therapy at Restart. There is an off work form that shows a date of injury of July 28 and that the employee had been off work for two weeks. (Employer-Insurer Exhibit 6 and Employee Exhibit A-3).

Dr. Sampson examined the employee on August 15 due to recurrent complaints of pain in the low back down the back of the left leg to the left heel. In the history, it stated that on July 28, while working as an EMT, she was lifting a patient when she had the sudden onset of pain in her back. She had a significant past history in that 3 or 4 months ago she was lifting a very heavy patient and had back and left leg pain and was diagnosed with a sacroiliac joint problem. She got better after 2 to 2 ½ months and was working for a short time when this incident occurred. In the past history it stated except for what she had described 3 or 4 months ago, she did not have a history of prior back problems. Dr. Sampson's diagnosis was left sciatica. He recommended a lumbar myelogram and CT scan to make sure there was no nerve impingement. The employee was to remain off work. The disability certificate showed the date of injury as July 29. Dr. Sampson stated that the employee continued to have pain radiating down the left leg and recommended a referral to a neurologist. (Employer-Insurer Exhibit 4).

On August 31, the employee saw Dr. Wayne, who noted that on July 28, as the employee was lifting a stretcher, she felt a twinge in her lower left back. Subsequently that day she was transferring a patient and she noticed the pain became very severe in the left lower back and hip region and down the back of her leg. She experienced numbness, burning, and tingling to the foot. The employee sustained a similar type injury to the left SI joint in the first week of May of this year, when she was transferring a patient. She had therapy, medications, and returned back to work about a month ago. His impression was left sacroiliac dysfunction secondary to the July 28 injury. Dr. Wayne noted that the employee most likely sustained a similar type of injury in the first week of May because she had very similar symptoms after the July 28 injury. He referred her for physical therapy for the SI joint dysfunction. He kept her on light duty and prescribed Soma. (Employer-Insurer Exhibit 8).

Employer-Insurer Exhibit 3 is record from Health Facilities Rehab Service. The evaluation is dated September 4. The handwritten notes are difficult to read but part of it states that the employee stated on July 28, she was lifting a patient from emergency room bed to cart. There does not appear to be any other date shown except for July 28, 2001.

The employee started receiving treatment from Dr. Harrison on September 5. There is an accidental injury report for a date of accident of July 28. It is described as an on the job injury and the circumstances was lifting a patient from the ER bed to the ambulance cot. The employee started missing days from work on July 29. The form is signed by the employee. There is also a second form that is filled out and signed by the employee that showed her condition which was SI joint dysfunction was due to an accident on July 28, while lifting a patient. In a disability certificate dated October 12, Dr. Harrison returned the employee to work without restriction with low back brace. (Employee Exhibit A-1 and Employer-Insurer Exhibit 7).

The employee saw Dr. Stone on October 15. He listed the date of injury of April 2, 2001. It is noted that the employee has completely resolved with regards to the symptoms of a lower back discomfort and radiation down the left leg. Testing done at Restart reveals normal function of the back so the employee could safely do her current duties. The employee had tenderness to palpation in the paraspinal muscles but no muscle spasms and no pain on sacroiliac stress. The straight leg raising had no discomfort. There was no weakness on walking on heels or tiptoe and sensation to touch is normal. The strength testing was all normal. The assessment was lumbar strain, radicular symptoms and SI dysfunction all resolved. Dr. Stone discharged the employee from care with a return to full duty. Maximum medical improvement was noted to have been reached. (Employee Exhibit A-2 and Employer-Insurer Exhibit 9-A)

Employer-Insurer Exhibit 2- shows that the employer-insurer paid the employee temporary total disability on three separate occasions. The first period was from April 3, 2001 through April 12, 2001. The second period was from May 8, 2001 through June 19, 2001. The last period was July 29, 2001 through October 13, 2001.

Employee Exhibit C is the January 26, 2005 report from Dr. Palen. Dr. Palen noted that the employee gave the history of April 2, 2001 she begin to have lower back pain after lifting a patient. Then on May 7, 2001 she had complaints of pain in her buttocks and down her left leg while going down steps with a patient on a stretcher. Then on July 29, 2001, she had a severe spasm in her back while moving a patient. At the present time, the employee complained of constant pain in her neck, left knee, right shoulder and back. She is unable to sleep and can only sustain physical activity for about 10 minutes at a time. She is unable to do any physical work and has not worked since sometime in 2002. The employee had decreased back flexion. Dr. Palen stated "it appears that the work related events on April 4, 2001 and exacerbators on May 7, 2001 and July 2001 was the substantial cause of her injuries". It was his opinion that the employee sustained a 20% permanent partial disability of the person as a whole.

With regard to Injury 01-046494, the Report of Injury was filed with the Division on May 18, 2001. It shows a date of injury of May 7, 2001, and the employer was notified the same day. It shows an injury to the low back, and that the employee had put a patient on stretcher and was carrying down 4 steps and felt something pop in her lower back. The Receipt and Notice of Termination of Compensation showed that the employer-insurer paid 6 and 1/7 weeks of temporary total disability starting May 8, 2001, and ending on June 19, 2001. The last payment was made on June 19, 2001. There was no claim filed and the file was administratively closed on June 24, 2002.

With regard to Injury No. 01-080159, the Report of Injury was filed with the Division on August 3, 2001. It shows a date of injury of July 28, 2001, and the employer was notified the same day. It shows an injury to the lower back, and the employee was lifting a patient and had pain in the low back. The Receipt and Notice of Termination of Compensation showed that the employer-insurer paid 11 weeks of temporary total disability starting July 29, 2001 and ending on October 13, 2001. The last payment was made on October 16, 2001. There was no claim filed and the file was administratively closed on November 16, 2002.

The employee and the employer-insurer both filed briefs on September 7, 2005.

FINDINGS OF FACT AND RULINGS OF LAW:

The initial question to be resolved is whether the employee sustained one accident and injury to her low back on April 2, 2001 or did she sustain 3 separate accidents and injuries to her low back on April 2, 2001, May 7, 2001, and July 28, 2001. The answer to that question substantially affects the outcome of the case and the rulings on the disputed issues.

The employer-insurer is not disputing that on April 2, 2001, the employee sustained an accident arising out of and in

the course of her employment. The employer-insurer position is that the employee sustained two additional accidents and injuries on May 7, 2001 and July 28, 2001. There were never any claims filed on these two alleged injuries. The employee's position is that she sustained the April 2, 2001 accident and injuries that caused her symptoms and complaints, and that the incidents on May 7, 2001 and July 28, 2001 were merely exacerbators and that all of her symptoms and conditions arose out of the April 2, 2001 accident and injury.

It is important to compare the employee's testimony with the medical records. The employee testified that immediately after the April 2, 2001, accident that in addition to her low back pain she had pain that radiated down her left leg into her foot. The medical records from April contradict her testimony. The records have no indication of any numbness or radiculopathy in her left leg. The Missouri Delta Medical Center records show that the employee had middle to lower back pain with no radiation and negative straight leg raises. The records from Dr. Stone's office show a thoracic and lumbar strain with negative straight leg raises and normal heel walking.

The employee testified that the reason Dr. Stone's April 12 records show that she had complete improvement of her lower spine discomfort, and had no persisting stiffness or discomfort, and indicated that she was ready to return to her normal duties, was that she lied to Dr. Stone on the date. The employee testified that the truth was that she had severe low back pain with radiculopathy. However, Dr. Stone's physical examination on that day contradicts her testimony. She had a completely normal examination including a full range of motion of her lumbar spine with no tenderness, the deep tendon reflexes were brisk bilaterally, her sensation was intact and she had normal strength.

The employee testified that since April 2, 2001, her pain in her low back and left leg has been consistent and ongoing, and her symptoms have been the same. It is important to compare the employee's complaints and the findings of the health care providers not only in April but also in May/June and then after July 28. In April the diagnosis was thoracic and lumbar strain with no mention of any leg pain, numbness or radiculopathy. The employee had negative straight leg raises, normal heel walking and full range of motion. It was not until the second alleged accident on May 7, that the medical records show that the employee had radicular pain and numbness in her left leg, positive straight leg raises, difficulty with heel walking, and loss of motion. None of the medical records in May, June, July, August and September indicate that the problems that the employee was being treated for started in April. All of those medical records show that the employee's problems started on May 7 and/or on July 28.

All of these contradictions affect the credibility of the employee's testimony that she had not recovered from the April 2 accident and injury.

In addition, all of the medical records from the treating doctors through September indicate that the employee had work related accidents and injuries on May 7, 2001, and July 28, 2001. The overwhelming evidence is that the employee had no radicular symptoms until May 7, and that the cause of her leg complaints was from the May 7 and /or July 28 accidents and injuries.

It is important to note what the records indicate regarding the history given on and after May 7 regarding the cause of the employee's low back and left lower extremity complaints. The May 7, 2001, records from Missouri Delta show that 45 minutes before arriving the employee sustained a workers' compensation accident and injury from going down steps carrying a patient on a stretcher. On May 11, the employee told Dr. Stone's office that as she was moving a patient she heard something pop in her back which caused excruciating pain to her lower back and left buttocks which radiated down the back of her leg and at times felt tingly. The injury report showed a date of injury of May 7. The physical therapy records from Restart stated that the onset of the employee's problems was May 7, and that on that date she felt a pop and injured her back while carrying a stretcher down stairs. The employee told Dr. Kapp that on May 7, as she was lifting a patient going down steps, she felt a pop in her low back and since that time had been having pain.

It is important to note what the records indicate regarding the history given on and after July 28, regarding the cause of the employee's low back and left lower extremity complaints. The records from the emergency room at Missouri Delta Medical Center on July 28 show that while moving a patient that day she had severe pain and spasms in her left lower back. The workers' compensation employee work status report showed an injury date of July 28, with the cause of injury as lifting a patient. On July 30, Dr. Trueblood noted that the employee had been having symptoms for two days and that the date of injury was July 28. The mechanism of the injury was a pop in her low back while adjusting a stretcher, and then later while moving a patient she twisted and had immediate and severe pain in her lower lumbar sacral area. The St. Francis Medical Center records show an injury on July 28, when she squatted down to release the wheels on a stretcher and experienced a pop in her low back. Dr. Sampson noted an accident and injury to her low back on July 28, while lifting a patient. The records from Dr. Wayne was that on July 28, the employee had an injury to her low back, left hip, and left leg while lifting a patient. Records from therapy show an injury of July 28, while lifting a patient. When the employee went to Dr. Harrison a chiropractor in September, she filled out and signed an accidental injury report which described an on the job injury

on July 28, while lifting a patient. Another form filled out and signed by the employee was she had SI joint dysfunction due to an accident on July 28, while lifting a patient.

The only medical records after May 7, 2001, that indicate her problems were from an accident and injury on April 2, 2001, was an entry by Dr. Stone on October 15. Dr. Stone noted that the employee's symptoms of lower back discomfort and radiation down the left leg had completely resolved. Except for that note, all of the other medical records including a May note from Dr. Stone's nurse practitioner, indicate the employee's problems were from either a May 7, 2001, injury or a July 28, 2001, or from both.

It is important to contrast the diagnosis in April to the diagnosis on and after May 7, and on and after July 28. In April, Dr. Stone's office diagnosed the employee with a thoracic and lumbar strain. On and after May 7, 2001, Dr. Stone's office diagnosed the employee with lumbar strain and radiculopathy, nerve compression and piriformis syndrome. Dr. Kapp's diagnosis was left SI joint dysfunction with left lower extremity radiculopathy. On and after July 28, 2001, Dr. Trueblood diagnosed an acute low back sprain with muscle spasms and truncal deviation.

Dr. Sampson's diagnosis was left sciatica. Dr. Wayne diagnosed left sacroiliac dysfunction. Dr. Stone diagnosed a lumbar strain, radicular symptoms and SI dysfunction.

Based on a review of the evidence, I find the following: On April 2, 2001, the employee sustained an accident which caused an injury to her lumbar and thoracic back but did not cause injury or symptoms to her left lower extremity including pain, numbness or radiculopathy. The employee returned to work on April 13, 2001, and continued to work until May 7, 2001. On May 7, 2001, the employee sustained an accident, which caused an injury to her lumbar back and left lower extremity including radiculopathy, pain and numbness. The employee returned to work on June 20, 2001 and continued to work until July 28, 2001. On July 28, 2001, the employee sustained an accident, which caused an injury to her lumbar back and left lower extremity.

The employee sustained three separate accidents and injuries arising out of and the course of her employment on April 2, 2001, May 7, 2001, and July 28, 2001.

Issue 1. Statute of Limitations:

Under Section 287.430 RSMo, the claim must be filed with the Division within two years after the date of the injury or the last payment made under this chapter on account of the injury, except that if a report of injury is not filed by the employer as required by Section 287.380 RSMo, the claim for compensation may be filed within three years.

Section 287.380 RSMO, in effect at the time of the injury, states, "Every employer or his insurer . . . shall within ten days after knowledge of an accident resulting in personal injury to any employee notify the division, therefore, and shall, within one month from the date of filing of the original notification of injury, file with the division under such rules and regulations and in such form and detail as the division may require, a full and complete report of every injury..."

Employer-Insurer Exhibit 2 shows that the formal report of injury for the April 2, 2001, injury was prepared on April 6, 2001. It shows that the injury was reported on April 3, 2001. The exhibit does not show when the report of injury was filed with the Division. The Court took judicial notice of the file. I find that the Report of Injury was electronically filed with the Division on April 27, 2001. I therefore find that the employer-insurer filed the formal Report of Injury within 30 days of the injury and notification of the injury. However, there was no evidence that the employer-insurer filed a notification of the injury with the division within 10 days after the knowledge of the accident as required in Section 287.380 RSMo. Such notification had to have been filed by April 13, 2001. The issue is whether the failure to notify the Division within 10 days extends the statute of limitations from 2 years to 3 years.

The Commission in Eluterio G. Hilario v. Mid-America Dairymen, Inc. a case decided on May 23, 2001, held that under Section 287.380 RSMO and 287.430 RSMO, the employer-insurer had a statutory duty to notify the Division of Workers' Compensation of the injury within 10 days after knowledge of an accident and injury and file the formal report of injury within 30 days thereafter. The Commission held that the failure to timely file under Section 287.380 RSMO extends the statute of limitations to three years.

Based on a review of Section 287.430 RSMo, and Section 287.380 RSMo, and the Commission opinion in

Eluterio G. Hilario v. Mid-America Dairymen, Inc., I find that there was no evidence that the employer-insurer filed a notification of the injury with the Division within 10 days of knowledge of the accident, and as a result the statute of limitations is extended to three years. I further find that the employee's Claim for Compensation was filed on November 21, 2003, which is within three years from the date of the injury. I therefore find that the employee's claim was filed within the time allowed by law.

Issue 2: Medical Causation and Issue 3: Nature and Extent of Permanent Partial Disability.

The employer-insurer is disputing that the employee's injury was medically causally related to the employee's April 2, 2001 accident and are disputing that the employee sustained permanent partial disability for the April 2, 2001 claim for compensation.

There is credible evidence that the employee had completely recovered from the April 2, 2001 accident and injury, and did not sustain any permanent partial disability as a result of that injury. I find that what was contained in the medical records from Dr. Stone regarding what the employee told him on April 12, 2001, is credible. I find that the employee's testimony at hearing that she lied to Dr. Stone about her condition is neither credible nor persuasive. All of the medical records starting in May and going through September show that the employee's problems started on May 7 and/or July 28. I find that by April 12, 2001, the employee had completely recovered from her injury and had no continuing symptoms or complaints. Dr. Stone examination of the employee was normal, and he stated that the employee's lumbar strain had resolved. In addition, when the employee saw Dr. Stone in October of 2001, she told him that her symptoms had completely resolved. This medical record is corroborated by the employee's testimony at her August 11, 2003, deposition when she answered that her back claim had resolved. However, even if it was determined that the employee still had continued problems with her low back and left leg, the employee still has the burden to prove that she sustained permanent partial disability as a result of his April 2, 2001 accident.

A party who claims benefits under the workers' compensation law has the burden to prove that an accident occurred and that it resulted in injury. A claimant must show that a disability resulted and the extent of such disability. Proof of permanent disability requires reasonable certainty. The claimant must produce evidence from which it reasonably may be found that such injury resulted from the causes for which the employer would be liable. See Griggs v. A. B. Chance, 503 S.W.2d 697 (Mo App. 1973).

In Plaster v. Dayco, 760 S.W.2d 911 (Mo. App. 1988), the employee had preexisting disability to her back and she reinjured her back at work. The employee had a rating of about 60% permanent partial disability for the overall back condition. There was no expert evidence as to what percentage of the 60% preceded the workers' compensation injury. The Court held that it was the employee's duty to offer sufficient expert testimony to prove the extent of the preexisting disability in order to determine what percentage of permanent partial disability is attributable to the job related injury which was the basis for the workers' compensation claim. Failure to do so bars the employee from recovering permanent partial disability benefits.

In Bersett v. National Supermarkets, Inc., 808 S.W.2d 34 (Mo. App. 1991), the employee had an injury to his right ankle. A week later, the employee injured his ankle again by pushing a cart. The employee only filed a claim on the first injury. The employee argued that the second alleged injury was a manifestation of the first injury and was not an injury. The Court found that the employee had sustained two injuries. The Court held that when there are two events, one compensable and one not compensable, which contribute to the alleged disability, it is the claimants burden to prove the nature and extent of disability attributed to the job related injury. The employee failed to present any evidence to exclude a finding that the non-compensable event did not cause some or all of the employee's disability. There was no evidence to support a finding of a separate percentage of disability and no evidence to support a finding that none of claimant's disability was attributable to a second non-compensable accident.

In Goleman v. MCI Transporters, 844 S.W.2d 463 (Mo. App. 1992), the Court held that it was the employee's burden to prove the nature and extent of the disability attributed to the compensable injuries. The employee had two work related injuries to his low back. The employee filed a claim on the second low back injury. A doctor rated the employee's permanent partial disability at 50% but did not differentiate between the two work injuries. The Court held that since the claim on the second injury was the only one being heard, the employee was only entitled to a recovery for the claim at issue. The Court held that the employee was not entitled to recover for the second injury where part or all of the disability was the result of the first accident. The Court held that it was the employee's burden to prove the nature and extent of disability attributed to the compensable injury even though both injuries were work related and sustained while employed by the same company where separate claims were pending for each injury.

In this case, since claims for compensation were not filed for the May 7, 2001, and July 28, 2001, accidents, the only compensable case the employee is entitled to a recovery on is the April 2, 2001 accident and injury. As set forth in the above cases, the employee has the burden to prove the nature and extent of disability attributable to the compensable injury even though the employee had two subsequent work-related accidents and injuries while working for the same employer.

Dr. Palen's medical opinion was that the employee had a 20% permanent partial disability of the person as a whole for the April 2, 2001, May 7, 2001, and July 28, 2001 events. Dr. Palen failed to separate what disability the employee had from the April 2, 2001 accident and injury. I find that Dr. Palen's medical opinion regarding the extent of disability was not sufficient for the employee to meet her burden of proof on her claim as set forth in the above cited Appellate cases.

Based on a review of all the evidence and case law, I find that the employee has failed to meet her burden of proof that the injury to her low back and left leg were medically causally related to her April 2, 2001, accident. I further find that the employee has failed to meet her burden of proof that she sustained permanent partial disability as a result of the April 2, 2001 accident. The employee is therefore not awarded any permanent partial disability benefits.

Based upon my rulings on the issue of permanent partial disability, the Second Injury Fund claim is moot and is therefore denied.

Date: _____ Made by:

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

A true copy: Attest:

Ms. Pat Secrest
Director
Division of Workers' Compensation

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