

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

Injury No.: 11-068793

Employee: Bobby Cureton  
Employer: Construction Trailer Specialists, Inc.  
Insurer: Zurich American Insurance Company

The above-entitled workers' compensation case is submitted to the Labor and Industrial Relations Commission (Commission) for review as provided by § 287.480 RSMo. Having reviewed the evidence and considered the whole record, the Commission finds that the award of the administrative law judge is supported by competent and substantial evidence and was made in accordance with the Missouri Workers' Compensation Law. Pursuant to § 286.090 RSMo, the Commission affirms the award and decision of the administrative law judge dated April 29, 2013, and awards no compensation in the above-captioned case.

The award and decision of Chief Administrative Law Judge Lawrence C. Kasten, issued April 29, 2013, is attached and incorporated by this reference.

Given at Jefferson City, State of Missouri, this 23<sup>rd</sup> day of August 2013.

LABOR AND INDUSTRIAL RELATIONS COMMISSION

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John J. Larsen, Jr., Chairman

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James G. Avery, Jr., Member

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Curtis E. Chick, Jr., Member

Attest:

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Secretary

ISSUED BY DIVISION OF WORKERS' COMPENSATION

**FINAL AWARD**

Employee: Bobby Cureton Injury No. 11-068793  
Dependents: N/A  
Employer: Construction Trailer Specialists, Inc.  
Additional Party: N/A  
Insurer: Zurich American Insurance Company  
Appearances: Sarah Heise and Mark Lanzotti, attorneys for the employee.  
Jared Cone, attorney for the employer/insurer.  
Hearing Date: Commenced: January 7, 2013 Checked by: LCK/rm  
Completed: January 31, 2013

**SUMMARY OF FINDINGS**

1. Are any benefits awarded herein? No.
2. Was the injury or occupational disease compensable under Chapter 287? No.
3. Was there an accident or incident of occupational disease under the Law? No.
4. Date of accident or onset of occupational disease? August 22, 2011.
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? No.
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: The employee tripped and fell.
12. Did accident or occupational disease cause death? No.
13. Parts of body injured by accident or occupational disease: N/A.
14. Nature and extent of any permanent disability: None.
15. Compensation paid to date for temporary total disability: None.
16. Value necessary medical aid paid to date by employer-insurer: \$3,834.21.
17. Value necessary medical aid not furnished by employer-insurer: None.
18. Employee's average weekly wage: Undetermined.
19. Weekly compensation rate: Undetermined.
20. Method wages computation: Undetermined.
21. Amount of compensation payable: None.
22. Second Injury Fund liability: N/A.
23. Future requirements awarded: None.

Said payments shall be payable as provided in the findings of fact and rulings of law, and shall be subject to modification and review as provided by law.

The Compensation awarded to the employee 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 employee: N/A.

## **STATEMENT OF THE FINDINGS OF FACT AND RULINGS OF LAW**

On January 7, 2013, the employee, Bobby Cureton, appeared in person and with his attorneys, Sarah Heise and Mark Lanzotti for a hearing for a temporary award. The employer-insurer was represented by its attorney, Jared Cone. The parties agreed on certain undisputed facts and identified the issues that were in dispute. These undisputed facts and issues, together with a statement of the findings of fact and rulings of law, are set forth below as follows:

### **UNDISPUTED FACTS:**

1. Construction Trailer Specialists, Inc. was operating under and subject to the provisions of the Missouri Workers' Compensation Act, and its liability was fully insured by Zurich American Insurance Company.
2. On August 22, 2011, Bobby Cureton was an employee of Construction Trailer Specialists, Inc. and was working under the Workers' Compensation Act.
3. On August 22, 2011, the employee sustained an accident arising out of and in the course of his employment.
4. The employer had notice of the employee's accident.
5. The employee's claim was filed within the time allowed by law.
6. The employer-insurer paid \$3,834.21 in medical aid.
7. The employer-insurer did not pay any temporary disability benefits.

### **ISSUES:**

1. Medical causation.
2. Claim for previously incurred medical aid.
3. Claim for mileage under Section 287.140 RSMo.
4. Claim for additional medical aid.
5. Attorney's fees and expenses under Section 287.560 RSMo by the employee.

### **EXHIBITS:**

#### Employee Exhibits:

- A. Letter from Dr. Lents dated December 5, 2011.
- B. Letter from Dr. Lents dated December 27, 2011.
- C. Account Statement from Twin City Pharmacy.
- D. Affidavit of Attorney's Fees and Expenses.
- E. Deposition of Dr. Palen.
- F. Certified medical records of Advanced Orthopedic Specialists.
- G. Certified medical records of Crosstrails Medical Center.
- H. Certified billing records of Crosstrails Medical Center.

Employer/Insurer's Exhibits:

1. Deposition of Dr. Strecker.

Joint Exhibits:

1. Supplemental pre-existing medical records (Note: On January 31, 2013 upon the agreement of the parties, the record was reopened for the admission of this exhibit. The exhibit was admitted into evidence and the record was closed).

Judicial Notice of the contents of the Division's file for the employee was taken.

**WITNESS:** Bobby Cureton

**BRIEFS:** The employee filed his brief on February 11, 2012. The employer-insurer filed its brief on February 7, 2013.

**STATEMENT OF THE FINDINGS OF FACT:**

2007:

The employee testified in 2007 he had a motorcycle accident where he ran off the road and crashed. He injured his right wrist but did not injure his back.

On October 7, 2007, the employee saw Dr. Schafer due to the motorcycle accident. Dr. Schafer diagnosed a perilunate dislocation of the right wrist; and performed a closed reduction of the transscaphoid perilunate dislocation and application of a short arm thumb spica cast. On October 10, Dr. Schafer diagnosed a transscaphoid perilunate dislocation of the right wrist with a scaphoid fracture and scheduled surgery. On October 16, Dr. Lents performed an open reduction and internal fixation of the right scaphoid fracture. In November, Dr. Lents noted the scaphoid fracture separated just a bit, but there was probably less gap than perceived. There was no sign of a malformation and no widening of the scaphoid lunate interval. A short arm thumb spica splint was continued. On December 12, the employee had some discomfort on the radial side. The x-rays showed alignment of the carpus was good and the scaphoid fracture was healing. Vicodin was prescribed. On December 20, Dr. Lents refilled the Vicodin. On December 27, a prescription for Darvocet was called in by Dr. Lents who denied the request for Vicodin.

2008:

On January 23, 2008, the employee's wife called asking for a prescription for pain medication which Dr. Lents denied since the employee did not keep his last appointment on January 9. On March 10, the employee saw Dr. Lents with continued difficulty with his wrist. On exam the employee was tender to palpation over the distal pole of the scaphoid. X-rays showed the carpus to be aligned nicely, however there was a large cystic lesion in the mid portion of the scaphoid which may go to a non-union. The alignment and fixation of the Acutrak screw

looked good. Dr. Lents ordered tomograms. On March 27, 2008 Dr. Lents stated the tomograms showed a clear non-union of the scaphoid and loosening of the previously placed Acutrak screw. Dr. Lents diagnosed a non-union of the right scaphoid.

On April 16, 2008, Dr. Lents performed an open reduction and internal fixation with bone graft for a non-union of the right scaphoid. On April 28, Dr. Lents stated that the x-ray showed good alignment and good fixation. Vicodin was prescribed. The employee was to return in two weeks. On May 8, a prescription refill for Vicodin was called in by Dr. Lents who stated that would be the last Vicodin refill. On May 12, the employee canceled his appointment. On May 15, the employee requested Vicodin that was denied. It was noted that the employee must make a follow up appointment. Dr. Lents prescribed Darvocet. On June 16, Dr. Lents stated that the employee was still having significant pain. The employee had been laid off and was not working. X-rays showed good position of the screw and union of the fracture was not noted. The employee was to return in two weeks. On June 30, the employee requested Vicodin stating that Darvocet was not helping. The request for Vicodin was denied. Dr. Lents called in a prescription for Ultracet with no refills.

The employee testified that it was his understanding that in June of 2008 he was diagnosed with a non-union of the right scaphoid. When he last saw Dr. Lents in 2008 he was prescribed medication for his wrist. After that he returned to work, and was able to complete all of his job duties. He started seeing Dr. Doyle at Cross Trails for his right wrist, low back and other conditions.

The employee went to Dr. Doyle on September 24, 2008, for a prescription refill due to right wrist pain. Dr. Doyle diagnosed chronic pain due to non-union of the right scaphoid fracture; prescribed pain medication and a cock-up splint; and physical therapy was discussed.

On October 20, the employee had right wrist pain, tenderness and decreased grip strength which affected its use and he was unable to work. Dr. Doyle diagnosed pain from the right scaphoid fracture and noted a referral to Dr. Tobin was due to the non-union. On November 17 the employee had continued pain in the right wrist due to a long standing scaphoid non-union. He had decreased grip in his right hand and tenderness. Dr. Doyle continued the medications and splint. On December 15, 2008, the employee had right wrist pain due to the non-union of the scaphoid fracture. It appeared the employee had, or Dr. Doyle recommended, a surgical consultation.

#### 2009:

On January 6, 2009, Dr. Doyle saw the employee for the scaphoid non-union and anxiety. The employee had increased pain in his right wrist and hand. On examination, there was crepitation and limited range of motion due to pain. There was a note to search for an orthopedic surgeon. The employee saw Dr. Doyle on January 29 with chronic right hand pain. Medications were prescribed and an orthopedic referral was discussed.

Dr. Doyle noted on February 25, 2009 that the employee had right wrist pain and was unable to lift without a cock-up splint. He had decreased grip in the right hand. Dr. Doyle prescribed Vicodin 7.5/500 and noted that the employee was waiting for a consult with a hand surgeon. On March 23, Dr. Doyle noted that the right wrist pain was getting worse due to the scaphoid non-union. The employee had tenderness and was using a cock-up splint. Medications were prescribed. Dr. Doyle noted on April 21, that the right wrist pain was worse. Prescribed were Vicodin 7.5/500 and Klonopin. On May 21, the employee returned for his monthly pain medication refill due to right wrist pain of 6 out of 10. The clinical impression was chronic pain and right scaphoid non-union. Medications were prescribed.

The employee saw Dr. Doyle on June 25, 2009, who noted that the right wrist and hand pain was worse; there was sensory loss; and decreased grip. The pain was mild to moderate and it interfered with work. There was swelling, pain on palpitation and decreased grip from the right scaphoid non-union. Medications were prescribed. On July 28, Dr. Doyle noted continuing pain and decreased grip. He diagnosed tenosynovitis and right scaphoid fracture non-union. Dr. Doyle prescribed pain medication and referred the employee to vocational rehabilitation.

2010:

On August 4, 2010, the employee saw Dr. Green after recently moving back from Kansas. Dr. Green noted chronic wrist pain as a result of a wreck on October 7, 2007. The employee had two surgeries and continued to have a fractured scaphoid bone. He was being treated for anxiety with Klonopin. On examination, the employee had decreased strength in his right wrist and hand. Dr. Green diagnosed chronic right wrist pain, anxiety, and tenosynovitis; and prescribed Hydrocodone 10/500 one four times a day as needed; and Klonopin. On August 10, Dr. Green refilled the Hydrocodone and Klonopin at the phone request of the employee. On August 23, the employee saw Dr. Doyle with moderate pain and swelling in the right hand and wrist. The employee had a right scaphoid non-union; and the pain was exacerbated by work.

On September 22 a refill of Hydrocodone was called in after the employee's wife called Dr. Doyle's office. On October 25, the employee saw Dr. Doyle with right hand and wrist pain and weakness due to the right scaphoid non-union. On examination the employee had pain and weakness in the right wrist. Prescribed was Hydrocodone 10/500 four times a day as needed and 400-600 mg of Ibuprofen every four to six hours for pain. Dr. Doyle diagnosed chronic right wrist pain and non-union of the right wrist.

On November 23, the employee called Dr. Doyle's office and noted that he had just started a new job and requested a refill of the prescription pain medication so the employee would not need to miss work to attend an appointment. The employee was instructed to keep his appointment. On November 24, the employee saw Dr. Doyle for chronic right hand and wrist pain that had increased. On examination, the employee had moderate pain with increased use. On palpation there was tenderness of the right hand and wrist. Prescribed was Hydrocodone 10/500 one four times a day as needed and 400-600 mg of Ibuprofen every four to six hours as needed for pain.

On December 27, 2010, the employee saw Dr. Doyle with a non-union of the right scaphoid with constant pain and weakness in the right wrist. The employee had a flare-up of back pain and increased pain in the right wrist. The employee was prescribed Hydrocodone 10/500 four times a day as needed for pain.

2011:

The employee saw Dr. Doyle on January 25, 2011, for back and right wrist pain with anxiety. The employee had chronic moderate pain with any use of the right wrist and weakness in the right wrist. He had a depressed affect and was anxious over the inability to work using his right wrist and hand. The employee was instructed to avoid repetitive activities and modify use of the hand and wrist to reduce symptoms; to wear the cock-up wrist splint until the pain resolves, then nightly for prevention; and to take the medication as provided. Hydrocodone 10/500 four times a day as needed was prescribed.

On February 24, Dr. Doyle stated that the employee complained of increased pain and weakness in the right wrist and hand and was now dropping light objects. There was positive palpation over the right scaphoid bone, weakened grip, and constant pain with range of motion. Dr. Doyle noted a depressed affect and was anxious over the right hand injury. The impression and recommendation was a history of surgery twice for the right wrist fracture with no improvement; a diagnosis of chronic right wrist pain; and prescribed was the continuing of the splint. Prescribed for the wrist pain was Hydrocodone 10/500. It was noted that the employee was unable to see a surgeon for his hand because he did not have insurance.

On March 25 the employee saw Dr. Doyle with back pain that radiated to both lower extremities and right wrist pain. The employee had pain and weakness in the right wrist with stiffness and arthritis secondary to non-union. On exam, the employee had increased back and right wrist pain with increased anxiety over the inability to work. On exam the employee had tenderness over the right radial head and ulnar styloid and pain with palpation over and above the right scaphoid. The impression was that the chronic right wrist condition had deteriorated. His back, anxiety and depression had deteriorated as well. Dr. Doyle prescribed Hydrocodone 10/500. On April 26, Dr. Doyle refilled the Hydrocodone 10/500 one four times as day as needed.

On May 23 the employee saw Dr. Doyle for back and hand pain and anxiety/depression. It was noted that the employee had pain and weakness in the right wrist with stiffness and arthritis secondary to non-union. On exam there was tenderness over the right radial head and over the right scaphoid; and increased pain with palpation. Dr. Doyle's impression was chronic right wrist condition and back that has deteriorated. Dr. Doyle prescribed one Hydrocodone 10/500 four times a day as needed and added Percocet 10-650 four times daily. The employee was to continue with the cock-up splint.

A note dated June 10, 2011 stated that the employee had called because he was going to run out of the Percocet. He started a new job and had to get up earlier; and he ran out of pain medication quicker. He requested 10/325 instead of 10/650 because it was too strong. Dr. Doyle

did not refill the medication since it was 10 days early. On June 23, the employee's wife called asking for a refill prior to the employee's appointment on July 5. Dr. Doyle prescribed Percocet 10/325.

On July 5, 2011, the employee saw Dr. Doyle for back pain and wrist pain. The employee had swelling, weakness in the right arm and right hand. The pain was dull, aching, radiating, and was continuous and worse with flexion, extension, activity, and work. On examination, the employee had tenderness of the right radial head, mild swelling, and the range of motion was an active flexion of 15 degrees, active extension, radial deviation, and ulnar deviation of 10 degrees; and passive flexion and extension of 10 degree. There was abnormal palpation of the right hand. Percocet 10/325 and Hydrocodone 10/500 were continued.

On August 4, 2011, the employee saw Dr. Doyle for wrist and back pain. In the history it was noted that the employee had pain, swelling, and weakness of the right arm and right hand which was continuous. On physical examination, it was noted that the employee was in moderate pain/distress and had constant pain in the right wrist/hand with a history of non-union and was status post two surgeries. There was tenderness in the first metacarpal, pain with palpitation and weak grip of the right hand. The employee had up and down pain with increased use of the right wrist. The Hydrocodone 10/500 was discontinued and Percocet 10/325 one four times daily was prescribed. The Klonopin was continued.

The employee testified that he saw Dr. Doyle on August 4, 2011, and the records regarding his complaints were accurate. When asked if some of the Cross Trail records prior to August 22, 2011 show right wrist pain, weakness and grip strength, the employee testified that he did not have any weakness, but would not contest what is contained in the medical records. Prior to August 22, 2011, he had some minor problems with his wrist and was taking some medication for his wrist and back. He was not taking medication just for his wrist. Prior to August 22, 2011, he could complete his job duties as a welder of trailer trucks which included being able to lift 60 pounds. On August 22, 2011, he was getting ready to weld the foundation of a trailer, tripped over it, and fell down. He landed with his weight on the right arm. The plant manager took him to Ferguson Medical Group and he had x-rays of his right wrist.

The employee's first monthly follow up for wrist and back pain to Dr. Doyle after the August 22, 2011 fall was on September 2, 2011. The employee noted that he tripped at work and fell on his outstretched hands. On physical examination, it was noted that the employee was in moderate pain/distress. The employee had a right wrist reinjury after the recent fall with both arms outstretched landing more on the right. The employee had mild discomfort of the lumbar spine and was complaining more of pain in the right wrist and hand. The employee was anxious over the pain in the right wrist and work situation. Dr. Doyle stated that the employee had chronic right wrist pain with a flare-up after a recent fall with his hand outstretched. Dr. Doyle discussed the need for a referral a hand surgeon as soon as the emergency room report was received. Percocet 10/325 one four times daily and Klonopin was continued.

On September 28, 2011, the employee returned for his monthly checkup. The employee had chronic pain in the right wrist, lumbar spine and lower legs. The employee had increased

anxiety and workers' compensation had referred him back to the original surgeon who operated two times without improvement. The employee appeared to be in mild/moderate pain/distress. On examination of the right wrist the employee had abnormal right radial head; it was unstable and there was tenderness and swelling in the right radial head. On examination of the right hand there was swelling and tenderness in the first metacarpal and positive palpation over the navicular with a weak grip. Dr. Doyle's assessment was chronic right wrist pain that had deteriorated; and he continued the current medications.

The employee testified that after the fall his wrist was extremely worse. He went from being able to pass a physical and work, to being hardly being able to drink soda without it falling out of his hand. The employee has problems writing and doing anything that involves the right wrist. He has trouble lifting things and trouble with fine motor skills. His pain is burning, stinging, stabbing, aching, shooting and numbing with the level being 10. He has numbness in the wrist and the pain sometimes goes up his arm. After the fall, the dosage of the pain medication was increased due to the wrist injury. The employer-insurer sent him to Dr. Lents.

The employee saw Dr. Lents on October 17, 2011, for right wrist pain. Dr. Lents noted that he had cared for the employee about three years ago for a scaphoid non-union with an open reduction and internal fixation after a transcaphoid perilunate fracture/dislocation. Dr. Lents last saw the employee in 2008, and at that time no union of the fracture had been noted. Dr. Lents stated that the employee had been fairly asymptomatic until August 22, 2011, when he fell on his outstretched arm and since then had pain which was getting quite severe. On examination of the right wrist, the employee was tender to palpation over the palmar aspect of his wrist and over the distal pole of the scaphoid. The motion was limited and quite painful. X-rays of the right wrist showed a loosency about the screw and possible avascular changes of the proximal scaphoid as well. No certain union was noted on the x-ray. The diagnosis was possible avascular necrosis and non-union right scaphoid. Dr. Lents ordered a CT scan; prescribed Vicodin for pain; continued the splint and no use of his right upper extremity at work.

On October 31 Dr. Doyle on examination noted moderate pain/distress and constant pain in the right hand/wrist. The employee was anxious over the pending third surgery on the right hand. Dr. Doyle's impression was deteriorated right chronic wrist pain and anxiety. The medications were continued.

On November 7 Dr. Lents noted that the CT scan clearly showed a non-union and avascular necrosis of the proximal fragment of his scaphoid which he thought would not heal. Dr. Lents recommended a proximal row carpectomy. The employee could continue to work without restrictions.

The employee went to the emergency room on November 20, 2011 due to a flash burn to his chest, abdomen and upper extremities. An x-ray of the right wrist was performed with no prior studies available for review. The x-ray showed a prior fracture of the scaphoid bone and a screw was seen traversing the fracture, there is persisting non-union or a fracture line appeared across the waist of the scaphoid. The radiocarpal alignment appears normal. The impression was

prior fracture of scaphoid bone with screw transversing fracture and no appreciable callus or bony union is seen.

On November 21, 2011, the employee saw Dr. Doyle. On examination, the employee was in moderate pain/distress of the right hand/wrist with constant pain. Burns were noted to the face, neck, abdomen and arms. On examination of the right wrist the inspection was normal, the palpation was abnormal to the right radial head; the wrist was stable; there was tenderness to the right radial head; there was no swelling; and there was pain with palpation of the right scaphoid. On examination of the right hand the inspection was normal; there was abnormal palpation and tenderness of the first metacarpal joint; and no swelling. Dr. Doyle noted that the chronic right wrist pain had deteriorated and continued the current medications.

On December 5 Dr. Lents stated that in the past he had treated the employee for a scaphoid non-union and underwent ORIF surgery in 2008. The employee had been doing very well and was asymptomatic until August 22, 2011, when he injured his arm while at work. The employee has had pain since that time. The employee now has avascular necrosis of the scaphoid and a scaphoid non-union. Dr. Lents stated that the employee would be best served with a proximal row carpectomy. It was Dr. Lents' opinion that the employee would not have needed the surgery if he did not have the recent injury while at work.

The employee testified that Dr. Lents diagnosed avascular necrosis, a scaphoid non-union and recommended surgery which he said was due to the fall at work on August 22. The employer refused the surgery, and sent him to Dr. Strecker.

On December 16, Dr. Doyle noted that the employee was in moderate pain/distress to the right wrist and healing burns to the right wrist. There was positive palpation over the anatomic snuff box of the right thumb and distal radius; and weakness of the right hand. The employee was anxious regarding his workers compensation case but was stable with present medication. On examination of the right hand there was abnormal palpation of the right radial head; no instability; tenderness to the right radial head; no swelling but decreased grip strength. On examination of the right hand; there was tenderness over the first metacarpal but no swelling. The current medications were continued.

On December 27, 2011, Dr. Lents felt that the employee was asymptomatic before the injury on August 22, 2011, which caused him to now be painful and therefore should be considered as such for his workers' compensation benefits.

2012:

On January 13, Dr. Doyle noted that the employee's right wrist and hand pain was worse after any use of the right hand. The anxiety was stable with medications. On examination of the right wrist, there was abnormal inspection of the left ulnar styloid. There was tenderness of the right radial head; no instability; no swelling but decreased grip strength. On examination of the right hand there was tenderness over the first metacarpal but no swelling. The impression was

chronic right wrist pain that had deteriorated secondary to navicular fracture. The current medications were continued.

On February 13, 2012 Dr. Doyle noted that the employee had back, right wrist pain and anxiety. On examination of the right hand there was tenderness over the right snuff box with thumb extended and no swelling. The current medications were continued.

The employee saw Dr. Strecker on February 15, 2012. In the history it was noted that on August 22, 2011, the employee slipped and fell injuring his right wrist. Since that time he has had severe pain in his wrist associated with some numbness and tingling of the thumb and long finger. The past history was significant due to a 2007 motorcycle accident where he had a fracture/dislocation to his right wrist which necessitated several surgeries. The employee stated that he always had some discomfort in the wrist but the fall seemed to exacerbate it. Currently, besides the numbness and tingling, the employee has pain with motion especially radial deviation. On exam the employee had generalized tenderness about the wrist. He had an equivocal Phalen's. He had decreased sensation over the thenar eminence. There was a positive Tinel's over the palmar cutaneous branch in the median nerve. The grip strength and pinch were diminished. X-rays demonstrated a non-union scaphoid with an Acutrak screw in place. There appeared to be avascular necrosis of the proximal pole. There were radial scaphoid degenerative changes and degenerative changes at the lunate.

It was Dr. Strecker's opinion that the employee had a symptomatic scaphoid non-union with avascular necrosis of the proximal pole which was a direct result of his motorcycle accident in 2007. As to the current exacerbation of the symptoms, Dr. Strecker felt that the fall on August 22, 2011, was a mere triggering event. The employee had pre-existing disease as well as arthropathy noted on the radiographs which Dr. Strecker stated was the typical natural history for non-union and avascular necrosis of the scaphoid. Prior to August 22, 2011, the employee was chronically taking Percocet for his wrist pain and according to his own history, the fall exacerbated his symptoms but did not cause them. Dr. Strecker felt that the need for a proximal low carpectomy was based on his original injury and not the event which occurred on August 22, 2011.

On March 14, 2012, Dr. Doyle noted that the employee's chief complaint was right hand pain and anxiety. The employee had chronic constant pain in the right wrist and hand with a recent orthopedic consult. On examination of the wrist, there was abnormal palpation of the right radial head with tenderness, no instability, no swelling, but decreased grip strength. On examination of the hand, there was tenderness over the first metacarpal, but no swelling. The impression was chronic right wrist pain that had deteriorated secondary to non-union of the right scaphoid fracture. The current medications were continued.

On April 12, Dr. Doyle noted that the employee had chronic pain in the right wrist and hand for non-union of right scaphoid fracture. The impression was chronic right wrist pain unchanged and the current medications were continued.

The employee saw Dr. Palen on May 1, 2012. Dr. Palen noted the August 22, 2011 injury when the employee landed on his outstretched right hand. The employee was evaluated that day

at Ferguson Medical Group for pain over the middle third of the volar aspect of his right wrist. An x-ray showed no acute findings but revealed a screw in the scaphoid from a previous injury. The employee told Dr. Palen that he had unbearable pain in the right wrist and numbness on the anterior aspect of his wrist and into his fingertips. He had a throbbing pain that kept him up at night. He wore his splint to work until it caused his wrist to go numb. He had a loss of grip in his right hand. On exam the employee had a markedly weakened grip strength in the right hand; a decreased range of motion in flexion of his fingers; and no flexion or extension at the wrist. Dr. Palen stated that although the employee had previous injuries to his right wrist he was having little to no symptoms before the August 22, 2011 injury. It was Dr. Palen's opinion that the work related injury that occurred on August 22, 2011, is the prevailing factor in his current medical status as it relates to his right upper extremity. Dr. Palen rated the right hand at 80% permanent partial disability of the right hand.

On June 1 the employee saw Dr. Doyle with increased pain in the right wrist which was worse after any use. Dr. Doyle continued the current medications.

On June 6, 2012, Dr. Palen issued a supplemental report that stated the 80% disability assumed the employee would not undergo any further treatment. It was Dr. Palen's opinion that the right proximal row carpectomy recommended by Dr. Lents would benefit the employee's condition. Dr. Palen did not place the employee at maximum medical improvement.

On July 16, Dr. Doyle noted that the right wrist pain was getting worse and wanted to see about getting something done. The employee had mild to moderate pain distress and weakness with right hand and wrist grip. On examination of the wrist, there was abnormal palpation of the right radial head with tenderness, no instability; no swelling, but decreased grip strength, weakness and positive Phalen's test. Medication added was Hydrocodone 10/650 four times a day.

On July 23 Dr. Doyle on examination of the right wrist there was instability, tenderness and mild swelling of the right radial head. There was pain with palpation of the radial and styloid heads. Dr. Doyle went back to prescribing Percocet 10/325 four times a day.

On August 21 Dr. Doyle noted that the employee had increased right wrist and hand pain with a history of non-union. The pain increased after work. The ongoing medications were not controlling the pain. The employee had mild to moderate pain and weakness of the hand and grip. On examination there was abnormal palpation of the right radial head with tenderness, no instability or swelling, and decreased grip strength. There was pain with palpation over the right snuff box and radial head. The impression was chronic severe pain of the right wrist and hand and referral to pain clinic. Percocet was continued.

On September 18 the employee saw Dr. Doyle with moderate to severe pain and weakness in the right hand and wrist. Percocet was continued. In October the employee had numbness, tingling and weakness in the right hand and wrist. Medications were continued. In November of 2012, Dr. Doyle noted that the employee had a flare-up in the chronic pain of the right wrist and weakness. The medications and the cock-up splint were continued.

Dr. Palen's deposition was taken on October 11, 2012. Dr. Palen recommended a right proximal row carpectomy. When asked if he agreed with the treatment Dr. Lents was recommending, Dr. Palen stated Dr. Lents was a real expert on that and he would not attempt to second guess him. Dr. Palen did not think the employee was going to get better until something was done. Dr. Palen did not see anything in the medical records to make him think that there was ever a union of the scaphoid. The natural progression of a fracture of the scaphoid with a non-union is the development of avascular necrosis and chronic disability in the hand at the wrist. Some people have more trouble than others but it was certainly disabling. When asked if an individual who has an asymptomatic non-union of the scaphoid who suffers a subsequent traumatic event whether that can accelerate the development of avascular necrosis, Dr. Palen stated that if the non-union was not avascular (the blood vessel is still intact and providing blood supply) and the secondary injury disrupted the blood supply then avascular necrosis would develop. Dr. Palen stated that if the employee testified that leading up to August 22, 2011, he had wrist pain and was taking pain medication that would possibly be considered significant but it depended on the degree and setting.

The deposition of Dr. Strecker was taken on November 7, 2012. Dr. Strecker noted the employee had limited range of motion with dorsiflexion and volar flexion. Dr. Strecker stated that he reviewed radiographs and took radiographs. Dr. Strecker stated that the radiographs that they took were consistent with a non-union of a scaphoid fracture, and the Acutrak screw appeared to be in place. The employee had avascular necrosis to the proximal pole of the scaphoid meaning that the proximal pole and the scaphoid fracture had lost its blood supply. The employee showed degenerative changes between his radius and his scaphoid as well as some degenerative changes between the radius and the lunate.

It was Dr. Strecker's opinion that with respect to August 22, 2011 accident the employee sustained an aggravation of a pre-existing non-union of the scaphoid fracture with collapse to the proximal pole and degenerative changes in his wrist for which he had been treated for approximately four years. Based upon the review of the medical records, there was no indication that the employee ever had a united scaphoid fracture. Dr. Strecker reviewed Dr. Bryant's note of August 22, 2011. Dr. Bryant stated that the x-ray showed a screw in the scaphoid and there were no acute findings. Dr. Strecker stated that he assumed that Dr. Bryant did not see any evidence of an acute fracture. All the changes that he saw radiographically appeared to be chronic. In the medical records from Cross Trails Medical Center there were numerous entries that the employee was on Oxycodone and Hydrocodone for chronic wrist pain. The pain medication could be for the low back condition as well as the wrist condition. The employee told Dr. Strecker that he always had pain in his wrist but at the time of the fall the pain got worse.

It was Dr. Strecker's opinion that the symptoms that the employee was experiencing and the degenerative changes in his wrist which would necessitate further surgery are due to the scaphoid non-union and degenerative changes that he had pre-existing his injury. That would be the prevailing factor. With regard to the fall provoking his symptoms, the symptoms one would expect would be increased pain and some increase in swelling. An increase in pain or swelling is an indication of an acute injury. Dr. Strecker stated that the signs and symptoms of avascular necrosis of the scaphoid are decreased range of motion; usually chronic swelling around the radial scaphoid joint; some weakness of the grip; and pain.

Dr. Strecker stated that he would not recommend the proximal row carpectomy suggested by Dr. Lents. Dr. Strecker would arthroscope the wrist to assess the articular surfaces of the distal radius and capitate. If there were degenerative changes of either then a proximal row carpectomy may be inadvisable. Other options would be to excise the scaphoid or remove it and perform a four corner fusion which would maintain the wrist height better than a proximal row carpectomy and possibly decrease stress on his wrist. The other option would be a wrist fusion. It was Dr. Strecker's opinion that the employee is in need of surgical intervention for the wrist and scaphoid region.

When asked how long that the avascular necrosis takes to develop, Dr. Strecker stated that it occurs at the time of the fracture. Changes start within about six weeks with an increase density to the proximal pole. In the employee's case, he had fragmentation which usually takes several months to develop. The secondary degenerative changes usually will occur within the first couple of years.

When Dr. Strecker was asked about the significance of pre-existing pain and swelling he stated that in 2007 the employee had a significant disruption to his wrist. A transscaphoid perilunate fracture dislocation is a significant disruption not only to the bony elements but all the ligamentous structures to the wrist. It was repaired but never achieved union and had avascular necrosis or actually collapse of the proximal pole of the scaphoid. Most of these individuals will have chronic degenerative changes over time, and it usually takes several years to develop. In the employee's case, he seemed to be showing evidence that his wrist was bothering him. He had limitation of motion and had early degenerative changes prior to his fall and his fall just exacerbated his symptoms or provoked them.

The employee testified that he is requesting the treatment recommended by Dr. Lents; that he is reimbursed for out of pocket expenses, unpaid medical, and mileage; the employer pay \$1,884.00 to Dr. Doyle for treatment; and the employer pay the attorney fees and expenses for the hearing.

## **RULINGS OF LAW:**

### ***Issue 1. Medical Causation***

The employer-insurer stipulated that the employee sustained a work accident but is disputing that the employee's injury was medically causally related to the accident.

Section 287.020.2 and Section 287.020.3 (1) and (2) RSMo states as follows:

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

3. (1) In this chapter the term “injury” is hereby defined to be an injury which has arisen out of and in the course of employment. An injury by accident is compensable only if the accident was the prevailing factor in causing both the resulting medical condition and disability. “The prevailing factor” is defined to be the primary factor, in relation to any other factor, causing both the resulting medical condition and disability.
- (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 an unrelated to the employment in normal nonemployment life.

The employee has the burden of proof that he suffered an accidental work-related injury and the accident was the prevailing factor in causing both the resulting medical condition and disability. See *Armstrong v. Tetra Pak, Inc.*, 391 S.W.3d (Mo. App. 2012) and *Bond v. Site Line Surveying*, 322 S.W.3d 165 (Mo. App. 2010). Under the current statute, a work injury is compensable only if the accident was the prevailing factor in causing both the resulting medical condition and disability. See *Gordon v. City of Ellisville*, 268 S.W.3d 454 (Mo. App. 2008). Under current law in order for an event that arises out of and in the course of employment to entitle an employee who has a prior disability to additional benefits the event must be the prevailing factor that results in further disability. It is not sufficient that the event simply aggravates a pre-existing condition. See *Johnson v. Indiana Western Express, Inc.*, 281 S.W.3d 885 (Mo. App. 2009).

It was Dr. Lents’ opinion that in 2008 after the two surgeries for the motorcycle accident there was non-union of the scaphoid fracture. Dr. Lents stated that the employee had been doing very well and was asymptomatic until August 22, 2011, when he injured his arm while at work and has had pain since then. Dr. Lents diagnosed a scaphoid non-union and avascular necrosis of the scaphoid and recommended a proximal row carpectomy. It was Dr. Lents’ opinion that the employee would not have needed the surgery if he did not have the recent injury while at work.

It was Dr. Palen’s opinion that the right proximal row carpectomy recommended by Dr. Lents would benefit the employee’s condition. He did not see anything in the medical records to believe that there was ever a union of the scaphoid. Dr. Palen stated that the natural progression of a scaphoid fracture with a non-union is the development of avascular necrosis and having chronic disability in the hand at the wrist. Dr. Palen stated that if leading up to August 22, 2011, the employee had wrist pain and was taking pain medication that would possibly be considered significant, but it depended on the degree and setting. Dr. Palen stated that even with his prior injury to his right wrist he was having little to no symptoms before the August 22, 2011 accident. It was Dr. Palen’s opinion that the work related injury that occurred on August 22, 2011 is the prevailing factor in his current medical status as it relates to his right upper extremity.

I find that the opinions of Dr. Lents and Dr. Palen are substantially affected by the following: In June of 2008, after the second surgery by Dr. Lents which was an open reduction and internal fixation with bone graft for the non-union of the right scaphoid, the employee was still having significant pain. Dr. Lents stated that a union of the fracture was not noted and he prescribed prescription pain medication. The employee started treating with Dr. Doyle at Cross Trails in September of 2008 for the non-union of the right scaphoid. He treated at Cross Trails from that time until August 4, 2011 with the exception of August of 2009 through July of 2010 when he was living in Kansas. While being treated at Cross Trails for the non-union of the scaphoid prescription pain medication was prescribed each month for the right hand and wrist. In June of 2009, Dr. Doyle referred the employee to vocational rehabilitation. It was not until December of 2010 that the employee was prescribed medication due to low back pain. After December of 2010 up through August 4, 2011, the employee was prescribed prescription pain medication each month for his right hand, right wrist and low back. The medical records mention referrals to hand surgeons and orthopedic surgeons for treatment to the right wrist including surgery in October of 2008, December of 2008, January of 2009, February of 2009 and February of 2011. In January of 2011, it was noted that the employee had inability to work using his right wrist and hand. In February of 2011, the employee had increased pain and weakness in the right hand and wrist and was dropping light objects, but was unable to see a hand surgeon as he did not have insurance. Up through August 4, 2011, the medical records reflect that the employee had pain, tenderness, decreased grip strength, crepitation, limited range of motion, sensory loss, stiffness and swelling of the right hand and wrist which caused him problems lifting and working. After the August 22, 2011 accident, Dr. Doyle prescribed the same medication and the same dosage as he had prescribed prior to August 22, 2011.

It was Dr. Strecker's opinion that the employee had a symptomatic scaphoid non-union with avascular necrosis of the proximal pole which was a direct result of his motorcycle accident in 2007. As a result of the 2007 accident, the employee had a significant disruption to the bony and ligamentous structures to the wrist. After surgery, it never achieved union and the employee had avascular necrosis and collapse of the proximal pole of the scaphoid. The signs and symptoms of avascular necrosis of the scaphoid are decreased range of motion; usually chronic swelling around the radial scaphoid joint; some weakness of grip; and pain. Prior to the August 22, 2011 fall the employee had limitation of motion and was chronically taking prescription medication for wrist pain. Dr. Strecker stated that all the radiograph changes appeared to be chronic. The x-rays were consistent with a non-union of a scaphoid fracture, and the Acutrak screw appeared to be in place. The employee had avascular necrosis to the proximal pole of the scaphoid and degenerative changes between his radius and his scaphoid as well as some degenerative changes between the radius and the lunate.

It was Dr. Strecker's opinion that with respect to the August 22, 2011 accident, the employee sustained an aggravation of the non-union of the scaphoid fracture with collapse to the proximal pole and degenerative changes in his wrist. It was Dr. Strecker's opinion that the scaphoid non-union and degenerative changes that pre-existed the injury was the prevailing factor for the symptoms and degenerative changes in the wrist that necessitated further surgery. The fall on August 22, 2011, was a mere triggering event which exacerbated or provoked his symptoms but did not cause them. It was Dr. Strecker's opinion that the need for surgical

intervention to the right wrist and scaphoid was due to the original 2007 injury and not the August 22, 2011 event.

Based on a thorough review of the evidence I find that the opinions of Dr. Strecker are very credible and persuasive and are more credible and persuasive than the opinions of Dr. Lents and Dr. Palen.

The employer-insurer stipulated that the employee sustained an accident on August 22, 2011. The more credible evidence shows that employee's right hand and wrist complaints are predominately pre-existing and not primarily due to the August 22, 2011 accident. I find that the accident simply aggravated a pre-existing condition and the accident was not the prevailing factor in causing both the resulting medical condition and disability. I find that August 22, 2011 accident was not the prevailing factor in the causing the injury and therefore the injury did not arise out of and in the course of the employment. I find that the employee did not meet his burden of proof that his August 22, 2011 accident was the prevailing factor in causing both his medical condition and disability. I find that the employee did not sustain a compensable work related injury and his claim against the employer-insurer is denied.

Although this case was heard as a temporary hearing, this award is final. Given the denial of the employee's claim, the remaining issues are moot and will not be ruled upon.

Made by:

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