

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

Injury No.: 00-042763

Employee: Charles Kuykendall

Employer: Gates Rubber Company

Insurer: Self-Insured

Date of Accident: On or about March 10, 2000

Place and County of Accident: Mississippi County, Missouri

The above-entitled workers' compensation case is submitted to the Labor and Industrial Relations Commission (Commission) for review as provided by section 287.480 RSMo. Having reviewed the evidence and considered the whole record, the Commission finds that the award of the administrative law judge is supported by competent and substantial evidence and was made in accordance with the Missouri Workers' Compensation Act. Pursuant to section 286.090 RSMo, the Commission affirms the award and decision of the administrative law judge dated September 13, 2005. The award and decision of Associate Administrative Law Judge Lawrence C. Kasten, issued September 13, 2005, is attached and incorporated by this reference.

The Commission further approves and affirms the administrative law judge's allowance of attorney's fee herein as being fair and reasonable.

Any past due compensation shall bear interest as provided by law.

Given at Jefferson City, State of Missouri, this 20th day of April 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: Charles Kuykendall

Injury No. 00-042763

Employer: Gates Rubber Company

Insurer: Self-Insured

Hearing Date: Commenced: December 10, 2004
Completed: March 30, 2005

Checked by: LK/sm

SUMMARY OF FINDINGS

1. Are any benefits awarded herein? Yes.
2. Was the injury or occupational disease compensable under Chapter 287? Yes.
3. Was there an accident or incident of occupational disease under the Law? Yes.
4. Date of accident or onset of occupational disease? On or about March 10, 2000.
5. State location where accident occurred or occupational disease contracted: Mississippi 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: Repetitive motion with upper extremities.
12. Did accident or occupational disease cause death? No.
13. Parts of body injured by accident or occupational disease: Right and left upper extremities.
14. Nature and extent of any permanent disability: 40% of right upper extremity at the shoulder, 20% wrist, 20% multiplicity, and 15 weeks disfigurement.
15. Compensation paid to date for temporary total disability: \$37,385.38
16. Value necessary medical aid paid to date by employer-insurer? \$121,092.95
17. Value necessary medical aid not furnished by employer-insurer? None.
18. Employee's average weekly wage: \$435.00
19. Weekly compensation rate: \$290.00
20. Method wages computation: By Agreement.
21. Amount of compensation payable:
 - 92.8 weeks of compensation for 40% permanent partial disability of the right upper extremity at the 232 week level at \$290.00 per week for a total of \$26,912.00.
 - 35 weeks of compensation for 20% permanent partial disability of the left wrist at the 175 week level at \$290.00 per week for a total of \$10,150.00.
 - 25.56 weeks of compensation for multiplicity at \$290.00 per week for a total of \$7,412.40.

15 weeks of disfigurement at \$290.00 per week for a total of \$4,350.00.

TOTAL: \$48,824.40.

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 25% of all payments hereunder in favor of the following attorney for necessary legal services rendered to the claimant: Steve Taylor.

FINDINGS OF FACT AND RULINGS OF LAW

On December 10, 2004, the employee, Charles Kuykendall appeared in person and by his attorney, Steve Taylor for a hearing for a final award. The employer was represented at the hearing by its attorney, Ken McManaman. The record was left open until March 15, 2005 for the submission of the records of Dr. Tobin and Dr. Graham and the depositions of Donna Abram, Dr. Lehman, and Dr. Strecker. An extension was requested and granted for the record to remain open until March 31, 2005. The exhibits were received and admitted on March 30, 2005, and the record was then closed. The employee filed his brief on April 11, 2005. The employer's brief was filed on May 6, 2005. A response to the employer's brief was received on May 18, 2005.

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. Gates Rubber Company was operating under and subject to the provisions of the Missouri Workers' Compensation Act of Missouri and was duly qualified as a self-insured.
2. On or about March 10, 2000, Charles Kuykendall was an employee of Gates Rubber Company and was working under the Workers' Compensation Act of Missouri.
3. The employee's claim was filed within the time allowed by law.
4. The employee's average weekly wage was \$435.00 and his rate of compensation is \$290.00 per week.
5. The employer has paid \$121,092.95 in medical aid.
6. The employer has paid \$37,385.38 in temporary total disability benefits. The time periods were August 30, 2000 through September 6, 2000, and from October 30, 2000 through May 2, 2003.

ISSUES:

1. Accident/occupational disease.
2. Notice.
3. Medical causation.
4. Claim for additional or future medical aid.
5. Nature and extent of permanent disability either permanent total or permanent partial disability.

EXHIBITS:

The following exhibits were offered and admitted into evidence:

Employee's Exhibits:

- A. Deposition of Dr. Eaton
- B. Deposition of James England
- C. Picture of burn to employee's arm taken on July 20, 2000

- D. Picture of burn to employee's arm taken on July 24, 2000
- E. Picture of burn to employee's arm taken on July 25, 2000
- F. Picture of burn to employee's arm taken on July 26, 2000
- G. The employee's transcript from Charleston High School
- H. 1-15 medical records in 3 parts

Employer's Exhibits:

1. Deposition of Dr. Coin
2. Deposition of Dr. Strecker (Admitted on March 30, 2005)
3. Deposition of Dr. Lehman (Admitted on March 30, 2005)
4. Deposition of Donna Abrahms (Admitted on March 30, 2005)
5. Medical Records of Dr. Graham including other health care providers (Admitted on March 30, 2005)
6. Medical Records of Dr. Tobin (Admitted on March 30, 2005)

SUMMARY OF THE EVIDENCE:

Testimony of the employee:

The employee was born in 1955, and graduated from Charleston High School. He has no further formal education but has had training and experience as a meat cutter. After high school, he worked as a butcher for about 16 years. He started working at Gates in July of 1988. He worked at Gates until his dismissal in 2002 or 2003.

He worked at Gates as a spiral line operator, which involved several different jobs. The first job was as a line yarn tech. He used an air ratchet gun. Each time he used the gun it would ratchet his wrist and had a lot of torque, which put pressure on wrist supination and pronation. On the average he used the air ratchet gun 5-6 hours a day. The second job was stripping the cover off hoses to salvage tubing to be fed back in the machine. He would use his wrists, elbows, and shoulder and his upper body to pull the coverings off of hoses. This was difficult to do because the hoses were vacuumed and pulled on tight. The third job was to relieve other employees performing the pan hose job, which was using his arms and hands in a pivot motion while the hose was moving at 140 feet per minute. The fourth job was to feed rubber into the extruders. A lot of the time the rubber was defective and would get hung in the extruders. He would then have to yank, tug and pull the rubber with his hands to get them out. Every time he pulled, the motion would separate the wrist from his arm. Most of the time he was operating the air ratchet, which is more twisting of the hands and arms, and would also affect his shoulders. It is more hand intensive than the stripping hose and panning hose. The last job, feeding rubber into the extruder, is more hand intensive than the air ratchet but he did that job the least. All of the different jobs were all repetitive use of hands and shoulders.

Most of time he would work 12-hour days, and averaged about 44 hours per week in work. Every 2 hours he would have a 15-minute break, would have a 20-minute break for lunch. He did not work for anyone else other than Gates Rubber. He did mow a few yards with a full size tractor, which was owned by the KC Hall. It was not hand intensive and did not cause any problems with his upper extremities.

The employee reported the injuries on March 10, 2000, because the plant manager had therapists from Restart at the plant. There had been a lot of injuries in the plant and they had come to observe the jobs. He had been having problems with his hands, arms and wrists for about three months before. The employee was swollen and hurting a lot that day and reported it to his supervisor, Marty Vied. Marty said that since the therapist was there for him to go see her. The therapist was out on the floor to watch his job, and saw the air ratchet gun twisting. He was using constantly using his hands and arms during a shift. Prior to that day, he did not know what was causing the problems. The employer had filled out a report of injury.

Prior to March of 2000, he had no other treatment for his upper extremity. Outside of Gates Rubber, he had no other hand or arm intensive work, hobbies, or anything else. On March 10, 2000, his symptoms included swelling of his fingers, wrists, and the elbows to the point of discolorment.

The company sent him to Dr. Tobin, Dr. Lents, and Dr. Brown for treatment. Dr. Brown performed surgery

on his right wrist on July 18, 2000. Employee Exhibits C, D, E and F, are pictures of a burn to his arm that resulted from surgery when his arm was placed in a stainless steel trough. Dr. Thornton debrided the burn and did a skin graft from right upper thigh. The burn was observed during the hearing. The burn was on the upper part of forearm to lower part of his arm at the elbow, and was about 3 x 4 inches. He did not continue under the care of Dr. Brown and went back to Dr. Lents. In 2001, Dr. Lents performed surgery on his right and left wrists. The employer sent the employee to Dr. Kapp for impingement of his shoulders. Dr. Kapp performed surgery on his right shoulder. The symptoms with right hand and shoulder improved somewhat but as not much as he thought they would. He did not have surgery on his left shoulder.

Dr. Lents performed surgery on his left wrist on June 11, 2001. Between June 11, 2001 and June 25, 2001, he was outside of his house and fell over garden hose. He was walking on an embankment and caught his right toe under garden hose and tripped. On the way down he twisted his body and landed on his left shoulder blade and back. His arm was up in the air. It did not affect his wrist. When he went back on June 25, had had no swelling that he knew of and no increase in symptoms.

He was sent to Dr. Chiu for pain management and for RSD. He continued to have problems and was sent to Dr. Strecker who performed surgery on his left hand and wrist where he shortened a bone and repaired cartilage. The surgery did not solve the problems and he had a fusion to his left wrist on December 20, 2002. After the surgery, the RSD got worse and he had a wound infection that required hospitalization. He saw Dr. Graham for pain management. The company sent him to Dr. Lehman who examined him but did not treat him. He went to Dr. Catron on his own, and is seeing him every 2 months. He has pain in left arm from RSD, and pain in his right arm. Dr. Catron has him on Duragesic patches and Hydrocodone for his arms.

The employer sent the employee to Dr. Tobin, Dr. Lents, Dr. Kapp, Dr. Chiu, Dr. Brown, Dr. Thornton, Dr. Strecker, Dr. Coin, and Dr. Lehman. The employee saw Dr. Eaton and Jim England at the request of his attorney.

The employee now has trouble now with range of motion, lack of sensation and trouble with heat or cold. With regard to his left hand and arm, his ring and little finger sit in a fist position. He cannot open a soda bottle with his hand, and cannot lift anything. The inside of his arm is very sensitive to heat, cold and touch. He cannot put anything on it and rolls up his sleeve. The outside of the forearm is numb. The redness in elbow is where the pain stops which is a little bit above the elbow. He keeps it in a 45-degree angle so it will not hurt. He is taking Hydrocodone 650mg every four hours. He uses Duragesic patches for pain which he uses one every three days. When he takes medication it causes him to be not as cognizant. He was not on it today for hearing at request of attorney. He does not use his left hand and arm to do anything except to assist. He has trouble with sleep. If he gets more than an hour-and-a-half of sleep, he feels very fortunate. He is not working now and is in pain. It is depressing not working. He does not do work around the yard and cannot mow. He can dress himself using only his right hand except for a couple of jeans that he cannot snap. He cannot squeeze a clipper. The left shoulder does not cause him any problems.

With regard to his right hand and arm, he cannot do everything that he could do before the surgeries. He cannot pick up gallon of milk with right hand and pour it. He has trouble twisting the cap off milk. He has limitations in his arm. He can lift it straight out but not overhead.

During the day, he does not read or watch TV. He visits with his mother. He does not do any housework. He does not sweep, wash dishes, or make beds, or wash clothes. He walks two blocks at a time and then stops because his legs give out. Walking does not cause problems with his hands or arms. He has trouble sitting because of his left arm, but no problem with standing. He can only walk about two blocks because he is out of condition and the inside of his knees start burning. He had put on about 40 pounds due to inactivity. After being released by Dr. Strecker, he attempted to return to Gates. He has permanent weight restrictions by Dr. Strecker so they would not let him go back. Since March 10, 2000, he has not had injuries to his left and right upper extremity, other than falling over the garden hose. He has not tried to find other work because of the medication he is on; and the fact he does not believe anybody would hire him. He is on pain medication all of the time.

During cross-examination, the employee stated that the first time he noticed that he had problems related to his wrists, arms or shoulders was 3 or 4 months prior to reporting it. It would come and go. It came to a point where he needed to do something and the opportunity arose and he reported it. He told Marti Vied about it when

Amy from Restart was there. When he turned it in, it was a significant problem and had gotten worse before he turned it in. When he was having problems prior to turning it in, the floor workers discussed it. He was not the only one having problems. People throughout the plants were wearing braces on arms and other parts of the body.

His shoulder got bad from pulling and tugging on rubber that got hung up in the extruders. He could lift weight up to his waist, but could not get it above his head. Dr. Kapp did surgery on his right shoulder and injections on the left shoulder. The right shoulder surgery helped the right shoulder to some degree. Today, he still cannot lift his arm above his shoulder.

The only medication he is on is Hydrocodone and Duragesic patches prescribed by Dr. Catron, his family doctor. None of the specialists have ordered the medication he is now on since he released him. He has applied for social security but has had no determination on it. He is on long-term disability from Gates through CIGNA insurance. The patch makes him think slower, and it takes him longer to think it out before answering. The Hydrocodone makes him drowsy and dizzy. He has a pretty short fuse but does not think counseling would help him get a job. He does not think he can hold down a job. He has not been to a psychiatrist or counselor. The RSD to the left arm is really sensitive and has swelling.

Medical Records:

2000:

The employee saw Dr. Tobin on March 7, 2000, after being referred by Amy Gordon. He worked at Gates Rubber Company, and went through his job description. Dr. Tobin stated that it sounded like he has a very highly repetitive rate of ulnar wrist impaction. The employee was having pain in and around the ulnar styloid on each side and his pain was increasing to include the lateral epicondyles and up to his shoulders. The exam for the left side showed he had tenderness at the ulnar styloid, the radial nerve, and the lateral epicondyle. The employee had weakness of the super spinatus and infra spinatus at the shoulder, and had generalized glenohumeral capsular tenderness. The right side was almost identical. Dr. Tobin's assessment was that the employee had ulnar impaction syndrome, which was possibly injuring his triangular fibro cartilage. Dr. Tobin noted he would like to tour the plant and see what the employee does so he can get a better handle on the role that his occupation is playing in this (Employer 6).

On March 28, it was noted that the right upper extremity was better with the treatment of splints and injections, but the left side was only minimally better. He had significant pain with subacromial palpation. Dr. Tobin stated that treating shoulders was outside his expertise. Dr. Tobin ordered arthrograms on each wrist and in the patient status report, checked the box that it was a workers' compensation case and not the box that it was non-work related (Employer 6).

The March 29 arthrogram report noted that the employee worked for a rubber company and performed repetitive tasks. On April 11, Dr. Tobin stated that the arthrogram reports showed evidence of bilateral triangular fibro cartilage tears and some suggestion of lunar triquetral ligament injuries. The employee had ongoing shoulder pain. In the patient status report, Dr. Tobin checked the box that it was a workers' compensation case and not the box that it was non-work related. Dr. Tobin referred him to Dr. Brown (Employer 6).

The employee saw Dr. Brown on April 21. In the new patient questionnaire that was filled out by the employee, he checked yes if he was here for a work-related injury. The description of his symptoms stated pain in both wrists up the arm to shoulder. The employee first noticed symptoms 1½ years. Dr. Brown's record stated that the employee was a right-handed dominant spiral line operator at Gates Rubber Company who has worked there for the past 12 years. He was referred for his upper extremities. The employee had an aching pain in both his wrists for approximately 1½ years. He does not recall any specific traumatic injury. Dr. Brown's impression was bilateral wrist pain with the cause not being clear (Employee H-11).

On May 12, Dr. Brown noted that the employee was continuing to have pain in his wrist worse on the left than right, and more localized to the ulnar side of the wrist. After reviewing the arthrogram, Dr. Brown recommended a bone scan. He further stated that he has a new complaint today, which was pain in both his shoulders for the past 1½ years. The examination showed evidence of bilateral shoulder impingement. Dr. Brown recommended conservative treatment, and recommended the employee see a shoulder specialist (Employee H-11).

The employee saw Dr. Kapp on May 24 for his bilateral shoulder pain. The employee stated that his shoulders had been bothering him for quite some time. He has worked at Gates Rubber for 12 years. His symptoms have been going on for at least three or four months in both shoulders. He denied any previous history of specific injury but does repetitive motion work. Dr. Kapp assessed bilateral shoulder impingement with rotator cuff tendonitis, and performed subacromial injections in both shoulders, placed him on antiinflammatory medication, and ordered therapy. Dr. Kapp stated that the employee could continue to work on modified duty with no overhead activity and no repetitive motion. It was Dr. Kapp's opinion that the employee's occupation was a contributing factor to his shoulder condition (Employee H-5).

The initial therapy evaluation was on May 25, with a diagnosis of bilateral shoulder tendonitis with impingement. In the history it states that the pain in the employee's shoulders and wrists began approximately four to five months ago. The job description is that of a spiral line worker for approximately 12 years who was working full duty. His job requires him to lift approximately a maximum of 70 pounds from waist to head and repetitive movements in the bilateral upper extremities across his body. The impingements tests were positive bilaterally, right greater than left. The employee presented with symptom magnification (Employee H-10).

A June 21 MRI arthrogram of both the right and left wrist was performed. The history showed a repetitive motion injury. The right wrist showed a full thickness radial sided TFC tear on the right, defects in the ulnar aspect of the TFC, and a volar full thickness tear of the lunotriquetral ligament. The left wrist showed a large radial sided full thickness TFC tear and an abnormal ulnar sided TFC (Employee H-12). On June 21, Dr. Brown noted that the employee had had MRI arthrograms of both wrists which showed a large tear of the right TFCC ligament and on the left a smaller defect in the left TFCC and a defect in the volar aspect of the left lunotriquetral ligament. Dr. Brown recommended a right wrist arthroscopy followed by arthroscopic debridement for repair of the ligament (Employee H-11).

On June 22, the employee cancelled therapy because his father was having surgery (Employee H-10). In July Dr. Kapp gave the employee another subacromial injection and was continued with the same work restrictions (Employee H-5).

On July 18, Dr. Brown performed an arthroscopic debridement of the large right central TFCC tear. After the surgery a burn localized over the medial aspect of the right proximal forearm was discovered when the employee's arm was removed from the traction tower. A blister over the burn was debrided and thoroughly cleansed and dressed. On July 31, Dr. Brown noted the employee had been treated by another physician for the burn over the medial aspect of his right forearm. The burn appeared to be a third-degree burn (Employee H-11 and H-12). On August 14 Dr. Thornton performed a skin graft of the right elbow and took a graft from the right anterior thigh (Employee H-2).

On August 22, Dr. Tobin noted that the employee suffered a full thickness burn during surgery, and did not want to see Dr. Brown again. Dr. Tobin offered to treat him. In the patient status report, Dr. Tobin again checked the box that it was a workers' compensation case (Employer 6). On September 21, the employee noted that he was better after the surgery but still had problems. In September it was noted that the employee had missed two weeks of physical therapy due to the death of his father-in-law. On October 5 it was noted that the employee's father had had a heart attack. On October 6 it was noted that the employee's father was very ill (Employee H-10). On October 10, Dr. Tobin noted the employee seemed to be depressed. The employee was having more pain and was beginning to grow tired of his lack of progress. The wrist had some swelling of the ulnar aspect and was significantly tenderer than before. In the patient status reports in September and October, Dr. Tobin checked the box marked workers' compensation as opposed to non-work related (Employer 6).

Dr. Kapp continued to treat the employee for his shoulders in August and September. In October he performed another injection (Employee H-5). The employee saw Dr. Catron on October 19 due to a chief complaint of anxiety and pain. It was noted that the employee had a bad year with workers' comp including burn on right elbow. His father had just died due to heart disease and stroke and was buried the day before. His father-in-law died about 5 weeks ago with lung cancer. Dr. Catron diagnosed anxiety and depression, and put him on Serzone and Valium. He had previously been on Ativan (Employee H-1).

The employee stated seeing Dr. Lents at the end of October for his wrists. He diagnosed bilateral torn triangular fibro cartilages and recommended an MRI of both wrists (Employee H-5). At the end of October the employee saw Dr. Kapp for his shoulders, and recommended right shoulder surgery. On November 20, Dr. Kapp performed a right shoulder arthroscopy with subacromial decompression due to impingement (Employee H-5 and H-8). In the prior medical history, it showed the employee was being treated for anxiety/panic attacks and that the employee's father and father-in-laws on both sides had died within the past 12 months (Employee H-8).

Dr. Catron continued to treat the employee in November and December of 2000 for depression/anxiety (Employee H-1). On November 22, Dr. Kapp removed the shoulder sutures and started passive range of motion. He noted that the employee was doing very nicely. On December 6, the employee still had pain but his range of motion was slowly improving. On December 20, Dr. Kapp noted that the employee had developed some myofascial pain in his upper extremity. The employee had fallen three times over the last week on the ice and snow, which slowed his progress down. Dr. Kapp sent him to the Hand Center for a myofascial release program (Employee H-5).

2001:

On January 3, 2001, the therapist at the Hand Center noted that the employee had symptoms of myofascial pain with decreased range (Employee H-13). The employee saw Dr. Lents on January 8 with a diagnosis of bilateral torn triangular fibro cartilage. Dr. Lents stated that the MRI showed bilateral tears of his TFCC and lunotriquetral ligament tears. On January 15, Dr. Kapp performed trigger point injections in the shoulders and noted that his myofascial release program was progressing slowly (Employee H-5). On February 23, Dr. Lents performed an open triangular fibro cartilage excision of the right wrist (Employee H-8 and H-5).

On March 8, Dr. Lents noted that the employee was doing well from the surgery, and the sutures were removed. He was sent for occupational therapy. On March 29, the employee still had pain with some swelling and dropping with the right hand. On April 20, Dr. Lents noted that the pain was better. On April 20, Dr. Kapp released him to go back to work with no restrictions for his shoulder, but noted that he was still off work by Dr. Lents (Employee H-5). The employee had therapy from January 3, 2001 through early May of 2001 (Employee H-13). Dr. Catron treated the employee in March and May of 2001 for depression/anxiety (Employee H-1).

On May 7 Dr. Lents noted that his right wrist continued to improve, but his left wrist remained symptomatic. On June 1, Dr. Lents performed an open excision of the triangular fibro cartilage (Employee H-5 and H-4). On June 11, the employee returned. Dr. Lents noted that the wound had healed nicely and he removed the sutures. The employee was having some pain, was to do therapy at home, and was to return in two weeks. Dr. Lents stated that the employee did not need to have x-rays when he returned in two weeks. On June 25 the employee saw Dr. Lents. The employee had recently tripped over a garden hose at home and fell. He had a lot more swelling and pain since then. The employee's wrist was more swollen than before and was tender to palpation. Dr. Lents stated that the repeat x-rays showed no fracture, but the wrist was quite swollen. Dr. Lents put the employee in a short arm cast and refilled his Vicodin. Dr. Lents continued the cast in July. On August 30, the employee's right wrist was fine. The employee had left wrist pain, and on his left hand was tender to even light touch of the skin. Dr. Lents stated that the employee might be developing RSD in the left wrist. He continued the restrictions of no use of his left hand and no lifting over 10 pounds with his right hand, and referred the employee to for further rehabilitation (Employee H-5).

On August 20, Dr. Catron noted that the employee was not doing well. His younger brother who is 36, has had two heart attack and strokes, abused alcohol and drugs, and recently tried to commit suicide. He had attacked the employee and threatened to kill him, and was now at the Mental Health Center in Farmington. Dr. Catron assessed depression and a family stress situation (Employee H-1).

On September 14, Dr. Lents noted that the employee complained of tingling in his fingers, extreme pain, and difficulty with even light touch and difficulty using his left hand. On exam the employee had pain to light touch, and dysesthesia diffusely over his hand in non-neurogenic patterns. The employee had pain with passive motion and was voluntarily guarding his hand. Dr. Lents felt that he had developed an RSD and needed treatment. The employee was referred to Dr. Graham (Employee H-5).

Included in Dr. Graham's records is a September 14 letter from Dr. Lents. Dr. Lents stated that the employee's diagnosis was reflex sympathetic dystrophy of the left upper extremity, which was causally related to his injury with dysfunction of the symptomatic nervous system in response to trauma. Dr. Lents recommended that he see a psychiatrist to have his RSD treated, and noted that RSD is difficult condition to treat (Employee 5).

On September 21, Dr. Catron stated that the employee has had a bad year. His father died, his father-in-law died, his brother threatened to kill him, he had a work injury with seven surgeries including a burn, has filed a claim and with light duty may lose his job. Dr. Catron diagnosed depression (Employee H-1).

The employee saw Dr. Strecker on September 28 for bilateral wrist pain with his left much more marked than the right. The problems with his wrists and shoulder began on March 10, 2000. He related the problems to the radial and ulnar deviation of his wrists and the constant motion in his shoulders from work. Dr. Strecker noted that on June 1 the employee had an excision of the left TFC and postoperatively was doing fairly well. On June 25, the employee slipped on a garden hose and landed on his left wrist. It was noted that there was some concern as to whether or not he may have had a fracture. The employee was placed in a short arm cast for approximately three weeks and since that time he has complaints of marked pain in the left wrist and inability to use the wrist. The employee stated that both of his shoulders were feeling fairly well with occasional discomfort on the right. His right wrist was not bothering him. The left wrist and arm were exceedingly painful. He does not like any motion or even incidental touching of the arm due to extreme pain. Dr. Strecker performed a physical examination on the employee. He stated that he felt that the employee had symptoms that far exceed his physical findings, which would be suggestive of a form of regional pain syndrome. Dr. Strecker noted that the employee may also have an ongoing ulnar abutment or TFC irritation but it was difficult to ascertain due to his exaggerated symptomatology. Dr. Strecker recommended evaluation and treatment by pain management. Dr. Strecker put him on one-handed work duties without the use of his left hand (Employee H-7).

The employee saw Dr. Chiu on October 5, after being referred by Dr. Strecker for evaluation of the left upper extremity RSD. The employee reported that soon after the June 1, 2001, surgery he began to develop left wrist, hand and forearm pain. He has had gradually worsening increased hypersensitivity over his hands and fingers, and very limited toleration of his hand. Physical examination showed that the employee's left upper extremity was mildly swollen compared to the right. It was very hypersensitive to light touch along the whole left hand. The employee had significantly decreased flexion and restricted extension with pain with tenderness over the ulnar side of the wrist. Dr. Chiu's assessment was left upper extremity RSD. Dr. Chiu performed a stellate ganglion block. Dr. Chiu continued Hydrocodone and started him on Neurotin and Nortriptyline (E-I 5). Dr. Chiu treated the employee with ganglion blocks in October with improvement in pain in the left lateral wrist and RSD improving. Dr. Chiu recommended a follow-up with Dr. Strecker for left lateral wrist

pain, which he did not feel was due to the RSD. By early November, Dr. Chiu had performed six stellate ganglion blocks. Dr. Chiu then performed trigger point injections. Dr. Chiu noted that he felt that the employee's left upper extremity RSD was controlled. He continued the employee on Hydrocodone, Neurontin and Nortriptyline (Employer 5 and Employee H-14).

Dr. Strecker saw the employee on November 13 and noted some improvement in his hypersensitivity. The employee still had ulnar sided wrist pain. The trigger point injections helped for a short time. The employee did not exhibit near the guarding that was previously noted, but still had tenderness. He was continued on limited work duty. On December 4, Dr. Strecker performed a wrist arthroscopy with partial synovectomy and debridement of the TFC and ulnar shortening using the Rayhack method for left ulnar sided wrist pain. On December 11, the employee was placed in a short arm cast and was on limited duty with no use of his left hand (Employee H-7).

2002:

Dr. Strecker continued to treat the employee in January and February of 2002 (Employee H-7). The employee received the therapy at Mid America Rehab starting on January 14 and ending on March 13. The therapist stated the program was very light and did not feel that it should be contributing to the employee's report of severe wrist pain (Employee H-15).

On March 19 the employee had severe unremitting pain over the ulnar aspect of his wrist which was unaffected by medicine. Dr. Strecker noted that the employee exhibited marked guarding and protection of the upper extremity, but when sometimes distracted, his range of motion was noted to be better than on physical examination. He thought that the employee had some symptom magnification (Employee H-7).

On March 27, the employee saw Dr. Graham at the request of Dr. Strecker. The examination showed some mild swelling over the left ulnar aspect of the left wrist with decreased range of motion. The employee would jump to any touch of the ulnar wrist and two focal areas of pain on the dorsal aspect of the wrist. Dr. Graham's assessment was left wrist pain but no findings on exam or in his history that in his view would be consistent with the diagnosis of RSD. In patients that have RSD, one would expect to see significant swelling, tenderness and temperature change in the hand as well as changes in skin texture, coloration, nails and hair distribution and coloration. Dr. Graham did not see any of that. Dr. Graham's differential diagnosis was sensitivity postsurgery that would improve with time. Dr. Graham adjusted his medication and placed him on Oxycotin. Dr. Graham ordered a repeat MRI and three-phase bone scan of the left wrist (Employer 5).

The radiologist report of the bone scan indicated mild to moderate increased activity along the base of the lunate which corresponded well with mild edema on the MRI of the left wrist which may reflect a sequelae of prior trauma (ulnar impaction syndrome) (Employer 5).

The employee saw Dr. Graham on April 11. Dr. Graham stated that the bone scan and MRI were consistent with the prior surgery. Dr. Graham did not find any evidence of anything consistent with RSD. On exam, Dr. Graham noted that the employee was inconsistent. When distracted the employee would let him touch around his previous surgical site without any obvious sign of distress or withdraw. However, when he was focused on watching his arm, any touch about the wrist or forearm on the ulnar aspect would cause the employee to noticeably withdraw. Dr. Graham stated that objectively the employee had a good outcome from the surgery. Dr. Graham did not find any objective findings that would account for the employee's severe complaints and the employee had several inconsistencies. The employee was not experiencing discomfort that would require ongoing narcotics. Dr. Graham recommended the employee continue his antiinflammatory medications, but not any narcotics. He recommended a functional capacity exam. (Employer 5).

The employee's functional capacity evaluation was performed on April 24. It was noted that the employee demonstrated functioning in the light work demand level and demonstrated musculoskeletal deficits. The therapist noted a color difference in the redness of the left hand compared with the right. The therapist stated that the employee's performance was punctuated by symptom magnification behavior and submaximal effort and the true level of function must be left to conjecture. The employee's behavior and movement patterns are different when directly measured versus associated conversation (Employer 5).

On May 8, Dr. Strecker noted that the employee had undergone a functional capacity evaluation. It was felt that the employee was capable of a light work demand level, but was functioning with sub-maximal effort and was noted to have symptom magnification. At his request the employee was placed in a short arm cast on the left side. If that alleviated all of his pain, then consideration could be given for a wrist fusion. In late May and in July, the employee stated that he had marked improvement in his symptoms after he was wearing the cast. Dr. Strecker recommended a wrist fusion but referred the employee to Dr. Coin (Employee H-7).

Dr. Coin saw the employee on August 13. The employee performed repetitive work at Gates Rubber for over 13 years. The employee denied any secondary or part-time jobs or any unusual hand manipulative hobbies. The employee stated that his right wrist was doing very well with little symptoms. With regard to his left hand and wrist, his number one problem was pain, and any movement causes pain. He also has decreased strength and decreased mobility. The employee had some intermittent numbness in his small and ring fingers. The pain is primarily centered from his hand to the wrist and radiating to the forearm. The pain was very severe and hinders any movement in the left wrist. His symptoms have been getting progressively worse over time. Dr. Coin did not feel that a limited fusion procedure would offer the employee any

improvement. When asked to comment on whether his condition was due to cumulative injury at work and whether the future treatment was related to his work, Dr. Coin stated that with regard causation, that an evaluation after such extensive treatment offered difficulties. Typically injuries of a TFCC resulted from forceful application of an extension-pronation force to the axial loaded wrist such as a fall on an outstretched hand were forceful rotation injuries. Other mechanisms included distraction force or fracture of the distal radius. It was his understanding that no "specific instance" of force was documented. Dr. Coin stated that unless such an instance was documented, a work-related origin would be in question. Dr. Coin stated that the employee's functional ability was light assistive use of the left wrist with a two pound lift limit and no repetitive duties (Employee H-6).

Dr. Catron continued to treat the employee for depression in 2002. On August 16, Dr. Catron stated that the employee was better with his depression than has been for ages. He stated that the employee was still disabled and was on disability (Employee H-1).

Dr. Coin, in a letter dated October 13, stated that if the employee did not elect to have fusion surgery on his left hand, it would be his opinion that the employee had a 30% permanent partial disability of the left wrist (Employer 1).

On October 16, the employee continued to note that his pain was relieved by immobilizing the wrist. In the interval history section, Dr. Strecker noted there was some concern with regard to the mechanism of injury as it related to him having fallen on his left arm under Dr. Lents' treatment. Dr. Strecker noted that the employee did not fall or land on his wrist, but landed on the upper portion of his arm. He did not see Dr. Lents back on an emergency basis, but waited to see him for his regularly scheduled appointment. Dr. Strecker stated that as to the fall, as the employee related to him, he did not feel that that was a significant contributing factor to his present problems. Dr. Strecker stated that the only surgical form of treatment would be a left wrist fusion, which he performed on December 20 (Employee H-7). After the surgery he was treated for a wound infection by Dr. Lents with IV antibiotics and later with oral antibiotics and a splint by Dr. Strecker (Employee H-7 and H-8).

2003:

In January Dr. Strecker started physical therapy (Employee H-7). The initial evaluation was done on January 22. The employee reported bilateral wrist pain, which he attributed to repetitive motion at work (Employee H-15). At the end of February, the employee noted that his preoperative pain was no longer present, but still had some pain along the ulnar border of the forearm and wrist with some associated numbness. Dr. Strecker continued therapy and limited duty with no use of the left arm (Employee H-7).

By March 10, the employee reported a significant increase in pain, cramping and swelling over the weekend and went to the hospital emergency room. He described discoloration in his left hand of red and purple. The therapist noted some visual difference in color, noted the left hand was red as compared to the right. The employee's range of motion had regressed (Employee H-15).

Dr. Catron noted that on April 2, the employee was not doing well. The employee was upset about losing his job. The examination showed a totally fused left wrist with fingers flexed. Dr. Catron thought the employee was probably disabled and should apply for disability (Employee H-1).

A functional capacity evaluation was done on April 29 but was limited by left wrist/hand function and subjective complaints of pain. There were inconsistencies noted in the exam. The employee exhibited poor tolerance of activities and demonstrated function of medium physical demand level. There was an indication of submaximal or over guarding of effort. The April 29 Green Leaf evaluation showed decreased protective sensation and static touch and pressure of both hands and right forearm (Employee H-15).

Dr. Strecker noted that the employee's functional capacity evaluation report stated that there were inconsistencies in the employee's active range of motion, especially of his elbow and shoulder as well as the findings that there may be some symptom magnification. Dr. Strecker felt that the employee had reached maximum medical improvement and noted that the employee has permanent restrictions of use of his left arm as an assist and no lifting greater than two pounds non repetitive (Employee H-7).

Dr. Catron noted on June 6 that private disability was approved and the employee was going to apply for social security disability. In September Dr. Catron stated that the employee's left hand was still useless. Dr. Catron noted that the employee was stressed. He had been denied on social security disability on his first attempt, and his brother had a stroke and can hardly speak (Employee H-1).

2004:

On January 23, 2004, Dr. Catron noted that the employee was under a lot of stress. His mother-in-law was

in a nursing home and his mother was diagnosed with Alzheimer's. The employee's wrist does not work at all (Employee H-1).

On February 24, Dr. Lehman stated that the employee came in with multiple complaints with no specific history of injury. The employee had complaints referable to wrists, his shoulder and his medial elbow. He functionally has no motion of his left wrist. He has complaints of pain with any type of palpable pressure on the left forearm. It was his opinion that the employee had bilateral TFCC tears and impingement syndrome of his shoulder. He had a wrist fusion on the left and subsequent surgery on the right for his TFCC for what appeared to be problems that were not curable surgically based on his symptom magnification. Any further treatment at this time would make him worse. His symptoms are far in excess of anything one can expect from his objective findings. Dr. Lehman thought the employee could work unrestricted in terms of his right wrist, right shoulder, and left shoulder. He felt that the employee could work in a light duty capacity, but not to use his left wrist for heavy or repetitive lifting. On March 25, Dr. Lehman stated that he did not believe that the medical documentation supported a causal relationship between the accident and injury. Dr. Lehman did not believe the employee was a permanent total. His functional mechanics appears to be quite good and his pain appeared to be subjective (Employee H-9).

In a July 27 letter, Dr. Catron stated that the employee has severe reflex sympathetic dystrophy with pain in his left wrist. His right wrist hurts due to overuse and requires continuous narcotics for pain relief. The employee continued to be totally disabled (Employee H-1).

In a letter dated November 12, Dr. Catron stated that the employee has ongoing reflex sympathetic dystrophy in his left hand, which causes severe and intense pain even with light touch. He has significant dysfunction of his right hand from overuse. He is disabled for the foreseeable future (Employee H-1). On November 16 Dr. Lehman stated that he felt that there was absolutely no causal connection between his problem and his work (Employee H-9).

On December 2, 2004, Dr. Strecker rated the employee's right upper extremity at 25% permanent partial disability of the right shoulder. Dr. Strecker took into consideration the surgeries that had been performed on his wrist as well as a subsequent burn and need for skin graft at the elbow and the impingement syndrome for which he underwent subacromial decompression of the right shoulder (Employee H-7).

Depositions:

Employee's Exhibit A is the deposition of Dr. Eaton. Dr. Eaton saw the employee on August 26, 2003. He performed evaluations, which showed the employee had severe depression, and somatization that is common with reflex sympathetic dystrophy (page 9).

It was Dr. Eaton's opinion that the employee's work was a contributing and substantial factor to the following injuries and disabilities and directly attributable to the work injury including the treatment and complications of treatment for the following conditions:

1. Three-phase fusion of his left wrist, which he rated at 90% disability of the left upper extremity at the level of the wrist.
2. Rayhack ulnoplasty and triangular fibro cartilage complex excision of the right wrist, which he rated at 40% of the right upper extremity at the level of the wrist.
3. Right shoulder bursectomy with a rotator cuff tear repair, which he rated at 25% of the right upper extremity at the level of the shoulder.
4. Complex regional pain syndrome/RSD of the left upper extremity, which he rated at 15% of the left upper extremity at the level of the shoulder.
5. Left shoulder rotator cuff strain or sprain which he rated at 15% of the left upper extremity at the level of the shoulder.
6. Right medial forearm full thickness burn with residual scar, which he rated at 15% of the right upper extremity at the level of the elbow.
7. Myofascial pain in both upper extremities at the shoulders, which he rated at 5% of the whole person.
8. Graft donor site on the right anterior thigh, which he rated at 5% at the right lower extremity at the level of the hip.
9. Anxiety with posttraumatic stress component, restless leg syndrome, and depression with sleep interference, which he rated at 25% of the whole person.

Dr. Eaton testified that the employee's pre-existing and work-related impairments combine in a synergistic fashion to have an effect greater than their simple mathematical sum (pages 11-15).

It was further Dr. Eaton's opinion that the employee would be difficult to employ. He only has a high school education and does not currently possess any skills transferable to a less demanding work environment. The employee's left

wrist is fused and he has a very difficult time using his right hand due to the injury, surgery and the complications. The employee also has a significant sleep interference complicating his ability to concentrate and the physical examination findings suggest he had some type of stroke, which made it unreasonable to expect any employer to hire the employee with his extensive list of injuries and current disabilities (page 15). Dr. Eaton put restrictions of a lifting limit of 5 pounds with his right upper extremity, and no more than 10 pounds with the left upper extremity on a routine basis. The employee should not at any time operate any vibrating or motorized equipment. The employee's attention and concentration are significantly impaired due to depression, anxiety, and medications (pages 16-17). It was Dr. Eaton's opinion that the employee was totally and completely disabled as a result of his work injury of March 10, 2000, and his associated problems. These injuries are all a hindrance or obstacle to his ability to work (pages 17-18).

It was further Dr. Eaton's opinion that the employee should have antiinflammatory medication, and be in a comprehensive pain management program which include injections, medications, TENS unit, electrical stimulation, physical and occupational therapy, antidepressants, maybe even psychotherapy and appropriate medications to help him function better. These recommendations for future medical care would be ongoing and are a result of the March 2000 injury (pages 18-19).

During cross-examination Dr. Eaton stated that a functional capacity evaluation is not an appropriate evaluation for someone with RSD because they almost by definition have significant impairments and neuropathic type pain. Symptom magnification cannot really be well differentiated from excessive pain (pages 22-23).

When asked about whether he was told that the employee had a slip and fall and hurt his arm, Dr. Eaton stated that he could not remember. When asked if that would have an effect on his evaluation or rating if the employee had an intervening event, Dr. Eaton stated that he would probably would have needed to have seen the employee before and after the event to determine the effect or had seen a very detailed examination of change of findings which he did not appreciate from the records that he had available. Dr. Eaton stated without having seen him before and after, it was hard to separate it out. He cannot remember that the employee mentioned it to him, and he did not have his notes (pages 26-27).

Employee's Exhibit B is the deposition of James England. Mr. England stated that the employee that the employee came across looking very tired and depressed, and emotional (Page 6-7). The employee can't read well and does not have much to keep him busy, but he will visit with his mother (page 11). The employee did not have any transferable skills to less physically demanding types of work. Based on testing, the employee's word recognition was at a third-grade level. His reading comprehension and math skills were at a sixth-grade level. With the sixth grade level, it limits the work that he can perform due to the employee's limited reading and math abilities (pages 14, 16).

All the work that the employee had performed appeared to be hand intensive and fairly laborious in nature. Based on a review of the medical records, the employee would not have the physical ability to do any of the kinds of jobs that he had done in the past. Mr. England did not think he had any skills that would transfer to other kinds of employment or jobs, and that considering what appeared to be his combination of impairments, he would not be able to successfully compete for other kinds of employment in the open labor market. Mr. England did not know of any work he could sustain based on the employee's day-to-day functional problems, and did not think that the employee would be an attractive candidate for a prospective employer. That is based on a combination of how he came across verbally as well as the obvious problems that he has with his upper extremities. Based upon what the employee described and what was in the medical records as far as his fatigue, the emotional side effects, as well as the physical problems, Mr. England did not see the employee being able to sustain any kind of regular work activity that he was aware of in the open labor market unless the employee can be improved significantly with additional treatment. It was his opinion that the employee would likely remain disabled from a vocational standpoint (pages 18-20).

Employer-Insurer Exhibit 4 is the deposition of Donna Abrams. She was scheduled to meet with the employee to conduct a vocational assessment but did not because the employee's attorney had declined the service. Ms. Abrams stated that an interview is extremely helpful because it gives an opportunity to personally observe the employee's pain level, how he processes information, and his ability to basically interact. Even without meeting him, she was able to come to conclusions within a degree of reasonable degree of certainty (pages 8-9).

The employee has a number of transferable skills and abilities. He demonstrated above average manual dexterity, average general learning, numerical aptitude, spacial and form perception, motor coordination and finger dexterity. He has demonstrated the ability to perform tasks that were more complicated than just unskilled labor jobs (pages 15-16). Ms. Abrams stated that using Dr. Lehman's, Dr. Eaton's, Dr. Strecker's, Dr. Coin's, Dr. Kapp's, and Dr. Lents' limitations, she found almost a thousand jobs that that the employee's profile matched. She outlined some of the jobs that she felt was representative of the types of jobs that he could do at this time but it was not an exclusive list (pages 17-18). It was Ms. Abrams' opinion that the employee is employable in the open labor market. Based upon her experience, expertise and information provided and review of that information, it was her opinion that the limitations are to his non-dominant arm, the employee can use his dominant arm and with his limitations and the information provided to her, he is able to perform a number of jobs that exist in the open labor market and at 48 years-old, he should be able to obtain those jobs fairly readily (pages 20-22).

Employer's Exhibit 3 is the deposition of Dr. Lehman. Dr. Lehman testified that the employee did not complain of

any repetitive cumulative trauma to his wrist, his forearms, his elbows or his shoulders. He gave no specific history of any accident or injury and gave no history of an injury or any specific problems in particular (page 9). Dr. Lehman did not believe that a TFCC tear is a repetitive trauma type problem. He believes that it is a traumatic problem such as from a fall on the wrist or a degenerative tear. Since the employee was 48 years-old, he is going to have some degeneration of his triangular fibro cartilage (page 10). Dr. Lehman testified since the operative reports showed a complete central deficiency of the TFCC with the rim being intact, that is usually a degenerative type tear, which might be from garden variety aging or from the mechanics of the wrist. If someone is ulnar positive where the ulnar is relatively long for the wrist, there will be some damage in the triangular fibro cartilage. Based on that, you might break down or tear the TFCC. That was probably one of the big components of the employee's TFCC problem (pages 10-11).

It was Dr. Lehman's opinion that the employee's complaints were not proportional to the objective medical problems. His treatment seems to have progressed due to his subjective complaints of pain with him ending up having a severe surgery. Dr. Lehman felt that the symptoms were in excess of his medical identifiable problems. Dr. Lehman felt that the employee should not be on narcotic pain medication because his symptoms seemed to be far in excess of what one would anticipate from the pathology identified on his testing, in his medical care and treatment and on physical exam. It was Dr. Lehman opinion that there was not a causal connection between his medical problems and his job activities. It was Dr. Lehman's opinion that the employee was able to work in the open labor market, and was not permanently and totally disabled (pages 11-15).

During cross-examination, Dr. Lehman stated that he does not believe that he specifically asked the employee what type of activities he performed with his hands and upper extremities while working at Gates Rubber (page 17). It was Dr. Lehman's opinion that the cause of the employee's injuries was not due to his job activities. Dr. Lehman stated that a component of the employee's injuries was degenerative. The employee had a degenerative central tear of the triangular fibro cartilage and what appeared to be an ulnar positive wrist. That combination is going to create a TFCC tear in a substantial number of people. As one gets older, they get a little bit of rotator cuff breakdown and impingement. Dr. Lehman did not agree that it would be difficult for him to make his conclusions if he did not fully understand the duties that the employee performed at Gates Rubber because the medical records show that the employee had a hand repetitive job. Dr. Lehman did not think the employee's problems were due to repetitive activities (pages 18-19).

Employer-Insurer Exhibit 2 is the January 19, 2005, deposition of Dr. Strecker. Dr. Strecker stated that x-rays taken on September 28, 2001 showed ulnar positive variance which meant that his ulna was longer than his radius which fits someone who has ulnar sided wrist pain and possible triangular fibro cartilage problems (pages 7-8). In September of 2001, Dr. Strecker did not think that the employee needed any further surgery for his TFC tears. Since the employee's symptoms exceeded his physical findings and as a result of his injuries he had regional pain syndrome/reflex sympathetic dystrophy, Dr. Strecker felt the employee would benefit from injections and/or ganglion blocks so see how much was attributable to his wrist versus the pain syndrome (pages 9-10). Dr. Strecker stated that due to persistent ulnar sided wrist pain, which can act as a trigger to overall pain syndrome, he arthroscoped his wrist to see if there were persistent problems or possibly shorten his ulna to unload that side of the wrist to see if it would help his pain (pages 10-11).

It was Dr. Strecker's opinion that the employee had sustained a 55% permanent partial disability of his upper extremity on his left side. The permanent restrictions were to use his left arm only as an assist and no lifting greater than two pounds with his left arm non-repetitive (pages 23-24). With regard to his right upper extremity, he did not place any restrictions on his right upper extremity. It was Dr. Strecker's opinion that the employee had a 25% permanent partial disability of the right upper extremity at the level of the shoulder. When Dr. Strecker released the employee, he did not see the necessity to put the employee on pain medication in the future for either shoulder or either arm (pages 24-25).

During cross-examination, Dr. Strecker stated that with regard to continued medication for pain management, the employee may need pain medication on an as-needed basis in the future. (Page 25). Dr. Strecker testified that it was not unreasonable that the employee would have a continued need for analgesics or pain medicine (pages 28-29).

Employer-Insurer Exhibit 1 is the November 28, 2002, deposition of Dr. Coin. He stated although repetitive motion work could potentially be a cause of triangular fibro cartilage tears, typically a triangular fibro cartilage tear usually results from a forceful stress in of the wrist, such as a forceful application of an extension and pronation type of force on a fixed wrist such as a fall on an outstretched hand forceful rotation type of injury. Other mechanisms can include a distraction force or a fracture (page 18).

Dr. Coin looked at the June 25, 2001 note from Dr. Lents, which stated, "Tripped over the garden hose at home and fell recently and has had a lot more swelling and pain since that time. On exam, his wrist is more swollen than before and is tender to palpation. Repeat x-rays show no fracture but he is quite swollen. I will put him in a short arm case, refill his Vicodin, return in two weeks, remove the cast, no x-rays needed, off of work." Dr. Coin stated that the note does not indicate the fall was on any other part of his left arm other than the wrist. He reviewed the September 28, 2001 record from Dr. Strecker, which says that on June 25, the employee slipped on a garden hose and landed on his left wrist. There was some concern as to whether he had a fracture. He was placed in a short arm case for approximately three weeks and since that time has had complaints of marked pain in his left wrist and inability to use the wrist (pages 10-11). Dr. Coin stated that after the fall over the garden hose, the employee has had a series of significant exacerbations of pain and symptoms leading to his current clinical status. If the employee fell on a garden hose and sustained a wrist injury that could very certainly be a

cause of the employee's significant complaints with his left wrist (page 19).

During cross-examination, Dr. Coin stated that the surgeries that he had on the right and left wrist for the TFCC occurred prior to the incident tripping on the garden hose (page 22). In Dr. Chiu's October 5, 2001 records, the employee reported that soon after the surgery the employee began to develop left hand wrist and forearm pain. When asked if the employee had the pain after the surgery and before the fall with the garden hose would change his position as to cause of the pain the employee was having at present, Dr. Coin stated that it was possible. It would be expected to normally have pain after surgery. However even with postoperative pain if the employee fell, it could cause the significant problems the employee currently has. If the employee tripped and fell after the surgery he could have continued ongoing pain from the tripping incident but it could be from the surgery (pages 23-24).

Dr. Coin stated that at the time he examined him in August of 2002, the employee did not appear to have RSD. Since he had such diffuse amount of pain, it is not possible to specifically determine where the pain is coming from and what specifically was causing the pain. His current condition and pain could be due to work-related general repetitive disorder, some age-related arthritic condition, the original triangular fibro cartilage injury, the extra stress and scarring from surgery, a potential inflammatory disorder, pain complexes, and the garden hose fall among others (pages 24-26). It is possible that the residual from the TFCC and prior surgery could be a cause of the employee's current pain (page 30).

Dr. Coin stated repetitive work would be a less likely cause of triangular fibro cartilage tear. It's hypothetically possible, but he would look for other stress related traumatic injuries as a predominant cause. The employee denied that he had any other stress related injuries prior to the time that he had the surgeries and there was nothing in the medical records concerning any preexisting injuries (pages 34-35).

FINDINGS OF FACT AND RULINGS OF LAW:

Issue 1. Accident/Occupational Disease and Issue 3. Medical Causation

The employee's uncontradicted testimony was that he started working in 1988 at Gates Rubber Company and all the jobs that he performed were highly repetitive and intensive involving his hands, arms and shoulders. He worked full time and had no other hand intensive jobs or activities. Sometime at the end of 1999 or in early 2000, he started having problems with his upper extremities. In early March of 2000, due to a therapist being at the plant, the employee reported his problems to his supervisor and was sent for treatment. I find that the employee had a highly repetitive and intensive occupation involving his upper extremities and did not have any repetitive and intensive activities involving his upper extremities outside of work.

Bilateral triangular fibro cartilage tears and treatment through June 11, 2001:

The employee was diagnosed with bilateral triangular fibro cartilage tears in both wrists by Dr. Brown, Dr. Lents, and Dr. Tobin. In July of 2000, Dr. Brown performed a debridement of the right central TFCC tear and during surgery the employee's right arm was burned. The employee had a skin graft for the burn and the graft was taken from the employee's right thigh. In February of 2001 Dr. Lents performed an open triangular fibro cartilage excision of the right wrist. The employee recovered from that surgery and was doing better at the end of April of 2001. On June 1, 2001, Dr. Lents performed an open excision of the left triangular fibro cartilage tear.

Dr. Brown stated that the cause of the pain in his wrists was not clear. Dr. Lehman agreed that the medical records showed that the employee had a hand repetitive job but he did not believe that a TFCC tear was a repetitive problem. It was Dr. Lehman's opinion that there was not a causal connection between the employee's job activities and his injuries.

Dr. Coin stated that repetitive motion work could cause triangular fibro cartilage tears but typically it resulted from a forceful stress of the wrist such as a fall, and unless such an instance was documented, a work-related origin would be in question. The employee denied that he had any other stress related injuries prior to the time that he had the surgeries and there was nothing in the medical records concerning any preexisting injuries.

In March of 2000, Dr. Tobin stated that it sounded like the employee had a very highly repetitive rate of ulnar wrist impaction, which was injuring his triangular fibro cartilage. In the employee's first visit, Dr. Tobin noted he would like to tour the plant and see what the employee did so he could get a better handle on the role that his occupation was playing. However, in every patient status report in March, April, August, September and October of 2000, Dr. Tobin indicated that it was a workers' compensation case.

It was Dr. Eaton's opinion that the employee's work was a contributing and substantial factor to the injuries and disabilities and directly attributable to the treatment and complications of treatment for the left wrist, the right wrist including the triangular fibro cartilage complex excision, the right medial forearm full thickness burn with residual scar, and the graft donor site on the right anterior thigh.

Based on the employee's testimony concerning his occupation and a review of all of the written evidence, I find that the opinions of Dr. Eaton and Dr. Tobin are more credible than the opinions of Dr. Brown, Dr. Coin, and Dr. Lehman.

I find that the employee sustained a compensable accident or occupational disease that arose out of and in the course of his employment with Gates Rubber. I further find that the employee's work was a substantial factor in causing his bilateral triangular fibro cartilage tears and was therefore clearly work related. The evidence supports the finding that the employee's bilateral torn triangular fibro cartilage tears followed as a natural incident of his work and can be fairly traced to his employment as the proximate cause. I further find that the employee's bilateral torn triangular fibro cartilage tears and the need for medical treatment through June 11, 2001 including the surgery by Dr. Brown, which caused the forearm burn and subsequent treatment, and the surgeries by Dr. Lents, are medically causally related to the employee compensable accident or occupational disease.

Left wrist and left upper extremity after June 11, 2001:

On June 1, 2001, Dr. Lents performed an open excision of the left triangular fibro cartilage tear. Dr. Lents saw the employee on June 11. Between June 11 and June 25, 2001, the employee tripped and fell over a garden hose at home. After this incident, the employee was diagnosed with and treated for RSD/regional pain syndrome in the left upper extremity, and had two additional surgeries on his left wrist. Dr. Strecker performed both surgeries. The first surgery was a wrist arthroscopy with partial synovectomy and debridement of the TFC and ulnar shortening for ulnar sided wrist pain. The last surgery was a fusion of the left wrist. The employee has the burden of proving that those conditions were clearly work related and that his work was a substantial factor in the cause of the resulting medical condition or disability, and treatment.

The employee testified that between June 11 and June 25, 2001, he was outside of his house and fell over garden hose. He was walking on an embankment and caught his right toe under the garden hose and tripped. On the way down he twisted his body and landed on his left shoulder blade and back. His left arm was up in the air and the fall did not affect his wrist. When he went back to Dr. Lents on June 25, he did not have swelling or an increase in symptoms in his left wrist.

The medical records contradict the employee's testimony. Dr. Lents' records show that on June 11 the employee's wound was healed nicely and the sutures were taken out. The employee was having some pain and was to do therapy at home. He was to return in two weeks. Dr. Lents specifically noted that when he returned, x-rays were not to be done. On June 25, Dr. Lents stated that recently the employee had tripped over a garden hose at home and fell. Since then, the employee was having a lot more swelling and pain. Dr. Lents stated that the employee's wrist was more swollen than before and was tender to palpation. He ordered repeat x-rays, which showed no fracture. Dr. Lents noted that the employee's wrist was quite swollen. He put the employee in a short arm cast and refilled his Vicodin. On August 30, Dr. Lents stated that the employee might be developing RSD in the left wrist. On September 14, Dr. Lents stated that employee had developed RSD, and needed treatment.

Dr. Coin stated that the June 25, 2001, record from Dr. Lents does not indicate the fall was on any other part of his left arm other than the wrist.

Dr. Strecker's records show that on September 28, 2001, the employee's left wrist pain was much more marked than his right. Dr. Strecker stated that after the June 1 surgery, the employee was doing fairly well until he slipped on a garden hose and landed on his left wrist. There was concern about a fracture and he was placed in a short arm cast. Since then he has had marked pain and inability to use the left wrist. Due to extreme pain, the employee did not like to move or even have his arm be touched. He thought the employee had a form of regional pain syndrome. When the employee saw Dr. Chiu on October 5, 2001, he stated that soon after the June 1 surgery, he began to develop left wrist, hand and forearm pain. Dr. Chiu diagnosed RSD.

Based on a review of the evidence including the June 11 and June 25, 2001 reports of Dr. Lents and the September 28, 2001 report of Dr. Strecker, and the testimony of Dr. Coin regarding the fall, I find that after the employee's June 1 surgery, the employee was recovering well until he tripped at home over a garden hose and landed on his left wrist. The fall aggravated the employee's left wrist and caused more swelling and pain. I find the employee's version of the fall that he did not land on his wrist and that he had no swelling or increase in symptoms on June 25, was not credible.

There are several causation opinions regarding the left upper extremity. Dr. Lents stated that the employee's RSD in the left upper extremity was causally related to his injury with dysfunction of the sympathetic nervous system in response to trauma. An important question is: Was the trauma from the original work-related injury or was it from the injury of falling over the garden hose? I find that Dr. Lents' opinion is affected by this ambiguity in his medical record.

It was Dr. Eaton's opinion that his work was a contributing and substantial factor to the injuries and disabilities and directly attributable to the treatment and complications of treatment for the three-phase fusion of his left wrist and the

complex regional pain syndrome/RSD of the left upper extremity. Dr. Eaton's opinion is substantially affected by the fact that he was unaware that the employee had slipped and fallen and hurt his arm. Dr. Eaton stated without having seen the employee before and after the fall, it was hard to separate it out if it had an effect on causation.

It is important to note that the employee told Dr. Strecker contradictory versions of the fall over the garden hose. On September 28, 2001, the employee told Dr. Strecker that he fell on his left wrist and since that time he had marked pain and inability to use his left wrist. On October 16, 2002, the employee told Dr. Strecker that he did not fall or land on his wrist but fell on the upper part of the arm. Dr. Strecker stated that based upon what the employee told him in October of 2002, he did not feel that that the fall was a significant contributing factor to his present problems. Dr. Strecker's causation opinion is substantially affected because it is based upon an incorrect history of the fall, which is the same version of the fall that the employee testified to at the hearing.

Dr. Coin stated that after the fall, the employee has had a series of significant exacerbations of pain and symptoms leading to his current clinical status. He further stated that if the employee fell and sustained a wrist injury that could very certainly be a cause of the employee's significant complaints with his left wrist. Dr. Coin stated that one would be expected to have some pain after surgery but if the employee fell on his wrist, it could cause the significant problems the employee currently has. Dr. Coin stated that the employee's current condition and pain could be due to work-related general repetitive disorder, some age-related arthritic condition, the original triangular fibro cartilage injury, the stress and scarring of the surgery, a potential inflammatory disorder, and pain complexes, or it could be due to the fall among other things.

It was Dr. Lehman's opinion that there was not a causal connection between his medical problems and his job activities.

It is important to compare what transpired after the employee's two right triangular fibro cartilage wrists surgeries and right shoulder surgery with no intervening fall to what transpired after the one triangular fibro cartilage surgery on the left wrist with an intervening fall at home on his left wrist. The employee appeared to have a routine recovery on the right side even after three surgeries and did not develop RSD or regional pain complex. The employee had one surgery on his left wrist and was recovering fairly well until he fell on his left wrist at home. In September of 2001, Dr. Strecker noted that the employee was doing fairly well until he slipped on a garden hose and landed on his wrist. Dr. Lents noted on June 11 that the employee was recovering fairly well and would not require another x-ray on his next appointment. Due to the fall at home, the employee experienced a lot more pain, tenderness, and swelling. At the next appointment, Dr. Lents changed his opinion and ordered another x-ray, and put the employee's left arm in a cast. The employee continued to have substantial problems and was diagnosed with RSD/regional pain complex, and needed two additional surgeries including a fusion. I find that the fall at home aggravated the employee's work-related condition and made it more symptomatic and disabling.

Based on a review of all of the evidence, I find that opinions of Dr. Lehman and Dr. Coin are more credible than the opinions of Dr. Lents, Dr. Strecker, and Dr. Eaton regarding the RSD/Regional Pain Syndrome in the left upper extremity, the left wrist arthroscopy with partial synovectomy and debridement of the TFC and ulnar shortening, and the left wrist fusion surgery. I find that there is insufficient evidence to support a finding that the employee's RSD/regional pain syndrome in the left upper extremity, the left wrist arthroscopy with partial synovectomy and debridement of the TFC and ulnar shortening, and the left wrist fusion surgery are medically causally related to the work-related accident or occupational disease. I find that the employee has failed to meet his burden of proof that those conditions were clearly work related and his work was a substantial factor in the cause of those medical conditions and disability.

Bilateral shoulder impingement with rotator cuff tendonitis with treatment through December 6, 2000.

Dr. Kapp diagnosed the employee with bilateral shoulder impingement with rotator cuff tendonitis. He treated the employee with subacromial injections in both shoulders, and therapy. Dr. Kapp ultimately performed subacromial decompression on the right shoulder in November of 2000.

It was Dr. Lehman's opinion that there was not a causal connection between the employee's job activities and his injuries. Dr. Tobin initially examined the shoulders before Dr. Kapp started treating the employee. In the patient status reports, Dr. Tobin indicated that it was a workers' compensation case. Dr. Kapp stated that the employee did repetitive motion work, and that it was his opinion that the employee's occupation was a contributing factor to his shoulder condition. It was Dr. Eaton's opinion that his work was a contributing and substantial factor to the injuries and disabilities and directly attributable to the treatment for the shoulders including the surgery to the right shoulder.

Based on the employee's uncontradicted testimony concerning his occupation and a review of all of the written evidence, I find that the opinions of Dr. Eaton, Dr. Tobin and Dr. Kapp are more credible than the opinion of Dr. Lehman. I find that the employee sustained a compensable accident or occupational disease that arose out of an in the course of his employment with Gates Rubber. I further find that the employee's work was a substantial factor in causing his bilateral shoulder impingement with rotator cuff tendonitis and was clearly work related. The evidence supports the finding that the employee's bilateral shoulder impingement with rotator cuff tendonitis followed as a natural incident of his work and can be fairly traced to his employment as the proximate cause. I further find that the employee's bilateral shoulder impingement

with rotator cuff tendonitis and the need for medical treatment through December 6, 2000 including the surgery by Dr. Kapp are medically causally related to the employee's compensable accident or occupational disease.

Bilateral shoulders after December 6, 2000:

The employee had right shoulder surgery on November 20, 2000. On November 22, Dr. Kapp removed the employee's sutures and started passive range of motion. He noted that the employee was doing very nicely. On December 6, the employee still had pain but his range of motion was improving. On December 20, the employee stated that he had fallen three times over the last week on the ice and snow, which had slowed his progress. Dr. Kapp stated that the employee had developed some myofascial pain in his upper extremity, and sent him to the Hand Center for a myofascial release program. The employee has the burden of proving that the myofascial pain condition was clearly work related and his work was a substantial factor in the cause of the resulting medical condition or disability, and treatment.

It was Dr. Eaton's opinion that his work was a contributing and substantial factor to the injuries and disabilities and directly attributable to the treatment and complications from treatment for the myofascial pain in both upper extremities to the shoulders which he rated at 5% of the body as a whole.

Dr. Kapp started treating the employee's shoulder on May 24, 2000. The employee was not diagnosed with myofascial pain until December 20 after the employee had fallen on the ice and snow three times in the week prior to December 20. I find that the employee has failed to meet his burden of proof on the issue of medical causation for the myofascial pain. I find that there is insufficient evidence to support a finding that the employee's myofascial pain is medically causally related to the work-related accident or occupational disease. I find that the employee has failed to meet his burden of proof that this condition is clearly work related and his work was a substantial factor in the cause of those medical conditions and disability.

Depression/Anxiety:

The employee has been diagnosed with depression and anxiety. The employee has the burden of proving that those conditions are clearly work related and his work was a substantial factor in the cause of the resulting medical condition or disability.

The first mention that the employee seemed depressed was by Dr. Tobin on October 10, 2000, which was early on in the treatment of the employee and prior to the RSD diagnosis. Unfortunately the employee has had a significant amount of personal hardships in his life. The medical records show that between June of 2000 and Dr. Tobin's diagnosis, the employee had missed therapy for his father having surgery and also due to the death of his father-in-law. Shortly before the diagnosis of depression, the employee's father had a heart attack and was very ill. The employee saw Dr. Catron on October 19, 2000, and he diagnosed anxiety and depression. It was noted that the employee has had a bad year. The employee's father had died and was buried the day before he saw Dr. Catron. His father-in-law had died 5 weeks earlier. He also had a workers' compensation injury. Dr. Catron prescribed Serzone and Valium. In August of 2001, Dr. Catron noted that the employee was not doing well. His younger brother has had two heart attacks and strokes, abused alcohol and drugs, and recently tried to commit suicide. He had attacked and threatened to kill the employee. Dr. Catron assessed depression and a family stress situation. In September of 2001, Dr. Catron stated that the employee has had a bad year, due to his father and father-in-law dying, his brother had threatened to kill him, he had had a work injury with multiple surgeries and burns, has a compensation claim, is on light duty and may lose his job. In September of 2003, Dr. Catron stated that the employee was stressed as he had been denied on social security disability on his first attempt, and his brother had a stroke and can hardly speak. In January of 2004, Dr. Catron noted that the employee was under a lot of stress. His mother-in-law was in a nursing home and his mother was diagnosed with Alzheimer's.

Dr. Eaton stated that the employee had severe depression and somatization that is common with reflex sympathetic dystrophy, anxiety with posttraumatic stress component and restless leg syndrome, and depression with sleep interference. It was Dr. Eaton's opinion that his work was a contributing and substantial factor to the anxiety with posttraumatic stress component, restless leg syndrome, and depression with sleep interference, which he rated at 25% of the whole person. The employee did not testify about restless leg syndrome and other than Dr. Eaton, there was no mention of this in the other medical records. Dr. Eaton stated that severe depression is common with RSD. However, I found that the RSD was not medically causally related to the work-related accident or occupational disease.

Based on a review of all the evidence including the employee's significant non work related personal hardships, and my ruling on medical causation on the RSD/ regional pain syndrome and left wrist fusion, I find that there is insufficient evidence to support a finding that the employee's anxiety with posttraumatic stress component, restless leg syndrome, and depression with sleep interference, are medically causally related to the work-related accident or occupational disease. I find that the employee has failed to meet his burden of proof that those conditions were clearly work related and his work was a substantial factor in the cause of those medical conditions and disability.

In summary, I find that the only injuries and conditions that are compensable are the employee's bilateral torn triangular fibro cartilage tears and the need for medical treatment through June 11, 2001 including the surgery by Dr. Brown which caused the forearm burn and subsequent treatment for the burn, and the surgeries by Dr. Lents; and the employee's bilateral shoulder impingement with rotator cuff tendonitis and the need for medical treatment through December 6, 2000

including the surgery by Dr. Kapp.

Issue 2. Notice

The employer has denied that it received proper notice under Section 287.420 RSMo. That section requires that the employee provide the employer with written notice of an injury within 30 days of the date of an accident. The reason is so the employer can timely investigate accidents and provide prompt medical treatment to minimize the injury. The statute excuses the written requirement if the employer is not prejudiced by the lack of written notice. A prima facie case of no prejudice is made if the employee can show the employer had actual notice of the injury.

However, the notice requirement does not apply to cases of occupational disease (See Elgersma v. DePaul Health Center, 829 S.W.2d 35 (Mo. App. 1992) and Endicott v. Display Technologies, 77 S.W.3d 612, 616 (Mo. 2002) or to cases involving repetitive trauma (See Kintz v. Schnucks Markets, Inc., 889 S.W. 2d 121 (Mo. App. 1994). Even if it still could be argued that some type of timely notice must be made in a repetitive trauma case, I find that the employee provided sufficient notice to the employer of a work-related injury.

The employee's testimony was that he had been having problems with his upper extremities for several months before March of 2000, when he reported it on the day a therapist was there from Restart. Prior to that day, he did not know what was causing the problems. He reported it to his supervisor, Marty Vied. He was then sent to Dr. Tobin, which was the first of numerous company doctors he was sent to. He testified that prior to that he had not received any medical treatment for his upper extremities. The employer prepared a report of injury on April 14, 2000, which was filed on April 20, 2000. The report indicated that the employer was notified on March 10, 2000.

I find that the employer had actual notice of a potential compensable injury. The employee has made a prima facie showing of no prejudice and the employer offered no evidence to indicate that it has been prejudiced by the failure of the employee to provide written notice. I find the employer had sufficient notice of the employee's injury.

Issue 4. Claim for additional or future medical aid

The employee is requesting future medical aid. Under Section 287.140 RSMo, the employee is entitled to medical treatment to cure and relieve the employee from the effects of the injury. The Court of Appeals in Sifferman v. Sears, Roebuck and Company, 906 S.W.2d 823 (Mo. App. 1995) held that future medical care must flow from the accident before the employer is to be held responsible.

The employee has the burden of proof that the future medical care flows from the compensable accident or occupational disease. The employer would only be responsible for the future medical for the injuries and conditions that are compensable as set forth in Issue 3. Although there is evidence that the employee is in need of future medical care for his overall condition, there is not sufficient medical evidence that the treatment that the employee needs is a result of the compensable injuries or conditions, and flows from the compensable accident or occupational disease. I find that the employee has failed to meet his burden of proof that future medical treatment is medically causally related to conditions caused by the work-related accident or occupational disease. The employee's claim for additional or future medical aid is therefore denied.

Issue 5. Nature and extent of permanent disability, either permanent total or permanent partial disability

It was Dr. Catron's opinion that the employee was disabled as a result of all of the problems including the employee's left upper including the reflex sympathetic dystrophy and the fusion surgery. Mr. England's opinion was that the employee was not employable in the open labor market due to the combination of all of his impairments including those not medically causally related to the work-related injury.

It was Dr. Eaton's opinion that the employee was totally disabled as a result of his work injury of March 10, 2000, and his associated problems. He rated each of those problems individually including 90% disability of the left wrist for the employee's three surgeries to the left wrist including the fusion; an additional 15% of the left upper extremity at the shoulder for the complex regional pain syndrome/RSD; and an additional 15% of the left shoulder for the rotator cuff strain or sprain. He also rated the employee's graft donor site on the right anterior thigh at 5% at the right lower extremity at the level of the hip; the employee's myofascial pain in both upper extremities to the shoulders at 5% of the whole person; and the employee's anxiety with posttraumatic stress component, restless leg syndrome, and depression with sleep interference, which he rated at 25% of the whole person. In his rationale for permanent total disability, Dr. Eaton highlighted the fact that

the employee's left wrist is fused and that the employee also has a significant sleep interference complicating his ability to concentrate.

All of the employee's evidence that he is permanently and totally disabled includes the problems and conditions not medically causally related to the work-related injury including those to the left upper extremity of reflex sympathetic dystrophy regional pain syndrome and wrist fusion, the diagnosis of myofascial pain in both upper extremities to the shoulders, and anxiety with posttraumatic stress component, restless leg syndrome, and depression with sleep interference. The employee's claim for permanent total disability is substantially affected by my rulings on medical causation that any surgeries and conditions to the employee's left upper extremity after June 11, 2001 are not medically causally related to the work-related conditions, and that the diagnosis of myofascial pain, anxiety with posttraumatic stress, restless leg syndrome, depression and sleep interference are not medically causally related to the work-related condition.

The employer-insurer's evidence regarding disability takes into account all of the employee's conditions, including those not medically causally related to the work-related accident or occupational disease. Dr. Strecker gave a 55 % permanent partial disability rating to the employee's left upper extremity which took into account all of the employee's surgeries and conditions including the fusion and RSD, and a permanent partial disability of 25% of the right upper extremity. He did not place any restrictions on the right upper extremity. Dr. Strecker did not state the employee was unemployable in the open labor market.

It was Dr. Lehman's opinion that the employee was able to work in the open labor market, and was not permanently and totally disabled. He felt he could work unrestricted in terms of his right wrist, right shoulder, and left shoulder. He felt he could work in a light duty capacity, but not using his left wrist for heavy or repetitive lifting.

It was Ms. Abrams' opinion that the employee was employable in the open labor market. It was further her opinion that the limitations are to his non-dominant arm, and the employee can use his dominant arm and with his limitations is able to perform a number of jobs that exist in the open labor market.

Based upon the review of the medical evidence and my rulings on medical causation, I find that the opinions of Dr. Lehman, Dr. Strecker, and Ms. Abrams that the employee is not permanently and totally disabled are more credible than the opinions of Dr. Catron, Dr. Eaton and Mr. England that the employee is permanently and totally disabled. I find that the employee has failed to satisfy his burden of proof that he is permanently and totally disabled as a result of his work-related injuries and conditions. Although the employee has failed to satisfy his burden of proof on the issue of permanent total disability, the evidence clearly supports a finding that the employee has sustained permanent partial disability to his left wrist and right upper extremity.

Left Shoulder:

The impingement syndrome originally diagnosed on the left shoulder was medically causally related to the work related injuries and condition. The only rating was Dr. Eaton's 15% permanent partial disability of the left shoulder for the rotator cuff strain or sprain. However, the employee's testimony was that the left shoulder does not cause him any problems. I therefore find that the employee has not sustained any permanent disability to his left shoulder as a result of his work-related injuries and conditions.

Left Wrist:

As a result of the work-related conditions and injuries, the employee had an open excision of the torn left triangular fibro cartilage. Dr. Eaton rated the employee's left wrist at 90% permanent partial disability which included the two surgeries after June 11, 2001, including the fusion, and 15% of the left upper extremity at the level of the shoulder for the RSD/regional pain syndrome. Dr. Strecker rated the employee's left upper extremity at 55% permanent partial disability, which included the three surgeries that the employee had including the fusion, and the RSD. Prior to the fusion surgery, Dr. Coin rated the employee's left hand at the wrist at 30% permanent partial disability.

Based on a review of the medical records including the ratings, the depositions, and the testimony of the employee, and my rulings on medical causation, I find that as a direct result of the work-related injuries and conditions, the employee has sustained a 20% permanent partial disability of the hand at the level of the wrist (175 weeks) and is therefore entitled to 35 weeks of compensation for permanent partial disability.

Right Upper Extremity:

As a result of the work-related conditions and injuries, the employee had a debridement of the right TFCC tear, which caused a burn to the employee's arm that had to be debrided and grafted, and an open triangular fibro cartilage excision of the right wrist. The employee had one surgery to his right shoulder, which was a subacromial decompression due to impingement syndrome.

Due to the surgery-related burn, a skin graft of the right elbow was done with the graft being taken from the right anterior thigh. Dr. Eaton rated the employee's graft site on the right anterior thigh at 5% of the right lower extremity at the hip. There was no testimony or evidence that the employee is having any problems with the donor site. I therefore find that the employee has not sustained any permanent disability to his right thigh or hip as a result of his work-related injuries and conditions.

Dr. Eaton rated the employee's right wrist at 40% permanent partial disability, the right elbow at 15% for the right medial forearm burn, and 25% of the right shoulder for the bursectomy and arthroscopic rotator cuff tear repair. Dr. Strecker rated the employee's right upper extremity at 25% permanent partial disability of the right shoulder which included and took into account the surgeries to the wrist, as well as the burn and need for skin graft at the elbow and the impingement syndrome for which he underwent subacromial decompression of the right shoulder.

Based on a review of the medical records including the ratings, the depositions, and the testimony of the employee, I find that as a direct result of the work-related injuries and conditions, that the employee has sustained a 40% permanent partial disability of the right upper extremity at the level of the shoulder (232 weeks) which includes the condition and surgeries of the wrist, elbow, and shoulder, and is therefore entitled to 92.8 weeks of compensation for permanent partial disability.

Multiplicity:

Dr. Eaton stated that work-related impairments combine in a synergistic fashion to have an effect greater than their simple mathematical sum. I find that the employee is entitled to an additional 20% for multiplicity, which is an additional 25.56 weeks of compensation (92.8 weeks for right upper extremity plus 35 weeks for left wrist = 127.8 weeks x 20 percent = 25.56 weeks).

The employer is therefore ordered to pay the employee 153.36 weeks of permanent partial disability at the rate of \$290.00 per week for a total of \$44,474.40.

Disfigurement:

The employee is also entitled to an award for disfigurement. After observing the employee's scars and reviewing the medical records, and based on my rulings on medical causation, I find that the employee is entitled to an award of 12 weeks for disfigurement of the right hand/wrist and right forearm/elbow and 3 weeks for disfigurement to his left hand/wrist due to the first left wrist surgery. The employer is therefore ordered to pay the employee 15 weeks of disfigurement at the rate of \$290.00 per week for a total of \$4,350.00.

The total amount awarded for permanent partial disability and disfigurement is therefore equal to \$48,824.40.

ATTORNEY'S FEE:

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

INTEREST:

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

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

