

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

Injury No.: 98-008526

Employee: Kathy Meyer

Employer: Pyramid Home Care, Inc.

Insurer: Missouri Rural Services Workers' Compensation Insurance Trust  
c/o CCMSI

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 Law. Pursuant to section 286.090 RSMo, the Commission affirms the award and decision of the administrative law judge dated August 10, 2009. The award and decision of Administrative Law Judge Maureen Tilley, issued August 10, 2009, 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 24<sup>th</sup> day of June 2010.

LABOR AND INDUSTRIAL RELATIONS COMMISSION

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William F. Ringer, Chairman

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Alice A. Bartlett, Member

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John J. Hickey, Member

Attest:

\_\_\_\_\_  
Secretary

ISSUED BY DIVISION OF WORKERS' COMPENSATION

**FINAL AWARD**

Employee: Kathy Meyer

Injury No. 98-008526

Dependents: N/A

Employer: Pyramid Home Care Inc.

Additional Party: N/A

Insurer: Missouri Rural Services Workers' compensation Insurance Trust c/o CCMSI

Hearing Date: May 5, 2009 (record closed May 19, 2009)

Checked by: MT/kh

**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? January 30, 1998
5. State location where accident occurred or occupational disease contracted: Osage 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: Employee was injured in an automobile accident.
12. Did accident or occupational disease cause death? No
13. Parts of body injured by accident or occupational disease: Forehead laceration at right eyebrow; right knee and ankle; left knee; and both wrists.
14. Nature and extent of any permanent disability: See findings
15. Compensation paid to date for temporary total disability: \$47,281.19
16. Value necessary medical aid paid to date by employer-insurer: \$215,462.96
17. Value necessary medical aid not furnished by employer-insurer: None
18. Employee's average weekly wage: \$578.18
19. Weekly compensation rate:  
Temporary total disability and permanent partial disability: \$385.46  
Permanent partial disability rate: \$278.42
20. Method wages computation: By agreement
21. Amount of compensation payable: See findings
22. Second Injury Fund liability: See findings
23. Future requirements awarded: See findings

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

The Compensation awarded to the employee shall be subject to a lien in the amount of 25% of all payments hereunder in favor of the following attorney for necessary legal services rendered to the employee: Thomas Collins

## FINDINGS OF FACT AND RULINGS OF LAW

On May 5, 2009, the employee, Kathy Meyer, appeared in person and with her attorney, Thomas Collins, for a hearing for a final award. The employer was represented at the hearing by its attorney, Paul Huck. 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 the findings of fact and rulings of law, are set forth below as follows:

### UNDISPUTED FACTS

1. On January 30, 1998, Pyramid Home Care, Inc. was operating under and subject to the provision of the Missouri Workers' Compensation Act, and its liability was fully self-insured through the Missouri Rural Services Workers' Compensation Insurance Trust c/o CCMSI.
2. On January 30, 1998, Kathy J. Meyer was an employee of Pyramid Home Care, Inc. and was working under the Missouri Workers' Compensation Act.
3. Accident: On January 30, 1998, employee sustained injury by accident arising out of and in the course of her employment.
4. Notice: Employer had timely notice of employee's accidental injuries.
5. Statute of limitations: The Claim for Compensation was timely filed.
6. The employee's average weekly wage was \$578.18, producing compensation rates of \$385.46 for TTD/PTD benefits and \$278.42 for PPD benefits and disfigurement.
7. Employer has paid medical expenses of \$215,462.96 as of the date of hearing.
8. Employer has paid temporary total disability benefits of \$47,281.19 (122-1/7 weeks) for healing periods dated January 31, 1998-September 10, 1999 (84 weeks) totaling \$32,378.64 and June 15, 2001-March 11, 2002 (38-1/7 weeks) totaling \$14,702.55 as of the date of hearing.
9. The parties stipulated Employer is entitled to a \$25,000 credit against future compensation awarded per the agreement entered into by the parties at the time of employee's prior third-party settlement.

### ISSUES

1. Medical causation: Whether there is a medical causal relationship between employee's accident and her subsequent right shoulder surgery (the parties stipulated employee's accident caused injury to the following body parts: right forehead eyebrow laceration; right knee and ankle fractures; left knee fracture; and both wrists attributable to the aggravation of pre-existing bilateral carpal tunnel from post accident use of assistive devices). Originally the employee was claiming that two right shoulder surgeries were causally related to the accident. On July 21, 2009, the ALJ has a phone conference with the employee's attorney and the employer-insurer's attorney. At that time the employee's attorney amended the issue to include only the first right shoulder injury.
2. Past and future medical aid: (1) Whether Employer is liable to reimburse the employee for past incurred medical bills related to her right shoulder surgery totaling \$5,122.50 and (2) Whether employer is liable for past incurred narcotic drug costs totaling \$16,564.60

consisting of Fentanyl patches and Percocet and (3) Whether employer's liability for these narcotic drug prescriptions should continue in the future (the parties stipulated medical benefits are to remain open for the injuries the employee sustained to her right knee and ankle, her left knee and for periodic physician visits related to her need for certain pain relief drugs).

3. Nature and extent of disability: (1) Whether employee is entitled to additional temporary total disability benefits and, if so, to what extent, and (2) Whether employee is entitled to an award of permanent and total disability benefits. (3) Whether the employee is entitled to an award of permanent partial disability. (4) Whether the employee is entitled to an award for disfigurement.

## **EXHIBITS**

The following exhibits were offered and admitted into evidence:

Employee's Exhibits:

- A. Missouri State Highway Patrol Accident Report, Report Number 025394 with accident date of January 30, 1998.
- B. Photographs of Kathy Meyer's vehicle.
- C. Photographs of Kathy Meyer's vehicle.
- D. Photographs of Kathy Meyer's vehicle.
- E. St. Mary's Health Center ER report of January 30, 1998, on Kathy Meyer.
- F. X-ray of Kathy Meyer's leg dated January 30, 1998.
- G. X-ray of Kathy Meyer's right leg/knee.
- H. X-ray of Kathy Meyer's foot.
- I. University of Missouri Hospitals and Clinics Operative Report of the Right Tibial plateau fracture on Kathy Meyer of January 30, 1998.
- J. Photograph of Kathy Meyer's leg with hardware.
- K. University of Missouri Hospitals and Clinics Operative Report of the right eyebrow laceration on Kathy Meyer of January 30, 1998.
- L. University of Missouri Hospitals and Clinics Operative Report of left knee arthroscopy and arthrotomy of right knee with meniscal repair on Kathy Meyer of February 2, 1998.
- M. Photographs of Kathy Meyer after surgery on her legs.
- N. University of Missouri Hospitals and Clinics Operative Report of the repair to the anterior talofibular ligament, fibulocalcaneal ligament and adjustment o external fixator of Kathy Meyer of February 4, 1998.
- O. X-ray of Kathy Meyers right knee with hardware.
- P. X-ray of Kathy Meyers right foot with hardware dated April 2, 1998.
- Q. Photographs of Kathy Meyer after skin graft and external fixator.
- R. X-ray of Kathy Meyers leg with external fixator.
- S. Photographs of Kathy Meyer after surgery and with external fixator.
- T. Photographs of Kathy Meyer with external fixator and ankle surgery.
- U. X-ray of right knee with hardware in place of Kathy Meyer.
- V. X-ray of right knee with hardware of Kathy Meyer dated July 1, 1999.
- W. X-ray of left knee with hardware of Kathy Meyer.

- X. X-ray of left knee with hardware of Kathy Meyer.
- Y. X-rays of Kathy Myers ankle with screw in place.
- Z. University of Missouri Hospitals and Clinics Discharge Summary of Kathy Meyer dated February 13, 1998.
- AA. Photographs of Kathy Meyer recovering in the hospital and her family.
- BB. Photographs of Kathy Meyer recovering at home.
- CC. Photographs of Kathy Meyer using walker with external fixator in place.
- DD. Photographs of Kathy Meyer using walker with the external fixator in place.
- EE. Photographs of Kathy Meyer using walker with assistances.
- FF. University of Missouri Hospitals and Clinics Operative Report for plastic surgery/resection of previous skin graft dated December 18, 1998.
- GG. University of Missouri Hospitals and Clinics Operative Report for Kathy Meyer's suture removal on December 29, 1998.
- HH. University of Missouri Hospitals and Clinics Operative Report for Kathy Meyer's right carpal tunnel release on July 7, 1999.
- II. University of Missouri Hospitals and Clinics Operative Report for Kathy Meyer's right knee arthroscopy, chondroplasty of the femoral and tibial.
- JJ. Photographs of Kathy Meyer and her mother showing Kathy's right ankle.
- KK. X-ray of Kathy Meyer's right wrist on January 19, 2001.
- LL. University of Missouri Hospitals and Clinics Operative Report for Kathy Meyer's right ankle arthrodesis and hardware removal on July 15, 2001.
- MM. X-ray of Kathy Meyer's ankle with plate and hardware.
- NN. University of Missouri Hospitals and Clinics Discharge Summary of Kathy Meyer dated July 19, 2001.
- OO. University of Missouri Hospitals and Clinics Operative Report for hardware removal on Kathy Meyer dated September 26, 2001.
- PP. Medical Records of Center of Orthopaedic Excellence, Inc. on Kathy Meyer.
- QQ. Medical Records of Bone & Joint Sports Injury Clinic/Dr. Galbraith on Kathy Meyer.
- RR. Medical Records of CMMP Surgical Center LLC on Kathy Meyer.
- SS. Bone & Joint Sports Injury Clinic billing statement on Kathy Meyer.
- TT. Orthopaedic Clinic's final report on Kathy Meyer dated August 26, 2008,
- UU. St Mary's Tipton Pharmacy prescription record on Kathy Meyer,
- VV. National Vital Statistics Reports, Volume 54, Number 14 - United States Life Tables, 2003.
- WW. Kathy Meyer's 2009 planning calendar.
- XX. CCMA Medical Records of Kathy Meyer.
- YY. Deposition of Dr. Timothy Galbraith of July 18, 2007.
- ZZ. Deposition of Dr. Peter Boyer of November 12, 2007.
- AAA. Deposition of Michael Dreilin of March 27, 2006.
- BBB. Deposition of Dr. Brent Koprivica of March 27, 2006.
- CCC. Medicals Records of University of Missouri Hospitals and Clinics.

Employer-Insurer's Exhibits:

1. Jefferson City Bone & Joint Clinic dated October 11, 1985- March 19, 1997.
2. Capital City Medical Associates/Peter Boyer, M.D. dated December 31, 1986 – December 11, 1997.
3. University Physicians & Clinics dated May 10, 1991 – July 22, 1993.
4. Jefferson City Medical Group/Michael L. Craighead, M.D. dated June 25, 1997 – November 10, 1999.
5. St. Mary's Health Center dated January 30, 1998.
6. University of Missouri Hospital & Clinics admissions dated January 30, 1998 – February 13, 1998.
7. University Hospital & Clinics dated February 19, 1998 – August 16, 1999.
8. University Hospital & Clinics/Robert R. Conway, M.D. dated December 18, 1998 – September 22, 1999.
9. Capital Region Rehabilitation Center dated December 23, 1998 – September 22, 1999.
10. Capital Region Medical Center Functional Capacity Evaluation dated August 24, 1999 – August 26, 1999.
11. Edwin E. Carter, M.D. IME narrative report dated March 14, 2001.
12. University Hospital & Clinics Orthopaedic Surgery Clinic reports of Drs. Walter B. Greene dated April 20, 2002 and Jeffrey O. Anglen dated May 21, 2001 – September 26, 2001.
13. Robert R. Conway, M.D. dated September 17, 2001.
14. Reza Farid, M.D. dated October 15, 2001 – March 11, 2002.
15. Jeffrey Anglen M.D. narrative report dated April 1, 2003.
16. Edwin E. Carter, M.D. IME narrative report dated September 17, 2003.
17. Jeffrey Anglen, M.D. narrative report dated March 4, 2004.
18. Not admitted.
19. Robert R. Conway, M.D. IME narrative report dated July 28, 2005.
20. Deposition of Robert R. Conway, M.D. dated May 16, 2006.
21. Deposition of Gregory Wingert dated September 1, 2006.
22. Deposition of Karen Kane-Thaler, MS ED, CRS dated September 10, 2008.
23. University of Missouri Transcript for Kathy J. Meyer.
24. Missouri Department of Vocational Rehabilitation records.

## **FINDINGS OF FACT**

### **Employee's testimony**

- The employee testified that she is 48 years old. On January 30, 1998 she began working as a home health nurse for Pyramid Home Care as a staff nurse for a nursing home.
- Before the accident, she had been a nurse for 18 years.
- At the hearing, the employee was visibly in pain. She had both of her legs propped up on a chair in front of her.
- On January 30, 1998 she was driving a 1991 Geo Prism when she was traveling to see a patient in Owensville. The employee was coming around the corner and a car was

sideways in front of her. At that point in time, the employee's car collided with the other car. The employee was trapped in the vehicle after the accident and her right foot was stuck on the pedal. The employee remained conscious while she was removed from the vehicle.

- The employee was then brought to Saint Mary's Hospital in Kansas City. The employee now has a two inch scar above her right eyebrow from the accident.
- The employee was hospitalized from January 30, 1998 through February 13, 1998.
- The employee then went to Tipton Manor, a local nursing home, to recover.
- The employee underwent multiple operations after the accident.
- The employee went through physical therapy after she was brought home from the nursing home; furthermore, the employer-insurer bought the employee a treadmill to exercise on at her home.
- After the accident, the employee's fingers would go numb and her hands would hurt because she was constantly using her hands. Eventually the employee had a carpal tunnel release performed. This was paid for by the employer-insurer.
- The employee developed problems with her right ankle. In June 2001, the employee began having severe swelling of her right ankle. The employee began wearing a special brace on her right foot.
- The employee stated that when her right ankle got bad, her tolerance to her pain medicines went up. The employee stated that the bones in her right ankle eventually died.
- She stated that because of this she can't flex her ankle. The employee now wears a specialized brace on her right foot and a specialized shoe on her right foot.
- The employee stated that after her ankle surgery on June 15, 2001, her ankle always hurts. She stated that it hurts more in the front. She stated that the pain initially got better after the surgery but as time goes on it gets worse.
- The employee stated that she keeps her right foot elevated whenever possible. She stated that this makes it difficult for her to drive. She stated that she can't physically point her toe. She stated that she needs to move her entire leg to press down on the gas pedal. She also said that she does not drive much anymore because of her limitations.
- The employee stated that she lives in Tipton, Missouri. She stated that she can drive to Jefferson City if she has to but she needs to do this in the afternoon because her medications make her sleepy. She stated that she can't drive to Columbia.
- The employee stated that she has pain in her ankle, shoulder, and wrist when the weather gets bad.
- The employee testified that she is unable to walk, sit or stand frequently and must alternate between standing and sitting in order to avoid pain, swelling and stiffness in her lower extremities as a result of the injuries she suffered arising out of the January 30, 1998, accident.
- The employee stated that she had some shoulder problems prior to the accident. She stated that she was once thrown off a bike. She stated that another time she was playing catch with her sister and she felt a pop in her right shoulder. The employee stated that the pain was not immediate after the accident. The employee stated that after about a year on crutches, she started leaning into the crutches because her hands were weak from the carpal tunnel. The employee eventually had shoulder surgery in 1999.

- The employee stated that her current level of pain on a day to day basis is a 5 without the Percocet. The employee stated that she currently is using the duragesic patches (Fentanyl). She stated that she puts the patches on her stomach and they provide a continuous dose of pain medication. She stated that these patches are prescribed by Dr. Boyer. She stated that she has been using the Fentanyl for 2 ½ years.
- The employee stated that on a bad day, when she is not taking the Percocet, her pain level is a 6. She stated that on a good day her pain is a 4. She stated that on an average day her pain is a 5.
- The employee stated that she takes 2 or 3 Percocet a day when she goes to an event that requires her to be up a lot.
- The employee stated that the employer-insurer paid for all of the medications that the authorized physicians prescribed. She also stated that the employer-insurer did not pay for her to see Dr. Boyer.
- The employee stated that prior to the accident she worked as a nurse. She had her associate's degree in nursing.
- She stated that after the accident she attended college through vocational rehabilitation. She stated that she attended the RN to BSN program. She stated that she got her BSN before her right ankle fusion. She said she was driving to the University of Missouri in Columbia and some of her classes were on line. She went to school from 1999 through 2003.
- The employee eventually obtained her master's degree in public health nursing in 2003. She stated that she took one class at a time. She stated that there was a lot of paper work.
- The employee stated that she was in the master's program from 2003 through 2009. She stated that the program usually takes two years.

### **Emergency room at Saint Mary's Health Center**

- As a result of the accident, the employee had an open fracture of her right ankle with the bone protruding out.
- The employee's right knee was swollen and deformed.
- The employee's left knee was swollen and tender.
- The employee was in severe pain as a result of her injuries and was given pain medicine.
- The employee reviewed and described x-rays taken at St. Mary's Health Center which showed a severely comminuted right knee fracture and an open talar neck fracture of the right ankle.
- The employee also had a tibial plateau fracture of the left knee.
- The employee's other complaints included tenderness over her left clavicle with abrasion and soreness over her anterior chest with bruising.
- The employee was transferred to University Hospital in Columbia, Missouri.

### **First series of surgeries during initial hospitalization**

- After transfer to University Hospital, the employee was subjected to several surgeries.
- On January 30, 1998, the employee underwent the first of numerous surgeries which

included a two incision fasciotomy of the right calf to relieve right calf compartment syndrome performed by Dr. Barry Gainor.

- During the fasciotomy, a large incision or incisions were made to the inside portion of the employee's right calf through the deep subcutaneous tissues and fat to relieve the pressure and swelling.
- During the initial surgery, Dr. Gainor irrigated the right ankle wound, debrided the edges of the right ankle wound and then packed the ankle wound. He also placed two 5mm Shantz pins into the right femor and two 5mm Shantz pins into the right tibia, as well as a pin through the calcaneus which exited on each side of the heel.
- Dr. Gainor constructed an external fixator in an A-frame fashion about the ankle and longitudinally across the knee. The tibia fracture was then reduced and the construct tightened.
- In the last stage of the initial surgery, Dr. Gainor made a 7 centimeter incision lateral to the patella down through the deep subcutaneous tissues and fat and sharply through the knee capsule. The knee was irrigated, re-approximated using interrupted vicryle sutures and covered with a sterile dressing.
- During January 30, 2009, surgery, Dr. Michael Metzler closed the 5 cm scar above Mrs. Meyer's right eyebrow.
- The employee has a 5 cm scar in the area of her right eyebrow.

### **Second series of surgeries during initial hospitalization**

- On February 2, 1998 the employee underwent another series of surgeries by Dr. Jeffrey Anglen.
- Dr. Anglen began with an arthroscopy of the employee's left knee which revealed chondromalacia on the medial femoral condyle and a 1 mm step-off fracture through its mid-portion.
- Dr. Anglen performed a chondromalacia debridement on the employee's left knee. See also, Exhibit L.
- Dr. Anglen reduced the employee's left knee fracture and placed two seven hole cannulated screws with washers to hold it in place.
- Dr. Anglen then turned his attention to the employee's right tibial plateau fracture. A four hole one-half tubular plate was placed on the medial aspect of the tibial metaphysis and four screws were placed.
- Dr. Anglen then re-opened and extended the lateral arthrotomy incision to expose the knee joint and the lateral tibial plateau. A large defect was noted, as well as, a complete meniscal tear of the lateral meniscus.
- Dr. Anglen repaired her meniscus and placed a Coral graft in the tibial defect. A penrose drain was placed in the medial incision.
- Dr. Anglen then placed 2 large cannulated screws from a lateral to medial direction in a percutaneous technique with appropriate drilling, tapping and placement to insure that the screw threads were not in the knee joint.
- Dr. Anglen then placed a hybrid fixator with three K-wire pins placed in the medial lateral aspect of the tibia and two half pins within the mid-shaft and distal third. Dr. Anglen then constructed the hybrid fixator using bars and appropriate clamps.

- Dr. Anglen noted a rupture of the anterior talofibular ligament and calcaneofibular ligament along with avulsion of the peroneal brevis Tendon.
- An incision was made over the lateral fifth metatarsal head and drill holes were placed within the avulsed fragment and in the shaft.
- Dr. Anglen then repaired the peroneal brevis Tendon, but determined that the employee was not a candidate for percutaneous screw fixation of her talar neck fracture and instead needed a third washout and repair of her lateral ankle ligaments in a separate operative procedure.

### **Third series of surgeries during initial hospitalization**

- On February 4, 1998, Dr. Anglen operated on the employee again.
- Dr. Anglen began with a fluoroscopic percutaneous screw fixation across the talus neck fracture. The guidewire was over drilled, tapped and a large cannulated screw was placed across the neck fracture of the talus.
- Dr. Anglen then turned his attention to repairing ligaments.
- A suture anchor was used in the lateral surface of the calcaneus to repair the calcaneal fibular ligament.
- The anterior talofibular ligament was repaired through soft tissue in the anterior aspect of the fibula and the lateral wound was closed.
- The broken first metatarsal was repaired using a 4 mm Shantz pin which was connected to the external fixator using a standard graphite bar to hold the forefoot in position.
- Dr. Anglen then closed the lateral fasciotomy wound.
- The medial fasciotomy wound would not close without undo tension so a split thickness skin graft was harvested from the anterior thigh on the left side and placed over the medial fasciotomy wound.
- Post-operative x-rays show the placement of the hardware in the employee's right ankle, as well as the hybrid fixator.
- The employee was discharged from University Hospital on February 13, 1998. Dr. Anglen's Discharge Summary notes the following Operations and Treatments:

1. Left knee arthroscopy, February 2, 1998.
2. Chondromalacia debridement, February 2, 1998.
3. Percutaneous screw fixation of left tibial plateau, February 2, 1998.
4. Incision and drainage of right side open wound, February 2, 1998.
5. Limited open reduction and internal fixation with percutaneous screw of right tibial plateau fracture, February 2, 1998.
6. Hybrid fixation of right tibial plateau, February 2, 1998.
7. External fixation removal, February 2, 1998.
8. Repair of right peroneal brevis tendon, February 2, 1998.
9. Right foot open reduction and internal fixation of talus, February 4, 1998.
10. Incision and drainage of fasciotomy wound, February 4, 1998.

### **Post surgery treatment and rehabilitation**

- At the time of her February 13, 1998, discharge from University Hospital, the employee was suffering from severe injuries and unable to care for herself. As a result, the employee was transferred to the Tipton Manor, a nursing home in Tipton, Missouri.
- The employee was discharged from Tipton Manor on March 13, 1998.
- The employee was allowed to return home almost two (2) months after the accident.
- The employee testified that as she healed more, she began physical therapy in California, Missouri and then moved to Capital Region Rehab in Jefferson City, Missouri. She proceeded with rehabilitation and was seen by Dr. Robert Conway at the University Hospital.
- Throughout most of 1999, the employee participated in various programs of physical therapy and rehabilitation, including work conditioning. During this time, she was also a patient at Capital Region Rehabilitation Center in Jefferson City, Missouri.
- The employee was released from care at maximum medical improvement by Dr. Conway on September 10, 1999.

#### **Subsequent surgeries after discharge from hospital**

- On December 29, 1998, the employee underwent surgery by Dr. Matthew Concannon to repair the fasciotomy scar on her right calf.
- Also on December 29, 1998, the employee underwent surgery by Dr. Anglen to remove a symptomatic stitch in her right foot.
- On July 7, 1999, the employee underwent surgery by Dr. Anglen. Dr. Anglen performed a right knee arthroscopy with chondroplasty of the femoral and tibial condyles for severe chondromalacia. Partial meniscectomy of the lateral meniscus was also performed.
- Dr. Anglen stated in his operative report: "severe degenerative changes were found in the joint."
- As a result of her severe lower extremity injuries and the corresponding need to ambulate with assistive devices, the employee developed carpal tunnel bilaterally.
- Also on July 7, 1999, the employee underwent right carpal tunnel release surgery performed by Dr. Gainor.
- The employee also underwent left carpal tunnel release surgery performed by Dr. Gainor.
- The employee was placed on permanent restriction of (light-medium) hand duties by Dr. Gainor.
- Following the crash at issue and during the employee's lengthy rehabilitation, the employee noticed increasing pain in her right shoulder.
- The employee sought treatment on her own for her right shoulder from Dr. Timothy Galbraith of the Bone and Joints Sports Injury Clinic in Jefferson City, Missouri.
- The employee had injured her shoulder approximately ten (10) years prior to her work related automobile accident as a result of a bicycle accident. The employee received conservative treatment for the injuries on a periodic basis from her primary care physician, Dr. Boyer.
- Under the care of Dr. Galbraith, the employee's injury did not respond to conservative treatment and surgery was recommended.

- On December 13, 1999, the employee underwent a diagnostic and operative arthroscopy on her right shoulder. At that time, Dr. Galbraith repaired an interioral labral tear. He also removed a spur on the medial border on the scapula and a corresponding lesion.
- In December of 2000, the employee began experiencing increasing pain in her right ankle. On January 19, 2001, the employee saw her family physician, Dr. Boyer, regarding the increasing pain in her right ankle.
- Dr. Boyer performed an x-ray of the employee's right ankle which showed bone on bone contact at the medial corner of the right ankle with inversion of the right foot.
- Dr. Boyer recommended that the employee see Dr. Anglen, the orthopedic surgeon who performed her previous ankle surgeries.
- On March 14, 2001, the employee attended an independent medical examination by Dr. Carter, a doctor selected by the employer/insurer. Dr. Carter agreed that the employee was in need of additional medical treatment for her right ankle.
- In the spring of 2001, the employee was experiencing severe pain in her right ankle.
- The employee testified that it was during this time that her pain got out of control.
- The employee testified that Dr. Boyer put her on OxyContin for the severe pain.
- Because of the increased pain and swelling in her right ankle, the employee was forced to ambulate with assistive devices, including crutches as depicted in Employee's Exhibit JJ.
- On June 15, 2001, the employee underwent a right ankle arthrodesis (fusion) and hardware removal by Dr. Anglen.
- Dr. Anglen noted that the employee developed avascular necrosis of the talar dome and postoperative degeneration in the tibiotalar joint.
- Dr. Anglen first removed the talar neck lag screw that was placed by Dr. Anglen on February 4, 1998. Dr. Anglen then performed an anterior ankle arthrotomy with extension up the shaft. The joint was debrided. Dr. Anglen cut the distal tibia using a small oscillating saw. The top of the tibia was cut off and the surfaces were cut to fit each other. Dr. Anglen then used a curet to remove small cysts on the talar dome. He drilled several holes in the talus to provide channels for healing and revascularization. Dr. Anglen then resected the distal fibula and removed the fibular articular cartilage to allow the joint to fit together with good bone-to-bone apposition. Dr. Anglen then made a separate incision over the left iliac crest and harvested bone for use in the bone graft. Dr. Anglen then turned his attention to the actual fixation. Dr. Anglen's planned technique of passing guidewires retrograde out the back of the tibia and into the fibula to place cannulated screws failed because of the difficulty of approaching from the back.
- Dr. Anglen then devised a new approach and used a 4-hole small fragment DC plate anteriorly on the joint with lag screws from the medial and lateral.
- The bone graft obtained from the left iliac crest was packed into the back of the joint before the arthrodesis was performed and then all along the front of the joint between the anterior tibial and the neck of the talus.
- Following the right ankle arthrodesis, the employee was in severe pain in her surgery area and was placed on morphine patient controlled analgesia.
- Mrs. Meyer was discharged on June 19, 2001, with orders for a hospital bed with trapeze, bedside commode, wheelchair and crutches.
- Mrs. Meyer was also prescribed physical therapy.

### **Removal of Prominent Lateral Fibular Screw and Washer**

- On September 26, 2001, the employee underwent surgery by Dr. Anglen because she was experiencing pain and discomfort in the area of a screw in her right ankle which was working itself out of the bone.
- Dr. Anglen re-opened her previous incision and used a screwdriver to remove the screw and a small hemostat to remove the washer.

### **Dr. Brent Koprivica**

- The employee was initially evaluated by Dr. P. Brent Koprivica on 11/20/02.
- Dr. Koprivica is board certified in occupational medicine and emergency medicine.
- Dr. Koprivica testified that as a direct and proximate result of the motor vehicle accident sustained out of her employment on January 30, 1998, the employee sustained multiple severe traumatic injuries.
- Regarding the employee's right lower extremity injuries, Dr. Koprivica stated that the employee sustained a severe displaced tibial plateau fracture with comminution involving the right knee. He stated that the tibial plateau is the big bone in your lower leg also known as the shin bone. The plateau is the top surface of that tibia that makes the bottom part of your knee. Part of that tibial plateau was broken off, like taking the edge of a table and cracking off a part of the edge of the table. He stated that she also had significant swelling with need for fasciotomy with later closure.
- Dr. Koprivica stated that the massive swelling in the right lower extremity is called compartment syndrome. The employee's compartment syndrome had to be addressed surgically. He stated that compartment syndrome is illustrated by using the segments of an orange. If you peel open an orange, you have different segments. The same is true of your leg. The swelling in a given area is called a compartment. If the pressure from the swelling gets too high in a given compartment, it cuts off the circulation that goes to the foot and you can lose the extremity. As a result of the compartment syndrome, the employee underwent a fasciotomy.
- Dr. Koprivica stated that the employee also had a fracture of her talus with radiographic evidence of avascular necrosis of the talar dome without collapse. This was also an open fracture with noted dislocation. He stated that the talus is the bone of your foot that makes the bottom part of the ankle joint. He stated that the employee broke the talus at the neck and the problem with that particular fracture is it disrupts the blood supply. The risk is that part of that bone may die where the neck breaks off. This leads to avascular necrosis.
- Dr. Koprivica stated that the employee has a fifth metatarsal fracture of her right foot. The metatarsal is the bone of the foot that goes from the mid foot out to your toes, so that the one on the outside part of the foot was broken. He stated that she had a peroneus brevis tendon rupture on the right.
- At the time of Dr. Koprivica's January 6, 2000, exam, He stated that the employee had valgus deformity of the right knee when she stood. Valgus deformity refers to if you stand up straight, your thigh and your lower leg should be in alignment. Her lower leg deviates, so that it makes an L where the foot is further out and doesn't line up directly with the hip

because of the injury that she sustained involving the right knee. He stated that this is a sign of significant deformity and degeneration that's occurring in the knee. It refers to lateral compartment losses where she had the lateral tibial plateau or the outside of the knee that's losing the cartilage. Instead of being bowlegged, the employee is knock-kneed on the right side, meaning the one knee is approaching the knee closer to it.

- Regarding the left lower extremity, Dr. Koprivica stated that the employee had a tibial plateau fracture. He also stated that the employee had some further problems with her left knee and had additional surgery on the left knee which consisted of a scope surgery where they went in, took out part of the lateral meniscus, which is one of the cartilage structures in the knee, and did a chondroplasty, where they're shaving the chondral surface on the bone.
- Regarding the employee's bilateral carpal tunnel, Dr. Koprivica stated that when the employee first got out of the hospital, she couldn't walk. She then went to a walker, then to crutches, and then to a cane. He stated that the employee developed problems with using these assistive devices in order to walk. She began having numbness in her hands.
- Dr. Koprivica stated that the employee developed symptomatic bilateral carpal tunnel syndrome. The bilateral carpal tunnel syndrome development was a direct and proximate result of the injuries sustained to the lower extremities on January 30, 1998. Specifically, the necessity for use of assistive devices for ambulation resulted in cumulative injury with the development of symptomatology from carpal tunnel syndrome. He stated that as a result of the employee's bilateral carpal tunnel syndrome, she had left carpal tunnel release surgery in April of 1999 and right carpal tunnel release surgery in July of 1999.
- Regarding the employee's right shoulder, Dr. Koprivica opined that the condition of the right shoulder for which she has received surgical intervention by Dr. Galbraith on December 13, 1999, is one which is a direct and probable consequence of the use of assistive devices for ambulation purposes. The use of crutches, in particular, as well as use of her arms, in general, that is necessitated by her lower extremity injuries resulted in the development of a degenerative labral tear and symptomatology from spur formation on the medial scapula.
- Dr. Koprivica stated that as a result, the medical care and treatment which the employee received from Dr. Galbraith for her right shoulder condition resulting in surgery on December 13, 1999, is causally related to the injuries of January 30, 1998. He stated that the medical care and treatment which Dr. Galbraith provided was medically appropriate and a direct necessity of the shoulder condition. Dr. Koprivica also stated that the direct injury sustained at the time of the motor vehicle accident would contribute to the right shoulder condition, although the primary cause for the development of the impairment of the right shoulder was cumulative from use of assistive devices for ambulation purposes.
- Dr. Koprivica opined that the employee should avoid repetitive pinching, repetitive grasping, repetitive wrist flexion/extension or repetitive ulnar deviation of the wrist in either upper extremity. She should also avoid exposing her upper extremities to vibration.
- Dr. Koprivica opined that the employee should avoid repetitive or sustained activities above shoulder girdle level on the right. She should also avoid forceful pushing/pulling activities on the right.
- Dr. Koprivica opined that the employee should do seated activities. Standing or walking would be very limited and should be minimized. Dr. Koprivica opined that the employee could stand up for three hours in an eight hour shift. He stated that the employee should do no climbing, squatting, crawling or kneeling.

- Dr. Koprivica opined that the employee should be allowed the opportunity to elevate her feet and legs based on swelling and discomfort.
- Dr. Koprivica opined that the employee should not drive vocationally. She should not operate heavy equipment vocationally.
- Dr. Koprivica opined that the employee has significant permanent partial disability based on the isolated impairing conditions associated with the January 30, 1998, injury.
- Dr. Koprivica stated that the employee has twenty-five (25) percent permanent partial disability of the right upper extremity at the level of the forearm (200-week level) because of the right carpal tunnel syndrome. He stated that the employee has a twenty (20) percent permanent partial disability of the left upper extremity at the level of the forearm (200-week level) because of the left carpal tunnel syndrome.
- Dr. Koprivica stated that based on the injuries to the right lower extremity with the severe valgus deformity that is present at the right knee level, the employee has a (40) percent permanent partial disability of the right lower extremity at the level of the knee (160-week level). He stated that based on the talar fracture with the surgeries that have been performed and the noted avascular necrosis, the employee has a a forty (40) percent permanent partial disability of the right foot at the level of the ankle (155-week level). He stated that based on the tibial plateau fracture on the left, the employee has a a twenty-five (25) percent permanent partial disability of the left lower extremity at the level of the knee (160-week level).
- Dr. Koprivica also stated that the employee had an additional fifteen (15) percent permanent partial disability to the body as a whole based on the residuals associated with the right shoulder and scapular injury and surgeries.
- As of January 6, 2000, Dr. Koprivica believed that the employee was permanently and totally disabled; however, he believed that a formal vocational evaluation was warranted prior to making a final determination.
- On February 9, 2001, after reviewing Mr. Dreiling's March 1, 2000, vocational rehabilitation report, Dr. Koprivica opined that the employee was permanently and totally disabled as of February 9, 2001, considering her multiple physical impairments and resultant permanent partial disabilities in combination.
- Dr. Koprivica opined that the employee would require a total knee arthroplasty in the future. Due to her age, Dr. Koprivica opined that would likely need a revision surgery in terms of the knee replacement.
- Dr. Koprivica opined that the employee is developing degenerative arthritis involving the subtalar joint in particular. He stated that future treatment needs to be considered including the possibility of need for fusion of the subtalar joint or possibly extending it to a triple talar arthrodesis based on her further clinical course. Dr. Koprivica opined that the employee would need ongoing pain management which includes the need to use chronic narcotics.

**Dr. Craig Galbraith**

- Dr. Craig Galbraith began treating the employee on July 30, 1999, for right shoulder pain since her automobile accident in January of 1998. Dr. Galbraith was not an authorized treating physician by the employer-insurer. The employee went to Dr. Galbraith on her own.
- Dr. Galbraith's initial treatment for the employee's shoulder pain was physical therapy.
- On August 17, 1999, Dr. Galbraith ordered an MRI of her shoulder. Dr. Galbraith determined that a lot of her pain was scapulothoracic. Dr. Galbraith continued with physical therapy and referred the employee for a second opinion with Dr. Woods.
- Dr. Galbraith ordered a CT scan and found a small spur on the medial border of her scapula right in the area of her pain.
- On December 13, 1999, Dr. Galbraith operated on the employee to remove the spur and his post operative diagnosis was a tear of the anterior labrum with a spur on her medial border of the scapula with scapulothoracic bursitis.
- Dr. Galbraith opined that this injury was a result of the employee's automobile accident in January, 1998, as the spur was a result of the load bearing on her shoulder due to the injuries suffered.

#### **Dr. Peter Boyer**

- Dr. Peter Boyer has been the employee's family doctor since December 31, 1986. Dr. Boyer is not an authorized treating physician from the employer-insurer. The employee went to Dr. Boyer on her own.
- As a result of the injuries Mrs. Meyer received in the January 1998 car accident, Dr. Boyer prescribes pain medications for the employee which include a Duragesic patch that releases medication at the rate of 100 mg per hour and Percocet, five 325, four times a day.
- Dr. Boyer also prescribes Naproxen, an anti-inflammatory medication taken for arthritis and musculoskeletal pain, for the employee.
- Dr. Boyer believes that Duragesic, Percocet and Naproxen are the most reasonable medications to manage the employee's pain.
- On November 12, 2007, Dr. Boyer testified that the employee is currently on Duragesic, 100 micrograms per hour. He stated that it's a patch you change every three days. He also stated that she is on Percocet. He stated that she was given a basic prescription for four a day over a month. He stated that she takes more some days and less others. He stated that these were the only pain medications that the employee was being prescribed. He stated that it was his opinion that the employee's current need for these medicines is the result of the car accident that she was in January of 1998.
- Dr. Boyer testified that on September 23, 2003, stated that his office note said "I wonder if some of her pain medications was out of fear of having pain, she actually describes this to some extent. I think she is psychologically addicted."
- Dr. Boyer testified that on September 24, 2004, he then referred the employee to Dr. Lucio, a pain management specialist because "pain medications were increased and he did not feel comfortable dealing with that situation."
- Dr. Boyer's office note of February 17, 2005 states that the employee had an altercation with Dr. Lucio. It also states that Dr. Lucio "fired" the employee. Dr. Boyer then referred the employee to Dr. Fisher. Dr. Boyer stated that he did not remember what happened with Dr. Fisher.

**Michael Dreiling**

- Mr. Dreiling met with the employee for the purposes of a full vocational assessment and personal interview. His report of that meeting is dated March 1, 2000.
- In addition to his personal assessment and interview with the employee, Mr. Dreiling also relied on the report of Dr. Koprivica's January 6, 2000 IME of the employee and Advent Enterprises' vocational evaluation report in preparing his opinions and report.
- Mr. Dreiling opined that the employee would have difficulty doing sustained sit-down, sedentary activity.
- Mr. Dreiling stated that the employee has worked her entire adult life in the nursing profession. He stated that the employee will not be able to return to employment in the nursing profession due to her physical limitations. He stated that the employee cannot expect to be gainfully employed due to her physical limitations.
- Mr. Dreiling stated that his opinions are not altered by the fact that Mrs. Meyer has earned her BSN and is working toward a master's degree.
- Mr. Dreiling's opinions are not altered by the fact that the employee has continued to participate in the State of Missouri Vocational Rehabilitation Program.
- Mr. Dreiling believes that the employee is not a candidate to return to work in the labor market. He stated that the level of pain medication taken by the employee would make her less likely to be able to access the open labor market.
- Mr. Dreiling stated that the employee would not be able to work as a correctional agency director, medical records administrator, clinical teaching dietician, investigator head nurse, physical therapist or probation parole officer as suggested in the Advent report.

**Functional capacity exam on August 24, 1999 and August 26, 1999**

- The employee's abilities were tested during a four hour Functional Capacity Evaluation performed at Capital Region Medical Center on August 24, 1999 and August 26, 1999. She did not perform kneeling, crawling or squatting activities. She was limited by complaints of pain and weakness in the right lower extremity. The exam concluded that she demonstrated the ability to perform sedentary to light work.

**Dr. Reza Farid**

- The employee's post-operative rehab was initially referred to Dr. Conway. On September 17, 2001, Dr. Conway recommended physical therapy, a TENS unit, a rocker bottom shoe and tapering doses of Vicodin. However, at the employee's request, her rehabilitation was transferred to Dr. Reza Farid as of October 15, 2001. Therapeutic interventions instituted by Dr. Farid included providing an AFO brace, pool therapy two times per week and tapering doses of Ultram, Tylenol, Elavil and Vicodin. In his report dated March 11, 2002, Dr. Farid placed the employee at maximum medical improvement. He indicated that the employee was capable of returning to a productive life within the realm of her limitations. He opined that the employee had a 14% disability at the right knee and 22% at the right ankle combining to a whole body impairment of 33%. He suggested permanent restrictions of no prolonged walking more than two to three hours in an eight hour shift and no prolonged driving over

two hours. He recommended no functional bending, squatting or climbing in the work place. He stated that with regards to lifting “she will have a requirement for sedentary position with no more than 10 to 20 pounds maximum.” He recommended long-term use of Ultram, Acetaminophen, Naprosyn, Elavil and occasional use of Vicodin.

### **Dr. Robert Conway**

- Dr. Conway, a physician specializing in physical medicine and rehabilitation, was the authorized treating physician following her initial hospitalization in January and February of 1998.
- On September 22, 1999, Dr. Conway opined that the employee had a 20% disability of the right lower extremity at the level of the knee and a 15% disability at the level of the ankle.
- On September 22, 1999, Dr. Conway opined that the employee had 0% disability rating as a result of her bilateral carpal tunnel release.
- Dr. Conway was then retained by the employer-insurer to perform an IME on the employee on July 28, 2005.
- After examining the employee on July 28, 2005, Dr. Conway opined that the employee suffered from persistent knee and ankle pain status post tibial plateau fracture and right talar fracture complicated by avascular necrosis requiring arthrodesis.
- Dr. Conway opined that the employee had a severe valgus deformity of the right knee and varus deformity of the right ankle, commonly known as knock-kneed.
- Dr. Conway opined that the employee’s right ankle was essentially ankylosed and she wore an AFO
- Dr. Conway opined that the employee should limit walking and standing to two to three hours in an eight hour shift.
- Dr. Conway opined that the employee should avoid prolonged driving with a one to two hour maximum.
- Dr. Conway opined that the employee should be limited to no bending or squatting and no crawling or climbing.
- Dr. Conway opined that the employee should limit lifting to 20 pounds.
- Dr. Conway opined that the employee had a permanent partial disability of 30% of the right lower extremity at the level of the ankle due to the talar fracture and subsequent avascular necrosis requiring arthrodesis.
- Dr. Conway opined that the employee had a permanent partial disability of 40% of the right lower extremity at the level of the knee related to her tibial fracture with valgus deformity.
- Dr. Conway assigned no disability rating to the employee’s left lower extremity injuries.
- Dr. Conway opined at his deposition that the employee had a 0% disability as a result of her bilateral carpal tunnel release surgeries.
- Dr. Conway did not address the employee’s right shoulder injury.
- Dr. Conway believes that the employee will need total knee replacement but will defer to an orthopedic specialist on that issue.
- Dr. Conway opined that it is appropriate for the employee to use an AFO on her right ankle. He stated that an AFO is a custom made brace for her ankle. He also stated that an AFO would need to be replaced every 4 to 5 years.

- Dr. Conway opined that a lot of people with permanent hardware in their joints suffer from on-going pain and that pain can range from modest to severe.
- Dr. Conway recommended that the employee's pain be managed with Ultram, acetaminophen, Naprosyn and Elavil, as well as up to 120 Vicodin per month for breakthrough pain.

**Dr. Edwin Carter**

- Dr. Edwin Carter performed an IME on behalf of the employer-insurer on March 14, 2001, and again on September 17, 2003.
- Dr. Carter stated that the employee had obvious avascular necrosis of the body of the talus with collapse, for which he recommended an arthrodesis. He assigned a rating of 40% of the right knee, indicating she would require future arthrodesis or total knee replacement. The left knee was found to function well and rated at 5% of the knee.
- Based on his review of the medical records, Dr. Carter was unable to identify any significant injury to the right shoulder attributable to her motor vehicle accident. He further indicated the employee's right shoulder was functioning well and no permanent partial disability was identified. He suggested that the employee was employable in a very limited fashion. He also suggested that proper surgical procedures be provided for the right ankle.
- Dr. Carter opined that the employee could only be employed in very limited fashion, probably in a wheelchair or at least on crutches. However, this would leave a very limited ability to work.
- On September 17, 2003, Dr. Carter did not change his opinions regarding the employee's permanent disability ratings outlined above.
- On September 17, 2003, the employee was re-evaluated by Dr. Carter. Dr. Carter identified a healed right ankle arthrodesis. He suggested 40% of the right knee and 50% of the right ankle resulting in approximate combined permanent partial disability attributable to the right lower extremity of 70% at the level of the right knee. He indicates there is a possibility that the employee could require further surgery on the right ankle in the future. He concluded that the employee was employable at a sedentary job not requiring much walking or climbing of stairs. He felt the twenty pound lifting restriction was reasonable.
- Dr. Carter opined that the employee should be capable of obtaining a nursing job, especially since she now held a Bachelor of Science degree in nursing. He further opined returning to work would be a positive factor in the employee's psychological make-up. He did not believe that the employee was permanently and totally disabled for all types of work.

**Karen Kane-Thaler**

- Karen Kane-Thaler, vocational consultant, conducted an employability assessment on the employee. She wrote a report dated December 15, 2006.
- Based on her review of the employee's medical and vocational records, Ms. Kane-Thaler concluded that the employee is capable of obtaining and maintaining full-time stable, gainful employment in the open labor market.

- Ms. Kane-Thaler stated that age was not a limiting factor. She stated that the employee's educational background and additional training in professional nursing provided through the Missouri Division of Vocational Rehabilitation indicates that the employee possesses the necessary technical capacity to gain access to the open labor market.
- She stated that the employee's vocational records indicate that the employee has already been providing volunteer nursing services at her church and also teaching children. She stated that there was nothing in the employee's social background which would negatively impact her ability to gain access to the open labor market. She stated that the employee's past work history was also consistent with providing Level 7 skilled services, on a scale of 1-9, per the Dictionary of Occupational Titles. She also stated that the employee's work restrictions also indicate she is capable of performing work at a sedentary physical demand level.
- Ms. Kane-Thaler performed a labor market survey within the employee's geographical area and identified possible jobs as a probation officer, nurse consultant, head nurse and nurse practitioner. She stated that the vocational records reflect that the employee had been obtaining vocational services since 1999. However, she stated that it did not appear that the employee had a strong interest in returning to the work force.

#### **APPLICABLE LAW:**

- Under the version of Section 287.020.2 RSMo., that was in effect at the time of the employee's accident, the term accident is defined to include only those injuries that are "clearly work related". Under this section an injury is "clearly work related if work was a substantial factor in the cause of the resulting medical condition or disability. An injury is not compensable merely because work was a triggering or precipitating factor".
- The burden is on the employee to prove all material elements of the employee's claim. *Melvies v Morris*, 422 S.W.2d, 335(Mo.App.1968). The employee has the burden of proving that not only the employee sustained an accident that arose out of and in the course of employment, but also that there is a medical causal relationship between the accident and the injuries and the medical treatment for which the employee is seeking compensation. *Griggs v A.B. Chance Company*, 503 S.W.2d 697(Mo.App.1973).
- Section 287.020.7 RSMo. provides as follows:

The term "total disability" as used in this chapter shall mean the inability to return to any employment and not merely mean inability to return to the employment in which the employee was engaged at the time of the accident.

- The phrase "the inability to return to any employment" has been interpreted as the inability of the employee to perform the usual duties of the employment under consideration, in the manner that such duties are customarily performed by the average person engaged in such employment. *Kowalski v M-G Metals and Sales, Inc.*, 631 S.W.2d 919, 922(Mo.App.1992). The test for permanent total disability is whether, given the employee's situation and condition, he or she is competent to compete in the open labor market. *Reiner v Treasurer of the State of Missouri*, 837 S.W.2d 363, 367(Mo.App.1992). Total disability means the "inability to return to any reasonable or normal employment". *Brown v Treasurer of the State of Missouri*, 795 S.W.2d 479, 483(Mo.App.1990). An injured employee is not

required, however, to be completely inactive or inert in order to be totally disabled. *Id.* The key is whether any employer in the usual course of business would be reasonably expected to hire the employee in that person's physical condition, reasonably expecting the employee to perform the work for which he or she is hired. *Reiner* at 365. See also *Thornton v Haas Bakery*, 858 S.W.2d 831,834(Mo.App.1993).

- The standard of proof for entitlement to an allowance for future medical aid cannot be met simply by offering testimony that it is "possible" that the claimant will need future medical treatment. *Modlin v Sunmark, Inc.*, 699 S.W. 2d 5, 7 (Mo.App.1995). The cases establish, however, that it is not necessary for the claimant to present "conclusive evidence" of the need for future medical treatment. *Sifferman v Sears Roebuck and Company*, 906 S.W. 2d 823, 838 (Mo. App.1995). To the contrary, numerous cases have made it clear that in order to meet their burden, claimants are required to show by a "reasonable probability" that they will need future medical treatment. *Dean v St. Lukes Hospital*, 936 S.W. 2d 601 (Mo.App.1997). In addition, employees must establish through competent medical evidence that the medical care requested, "flows from the accident" before the employer is responsible. *Landers v Chrysler Corporation*, 963 S.W. 2d 275, (Mo.App.1997).
- Temporary total disability benefits are intended to cover the healing period, and are not warranted beyond the point in which the employee is capable of returning to work. Temporary total disability benefits are not intended to compensate the employee after his condition has reached the point where further progress is not expected. *Brookman v Henry Transportation* 924 S.W.2d 286 (Mo.App.1996). See also *Williams v Pillsbury Company* 694 S.W.2d 488, 489 (Mo.App.1985). The pivotal question in determining whether an employee is totally disabled is whether any employer, in the usual course of business, would reasonably be expected to employ the claimant in his present physical condition. *Brookman Id.* at 290.
- Section 287.140.1 RSMo. states that if the employee desires he shall have the right to select his own physician, surgeon, or other such requirement at his own expense.

## **RULINGS OF LAW:**

### ***Issue 1. Medical causation***

The employee is claiming that her shoulder problems and the surgery that occurred in 1999, is medically causally related to the January 30, 1998 accident.

The employee testified that after about a year on crutches, she started leaning into the crutches because her hands were weak from the carpal tunnel. The employee then began experiencing right shoulder pain.

Dr. Craig Galbraith began treating the employee on July 30, 1999, for right shoulder pain. On December 13, 1999, Dr. Galbraith operated on the employee to remove the spur and his post operative diagnosis was a tear of the anterior labrum with a spur on her medial border of the scapula with scapulothoracic bursitis.

Dr. Galbraith opined that this injury was a result of the employee's automobile accident in January, 1998, as the spur was a result of the load bearing on her right shoulder due to the injuries suffered.

Based on all of the evidence presented, I find that the employee's injury that occurred on January 30, 1998 was the substantial factor in the need for the employee's right shoulder surgery on July 30, 1999. Furthermore, I find that the employee's July 30, 1999 right shoulder surgery was medically causally related to the employee's accident on January 30, 1998.

*Issue 2. Additional medical aid-Past and future*

**(A) Whether employer is liable to reimburse the employee for past incurred medical bills related to her right shoulder surgery that occurred on July 30, 1999.**

The employee is claiming that the employer is liable to reimburse the employee for past incurred medical bills related to her right shoulder surgery that occurred on July 30, 1999. These bills totaled \$5,122.50.

Section 287.140.1 RSMo. states that if the employee desires he shall have the right to select his own physician, surgeon, or other such requirement at his own expense.

Dr. Craig Galbraith performed this right shoulder surgery. Dr. Galbraith was not an authorized treating physician by the employer-insurer. Furthermore, there was no evidence presented by the employee that proved that the employee made a specific request to the employer to receive treatment for her right shoulder

Based on all of the evidence presented, I find that the employee did not meet her burden of proof in showing that the employer is responsible for her right shoulder surgery that occurred on July 30, 1999. Therefore, the employee's request for past medical aid, regarding her right shoulder surgery, is denied.

**(B) Whether the employer is liable for past incurred narcotic drug costs totaling \$16,564.60 consisting of Fentanyl patches and Percocet.**

Dr. Peter Boyer has been the employee's family doctor since December 31, 1986. Dr. Boyer is not an authorized treating physician from the employer-insurer. Dr. Boyer is the doctor who prescribed the Fentanyl patches and the Percocet. Section 287.140.1 RSMo. states that if the employee desires he shall have the right to select his own physician, surgeon, or other such requirement at his own expense.

Dr. Boyer was not an authorized treating physician. Therefore, the employer is not responsible for the treatment and medications that Dr. Boyer prescribed. I find that the employee did not meet her burden in proving that the employer was responsible for the past incurred costs of the Fentanyl patches and the Percocet. Furthermore, based on all of the evidence presented, I find that the employer is not responsible for the past incurred costs of the Fentanyl patches and the Percocet.

**(C) Whether the employer's liability for the Percocet and the Fentanyl patches should continue in the future.**

Dr. Boyer, who currently prescribes the employee's Percocet and Fentanyl patches, established the need to taper down the drugs that the employee had once used. Dr. Boyer acknowledged the employee's lack of commitment to successfully go to a pain management specialist. Furthermore, Dr. Boyer never explained why the employee's pain complaints could not be managed by the medications recommended by the employee's authorized treating physicians. Based on the evidence presented, I find that the employee did not meet her burden of proof in establishing that the Percocet and Fentanyl patches are reasonable and necessary to manage the employee's chronic pain complaints. The employee's request for future medical to include Percocet and Fentanyl patches is therefore denied.

Per stipulation, medical benefits are to remain open for the injuries the employee sustained to her right knee and ankle and her left knee. Based on the stipulation of the parties, I direct the employer provide medical treatment that will include periodic physician monitoring of the employee's medication needs up to four times per year consistent with the recommendations of employer's authorized treating physicians or, in the alternative, pursuant to the recommendations of a pain management specialist designated by employer.

***Issue 3. Nature and extent of disability***

**(A) Permanent total disability**

The employee is claiming that she is permanently and totally disabled.

After the accident, the employee went back to school and eventually received her BSN in nursing and her master's degree in public health. The employee testified that many of these classes were on line. Furthermore, the employee took substantially longer than most students to receive these degrees

The employee testified that she is in constant pain. She testified that she is unable to walk, sit or stand frequently and must alternate between standing and sitting in order to avoid pain, swelling and stiffness in her lower extremities as a result of the injuries she suffered arising out of the January 30, 1998, accident.

During the hearing the employee was visibly in pain. In fact, she had to prop her legs up while she was testifying because of the pain and discomfort in her legs. After observing the employee during the hearing and reviewing all of the evidence, I find that the employee was a credible witness.

The employee was sent to many doctors at the request of her employer.

Dr. Farid, a doctor authorized by the employer, placed the employee at maximum medical improvement on March 11, 2002. He indicated that the employee was capable of returning to a productive life within the realm of her limitations. He suggested that the employee should be limited to sedentary work.

The employee also saw Dr. Carter at the request of the employer. He concluded that the employee was employable at a sedentary job not requiring much walking or climbing of stairs. He felt the twenty pound lifting restriction was reasonable. Dr. Carter opined that the employee should be capable of obtaining a nursing job, especially since she now held a Bachelor of Science degree in nursing. He further opined returning to work would be a positive factor in the employee's psychological make-up. He did not believe that the employee was permanently and totally disabled for all types of work.

The employee also saw Dr. Conway at the request of the employer. Dr. Conway opined that the employee should limit walking and standing to two to three hours in an eight hour shift. In essence, Dr. Conway suggested that the employee should be limited to sedentary work.

Karen Kane-Thaler, vocational consultant, conducted an employability assessment on the employee. She wrote a report dated December 15, 2006. Based on her review of the employee's medical and vocational records, Ms. Kane-Thaler concluded that the employee is capable of obtaining and maintaining full-time stable, gainful employment in the open labor market. Ms. Kane-Thaler stated that age was not a limiting factor. She stated that the employee's educational background and additional training in professional nursing provided through the Missouri Division of Vocational Rehabilitation indicates that the employee possesses the necessary technical capacity to gain access to the open labor market.

The employee's attorney sent the employee for a full vocational assessment performed by Mr. Dreiling. His report of that meeting is dated March 1, 2000. Mr. Dreiling opined that the employee would have difficulty doing sustained sit-down, sedentary activity. Mr. Dreiling stated that the employee has worked her entire adult life in the nursing profession. He stated that the employee will not be able to return to employment in the nursing profession due to her physical limitations. He stated that the employee cannot expect to be gainfully employed due to her physical limitations. Mr. Dreiling opined that the employee is not a candidate to return to work in the labor market.

The employee's attorney sent her to Dr. Koprivica for an evaluation. On January 6, 2000, Dr. Koprivica believed that the employee was permanently and totally disabled; however, he believed that a formal vocational evaluation was warranted prior to making a final determination. On February 9, 2001, after reviewing Mr. Dreiling's March 1, 2000, vocational rehabilitation report, Dr. Koprivica opined that the employee was permanently and totally disabled as of February 9, 2001, considering her multiple physical impairments and resultant permanent partial disabilities in combination.

Although the employee received her bachelor of science in nursing and her master's degree in public health, it is abundantly clear that the employee was able to take her time and work

at her own speed in order to get these degrees. Furthermore, many of the classes the employee took were online. Therefore this is not an indication that the employee is employable in the open labor market.

Based on all of the evidence presented, including the employee's testimony, I find that Mr. Dreilings opinion regarding whether the employee is employable in the open labor market is more credible than Ms. Kane-Thaler's opinion. Furthermore, I find that Dr. Koprivica's opinion regarding whether the employee is permanently and totally disabled is more credible than the opinions of Dr. Farid, Dr. Carter, and Dr. Conway.

Based on the credible testimony of the employee and the supporting medical and vocational evidence, I find that no employer in the usual course of business would reasonably be expected to employ the employee in her present physical condition and reasonably expect the employee to perform the work for which she is hired. I find that the employee is unable to compete in the open labor market and is permanently and totally disabled because of this accident. I therefore direct the employer-insurer to pay \$385.46 per week in permanent total disability benefits. I find that the employee reached maximum medical improvement on March 11, 2002. Therefore, commencing on March 12, 2002, the employer is responsible for paying the employee at the permanent total disability rate of \$385.46 per week.

These payments for permanent total disability shall continue for the remainder of the employee's lifetime or until suspended if the employee is restored to her regular work or its equivalent as provided in Section 287.200 RSMO.

Because the employee was awarded permanent total disability, the issue of permanent partial disability is moot and shall not be ruled on.

**(B) Additional temporary total disability**

The employer paid the employee temporary total disability from January 31, 1998 through September 10, 1999. The employer also paid the employee temporary total disability from June 15, 2001 through March 11, 2002. I previously found that the employee reached maximum medical improvement on March 11, 2002; therefore the employer is not responsible for temporary total disability after March 11, 2002.

Temporary total disability benefits are intended to cover the healing period, and are not warranted beyond the point in which the employee is capable of returning to work. The employee did not pay for temporary total disability for the time period of September 11, 1999 through June 14, 2001. I find that the employee was still in the healing period from September 11, 1999 through June 14, 2001. This time period equals 644 days or 92 weeks. The employer is therefore directed to pay the employee the rate of \$385.46 for 92 weeks which equals \$35,462.32.

**(C) Disfigurement**

Based on all of the evidence presented, I find that the employee sustained scars on each hand which are worth 1 week of compensation for each hand. Accordingly, the employer is directed to pay the amount of \$278.42 for 2 weeks for a total of \$556.84.

Based on all of the evidence presented, I find that the employee sustained a scar on her face which is worth 5 weeks of compensation. Accordingly, the employer is directed to pay the amount of \$278.42 for 5 weeks for a total of \$1,392.10.

**ATTORNEY'S FEE**

Thomas Collins, 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.

Employee: Kathy Meyer

Injury No.: 98-008526

Date: \_\_\_\_\_

Made by:

\_\_\_\_\_  
Maureen Tilley  
*Administrative Law Judge*  
*Division of Workers' Compensation*

A true copy: Attest:

\_\_\_\_\_  
Naomi Person  
*Division of Workers' Compensation*