

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

Injury No.: 09-109067

Employee: Colleen Nichols  
Employer: Belleview R-III School District  
Insurer: Missouri United School Insurance  
Additional Party: Treasurer of Missouri as Custodian  
of Second Injury Fund

The above-entitled workers' compensation case is submitted to the Labor and Industrial Relations Commission (Commission) for review as provided by § 287.480 RSMo. Having reviewed the evidence and considered the whole record, the Commission finds that the award of the administrative law judge is supported by competent and substantial evidence and was made in accordance with the Missouri Workers' Compensation Law. Pursuant to § 286.090 RSMo, the Commission affirms the award and decision of the administrative law judge dated June 13, 2016. The award and decision of Chief Administrative Law Judge Lawrence C. Kasten, issued June 13, 2016, 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 12<sup>th</sup> day of January 2017.

LABOR AND INDUSTRIAL RELATIONS COMMISSION

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John J. Larsen, Jr., Chairman

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James G. Avery, Jr., Member

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Curtis E. Chick, Jr., Member

Attest:

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Secretary

ISSUED BY DIVISION OF WORKERS' COMPENSATION

**FINAL AWARD**

Employee: Colleen Nichols Injury No. 09-109067  
Dependents: N/A  
Employer: Belleview R-III School District  
Additional Party: Second Injury Fund  
Insurer: Missouri United School Insurance  
Appearances: Kenneth Seufert, attorney for the employee.  
Karen Mulroy and Mary Anne Lindsey, attorneys for the employer-insurer.  
Jackson Otto, attorney for the Second Injury Fund.  
Hearing Date: March 15, 2016 Checked by: LCK/kg

**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? October 29, 2009.
5. State location where accident occurred or occupational disease contracted: Iron County, Missouri.
6. Was above employee in employ of above employer at time of alleged accident or occupational disease? Yes.
7. Did the 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 the employer insured by above insurer? Yes.
11. Describe work Employee was doing and how accident happened or occupational disease contracted: The employee fell down steps, and the left side of her body hit the ground.
12. Did accident or occupational disease cause death? No.
13. Parts of body injured by accident or occupational disease: Body as a whole referable to the neck and low back; left leg; left upper extremity including shoulder and elbow.
14. Nature and extent of any permanent disability: Permanent total disability against the employer-insurer.
15. Compensation paid to date for temporary total disability: \$3,904.85
16. Value necessary medical aid paid to date by the employer-insurer: \$70,079.14
17. Value necessary medical aid not furnished by employer-insurer: N/A.
18. Employee's average weekly wage: \$157.69 for temporary total disability. \$311.10 for permanent partial and permanent total disability.
19. Weekly compensation rate: \$105.13 per week for temporary total disability. \$207.74 per week for permanent partial disability and permanent total disability.
20. Method wages computation: By agreement.
21. Amount of compensation payable:  
  
\$9,356.55 in additional temporary total disability benefits.  
Permanent total disability against the employer-insurer.
22. Second Injury Fund liability: None.
23. Future requirements awarded: See Rulings of Law.

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: Kenneth Seufert.

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

On March 15, 2016, the employee, Colleen Nichols, appeared in person and with her attorney, Kenneth Seufert for a hearing for a final award. The employer-insurer was represented by its attorneys Karen Mulroy and Mary Anne Lindsey. The Second Injury Fund was represented by Assistant Attorney General Jackson Otto. The parties agreed on certain undisputed facts and identified the issues that were in dispute. These undisputed facts and issues, together with a statement of the findings of fact and rulings of law, are set forth below as follows:

### **UNDISPUTED FACTS:**

1. Belleview R-III School District was operating under and subject to the provisions of the Missouri Workers' Compensation Act, and its liability was fully insured by Missouri United School Insurance c/o T/P/A Gallagher-Bassett Services, Inc.
2. On or about October 29, 2009, Colleen Nichols was an employee of Belleview R-III School District and was working under the Workers' Compensation Act.
3. On or about October 29, 2009, the employee sustained an accident arising out of and in the course of her employment.
4. The employer had notice of the employee's accident.
5. The employee's claim was filed within the time allowed by law.
6. The employee's average weekly wage for temporary total disability was \$157.69 and her rate of compensation for temporary total disability is \$105.13 per week. The average weekly wage for permanent partial disability and permanent total disability is \$311.10. The rate of compensation for permanent partial disability and permanent total disability is \$207.74 per week.
7. The employee's injury to the left upper extremity is medically causally related to the accident.
8. The employer-insurer paid \$70,079.14 in medical aid.
9. The employer-insurer paid \$3,904.85 in temporary disability benefits for a total of 37 1/7 weeks of compensation. The first period paid was March 23, 2010 through April 27, 2010. The second period paid was February 22, 2011 through March 14, 2011. The third period paid was January 12, 2012 through August 1, 2012.
10. The employee reached maximum medical improvement on August 1, 2012.

### **ISSUES:**

1. Medical causation as to the cervical and lumbar spine.
2. Claim for additional or future medical aid.
3. Claim for additional temporary total disability.
4. Nature and extent of permanent disability against the employer-insurer, either permanent partial disability or permanent total disability.
5. Liability of the Second Injury Fund for permanent partial disability or permanent total disability.

**EXHIBITS:**

Employee Exhibits:

- Exhibit 1-A: Report of Dr. Volarich
- Exhibit 1-B: Curriculum Vitae of Dr. Volarich
- Exhibit 1-C: Deposition of Dr. Volarich
- Exhibit 2-A: Report of Delores Gonzalez
- Exhibit 2-B: Curriculum Vitae of Delores Gonzalez
- Exhibit 2-C: List of Exhibits (Records) provided to Delores Gonzalez
- Exhibit 2-D: Deposition of Delores Gonzalez
- Exhibit 2-E: Report of Delores Gonzalez
- Exhibit 2-F: Deposition of Delores Gonzalez
- Exhibit 3 : Medical history of the employee regarding the October 29, 2009 accident and medical records from Mineral Area Regional Medical Center; Dr. Steele; Dr. Moore; Midwest Imaging Center; Dr. Doll; Dr. Rende; ProRehab; Dr. Paletta; Farmington Hand and Physical Therapy; Dr. Peeples; Farmington Sports and Rehabilitation Center; Washington County Memorial Hospital; Dr. Weber; and Dr. Chabot
- Exhibit 4: Second Amended Claim for Compensation in Injury No. 09-109067
- Exhibit 5: Report of Injury
- Exhibit 6: Medical treatment history of the employee prior to October 29, 2009 and medical records from Mineral Area Regional Medical Center; Dr. Steele; Highland Health Clinic; and Dr. McGarry
- Exhibit 7: Education history of the employee
- Exhibit 8: Work history of the employee
- Exhibit 9: Social Security Administration Retirement, Survivors and Disability Insurance - Notice of Award
- Exhibit 10: Walgreens Pharmacy Printout
- Exhibit 11: Social Security Statement, dated October 13, 2009
- Exhibit 15: Medical Records of Dr. Weber
- Exhibit 16: Pharmacy records for the employee
- Exhibit 17: Division of Workers' Compensation minute entries in Injury Number 09-109067
- Exhibit 18: Letter to attorney for the employer-insurer dated November 21, 2012 from employee's attorney
- Exhibit 20: Temporary total disability benefits of the employee.

Note: Exhibits 12, 13, and 14 were withdrawn. Exhibit 19 was not offered.

Employer-Insurer Exhibits:

- Exhibit A: Deposition of Dr. Chabot including his C.V., report and other document
- Exhibit B: Deposition of Dr. Paletta
- Exhibit C: Deposition of James England including his C.V., report and other documents
- Exhibit D: Supplemental Report of James England dated August 26, 2015

- Exhibit E: Medical record and report of Dr. Doll
- Exhibit F: Spreadsheet prepared by employer on temporary total disability benefits paid by the employer-insurer.
- Exhibit G: Letter of termination of employment issued by employer to employee dated February 17, 2010

The Second Injury Fund did not offer any exhibits.

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

**WITNESS:** Colleen Nichols, the employee.

**BRIEFS:** The employee's proposed Award was received on April 8, 2016. The employer-insurer's Brief was received on May 2, 2016. The Second Injury Fund's letter Brief was received on May 4, 2016.

**STATEMENT OF THE FINDINGS OF FACT:**

The employee testified that she was born on January 19, 1954, and is 62 years old. She lives in Belleview, Missouri. She is 5'7" tall and weighs about 162 pounds. At the time of the injury she weighed 180 pounds. She attributes the weight loss on nerves, pain and not eating. Her symptoms affected her appetite. She has been married for 45 years. She and her husband have two children, two grandchildren, and one great grandchild. The employee left high school in the 10<sup>th</sup> grade and never got a GED. She agreed with the work history in Employee Exhibit 8. She performed factory work at Brown Shoe and at other places; has been a cook and waitress at several places; and did nurse's aide work where she bathed, fed and clothed residents. She worked for home care and supervised other employees, including performing evaluations. From 2006-2009 she worked at Disabled Citizens Alliance, where she helped the elderly and disabled including fixing meals, bathing and house cleaning. She worked there until the lady she cared for passed away. Prior to October 29, 2009, she was able to perform all the aspects of her jobs.

The employee testified regarding her pre-existing medical conditions. She had a mild stroke which affected the left side of her face. It caused twitching to the left side of face and her left eye. She took Gabapentin for the twitching. In 2007 she was in a hospital for gastric bleeding and anemia which caused fatigue, but no longer has issues with bleeding and anemia. She was diagnosed with COPD/emphysema 12-15 years ago and received treatment including inhalers. Up to October 29, 2009, she had trouble breathing; shortness of breath; coughed; got tired and was fatigued. She had problems at work where she would sit down and rest. She continued using inhalers about three times a week. She worked full duty without restrictions, and was able to do everything with her job, but it slowed her down performing her job.

In September of 2006, the employee had a heart stress test at Mineral Area Regional Medical Center for dyspnea. The results were normal wall motion and ejection fraction. She had normal bilateral venous duplex studies of the lower extremities due to a history of edema.

In February 2007, the employee was hospitalized for four days at Mineral Area Medical Center due to severe dizziness and a suspected GI bleed. She was severely anemic. Past medical history showed a TIA about eight years ago; GERD; and asthma. She was on Prilosec and Albuterol nebulizer. On examination there was mild paraspinal tension in the lumbar spine but no tenderness. The discharge diagnoses were severe anemia secondary to gastrointestinal blood loss; gastric ulcer; esophagitis, and COPD/ Emphysema Complex. Discharge medications included Advair Diskus one puff twice a day. The employee was to follow up with Dr. Steele, her family doctor, and was told to quit smoking due to her lung disease and peptic ulcer.

The employee had a lumbar MRI on July 24, 2007, that was ordered by Dr. Weiss due to a history of low back pain and lower extremity weakness. The findings were minimal narrowing of the lumbar discs and a loss of T2 cartilage signal but no evidence of disc herniation, spinal stenosis or facet hypertrophy. The impression was mild degenerative changes involving multiple lumbar discs.

The employee testified that prior to October 29, 2009, she was not having any low back pain or problems. When asked about the July of 2007 lumbar MRI the employee stated that she did not have any low back pain or lower extremity weakness prior to the MRI. She does not know why that is in the history. She is not sure why she had the lumbar MRI because she did not have any low back problems. From July of 2007 up to October 29, 2009, she did not have any low back aches or pains, and did not use any over-the-counter medicine for her back.

The employee saw Dr. Steele on January 24, 2008, for refills. The employee had a minimal cough. Diagnosed was stable COPD. On May 21, 2008, the employee saw Dr. Steele. It was noted that the employee was easily fatigued. In the musculoskeletal section, stiffness and pain in her joints were noted. On examination, her skin had a bronze cast and there was positive left blepharospasm. Assessed was COPD and possible hemochromatosis.

The employee testified that she does not remember telling Dr. Steele that she was easily fatigued and that her joints hurt and were stiff. On August 8, 2008, she went to work at Belleview School. At first she was a part-time substitute teacher aide and helped with the children. She later worked part time as substitute cook. She was working at Disabled Citizen Alliance and at Belleview prior to October 29, 2009. At Belleview she regularly worked three days a week as a teacher and occasionally as a cook.

On November 19, 2008, the employee saw Dr. Steele. Due to the continued eye spasms, Dr. Steele prescribed Neurontin and Biaxin. The employee saw Dr. Steele on August 25, 2009. She had exertional shortness of breath. Her eye was doing well on Neurontin. Assessed was COPD and she was instructed to stop smoking.

The employee testified that on October 29, 2009, she started work at 1:30 p.m. She was working at the pre-school in a modular building. To get into the classroom, she went up steps and onto a porch and then into the classroom door. It was a very rainy day and the porch and steps were wet, slippery and muddy. When her shift ended, she clocked out along with Andrea, a co-worker, and they left the building with Andrea in front. There were four steps leading from

the porch to the ground. The porch was 3-4 feet off the ground. As the employee started going down the steps, her foot slipped and she fell down the steps. The whole left side of her body hit the ground which was stone and gravel. When she hit the ground, she rolled and her left side struck and broke the metal underpinning. Andrea helped her up and the employee went home. When she got home, she had bruises and knots all over her left leg, calf and thigh, and to the left upper extremity from the hand to her shoulder. She took Aleve and went to bed. When she woke up the next day she was sore all over. Her left arm, left shoulder, left leg, low back and neck hurt. Her husband took her to the employer and she was sent to the emergency room.

On October 30, 2009, the employee went to Mineral Area Regional Medical Center with pain of 9 in multiple levels after falling at work. She had pain in her neck, left shoulder, left elbow and left lower leg. The past medical history was positive for CVA, GERD, and COPD. She was on Gabapentin, Prilosec, and Combivent inhaler. On examination there was moderate spasm of the left paracervical muscles with moderate tenderness to palpation. The left shoulder had moderate tenderness to palpation with diffuse tenderness. The elbow had small ecchymosis present and moderate tenderness to palpation. She was diffusely tender over the entire left elbow joint. There was a small amount of tissue swelling. The left lower extremity had small ecchymosi present with mild tenderness to palpation with small amount of soft tissue swelling. X-rays of her left shoulder, elbow, tibia and fibula were negative. The cervical spine X-ray showed moderate degenerative changes at C5-6. Diagnosed were contusions of the neck, left shoulder, left elbow and left lower leg. Prescribed were Lodine and Cyclobenzaprine.

The employee saw Dr. Steele on November 11, 2009, who noted that the employee was still having left hip pain from the fall. The employee had left posterior hip pain with positive tenderness to palpation just lateral to the SI joint. X-rays of the low back showed no evidence of spondylolysis or spondylolisthesis and there were mild degenerative disc changes at L4-5. Lodine and Flexeril were refilled.

The employer sent the employee to Dr. Moore on November 16, 2009. She had had low back and left hip pain. There was a single spot in the mid lumbosacral area that caused sharp pain that took her breath away. The employee was alternating ice and heat. Her bruising to the left arm, left leg, left ribs and left abdomen had resolved. The employee was having trouble sitting and standing. Dr. Moore's impression was continued midline low back pain at L4, L5 and S1; and multiple contusions of the left arm, leg, chest and abdomen that had essentially resolved. Dr. Moore refilled the Lodine and ordered physical therapy at ProRehab.

On December 7, 2009, Dr. Moore noted that the lower back pain had resolved after three weeks of therapy. It was noted other than soreness she felt good. She had good range of motion and was ready to return to work. Dr. Moore released her to regular duty.

The employee testified that when she saw Dr. Moore on December 7, 2009, she did not tell him that she was good enough to return to work. She was still having problems to her left arm and shoulder, neck, back and leg. She returned to work but had a lot of problems. She could not play on the playground, because she could not get back up if she got down, she could not pick up and hold the kids due to her arm giving away, and could not get down to do exercises with the

children. She had trouble doing normal activities with the preschool children. She tried to do cooking but could not lift pots. She had to put the pots on the trays to roll them. She could not wash the tables off due to inability to lift up and carry a bucket of water.

The employee testified up to February 8, 2010, she continued to be symptomatic in the left leg, left shoulder, left arm, neck and low back. She worked three days a week as a teacher's aide from 1:30 to 5:30 p.m. She would work as a cook whenever they needed her to fill in. The fall affected her ability to work. She was unable to do things with her children including not playing with them. She could not handle big pots and buckets of water due to her back and arms hurting from the October 29, 2009 fall. The last time she physically worked was on February 8, 2010. On February 9, 2010 she was verbally informed that she was terminated without explanation. Afterwards, she asked Laurie who was the Director of the Preschool why she was terminated and was told they thought she could not perform her job duties. She never returned to work anywhere.

On February 17, 2010, the Superintendent of the Belleview R-3 School District sent the employee a letter that stated "The decision has been made that your services will no longer be needed as a substitute teacher's aide for the Belleview R-3 Preschool Program, effective this date, February 17, 2010."

The parties stipulated that the employee was paid unemployment benefits for three weeks from February 28, 2010 through March 20, 2010

The employee testified that she received unemployment for three weeks. She filled out some forms on the computer. She does not remember if she stated that she was able to work. After the three weeks, the person at the unemployment office said she was not eligible for unemployment. She stopped applying for unemployment and agreed she could not work.

The employee testified that she went back to Dr. Steele due to her continued problems.

The employee saw Dr. Steele on March 1, 2010, with left hand and left arm numbness and tingling, along with left hip pain. It was noted that she had five sessions of therapy ordered by the workers' compensation doctor, but there was no relief in the left hip. The employee had left cervical paravertebral numbness; left hand numbness and tingling; and left buttock numbness. Dr. Steele diagnosed ulnar neuropathy, a neck injury and lumbar radiculopathy. Dr. Steele recommended electrodiagnostic studies, cervical and lumbar spine X-rays.

The employee was sent back to Dr. Moore on March 23, 2010, due to numbness in the left hand and pain in the left hip. Dr. Moore noted that the employee had not improved. She was having left arm neuropathy with decreased sensation to the left ring and pinky finger; left hip pain; and left buttocks, lumbar and sacroiliac joint numbness. Dr. Moore recommended a cervical MRI; a lumbar MRI; NCV studies of the upper extremities; and referral to a neurosurgeon.

The cervical MRI performed at Midwest Imaging on April 7, 2010, showed disc bulges from C3-4 through C5-6. At C3-4 there was a mild disc bulge slightly eccentric to the right. At C4-5 there was a minimal disc bulge. At C5-C6 there was disc space loss and mild broad based disc bulge slightly eccentric to the right.

On April 13, 2010, the nerve conduction study by Dr. VanNess showed the left ulnar amplitude was outside normal limits.

The employee returned to Dr. Moore on April 20, 2010, with not much improvement. The employee asked when she could go back to work. Dr. Moore reported cervical neck pain with left arm ulnar neuropathy and bulging discs; and persistent left low back pain with SI joint pain and numbness. Dr. Moore again recommended a lumbar MRI. He ordered therapy at ProRehab for the neck and left arm pain and numbness. He prescribed Lodine and noted that she may need to see a chronic pain specialist such as Dr. Fan.

The employee testified that the employer-insurer sent her to Dr. Doll. He continued therapy and then released her after a couple of appointments.

On April 27, 2010, the employee saw Dr. Doll a physiatrist due to ongoing neck and back symptoms. Dr. Doll reported pain of 5 on a scale of 0-10, worse with bending, lifting, mopping and sweeping. She reported left fifth finger numbness. On examination the employee had mild left-sided neck discomfort with mildly decreased sensation in the left 5<sup>th</sup> finger. There was tenderness to palpation in the left lumbar paraspinal muscles and left lumbosacral pain in all planes of motion. Dr. Doll diagnosed left neck and left arm pain and paresthesias; cervical spondylosis; and left lumbosacral pain with history of left SI joint sprain. He recommended a home exercise program. Dr. Doll continued restricted activities with avoiding lifting over 20 pounds and avoid repetitive bending, twisting and squatting activities. He ordered an electrodiagnostic study of the left upper extremity due to the numbness and recommended over-the-counter medication.

The initial notes of ProRehab on April 26, 2010, show that the employee had neck pain and numbness in the left 4<sup>th</sup> and 5<sup>th</sup> digits. On April 29, 2010, Dr. Doll performed a nerve conduction study to the left upper extremity which showed no abnormalities. Dr. Doll's impression was mechanical neck pain; multilevel degeneration of the cervical spine spondylosis; mild left ulnar neuropathy; mechanical back pain; and degeneration of the lumbar spine-spondylosis. Dr. Doll found the employee at maximum medical improvement and released her.

The office note from ProRehab dated May 11, 2010, showed that she had minimal overall change since her initial evaluation. Objectively, she had limitations in the cervical range of motion and her radicular symptoms appear to follow a dermatomal distribution. She was given a home exercise program and no additional formal therapy was planned.

The employee saw Dr. Steele on June 17, 2010. Dr. Steele noted that the MRI was positive for cervical discs. The employee was tearful and agitated. Dr. Steele diagnosed

depression and prescribed Effexor and Darvocet. On July 16, 2010, Dr. Steele noted that the medications were helping and the situational depression was improved.

The employee testified that she was sent by the employer to Dr. Rende.

On July 21, 2010, the employee saw Dr. Rende with continued neck, left shoulder and low back pain that had not improved with treatment. The low back did not radiate and she denied numbness or tingling in her legs or feet but had occasional leg cramps. Her neck pain went down the left arm into her 5<sup>th</sup> finger. She had diffuse shoulder pain. On examination, she had left shoulder tenderness along the coracoacromial arch with mild impingement signs. The lower back had some left-sided paraspinal spasms. Dr. Rende diagnosed cervical strain which aggravated her pre-existing cervical spondylosis and appeared to have a new onset of left-sided nerve root irritant affecting the left 5<sup>th</sup> digit. He recommended an epidural steroid injection. He diagnosed a left shoulder strain resulting in impingement or tendonitis requiring additional physical therapy and cortisone injection. If there was no response, an MRI should be obtained. Dr. Rende diagnosed a lumbar strain requiring additional physical therapy. Dr. Rende did not feel the employee should be out of work and recommended that she return to her job as a teacher's aide without restriction.

Additional physical therapy was performed at ProRehab beginning on September 9, 2010, due to continuing complaints of pain in the neck and left hip. The October 4, 2010 ProRehab note stated that she had minimal improvement in the cervical pain; and no change in the low back pain or left upper extremity numbness. Bending forward for an extended period of time caused numbness and a giving way sensation. Her pain was a 3-5 out of 10.

The employee was sent back to Dr. Doll on October 5, 2010, with neck, left shoulder and low back pain. He ordered a left shoulder MRI due to left upper radiculopathy and weakness in the 4<sup>th</sup> and 5<sup>th</sup> digits. The radiologist's impression was intrasubstance tear in the proximal supraspinatus tendon near the hypertrophic AC joint; and subdeltoid-subacromial bursal fluid, suggesting possibility of a full thickness tear within the supraspinatus rotator cuff. Dr. Doll recommended an orthopedic consultation.

On October 27, 2010, the employee saw Dr. Paletta, an orthopedic surgeon. The employee had left shoulder pain with persistent numbness and tingling in the 4<sup>th</sup> and 5<sup>th</sup> fingers of her left hand. On examination, the employee had dramatically positive impingement signs, pain on resisted supraspinatus testing and loss of strength. The left elbow had tenderness at the cubital tunnel and positive Tinel sign. She had decreased sensation in the ulnar nerve distribution involving the 4<sup>th</sup> and 5<sup>th</sup> fingers. X-rays of the shoulder show mild degenerative changes. Dr. Paletta reviewed the MRI which showed a tear of the supraspinatus tendon which was an intrasubstance tear with horizontal delamination and was a partial thickness tear. There was significant subacromial bursitis with fluid in the subacromial space. Dr. Paletta diagnosed partial thickness rotator cuff tear with chronic impingement. He recommended surgery but if she was reluctant to have surgery, then an injection and therapy. She was placed on limited duty with no overhead work, including repetitive lifting or lifting over 20 pounds floor to waist.

On November 5, 2010, the employee had a subacromial steroid injection to her left shoulder performed by Dr. Bayes. Physical therapy was started for the left upper extremity at ProRehab on November 11.

The employee returned to Dr. Paletta on December 22, 2010, and reported no improvement from the injection, but the therapy was helping. The employee continued to have numbness and tingling in her fingers. Dr. Paletta diagnosed resolving impingement syndrome in the setting of a partial thickness rotator cuff tear in the left shoulder; and ulnar nerve symptoms from possible cubital tunnel versus cervical radiculopathy. He continued the therapy and the same work restrictions. He ordered a repeat EMG/nerve conduction study.

On December 30, 2010, a nerve conduction velocity study was performed by Dr. Peeples. The history was constant numbness in the ring and little finger not associated with elbow pain or neck movements. Prolonged elbow flexion increased the numbness. She felt her hand was weak and she had an intermittent tremor in the left upper extremity. On examination the elbow flexion test was mildly positive, there was mild weakness in the intrinsic ulnar innervated left hand muscles, and an occasional left arm tremor. Sensation was reduced in the ulnar distribution of the left hand. The electrodiagnostic findings were ulnar neuropathy at the left cubital tunnel with axonal sensory loss and mild chronic denervation. There were no findings for cervical radiculopathy or generalized peripheral neuropathy.

Dr. Paletta on January 4, 2011, diagnosed cubital tunnel syndrome with ulnar neuropathy including axonal sensory loss and some mild denervation. Dr. Paletta recommended an ulnar nerve transposition.

The employee saw Dr. Steele on January 17, 2011. She used Darvocet to control the pain. The left shoulder was not any better, her depression was worse, and her lungs were clear. Dr. Steele increased Effexor.

The left shoulder therapy at ProRehab went through January 21, 2011. On February 22, 2011, Dr. Paletta performed a left elbow ulnar nerve transposition for left cubital tunnel syndrome with ulnar neuropathy. On March 14, Dr. Paletta ordered therapy and placed her on limited duty of 10 pound lifting limit with no repetitive use of the left upper extremity, including no repetitive forearm rotation or wrist flexion and to avoid direct pressure of the nerve.

The employee started therapy on March 16, 2011, at ProRehab. On March 21, 2011, the employee saw Dr. Steele for depression. The employee was taking a lot of Ibuprofen for back pain and Dr. Steele recommended discontinuing them. On examination her lungs were clear and there was tenderness in the cervical paravertebral.

On April 25, 2011, the therapist noted that her numbness had not changed. She had weakness and difficulties with coordination of the ulnar side of her left hand. She was having 4 out of 10 pain.

The employee saw Dr. Paletta on April 27, 2011. At the time of the surgery she had severe neuropathy and there was slow improvement after surgery. She had persistent numbness in the 4<sup>th</sup> and 5<sup>th</sup> fingers which has minimally improved and some numbness along the lateral forearm. He released her to full activities and did not think she needed any more formal therapy.

The employee saw Dr. Morris on May 16, 2011, for facial contractions and mild twitching. She was referred to a neurologist. The employee saw Dr. McGarry on June 1 for the left facial contractions. For the last two months her face kept drawing on a daily basis and her eye will shut, which lasts about 2-5 minutes. She had a mini stroke about 14 years ago with full recovery, except her left eye kept drawing up and twitching. Neurontin controlled it completely until recently. After the 2009 fall, she had left hand weakness and numbness in the left little finger and medial elbow. The ulnar nerve transposition did not help. In the review of systems she had a cough and occasional wheeze. She was depressed but doing well on medication. Dr. McGarry noted that she could not work anymore due to back and neck pain. On examination she had decreased sensation in the left ulnar distribution; slight pain present in all directions and tenderness to the lower lumbar spine at midline, with limitations of spine movement. Dr. McGarry assessed ulnar nerve lesion, low back pain and facial hemi spasm. He recommended increasing the Neurontin. He ordered a brain MRI for the left facial twitch and facial hemi spasms which was done on June 6, 2011. No acute infarct, hemorrhage, mass effect, extra axial fluid collection or abnormal contrast enhancement was seen.

The employee saw Dr. Paletta on June 22, 2011, with numbness, difficulty lifting due to weakness, and dropping things. The employee stated she had no changes in her pre-operative symptoms of numbness in the left ring and little finger and discomfort in her left radial forearm. On examination, there was slight weakness of the ulnar innervated left hand intrinsic and decreased sensation in the ulnar distribution of the left hand. Dr. Paletta ordered a nerve conduction study. Dr. Peeples stated that it showed improved ulnar conduction across the left elbow segment compared to the prior study on December 30, 2010. Dr. Peeples noted that since she had axonal sensory loss and denervation prior to the surgery, it was not surprising that she has residual numbness. There were no findings for ongoing ulnar entrapment or acute denervation. Dr. Paletta stated that the EMG nerve conduction studies were consistent with significant improved ulnar nerve conduction function compared to the December 30, 2010 study. Dr. Paletta stated that the employee had severe ulnar neuropathy prior to surgery and it was not surprising that she had residual numbness which might take up to a year to recover. Dr. Paletta stated that the employee could use her hand as much as her symptoms allow; and stated she was not able to return to work due to back and neck issues.

On September 19, 2011, Dr. Paletta noted that the employee had numbness predominately in the 5<sup>th</sup> finger. On examination there was continued decreased sensation in the ulnar nerve distribution and some loss of grip strength. Dr. Paletta's impression was persistent sensory alteration status post ulnar nerve transposition for severe pre-existing ulnar neuropathy and mild residual grip weakness. Dr. Paletta stated that the employee was at maximum medical improvement, there had not been any significant clinical improvement and the likelihood of continued improvement was low. Dr. Paletta thought the employee will likely have some

persistent numbness in the 5<sup>th</sup> finger and some mild grip weakness; and did not require any additional treatment.

The employee testified that when Dr. Paletta released her she still had problems to her left shoulder, neck and low back.

The employee went to Highland Health Clinic on September 26, 2011. She had symptoms of the left side of the face drawing up and twitching. The medication has not helped. She had numbness and tingling in the left cheek. Assessed were esophageal reflux, neuralgia and depression. A CT of the head was ordered due to the increased side of facial twitching with numbness at times. It was performed on September 29 and there was no evidence of acute edema, hemorrhage, infarction or mass; and no evidence of abnormal enhancement. There was a suggestion of central and cortical atrophy. On October 18, 2011, Highland Health Clinic phoned the employee that the CT of the brain was normal.

The employee returned to Dr. Paletta on December 12, 2011, due to left shoulder pain, particularly with her arm overhead. Dr. Paletta recommended a repeat MRI. The radiologist's impression of the December 23 MRI/arthrogram of the left shoulder was a moderate sized anterior insertional tear of the supraspinatus tendon.

On December 28, 2011, Dr. Paletta reviewed the MRI and stated that there was a progression of the tear to a full-thickness rotator tear of the left shoulder measuring 15 mm. He recommended surgery.

On January 12, 2012, Dr. Paletta performed left shoulder surgery which included an arthroscopy with partial synovectomy; subacromial decompression, bursectomy, and acromioplasty; and rotator cuff repair at Timberlake Surgery. The surgery report described the rotator cuff repair as a double row repair with multiple corkscrew type anchors. The post operative diagnoses were left shoulder pain, impingement syndrome, rotator cuff tear, and synovitis of the glenohumeral joint. The surgery was complicated by hypoxic respiratory failure due to COPD. She was admitted to Des Peres Hospital and released on January 14, after being treated with oxygen, nebulizers and steroids.

The employee testified that she had complications from the surgery with trouble breathing and not having enough oxygen.

The employee saw Dr. Paletta on January 23, 2012, and was continued off work. The employee started therapy at Farmington Hand and Physical Therapy on February 3, 2012. On February 29, the employee had increasing pain after therapy. Dr. Paletta held off therapy for the next two and a half weeks. The employee was restricted to clerical or sedentary work only with one-handed duty with the left arm assisting on light tasks only with no overhead activities and no lifting. The employee resumed therapy on March 20, 2012. On March 28, the employee had 0 to 3 intermittent pain in the left shoulder.

The employee had an initial physical therapy evaluation at Farmington Sports and Rehabilitation Center on April 10. It was noted that Farmington Hand and Physical Therapy had closed down. The employee had left shoulder pain, decreased active and passive range of motion, and left upper extremity weakness.

The employee returned to Dr. Paletta on April 11, 2012, with continued pain. She had difficulty with active motion which elicited tremors in her arm. She had some pre-operatively, but it had been significantly exacerbated postoperatively. Dr. Paletta's impression was slow progress after rotator cuff surgery. He held her off on therapy and referred her to Dr. Peebles, a neurologist for evaluation of the tremor. He put restrictions of no reaching overhead/overhead work, no pushing or pulling greater than 10 pounds, and no lifting greater than 10 pounds from floor to chest.

On April 13, 2012, the employee told the therapist that Dr. Paletta told her to hold off therapy. The employee tolerated treatment that day but her left hand began to tremble when doing shoulder isometrics.

The employee saw Dr. Peebles on May 7, 2012, for an evaluation of tremors. He noted involuntary twitching of the left eye and left face which had been going on for at least ten years and has been worse since the shoulder incident. She had shaking in her left arm which progressed after having an incident at therapy. Dr. Peebles noted that on December 30, 2010, when he saw the employee, she reported an intermittent tremor in the left upper extremity. Motor examination was notable for the prominent involuntary movements of her left face and to a lesser degree to the left upper extremity. At one point it was observed to completely shut the left eye with spasm. The left hemi facial spasm had spread to the left shoulder girdle and upper extremity. Dr. Peebles diagnosed a chronic left hemi facial spasm/blepharospams with associated involuntary movements and tremors of the left upper extremity. It was his opinion that it was not caused or altered by the October 29, 2009 work injury or subsequent treatment including the left ulnar nerve transposition or shoulder surgery.

The employee returned to the therapist on May 15, 2012 with continued weakness in her entire left shoulder girdle.

The employee saw Dr. Paletta on June 13, 2012. The therapy had been improving the involuntary muscle spasms. He continued shoulder therapy. He recommended the employee not do any significant lifting above the chest except for the therapy exercises and no repetitive overhead activities. She can lift no more than 20 pounds from floor to chest, any lifting should be done close to the body, and no pushing or pulling more than 10 pounds.

The employee testified that Dr. Steele, her primary care doctor, passed away and she starting going to Dr. Weber.

On June 14, 2012, the employee saw Dr. Weber to establish care for her low back pain and leg weakness. He ordered lumbar X-rays and a lumbar MRI which were performed that day. The lumbar X-rays showed chronic appearing loss of vertebral body height at L2 and mild

levoscoliosis, degenerative changes at L2-3 and to a lesser extent of L3-4. The lumbar MRI showed L3-4 degenerative changes with mild diffuse disc bulging somewhat eccentrically to the right, minimally deforming the contiguous thecal sac and approaching the L4 nerve root as it course posteriorly in the canal, but probably not significantly impinging it. At L4-5 there were degenerative changes with minimal diffuse disc bulging. The radiologist's impression was diffuse disc bulging at L3-4 with no evidence of central canal stenosis or neuroforaminal narrowing. The diffuse disc bulging appeared to be slightly eccentric to the right where it approaches the L4 nerve root as it courses posteriorly.

Dr. Weber ordered a nerve conduction study of the left upper extremity. It was performed on July 13, 2012, and showed findings compatible with a mild sensory left ulnar nerve neuropathy. The employee returned to Dr. Weber on July 18 for low back pain and paresthesias.

On July 25, 2012, the therapist noted 0 out of 10 pain unless she was gardening or vacuuming and then the pain was a 4. She thought her range of motion and strength had improved but was unable to reach overhead to do such things as put her dishes away. The therapist noted that her active range of motion had limitations in flexion and abduction; and the passive range of motion showed limitations in all planes. The employee did not think she needed continued therapy.

When the employee saw Dr. Paletta on August 1, 2012, she was having 2 out of 10 pain and felt like her strength and motion had improved significantly. The employee thought she was virtually able to do all of her normal day-to-day activities. Dr. Paletta stated there was good range of motion with only some mild rotational losses and end range abduction and forward elevation losses, but they were not of functional significance. She has mild residual weakness of the supraspinatus. It was his opinion that the employee did not need any restrictions or limitations, was at maximum medical improvement and released her from care.

Dr. Weber ordered an EMG that was performed on August 14, 2012 and showed findings compatible with a mild sensory neuropathy involving the left ulnar nerve.

On September 25, 2012, Dr. Paletta stated that when he last saw the employee on August 1, she had mild residual motion loss actively but full passive motion. Forward elevation and abduction were both about 150 degrees versus 160 on the right. She had mild rotational losses with external rotation to side being 30 degrees 45 on the opposite side. In the 90/90 position she lacked 10 degrees of external rotation and 15 degrees of internal rotation compared to the opposite side. Supraspinatus strength was 5-/5. It was his opinion that the employee had a 10% permanent partial disability rating of the left upper extremity at the shoulder based primarily on the mild motion losses and minimal residual rotator cuff weakness.

The employee testified that she continued to have neck and back complaints after Dr. Paletta released her.

The employee saw Dr. Weber on November 19, 2012, for neck and back pain with tremors. On examination, the employee had chronic left eye blepharospasm and cervical muscle spasms. Assessed was low back pain and lumbar disc displacement without myelopathy.

The employee testified that she had a setting at the Division seeking treatment for her neck and low back.

A mediation was held on November 20, 2012, in front of an Administrative Law Judge. The employee was requesting an evaluation on her back. It was noted the employer-insurer's attorney was to contact the employee's attorney regarding the request. On November 21, the employee's attorney sent a letter to the employer-insurer's attorney confirming their conversations at the mediation requesting medical treatment for continuing low back problems.

The employee was sent to Dr. Chabot on January 21, 2013. The employee had a variety of complaints to her back, left arm and left shoulder with history of COPD. She had 3 out of 10 pain in the interscapular region and low back. The employee cannot bend over for too long while working on her flower bed; and had pain with activity and she may have to sit in between mopping and sweeping at home. Dr. Chabot stated that the employee had a multitude of subjective musculoskeletal complaints that do not appear to be supported by her physical examination. She sustained contusion injuries to her neck and low back as a result of the injury. Dr. Moore's records indicate that she responded quickly to conservative measures and was released to return to regular duties on December 7, 2009, due to resolution of her back and neck complaints. The diagnostic studies performed after the injury did not reveal evidence of acute changes involving the cervical or lumbar spine. X-rays on January 21, 2013, showed evidence of osteopenic changes involving the lumbar spine, pelvis and hips. There was evidence of compression along the superior endplate of L2 with an approximately 15% collapse. There was evidence of scoliotic deformity apex to the left at the L3-4.

It was Dr. Chabot's opinion that the employee's present complaints were not causally related to her alleged work injury of October 29, 2009. It was his opinion that the employee did not need further medical treatment to the lumbar spine as it related to the alleged October 29, 2009 injury. It was his opinion that the employee had reached maximum medical improvement as it relates to her neck and back injuries on October 29, 2009.

The employee testified that Dr. Chabot was present for just a very few minutes and did not show any interest in her. He said there was nothing wrong with her. She continued to have back and neck pain and continued to treat with Dr. Weber to cope with her symptoms. She has seen Dr. Weber numerous times for back and neck pain and swelling. The employee believes she needs pain management for her neck and low back due to pain which was not present prior to October 29, 2009. She has had no other event or occurrence that explains pain.

When asked about Dr. Chabot's records on January 21, 2013, that that she was using oxygen when walking, the employee testified that she does not remember giving that history. She does use oxygen almost every night and carries it with her in case of emergency but did not have it with her when she saw Dr. Chabot.

On April 2, 2013, the employee saw Dr. Weber for low back and neck pain. She had mild to moderate upper and lower back pain with no radiation. Symptoms are relieved by over-the-counter medication. The lumbar MRI was reviewed. On examination, the cervical spine was tender with moderate pain with range of motion. There were muscle spasms in the lumbar spine.

The employee saw Dr. Weber on April 7, 2014, for arthralgias which was diffuse and chiefly spinal. The employee was in pain management. Lumbago was a chronic condition. In the review of systems the employee had back and joint pain with muscle weakness.

On September 22, 2014, the employee saw Dr. Weber for oxygen refill to use as needed. It was 83% at rest. It was noted that the employee had chronic low back pain.

The employee testified that Dr. Weber did not put her on oxygen. She was on oxygen after the shoulder surgery due to breathing issues. Dr. Weber refilled the oxygen prescription.

On June 15, 2015, the employee saw Dr. Weber with chronic COPD. She had decreased breath sounds; and chronic back pain. She returned to Dr. Weber in September of 2015 due to COPD aggravated by activities of daily living and anxiety. Her symptoms are relieved by oxygen use. She had decreased breath sounds. On October 2, 2015, a left and right lower extremity venous duplex examination showed no evidence of deep venous thrombosis. A left lower extremity arterial duplex examination showed mild to moderate stenosis; and the right side showed moderate stenosis. A bone scan in the lumbar spine and hips showed osteopenia in the lumbar spine and left hip.

On November 2, 2015, the employee saw Dr. Weber with fatigue and swelling. The constant fatigue symptoms began gradually and have worsened. Fatigue was associated with generalized weakness. She had swelling in her legs. An echocardiogram was performed.

Dr. Chabot's deposition was taken on February 20, 2015. The employee reported that she fell off a porch at work on October 29, 2009, landing on her left side. She had complaints to her back, arm and shoulder. The employee had 3 out of 10 low back pain, she cannot bend over very long, has pain with activity, and when she mops or sweeps, she may have to sit in between. She rarely uses pain medication and has been out of pain medication for the last six months or so. The employee moved about the examination room without difficulty and did not walk with a list or limp and did not using a cane or walker to ambulate. The neck examination was essentially normal. The range of motion of the lumbar spine was essentially normal. The employee had normal muscle strength and normal lower extremity neurologic examination.

The employee's past medical history showed shortness of breath, chronic cough, COPD, back pain, stroke, numbness in the hands and feet, neck pain, depression, hypoxia, tremor, blepharospasm and left hemi facial spasm. At the time of her appointment, she was taking Ibuprofen and methocarbamol (muscle relaxer) as needed. Dr. Chabot stated that when he said "the past medical history" was before his January 21, 2013 evaluation and not before October 29, 2009. Dr. Chabot did not review any records before the work injury of October 29, 2009, did not

ask the employee about her medical history before October 29, 2009, and did not ask the employee whether what she wrote was prior to October 29, 2009.

Dr. Chabot stated that the employee had severe and debilitating COPD. She used oxygen at home and used 3 liters of constant flow oxygen when she was walking to allow her to ambulate for prolonged distance. Dr. Chabot stated that documented a dependency on external oxygen to move around. Dr. Chabot stated that the COPD disease process is usually progressive and is compounded more in people that continue to smoke. If she was not using oxygen on October 29, 2009, that would signify progression of her disease.

Dr. Chabot had X-rays taken of the low back which showed osteopenia changes in the lumbar spine, pelvis and hips; and compression along the end plate of T2 with a 15% collapse of disc height. Dr. Chabot reviewed the June 14, 2012 lumbar MRI which showed desiccation and degeneration with diminished disc space height involving all levels of the lumbar spine. There was evidence of facet degeneration at L3-4, L4-5 and L5-S1 and no evidence of a disc herniation or an old fracture of T2.

Dr. Chabot's diagnostic impression was history of slip and fall on October 29, 2009; history of chronic neck and back pain; history of osteopenia based on X-ray examination; history of old chronic compression fracture L2; and scoliosis. It was his opinion that the employee had a multitude of subjective musculoskeletal complaints that did not appear to be supported by her physical examination which was relatively benign. The diagnostic studies performed subsequent to the injury did not reveal evidence of acute changes involving the cervical or lumbar spine.

It was Dr. Chabot's opinion that none of the employee's complaints on January 21, 2013, were medically causally related to the October 29, 2009 work-related injury. His opinion was based on the initial treating doctors not documenting severe injuries to the neck or back after the accident; and her conditions with appropriate treatment resolved in a typical period of time which was documented by Dr. Moore, who indicated that the neck and back symptoms essentially resolved as of December 7, 2009. It was Dr. Chabot's opinion that the resurgence of complaints some months later was not causally related to her alleged injuries. However, Dr. Chabot did not review all of the medical treatment records including those of Dr. Steele and Dr. Weber which included treatment records for the October 29, 2009 work accident.

It was Dr. Chabot's opinion that the employee was at maximum medical improvement, as it relates to her neck and back injuries sustained on October 29, 2009. It was Dr. Chabot's opinion that the employee does not need additional medical treatment for the lumbar or cervical spine related to the October 29, 2009 injury. It was his opinion that the employee did not sustain any permanent partial disability to her neck and low back associated with the October 29, 2009 injury.

When asked if the employee was permanently and totally disabled solely as a result of the effects of the October 29, 2009 injury, Dr. Chabot stated that Dr. Paletta returned her to full duty on August 1, 2012, and gave a recommendation of permanent partial disability regarding the upper extremity. Dr. Chabot did not contest Dr. Paletta's findings or recommendations. It was

Dr. Chabot's opinion that there was no permanent partial disability associated with the alleged injury.

It was Dr. Chabot's opinion that the multitude of comorbidities are playing a large role in her persistent complaints including her musculoskeletal complaints. She has severe COPD and is dependent on external oxygen to ambulate. Her inability to ambulate is primarily due to her hypoxia and COPD. She has a chronic cough, evidence of osteopenic changes in the lumbar spine, and evidence of multi-level degeneration involving the cervical and lumbar spine, including disc and facet degeneration which contribute to her condition. The history of prior stroke, her blepharospasms and left hemi facial spasms can contribute to her debility as well, so it all adds in total to her condition. A chronic cough can lead to aggravation of musculoskeletal condition due to being an explosive jerking event. It was Dr. Chabot's opinion that the combination of those conditions and her age are accounting for her present persisting complaints and not her alleged injury of October 29, 2009. Dr. Chabot did not assess any disability to any pre-existing medical conditions. Dr. Chabot believed her neck and back pain, after the October 29, 2009 accident, resolved as of December 7, 2009, and then reappeared for unknown reasons.

The deposition of Dr. Paletta was taken on April 30, 2015. Dr. Paletta testified that the June of 2011 electrodiagnostic study showed no evidence of ongoing entrapment or compression of the nerve so there was a successful decompression with interval recovery of the nerve but not to the point where the nerve was normal. The ulnar neuropathy was moderately severe with axonal sensory loss and mild chronic denervation which are changes in the muscles due to not getting the appropriate signal from the nerve. The surgery to repair the ulnar neuropathy was open and the nerve damage was significant enough that she may not make a recovery fully. Dr. Paletta stated that the delay in treatment may have complicated the treatment or caused worsening problems in the left elbow. In September of 2011 the employee had continued decreased sensation of the ulnar nerve distribution which is the 4<sup>th</sup> and 5<sup>th</sup> fingers and a little bit of weakness of some of the small interossei muscles in the hand. Objectively she had evidence of mild weakness of grip and pinch; and altered sensation in the ulnar nerve distribution but he did not put any restrictions on her elbow. It was his opinion that she had a 10% permanent partial disability of the upper extremity at the elbow.

Dr. Paletta stated that by December of 2011, the partial thickness rotator cuff tear in the left shoulder progressed to a complete full tear which was not unexpected. He performed a repair to the muscles and the tendons which were reattached with a double row of anchors and screws. In April of 2012, the employee told Dr. Paletta that when she actively tried to move her arm she noticed tremors under her arms and reported tremors to her eye. He observed the tremors when she tried to raise her left arm but did not see any facial twitching. The twitching or tremors was noticed by Dr. Paletta after the left shoulder surgery. It was his opinion that the observed tremors were not related to her rotator cuff surgery. In August of 2012 Dr. Paletta found minimal weakness and minimal motion loss of the left shoulder which were not of functional significance. Most of the losses were 10 degrees or less and will not affect her ability to do anything with respect to day-to-day activity with normal use of the shoulder. There was nothing that would compromise her ability to work with her hands down the side at waist level. It was his opinion that the employee had a 10% permanent partial disability of the shoulder.

It was Dr. Paletta's opinion that the employee is not permanently and totally disabled based on the left upper extremity alone, including the left shoulder and left elbow. It was his opinion that based on the studies and his examination, it did not appear that the cervical spine was the origin of either her hand numbness or shoulder pain.

The employee was seen by Dr. Volarich on December 23, 2013. His deposition was taken on August 28, 2014. With regard to pre-existing medical conditions, Dr. Volarich diagnosed mild degenerative disc disease and degenerative joint disease of the lumbar spine which was asymptomatic prior to October 29, 2009. The degenerative changes at L4-5 and the reversal of the lordotic curve between L4 and L5 shown on the November 16, 2009 X-rays were pre-existing. It was Dr. Volarich's opinion that based on the 2007 MRI the employee had a minor disc bulge at L3-4. It was Dr. Volarich's opinion that the employee had a pre-existing 5% permanent partial disability of the body as a whole of the lumbar spine due to the mild degenerative disc disease and degenerative joint disease that was asymptomatic prior to October 29, 2009. Dr. Volarich did not usually rate without symptoms, but due to the MRI that showed a minimal disc bulge at L3-4, he thought there was some mild impairment from that structural change. The employee could not recall why she had a lumbar MRI in 2007, and does not know Dr. Weiss who ordered it.

Dr. Volarich diagnosed pre-existing chronic obstructive pulmonary disease which had been present since at least 2007. Leading up to October 29, 2009, the employee suffered from lack of endurance. She was able to work full duty but used an inhaler about three times a week. It was his opinion that the employee had a pre-existing 20% permanent partial disability of the body as a whole rated at the pulmonary system due to her obstructive pulmonary disease that required intermittent use of an inhaler leading up to October 29, 2009. It was Dr. Volarich's opinion that the pre-existing COPD was an obstacle or hindrance to employment or re-employment due to shortness of breath, fatigue and use of the inhaler.

Dr. Volarich did not see the employee using oxygen and she did not tell him that she was using oxygen. If the employee had been using oxygen, then she would have moderately severe COPD. If the history contained in Dr. Chabot's report was correct and she was using oxygen, there would have been subsequent deterioration of her COPD condition which could have been caused by her continued smoking. Dr. Volarich stated that the permanent partial disability attributable to the COPD would probably increase if she was on oxygen in 2013, but he needed to see all of the information before assessing a certain disability. A subsequent deterioration would probably affect her ability to work. However that would not affect his 20% permanent partial disability rating with respect to the COPD, because he considered what her COPD condition was up to the injury of October 29, 2009.

Dr. Volarich stated that with regard to her pre-existing medical conditions as they existed up to October 29, 2009, he would not have given any restrictions based on her low back or pulmonary conditions but would have advised her to stop smoking cigarettes. The employee denied any difficulties with her neck, left shoulder, left elbow or back prior to her injury of October 29, 2009. The employee stated that as a result of the October 29, 2009 injury she continued to have pain, limited motion and weakness in her left shoulder with difficulty reaching

overhead, such as putting dishes in a cabinet and often drops them because of fatigue in the left arm. Reaching her arm out to her side and reaching back behind her causes increased pain and pulling sensation. She cannot lift with her left upper extremity due to weakness in her left elbow. Her elbow tingles if she rests it on a table top. She had ongoing numbness and tingling in the small and ring fingers. She is left hand dominant.

The employee told Dr. Volarich that she has limited motion in her neck and has occasional headaches for which she takes Ibuprofen. Any overhead activity causes increasing popping and pain in her neck and quick movements of her neck causes increased pain. She had ongoing pain in her low back that radiated down her lateral left leg to her calf and numbness and tingling. Prolonged activity caused pain into her left hip. She was able to climb stairs, but takes them one at a time. She is able to maintain fixed sitting or standing for about 15 minutes. She is most comfortable if she sits in a chair and leans forward. She has a special cushion she uses at home. She is able to bend, twist, push and pull a little and limits lifting to about 10 pounds. Household chores exacerbate her symptoms in her back, especially when sweeping, mopping and vacuuming. She can no longer walk due to back pain and no longer works in her flower beds because of bending. It is difficult to drive because of limited motion and pain in her neck. She can drive short distances but her husband drives otherwise. Her husband drove her to the appointment. At times, she wakes at night due to cramping in her left leg and cold and rainy weather exacerbates her back and neck symptoms.

The employee stated that she spends her day doing not much of anything unless she has a good day, then she does light house work. She could no longer perform the duties required of her job at Belleview School District which included lifting children, cleaning up after the children, vacuuming, mopping, taking out the trash, and wiping down the tables.

On examination, the employee had scattered rales and rhonchi in the lungs. The left shoulder was weak with a 10% loss of power in external rotation and abduction. She could toe and heel walk but complained of back pain. Her cervical motion was restricted with a 40% loss in flexion and in extension, 44% loss in right-side bending, 38% loss in left-side bending, 37% loss in right rotation, and 32% loss in left rotation. Palpation elicits pain in the left paraspinal muscles at C7 and in the left trapezius where trigger points were identified. Lumbar motion was restricted with 13% loss in flexion, 60% loss in extension, 52% loss in right-side bending, and 36% loss in left-side bending. Palpation elicited pain in both sacroiliac joints and at the L5 level in the paraspinal muscles. Straight leg raise was accomplished at 80 degrees on the right without difficulty and at the left at 60 degrees that was stopped due to back and left buttock pain. In the left shoulder there was a 25% loss of motion, passively only 15%. Impingement tests were positive. Trace crepitus was found with circumduction. She had mild atrophy in the deltoid and rotator cuff. In the left elbow the medial epicondyle and cubital tunnel was slightly tender to palpation.

It was Dr. Volarich's opinion that from the time she was terminated on February 9, 2010, until she reached maximum medical improvement when released by Dr. Paletta on August 1, 2012, the employee was temporarily and totally disabled. She was not capable of performing the duties of her job as a cook or teacher's aide with her employer; and could not have competed for

other work given her difficulty lifting and moving. His opinion on temporary total disability is based upon the symptoms to her left shoulder, left elbow, neck and back.

As a result of the October 29, 2009 injury, Dr. Volarich diagnosed internal derangement of the left shoulder which was impingement with a rotator cuff tear and was status post synovectomy, subacromial decompression, bursectomy, acromioplasty and rotator cuff repair; left elbow cubital tunnel syndrome status post ulnar nerve decompression and subcutaneous transposition; cervical syndrome secondary to disc bulging at C3-4, C4-5 and C5-6 without radiculopathy; and lumbar left hip girdle radicular syndrome secondary to disc bulging at L3-4.

It was Dr. Volarich's opinion that the bulging discs at C3-4, C4-5 and C5-6 were in part due to the work injury and part pre-existing. The C3-4, C4-5 and C6-7 discs are possible pain generators in the neck. She had no neck problems prior to the injury and she now has ongoing cervical pain.

It was his opinion that in comparing the July of 2007 lumbar MRI with the June of 2012 lumbar MRI, the only change was that the L3-4 bulge was a little more prominent. The pain from palpation in both SI and at L5 paraspinal would not have anything to do with the L3-4 disc bulge. It was his opinion that it was myofascial pain resulting from the work injury due to the employee having back pain since the injury. It was his opinion that the pain in the left hip girdle was associated with the L3-4 disc bulge. Dr. Volarich stated that there was not any pathology on the lumbar MRI that he identified that would be consistent with low back pain that radiated down the lateral left leg to the calf or numbness or tingling into the left lower extremity.

It was Dr. Volarich's opinion that the injury that occurred on October 29, 2009, is the substantial contributing factor as well as the prevailing or primary factor causing the left shoulder internal derangement that required arthroscopic repair; the left cubital tunnel that required ulnar nerve transposition; the cervical syndrome secondary to disc bulging at C3-4, C4-5 and C5-6; and the lumbar left hip girdle radicular syndrome due to disc bulging at L3-4. It was his opinion that the work injury was the prevailing factor causing her symptoms, need for treatment, and resulting disabilities.

It was Dr. Volarich's opinion that as a direct result of the October 29, 2009 accident, the employee sustained a 40% permanent partial disability of the left upper extremity at the shoulder due to rotator cuff tear and impingement that required surgery, and the rating includes the ongoing discomfort, lost motion, weakness, crepitus, and atrophy in the dominant arm; a 35% permanent partial disability of the left upper extremity at the elbow due to the cubital tunnel syndrome that required surgery, and the rating includes the ongoing discomfort, weakness, and paresthesias in the dominant arm; a 20% permanent partial disability of the body as a whole rated at the cervical spine due to her cervical syndrome from disc bulging at C3-4, C4-5, and C5-6, and the rating includes her neck pain syndrome and lost motion without radicular symptoms; and a 25% permanent partial disability of the body as a whole rated at the lumbar spine due to her lumbar left hip girdle radiculopathy, and the rating includes the back pain and lost motion due to her L3-4 disc bulge. It was Dr. Volarich's opinion that these disabilities are a hindrance to her employment or reemployment.

It was Dr. Volarich's opinion that the combination of all her disabilities creates a substantially greater disability than the simple sum of each and a loading factor should be added.

Dr. Volarich stated that with regard to work and other activities referable to the left shoulder due to the October 29, 2009 work injury, he recommended that the employee should avoid all overhead use of the left arm and prolonged use of the left arm away from the body, especially above chest level; she should minimize pushing, pulling and particularly traction maneuvers with the left upper extremity and was advised on the proper ergonomic use of the upper extremities; she should not handle weights greater than about three pounds with the left arm extended away from the body or overhead, and limit these tasks to an as needed or as tolerated; she can handle weight to tolerance with the left arm dependent, assuming proper lifting techniques, but in general, he recommended 15 pounds with the left arm alone; and is advised to pursue an appropriate stretching, strengthening, and range of motion exercise program daily for the shoulder to tolerance.

Dr. Volarich stated that with regard to work and other activities referable to the left elbow due to the October 29, 2009 work injury, he recommended to avoid using the left elbow/forearm/wrist/hand in an awkward or blind fashion; she should minimize repetitive gripping, pinching, squeezing, pushing, pulling, twisting, rotatory motions, and similar tasks and limit use to as needed; she should avoid impact and vibratory trauma to the left hand, and should use appropriate braces, anti-vibration gloves, support straps and other protective devices; she should not handle any weights greater than 3 pounds with the left arm extended away from the body, and again, 15 pounds with the arm dependent, close to the body; and an exercise program for strengthening, stretching, and range of motion daily to tolerance.

Dr. Volarich stated that with regard to work and other activities referable to the spine, and specifically to her neck and back due to the October 29, 2009 work injury, she was advised to limit repetitive bending, twisting, lifting, pushing, pulling, carrying, climbing and other similar tasks to as needed; she should not handle any weight greater than 20-25 pounds, and limit this task to an occasional basis; she should not handle weight over her head or away from her body nor should she carry weight over long distances or uneven terrain; she should avoid remaining in a fixed position for any more than about 45-60 minutes at a time including both sitting and standing; she should change positions frequently to maximize comfort and rest when needed; and she was advised to pursue a stretching, strengthening, and range of motion exercise program.

It was Dr. Volarich's opinion that the employee is in need of future medical treatment due to the October 29, 2009 work-related injury including ongoing care for her pain, including over-the-counter medications such as Ibuprofen, which she is presently taking, but with occasional prescription medication for flare-ups or worsening pains including narcotics, muscle relaxers, physical therapy and similar treatments all of which would be related to her work injury.

Dr. Volarich stated that prior to October 29, 2009, the employee was asymptomatic in her lumbar spine. The employee reported only minimal symptomatology from the COPD with mild shortness of breath with exertion and the need for the use of inhalers 2 or 3 times a week for breathing difficulties. Leading up to October 29, 2009, the employee was working thirty hours a

week and at times taking care of twenty children, who ranged from ages two to five, with activities including feeding, cleaning, vacuuming, mopping and taking out trash, as well as wiping down tables. There was no history of any physician-imposed restrictions, self-imposed restrictions or missing time from work, or any problems with getting or maintain employment.

It was his opinion that the severity of the October 29, 2009 injury and resulting disabilities from that injury far outweigh the pre-existing disabilities that she had prior to October 29, 2009. Dr. Volarich noted that the employee is 59 years old which is advanced age, her education was limited to the 10<sup>th</sup> grade, she never earned a GED, she performed labor or service type work during the majority of her work career, has been unable to get back to work since February 9, 2010, and has received social security benefits.

It was Dr. Volarich's opinion that the employee is unable to continue in her line of employment that she last held as a teacher's aide at Belleview R-3 Elementary, nor can she be expected to work on a full-time basis in a similar job. It was Dr. Volarich's opinion that the employee is unable to engage in any substantial gainful activity, nor can she be expected to perform in an ongoing working capacity in the future. It was his opinion that the employee cannot be reasonably expected to perform in an ongoing basis, eight hours per day, five days per week, throughout the work year. Dr. Volarich took the limitations and restrictions from the October 29, 2009 accident into consideration when giving his opinion that the employee was unemployable in the open labor market. It was Dr. Volarich's opinion that based on his medical assessment alone, the employee was permanently and totally disabled as a direct result of the work-related injury of October 29, 2009, standing alone.

Dr. Volarich first looked at the extent of the work-related injury alone without consideration of any pre-existing conditions. In reaching his opinion he looked at the effects from the October of 2009 injury to the left shoulder, left elbow, neck and low back, and the resulting limitations and disabilities that injury alone resulted in. In his opinion that injury alone without considering the pre-existing conditions or subsequent deterioration resulted in the employee being permanently and totally disabled.

The employee was seen by Delores Gonzalez for a vocational rehabilitation evaluation on March 1, 2014. Ms. Gonzalez's report was dated March 21, 2014, and her deposition was taken on October 24, 2014. The employee met with Ms. Gonzalez for approximately two and a half to three hours. She was born on January 9, 1954. At the time of the evaluation the employee was 60 years old, which is approaching retirement age. Individuals over the age of 50 have a harder time finding suitable employment and it is a limiting factor in and of itself. The employee last worked on February 10, 2010, when she was terminated by her employer. She has a 9<sup>th</sup> grade education with no GED. Ms. Gonzalez stated that failure to have a high school diploma or GED makes it more difficult for a potential employee to compete for employment and they are relegated to entry level positions. The employee is left hand dominant.

The employee's vocational history was light semi-skilled work as a teacher's aide from 2006 through 2010. She has an extended history from 1989 to 2006 of working as a home health aide which is medium semi-skilled work. Prior to that, she worked as a hand packager which is

medium unskilled work. She worked at a senior center as a cook; an assistant at the Baptist Home for the aged, as well as a cook in a cafeteria or restaurant, which are all medium semi-skilled work. She worked as a short-order cook/waitress and as a sewer at Brown Shoe Company, which were both light unskilled work. It was Ms. Gonzalez's opinion that due to her residual functional capacity limitations, the employee had no transferable skills which left her with the ability to work only at unskilled laborer positions. The restrictions are such she would not be able to do sedentary work.

Ms. Gonzalez performed vocational testing which was the WRAT-4 in reading, spelling and mathematical computation and the employee scored very poorly. In reading she was at 6<sup>th</sup> grade second month level; 3<sup>rd</sup> grade 7 month level in spelling; and 4<sup>th</sup> grade level in math. Ms. Gonzalez stated that the employee would not be expected to assimilate into a new work environment or learning situation that required even basic reading, spelling or math skills and could not perform adequately in clerical positions that required basic reading, sentence comprehension, spelling or math computation.

The employee stated with regard to her daily living activities that she stays home. She has pain in her neck and low back with occasional numbness in her left leg. She has numbness in her little finger and left hand which makes dexterity actions difficult. She cannot sit for more than 10 minutes before needing to change positions; she cannot stand for more than 15 minutes or walk more than 10 minutes before needing to sit and rest. She cannot lift more than 10 pounds with her left arm and cannot reach in any direction with her left arm. Bending causes increased low back pain, and stooping causes increased neck pain. She climbs stairs one at a time holding on for support. At times she experiences shortness of breath. She drives locally only but has difficulty in turning her neck while driving. Long distance driving is performed by her husband. She does not sleep well and often awakens 2-3 times a night. As a result she takes naps during the day. Her husband takes care of the household outside maintenance and they share interior household chores such as cooking, dishes, laundry, etc. Activity, cold weather and wet weather increases her back and neck pain. Her day is spent resting, including sitting in a recliner. Ms. Gonzalez stated that the employee's trouble standing and walking is due to her back and breathing.

In formulating the employee's residual functional capacity, Ms. Gonzalez stated that if one considered just what Dr. Paletta and Dr. Chabot said, she would be able to return to work including at her former position as a teacher's aide. Based on the opinion of Dr. Volarich, who evaluated her as a whole person, the employee has permanent physical disabilities which prevent her from performing her past jobs or any other job on the labor market, as a result of her severe reduced residual functional capacity which is less than sedentary work. When abiding by Dr. Volarich's restrictions, the employee would be left with a residual functional capacity of less than sedentary work. From a vocational perspective it was not reasonable to expect an employer to hire an individual with the employee's physical disabilities/conditions over younger workers who would not have to be accommodated. Ms. Gonzalez's opinion is based on restrictions for her left upper extremity and spine.

Ms. Gonzalez performed a vocational analysis of the employee's employability in the open labor market. It was her opinion that the employee was not employable in the open labor market due to her advanced age, limited education, impoverished learning and academic skills, work history and significantly reduced residual functional capacity. It was her opinion that the employee is permanently and totally disabled as a result of the work-related injury of October 29, 2009 standing alone.

It was Ms. Gonzalez's opinion that the employee was not employable as a result of the last injury alone, but is also totally disabled due to everything. It was her opinion that the employee cannot work due to the last injury because she was working without any restrictions prior to the last injury.

It was Ms. Gonzalez's opinion that even if the employee was employable, she would face resistance in the workforce as a direct result of her age, lack of education and limited work experience. Based on her education and experience, the employee would be searching for jobs in the unskilled level of work. The best candidates to fill unskilled positions have a minimum of a GED or better. The employee would be competing for jobs with younger and generally more educated persons which is a significant hindrance in her ability to find work and greatly erodes her occupational base in addition to her limited residual functional capacity. Prospective employers in the usual course of selecting new employees for jobs that offer significant and competitive wages would avoid hiring an individual with the employee's overall profile in favor of individuals who are younger, more work ready, have higher academic skills and would not have to be accommodated.

Ms. Gonzalez stated that the employee's impairments have severely compromised her ability to either return to her past relevant jobs or to perform any job on a sustained basis. It was her opinion that the employee is not a candidate for vocational rehabilitation as she is clearly not capable of any competitive work for which there is a reasonably stable job market.

It was her opinion that the defining limitation that makes the employee unemployable was limited to lifting no more than three pounds with the left upper extremity and having to change positions frequently and maximize comfort and rest when needed. She stated that considering those together the employee cannot work. Ms. Gonzalez stated that Dr. Volarich was the only doctor who had made a global assessment of her functioning. Dr. Chabot's opinions were isolated to the back and neck and Dr. Paletta's opinion was isolated to the left shoulder, left elbow and left upper extremity. Even if the restrictions of Dr. Paletta and Dr. Chabot are taken into account, the employee is not going to be able to work due to her age, very limited education and impoverished educational skills. In forming her vocational opinion, Ms. Gonzalez relied on the physical limitations and restrictions imposed by Dr. Volarich. Ms. Gonzalez stated that in just looking at the effects and restrictions that come with the primary work injury of October of 2009, she cannot identify any work that the employee would be capable of doing.

James England performed a vocational rehabilitation evaluation of the employee on April 23, 2014, to determine her employability in the open labor market. His report was dated May 5, 2014. Mr. England's deposition was taken on March 11, 2015. Mr. England noted that the

employee did not drive to the appointment, but was brought by her husband because she only drives short distances. The employee was appropriately dressed and groomed and would make a nice impression in an interview the way she appeared initially. The employee was initially pleasant, cooperative, had a good sense of humor and sat without noticeable difficulty. She started crying after taking the math test. She scored at the 5<sup>th</sup> grade level on math which was in line with 90% of the people that he tests.

Mr. England stated that since the employee had been tested using the WRAT-4, he administered the WRAT-3 which is a different version of the same test. On the WRAT-3, the employee scored at the 5<sup>th</sup> grade level on word recognition and math. Mr. England stated that her academics were not very high but were adequate for her to perform a variety of work activities, and would allow the employee to perform a number of entry level types of work. The employee would need a great deal of remediation to prepare for a GED.

The employee completed the 9<sup>th</sup> grade, did not start the 10<sup>th</sup> grade and dropped out of school when she was 16. She later completed CNA training at a nursing home in Arcadia. She was employed at Belleview from 2006 through 2010 and last worked around February of 2010. Her job was considered light from a physical standpoint. She worked at Disability Services as a home health aide. While employed at Missouri Home Health Care, the employee went from home health aide to field assistant where she traveled checking the vital signs of senior citizens. She performed a combination of CNA and regular home health duties which was a medium job from a physical standpoint. The employee also worked as a line worker, cook, and waitress.

Mr. England stated that the employee had very rudimentary computer knowledge from using her home computer and did not use a computer much at work. She had no experience with bookkeeping, scheduling or supervising. It was Mr. England's opinion that the employee did not have any transferable skills below a light level of exertion, but had acquired skills as a substitute teacher's aide which could be utilized at the light level.

The employee took medication for high cholesterol, acid reflux, anxiety and depression, and used an inhaler for COPD. She took up to 10-12 tablets of Ibuprofen a day. The employee's worst pain was in her left shoulder, back, and neck. She had numbness in the last two fingers of her left hand, and at times in her lumbar spine. She could not reach up well with her left arm, and avoided doing so. The employee could stand approximately half an hour and walk a block. She can bend over but at a certain point it hurts. She avoids kneeling because of trouble getting back up. She can squat on a limited basis. She could lift a gallon of milk, but primarily used her right arm, keeping it close to her body. The employee could sit for half an hour before needing to get up and move around. The employee only drove close to her home due to limited range of neck motion. The employee performed limited gardening and yard work and was able to take care of household chores if she paced herself.

At the time of Mr. England's evaluation, the employee was 60 years old and approaching normal retirement age. She had a limited education, no GED, and was functioning at mid-grade school level. Assuming the findings of the treating doctors, it was Mr. England's opinion that she could return to her work as a teacher's assistant, which is a light job normally.

Mr. England stated that assuming Dr. Volarich's ultimate opinion, the employee would apparently be disabled. Mr. England stated that based on Dr. Volarich's limitations and restrictions, the employee would be capable of some cashiering positions, some security positions, and potentially to the home health agency work of the nature she previously performed as a field assistant taking patients' vital signs, and recording that information. She could not work a full range of home health such as assisting and transferring patients. The employee would be able to perform entry-level work, such as security positions working in an office building, greeting people as they came in, and telling them the floor where the office they were seeking was located. Security positions do not require much use of the arms at all. The employee could work in some cashiering positions, particularly at a movie theater or a parking lot, where she could alternate sitting and standing and take money from customers and give them change. She could use one arm as a cashier. Dr. Volarich's restrictions would limit her options as far as overall work but not from cashiering, security and some home health work.

It was Mr. England's opinion that even given Dr. Volarich's restrictions, there was some work the employee would still be able to perform and she was intelligent enough to perform these entry-level positions. Medically the employee could work at a job where she had the ability to intermittently sit and stand as needed and those types of occupations fell within Dr. Volarich's restrictions. It was Mr. England's opinion that the employee was not permanently and totally disabled solely as a result of the October 29, 2009 accident and injuries.

The employee felt that she is totally disabled and not interested in exploring any other vocational options. Mr. England stated that Dr. Volarich was the only physician that examined the employee for all of her different medical problems. Mr. England stated that if a person has to lie down in a recumbent fashion it would negate their ability to work. If rest meant that the person had to rest, lie down, sit or do something else away from work that would eliminate them from work. If rest means getting up and moving around it would not. Although Dr. Volarich found that the employee should change positions frequently to maximize comfort, and rest when needed, he did not indicate claimant should rest in a recumbent position.

On June 13, 2015, Mrs. Gonzalez issued a supplemental report responding to the opinions of Mr. England. Ms. Gonzalez reviewed the report and deposition of Mr. England. Ms. Gonzalez supplemental deposition was taken on August 26, 2015. She testified that Mr. England did not include a transferability of skills analysis but he indicated that the employee acquired some skill as a substitute teacher which could be utilized at a light level. He failed to identify what skills were acquired or what jobs the unidentified skills were transferable to and at what exertional level. Based solely on Dr. Volarich's limitations, Mr. England stated that the employee could perform work in some cashiering positions, some security guard positions and some home health positions.

Ms. Gonzalez stated that the restrictions of Dr. Volarich alone resulted in her residual functional capacity of less than sedentary work. The restrictions regarding the left upper extremity are significant and Mr. England failed to acknowledge that the employee is left hand dominant. The positions suggested by Mr. England would require frequent reaching and handling of the left upper extremity that would exceed Dr. Volarich's restrictions. Ms. Gonzalez

stated that according to the dictionary of occupational titles, parking lot cashier requires frequent reaching and handling, including extending the hands and arms in any direction and handling, seizing, holding, grasping, turning or working with hands. These demands exceed the restrictions of Dr. Volarich, as would any cashiering positions or security guard positions that require frequent reaching and handling.

Ms. Gonzalez stated that Mr. England failed to acknowledge with regard to limitations of the spine that the employee was to avoid remaining in a fixed position for any more than 45 to 60 minutes at a time, including both sitting and standing. When performing sedentary work, there is an expectation that an employee have the ability to sit for two hours before needing to take a break. It assumes that the employer would make an accommodation, and when work needs to be accommodated seeking work in the competitive open labor market is significantly hindered and ultimately preclusive.

Ms. Gonzalez stated that Dr. Volarich's limitation that the employee should change positions frequently to maximize comfort and rest when needed is inconsistent with any employment. Employers expect employees to work in blocks of two hours at a time without interruption. Any need of the employee to rest as needed is inconsistent with any type of employment.

After his deposition, Mr. England was provided with Ms. Gonzalez's deposition and her supplemental report. Mr. England issued a supplemental report on August 25, 2015. Assuming the findings of Dr. Doll, Dr. Chabot and Dr. Paletta, it was his opinion that the employee could have returned to her past job. It was his opinion that Dr. Volarich's restrictions would allow the employee to perform some security positions and the home health position she had previously performed. He did not indicate that she could do a full range of home health work but under his restrictions the employee could consider going back to taking vital signs as a field assistant. Dr. Volarich did not indicate that the employee could not use her left arm. The field assistant position would allow a lot of downtime in between use of employee's left arm, and would not require repetitive use of the left upper extremity. The security positions that Mr. England recommended involved very limited use of either arm such as found in positions in office buildings in the St. Louis area where the security guard essentially greets people and tells them what floor an office is on. In these positions, the employee could alternatively sit, stand, and move about during the day, as needed.

Mr. England stated that the position of cashier at a movie theater or parking lot is performed at a level of exertion which allowed the person to alternatively sit and stand, and would not involve lifting over ten pounds. The employee could perform the reaching and handling required by such a job with her right arm if she truly had such limitation with the left. Mr. England stated that a person capable of staying in a fixed position for 45-60 minutes at a time would be capable of performing those types of jobs. There is no expectation to sit for two hours in a sedentary job before getting up to move around. These job positions are not accommodated work, but work actually performed in the real workforce. It was Mr. England's opinion that given Dr. Volarich's restrictions, the employee would not be totally disabled. Since Dr. Volarich did not find employee needed to rest in a recumbent fashion, and assuming that by

rest Dr. Volarich meant changing positions within a 45- to 60-minute range, the employee would be able to work within those restrictions.

The employee testified that in the past she took Neurontin for her eye twitch, but she has not taken Neurontin for several years. The cheek feels different and is worse than her eye twitch and came on after the shoulder surgery. During the hearing she was rubbing her cheek and neck. There is a place on the left part of neck that she massages which makes her twitch go away. It seems to be related to her neck and shoulder. She did not start using oxygen until after the 2012 shoulder surgery. She uses oxygen mostly at night. She did not have the oxygen with her at the hearing, and she did not need to use oxygen during the hearing.

The employee testified that she is currently on Cymbalta for pain and depression, an anxiety medication, an inhaler, and Ibuprofen. The medications she takes as a result of the accident are Cymbalta and Ibuprofen. She takes Ibuprofen for her back, neck, left elbow and left shoulder, and takes 10-14 pills per day depending on her symptoms. She does not like prescription drugs and will not take pain killers. She was first prescribed an anti-anxiety pill after the October of 2009 accident. She takes the nerve pill because due to the fall and injuries, she cannot do things like she used to and it affected her emotionally. She enjoys doing activities, had always been independent, and never asked people to do things for her. Now she has to ask for help and it is not very pleasant. Dr. Weber is prescribing the nerve medicine.

The employee testified with regard to her left elbow that she cannot lift with it. If she puts dishes in a cabinet, she cannot reach in cabinet with her left hand. She will use her right hand or get someone to help. She is left handed. She has tingling in the elbow and into the ring and small fingers. If she rests her left elbow on the table it tingles and goes numb. She has no strength in the left hand and arm and has trouble lifting. She cannot do any repetitive activities and no longer crochets. If she does, her hands cramp and she gets knots. She can raise her left shoulder to about shoulder height and not higher. She has loss of strength in the left upper extremity. She has pain with shoulder movement. On an average day her pain is 4-5 and on a bad day is 8 out of 10. She will wake up at times at night due to her left shoulder and left elbow. She has swelling in the left hand most of the time and it was swollen at the hearing. She has problems dropping things such as an armload of folded clothes due to her arm giving away. She can hold a glass of water but will not try to throw with her left arm. Prior to the accident she could lift small children, but now she cannot lift her grandchildren. She does most of her activities with her right hand, including washing her hair.

The employee testified that with regard to her neck, her pain on a good day is a 3-4, and on a bad day 6-7. She has limitations turning her neck right to left when driving and that is why she does not drive much. She can move her head up and down but it hurts. Her neck pops 4-5 times a week but there is no pain. Quick movements of her head cause pain. She had no neck problems before the accident on October 29, 2009.

The employee testified that with regard to her low back, she has pain that sometimes goes into her left leg to the knee and it tingles and goes numb. Activity causes the low back pain to increase and radiates to the left leg. If she is not too active the pain is just to the low back. She

can get on her knees but has trouble getting up due to her back. She cannot sit for very long, and is constantly moving due to pain. At the hearing she was moving around and leaning on a chair. Her back was numb. She goes up stairs one stair at a time and uses her right hand. She uses a back cushion when she sits, and has a cushion in the car and at home. If she stands for a long time, her back goes completely numb and she has left leg cramps. When taking a shower, she uses a shower chair if she is tired and her back gives out.

The employee testified that she was able to drive anywhere prior to October 29, 2009. She does not drive much anymore and she could not drive to St. Louis from her home. Her husband and daughter drive her, and he brought her to the hearing. When she rides in a car she has back pain. She cannot ride for very long until she has to stop, get out, stretch and walk due to back pain. She attributes her inability to drive to her injury.

The employee testified that cold and rainy weather increases the pain significantly in her neck, low back and left upper extremity. She avoids all types of lifting and the most she can lift with her left hand is five pounds or less. She wakes up 3-4 times a night due to pain in her neck and back. She used to sleep on her left side and was able to sleep through the night. Now if she turns onto her left side she wakes up immediately. She is always tired. During the day she sits in a recliner and will also lie down to relieve pain, symptoms and to rest from being tired. She rests 5-6 times a day, where she gets off her feet in her recliner or bed. Each time it is at least for 20 minutes. To help with pain, besides lying down and taking Ibuprofen, she uses a heating pad that gives some relief to her low back and neck. Prior to the 2009 accident, she did not have to stop and lie down. She reads during the day and walks her little dog once in a while but does not go very far. She cannot walk very far without assistance. The pain affects her ability to focus.

The employee testified that prior to October 29, 2009, she used to enjoy bike riding and had an extensive flower garden. She was called the flower lady. She no longer rides a bike and she gardens only a small amount of time. Prior to accident she went out in her husband's boat and they used to camp a lot. She is no longer able to go out in the boat and last year they camped twice. Her husband takes care of the outside maintenance and he does most of the household chores. She can do some household chores but it takes time due to having to take breaks.

The employee testified that she was unable to work from February of 2010 through August 1, 2012, due to her inability to stand or sit long enough, or raise her left arm to do anything. She did not have any significant benefit from the treatment. The therapy was a temporary fix. Her left shoulder, left elbow, low back and neck did not get any better.

The employee testified that she has not looked for a job since leaving Belleview. She does not feel that she can work due to having to lie down during the day multiple times. She cannot use left arm and had used her left arm to carry and lift to make a living. She does not really have enough computer skills to do anything. She does not know how to do Microsoft Word and does not use email. She feels she is totally disabled and does not know of any job she could do without being fired in two days. She does not think she can work due to so much pain and fatigue. Prior to the 2009 injury she could drive, she had no trouble walking or standing with her job or any problems climbing or sitting for extended period of time.

**RULINGS OF LAW:*****Issue 1. Medical causation as to the cervical and lumbar spine.***

It is disputed that the employee's injury to her cervical and lumbar spine was medically causally related to the October 29, 2009 accident.

Section 287.020.3 RSMo states that "An injury by accident is compensable only if the accident was the prevailing factor in causing both the resulting medical condition and disability. 'The prevailing factor' is defined to be the primary factor, in relation to any other factor, causing both the resulting medical condition and disability."

The employee's credible testimony was that prior to October 29, 2009, she was not having any low back pain or problems or lower extremity weakness. From July of 2007 to October 29, 2009, she did not have any low back aches or pains, and did not use any medicine for her back. She had no neck problems before October 29, 2009. On October 29, 2009, she fell down steps, and the left side of her body hit the stone and gravel ground. She struck and broke the metal underpinning. She was hurting all over including her neck, low back and left leg.

The medical records show that at the emergency room she had pain of 9 at multiple levels after falling at work. When she saw Dr. Steele in November of 2009, she had left posterior hip pain with positive tenderness lateral to the SI joint. Dr. Moore in November stated that the employee had left hip pain with sharp pain in the lumbosacral spine which took her breath away; and caused trouble sitting and standing. On December 7, 2009, Dr. Moore noted that the lower back pain had resolved after three weeks of therapy but she still had soreness. He released her to regular duty.

The employee's credible testimony was that although she returned to work she continued to have problems with her neck, low back and left leg which affected her ability to work.

The medical records corroborate the employee's testimony that her neck and back symptoms never improved. On March 1, 2010, Dr. Steele noted that the therapy performed in late 2009 did not give the employee any relief in her left hip; and she had left cervical and left buttock numbness. Dr. Steele diagnosed a neck injury and lumbar radiculopathy. In late March, Dr. Moore stated that the employee had not improved and was having left hip pain; and left buttocks, lumbar and sacroiliac joint numbness. Dr. Moore recommended a cervical MRI, a lumbar MRI, and referral to a neurosurgeon. In late April of 2010 Dr. Moore noted that the employee did not have much improvement and continued to have cervical neck pain and persistent left low back pain with SI joint pain and numbness. Dr. Moore again recommended a lumbar MRI and stated she may need to see a chronic pain specialist. In late April the employee saw Dr. Doll with left-sided neck discomfort and tenderness to palpation in the left lumbar paraspinal muscles and left lumbosacral pain in all planes of motion. Dr. Doll diagnosed left neck pain; cervical spondylosis; and left lumbosacral pain with history of left SI joint sprain. In July of 2010, Dr. Rende noted continued neck and low back pain with leg cramps. The lower back had left sided paraspinal spasms. Dr. Rende diagnosed a cervical strain which aggravated

her pre-existing cervical spondylosis; and a lumbar strain. Physical therapy was performed due to neck and left hip pain. The employee saw Dr. Doll in October of 2010 with neck and low back pain. In March of 2011, Dr. Steele noted that the employee took a lot of Ibuprofen for back pain. In June of 2012, Dr. Weber saw the employee due to low back pain and leg weakness and ordered a lumbar MRI. In November of 2012, Dr. Weber saw the employee due to neck and back pain. On examination, the employee had cervical muscle spasms. Assessed was low back pain and lumbar disc displacement. In April of 2013, the employee saw Dr. Weber with mild to moderate neck and lower back pain. On examination, the cervical spine was tender with moderate pain with range of motion and there were muscle spasms in the lumbar spine.

It was Dr. Chabot's opinion that the employee had a multitude of subjective musculoskeletal complaints that did not appear to be supported by her physical examination. The diagnostic studies performed subsequent to the injury did not reveal evidence of acute changes involving the cervical or lumbar spine. It was Dr. Chabot's opinion that the employee's complaints on January 21, 2013, were not causally related to her alleged work injury of October 29, 2009, because the doctors did not document severe injuries to the neck or back; and her neck and back symptoms essentially resolved as of December 7, 2009. It was Dr. Chabot's opinion that the resurgence of low back and neck complaints some months later was due to unknown reasons and was not causally related to her alleged injuries. Dr. Chabot did not review all of the medical treatment records, including those of Dr. Steele and Dr. Weber, which included treatment records for the October 29, 2009 work accident.

I find that Dr. Chabot's opinion is adversely affected by the fact that he did not review all of the treatment records and the medical records show that the employee's neck and low back symptoms never resolved after the October 29, 2009 accident.

Dr. Volarich stated that prior to October 29, 2009, the employee was asymptomatic in her lumbar and cervical spine. She was working with no history of any physician or self-imposed restrictions; missing time from work; or any problems with getting or maintaining employment. Dr. Volarich diagnosed pre-existing mild degenerative disc disease and joint disease of the lumbar spine which was asymptomatic prior to October 29, 2009. The lumbar MRI from 2007 showed a minimal disc bulge at L3-4. Dr. Volarich stated that he would not have given any restrictions based on the low back condition prior to October 29, 2009.

As a result of the October 29, 2009, injury Dr. Volarich diagnosed cervical syndrome secondary to disc bulging at C3-4, C4-5 and C5-6 without radiculopathy; and lumbar left hip girdle radicular syndrome secondary to disc bulging at L3-4. It was Dr. Volarich's opinion that the bulging discs at C3-4, C4-5 and C5-6 were in part due to the work injury and part pre-existing and those discs are possible pain generators in the neck. She had no neck problems prior to the injury and she now has ongoing cervical pain.

It was his opinion that in comparing the July of 2007 lumbar MRI with the June of 2012 lumbar MRI the L3-4 bulge was a little more prominent. It was his opinion that the pain in the left hip girdle was associated with the L3-4 disc bulge. The pain from palpation in the SI joint and at L5 paraspinal was due to myofascial pain from the work injury. Dr. Volarich stated that

there was not any pathology on the lumbar MRI that would be consistent with the low back pain that radiated down the lateral left leg to the calf or numbness or tingling into the left lower extremity.

It was Dr. Volarich's opinion that the October 29, 2009 injury is the prevailing or primary factor causing the cervical syndrome secondary to disc bulging at C3-4, C4-5 and C5-6; and the lumbar left hip girdle radicular syndrome due to disc bulging at L3-4. It was his opinion that the work injury was the prevailing factor causing her symptoms, need for treatment, and resulting disabilities.

Based on a thorough review of the evidence including the credible testimony of the employee, I find that the opinion of Dr. Volarich is very persuasive and is more persuasive than the opinion of Dr. Chabot on the issue of medical causation including the prevailing factor for the injury, condition and disability to the cervical and lumbar spine.

Based on a thorough review of all of the evidence, I find that the October 29, 2009 accident was the prevailing factor in causing the employee's resulting cervical and lumbar spine injuries, resulting medical conditions and disability, the need for treatment to the cervical and lumbar spine, and the employee's symptoms to her cervical and lumbar spine. I further find that the injury to the employee's cervical and lumbar spine and resulting medical conditions and disability, the employee's symptoms and the need for treatment is medically causally related to the October 29, 2009 work accident.

***Issue 2. Claim for additional or future medical aid.***

The employee is requesting future medical aid. Under Section 287.140 RSMo, the employee is entitled to receive all medical treatment that is reasonably required to cure and relieve her from the effects of the work-related injury. In *Landers v. Chrysler Corporation*, 963 S.W.2d 275 (Mo. App. 1997), the Court held that it is sufficient to award medical benefits if the employee shows by "reasonable probability" that she is in need of additional medical treatment by reason of her work-related accident. Section 287.140.1 does not require that the medical evidence identify specific procedures or treatments in the future. See *Talley v. Runny Meade Estates, Ltd.*, 831 S.W.2d 692, 695 (Mo. App. 1992).

The employee's credible testimony was that she continued to treat with Dr. Weber to cope with her back and neck pain. She believes that she needs pain management for her neck and low back. She is taking Ibuprofen for her back, neck, left elbow and left shoulder. She takes 10-14 Ibuprofen per day. Dr. Weber is prescribing Cymbalta for pain and depression.

It was Dr. Paletta's opinion that the employee did not require any additional treatment for the left upper extremity. It was Dr. Chabot's opinion that the employee does not need additional medical treatment for the lumbar or cervical spine related to the October 29, 2009 injury.

It was Dr. Volarich's opinion that due to the October 29, 2009 work-related injury, the employee is in need of future medical treatment. It was his opinion that due to her pain she needs

over-the-counter medications such as Ibuprofen which she is presently taking, occasional prescription medication for flare ups or worsening pain including narcotics and muscle relaxers, physical therapy and similar treatments, all of which would be related to her work injury.

Based on a review of the evidence, I find the opinion of Dr. Volarich is more persuasive than the opinions of Dr. Paletta and Dr. Chabot.

I find that the employee is in need of additional medical care to cure and relieve her from the effects of the October 29, 2009 work accident and injuries. The employer-insurer is ordered to provide to the employee all the medical treatment that is reasonable and necessary to cure and relieve her from the effects of her work-related injury pursuant to Section 287.140 RSMo, including but not limited to the treatment recommended by Dr. Volarich.

***Issue 3. Claim for additional temporary total disability.***

The employee is claiming temporary total disability from February 9, 2010 through August 1, 2012. The parties stipulated that the employer-insurer is entitled to a credit for previously paid temporary total disability set forth in Stipulation 9. The parties stipulated that the employer-insurer paid 37 1/7 weeks of temporary total disability. The first period was March 23, 2010 through April 27, 2010. The second period was February 22, 2011 through March 14, 2011. The third period was January 12, 2012 through August 1, 2012. The employer-insurer paid \$3,904.85 in temporary disability benefits.

The parties stipulated that the employee was paid unemployment benefits for three weeks from February 28, 2010 through March 20, 2010 and the employee is not entitled to temporary total disability under Section 287.170.3 RSMo. After deducting the stipulated credits the amount being claimed by the employee is \$9,356.56.

Temporary total disability benefits are intended to cover healing periods and are payable until the employee is able to return to work or until the employee has reached the point where further progress is not expected. 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 or her present physical condition. See *Brookman v. Henry Transportation*, 924 S.W. 2d 286 (Mo. App. 1996). The mere fact that the employee might be able to do some light duty cannot be taken as conclusive evidence against his right to temporary total disability benefits. *DuPonte v. Chevrolet-St. Louis Division of General Motors*, 188 S.W.2d 641 (Mo. App. 1938). The fact that an employee was capable of, but did not seek, sporadic or light duty work, would not in itself disqualify the claimant from receiving temporary total disability benefits. *Cooper v. Medical Center of Independence*, 955 S.W.2d 578 (Mo. App. 1997).

The employee's credible testimony was that up through February 8, 2010, she continued to be symptomatic in the left leg, left shoulder, left arm, neck and low back and that affected her ability to work. She worked three days a week for four hours a day. She was unable to do activities with her children including playing with them. She could not handle big pots and

buckets of water. The last time she physically worked was on February 8, 2010. She was verbally informed that she was terminated on February 9, 2010 without explanation. Afterwards, the Director of the Preschool told her that she was terminated because she could not perform her job duties. When the employee applied for unemployment she could not remember if she stated she was able to work. After three weeks she stopped applying for benefits when she was told by the unemployment office that she was not eligible.

On March 1, 2010, Dr. Steele recommended electrodiagnostic studies and X-rays of the cervical and lumbar spine. On March 23, 2010, the employee returned to Dr. Moore who noted she had not improved. He recommended a cervical MRI, a lumbar MRI, and NCV studies of the upper extremities; and referral to a neurosurgeon. The cervical MRI was performed on April 7, 2010, and the nerve conduction study was performed on April 13, 2010. On April 20, Dr. Moore recommended a lumbar MRI and ordered therapy. On April 27, Dr. Doll continued restricted activities with avoiding lifting over 20 pounds and avoid repetitive bending, twisting and squatting activities. He ordered an electrodiagnostic study of the left upper extremity.

The employer-insurer paid temporary total disability from March 23, 2010 through April 27, 2010.

On April 29, 2010, after performing the nerve conduction study, Dr. Doll stated that the employee was at maximum medical improvement and released her. In mid June of 2010, Dr. Steele prescribed medications. On July 21, 2010, Dr. Rende recommended an epidural steroid injection to the cervical spine; therapy and an injection to the left shoulder with possible left shoulder MRI; and additional physical therapy for the lumbar spine. Dr. Rende did not feel the employee should be out of work and recommended that she return to her job as a teacher's aide without restriction. Additional physical therapy was performed at ProRehab beginning on September 9. On October 5, 2010, Dr. Doll ordered a left shoulder MRI that showed a possible full thickness tear of the rotator cuff. He recommended an orthopedic consultation. On October 27, 2010, Dr. Paletta diagnosed a partial thickness left rotator cuff tear with chronic impingement and recommended surgery. She was placed on limited duty with no overhead work, including no repetitive lifting or lifting over 20 pounds from floor to waist. An injection to her left shoulder was performed on November 5 and therapy was begun on November 11. On December 22, the employee reported that therapy helped. Dr. Paletta continued the therapy and the same work restrictions; and ordered a repeat EMG/nerve conduction study which was performed on December 30, 2010. In early January of 2011, Dr. Paletta recommended an ulnar nerve transposition which he performed on February 22, 2011.

The employer-insurer paid temporary total disability from February 22, 2011 through March 14, 2011.

On March 14, Dr. Paletta ordered physical therapy and put the employee on limited duty with a 10 pound lifting limit and no repetitive use of the left upper extremity and to avoid direct pressure of the nerve. Therapy was started on March 16. On April 27, 2011, Dr. Paletta released her to full activities and stopped therapy. The employee returned to Dr. Paletta on June 22, 2011, and he ordered a nerve conduction study. Dr. Paletta stated that the employee could use her hand

as much as her symptoms allow; and stated she was not able to return to work due to back and neck issues. On September 19, Dr. Paletta stated that the employee was at maximum medical improvement, there had not been any significant clinical improvement and the likelihood of continued improvement was low.

The employee returned to Dr. Paletta on December 12, 2011 for left shoulder pain. He ordered an MRI/arthrogram which was performed on December 23. On December 28, 2011, Dr. Paletta recommended left shoulder surgery which was performed on January 12, 2012.

The employer-insurer paid temporary total disability from January 12, 2012 through August 1, 2012.

Dr. Paletta kept the employee off work and ordered therapy. On February 29, 2012, Dr. Paletta gave restrictions of clerical or sedentary work only with one-handed duty with the left arm assisting on light tasks only, with no overhead activities and no lifting. On April 11, he put the employee on restrictions of no reaching overhead/overhead work, no pushing or pulling greater than 10 pounds, and no lifting greater than 10 pounds from floor to chest. On June 13, 2012, Dr. Paletta continued shoulder therapy and put restrictions of no significant lifting above the chest except for the therapy exercises; and no repetitive overhead activities. She could lift no more than 20 pounds from floor to chest and any lifting should be done close to the body. There should be no pushing or pulling more than 10 pounds.

On June 14, due to low back pain and leg weakness, Dr. Weber ordered a lumbar MRI. In July a nerve conduction study of the left upper extremity was ordered by Dr. Weber. The last shoulder therapy was on July 25, 2012. On August 1, 2012, Dr. Paletta released the employee from care and stated that she was at maximum medical improvement.

The employee testified that she was unable to work from February 9, 2010 through August 1, 2012, due to her inability to stand or sit long enough or raise her left arm to do anything. It was Dr. Volarich's opinion that from the time she was terminated on February 9, 2010, until she reached maximum medical improvement when released by Dr. Paletta on August 1, 2012, the employee was temporarily and totally disabled. She was not capable of performing the duties of her job as a cook or teacher's aide with her employer; and could not have competed for other work given her difficulty lifting and moving. His opinion on temporary total disability is based upon the symptoms to her left shoulder, left elbow, neck and back.

Based on the evidence, I find that from February 9, 2010 through August 1, 2012, the employee was unable to compete in the open labor market, was still in her healing period, had not reached the point where further progress was not expected, that no employer in the usual course of business would reasonably be expected to employ the claimant in her present physical condition, and she was unable to work and was temporarily totally disabled. I therefore find that the employee was temporarily totally disabled for 129 1/7 weeks of compensation for the time period of February 9, 2010 through August 1, 2012.

The parties stipulated that the employee was paid unemployment benefits for three weeks from February 28, 2010 through March 20, 2010 and the employee is not entitled to temporary total disability under Section 287.170.3 RSMo. I therefore find that the employee is owed and the employer-insurer is obligated to pay the employee 126 1/7 weeks of compensation at the rate of \$105.13 per week for a total of \$13,261.40. The employer-insurer is entitled to a credit for the 37 1/7 weeks of temporary disability benefits that were previously paid in the amount of \$3,904.85. The employer-insurer is ordered to pay the employee \$9,356.55 in additional temporary total disability benefits.

***Issue 4. Nature and extent of permanent disability against the employer, either permanent total disability or permanent partial disability; and Issue 5. Liability of the Second Injury Fund for permanent total disability or permanent partial disability.***

The term “total disability” in Section 287.020.7 RSMo, means inability to return to any employment and not merely inability to return to the employment in which the employee was engaged at the time of the accident. The phrase “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. See *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. See *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.” An injured employee is not required, however, to be completely inactive or inert in order to be totally disabled. See *Brown v. Treasurer of State of Missouri*, 795 S.W.2d 479, 483 (Mo. App. 1990). The question is whether any employer in the usual course of business would reasonably be expected to employ the employee in that person’s present physical condition, reasonably expecting the employee to perform the work for which he or she entered. See *Reiner* at 367, *Thornton v. Haas Bakery*, 858 S.W.2d 831, 834 (Mo. App. 1993), and *Garcia v. St. Louis County*, 916 S.W.2d 263 (Mo. App. 1995).

The first question that must be addressed is whether the employee is permanently and totally disabled.

I find that the employee was a very credible and persuasive witness on the issue of permanent total disability. The employee offered detailed testimony concerning the impact her condition has had on her daily ability to function in the workplace or at home. Her testimony supports a conclusion that the employee will not be able to compete in the open labor market.

The employee was observed during the hearing. She moved around in her chair several times in an effort to get comfortable. She appeared to be in a lot of pain. The employee requested permission to stand and stood during her testimony. She requested to take a break during the hearing. The testimony and observed behavior of the employee was important on the issue of permanent total disability.

There is both medical and vocational evidence that addresses whether the employee is permanently and totally disabled.

Dr. Paletta stated that with regard to the left elbow, the employee had severe neuropathy and nerve damage. After surgery the employee had objective evidence of mild weakness of grip and pinch strength; and altered sensation in the ulnar nerve distribution. Dr. Paletta released her to full activities and put no restrictions on her elbow. It was his opinion that the employee sustained a 10% permanent partial disability of the upper extremity at the level of the elbow. Dr. Paletta stated that with regard to the left shoulder there was minimal weakness and loss of motion which would not affect her ability to do day-to-day activity with normal use of the shoulder. There was nothing that would compromise her ability to work with her hands down the side at waist level. It was his opinion that the employee had a 10% permanent partial disability of the left upper extremity at the shoulder. It was Dr. Paletta's opinion that the employee is not permanently and totally disabled based on the left upper extremity alone.

It was Dr. Chabot's opinion that there was no permanent partial disability associated with the injury to the neck and low back; and he agreed with Dr. Paletta returning the employee to full duty and assessing permanent partial disability of the left upper extremity.

Dr. Volarich stated that due to the October 29, 2009 work injury, he put restrictions on the left shoulder, left elbow, neck and low back. The restrictions to her left shoulder was to avoid all overhead use of the left arm and prolonged use of the left arm away from the body, especially above chest level; minimize pushing, pulling and particularly traction maneuvers with the left upper extremity; not handle weights greater than about three pounds with the left arm extended away from the body or overhead, and limit these tasks to as needed or as tolerated; and handle weight to tolerance with the left arm dependent, but recommended 15 pounds with the left arm alone. The restrictions to her left elbow were to avoid using the left elbow, forearm, wrist, and hand in an awkward fashion; minimize repetitive gripping, pinching, squeezing, pushing, pulling, twisting, rotatory motions, and similar tasks to as needed; avoid impact and vibratory trauma to the left hand; and not handle any weights greater than three pounds with the left arm extended away from the body, and 15 pounds with the arm dependent, close to the body.

Dr. Volarich's restrictions to the neck and low back were to limit repetitive bending, twisting, lifting, pushing, pulling, carrying, climbing and other similar tasks to an as needed basis; not handle any weight greater than 20-25 pounds, and limit it to an occasional basis; not handle weight over head or away from her body nor should she carry weight over long distances or uneven terrain; avoid remaining in a fixed position for any more than about 45-60 minutes at a time including both sitting and standing; and should change positions frequently to maximize comfort and rest when needed.

It was Dr. Volarich's opinion that the employee is unable to engage in any substantial gainful activity nor can she be expected to perform in an ongoing working capacity in the future. It was his opinion that the employee cannot be reasonably expected to perform in an ongoing basis eight hours per day five days per week; and the employee was permanently and totally disabled.

It was Mr. England's opinion that the employee did not have any transferable skills below a light level of exertion, but had acquired skills as a substitute teacher's aide which could be utilized at the light level. Assuming the findings of the treating doctors, it was Mr. England's opinion that she could return to her work as a teacher's assistant. Based on Dr. Volarich's limitations and restrictions, the employee would be capable of some cashiering positions, some security positions, and potentially to home health work of the nature she previously performed as a field assistant taking and recording vital signs. She could not work a full range of home health such as assisting and transferring patients. Security positions do not require much use of the arms at all. The employee could work in some cashiering positions where she could alternate sitting and standing and take money from customers and give them change. She could use one arm as a cashier. Dr. Volarich's restrictions would limit her overall work options. It was Mr. England's opinion that even given Dr. Volarich's restrictions, there was some work the employee would still be able to perform and she was intelligent enough to perform these entry-level positions. Medically the employee could work at a job where she had the ability to intermittently sit and stand as needed and those types of occupations fell within Dr. Volarich's restrictions.

It was Mr. England's opinion that the employee was not permanently and totally disabled. It was Mr. England's opinion that given Dr. Volarich's restrictions, the employee would not be totally disabled. Since Dr. Volarich did not find employee needed to rest in a recumbent fashion, and assuming that by rest, Dr. Volarich meant changing positions within a 45- to 60-minute range, the employee would be able to work within those restrictions. If a person has to lie down in a recumbent fashion it would negate their ability to work. If rest meant that the person had to rest, lie down, sit or do something else away from work that would eliminate them from work. If rest means getting up and moving around it would not.

The employee's credible testimony was that 5-6 times a day she has to get off her feet for at least 20 minutes each time and lies down in her recliner or bed to help relieve pain and symptoms to her low back and neck.

Ms. Gonzalez stated that if just the opinions of Dr. Paletta and Dr. Chabot were considered, the employee would be able to return to work including her former position as a teacher's aide. Dr. Volarich was the only doctor who had made a global assessment of her functioning and evaluated her as a whole person. With Dr. Volarich's restrictions to the left upper extremity and spine the employee would have a residual functional capacity of less than sedentary work. Based on the opinion of Dr. Volarich the employee has permanent physical disabilities which prevent her from performing her past jobs or any other job on the labor market, as a result of her severely reduced residual functional capacity. From a vocational perspective it was not reasonable to expect an employer to hire an individual with the employee's physical disabilities/conditions over younger workers who would not have to be accommodated.

It was Ms. Gonzalez's opinion that the employee was not employable in the open labor market due to her advanced age, limited education, impoverished learning and academic skills, work history and significantly reduced residual functional capacity. The employee's impairments have severely compromised her ability to either return to her past relevant jobs or to perform any job on a sustained basis. The defining limitation that makes the employee unemployable was

limited to lifting no more than three pounds with the left upper extremity and the need to change positions frequently and maximize comfort and rest when needed. Dr. Volarich's limitation that the employee should change positions frequently to maximize comfort and rest when needed is inconsistent with any type of employment. It was her opinion that the employee is permanently and totally disabled.

Based on a review of all the evidence, I find that the opinions of Dr. Volarich and Ms. Gonzalez are more persuasive than the opinions of Dr. Paletta, Dr. Chabot and Mr. England on whether the employee is permanently and totally disabled.

Based on the persuasive testimony of the employee and the supporting medical and vocational rehabilitation evidence, I find that no employer in the usual course of business would reasonably be expected to employ the employee in her present 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.

Given the finding that the employee is permanently and totally disabled, it must be determined whether the October 29, 2009 accident alone and of itself resulted in permanent total disability.

The employee credible testimony was that prior to October 29, 2009, she was not having any low back or neck pain or problems. She did not have to lie down, and had no trouble walking, standing, or sitting for an extended period of time. She was able to perform all the aspects of her jobs. Since the October 29, 2009 accident she has to lie down, take Ibuprofen, and use a heating pad to get some relief. She attributes the need to do this to the accident to her low back and neck.

It was Dr. Paletta's opinion that the employee is not permanently and totally disabled based on the left upper extremity alone, including the left shoulder and left elbow.

When asked if the employee was permanently and totally disabled solely as a result of the effects of the October 29, 2009 injury, Dr. Chabot agreed with Dr. Paletta returning the employee to full duty and assessing permanent partial disability of the left upper extremity. It was Dr. Chabot's opinion that there was no permanent partial disability associated with the alleged injury to the neck and low back. It was Dr. Chabot's opinion that the multitude of comorbidities are playing a large role in her persistent complaints, including her musculoskeletal complaints. The severe COPD, chronic cough, osteopenic lumbar spine changes, multi-level degeneration involving the cervical and lumbar spine, the prior stroke with blepharospasms and left hemi facial spasms all contribute to her condition. It was Dr. Chabot's opinion that the combination of those conditions and her age accounts for her present persisting complaints and not her alleged injury of October 29, 2009.

It was Mr. England's opinion that the employee was not permanently and totally disabled solely as a result of the October 29, 2009 accident and injuries.

It was Dr. Volarich's opinion that the employee had pre-existing mild degenerative disc disease and degenerative joint disease of the lumbar spine that was asymptomatic prior to October 29, 2009. Dr. Volarich would not have given any restrictions for the pre-existing low back medical condition.

It was Dr. Volarich's opinion that as a direct result of the October 29, 2009 accident, the employee sustained a 40% permanent partial disability of the left upper extremity at the shoulder; a 35% permanent partial disability of the left upper extremity at the elbow; a 20% permanent partial disability of the body as a whole at the cervical spine; and a 25% permanent partial disability of the body as a whole at the lumbar spine. It was Dr. Volarich's opinion that these disabilities are a hindrance to her employment or reemployment. It was Dr. Volarich's opinion that the severity of the October 29, 2009 injury and resulting disabilities from that injury far outweigh the pre-existing disabilities that she had prior to October 29, 2009. Dr. Volarich first looked at the extent of the work-related injury alone without consideration of any pre-existing conditions. It was his opinion that injury alone without considering the pre-existing conditions or subsequent deterioration resulted in the employee being permanently and totally disabled. It was Dr. Volarich's opinion that based on his medical assessment alone the employee was permanently and totally disabled as a direct result of the work related injury of October 29, 2009 standing alone.

It was Ms. Gonzalez's opinion that the employee was not employable in the open labor market due to her advanced age, limited education, impoverished learning and academic skills, work history and significantly reduced residual functional capacity. It was her opinion that the employee is permanently and totally disabled as a result of the work-related injury of October 29, 2009 standing alone. In just looking at the effects and restrictions from the primary work injury of October of 2009, she cannot identify any work that the employee would be capable of doing. It was Ms. Gonzalez's opinion that the employee was not employable as a result of the last injury alone.

I find that the opinions of Dr. Volarich and Ms. Gonzalez that the October 29, 2009 work accident alone caused the employee to be permanently and totally disabled are very persuasive and are more persuasive than the opinions of Dr. Paletta, Dr. Chabot and Mr. England.

Based upon the evidence, I find that as a direct result of the October 29, 2009 accident and injury alone, the employee is permanently and totally disabled. Based on the stipulation and the evidence, I find that the employee's maximum medical improvement date was August 1, 2012. As set forth in Issue 3, I find that the employee was in her healing period through August 1, 2012, and was entitled to temporary total disability benefits.

I find that as of August 2, 2012, the employee was no longer able to compete in the open labor market and was permanently and totally disabled. I find that the employer-insurer is liable to the employee for permanent total disability benefits. The employer-insurer is ordered to pay permanent total disability benefits at the rate of \$207.74 per week beginning on August 2, 2012. 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.

Since the employee has been awarded permanent total disability benefits, Section 287.200.2 RSMo mandates that the Division “shall keep the file open in the case during the lifetime of any injured employee who has received an award of permanent total disability.” Based on this section and the provisions of 287.140 RSMo., the Division and Commission shall maintain an open file in the employee’s case for purposes of resolving medical treatment issues and reviewing the status of the employee’s permanent disability pursuant to Sections 287.140 and 287.200 RSMo.

Claim against the Second Injury Fund for permanent partial or permanent total disability.

I find that since the employee was permanently and totally disabled as a result of the October 29, 2009 accident alone, the Second Injury Fund has no liability for either permanent total or permanent partial disability benefits. The employee’s claim against the Second Injury Fund is denied.

**ATTORNEY’S FEE:**

Kenneth Seufert, 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.

Made by:

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