

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

Injury No.: 98-172549

Employee: Patricia Payne
Employer: Colonial Baking, d/b/a Earthgrains/Sara Lee Corporation
Insurers: Pacific Employers Insurance Company/
Self-Insured c/o Indemnity Insurance Company of North America
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 section 287.480 RSMo. Having reviewed the evidence and considered the whole record, the Commission finds that the award of the administrative law judge is supported by competent and substantial evidence and was made in accordance with the Missouri Workers' Compensation Law. Pursuant to section 286.090 RSMo, the Commission affirms the award and decision of the administrative law judge dated December 28, 2010. The award and decision of Administrative Law Judge Victorine R. Mahon, issued December 28, 2010, 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 8th day of November 2011.

LABOR AND INDUSTRIAL RELATIONS COMMISSION

William F. Ringer, Chairman

Alice A. Bartlett, Member

Curtis E. Chick, Jr., Member

Attest:

Secretary

AWARD

Employee: Patricia Payne

Injury No. 98-172549

Dependents: N/A

Employer: Colonial Baking d/b/a Earthgrains/
Sara Lee Corporation¹

Before the
**DIVISION OF WORKERS'
COMPENSATION**
Department of Labor and
Industrial Relations of Missouri
Jefferson City, Missouri

Additional Party: Treasurer of Missouri, as custodian
of the Second Injury Fund

Insurer: Pacific Employers Insurance Co./
Self-Insured; Helmsman Management Services

Hearing Date: October 12, 2010

Checked by: VRM/db

Record Closed: November 10, 2010

FINDINGS OF FACT AND RULINGS OF LAW

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: July 7, 1998.
5. State location where accident occurred or occupational disease was contracted: Greene County, Missouri.
6. Was above employee in employ of above employer at time of alleged accident or occupational disease? Yes.
7. Did employer receive proper notice? Yes.
8. Did accident or occupational disease arise out of and in the course of the employment? Yes.
9. Was claim for compensation filed within time required by Law? Yes.
10. Was employer insured by above insurer? Yes.

¹The parties agreed that The Sara Lee Corporation, a self-insured entity, purchased Colonial Baking and stands in the shoes of Colonial Baking for purposes of this Claim for Compensation.

11. Describe work employee was doing and how accident occurred or occupational disease contracted: Claimant slipped and fell, striking her head, neck and shoulder.
12. Did accident or occupational disease cause death? No. Date of death? N/A
13. Part(s) of body injured by accident or occupational disease: Neck and left shoulder.
14. Nature and extent of any permanent disability: 15% body as a whole.
15. Compensation paid-to-date for temporary disability: \$35.25.
16. Value necessary medical aid paid to date by employer/insurer: \$41,365.67.
17. Value of necessary medial aid not furnished by employer/insurer: None.
18. Employee's average weekly wages: \$620.00.
19. Weekly compensation rate: \$ 413.35 / \$294.73.
21. Method wages computation: By agreement.

COMPENSATION PAYABLE

22. Amount of compensation payable:
15% body as a whole (60 weeks) x \$294.73 = \$17,683.80.

TOTAL FROM EMPLOYER: \$17,683.80

23. Second Injury Fund liability:
15% body as a whole primary disability = 60 weeks
25% to the right upper extremity (at the 175 week level) = 43.75
60 + 43.75 = simple sum of 103.75
103.75 x 10% load = 10.375 weeks x \$294.73 = \$3,057.82.

TOTALFROM FUND: \$3,057.82

24. Future requirements awarded: None.

The compensation awarded to the claimant shall be subject to a lien of 25 percent of all payments in favor of the following attorney for necessary legal services rendered to the claimant: Jay Cummings.

FINDINGS OF FACT and RULINGS OF LAW:

Employee: Patricia Payne

Injury No. 98-172549

Dependents: N/A

Employer: Colonial Baking d/b/a Earthgrains/
Sara Lee Corporation

Before the
**DIVISION OF WORKERS'
COMPENSATION**
Department of Labor and
Industrial Relations of Missouri
Jefferson City, Missouri

Additional Party: Treasurer of Missouri, as custodian
of the Second Injury Fund

Insurer: Pacific Employers Insurance Co./
Self-Insured; Helmsman Management Services

Hearing Date: October 12, 2010

Checked by: VRM/db

Record Closed: November 10, 2010

INTRODUCTION

The undersigned Administrative Law Judge conducted the final hearing in this case on October 12, 2010, in Springfield, Greene County, Missouri. Attorney Jay Cummings represented Patricia Payne (Claimant). Employer The Sara Lee Corporation, a self-insured entity, appeared through Attorney Patrick Platter. Assistant Attorney General Susan Colburn appeared for the Treasurer of Missouri, as custodian of the Second Injury Fund.

At the hearing, Claimant sought to introduce a number of medical bills. Employer objected based on the seven-day-rule. The record remained open seven days to allow Employer's counsel an opportunity to review the bills and submit any contrary evidence or argument. Employer made its timely submission of argument and requested that the same be marked as Exhibit 18. Hearing no objection from opposing parties, Employer's submission is admitted. Employer's objection to Exhibit E is overruled.

Claimant also sought additional time to submit evidence of a settlement agreement relating to a pre-existing disability. Due to the age of the settlement, the Division did not have a

scanned copy of the document in its computer files. First, the record was left open for seven days. When it appeared that the document still was not available from the Division, and with the consent of the opposing parties, the Administrative Law Judge allowed the record to remain open until November 10, 2010. On November 3, 2010, Claimant submitted evidence of Claimant's settlement relating to her earlier workers' compensation claim. The documentation is marked as Exhibit F and is admitted.

Also on November 3, 2010, Claimant submitted supplemental materials relating to medical bills, to which Employer has objected in writing. As Employer correctly noted in its written objection, the record remained open past the original seven day period, from October 17, 2010 to November 10, 2010, solely for the receipt of documents relating to the prior workers' compensation settlement. The Administrative Law Judge made no ruling that contemplated the receipt of any supplemental documentation relating to medical bills. Employer's objection to the additional medical billing documents, submitted on November 3, 2010, is sustained.

Employee's supplemental submission relating to medical bills, along with Employer's objection thereto, as well as the Administrative Law Judge's electronic mail message and related minute entry, are marked as Court's Exhibit I, and shall remain with the file for purposes of review.

STIPULATIONS

The parties have reached the following stipulations:

1. On July 7, 1998, Claimant was in an accident.
2. At the time of the accident, Claimant was an employee of Colonial Baking, d/b/a Earthgrains.
3. All parties were subject to and covered by the Missouri Workers' Compensation Law at the time of the accident.
4. The events occurred in Greene County, Missouri. Venue and jurisdiction are appropriate in Springfield, Missouri, where the hearing occurred.
5. Notice and statute of limitations are admitted.

6. Employer is fully insured. The Sara Lee Corporation, a self-insured entity, purchased all assets and liabilities of Earthgrains.
7. Claimant's average weekly wage was \$620.00, yielding the following rates: \$413.35 for Temporary Total Disability and Permanent Total Disability, and \$294.73 for Permanent Partial Disability.
8. Employer has paid \$41,365.67 in medical expenses. Claimant seeks reimbursement for additional medical bills.
9. Employer has paid \$35.25 in temporary total disability.

ISSUES

The parties agree that the following are the issues for this hearing:

1. Did Claimant sustain an injury by accident within the course and scope of employment?
2. Is Claimant's alleged seizure disorder medically and causally related to the work accident?
3. What is the extent of any permanent disability?
4. Is Employer liable for the payment of past medical bills?
5. Is Employer liable for future medical treatment?
6. What, if any, is the liability of the Second Injury Fund?

EXHIBITS

The following exhibit was offered jointly by Employer and Claimant and admitted:

Joint Exhibit C-12 – Deposition of Dr. Jeremy Daniel Slater

The following exhibits were offered by Claimant and admitted:

- | | |
|-----------|--|
| Exhibit A | Deposition of Dr. Earl Hackett |
| Exhibit B | Deposition of Dr. Shane L. Bennoch |
| Exhibit D | Deposition of Dr. Robert Burger – dated January 27, 2005 |
| Exhibit E | Medical Bills Submitted on the Date of Hearing |
| Exhibit F | Division Documents Pertaining to Injury No. 86-017171 |

The following exhibits were offered by Employer and admitted:

- | | |
|-------------------------------|---|
| Exhibits 1 through 11, and 13 | Medical Records |
| Exhibit 14 | Deposition of Dr. Charles Mauldin |
| Exhibit 15 | Deposition of Dr. Robert Burger (Supplemental 2010) |
| Exhibit 16 | Driver's License of Patricia Payne |
| Exhibit 17 | Follow-up Note of Dr. Park dated July 29, 1998 |
| Exhibit 18 | Written Arguments Received October 19, 2010 |

FINDINGS OF FACT

The Accident

Claimant Patricia Payne is 56-years-old, married, and the mother of two children. She graduated from high school. Her entire working career has been in production or factory work. On July 7, 1998, Claimant was working as a sanitation foreman for Earthgrains when she slipped and fell. Her arm became entangled in a nearby conveyor belt. She also hit her head on the concrete floor and a bar or pipe that was affixed to the floor. She did not lose consciousness. She continued her shift. She reported the injury the following day after she awoke with a swollen and bruised left arm. Her neck and head also hurt. Employer sent Claimant for medical care. She was paid temporary total disability for part of one day. But, she essentially missed no other work due to her injuries up to the date that the Earthgrains facility shut down many years later.

Treatment for the Neck and Left Shoulder

Employer does not seriously dispute that Claimant sustained some physical injury in the fall, particularly to the neck and shoulder. Dr. William Berner saw Claimant shortly after the work accident and diagnosed a contusion and strain of the neck and left shoulder. X-rays were normal. When Claimant's condition did not improve, Dr. Berner referred Claimant to a neurosurgeon, Dr. Bert Park.

Dr. Park first saw Claimant in July and August 1998. He ordered an MRI which revealed minimal degenerative changes in the cervical spine at the C-3-4, 4-5 levels. He recommended conservative treatment and light duty work for a few weeks.

Claimant next saw Dr. Ted Lennard on September 3, 1998, who recommended additional physical therapy, but returned Claimant to work without restrictions. He also referred Claimant

to Dr. Mark Crabtree, who saw Claimant on October 13, 1998. A myelogram ordered by Dr. Crabtree, and read by Dr. Goodman on October 26, 1998, revealed a ventral defect arising from the C4-5 disc space "which appears to be secondary to osteopenic sprurring." (Exhibit 5). Dr. Goodman opined that Claimant suffered degenerative changes with no significant impingement. No surgery was indicated as a result of the work accident.

Dr. Lennard again saw Claimant in November 1998. An EMG of the upper left extremity was normal. An arthrogram of the left shoulder was normal. Injections in the subacromial space in the left shoulder on November 20, 1998, provided a 50 percent improvement in symptoms, but Claimant refused any more injections. Dr. Lennard referred Claimant to Dr. David Rogers, an orthopedic surgeon, but he recommended against surgery. Dr. Lennard referred Claimant to physical therapy, but she had no long-lasting relief. Dr. Lennard then issued a rating of eight percent to the body as a whole on March 9, 1999. In a letter dated May 12, 2000, Dr. Lennard said that Claimant's MRI of the cervical spine revealed general spondylosis but no disc herniation. The MRI of the head revealed what might represent an old temporal lobe infarct, which Dr. Lennard did not believe was related to Claimant's work injury.

Not satisfied with the medical treatment thus far, Claimant sought treatment on her own from Dr. John Ferguson, a local neurosurgeon. She saw him 18 months after her accident, and 10 months after her rating from Dr. Lennard. Dr. Ferguson found small defects in the neck which he believed were of no clinical significance. Dr. Ferguson recommended only conservative treatment.

Claimant also saw Dr. Park on March 22, 2000, while still treating with Dr. Ferguson. She told Dr. Park that she had fibromyalgia. Dr. Park reviewed an MRI scan which he believed demonstrated a small disc at C5-6 on the left that contributed to Claimant's problem, but he said

any surgical result would be less than one hundred percent. He indicated conservative treatment.

Treatment of Alleged Seizure Symptoms

Earl R. Hackett, M.D., saw Claimant on April 19, 2000, to evaluate her neurological state. He reviewed an MRI, and observed a lesion in the left temporal area which Dr. Hackett believed was a contusion associated with the original injury at work. He opined, however, that the lesion could have resulted from a stroke or a small intracerebral hemorrhage that had resolved. In any event, Dr. Hackett believed the condition was asymptomatic. He did, however, caution that there was the possibility of developing complex partial seizures. Dr. Hackett's report indicates that he provided a copy to Claimant (Exhibit A). Claimant did not have any purported seizures until after Dr. Hackett had provided this opinion.

On December 31, 2001, more than three years after the work accident in July 1998, Claimant described an incident in which she had blurred vision, head pain, and muscular flinching, and uncontrollable shaking on her right side. She testified that she could not function and could not see. She went to Cox Medical Center South, arriving about 10:35 p.m. Although Claimant believed this was her first significant seizure, she thought she had experienced a minor incident prior to this.

The hospital medical records disagree with Claimant's description of what occurred on New Years' Eve 2001. The medical records indicate complaints of pain and numbness and tingling to the right side. Nothing indicates complaints of a seizure or seizure-like symptoms. The physician's impression was muscular spasms. Claimant was prescribed Vicodin for pain, Norflex for muscle spasms, and advised to apply ice to her back and follow-up with her personal physician.

Less than one week later, on January 5, 2002 at 4:30 p.m., Claimant again went to an emergency room, this time to St. John's Regional Health Center. She had complaints of numbness and tingling in her hands and right leg of two weeks' duration, and pain to the head, neck and shoulder. The medical record states that Claimant had been hyperventilating and "also c/o all over shaking (not sz activity)" with no "LOC" or weakness (Exhibit 5). At 7:20 p.m., Claimant was discharged with no complaints. The medical records, again, do not support Claimant's contention that she was suffering seizures.

Claimant followed up with her personal physician, Dr. Shanti Yerra, who doubted that these episodes reflected seizure activity. She recommended that Claimant refrain from smoking and see Dr. Jeremy Slater, a neurologist.

On March 12, 2002, Claimant again appeared at the St. John's emergency room. She was admitted after she had refused to go home. In addition to complaints of numbness, tingling, and weakness, she complained of confusion, disorientation, and blurred vision. Records indicate that she said she had not suffered these symptoms before. The admitting physician referred Claimant to Dr. Slater. It is significant that at this time a CT and EEG were negative. The medical records of March 14, 2002, indicated that Claimant's neurologic examination was completely normal. An MRI of the brain with contrast was normal. An MRI of the C-spine revealed cervical spondylosis. Claimant was discharged in stable condition to follow up with "neuropsychiatry and psychiatry counseling." (Exhibit 5).

Dr. Phillip Mothershead evaluated Claimant on March 14, 2002. He concluded that all of Claimant's MRIs of the brain and EEGs have been normal. He said Claimant exhibited histrionic personality traits, and was either magnifying symptoms or underlying stress. He recommended further evaluation and testing on May 7, 2002, but Claimant cancelled.

Claimant continued to treat with Dr. Yerra. Records from July 22, 2002 through December 18, 2009, indicate a variety of complaints, including the purported “seizure activity.” Dr. Yerra suspected that at least some of Claimant’s symptoms were psychogenic. She recommended Cymbalta.

In July 2002, Claimant first began seeing Dr. Robert Burger at the University of Missouri Medical Center in Columbia, Missouri. Dr. Burger has ordered EEGs, which all have been normal. Even though Dr. Burger has not documented the presence of seizures, he prescribes medication for an alleged seizure disorder based on the subjective reports of Claimant and her family.

Video EEG Testing – Barnes Jewish Medical Center

Employer referred Claimant for video EEG testing. She was admitted to Barnes-Jewish Hospital in St. Louis on December 2, 2008. Seizure detection software was used. Anti-seizure medication was withdrawn, as ordered by the attending physician. Claimant advised the staff that when she suffered seizures she drools, her right arm should shake and then her right leg. She said she never lost consciousness, but would be disconnected from the world. She did not bite her tongue. She experienced no smells or flashing lights. She indicated that she would walk into walls, lose balance, and that stress triggered these events. Claimant was continuously monitored. Medical records indicate she was discharged on December 7, 2008. After five days of testing, the Barnes nursing staff found no abnormality, and the final interpretation was that a full typical clinical event was not recorded.

Current Complaints

Claimant contends she is unable to do anything. She states that the “seizures” are limiting to her life. When she suffers an alleged “seizure,” she drools, her eyesight is blurred,

she suffers severe pain, shakes, twitching, has confused speech, and she just wants to go to sleep. She states that she is unable to take a bath because she starts shaking. She believes her seizures have worsened in frequency and intensity; i.e., Claimant admitted that she recently renewed her driver's license. She said her physician knows that she drives, and never suggested that she refrain from driving a vehicle.

Claimant's sister, Terry J. Thompson, corroborated Claimant's testimony regarding her episodes of alleged seizures. Ms. Thompson said her sister drools, suffers severe headaches, becomes confused and slurs her words. Ms. Thompson admitted that her sister still drives.

Expert Testimony

1. Dr. Jeremy Slater

Dr. Slater is Director of the Texas Comprehensive Epilepsy Program and Medical Director for the Department of Neurology, Memorial Hermann Clinical Neurophysiology Lab, and an epilepsy monitoring unit at the University of Texas-Houston Medical Center. He had been a staff neurologist and Medical Director of the EEG at St. John's in Springfield, Missouri from 1998 and 2003. He was the attending neurologist during Claimant's March 2002 hospitalization.

Dr. Slater found no clinical evidence of seizures either during Claimant's hospitalization or during two follow-up visits. Although he was aware there was some scarring within the left temporal lobe, he said there was no way to tell what it was from. He said there were a number of explanations, such as a stroke. He said the more remote in time a head injury occurred, the less likely that a seizure would be related to the trauma. He particularly noted that unlike strokes or transient ischemic attacks, seizures will produce positive symptoms rather than weakness. He said weakness is considered a negative symptom. Dr. Slater noted that three years was a

moderate to long time for a seizure disorder to develop from a head trauma. Moreover, when an individual does not lose consciousness, the traumatic event is considered mild. Dr. Slater said Claimant's descriptions were not terribly suggestive of seizure activity. He also noted that Claimant told him multiple times that she was disabled from working. That, he indicated, does not confirm mental illness, but it tells the physician something about the patient's attitude toward their own illness. Dr. Slater did not connect the encephalomalacia on the left frontal lobe to any event or condition. This is, in effect, scarring that could be due to either trauma, infection, or a stroke.

2. Dr. Charles Mauldin

Dr. Mauldin was the treating physician designated by Employer from 2000 to 2002. He was affiliated with Springfield Physical Medicine and Rehabilitation during this time. His colleague, Dr. Ted Lennard, also was the treating physician for Claimant between 1998 and 2000. Dr. Mauldin found non concussion or head injury. He found no objective indications for a seizure disorder. He diagnosed Claimant as suffering from an anxiety disorder with panic attacks.

Dr. Mauldin noted that even before Claimant began suffering the purported seizures, she presented herself for treatment on September 2, 2001, due to shortness of breath. She had been undergoing treatment due to an apparent respiratory disorder. She informed Dr. Mauldin that she had to physically rush to obtain her inhaler. Dr. Mauldin noted that such comments were incongruous as one would not have been able to physically run or rush to obtain an inhaler if she were truly suffering from a lack of oxygen. Dr. Mauldin did not believe the MRI finding from March 2000 necessarily reflected trauma.

3. Dr. Earl Hackett

Dr. Hackett is a retired neurologist who was affiliated with St. John's Regional Medical Center. He first saw Claimant in April 2000, upon the referral of Dr. John Ferguson. As noted above, Dr. Hackett believed he saw a contusion in the left temporal area, and cautioned about the possible development of seizure activity. He testified that the MRI showed a left-sided temporal contusion which could be consistent with hitting the left side of the head, but it also could have been evidence of a stroke or a small resolved hemorrhage. He said the only way to definitively determine whether the spot shown on the MRI was from an infarct or trauma was through a brain biopsy.

Dr. Hackett testified that contusions "theoretically" can cause seizures, but there is no way to reasonably say whether seizures are going to happen or not. The further in time one is removed from the initial trauma, the less likely the individual will have a seizure. Additionally, seizures can be caused by too much drinking, drug withdrawal, family history, toxic substances, renal failure, or hypoxia. There also are seizures that are idiopathic. He said absent seizures, the lesion on the brain is not impairment.

4. Dr. Shane Bennoch

Dr. Bennoch is an examining physician who testified on Claimant's behalf. His diagnoses included: a fall at work with traumatic injury to the head, left shoulder, neck and lower back; degenerative disc disease of the cervical spine that became symptomatic following the fall; a strain to the right trapezium muscle; a contusion to the temporal lobe resulting in persistent headaches and complex partial seizures; and pre-existing carpal tunnel syndrome to the right hand and cubital tunnel syndrome, with ulnar nerve transposition on the right.

As of the date of his report dated May 24, 2007, Dr. Bennoch opined that Claimant had reached maximum medical improvement. He believed Claimant's accident at work was the prevailing factor in causing injuries to her neck, cervical spine and muscles, contusion to the brain, and resulting complex seizures. He found these to be a hindrance or obstacle to employment or re-employment. He assigned a 25 percent permanent partial disability to the body as a whole due to the seizures and a 15 percent permanent partial disability to the body as a whole for musculoskeletal injuries. With respect to the pre-existing disabilities, Dr. Bennoch also found these to be a hindrance or obstacle to employment or re-employment. He assigned a 25 percent permanent partial disability to the right arm at the level of the wrist and an additional 25 percent permanent partial disability to the right arm at the elbow.

On cross-examination, Dr. Bennoch recognized that there are seizures known as psychogenic seizures. He defined them as having an underlying mental or personality disorder or otherwise somatic preoccupation. He also admitted that he had no evidence of Claimant having problems with her pre-existing conditions once they were corrected with surgery.

5. Dr. Robert Burger

Dr. Burger testified by deposition on two occasions: January 27, 2005 and July 9, 2010. He is the neurologist at the University Hospital in Columbia, Missouri who has treated Claimant for her alleged seizure disorder for many years. He began seeing Claimant on July 5, 2002. He continues to see Claimant approximately every six months for treatment of headaches, neck pain, and seizures. He believes the terms "epilepsy" and "seizure disorder" are synonymous for purposes of his deposition. Dr. Burger monitors Claimant's condition and prescribes an anticonvulsant, muscles relaxers, and analgesics. Dr. Burger said he has seen an improvement in

Claimant's condition since she has been on anti-convulsive medications. In particular, she has had fewer headaches. Dr. Burger does not believe that Claimant is exaggerating her symptoms.

In his first deposition, Dr. Burger was asked about the three year delay between the head trauma and Claimant's complaints of seizures. Dr. Burger said that seizures can develop within five years of a trauma. He said Claimant suffers some degree of disability as a result of the seizures, headaches, and head pain.

Dr. Burger admitted on cross-examination that there are a number of causes for seizures, including idiopathic reasons or toxic substances. He agreed that the more severe the head trauma the more likely that one will develop seizures. He agreed that most neurologists would accept, given the history of the event, that Claimant suffered only a mild head injury. He said it is possible that Claimant had suffered a mild stroke and that is what led to her seizures. Moreover, the finding on the MRI could be from any number of causes. He said "undoubtedly" reasonable minds could differ even on the diagnosis of seizures. (Exhibit D, page 47). He said reasonable minds could even differ on the cause of the seizures.

In his supplemental deposition, Dr. Burger acknowledged that the video EEG performed at Barnes Hospital in St. Louis in 2008 showed no epileptic form of activity. He also acknowledged that no evidence of seizure activity was found in any of the routine EEGs that had been performed in the past. Dr. Burger was unaware that Claimant had renewed and obtained an unrestricted driver's license in January 2010, even though Dr. Burger had recommended that Claimant be restricted from driving due to her alleged seizures.

Pre-existing Disabilities

Claimant had work-related injuries before the accident on July 7, 1998. The Administrative Law Judge observed surgical scars on the right wrist and right elbow. Claimant

could not recall a settlement with respect to a wrist. She remembered a settlement regarding her right elbow.

The Administrative Law Judge granted leave to submit Claimant's Exhibit F, which consists of copies of documents maintained by the Division of Workers' Compensation related to Injury Number 86-017171. Medical records maintained by the Division include a surgeon's report. It indicates that Claimant suffered *bilateral* carpal tunnel. Other medical records indicate that Claimant underwent a *right* carpal tunnel release on November 7, 1986, and as of March 3, 1987, she was exhibiting symptoms of mild to moderate *right* lateral epicondylitis. There are no medical records indicating any surgical intervention on the *left* wrist or elbow. On March 3, 1987, Dr. Janie Vale, M.D., rated Claimant as having a 20 percent impairment of the "dominant right upper extremity at the 222 week level." Records fail to indicate that Dr. Vale provided any rating for the *left* upper extremity. As noted above, Dr. Bennoch provided ratings for the *right* wrist and elbow.

Claimant testified that she had to give up various hobbies such as bowling because of pain in her dominant right arm. She said the right arm swelled and was painful even after the corrective surgery. She had to ask co-workers to assist in the performance of job duties. This suggests that any pre-existing disability was to the right arm, and the left arm was only minimally affected by carpal tunnel syndrome. On September 16, 1998, Legal Advisor William C. Billings approved a stipulation for compromise settlement in Injury Number 86-017171 for 25 percent permanent partial disability to the *left hand*. It is difficult to believe that there was a settlement for the *left* upper extremity at the 175 week level and nothing for the dominant *right* arm, which clearly appears to be the more severely affected extremity.

Based on the whole record, I find that the earlier settlement erroneously cited the left arm when, in fact, it was the right upper extremity that was in issue. Such finding is consistent with the ratings of Dr. Vale and Dr. Bennoch, and the surgical scars I observed.

The evidence, however, is conflicting as to the degree of pre-existing disability. On cross-examination by the Second Injury Fund, Claimant contended she “done it all,” including pulling air hoses, climbing, lifting 15 to 20 pounds, and working 40 to 60 hours a week. She said prior to 1998 she had no physical problems that interfered with her job duties, and left her job only because the bakery closed. Claimant did explain, however, that as a sanitation foreman she relied on other workers to assist her in performing tasks. And given that there is expert testimony substantiating a significant degree of disability in Claimant’s right arm, I accept the stipulation for compromise settlement as an accurate reflection of the degree of disability existing at the time of the last accident to the *right* arm. Moreover, given the whole record, I find the record minimally sufficient to demonstrate that Claimant’s pre-existing disability was a hindrance or obstacle to employment or re-employment.

Medical Bills

Although Claimant testified that she has intermittent problems with speech and memory, she knew she had incurred \$13,778.64 in out-of-pocket expenses for medical treatment of her alleged seizure disorder that she contends is related to her work accident. She claims approximately another \$47,000.00 that had been paid by insurance. She knew she had extensive medical bills relating to diagnostic testing and treatment as well as prescription medications prescribed by her treating physicians. She identified a number of anti-seizure and pain medications that had been prescribed for her. Her medical bills, submitted at the time of the original hearing, have been admitted.

CONCLUSIONS OF LAW

Claimant has the burden to prove her right to compensation under the Missouri Workers' Compensation statute. *Duncan v. Springfield R-12 School District*, 897 S.W.2d 108, 114 (Mo. App. S.D. 1995). This includes the burden of proving all essential elements of her claim. *Decker v. Square D. Co.*, 974 S.W.2d 667, 670 (Mo. App. W.D. 1998); *Bruflat v. Mr. Guy, Inc.*, 933 S.W.2d 829, 835 (Mo. App. W.D. 1996). It is not enough for Claimant to demonstrate that she fell at work and thereafter developed some physical difficulties. Claimant's burden includes proving that her injury arose out of and the course of her employment. An injury shall be deemed to arise out of and in the course of employment only if:

- (a) It is reasonably apparent, upon consideration of all the circumstances, that the employment is a substantial factor in causing the injury; and
- (b) It can be seen to have followed as a natural incident of the work; and
- (c) It can be fairly traced to the employment as a proximate cause; and
- (d) It does not come from a hazard or risk unrelated to the employment to which workers would have been equally exposed outside of and unrelated to the employment in normal unemployment life;

§ 287.020.3(2) RSMo 1994.

Moreover, medical causation not within the common knowledge or experience must be demonstrated by scientific or medical evidence showing a relationship between the asserted cause and the alleged condition. *Lingo v. Midwest Block and Brick, Inc.* 307 S.W.3d 233 (Mo. App. W.D. 2010). Even considering that the above statute in effect at the time of Claimant's accident employs a lesser standard than that adopted by the Missouri General Assembly in 2005, and that the Workers' Compensation Law in 1998 was to be construed liberally, § 287.800 RSMo 1994, I conclude that Claimant's alleged seizure disorder is not compensable. I do, however, conclude that Employer has

liability for permanent partial disability for injuries to the neck and shoulder. I further conclude that the Second Injury Fund has liability for enhanced permanent partial disability.

In this case, there is medical testimony in Claimant's favor, but the Administrative Law Judge may reject all or part of one party's expert testimony and accept as true the contrary testimony given by the other litigant's experts. *George v. Shop 'N Save Warehouse Foods, Inc.*, 855 S.W.2d 460, 462 (Mo. App. E.D.1993). Here, the overwhelming medical evidence in the record indicates that Claimant does not even suffer seizures, but instead, suffers psychological problems. If she does suffer seizures, the credible evidence in the record is insufficient to demonstrate the causal connection between the fall and the condition.

There is no objective evidence of any seizures. Neither routine EEG nor the extensive testing performed over several days at Barnes-Jewish in St. Louis has revealed any objective evidence of seizures. The only evidence that Claimant suffers from seizures is the subjective reports from Claimant and her relatives. But there has been no medical verification of any seizure at any time since they purportedly began three years after the work accident. Even Dr. Burger, who currently treats Claimant for her alleged seizure disorder, admitted that he has not confirmed the presence of seizures through any diagnostic testing.

Medical records confirm that Drs. Slater, Mauldin and Yerra all *independently* suspected that Claimant suffered anxiety-related or psychological problems that would explain her condition. Neuropsychologist Philip Mothershead did not disagree.

The subjective complaints of Claimant and her relatives are suspect. For instance, when Claimant went to the emergency room on New Years' Eve in 2001 and later in January 2002, nothing in those medical records suggests that Claimant was suffering from seizures despite Claimant's contention to the contrary.

The professionals at the St. John's facility in Springfield who hospitalized Claimant in March 2002, did so only upon her insistence. These are independent medical providers not affiliated with Employer. It was Claimant's own personal physician, Dr. Yerra, who was the attending physician. An EEG authorized by Dr. Yerra was normal. Dr. Yerra found no physical abnormalities, and noted that emotional upset would trigger the symptoms that Claimant complained about.

Claimant might point to the MRI scan of the brain on March 7, 2000, as medical-causal evidence that her alleged seizure condition exists and is related to the work accident. But the experts have almost uniformly noted that the spot on the MRI could be from a stroke or infection, or even idiopathic. As Dr. Hackett explained, there is no way to know the cause without a brain biopsy. While Dr. Bennoch and Dr. Burger causally connect the MRI finding to seizures, the fact remains that the seizures themselves have never been confirmed through traditional or video EEG testing.

Merely because an accident causes injury to one part of Claimant's body does not mean the same accident causes injuries to other parts of the body. *See e.g., Selby v. Transworld Airlines*, 831 S.W.2d 221 (Mo. App. W.D. 1992) *overruled on other grounds*, *Hampton v. Big Boy Erection*, 121 S.W.3d 220 (Mo. banc 2003) (denying compensation for brain damage that Claimant believed was related to a fall at work during which she hit her head), and *Royal v. Advantica Rstaurant Group, Inc.*, 194 S.W.3d 371 (Mo. App. W.D. 2006) (finding that somatoform disorder was not caused by slip and fall at work). I am not persuaded by Claimant's evidence. I conclude that the alleged seizure disorder is not medically and causally related to her 1998 fall at Earthgrains. The alleged seizure disorder did not arise out of and within the course of Claimant's employment.

Past Medical Bills

Claimant has failed to demonstrate that any of her past medical bills was for treatment of conditions other than her alleged seizure disorder. Since I have specifically found and concluded that the purported seizure disorder is unrelated to the 1998 work accident, no past medical benefits are awarded.

Future Medical Benefits

Claimant is not required to present evidence demonstrating with absolute certainty a need for future medical care and treatment. *Sifferman v. Sears, Roebuck & Co.*, 906 S.W.2d 823, 828 (Mo. App. S.D. 1995), *overruled on other grounds*, *Hampton v. Big Boy Steel Erection*, 121 S.W.3d 220 (Mo. banc 2003), but she must demonstrate there is a reasonable probability that additional treatment is needed and related to the work injury. *Bowers v Hiland Dairy Co.*, 188 S.W.3d 79, 86 (Mo. App. S.D. 2006). Claimant has failed to prove the need for future medical care is related to the work accident. No future medical benefits are awarded.

Permanent Partial Disability

The fact finder is not bound by the exact percentages of any expert witness and has authority to find another percentage of disability supported by the record. *Ransburg v. Great Plains Drilling*, 22 S.W.3d 726, 732 (Mo. App. W.D. 2000). Dr. Bennoch assigned a 15 percent permanent partial disability to the body as a whole for musculoskeletal injuries. Considering the whole record, I accept this percentage of disability as an accurate degree of disability due to cervical spondylosis, as well as chronic strains to the neck and left shoulder. At the agreed rate of \$294.73, Employer is liable to Claimant for \$17,683.80 in permanent partial disability.

Second Injury Fund Liability

As noted above, I have found that Claimant suffered a 25 percent permanent partial disability to the upper right extremity (at the level of the wrist), and that such disability was a

hindrance or obstacle to employment or reemployment. This degree of disability meets the statutory threshold for Second Injury Fund liability set forth in § 287.220 RSMo 1994. I conclude, based on the whole record, that the pre-existing disability to the right arm combines synergistically with the disabilities resulting from the 1998 work accident. The permanent partial disabilities from the 1998 work accident also pose a hindrance or obstacle to employment or re-employment. The simple sum of 60 weeks of disability from the last work accident, and the pre-existing disability of 43.75 weeks, is 103.75 weeks. Applying a 10 percent load, the Second Injury Fund is liable for \$3,057.82 (10.375 x \$294.73).

Attorney's Fee

Claimant is entitled to an Award of \$17,683.80 in permanent partial disability from Employer and \$3,057.82 from the Second Injury Fund. Claimant's attorney, Jay Cummings, is awarded a lien of 25 percent of these amounts as a reasonable fee for necessary legal services provided to Claimant.

Interest shall be paid according to law.

Date: December 28, 2010

Made by: /s/ Victorine R. Mahon
Victorine R. Mahon
Administrative Law Judge
Division of Workers' Compensation

A true copy: Attest:

/s/ Naomi Pearson
Naomi Pearson
Division of Workers' Compensation