

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

Injury No.: 07-110366

Employee: Shirley Pioske-Schlueter  
Employer: Extended Stay America (Settled)  
Insurer: Zurich American Insurance (Settled)  
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 October 1, 2010. The award and decision of Administrative Law Judge Grant C. Gorman, issued October 1, 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 29<sup>th</sup> day of April 2011.

LABOR AND INDUSTRIAL RELATIONS COMMISSION

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William F. Ringer, Chairman

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Alice A. Bartlett, Member

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John J. Hickey, Member

Attest:

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Secretary

## AWARD

Employee: Shirley Pioske-Schlueter

Injury No. 07-110366

Dependents: N/A

Employer: Extended Stay America (settled)

Additional Party: Second Injury Fund

Insurer: Zurich American Insurance (settled)

Hearing Date: June 29, 2010

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

Checked by: GCG/ln

### 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: November 9, 2007
5. State location where accident occurred or occupational disease was contracted: St. Charles County, Missouri.
6. Was above employee in employ of above employer at time of alleged accident or occupational disease? Yes
7. Did employer receive proper notice? Yes
8. Did accident or occupational disease arise out of and in the course of the employment? Yes
9. Was claim for compensation filed within time required by Law? Yes
10. Was employer insured by above insurer? Yes
11. Describe work employee was doing and how accident occurred or occupational disease contracted: Claimant slipped and fell while performing her job duties.
12. Did accident or occupational disease cause death? No
13. Part(s) of body injured by accident or occupational disease: right lower extremity and low back
14. Nature and extent of any permanent disability: 15% of the right leg at the 160 week level, 5% body as a whole at the low back.
15. Compensation paid to-date for temporary disability: None
16. Value necessary medical aid paid to date by employer/insurer? \$10,569.65

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17. Value necessary medical aid not furnished by employer/insurer? None
18. Employee's average weekly wages: \$245.70
19. Weekly compensation rate: TTD \$163.80/PPD \$163.80
20. Method wages computation: Stipulation

**COMPENSATION PAYABLE**

21. Amount of compensation payable:

22. Second Injury Fund liability: Yes

Permanent total disability benefits from Second Injury Fund:  
\$163.80 payable weekly by SIF beginning February 23, 2009 and,  
thereafter, for Claimant's lifetime

TOTAL: UNDETERMINED AT THIS TIME

Said payments to begin as of the date of this Award, and to be payable and be subject to modification and review as provided by law.

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

Thomas J. Gregory

Employee: Shirley Pioske-Schlueter

Injury No. 07-110366

## **FINDINGS OF FACT and RULINGS OF LAW:**

Employee: Shirley Pioske-Schlueter

Injury No: 07-110366

Dependents: N/A

Before the  
**DIVISION OF WORKERS'  
COMPENSATION**

Employer: Extended Stay America (settled)

Department of Labor and Industrial  
Relations of Missouri  
Jefferson City, Missouri

Additional Party Second Injury Fund

Insurer: Zurich American Insurance (settled)

Checked by: GCG/ln

### **PRELIMINARY STATEMENT**

The parties appeared before the undersigned Administrative Law Judge on June 29, 2010 for a final hearing to determine the liability of the Second Injury Fund in the matter of Shirley Pioske-Schlueter (Claimant). Attorney Thomas J. Gregory represented Claimant. Assistant Attorney General Barbara Toepke represented the Second Injury Fund. Employer, Extended Stay America, and its Insurer, Zurich American Insurance Co., previously settled with Claimant and did not participate in the hearing. Mr. Gregory requested a fee in the amount of 25%.

The parties stipulated to the following:

1. On or about November 9, 2007, Claimant sustained an accidental injury arising out of and in the course of employment that resulted in injury to Claimant. The accident occurred in St. Charles County, Missouri.
2. Claimant was an employee of Employer pursuant to Chapter 287 RSMo.
3. Venue is proper in St. Charles County.
4. Employer received proper notice of the claim.
5. Claimant filed the claim within the time allowed by law.
6. Claimant earned an average weekly wage of \$245.70, resulting in applicable rates of compensation of \$163.80 for temporary total disability (TTD), and \$163.80 for permanent partial disability (PPD).
7. Employer did not pay any TTD benefits.

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8. Employer paid medical benefits totaling \$10,569.65.

The issues to be determined are:

1. Liability of the Second Injury Fund; and
2. Date Claimant reached maximum medical improvement (MMI).

### **SUMMARY OF THE EVIDENCE**

Only evidence necessary to support this Award will be summarized. Any objections not expressly ruled on during the hearing or in this award are now overruled. To the extent there are marks or highlights contained in the exhibits, those markings were made prior to being made part of this record, and were not placed thereon by the Administrative Law Judge.

Claimant offered the following exhibits which were received into evidence without objection:

- A. Stipulation for Compromise Settlement in primary claim  
Injury Number 07-110366
- B. List of job duties with employer
- C. Office records of Dr. Lewis Meyerson from 3/28/06 to 4/27/08
- D. Office records of Dr. Brett Taylor from 12/9/08 to 3/18/09
- E. Office record of Dr. Christopher Creighton from 2/18/08
- F. Office records of Dr. John McAllister, St. Peters Bone & Joint Surgery,  
from 11/13/07 to 4/21/08
- G. Office records of Dr. Gary Farley, Northland Orthopedic Group,  
from 11/13/07 to 11/4/08
- H. Office records of Dr. James Strickland from 4/7/08 to 1/26/09
- I. Deposition of Dr. David Volarich
- J. Deposition of Jeffrey Magrowski, PhD

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The Second Injury Fund offered the following exhibit, which was received into evidence without objection:

I. Deposition of James England

LIVE TESTIMONY

The claimant was 73 years old at the time of the hearing, and she would have been 70 years old at the time of her primary injury on November 9, 2007, as her date of birth was 11/20/36. The claimant is a high school graduate and had one year of training in the 1960s to become a licensed practical nurse. She also attended truck driving school in the 1970s and received a commercial driver's license following completion of that course.

From approximately 1960 to 1975, she worked as a licensed practical nurse, which required her to lift and turn patients and administer medications and other forms of medical treatment. From approximately 1976 to 1990, claimant was a tractor trailer driver, and she would haul produce from Texas to Chicago for F & S Produce out of McAllen, Texas.

The claimant testified that in approximately 1990, she returned to the St. Louis area to take care of her mother, who was ill. She testified that she took care of her mother from 1990 until 1995, when she died. During the time period from 1990 to 1995, she worked a part-time job at Winfield Elementary School, where she would work four hours a day, three days a week giving computer training to young children. The claimant testified that since 1990, all of the jobs she had worked at since that time were part-time jobs. The claimant testified that from approximately 1997 to 1999, she worked at the Holiday Inn in St. Peters, where she would work in banquet set up. She indicated that she would only work when there would be a special event, such as a wedding, a party, etc. In approximately 2000, she moved to Minnesota, where her new husband lived. During their two year marriage, they would spend their winters in Arizona, and during the time they spent in Arizona, she worked part-time as a cashier at a Dollar Tree store.

After her divorce in approximately 2002, the claimant moved back to the St. Louis area from Minnesota, and she began working for the employer in this case, Extended Stay of America in St. Peters. This was also a part-time job, and she was the night clerk on weekends working from 11:00 p.m. to 7:00 a.m. on both Friday and Saturday nights, for a total of 16 hours a week. She indicated that she would occasionally work on weeknights in the same position covering for the weeknight employee who held the same job. The claimant testified with respect to her job duties with the employer and also introduced into evidence Employee's Exhibit B, which was a list of those job duties set out by the employer. The claimant's primary duties were doing the laundry and stocking linen closets with the clean laundry produced by the housekeepers in the morning. In addition, claimant was required to do a lot of dishes, since this was an extended stay hotel with a kitchen in each room. Finally, the job description required the claimant to walk the premises and make sure all doors were locked and make sure all safety devices were working and make sure that everything on the premises was in order during the night. In addition, she was required to check in any late night arrivals at the hotel, although she indicated that there were not usually that many people arriving during her work hours.

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The claimant was questioned concerning any medical problems she had prior to her on the job injury on November 9, 2007. She indicated that in 1975, after a work injury, she had low back surgery in St. Louis. She testified at trial, and the medical records corroborate that after a period of recovery, that she did very well with respect to her low back, and she never had pain radiating down either leg after that surgery.

In October of 2006, the claimant sustained a fall while shopping at Wal-Mart and she sustained a right hip fracture that required surgery. Following that fall, she had continuous pain in both her right hip and her low back, mainly on the right side. The claimant testified that she was not taking any pain medication, like Vicodin, before October of 2006, but after her fall while working in October of 2006, she was taking Vicodin on a regular basis up until her fall on November 9, 2007.

The claimant admitted to going to see her primary doctor, Dr. Meyerson, in June of 2007, five months before her primary injury and asked him for a cane to use because of right leg pain, and she also noted that she saw Dr. Meyerson in September of 2007 with right hip and leg pain and told the doctor that she was falling and having trouble getting up, and she had an injection in her right hip on that occasion.

The claimant testified that at the time of her fall in October of 2006 up until the injury on November 9, 2007, she had pain in her low back and right hip and her right leg was weak and it felt like it would give way, and on occasion, it did give way. She further testified that the pain in her hip was constant and that she would have low back pain on a regular basis, but it was not constant.

With respect to other pre-existing medical conditions, the claimant indicated that she had right knee replacement surgery in approximately 1991. She then had left knee replacement surgery in 2002. She explained that the left knee replacement surgery occurred while she was married and living in Minnesota, and following the surgery when she went to Arizona for the winter, she continued to have problems following the surgery, and she saw a doctor in Arizona who said he wouldn't touch her and she should go back to Minnesota and see the original doctor who did the surgery. She returned to Minnesota, where they found that an infection had set in, and she ended up having a second surgery on the left knee. She indicated that because of the left knee replacement and the complications, she was basically laid up for a year and she was in a rehab center following the post-surgical infection surgery.

The claimant testified that following her knee surgeries she continued to have ongoing problems with both her knees. She had pain and she couldn't kneel and she found it hard to bend over. She couldn't get down and apply pressure on either knee and she couldn't walk very far, and she also noted that she walked with a limp. At work, she said she would avoid steps and use the elevator whenever she could. She indicated that despite these problems that she continued to force herself to work. She indicated that before her November 9, 2007 injury, her primary limitations were with her right hip and both knees.

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The claimant testified that she sustained an injury at work on November 9, 2007 while she was doing laundry, and there was a leak from a washer and the laundry room had water on the floor, which caused her to slip and fall, landing primarily on her right side. She immediately noticed pain in her right knee, right hip and low back. She ended up finishing her shift that day, and she was able to get an appointment with her family doctor, Dr. Meyerson, on November 13, 2007. She indicated that Dr. Meyerson initially gave her some medication and took a number of x-rays, and at that time, the employer-insurer took over her treatment and referred her to Dr. McAllister, an orthopedist, whom she first saw on December 1, 2007. At the time of that visit, Dr. McAllister recommended physical therapy, but she had previously had cataract surgery scheduled and she couldn't start physical therapy until January of 2008, when she had been cleared from having had cataract surgery. The claimant testified that she went to physical therapy approximately three times a week for about three months in early 2008, and she also had pain management during that time by Dr. Christopher Creighton.

The employer-insurer sent claimant for an IME by Dr. James Strickland in April of 2008, and he initially prescribed more physical therapy and then released her. The claimant had an EMG study in April of 2008, and on April 21, 2008, she saw Dr. McAllister, who injected her right hip. At that time, Dr. McAllister indicated that any problems she had with her knees from the fall should have cleared up and her ongoing complaints at that point would have been related to her old knee replacement surgery and he recommended she see her personal physician.

The claimant testified that she did what Dr. McAllister suggested and saw Dr. Gary Farley at Northland Orthopedic on May 6, 2008. He gave her an injection for her back and recommended the possibility of re-doing bilateral knee replacements. At that point, because the employer-insurer would not provide any treatment, claimant's attorney sent her to Dr. David Volarich in October of 2008, and he issued a report recommending more treatment. The employer-insurer complied with claimant's request for treatment and sent her to Dr. Brett Taylor in January of 2009, and he recommended physical therapy, pain management, and injections. The claimant testified that she did have more physical therapy, but she refused the injections because she felt they didn't help her in the past. The claimant last saw Dr. Taylor on March 18, 2009, and she indicated that the doctor felt that if she didn't want surgery, she should see a pain management specialist. Claimant followed up with treatment by Dr. Meyerson and Dr. Farley, who continued to prescribe pain medications, including Vicodin 750 mg, which she takes four times a day.

The claimant indicated that she never returned to full duty with the employer after the injury. She indicated that light duty still required her to do laundry and clean dishes, but she was not required to patrol the premises anymore, and with respect to the laundry, she was not required to deliver clean laundry to the floors. The claimant testified that the housekeepers would pick up the clean laundry and take it to the floors so claimant would not have to do much walking.

The claimant indicated that she could not recall the exact date that she last worked and indicated it could have been as late as March or April of 2008, but she was fairly certain that she was not working in May of 2008. She indicated that the reason she stopped working was since she couldn't do the entire job, they couldn't use her anymore. The claimant testified that she has not worked at any other job since the March or April of 2008 date.

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The claimant further testified that she has not had any re-injuries to either knee, hip or back since November 9, 2007. She indicated that she did have a fall at home in August of 2008 and broke her wrist and sustained a head injury, but she did not re-injure those parts of her body in that fall.

At the time of hearing, the claimant testified that she had constant low back pain radiating from the hip to the mid-back and her right leg goes to sleep and she can't feel her right foot. She testified that she walks with a cane because of numbness and tingling in her right leg, and she is always afraid that her right leg will give out. She said using the cane also helps take pressure off her knees and back. The claimant indicated that she could only lift items weighing three to five pounds and she would have difficulty climbing stairs or stay in a fixed position for any length of time. She indicated that the most comfortable position for her was lying down on the couch or in a recliner with two pillows behind her and one pillow beneath her feet to take the pressure off her low back, hip and knees. She testified that she spends most of the day in that position.

The claimant testified that since November 9, 2007, she has had pain in both knees, but the right is worse than the left. She testified that both knees swell and she can't stoop, squat, crawl or kneel, and her knees also hinder her while climbing stairs. She indicated that it is hard for her to get up from a seated position and she could only sit 30 to 45 minutes before her pain becomes so great and she has to get up and move around. She testified that she could walk on level ground about a half block while using her cane, and she could only stand for about 10 minutes with the cane.

With respect to her daily activities, the claimant stated that she lives in a duplex, and her brother and sister-in-law live in the other part of the duplex, and they basically share their food with her. She can make a sandwich or cereal for herself and she can take care of her two small dogs. She indicated that she cannot cut grass and she can't do much house cleaning because she can't move her furniture. She is able to use a Shark, a very light-weight vacuum cleaner, to pick up dirt on the floor. She testified that she plays solitaire on the computer and watches TV.

On cross-examination, she admitted that she told Dr. McAllister that she had fallen eight times since April of 2008 because of numbness in her right leg and foot. She did admit that she had some right leg numbness before her November of 2007 injury, but stated it became much worse after her on the job injury in November of 2007. She stated that she may have been working light duty as late as April of 2008, but she was certain that she was not working anymore in May of 2008.

#### SUMMARY OF MEDICAL RECORDS

The only medical records in the file that are relevant to the claimant's pre-existing medical conditions prior to November 9, 2007 are the records of her primary care physician, Dr. Lewis Meyerson, Claimant's Exhibit C. These records begin on March 28, 2006 and indicate that at that time, the claimant was a new patient of Dr. Meyerson, who had moved here from Minnesota. Her initial visit reported that she was taking medication to control her diabetes and that she was under stress because her husband had cancer.

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At her office visit on May 16, 2006, the claimant complained of left knee pain and said she had a knee replacement in 2001 and had multiple surgeries since then due to complications. She also complained of right foot pain and said she was given Vicodin for pain in the past. The doctor noted that she had diminished sensation in her right foot and that her diabetes was uncontrolled.

At her July 12, 2006 office visit, the claimant complained of pain and swelling in her right foot and leg for the past few days and that she got numb up to the knee. A nerve conduction study apparently indicated that there was some diabetic neuropathy involved. She reported that she had pain across her mid-foot and described an accident in the past where she had pinned both legs.

The next office note from Dr. Meyerson was dated November 3, 2006 and makes reference to a fall at Wal-Mart and right hip surgery on October 10, 2006. She needed two prescriptions for her Vicodin, and she had complaints of her lower leg falling asleep at night when she sleeps on her back. She had no pain with walking and no symptoms in other positions. A pillow under her leg at night worsened this, and she couldn't sleep on her side because of her surgery.

On April 9, 2007, the claimant was seen and she asked if her Vicodin prescription could be increased. She was complaining of incontinence, and she also had pain in her low back and her shoulder on the right side, and she indicated that Vicodin wasn't helping as much as it used to. The doctor gave a diagnosis of pain in the low back.

On June 19, 2007, the claimant was seen at Dr. Meyerson's office with complaints of pain in the right leg and swelling of her right foot. She indicated that she had not had any pain medication since leaving on a trip when she put them out of the way and she couldn't remember where she put them, and she indicated that she needed a cane for a couple days due to her pain.

The claimant's last visit to Dr. Meyerson prior to her November 9, 2007 injury was on September 7, 2007, approximately two months prior to her primary injury. At that time, she complained of her leg hurting badly and that she had been having falls and had trouble getting up. The note indicates that the patient was having pain over the outer thigh, with pain severity a 9-10/10. She also indicated that the pain was getting worse over the last few months and was getting severe, and her family felt she was unsafe at home. She requested a three month supply of Vicodin and she complained of going through four Depends a day and two at night, and this was worse since her hip surgery. The doctor prescribed her a 90 day supply of Vicodin, which was to be taken one tablet every eight hours as needed for pain.

#### SUMMARY OF TREATMENT RECORDS

The claimant indicated that her first medical treatment following her November 9, 2007 on the job injury was a November 13, 2007 office visit to her family doctor, Dr. Meyerson. The note indicates that the patient gave a history that a washer was leaking, she works nights, she hit the floor. The note indicates that she had had bilateral knee replacements and she was now having pain in the lateral right thigh and both knees, and also some pain in the right groin. He

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noted she had been taking one to two Vicodin regularly, but she was out at that time. She said it hurts in her groin when she walks, and she did not know if she hit her hip or not. X-rays of both knees and pelvis were ordered, and on the next visit on November 20, 2007, Dr. Meyerson indicated that the x-rays showed loosening of the components in both knees, and he noted that she still had pain with walking. Dr. Meyerson referred her back to the doctor who performed her prior right hip surgery.

A review of Dr. Meyerson's records indicate a gap in the claimant's treatment related to her on the job injury, which is consistent with the claimant's testimony that the employer-insurer ultimately authorized her to be seen by Dr. McAllister. Dr. McAllister's records were introduced into evidence and were marked as Claimant's Exhibit F. Dr. McAllister is an orthopedic surgeon with St. Peters Bone & Joint Surgery. He first saw the claimant on December 10, 2007 and took the following history:

"Fell on or about November 11, 2007. She slipped on water at work and fell landing on her knees and then falling over onto her right side striking her hip. Approximately 2 days later she had x-rays of both knees at Lincoln Medical Center. I reviewed those x-rays. She states she was initially able to continue working on the weekends at her normal job folding laundry, but last weekend missed because her knees had increased pain.

Her past history is significant for right total knee arthroplasty in 1991 and a left knee replacement in 2002 complicated by infection. It was treated with multiple surgeries over an 8-month period of time. She has also had a right hip hemiarthroplasty for a fracture on October 11, 2006."

Dr. McAllister initially diagnosed bilateral knee pain and indicated this represented contusions to both knees, and he indicated that subtle lucencies and perhaps evidence of loosening were consistent with the surgery which she had done and did not represent post-traumatic changes. Dr. McAllister indicated that her injury was the prevailing factor in causing her current complaints of knee pain, and he indicated that he did not believe the fall was the prevailing factor in any loosening of the components, which may or may not have been present. Dr. McAllister recommended physical therapy and had her come back in a couple weeks.

The claimant returned to see Dr. McAllister on January 7, 2008 and reported she couldn't do the physical therapy because of her intervening eye surgery, and she reported continuing complaints of bilateral knee pain and right hip pain. Dr. McAllister indicated that he still felt that a course of physical therapy would be of benefit.

The claimant undertook physical therapy, which she attended through April of 2008. When the claimant returned to see Dr. McAllister on April 21, 2008, she complained of a bump on her right hip that was painful, along with numbness on the bottom of her right foot that made it difficult for her to feel it at all, and she felt she couldn't drive because she couldn't feel the bottom of her right foot. Dr. McAllister reported that her physical exam revealed the following:

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"PHYSICAL EXAMINATION: Her exam demonstrates subjectively decreased sensation in the plantar aspect of her right foot. She states it is completely numb compared with the left. She has good pulses. The dorsum of her foot has intact sensation. Her ankle jerks are absent bilaterally and knee jerk is 1+ on the right and absent on the left. She has a little EHL weakness on the right side with 5/5 strength on the left EHL and symmetric anterior tibialis strength to dorsiflexion. There is tenderness over the greater trochanter of the right hip and perhaps a little soft tissue swelling just along the anterior and lateral aspect of the greater trochanter. Apparently it may be more than two weeks since the numbness in her foot started. She is having a workup with a nerve conduction study through her primary care physician for the right foot numbness. She is able to straight leg raise on the right side with reasonable strength. Again, she has tenderness over the greater trochanter of the right hip. Both wounds are well healed, with reasonable good range of motion, and are stable. She does have a history of rheumatoid arthritis and diabetes. She normally works in laundry and stands all night. She notes she has been unable to go to work because of the numbness in her foot and inability to drive."

Dr. McAllister gave the claimant a cortisone injection in the right hip for bursitis and gave his opinion as follows with respect to causation and the need for further treatment:

"ASSESSMENT: Right hip pain and knee pain after a fall.

PLAN: At this point, the hip pain may be due to trochanteric bursitis, certainly that could result from a fall and is actually quite common after hip prosthesis surgery due to the scar tissue over the lateral aspect of the hip. Any residual knee pain is likely due to problems with her joint replacements but any sprain as a result of a fall should be reasonably healed at this point. I do not believe that the current complaints of numbness in her foot can be causally related to a fall in November, particularly given the more recent onset of symptoms. I would suggest a cortisone injection in the right hip for bursitis. I injected her trochanteric bursa today with 5 cc of Marcaine and 40 mg of Depo-Medrol. I think at this point, she has reached maximum medical improvement. She should be able to do full-duty work from the standpoint of a fall that she had in November with contusions and sprains, those have healed."

Dr. McAllister indicated that claimant was discharged from his care and that she had reached maximum medical improvement at that time from a standpoint of the fall.

A review of Dr. Meyerson's records indicate that the claimant did as Dr. McAllister suggested and returned two days after her visit to Dr. McAllister to Dr. Meyerson and told him that any problems she was having with her knees at that time were not work-related. The doctor noted that some physicians were suggesting a bilateral knee replacement and that a nerve conduction study was abnormal at the right tibial nerve and L5-S1 nerve root.

In the interim, the employer-insurer sent the claimant to Dr. James Strickland for an evaluation on April 7, 2008. When he first saw her in April of 2008, Dr. Strickland indicated that her findings were consistent with soft tissue sprains in both knees and mild sprain of the

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right hip area, and he recommended that she attend a physical therapy program, which she subsequently underwent.

The claimant ultimately was referred by Dr. Meyerson to orthopedist Gary Farley, whom the claimant first saw on May 6, 2008 with problems with both knees and the right hip. Dr. Farley's initial diagnosis was synovitis of the bilateral knees with possible loosening of the total knee components, trochanteric bursitis of the right hip, and rule out lumbar radiculopathy on the right. Dr. Farley gave the claimant an epidural steroid injection for relief of her right lower extremity pain.

The claimant returned to Dr. Farley on June 3, 2008, and he indicated that the claimant continued to have significant symptoms of radiculopathy with her right leg giving way and complaining of paresthesias through the right lower extremity. The doctor recommended an epidural injection and indicated that he would keep her off work and schedule her for an injection and see her back within the next few weeks to see if it gave her any relief.

The claimant returned to Dr. Farley on July 15, 2008 for a re-check of the problems with her back and right lower extremity, and she indicated that she had the sacroiliac injection by the pain specialist, but it gave her only temporary relief. At that time, Dr. Farley recommended an MRI to rule out a herniated disc and said she should stay off work.

The claimant returned to Dr. Farley on July 24, 2008, and he indicated that he felt she still needed an epidural injection, as he thought this was nerve root irritation, and he gave her some pain patches for her back and told her he would keep her off work.

Claimant's last visit to Dr. Farley was on November 4, 2008. The claimant was complaining of knee pain and said she had seen other doctors and had MRIs of her low back, which apparently showed she had some radicular findings. The patient was complaining of right knee pain that day, and the doctor noted evidence of some loosening of the prosthesis on examination. Dr. Farley opined that he didn't think the claimant was capable of work due to the radiculopathy as well as the failure of her knee implants, and he recommended that she stay off work and get resolution of her medical problems before considering doing any revision of the knee replacements.

In the interim, as the claimant testified, she was sent by her attorney to see Dr. David Volarich, who first examined her on October 23, 2008. Dr. Volarich reviewed the various diagnostic studies and indicated the MRI of the lumbar spine of July 21, 2008 showed a collapse of the L4-L5 disc space and L3-L4 and L5-S1 central disc protrusions were appreciated as well. Degenerative disc disease and degenerative joint disease were seen throughout the lumbar spine. Dr. Volarich also looked at two views of the claimant's right knee and felt that the prosthesis appeared to be in position and did not appreciate any loosening based on the x-rays. His review of the right hip x-ray showed the hip prosthesis was in an appropriate position without obvious loosening, and that the acetabular component looked to be rotated somewhat inferiorly and the soft tissues adjacent to the hip show a density that was probably a hematoma. At that point, Dr. Volarich indicated that it was his opinion that the claimant had the following injuries that were medically causally related to the November 9, 2007 fall:

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1. Right hip contusion with continuing pain of the lateral thigh adjacent to the hip joint and soft tissue mass most consistent with organized hematoma.
2. Right knee contusion with considerable pain most consistent with at least partial loosening of her knee joint prosthesis.
3. Lumbar right leg radicular syndrome with documented L4-5, and to a lesser degree, L5-S1 radiculopathy.
4. Left knee pain syndrome secondary to abnormal weight bearing favoring the right lower extremity.

It was also Dr. Volarich's testimony that claimant was not at maximum medical improvement and he recommended the following treatment:

"EVALUATION AND TREATMENT CONSIDERATIONS: Ms. Pioske-Schlueter requires additional care for her lumbar radicular syndrome, right hip and right knee injuries. She requires pain management for the lumbar radicular syndrome. I recommend she return to the pain center of her choice for additional care that should include epidural steroid injections, foraminal nerve root blocks, trigger point injections, TENS units and similar treatments. A myelogram CT of the lumbar spine would also be informative to help evaluate any instability present in the low back because of the collapse of the L4-5 disc space. I recommend she undergo a triple phase bone scan of the right hip and right knee to determine whether or not her prostheses have loosened. Logical treatment decisions can then be made.

With reference to the right hip, I recommend an aspiration and/or excision of the soft tissue mass anterior to the hip joint that has developed since she fell. It appears to be an organized hematoma that is painful to palpation and any pressure.

With reference to the right knee, it appears that she has a loose prosthesis that requires replacement. I recommend she return to the orthopedic surgeon of her choice for additional care for her right knee."

The employer-insurer honored the claimant's request for more treatment and sent her back to Dr. Strickland for her knee complaints. Dr. Strickland saw the claimant on January 26, 2009 and noted she complained of discomfort and aching in her right hip laterally over the greater trochanteric area as well as her right knee over the lateral aspect, along with numbness in the bottom of her foot. It was Dr. Strickland's opinion with respect to her knee and her hip on the right side that she had reached maximum medical improvement and there was some concern that she may have significant sciatic nerve or nerve involvement from her lumbar spine, and he indicated that it was possible, if there was neurologic involvement involving her right lower extremity from this, that it may cause her to be weak in the right lower extremity and cause her to have aching in her right hip and right knee from muscle weakness. Dr. Strickland felt that her right knee and right hip strains were relieved, and he indicated that he was not asked to evaluate

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her back, and he felt that any current problems she was having from her hips and knees were not related to the primary injury.

With respect to the claimant's low back pain, the employer-insurer sent her to see Dr. Brett Taylor, an orthopedic surgeon. Dr. Taylor first saw the claimant on January 13, 2009 and took the following history:

"This individual is a very pleasant woman; she is not a very good historian. She describes that she had a fall at work on November 9, 2007 because of water leaking from a machine. She reports that she slipped and fell. She was able to continue to work and she did tell her boss about the injury. She reports that up until April she had the onset of foot numbness driving to work. She reports that she called work and did not return to work since April because of this numbness. She reports that her leg has gone numb, and this has resulted in an August 2008 fall where she fractured her wrist. She reports she has had multiple falls due to her 'right leg numbness'."

Dr. Taylor recommends EMG studies, an MRI with gadolinium of her lumbar spine, and review of additional prior records. Following her diagnostic studies, the claimant returned to Dr. Taylor on February 3, 2009. He noted claimant had an antalgic gait. She was able to heel and toe gait. Her range of motion was markedly limited with normal motor function. Her MRI revealed longstanding degenerative changes, most severe at L4-5 with osteophyte related foraminal stenosis, as well as facet hypertrophy and ligamentum flavum hypertrophy. He also noted degenerative disease at L1-2, and 2-3 as well as L5-S1, however, the L4-5 disease was most severe. He indicated the EMGs revealed evidence of chronic diabetic type sensory motor peripheral neuropathy, chronic lumbar radiculopathy, and mild peroneal neuropathy. Dr. Taylor issued the following opinions at this visit:

"At this juncture, this individual appears clear to have evidence of pre-existing disease that was aggravated by her work related event. I do not feel her work related event was a prevailing factor causing her symptomatology. Non-operative treatment for a condition of this nature would include physical therapy and injections. At this juncture, she is refusing any additional injections stating that the previous injections caused her more back pain. Based on this, we can offer her physical therapy. She would, in my opinion, return to see us in the next two to three weeks. I anticipate that she would be at a state of MMI from non-operative care within the next two months under a normal course of non-operative treatment, including physical therapy, advancing to land therapy and work hardening/work conditioning. I do feel that her condition is primarily related to her pre-existing degenerative disc disease that was aggravated by her work related event, but the work related event was not the prevailing factor."

The claimant's last visit to Dr. Taylor was on March 18, 2009. Dr. Taylor took the following interim history. On examination, Dr. Taylor noted an antalgic gait, however, she was able to heel and toe gait. She was unable to perform rapid alternating movements on the right. It was Dr. Taylor's opinion that she had symptoms consistent with discogenic pain, stenosis, and more importantly, diabetic pathologies, and since the claimant was not interested in surgery, he would transfer her to a non-operative specialist.

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Dr. David Volarich re-examined the claimant on July 9, 2009, after all of her treatment had been completed, and testified by deposition at the hearing. In his deposition, Dr. Volarich testified that it was his opinion, with a reasonable degree of medical certainty, that the claimant had the following pre-existing disabilities that were present before her November 9, 2007 injury which were a hindrance or obstacle to her employment or obtaining employment:

1. 65% permanent partial disability of the right lower extremity rated at the hip due to the total hip replacement that occurred as the result of the fall in October of 2006, which caused her loss of motion, weakness, and discomfort prior to November 9, 2007.
2. 65% permanent partial disability of the right lower extremity rated at the knee due to the total knee joint replacement, causing loss of motion, discomfort, and weakness prior to November 9, 2007.
3. 65% permanent partial disability of the left lower extremity rated at the knee due to the total knee joint replacement, causing loss of motion, discomfort, and weakness prior to November 9, 2007.

Dr. Volarich indicated that the disability from her lumbar laminectomy in 1975 was too small to quantitate, since she was essentially asymptomatic with her low back as the result of the old surgery.

It was Dr. Volarich's opinion that the claimant had the following permanent partial disabilities related to the November 9, 2007 on the job injury:

1. 10% permanent partial disability of the right lower extremity rated at the hip due to the contusion that has caused soft tissue hematoma, accounting for ongoing discomfort about the right hip joint.
2. 20% permanent partial disability of the right lower extremity rated at the knee due to the contusion that has caused a significant increase in pain about her prior knee joint replacement.
3. 25% permanent partial disability of the body as a whole rated at the lumbar spine due to the aggravation of underlying degenerative disc disease and degenerative joint disease, as well as disc bulging causing bilateral foraminal stenosis. Dr. Volarich indicated that this rating accounts for back pain as well as intermittent right lower extremity paresthesias and occasional radicular symptoms.

In his deposition testimony, Dr. Volarich discussed the organized hematoma that he found upon examination of her right hip area. He noted the hematoma was a collection of blood underneath the skin embedded within the muscle, and he pointed out that when she fell on that side and bruised her thigh, she had bleeding under the skin near the hip, and while it didn't break the bone, it caused bleeding from the muscle to occur. Dr. Volarich testified that it was a

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relatively extensive 10 cm mass, which is about the size of a baseball, and it was still present when Dr. Volarich first saw her some ten months after the primary injury. Dr. Volarich did note that when he saw the claimant in June of 2009, some nine months later, the hematoma was still present, but it had decreased in size and was approximately three to four centimeters in diameter at that time.

Dr. Volarich also testified that it was his opinion, based on his medical assessment alone, that the claimant was permanently and totally disabled as the direct result of the work-related injury she sustained on November 9, 2007 in combination with her pre-existing medical conditions. He noted she was 72 years old, which is advanced age, and she had an education limited to graduation from high school, and she had studied accounting, bookkeeping, and she had a degree in teaching. Dr. Volarich noted that she had been unable to get back to work since early 2008 and she was receiving Social Security benefits. Dr. Volarich set out no specific restrictions in his report, since he found that the claimant was permanently and totally disabled based on his medical assessment alone.

On cross-examination, Dr. Volarich was asked by the attorney for the Second Injury Fund as to what restrictions he would impose on the claimant if he were looking at the last injury that occurred on November 9, 2007 alone, and he indicated that he would probably put her on a 15-20 pound weight restriction, fixed positions of probably 30 minutes, and tell her to move about frequently and not to stay standing or sitting for any long periods of time, and he would also tell her she should avoid bending, twisting, lifting, carrying, and to lay down when she needed to as well. Dr. Volarich indicated that he would have already had restrictions in place for the pre-existing joint replacements of her hips and knees of no stooping, squatting, crawling, kneeling, impact maneuvers, no uneven surfaces, no ladders, no slopes, and work at ground level only.

Dr. Volarich was asked on cross-examination whether based on the restrictions that he indicated he would have given her from the last injury alone, with the 15-20 pound lifting restriction and to avoid bending, and to lay down throughout the day, and also, looking at the complaints she had from the last injury alone, why wouldn't she be permanently and totally disabled based on the last injury alone. Dr. Volarich responded that in his opinion she was permanently and totally disabled because of the combination effect of the joint replacements in the lower extremities (hip and both knees) and her back, even though she had no symptoms, was in a compromised posture because of the past surgery. He also indicated that she had a collapse of the L4-5 disc space, and she was prone to developing radicular symptoms above and below the operated level, and therefore, he thought that it was not just the last injury alone that rendered her permanently and totally disabled. He also noted she had hip and back symptoms since the October of 2006 fall and consequent hip surgery.

#### VOCATIONAL EVIDENCE

The employee introduced into evidence the testimony of Dr. Jeffrey Magrowski, a vocational expert and rehabilitation consultant. It was Dr. Magrowski's opinion that the claimant could not compete in the local economy for a job based on her pre-existing medical conditions and injuries in combination with her injuries and medical conditions that resulted from her

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November 9, 2007 on the job injury and her complaints, history of treatment, and prescribed medication usage as prescribed by her physicians of record.

The Second Injury Fund introduced into evidence the deposition of vocational expert James England. It was Mr. England's opinion that based on Dr. Volarich's restrictions with the exception of her need to lie down for her back, which he said had occurred since the primary injury, that he could see no reason why she could not return to being a night clerk as it is normally performed in the open labor market, and he felt she could perform such as dispatcher, customer service clerk, and general office clerk. Mr. England further indicated that if one assumes the need for her to lie down during the day, one could conclude she is unemployable. He also noted that it was his opinion that her need to lie down during the day would be due to the effects of the primary injury rather than any problems before that time, based on Dr. Volarich's testimony and the claimant's testimony.

On cross-examination, Mr. England was questioned about his statement that Dr. Volarich was not asked to place any restrictions on the claimant, and he conceded that since Dr. Volarich's opinion was that she was permanently and totally disabled based on his medical assessment alone, he would not normally then give any restrictions. He also indicated that Dr. Volarich testified that it was his belief that the claimant was not taking Vicodin on a regular basis prior to the primary injury, but he did note in the treatment records that he reviewed they showed that she was taking Vicodin at least seven months before the primary injury on a regular basis.

Mr. England was also questioned on cross-examination that if it was assumed by history that her back and right hip pain was not severe enough that she did not have to lie down before the primary injury, would Mr. England agree from at least a medical standpoint that the pain she is now having in her low back and right hip is the result of both her pre-existing medical conditions of the low back and right hip and any additional complaints that occurred as the result of her primary injury to her low back. He indicated that at that point he would have to defer to the doctors on that question.

Mr. England was then directed to Dr. Volarich's opinion in his deposition where he testified clearly on cross-examination that the claimant's back pain and her need to lie down was based on her pre-existing medical problems and her primary injury because he thought her back was in a compromised posture because of her prior surgery and she was prone to developing radicular symptoms above and below the operated level. He further conceded that the records showed she did have a right hip fracture in 2006 which was causing her significant complaints with her low back and right hip before the November 9, 2007 injury.

Mr. England also conceded that Dr. Brett Taylor's exam on February 3, 2009, where the doctor stated a lumbar MRI revealed evidence of degenerative changes which were long-standing and most severe at L4-5 with osteophyte related foraminal stenosis as well as facet hypertrophy and ligamentum flavum hypertrophy and disease at L1-L2, L2-L3, L4-5, and L5-S1, and therefore, there was clear evidence that the claimant had pre-existing disease in her low back which was aggravated by her work-related event. Mr. England agreed, again deferring to the medical experts, it was Dr. Taylor's opinion that the source of the claimant's low back would be

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the pre-existing problems with her back in combination with the aggravation of her back condition caused by the primary injury.

Mr. England also conceded that based on the medical sources that it appeared that the source of her low back complaints and the hip complaints that result in her having to lie down are coming from both the prior condition of her low back and the additional complaints resulting from the primary injury.

Mr. England further conceded that he noted that a number of the treating physicians indicated that the claimant was a poor historian, and his review of her own deposition appeared that she had memory problems. He indicated that a person with short-term memory problems would have a hindrance to their ability to work. He also conceded, as he did in his report, that her age would be another factor that would make it difficult for her to compete for employment, and he also noted that the claimant referenced throughout the medical records a history of falls, and it would be difficult to place somebody in employment if they had a history of falls.

Mr. England agreed that claimant's age, memory problems, her history of falls, the number of medical problems she has, her complaints from both the pre-existing and primary injuries, and her prior hip fractures and bilateral knee replacements, are all factors that would make it difficult for her to compete for employment.

## **FINDINGS OF FACT AND CONCLUSIONS OF LAW**

### **1. DATE CLAIMANT REACHED MAXIMUM MEDICAL IMPROVEMENT:**

The claimant testified that she believed she last worked with the employer in March or April of 2008. She couldn't remember exactly which month, however. She was sure in her testimony, however, that she did not work at all during the month of May of 2008. She testified that she has not worked at any other job since leaving the employer in this case.

Dr. John McAllister was claimant's primary treating physician in this case, and in an office note from claimant's April 21, 2008 visit, he indicated at that time that he felt that she had reached maximum medical improvement and should be able to perform full duty at least from the standpoint of the fall that she had in November with the contusions and sprains, although he indicated that she did have other medical issues that needed treatment for which the November of 2007 fall was not the prevailing factor.

Therefore, the claimant's testimony and Dr. McAllister's records appear to be consistent, and I therefore find that the claimant reached maximum medical improvement on April 21, 2008, and I further find that claimant has not worked at any job since April 21, 2008.

### **2. SECOND INJURY FUND LIABILITY:**

Having settled her claim against the employer, Shirley Pioske-Schlueter, the employee, seeks an award under Section 287.220.1, Mo.Rev.Stat. (2000) for permanent total disability compensation against the Second Injury Fund. Ms. Pioske claims that she is permanently and

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totally disabled as a result of the combination of the disability to her low back sustained in the accident of November 9, 2007 and her many pre-existing disabilities.

Section 287.220.1 Mo.Rev.Stat. (2000) provides that where a previous partial disability or disabilities, whether from a compensable injury or otherwise, and the last injury combine to result in total and permanent disability, the employer at the time of the last injury is liable only for the disability which results from the last injury considered by itself, and the Second Injury Fund shall pay the remainder of the compensation that would be due for permanent total disability under Section 287.200. Brown v. Treasurer of Missouri, 795 S.W.2d 479, 482 (Mo.App. 1990). The employee must prove that a prior permanent partial disability, whether from a compensable injury or not, combined with the subsequent compensable injury to result in total and permanent disability.

Where the last injury alone causes the employee to become permanently and totally disabled, then the employer and not the Second Injury Fund is liable for permanent total disability payments under Section 287.200. Feldman v. Sterling Properties, 910 S.W.2d 808 (Mo.App. 1995).

In this case, all of the medical evidence clearly indicates that the claimant had a number of pre-existing disabilities involving her spine and lower extremities and that her compensable fall was the prevailing factor resulting in an aggravation, worsening, and increase in some of those previously injured areas. There is no evidence that the employee became permanently and totally disabled as a result of the injury sustained on November 9, 2007 without regard to any pre-existing disabilities.

The first determination to be made is the extent of the compensation liability of the employer for the last injury considered alone. Hughey v. Chrysler Corp., 34 S.W.3d 845 (Mo.App. 2000). After that has been determined, then the extent of pre-existing disabilities is to be determined. Lastly, the fact finder is to determine whether the pre-existing disabilities combine with disabilities from the primary injury to create permanent total disability. Where the combination of those disabilities causes permanent total disability, the Second Injury Fund is liable for permanent total disability, but only after the employer has paid the compensation due for the disability resulting from the primary injury. Cartwright v. Wells Fargo Armored Serv., 921 S.W.2d 165, 167 (Mo.App. 1996).

The employee settled her primary claim for 15% of the right knee and 5% of the body referable to the low back. While the terms of the settlement are not binding upon the Court, I find that the evidence supports that level of disability, and I therefore find the claimant's primary injury has resulted in 15% permanent partial disability of the right knee and 5% of the low back.

The employee must next prove that she had a permanent partial disability or disabilities pre-existing the present injury and the amount thereof which existed at the time of the compensable injury. Garcia v. St. Louis County, 916 S.W.2d 263 (Mo.App. 1995).

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I find that based on the uncontroverted medical evidence that the claimant had the following pre-existing disabilities which were a hindrance or obstacle to her employment:

1. 65% of the right lower extremity at the 207 week level due to the total hip replacement which resulted in ongoing hip and back pain and gait problems.
2. 65% of the left lower extremity at the 160 week level due to prior knee replacement surgery with post-surgery infection requiring additional surgery.
3. 50% of the right lower extremity at the 160 week level due to the prior knee replacement.

Section 287.020.7 Mo.Rev.Stat. (2000) defines total disability as the "inability to return to any employment and not merely ...[the] inability to return to the employment in which the employee was engaged at the time of the accident." The words "inability to return to any employment" mean "that the employee is unable to perform the usual duties of the employment under consideration in the manner that such duties are customarily performed by the average person engaged in such employment." Kowalski v. M-G Metals and Sales, Inc., 631 S.W.2d 919, 922 (Mo.App. 1982). The words "any employment" mean "any reasonable or normal employment or occupation; it is not necessary that the employee be completely inactive or inert in order to meet this statutory definition." Id. at 922; Brown v. Treasurer of Missouri, 795 S.W.2d 479, 483 (Mo.App. 1990); Crum v. Sachs Elec., 769 S.W.2d 131, 133 (Mo. App. 1989); "[W]orking very limited hours at rudimentary tasks [is not] reasonable or normal employment." Grgic v. P & G Const., 904 S.W.2d 46, 466 (Mo.App. 1995). The primary determination with respect to the issue of total disability is whether, in the ordinary course of business, any employer would reasonably be expected to employ the claimant in his or her present physical condition and reasonably expect him or her to perform the work for which he or she is hired. Reiner v. Treasurer of State of Mo., 837 S.W.2d 363, 367 (Mo.App. 1992); Talley v. Runny Mead Estates, Ltd., 831 S.W.2d 692, 694 (Mo.App. 1992); Brown v. Treasurer of Missouri, at 483; Fischer v. Archdiocese of St. Louis, 793 S.W.2d 195, 199 (Mo.App. 1990); Sellers v. Trans World Airlines, Inc., 776 S.W.2d 502, 504 (Mo.App. 1989). The test for permanent and total disability is whether given the employee's condition, he or she would be able to compete in the open labor market; the test measures the employee's prospects for obtaining employment. Reiner at 367; Brown at 483; Fischer at 199. A claimant who is "only able to work very limited hours at rudimentary tasks is a totally disabled worker." Grgic v. P & G Const., 904 S.W.2d 464, 466 (Mo.App. 1995).

The finder of fact can also take into consideration the claimant's age in determining whether she was permanently and totally disabled. Reves v. Kindells Mercantile Co., Inc., 793 S.W.2d 917 (Mo.App. 1990).

Both vocational experts agree that claimant has a combination of adverse vocational factors that would make it difficult to compete for employment in the open labor market. Claimant's age, memory problems, her history of falls, her numerous complaints and restrictions from both her pre-existing injuries and primary injury combine to render her permanently and totally disabled.

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In addition, claimant's credible testimony establishes that she could not reasonably be expected to sustain employment if hired. Claimant testified in a credible and straight forward manner. Her subjective complaints were endorsed by Dr. Volarich. Claimant testified that her impairments have produced pain of severe intensity, frequency and duration and have affected her ability to perform basic work-related functions. She could not, therefore, reasonably be expected to maintain an acceptable level of work performance necessary to carry on gainful employment.

The Second Injury Fund is therefore liable for permanent total disability benefits commencing 44 weeks after April 21, 2008, the date of maximum medical improvement, or February 23, 2009 in the amount of \$163.80 per week for life. Thomas Gregory, attorney for Claimant, shall be entitled to an attorney fee of 25% of this award for necessary legal services provided.

Made by: /s/ GRANT C. GORMAN  
GRANT C. GORMAN  
*Administrative Law Judge*  
*Division of Workers' Compensation*

This award is dated and attested to this 1<sup>st</sup> day of October, 2010.

/s/ NAOMI PEARSON  
NAOMI PEARSON  
*Division of Workers' Compensation*