

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

Injury No.: 02-064719

Employee: Mary Sieberg  
Employer: American Food & Vending, Inc.  
Insurer: Hanover Insurance Company  
Additional Party: Treasurer of Missouri as Custodian  
of Second Injury Fund

Date of Accident: June 4, 2002

Place and County of Accident: St. Louis County, Missouri

The above-entitled workers' compensation case is submitted to the Labor and Industrial Relations Commission (Commission) for review as provided by section 287.480 RSMo. Having reviewed the evidence and considered the whole record, the Commission finds that the award of the administrative law judge is supported by competent and substantial evidence and was made in accordance with the Missouri Workers' Compensation Act. Pursuant to section 286.090 RSMo, the Commission affirms the award and decision of the administrative law judge dated April 30, 2004. The award and decision of Administrative Law Judge Joseph E. Denigan, issued April 30, 2004, 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 27<sup>th</sup> day of April 2005.

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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DISSENTING OPINION FILED

Attest: John J. Hickey, Member

\_\_\_\_\_  
Secretary

SEPARATE OPINION  
CONCURRING IN PART  
AND DISSENTING IN PART

I must respectfully dissent from the award and decision of the majority of this Commission affirming the award and decision of the administrative law judge. Based upon my review of the evidence as well as my consideration of the relevant provisions of the Missouri Workers' Compensation Law, I believe the decision of the administrative law judge should be modified. I concur in the portion of the award and decision awarding compensation for employee's low back injury but I must dissent from the portion of the award denying compensation for her left ankle injuries. I find employee has established that she sustained compensable injuries to her left ankle.

I find employee to be a credible witness. Employee testified that she had no problems with her left ankle before the work accident. She testified that she began having pain in her left ankle about one week after the work accident. She testified that she reported the pain to the physical therapist no later than June 18, 2002 – thirteen days after the accident. The physical therapist observed employee was limping on that day which corroborates employee's testimony. On June 26, 2002, employee reported ankle pain to the physician at Barnes Care. On June 29, 2002, employee reported to the emergency room because her ankle pain became unbearable. The medical records of St. Anthony's confirm employee's ankle complaints.

Employee's testimony and the medical records clearly establish that employee suffered from ankle problems in the weeks immediately following her work injury. Notwithstanding employee's ankle complaints on June 26, 2002, the Barnes Care physician released employee to work at her standing-intensive job.

Dr. Weltmer, the treating surgeon, explained that the accident as described by employee could cause a degenerating tendon to rupture or could cause an asymptomatic torn tendon to become symptomatic. Dr. Weltmer testified within a reasonable degree of medical certainty that the work accident was the substantial factor in causing employee's need for ankle surgery and her resultant disability. Dr. Weltmer believes employee's permanent disability is in the neighborhood of 25% (presumably at the level of the ankle). I am persuaded by Dr. Weltmer's testimony regarding causation.

I would issue a modified award finding employee's left ankle injury compensable. I would find employer liable for past medical expenses, temporary total disability benefits, and permanent partial disability benefits for the left ankle injury.

For the foregoing reasons, I must respectfully dissent from the portion of the award of majority affirming the denial of compensation for the left ankle injury.

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John J. Hickey, Member  
AWARD

Claimant: Mary Sieberg

Injury No.: 02-064719

Dependents: N/A

Before the  
Division of Workers'  
Compensation  
Department of Labor and Industrial  
Second Injury Fund Relations of Missouri  
Jefferson City, Missouri

Employer: American Food & Vending, Inc.

Additional Party:

Insurer: Hanover Insurance Company

Hearing Date: February 3, 2004

Checked by: JED:tr

#### FINDINGS OF FACT AND RULINGS OF LAW

1. Are any benefits awarded herein? Yes



23. Future requirements awarded: None

Said payments to begin immediately 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:

Inez Ross

## FINDINGS OF FACT and RULINGS OF LAW:

Claimant: Mary Sieberg

Injury No.: 02-064719

Dependents: N/A

Before the  
Division of Workers'

Employer: American Food & Vending, Inc.

Compensation

Additional Party: Second Injury Fund (Open)

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

Insurer: Hanover Insurance Company

Checked by: JED

This case involves a low back injury to Claimant, Mary Sieberg, with the reported accident date of June 4, 2002. Employer, American Food and Vending, Inc., agrees that Claimant was employed on said date and that any liability was fully insured by Hanover Insurance Co. The Second Injury Fund is a party to this claim. All parties were represented by counsel.

### Issues for Trial

1. medical causal connection;
2. nature and extent of temporary total disability;
3. nature and extent of permanent partial disability;
3. unpaid medical expenses;
4. liability of the Second Injury Fund.

FINDINGS OF FACT

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## Stipulations

1. The parties stipulated that the Claimant was a Claimant of the Employer, and on June 4, 2002 was acting in the course and scope of her employment when she sustained an accident. It was stipulated that appropriate notice was given, and the claim was timely filed by the Claimant.
2. It is further stipulated that the Claimant had an average weekly wage of \$307.50, which results in a permanent partial disability and a temporary total disability rate of \$205.00 per week.
- 3 Employer paid \$895.41 in medical benefits and no TTD was paid to date.
4. It is stipulated further that the Employer had made advances on permanent partial disability in the aggregate amount of \$2,104.00.
5. Disputed and unpaid medical expenses are stipulated in amount at \$23,674.09.

## Claimant's Testimony

Claimant testified she normally worked a 40-hour day. Her job duties involved working as a grill cook and a server. She testified that her job required her to stand 8 hours a day.

On the accident date, she was leaving the cafeteria. She noticed that a cart was backing up and, subsequently, knocked her down. She testified that the cart hit her in the legs and knocked her straight backwards. She hit her head upon the floor and landed on her tailbone. She testified that the bumper of the cart hit her right leg. Her supervisor came over to check on her, and ultimately paramedics were called. She initially went to the infirmary in the Chrysler building. They looked at her head and her right leg and her tailbone. She was given pain medications and released. She was returned to work on 6/10/02 on light duty. According to the Claimant, light duty was not available, but she was able to work.

She had treatment and physical therapy for pain in her tailbone. At her last physical therapy appointment, prior to being released, she complained about her left ankle. She complained that she had no examination of her left ankle at that time. She was released to full duty by Barnes Care on 6/26/2002.

Claimant then testified that she went to the St. Anthony's Emergency Room on 6/29/2002 with complaints to her left ankle. She testified that she told the nurse and doctor at St. Anthony's that she fell at work and hurt her left ankle. She was given an X-ray and released.

Then, because of further problems, she went to see her own doctor, Dr. Mehra. She was unclear about the dates. She testified that she gave him a history that she had hurt her left ankle in the initial incident. He prescribed an MRI for her, and after the MRI, referred her to Dr. Weltmer. Dr. Weltmer performed surgery on her left ankle on October 29, 2002.

Claimant testified about her lack of satisfaction with treatment at Barnes Care. She testified about re-injuring her ankle while walking at work. She testified that her ankle gave way. She was sent to Barnes Care West where they treated and released her without restrictions. She has not worked since the date of her first surgery.

She underwent a second left ankle surgery in May 2003.

She testified that her current complaints are primarily her left ankle. She stated that she's lucky to go a single day without any pain in the left ankle. She can stand for four hours at a time and she has pain after walking a couple of miles. She is taking medications for her left ankle but did not specify them. She testified that her tailbone is still troubling her. She has trouble sitting still, and she has some soreness in her tailbone. She testified that she cannot stand for a long time also because of her tailbone.

She identified her medical records and bills corresponding to her two surgeries.

On cross-examination regarding her medical records from St. Anthony's, she denied telling the nurse that she had only complained on June 29, 2002 of left ankle pain for the past five or six days. She denied stating that the pain became worse during the night and it became difficult to bear weight. She denied telling the nurse that there was no history of any injury to the left ankle. See Exhibit C.

She admitted giving a history to the physical therapist that she had a 1995 back injury with disc surgery and complained of left leg weakness as a result of that surgery. She did state that she told the therapist that her left ankle was hurt, but she admitted she did not make left ankle complaints at Barnes until her last visit (June 26, 2002).

She has not looked for work since the date of the surgery.

Claimant had prior surgery to her low back and acknowledged that the surgery caused some weakness in her left leg. She acknowledged that she was on multiple medications for her left leg and back complaints. She tried to make a distinction between the back surgery and her left leg complaints. These medications included Neurontin, Vicoprofen, Tegretol, and Carbamazepine.

She did not recall telling Dr. Weltmer of a subsequent incident on 9/26/02. When asked, she conceded she may have told Dr. Weltmer that she was walking on flat concrete and all of a sudden her ankle felt unstable.

### Medical Evidence

The medical records are reviewed in chronological order. Exhibit E, the dispensary note, reflects an apparently erroneous first treatment date of 6/6/02 which is of no consequence herein. The history largely corroborates Claimant's accident description but gives additional details of her fall. She fell backward and hit her head on the floor and was hit on her right anterior shin. Upon examination of her right leg, there were no signs of bruising or other signs of injury to the right leg. There were no complaints referable to the left leg or left lower extremity. She did hit her head and tailbone but no loss of consciousness was noted. The notes reveal Claimant was able to ambulate without difficulty.

The records of treatment from Barnes Care (Exhibit J) note complaints of her tailbone, right leg, and head. She complained of nausea and a headache. She noted a prior history of low back pain and current. She was diagnosed with head, back, and leg contusion, mild neck strain. She was prescribed physical therapy and continued to treat for the next 20 days, 6/6/02 through 6/26/02. There is no mention of injury to the left ankle until the last date of treatment of 6/26/02. On the 26<sup>th</sup>, there is a note by Dr. Maslanko, "Overall complaints were much improved ... has some stiffness, soreness ... should resolve with time. Also a complaint of left ankle pain, likely related to anatomic/alignment factors, no signs of injury."

The records of St. Anthony's Medical Center Emergency Room (Exhibit F) document a visit on June 29, 2002 -- 3 days after her release from Barnes Care. Initial nursing notes include patient complains of right ankle swelling and denial of any injury. A physician's handwritten notes of the same date, "There was left ankle pain/swelling for the past 5 to 6 days. Swelling increased when she is off work, on her feet all day. It's only worse after work ... past medical history of depression, lumbar surgery, and chronic leg pain."

Separate nursing notes of the same date state that the Claimant presented to the emergency room with complaints of "left ankle pain for the past five to six days. Patient states pain became worse during the night and became more difficult to bear weight. Patient states negative injury, negative edema, and pain is the only complaint at this time."

The records of Dr. Mehra (Exhibit D) indicate that the Claimant first saw Dr. Mehra for these complaints on

7/8/02, noting a history of being hit by an electric car at work on 6/5/02. The initial complaint was pain in the tailbone, went to Workers' Compensation doctor at BJC Clinic, released back to work, now complain of left ankle, and some swelling.

She was seen again over a month later with complaints to the left leg and foot pain, "I can't stand it anymore." It started with tingling and now changed to pain. Increased with going up and down steps. Noted some swelling of left ankle. No history of trauma." She was ultimately referred to Dr. Weltmer.

The records of Dr. Weltmer (Exhibit I) indicate Claimant was first seen on September 10, 2002. The history given was that she was hit by a car last June. She was treated at Barnes Care, the X-ray report was negative, and no treatment was given. She stated that she continued to have complaints and was seen by her family doctor, X-rays were obtained 8/19/02 at St. Anthony's Medical Center. Dr. Weltmer diagnosed her with left ankle synovitis, and an MRI on 10/7/02 revealed tenosynovitis of the peroneal tendon sheath with a tear of the peroneus longus tendon. Impression was tenosynovitis of the peroneal tendon sheath with a partial intra substance tear of the peroneus longus tendon.

Dr. Weltmer's notes on 10/3/02 also contained a history of a subsequent incident. On 10/3/02 he takes a history that she stated sometime before October 3<sup>rd</sup> she was walking on flat concrete when all of a sudden her ankle felt unstable, and she experienced acute sharp pains over the outer aspect of the left ankle. She did not fall on the ground because of the ankle instability ... but was concerned she would not be able to ambulate.

Dr. Weltmer performed surgery on 10/29/02. The operative note relates that the peroneal tendon sheath was opened up and found to have complete degeneration of the peroneus longus tendon. There were just a few widths of the tendon present. Distally it degenerated enough to where nothing really can be significantly reconstructed.

On December 23, 2002, in response to a question from an unidentified party, Dr. Weltmer prepared a to-whom-it-may-concern letter on causation of the peroneal tendon tear. That report states, "It is possible the peroneal tendon tear was caused by the accident, but with the history she describes, it is hard to be consistent with the tear. I cannot say for sure whether the tear was caused or aggravated by the accident."

She did not respond well to treatment, and the doctor saw her again in 2003 for treatment. After the repeat MRI, Dr. Weltmer recommended additional surgery which he performed on 5/6/03. She was seen for the final time on 9/16/03. He states that she was doing a lot better, was not pain-free, but definitely improved.

### Opinion Evidence

*Dr. Weltmer*

The deposition of Dr. Weltmer (Exhibit I) was taken on December 1, 2003. He testified consistently with his medical records. He did not have any notes from the referring doctor, Dr. Mehra. He testified that after the first surgery she got better, but the pain never went away. A repeat MRI showed increased inflammation and new changes. He testified that he had not place her at MMI.

He testified in his opinion that the twisting injury she incurred on June 2002 was a substantial factor in her condition. He believed that the Claimant was always going to have some persistent tenderness and swelling of the ankle. He believes that she's going to have difficulty with an occupation that involves prolonged standing or walking. He did not express a definitive opinion with regard to the need for any further medical treatment.

On cross-examination he agreed that Claimant had a high arch and inverted ankle. He agreed that individuals with this condition tend to walk on the outside of their foot which puts pressure on the peroneal tendon. He did agree that when he operated on her, she had a degenerative process of the peroneal tendon, where it had frayed almost to the point of breaking.

He further testified that her description of her accident is not the typical way to get a peroneal tendon tear. He did agree that in order to completely tear the peroneal tendon there has to be a fairly significant trauma to the ankle. You have to turn it over pretty well.

He said he also did not have Dr. Mehra's records prior to his treatment. He did not have the records from Barnes Care. Separately he acknowledged that if someone has a peroneal tendon tear, they would notice swelling, pain, and difficulty to walking at the outset.

*Dr. Schmidt*

The deposition of Dr. Schmidt (Exhibit 1) was taken on January 6, 2003. Dr. Schmidt is an orthopedic surgeon and confines his practice to the feet and ankles. Dr. Schmidt took a history by the Claimant where she was struck by a cart and knocked backwards, striking her head and tailbone and complaining of an inversion internal rotation of her ankle.

She gave additional history of being taken to Barnes and was then diagnosed with a contusion of the head and injury to her tailbone. According to the history, she told the Barnes Care people about her ankle and was told that she had to see her family physician. She returned to work on Monday with a very painful and swollen ankle and having to cut the tops of her shoes off in order to work. She continued to work until August when she was referred to a specialist who sent her to physical therapy. She continued to work during this time. She reported a painful swollen ankle that frequently gave out.

Dr. Schmidt's impression was cava varus foot with hammer toes and a degenerative tear with peroneus longus tendon. He found nothing in the medical records about massive swelling to the point where she had to cut the tops of her shoes off. He noted that this would likely be considered an abnormal finding. He noted in the medical records no documentation of injury to her left side, no documentation of left ankle complaints until 6/26/02, and it was noted to be due to an anatomic variation. His diagnosis was chronic peroneus longus tear.

He noted it was significant in his review of the medical records that there was a lack of any recognition of a left ankle injury in the initial medical records.

He noted that she had cava varus deformity, and he noted that it's a high-arched foot with a heel that's inverted. This is an anatomic variation. He noted people with a cava varus foot bear much more weight on the outside part of the foot, and their peroneal tendons do develop degenerative tears. The operative report described a degenerative tear. He felt that her tear was chronic because of the nature of the tear as described in the operative note, the fact that she had an anatomical variation and the fact that other than her history there was no documentation of injury to her left ankle.

He did note that while it is possible to have an acute tear of the peroneal tendon, there has to be a very significant twist. He testified that if she had fallen and suffered a tear of her tendon on 6/4/02, it would have been markedly swollen, bruising of the ankle with significant difficulty in bearing weight on it. He stated that the history contained in St. Anthony's medical records are more consistent with a degenerative as opposed to an acute process. He testified it's not unusual for a person with an anatomic presentation to develop this type of tear.

He agreed with the course of treatment by Dr. Weltmer.

## RULINGS OF LAW

### Medical Causation – Left Ankle

### *Medical Records*

Medical records are relied upon as business records. This point is manifest in the statutory expedients permitting ease of admissibility upon compliance with authentication requirements. Sections 287.140.7, 490.692 RSMo (2000). Here, the medical records consistently reflect minor injuries on the reported accident date without mention of left ankle injury. Neither the Claimant nor the health providers are shown in the records to have noted left ankle complaints.

Separately, business records are considered reliable because they are created for a purpose independent of the litigation and, as such, constitute an exception to the hearsay rule. Dr. Weltmer, although an able surgeon, was not provided the business records underlying Claimant treatment at Barnes Care or those of Dr. Myra. It seems reasonable that the decision-maker in this transaction be provided with at least the immediately preceding business records. This deficit in background notes undercuts Dr. Weltmer's ability to render a persuasive opinion.

Finally, accepting Claimant's theory of work relatedness would require assuming multiple doctors and nurses missed noting both Claimant's complaints and clinical signs of injury. For the same reasons medical records are admissible as business records, there is no basis to make this fantastic assumption. Claimant provided no evidence of discrepancy or challenge to the medical records authenticity.

### *Claimant's Testimony*

Claimant's testimony was passionate but lacked important details. Specifically, Claimant's testimony, regarding causation, demonstrated the seriousness of her condition rather than a connection between very serious, chronic congenital foot problems and the reported accident. As stated above, the medical records do not provide a basis to prove either acute or aggravating accident history resulting in left ankle symptoms. Thus, while Claimant's testimony at times contrasts with the medical records, she also made some admissions about her complaints and ability to ambulate, etc. after the accident. It is noted that the Claimant had no problem walking into the dispensary. Further, she returned to work and was able to work in excess of her restrictions.

Claimant was also impeached with the medical records of June 24, 2002 in which a patient history reflects left ankle symptoms for the prior five or six days. Supporting the theory of chronicity, the note further reflects Claimant was still ambulatory. Other records reflect surgery still months later in October 2002. Claimant's testimony simply is not reliable regarding causation.

### *Opinion Evidence*

Both Dr. Weltmer and Dr. Schmidt noted that a twisting injury causing a peroneal tendon tear would cause immediate noticeable swelling, bruising, pain, and difficulty standing. None of this was noted in the 30 days following the alleged incident of June 4, 2002. In fact, no significant swelling was noted at St. Anthony's on June 29, 2002. No significant swelling was noted in Dr. Mehra's notes in July 2002.

It is noted that Dr. Weltmer did not have the records of Dr. Mehra, St. Anthony's medical records at St. Anthony's Medical Center, the dispensary, or from Barnes Care. Thus, he was unaware that there was no immediate clinical documentation of any limp, swelling of her ankle, the pain in the left ankle, and difficulty walking or standing, or, in fact, that the history regarding her ankle was inconsistent with the objective findings in the medical records. On the other hand, Dr. Schmidt was better informed as regards history and records review. Like Dr. Weltmer he is an experience foot surgeon.

Both experts agreed that the injury, described post operatively as a chronic condition of tearing, particularly evidenced by extreme fraying, together with the lack of significant swelling to the left ankle, limping, or her inability to bear weight on the left ankle contemporaneous to the reported injury date, made it unlikely that the tear was acute. Both Dr. Weltmer and Dr. Schmidt agree that the peroneal tendon tear reflected chronic changes. Dr. Schmidt opines that these chronic changes occurred prior to the reported injury.

In the operative note of Dr. Weltmer, he clearly notes that the peroneal tendon had completely degenerated, to use his words. Claimant failed to carry her burden of proof that the peroneal tendon tear was caused or

aggravated by the reported accident.

Nature and Extent of PPD

The stipulated amounts for medical treatment and the lack of temporary total disability are consistent with the minor injury described in the medical records. This is a no lost time case. Employer is not liable for any lost time since Claimant continued to work until the unrelated left ankle surgery in October. The only complaints at trial from Claimant that correspond to body parts noted as treated in the days and weeks following the reported accident were pain in the area of the tail bone and the inability to sit still. Claimant apparently had a prior low back surgery. It is reasonably inferred that a fall to the buttocks or tailbone incrementally aggravates an operated lumbar spine more than it would a healthy lumbar spine.

Conclusion

Accordingly, on the basis of the substantial competent evidence contained in the whole record, Claimant is found to have sustained a five percent PPD of the low back. In addition, Employer shall have credit for advance payment \$2,104.00 against any indemnity awarded herein. The SIF claim is denied since the award herein precludes satisfaction of the statutory threshold. Section 287.220.1 RSMo (2000).

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

Made by: \_\_\_\_\_

Joseph E. Denigan  
*Administrative Law Judge*  
*Division of Workers' Compensation*

A true copy: Attest:

\_\_\_\_\_  
Reneé T. Slusher  
*Director*  
*Division of Workers' Compensation*