

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

Injury No.: 98-068375

Employee: Diane Smith  
Employer: The Board of Education of the City of St. Louis  
Insurer: Self-Insured  
Additional Party: Treasurer of Missouri as Custodian  
of Second Injury Fund  
Date of Accident: May 7, 1998  
Place and County of Accident: St. Louis, 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 November 14, 2005. The award and decision of Administrative Law Judge Margaret D. Landolt, issued November 14, 2005, is attached and incorporated by this reference.

The Commission further approves and affirms the administrative law judge's allowance of attorney's fee herein as being fair and reasonable.

Any past due compensation shall bear interest as provided by law.

Given at Jefferson City, State of Missouri, this 24<sup>th</sup> day of August 2006.

LABOR AND INDUSTRIAL RELATIONS COMMISSION

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William F. Ringer, Chairman

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Alice A. Bartlett, Member

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John J. Hickey, Member

Attest:

\_\_\_\_\_  
Secretary

**AWARD**

Employee: Diane Smith

Injury No.: 98-068375

Dependents: N/A Before the  
**Division of Workers'**  
Employer: The Board of Education of the City of St. Louis **Compensation**  
Department of Labor and Industrial  
Additional Party: Second Injury Fund Relations of Missouri  
Jefferson City, Missouri  
Insurer: Self-Insured  
Hearing Date: August 8, 2005 Checked by: MDL:tr

### 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: May 7, 1998
5. State location where accident occurred or occupational disease was contracted: St. Louis
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:  
Repetitive use of his wrists, right upper extremity, shoulders and neck.
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: Wrists, right shoulder, and neck
14. Nature and extent of any permanent disability: 17 ½% permanent partial disability of the right wrist, 10% of the right shoulder, and 25% of the body as a whole
15. Compensation paid to-date for temporary disability: -0-
16. Value necessary medical aid paid to date by employer/insurer? \$6,780.65

Employee: Diane Smith Injury No.: 98-068375

17. Value necessary medical aid not furnished by employer/insurer? \$40,052.80
18. Employee's average weekly wages: \$359.06
19. Weekly compensation rate: \$239.37/\$239.37
20. Method wages computation: Stipulation

### COMPENSATION PAYABLE

21. Amount of compensation payable:

Unpaid medical expenses: \$40,052.80

46 2/7 weeks of temporary total disability (or temporary partial disability) \$11,079.41

175 weeks of permanent partial disability from Employer \$41,889.75

22. Second Injury Fund liability: No

TOTAL: \$93,021.96

23. Future requirements awarded:

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:

Mr. Charles Bobinette

## FINDINGS OF FACT and RULINGS OF LAW:

Employee:	Diane Smith	Injury No.: 98-068375
Dependents:	N/A	Before the <b>Division of Workers'</b>
Employer:	The Board of Education of the City of St. Louis	<b>Compensation</b> Department of Labor and Industrial
Additional Party:	Second Injury Fund	Relations of Missouri Jefferson City, Missouri
Insurer:	Self-Insured	Checked by: MDL:tr

### PRELIMINARIES

A hearing was held on August 8, 2005, at the Division of Workers' Compensation in the City of St. Louis. Diane Smith ("Claimant") was represented by Mr. Charles Bobinette. The Board of Education of the City of St. Louis ("Employer"), which was self-insured, was represented by Ms. Robin Higgins. The Second Injury Fund was represented by Assistant Attorney General Rachel Paul. Claimant filed four claims: 98-068375 (date of injury May 7, 1998); 99-054526 (date of injury April 30, 1999); 00-005912 (date of injury January 11, 2000); and 01-161057 (date of injury November 14, 2001). By agreement, the claims were consolidated and tried together. Claimant's attorney requested a fee of 25% of Claimant's awards.

In Injury Number 98-068375, the parties stipulated that Claimant's average weekly wage is \$359.06, and the permanent partial and temporary total disability rate is \$239.37. Employer paid \$6,780.65 in medical expenses. The issues

in this claim are occupational disease, medical causation, past due temporary total disability benefits, past medical expenses, disfigurement, and nature and extent of permanent partial disability referable to the right and the left wrists, right upper extremity, shoulder and neck.

In Injury Number 99-054526, the parties stipulated that as of April 30, 1999, Claimant's average weekly wage was \$416.21, yielding a permanent partial disability rate of \$277.47. Employer paid \$342.13 in medical expenses, and no temporary total disability benefits. The issues presented are nature and extent of permanent partial disability referable to the back, and liability of the Second Injury Fund.

In Injury Number 00-005912, the parties stipulated Claimant's average weekly wage is \$434.94 and the permanent partial disability rate is \$289.96. Employer paid \$1,976.93 in medical expenses, and no temporary total disability benefits. The issues are nature and extent of permanent partial disability of the neck and lower back, and liability of the Second Injury Fund.

In Injury Number 01-161057, the parties stipulated Claimant's average weekly wage is \$460.18, and the total disability and permanent partial disability rate is \$306.79. Employer paid \$1,005.11 in medical expenses, and no temporary total disability benefits. The issues presented for resolution are occupational disease, medical causation, past due temporary total disability benefits, disfigurement, past and future medical expenses, nature and extent of permanent partial disability, permanent total disability, and liability of the Second Injury Fund.

### **FINDINGS OF FACT**

Claimant is 50 years old and is right-handed. In 1972, after completing the eleventh grade at Sumner High School, she dropped out of school. In the early 1980s, she obtained her GED. Claimant has no vocational training, office experience, or computer or typing skills. In the early 1970s, Claimant worked at a McDonald's restaurant as a food service worker for a couple of months. She then moved to Michigan where she worked at a factory assembling toys for about a year. In 1973, she returned to St. Louis.

In 1978, Employer hired Claimant as a food service worker preparing lunches. She was promoted to Baker, and eventually to a Head Cook II. She worked from 6:00 a.m. to 2:30 p.m., Monday through Friday, ten months a year. She prepared approximately 200 breakfasts and 600 lunches each day as a Head Cook. She supervised ten to eleven workers. She was not required to plan menus, order food, or perform personnel work. Sometimes, she had to help serve the food as a fill-in when another worker was absent. She spent most of her time on her feet, and performed paperwork at the end of the day. Daily, she used both hands for slicing, dicing, peeling, scooping, pulling, cutting and stirring. When cooking, the heaviest she had to lift were pans, which weighed between 35 and 40 pounds when filled. She was required to reach overhead and use her upper extremities constantly. Claimant continuously looked down as she cooked, and raised her head backwards when she lifted. When lifting, she had to stand on her toes holding the pans in her hand and reach overhead to put them into the oven or rack. Claimant asked her supervisor for a step stool, but was never provided with one.

Claimant began experiencing problems with her hands, right shoulder and neck in late 1996 or early 1997. Although she requested medical treatment on several occasions, her supervisor did not prepare a report until Claimant lost control of her hand and spilled hot soup on a customer. On April 7, 1998, Claimant was seen by her private physician, Dr. Josyula, who suspected bilateral carpal tunnel syndrome and diagnosed cervical strain. Dr. Josyula felt that her condition was work related.

Eventually, on April 29, 1998, Employer referred Claimant to Dr. Ollinger, who diagnosed possible bilateral carpal tunnel syndrome substantially related to her work activities, and a small ganglion volar of the right wrist (not work related). Nerve conduction studies performed on the same day were abnormal on the right hand and normal on the left. On May 7, 1998, Dr. Ollinger prescribed medications and hand splints to be worn at night. Dr. Ollinger suggested that if she did not respond to medical treatment, she should be referred to an orthopedist for her shoulder complaints.

On June 11, 1998, Claimant continued to complain of bilateral numbness and tingling of her hands, and right shoulder pain. Dr. Ollinger recommended surgery on the right wrist, and an orthopedic referral for her right shoulder problem if her symptoms continued after her carpal tunnel syndrome surgery and post op rest.

Surgery was performed at Missouri Baptist Hospital on June 23, 1998. On July 6, 1998, Dr. Ollinger recommended alternative work with light use of the right hand, no power gripping, and a five-pound lifting restriction. Dr. Ollinger released Claimant to regular work on September 24, 1998. On December 3, 1990, Dr. Ollinger gave Claimant a 0% permanent partial disability rating on both wrists, and found no symptoms or signs of left carpal tunnel syndrome. He noted that her NCVs were normal. He did not feel that Claimant required any additional evaluation, care or work restrictions, and felt Claimant was at maximum medical improvement. On January 7, 1999, Employer refused to authorize any additional

medical treatment for Claimant based upon Dr. Ollinger's report.

Claimant planned to work during the summer school break cleaning offices with her sister. Because of the planned surgery and her recovery, she remained unemployed between June 5 and the start of school on August 26, 1998. On September 24, 1998, Dr. Ollinger released Claimant for regular work.

Claimant continues to have difficulty with her right hand following her surgery. She frequently rubs her right hand to alleviate her pain. She has reduced strength, which results in difficulty with such tasks as opening jars, combing her hair, vacuuming, and grasping items. She frequently drops things.

On January 15, 1999, Claimant was seen by Dr. Josyula for right shoulder problems. Claimant reported that for the past several months, she had been having progressive discomfort in her right shoulder area, and that her work involved picking up steam table pans on a regular basis. At the time of her examination, she could not raise her arm above her head. She was diagnosed with a history of rotator cuff strain versus tear. She was prescribed medications, and referred to Dr. Kenneth Yamaguchi, an orthopedic surgeon.

On February 22, 1999, Claimant was seen by Dr. Yamaguchi. On physical examination, she had pain with increased internal rotation, weakness and tenderness. Claimant also had pain with extreme cervical spine extension with some recreation of the shoulder pain symptoms. She complained of fatigue in her arm with mild activities. Dr. Yamaguchi felt that she had right rotator tendonitis with possible cervical spine radiculopathy. The area was injected, physical therapy was prescribed, and she was referred to Dr. Heidi Prather.

Dr. Prather evaluated Claimant on March 11, 1999, and diagnosed cervical segmental dysfunction and to rule out cervical radiculopathy and rotator cuff tendonitis. Claimant was prescribed Lodine for pain control, physical therapy for flexibility, and strengthening exercises for her cervical spine. X-rays of the cervical spine taken on March 11, 1999 revealed mild degenerative disc disease at the C4-5 levels.

On March 17, 1999, Claimant, through her counsel, notified Employer that she was seeking medical treatment on her own and would look to Employer for reimbursement.

Between March 11 and May 13, 1999, Claimant had eight sessions of physical therapy. Although her right shoulder pain improved, her right lateral neck pain continued.

On April 30, 1999, Claimant suffered a work-related injury when she jolted her mid back when pulling a bread rack from the walk-in refrigerator at work. She was seen at BJC Corporate Health on April 30, 1999. X-rays of her thoracic spine were negative, and Ibuprofen was prescribed. Claimant was diagnosed with a parathoracic sprain. Claimant was off work until May 3, 1999, at which time she was returned to full duty.

On July 27, 1999, Claimant was in tears when she was seen by Dr. Josyula complaining of worsening of her right shoulder discomfort. Claimant was unable to elevate her shoulder above her head and was having difficulty ambulating normally. Claimant was given a Toradol shot and referred back to Dr. Prather. An MRI of the cervical spine performed on August 17, 1999 revealed focal kyphosis with surrounding muscle spasm from C4-C5 intervertebral disc herniation, with extruded disc material.

Claimant came under the care of Dr. Daniel Riew on August 31, 1999. According to his records, she complained of neck and arm pain for approximately 1-½ years, which she related to lifting at work. She also reported having problems picking up small objects. She reported her worst position was standing, and lying down eased her pain. Dr. Riew diagnosed interscapular pain, shoulder pain, radiculopathy secondary to herniated disc at 4-5, cervical kyphosis and foraminal stenosis at 4-5 and to a lesser extent at 5-6. He recommended epidural steroid injections and, if they failed to resolve the problem, surgery.

On September 22, 1999, Claimant was seen at the BJC Pain Management Center by Dr. Karanikolas complaining of pain in the neck, right shoulder, and right upper extremity radiating into the fingers since April 1997. Initially, the pain was sharp in her neck and shoulder and became a continuous dull pain down her right arm and into her fingers. Associated symptoms included nausea, dizziness, blurred vision, numbness, tingling, noise sensitivity, and irritability. Examination of the neck showed muscle spasms and trigger points with tenderness over the cervical vertebrae. Dr. Karanikolas diagnosed bilateral foraminal C4-5 and C5-6 stenosis, chronic right sided neck and upper extremity pain, with significant myofascial pain components, right sided radiculopathy, and slight weakness of the right upper extremity, apparently related to radiculopathy. The recommended treatment plan included physical therapy, epidural injections, Medrol dose pack, and

trigger point injections.

On January 11, 2000, Claimant was putting chicken wraps into the oven when she knocked over a bucket of grease, slipped, and fell, burning her left hip on hot grease. Claimant was treated at Barnes Care where x-rays were taken of the low back and left hip. Left hip films revealed mild bilateral hip osteoarthritis without fracture. Low back films were negative. Cervical spine films showed: a straightening of the cervical spine without evidence of fracture, incomplete visualization of the C7 vertebral body and mild cervical spondylosis at the C4-5. Claimant was prescribed physical therapy and medications and given a ten-pound lifting restriction. Claimant was referred to Dr. Wayne who diagnosed right worse than left sacroilitis, lumbosacral sprain, cervical sprain, and status post left elbow contusion, and continued Claimant's conservative treatment.

On February 28, 2000, Dr. Wayne recorded that Claimant had moderate improvement with therapy, but continued to experience pain in her neck and low back. Her cervical range of motion was approximately 80% of normal. She was 75% of normal on left rotation with most of the pain being in the right lower neck, left rotation. Lumbosacral range of motion showed 75% of normal on flexion. Dr. Wayne prescribed three more weeks of physical therapy and limited duty. On March 14, 2000, Claimant reported that she continued to have difficulty performing her job because of her pain in the trapezius region with stirring and overhead lifting. Lumbosacral range of motion was within normal limits. Cervical range of motion was approximately 80% of normal for extension and in flexion. Dr. Wayne found her to be at maximum medical improvement and released her to full duty. As of April 5, 2000, Dr. Wayne felt that Claimant sustained a 5% permanent disability of the neck, but no disability to the lumbar region as a result of her work accident of January 11, 2000.

Claimant continued her medical treatment with Drs. Josyula and Riew. On November 17, 2000, she reported to Dr. Josyula that she had complaints of pain and discomfort involving her right shoulder area and that her arm strength was diminished. Medications were prescribed and she was referred to Dr. Riew for possible surgical intervention. She next saw Dr. Josyula on December 4, 2000 for pain in the upper neck and shoulders and asked to be taken off work because of her problems.

On January 23, 2001, she was seen by Dr. Riew. A repeat MRI of the cervical spine was performed on February 5, 2002, which revealed cervical kyphosis, cord compromise at C4-5 and to a lesser extent, at C5-6. Dr. Riew suggested surgery.

Claimant was referred for a second opinion to Dr. Christina Lenk, who recommended an EMG and nerve conduction study, and prescribed medications for her pain symptoms. The March 1, 2001 EMG nerve conduction studies were consistent with C4-5 radiculopathy and milder underlying median nerve lesion at the right wrist. Dr. Lenk suggested it was likely that surgery would be needed, but recommended a more conservative approach, including another course of physical therapy and pain medications.

According to the Barnes Jewish Hospital medical records, on March 12, 2001, Dr. Riew performed a carpectomy of the C5, and fusion of the C4-C6 with anterior cervical plate mesh cages, and right iliac crest bone grafting. The postoperative diagnosis was cervical herniated disc and spondylosis causing mild radiculopathy at the C4-5 and C5-6 levels.

Claimant was taken off of work while she recuperated from her surgery. When Claimant followed up with Dr. Riew on April 24, 2001, she stated that she continued to have upper trapezial pain, but that her arm symptoms had resolved. On June 19, 2001, she continued to complain of trapezial pain and occasional pain in her arm, although her tingling and numbness had improved. Dr. Riew felt that there were two explanations for her continued problems: (1) that she was beginning to heal; and, (2) there was a possibility that she was having problems at the C4-5 and C6-7 levels. He recommended that Claimant continue to wear her cervical collar and try to increase her aerobic exercise. On July 24, 2001, Dr. Riew referred Claimant to Dr. Galatz for treatment of her right shoulder pain.

Claimant complained to Dr. Galatz that she could not sleep at night, and she had trouble lifting her right arm over her head. Claimant was diagnosed with rotator cuff tendonitis and was injected with Cortisone and Lidocaine.

Claimant was next seen by Dr. Galatz on September 18, 2001. She reported that her shoulder felt good after the injection, however the pain had returned in moderate intensity. Dr. Riew ordered physical therapy.

Between January 1999 and September 18, 2001, Claimant incurred medical expenses for treatment of her right shoulder and neck while under the treatment of Drs. Josyula, Yamaguchi, Prather, Riew, Karanikolas, Lenk and Galatz in the sum of \$40,052.80.

Claimant returned to work with Employer on October 1, 2001. On October 9, 2001, she was seen by Dr. Josyula for complaints of numbness in her fingers and left hand for the past four or five days, and weakness in her hand muscles. On October 25, 2001, Claimant had electro diagnostic studies performed by Dr. John P. Metzler and an MRI. The MRI showed a disc herniation at the L3-4, and a bulge at the C6-7 levels. Dr. Riew referred Claimant to Dr. Greg Smith for nerve root injections, which were performed in November and December 2001.

On January 2, 2002, Claimant returned to see Dr. Josyula, who referred her to Dr. Riew. It was Dr. Riew's opinion that Claimant's symptoms arose from problems at the C3-4 and C6-7 levels. He recommended a circumferential fusion at both levels. He also stated, "she is going to need to get workers' compensation approval for this and then she will return to see me." At the request of Employer, Claimant was seen by Dr. Dennis M. McGraw on January 28, 2002. Dr. McGraw felt that her ruptured disc was not work related because there was "no specific injury associated", and referred her back to Dr. Riew as soon as possible for treatment.

On March 19, 2002, Claimant underwent a myelogram CT scan which showed a large disc herniation at the C3-4 on the right that compressed the spinal cord. Dr. Riew recommended urgent surgery to remove the old plate and to do an anterior cervical discectomy and fusion at C3-C4, using autograft and a cross plate. On March 25, 2002, surgery was performed. The post-operative diagnoses were herniated nucleus pulposus, C3-4 with myeloradiculopathy, post C4-6 anterior cervical decompression and fusion.

Following her surgery, she continued to treat with Dr. Riew. Claimant's x-rays taken on August 20, 2002 showed a small disc protrusion at C6-7, which was causing some neck pains and numbness and tingling in the left long finger on the left side. Dr. Riew recommended that she should consider surgery if her symptoms worsened. Dr. Riew restricted her lifting to not more than 10 pounds and pushing or pulling to not more than 20 pounds. Claimant testified that the last time she saw Dr. Riew was on February 18, 2003. She was unable to see him because she no longer had insurance. Claimant testified that Dr. Nester is her physician now and he prescribes Hydrocodone for neck and shoulder pain and a muscle relaxant. She uses a cane for foot pain, and for low back pain, which she attributes to her slip and fall on January 11, 2000.

Between October 25, 2001 and February 18, 2003, Claimant incurred medical expenses for treatment while under the care of Drs. Josyula, Smith, Metzler and Riew for treatment of her right and left upper extremities and neck pain in the sum of \$29,989.00.

Dr. Thomas Lee, an orthopedic surgeon, testified on behalf of Employer. Dr. Lee examined Claimant on November 10, 2003. On physical examination, Dr. Lee noted Claimant's forward flexion of the neck was 35 degrees compared to 65 degrees in a normal patient her age. Extension of her neck was limited to 25 degrees compared to normal of 55-65 degrees. Rotation of the neck was limited to 35 degrees in each direction compared to normal of 80-85 degrees. Claimant's limitations were consistent with her two spinal surgeries. Impingement sign and internal rotation testing showed a slightly decreased internal rotation on the right with internal rotation to the L3 verses the T12, suggesting adhesive capsulitis on the right. On testing of the wrist, Phalen's was positive on the right, which suggested that there was some residual from the carpal tunnel syndrome.

Based upon a reasonable degree of medical certainty, Dr. Lee opined that Claimant's right carpal tunnel syndrome was causally related to her work activities as a Head Cook. He ascribed a 6% permanent partial disability to her right wrist, but no disability to her left wrist because of the lack of symptoms at the time of the examination. Dr. Lee did not believe that Claimant's right shoulder and neck complaints were work related, and therefore did not offer an opinion on nature and extent of disability.

On cross-examination, Dr. Lee acknowledged that Dr. Ollinger and BJC treated Claimant for right shoulder and cervical complaints. Dr. Lee further acknowledged that tendonitis and adhesive capsulitis, as a secondary response to tendonitis, could be caused by repetitive motion. Likewise, under some circumstances, herniation of the cervical disc could be caused by repetitive trauma to the neck.

According to the medical records reviewed by Dr. Lee, on April 30, 1999, Claimant sustained a parathoracic strain which required conservative medical treatment. Dr. Lee described her injury to the upper back between the shoulder blades. Further, the record showed that Claimant sustained a work injury on January 11, 2000 that required medical treatment provided by Dr. Andrew Wayne. According to the medical records, Claimant sustained a cervical strain, which could have weakened the integrity of the cervical spine temporarily, including the neck, which could have made her more vulnerable to cervical disc herniation. The cervical x-rays taken by Dr. Wayne and the August 17, 1999 MRI were consistent in that both showed wear and tear changes in the spine. Finally, Dr. Lee acknowledged that the medical treatment provided Claimant was reasonable and necessary to help relieve Claimant's shoulder and neck complaints, and that the charges for such treatment

were reasonable.

Dr. David Volarich testified on behalf of Claimant. When Dr. Volarich saw Claimant in March 2003, she continued to have problems with diminished motion and pain at the base of the skull in both trapezius muscles, right more left. She was having problems with radiating pain into the index and long fingers of both hands. She also reported headaches that occurred two or three days of the week, which were located in the temple portion of the skull, the forehead, and at the base of the skull and neck. She reported that fixed positions aggravated her neck pain, and that she could only sit for 30 minutes. Overhead use of her arms was difficult because of the diminished motion of her neck, and that she could not look up without having neck pain. Claimant has difficulty performing any repetitive hand activities. If she writes one letter, her hand fatigues. Dexterity is diminished to the point where she is unable to work on the computer. Her grip strength is diminished and she has difficulty using tools.

On physical examination, Claimant's cervical spine range of motion was severely restricted. Palpation of the neck elicited pain in the trapezius muscles at the insert of the dorsal junction, the right being worse than the left. Dr. Volarich also found trigger points at the C6-7 midline. There was also loss of range of motion of the thoracic spine. Palpation of the mid back elicited pain in the paraspinal muscles, the right being worse than the left, from the T4 to the T8. Further, there was loss of range of motion in the lumbar spine. Dr. Volarich also found a right trigger point in the right sacrospinous notch. Straight leg raising was accomplished at 70 degrees on the left with back pain and on the right at 45 degrees with back pain that radiated into the right thigh and calf. In the right shoulder, there was a 10% loss of motion as evaluated by the Apley Scratch Test. There was also a similar loss of motion in the left shoulder and trapezius pain with weakness.

Examination of the hands showed the dexterity to the fingers was slow bilaterally. There was a one-centimeter scar over the ventral surface of the right wrist from her carpal tunnel release. Grip strength in the right as compared to the left was weak. Further, Dr. Volarich found asymmetric bulk loss in the upper extremities. Strength in both shoulders was weak to confrontational testing of the deltoid and rotator cuff. The tricep on the right was also weak. Finally, Dr. Volarich noted that Claimant walked with forward flexion at the waist by approximately 15 degrees and she moved about the examination room slowly.

After reviewing the medical records and taking a detailed job description from Claimant, Dr. Volarich concluded that her work activities were a substantial contributing factor in causing bilateral carpal tunnel syndrome, which required right endoscopic carpal tunnel release and cervical disc herniations at the C4-5 and C5-6 that required a two level discectomy and fusion with instrumentation. Further, Claimant's repetitive activities also aggravated her right shoulder AC joint, degenerative arthritis, and caused some rotator cuff tendonitis. Specifically, Dr. Volarich felt that these conditions were a result of her having to lift heavy objects at work, work in awkward positions, and perform a lot of bending, twisting, stooping and overhead work. Dr. Volarich also testified that the medical treatment offered by Drs. Josyula, Yamaguchi, Prather, Riew and Lenk was reasonable and necessary to alleviate the effects of her work-related injuries to her right upper extremity, shoulder and neck. Dr. Volarich further testified, based upon a reasonable degree of medical certainty, the normal recuperative period following an endoscopic release of carpal tunnel was approximately six weeks.

Dr. Volarich testified that after her first neck surgery, Claimant was vulnerable to further herniation of the disc space above or below the fusion. Dr. Volarich explained that when a patient bends her head forward, for example, all of the stress is going to be at the C3-4 level, or at the C6-7 level. After she returned to work as a Head Cook on October 1, 2001, Claimant herniated the cervical disc space above the fused disc as a result of her repetitive work activities.

With respect to the May 7, 1998 claim, based upon a reasonable degree of medical certainty, Dr. Volarich opined that there is a 35% permanent partial disability of the right upper extremity rated at the right wrist due to the carpal tunnel syndrome that required endoscopic carpal tunnel release. The rating accounts for her pain, paresthesias and weakness in her dominant hand. Additionally, there was a 20% permanent partial disability of the left upper extremity rated at the wrist due to mild carpal tunnel syndrome. The rating accounted for pain, paresthesias and weakness in the non-dominant hand. Further, there is a 15% permanent partial disability of the right upper extremity of the shoulder due to aggravation of the AC joint, degenerative arthritis, and rotator cuff tendonitis, that required conservative care. The rating takes into account her pain, paresthesias and weakness in the dominant shoulder. There is also a 40% permanent partial disability of the body as a whole, rated at the cervical spine, due to the cervical disc herniation at the C4-5, and at the C5-6, which required discectomy and fusion with instrumentation. The rating accounted for the injury's contribution to neck pain, loss of motion and headaches.

Dr. Volarich opined as a result of the November 14, 2001 injury, there is an additional 25% permanent partial disability to the body as a whole, rated at the cervical spine due to the disc herniation at C3-4 (above the prior fusion), which required discectomy and fusion with instrumentation. The rating takes into account the injury's contribution to her neck pain and loss of motion.

Pertaining to the April 30, 1999 injury, he attributed is a 15% permanent partial disability of the body as a whole rated at the thoracolumbar spine due to the sprain/strain injury that required conservative care. The rating takes into account claimant's ongoing pain and loss of motion.

With respect to the January 2000 injury, he found a 10% permanent partial disability referable to the body as a whole, rated at the lumbosacral spine due to the sprain/strain injury that required conservative care, and a 5% permanent partial disability of the body as a whole rated at the cervical spine due to the sprain/strain injury that required conservative care. Dr. Volarich further concluded that the disabilities suffered by Claimant were greater than their simple sum and that a loading factor should be added to the disability ratings.

Dr. Volarich advised Claimant to limit repetitive bending, twisting, lifting, pushing, pulling, carrying and climbing and other similar tasks to an as-needed basis. He recommended that she not handle any weight greater than 10 to 15 pounds and to limit this task to an occasional basis assuming proper lifting techniques. He recommended against handling weight over her head and away from her body, and/or carrying weight over long distances or on uneven terrain. She was advised to avoid remaining in fixed positions for longer than 15 to 30 minutes, including both sitting and standing, and to change positions frequently to maximize comfort and to rest when needed. Claimant was directed not to handle any weights greater than 1 to 2 pounds with either upper extremity alone, particularly with her arms extended away from her body. Close to the body, he recommended against lifting more than 3 to 5 pounds. Finally, he recommended appropriate stretching, strengthening and range of motion exercise programs, in addition to non-impact aerobic conditioning such as walking, biking or swimming to tolerance daily.

Based upon his May 2003 examination, he felt Claimant had reached maximum medical improvement as a result of her work accidents, but cautioned that she may require additional care for her disc protrusions at the C3-4 and C6-7 as well as the reported lumbar spine disc herniations. Further, in order to maintain her current state, Dr. Volarich opined that she would require ongoing care for her pain syndrome using narcotics and non-narcotic medications (NSAIDS), muscle relaxants, other such similar treatments for symptomatic relief.

Finally, Dr. Volarich recommended that Claimant undergo vocational evaluation and assessment to determine if she might be able to return to work. Claimant was evaluated by Mr. Timothy Lalk on September 25, 2003.

Mr. Lalk testified on behalf of Claimant. Based upon a reasonable degree of professional certainty, Mr. Lalk concluded Claimant is not able to secure and maintain employment in the open labor market, and is not able to compete for any position because of her medical conditions.

In summary, Mr. Lalk described Claimant as having basically worked in entry-level positions, primarily in food service. Considering the restrictions given to her by Dr. Volarich, Claimant would not be able to function in an unskilled sedentary position on a regular basis. At the time of her evaluation, she had been out of school for approximately 30 years. Mr. Lalk explained persons in Claimant's position often have difficulty getting back into the discipline of a formal education program. Based upon her physical restrictions and problems, Claimant is not a candidate for vocational rehabilitation.

Based upon Dr. Volarich's review of the report of Dr. Lalk, he determined that Claimant was permanently and totally disabled as a result of the combination of her work related injuries leading up to May 7, 1998, April 30, 1999, January 11, 2000, and November 14, 2001.

Claimant last worked on January 31, 2002. She does not believe she can return to any form of work because of her chronic pain. She has limitation of motion in her neck and shoulders. She habitually rubs her right hand because of numbness and tingling in her fingers. She has difficulty gripping and firmly holding onto objects. She has difficulty standing and sitting for prolonged periods of time and uses a cane. During the hearing she frequently changed positions, had difficulty rising from a seated position, and asked for water to take pain medication. The pain medication interferes with her ability to concentrate, and makes her drowsy. Throughout the day, she needs to lie down or sit in a reclined position using a pillow to support her neck. She has a pain in her neck at night that interferes with sleep. She is continuously fatigued. Although she has a driver's license and a handicap license plate, she relies upon her daughters to drive her, except when traveling short distances. She also relies upon her daughters to perform housework, daily chores, and cooking. Claimant also needs assistance getting in and out of the shower.

As a result of the two neck surgeries, Claimant is left with a large surgical scar across her neck. Claimant has been asked if she was attacked, causing her embarrassment. Claimant is not, however, bothered by her right wrist surgical scar.

Claimant testified in a credible and truthful manner.

## RULINGS OF LAW

Based upon my observations of Claimant at hearing, my comprehensive review of the medical evidence, and the application of Missouri law, I find:

As a result of the May 7, 1998 injury, Claimant sustained a 17 ½% permanent partial disability of the right upper extremity rated at the wrist. Claimant failed to prove that she sustained any permanent partial disability as a result of her left carpal tunnel syndrome. I further find Claimant has a 10% permanent partial disability of the right upper extremity at the shoulder due to aggravation of the AC joint, degenerative arthritis, and rotator cuff tendonitis. Further, Claimant sustained a 25% permanent partial disability of the body as a whole, rated at the cervical spine due to a disc herniation of the C4-5 and C5-6, which required surgery in 2001. A load factor of 10% should be applied. Accordingly, Claimant is entitled to 169 weeks of permanent partial disability benefits from Employer. Further, she is entitled to an additional 6 weeks of disfigurement for her neck scar. No disfigurement is awarded for her right wrist scar.

As a result of the May 7, 1998 injury, Claimant is awarded \$40,052.80 which are reasonable necessary medical expenses to help cure and alleviate the effects of her work related injury. Further, Claimant is owed temporary total disability benefits as a result of her surgery on the right wrist from June 5, 1998 to August 26, 1998 (11 5/7 weeks), and from January 31, 2001 to October 1, 2001 as a result of her first neck surgery (34 4/7 weeks).

Claimant failed to prove that she sustained any permanent partial disability as a result of her April 30, 1999 injury, and no permanent partial disability benefits are awarded. The claim against the Second Injury Fund is dismissed.

Claimant has a 5% permanent partial disability of the body as a whole rated at the lumbar spine due to a sprain/strain injury, and no additional permanent partial disability at the cervical spine due to her sprain/strain injury resulting from her January 11, 2000 work accident, for a total of 20 weeks of permanent partial disability. Because it does not rise to the requisite level of permanent partial disability to trigger Second Injury Fund liability, no benefits are awarded, and the claim against the Second Injury Fund is dismissed.

Claimant's repetitive work activities are a substantial factor in causing her diagnosed herniated disc in October 2001, her subsequent medical treatment and resulting disability. As a result of the November 14, 2001 work related injury, Claimant sustained a 25% permanent partial disability of the body as a whole rated at the cervical spine due to the disc herniation at the C3-4 that required a discectomy and fusion with instrumentation. Additionally, Claimant is entitled to recovery of 6 weeks of disfigurement for her second surgical scar. Further, Claimant is entitled to recover her reasonable and necessary medical expenses incurred to alleviate the effects of her work related injury in the total sum of \$29,989.00 for treatment rendered between October 25, 2001 and February 18, 2003. As a result of this last injury, Claimant was temporarily and totally disabled from January 17, 2002 through January 25, 2002, and from January 31, 2002 through February 18, 2003, when she last saw Dr. Riew (55 6/7 weeks).

Claimant has failed to meet her burden of proving that Employer is liable for future medical benefits, and none are awarded.

Claimant's employment as a Head Cook was hand intensive, and she was required to lift heavy objects on a frequent and routine basis, in awkward positions, at and above her head. Based upon the well-reasoned opinions of Dr. Volarich, and taking into consideration the repetitive nature of her work over a period of more than 20 years, I conclude her work activities were a substantial factor in causing her diagnosed conditions referable to her wrists, right shoulder, and neck, resulting in substantial medical treatment, lost time from work, and severe permanent disabilities.

In arriving at my decision, I note Employer failed to promptly respond to Claimant's requests for medical treatment and refused her requests for a step stool to avoid having to stand on her toes and lift at or above her shoulders. Claimant had been experiencing problems for more than a year before her supervisor completed a report of injury and referred her for treatment. A report was not completed until after Claimant lost control of her right hand and spilled soup on a customer. According to the medical records, Claimant's complaints were not limited simply to her right and left wrists. She also complained of right shoulder and neck pain. Dr. Ollinger, Employer's authorized medical provider, treated her with prescription medications for her right shoulder complaints. Despite the recommendations of Dr. Ollinger, Employer refused to refer Claimant to an orthopedist.

Drs. Ollinger, Volarich and Lee agree that Claimant's diagnosed carpal tunnel syndrome is work related. Dr. Lee disagrees, however, with Dr. Volarich on the causal relationship between claimant's work activities and her diagnosed right shoulder and neck problems. I find Dr. Lee's opinion on the issues of causation with regard to the neck and shoulder

unpersuasive.

Dr. Lee's conclusion that Claimant's right shoulder problems are not work related lacks explanation. Dr. Lee's conclusionary opinion overlooks the fact that Dr. Ollinger provided treatment for Claimant's shoulder. Dr. Lee's opinion on causation also ignores the repetitive nature of Claimant's work and is inconsistent with his own testimony that tendonitis and adhesive capsulitis, as a secondary response to tendonitis, can be caused by repetitive motion.

For similar reasons, I reject Dr. Lee's causation opinion regarding Claimant's multi-level cervical disc herniations. Dr. Lee attributes Claimant's neck problems to degenerative changes in the spine. Dr. Lee's opinion, however, disregards the cause of the degenerative changes. By his own description, the August 17, 1999 MRI findings and the x-rays taken by Dr. Wayne showed wear and tear change. Furthermore, Dr. Lee admitted that Claimant's disc herniations could have been caused by repetitive trauma.

With respect to the November 2001 claim, I find Dr. McGraw's causation opinion is unsupported by a rational explanation and is otherwise unconvincing. Following her first neck surgery, and within days after returning to work, Claimant began to experience new problems with her neck and right upper extremity. As explained by Dr. Volarich, her first spinal fusion made her vulnerable to additional cervical disc herniations above or below the fused disc space. Although Claimant was returned to work with restrictions, it is clear that Claimant's work activities were a substantial factor in causing the large disc herniation at the C3-4 level on the right requiring medical treatment, including surgery, and resulting in additional disability.

Finally, as a result of the last injury in combination with her preexisting disabilities, Claimant was rendered permanently and totally disabled under the Workers' Compensation Act. Accordingly, the Second Injury Fund is liable for the payment of permanent total disability benefits for the rest of Claimant's life.

Claimant suffered disabilities as a result of her May 7, 1998, January 11, 2000, and November 14, 2001 work injuries. These disabilities constituted a hindrance or obstacle to employment. Following her last injury, she has not been able to return to work because of her intractable pain. I find Claimant's testimony to be credible. The record also shows that Claimant suffers from disabling pain that severely limits her ability to perform her daily activities, let alone unskilled sedentary work on a sustained basis. Accordingly, based upon

Claimant's credible testimony and the expert reports and testimony of Dr. Volarich and Mr. Lalk, I find that Claimant is unable to compete in the open labor market and, thus, is permanently and totally disabled.

This award is subject to an attorney's lien of 25% in favor of Claimant's attorney, Mr. Charles Bobinette.

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

Margaret D. Landolt  
*Administrative Law Judge*  
*Division of Workers' Compensation*

A true copy: Attest:

\_\_\_\_\_  
Patricia "Pat" Secret  
*Director*  
*Division of Workers' Compensation*

Issued by THE LABOR AND INDUSTRIAL RELATIONS COMMISSION

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

Injury No.: 99-054526

Employee: Diane Smith

Employer: The Board of Education of the City of St. Louis

Insurer: Self-Insured

Additional Party: Treasurer of Missouri as Custodian  
of Second Injury Fund

Date of Accident: Alleged April 30, 1999

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

The above-entitled workers' compensation case is submitted to the Labor and Industrial Relations 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 November 14, 2005, and awards no compensation in the above-captioned case.

The award and decision of Administrative Law Judge Margaret D. Landolt, issued November 14, 2005, is attached and incorporated by this reference.

Given at Jefferson City, State of Missouri, this 24<sup>th</sup> day of August 2006.

#### LABOR AND INDUSTRIAL RELATIONS COMMISSION

\_\_\_\_\_  
William F. Ringer, Chairman

\_\_\_\_\_  
Alice A. Bartlett, Member

\_\_\_\_\_  
John J. Hickey, Member

Attest:

\_\_\_\_\_  
Secretary

### AWARD

Employee: Diane Smith Injury No.: 99-054526

Dependents: N/A Before the  
**Division of Workers'**

Employer: The Board of Education of the City of St. Louis **Compensation**  
Department of Labor and Industrial

Additional Party: Second Injury Fund Relations of Missouri  
Jefferson City, Missouri

Insurer: Self-Insured

Hearing Date: August 8, 2005 Checked by: MDL:tr

**FINDINGS OF FACT AND RULINGS OF LAW**

- 1. Are any benefits awarded herein? No
- 3. 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
- 6. Date of accident or onset of occupational disease: April 30, 1999
- 7. State location where accident occurred or occupational disease was contracted: St. Louis
- 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
- 10. 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:  
Employee was pulling a bread rack.
- 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: N/A
- 15. Nature and extent of any permanent disability: N/A
- 15. Compensation paid to-date for temporary disability: -0-
- 16. Value necessary medical aid paid to date by employer/insurer? \$342.13

Employee: Diane Smith Injury No.: 99-054526

- 17. Value necessary medical aid not furnished by employer/insurer? -0-
- 19. Employee's average weekly wages: \$416.21
- 19. Weekly compensation rate: \$277.47/\$277.47
- 20. Method wages computation: Stipulation

**COMPENSATION PAYABLE**

- 21. Amount of compensation payable: -0-
- 22. Second Injury Fund liability: No
- 23. Future requirements awarded: N/A

TOTAL: -0-

Said payments to begin N/A 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 N/A of all payments hereunder in favor of the following attorney for necessary legal services rendered to the claimant:

N/A

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

Employee:	Diane Smith	Injury No.: 99-054526
Dependents:	N/A	Before the <b>Division of Workers' Compensation</b>
Employer:	The Board of Education of the City of St. Louis	Department of Labor and Industrial Relations of Missouri
Additional Party:	Second Injury Fund	Jefferson City, Missouri
Insurer:	Self-Insured	Checked by: MDL:tr

### **PRELIMINARIES**

A hearing was held on August 8, 2005, at the Division of Workers' Compensation in the City of St. Louis. Diane Smith ("Claimant") was represented by Mr. Charles Bobinette. The Board of Education of the City of St. Louis ("Employer"), which was self-insured, was represented by Ms. Robin Higgins. The Second Injury Fund was represented by Assistant Attorney General Rachel Paul. Claimant filed four claims: 98-068375 (date of injury May 7, 1998); 99-054526 (date of injury April 30, 1999); 00-005912 (date of injury January 11, 2000); and 01-161057 (date of injury November 14, 2001). By agreement, the claims were consolidated and tried together. Claimant's attorney requested a fee of 25% of Claimant's awards.

In Injury Number 98-068375, the parties stipulated that Claimant's average weekly wage is \$359.06, and the permanent partial and temporary total disability rate is \$239.37. Employer paid \$6,780.65 in medical expenses. The issues in this claim are occupational disease, medical causation, past due temporary total disability benefits, past medical expenses, disfigurement, and nature and extent of permanent partial disability referable to the right and the left wrists, right upper extremity, shoulder and neck.

In Injury Number 99-054526, the parties stipulated that as of April 30, 1999, Claimant's average weekly wage was \$416.21, yielding a permanent partial disability rate of \$277.47. Employer paid \$342.13 in medical expenses, and no temporary total disability benefits. The issues presented are nature and extent of permanent partial disability referable to the back, and liability of the Second Injury Fund.

In Injury Number 00-005912, the parties stipulated Claimant's average weekly wage is \$434.94 and the permanent partial disability rate is \$289.96. Employer paid \$1,976.93 in medical expenses, and no temporary total disability benefits. The issues are nature and extent of permanent partial disability of the neck and lower back, and liability of the Second Injury

Fund.

In Injury Number 01-161057, the parties stipulated Claimant's average weekly wage is \$460.18, and the total disability and permanent partial disability rate is \$306.79. Employer paid \$1,005.11 in medical expenses, and no temporary total disability benefits. The issues presented for resolution are occupational disease, medical causation, past due temporary total disability benefits, disfigurement, past and future medical expenses, nature and extent of permanent partial disability, permanent total disability, and liability of the Second Injury Fund.

### **FINDINGS OF FACT**

Claimant is 50 years old and is right-handed. In 1972, after completing the eleventh grade at Sumner High School, she dropped out of school. In the early 1980s, she obtained her GED. Claimant has no vocational training, office experience, or computer or typing skills. In the early 1970s, Claimant worked at a McDonald's restaurant as a food service worker for a couple of months. She then moved to Michigan where she worked at a factory assembling toys for about a year. In 1973, she returned to St. Louis.

In 1978, Employer hired Claimant as a food service worker preparing lunches. She was promoted to Baker, and eventually to a Head Cook II. She worked from 6:00 a.m. to 2:30 p.m., Monday through Friday, ten months a year. She prepared approximately 200 breakfasts and 600 lunches each day as a Head Cook. She supervised ten to eleven workers. She was not required to plan menus, order food, or perform personnel work. Sometimes, she had to help serve the food as a fill-in when another worker was absent. She spent most of her time on her feet, and performed paperwork at the end of the day. Daily, she used both hands for slicing, dicing, peeling, scooping, pulling, cutting and stirring. When cooking, the heaviest she had to lift were pans, which weighed between 35 and 40 pounds when filled. She was required to reach overhead and use her upper extremities constantly. Claimant continuously looked down as she cooked, and raised her head backwards when she lifted. When lifting, she had to stand on her toes holding the pans in her hand and reach overhead to put them into the oven or rack. Claimant asked her supervisor for a step stool, but was never provided with one.

Claimant began experiencing problems with her hands, right shoulder and neck in late 1996 or early 1997. Although she requested medical treatment on several occasions, her supervisor did not prepare a report until Claimant lost control of her hand and spilled hot soup on a customer. On April 7, 1998, Claimant was seen by her private physician, Dr. Josyula, who suspected bilateral carpal tunnel syndrome and diagnosed cervical strain. Dr. Josyula felt that her condition was work related.

Eventually, on April 29, 1998, Employer referred Claimant to Dr. Ollinger, who diagnosed possible bilateral carpal tunnel syndrome substantially related to her work activities, and a small ganglion volar of the right wrist (not work related). Nerve conduction studies performed on the same day were abnormal on the right hand and normal on the left. On May 7, 1998, Dr. Ollinger prescribed medications and hand splints to be worn at night. Dr. Ollinger suggested that if she did not respond to medical treatment, she should be referred to an orthopedist for her shoulder complaints.

On June 11, 1998, Claimant continued to complain of bilateral numbness and tingling of her hands, and right shoulder pain. Dr. Ollinger recommended surgery on the right wrist, and an orthopedic referral for her right shoulder problem if her symptoms continued after her carpal tunnel syndrome surgery and post op rest.

Surgery was performed at Missouri Baptist Hospital on June 23, 1998. On July 6, 1998, Dr. Ollinger recommended alternative work with light use of the right hand, no power gripping, and a five-pound lifting restriction. Dr. Ollinger released Claimant to regular work on September 24, 1998. On December 3, 1990, Dr. Ollinger gave Claimant a 0% permanent partial disability rating on both wrists, and found no symptoms or signs of left carpal tunnel syndrome. He noted that her NCVs were normal. He did not feel that Claimant required any additional evaluation, care or work restrictions, and felt Claimant was at maximum medical improvement. On January 7, 1999, Employer refused to authorize any additional medical treatment for Claimant based upon Dr. Ollinger's report.

Claimant planned to work during the summer school break cleaning offices with her sister. Because of the planned surgery and her recovery, she remained unemployed between June 5 and the start of school on August 26, 1998. On September 24, 1998, Dr. Ollinger released Claimant for regular work.

Claimant continues to have difficulty with her right hand following her surgery. She frequently rubs her right hand to alleviate her pain. She has reduced strength, which results in difficulty with such tasks as opening jars, combing her hair, vacuuming, and grasping items. She frequently drops things.

On January 15, 1999, Claimant was seen by Dr. Josyula for right shoulder problems. Claimant reported that for the past several months, she had been having progressive discomfort in her right shoulder area, and that her work involved

picking up steam table pans on a regular basis. At the time of her examination, she could not raise her arm above her head. She was diagnosed with a history of rotator cuff strain versus tear. She was prescribed medications, and referred to Dr. Kenneth Yamaguchi, an orthopedic surgeon.

On February 22, 1999, Claimant was seen by Dr. Yamaguchi. On physical examination, she had pain with increased internal rotation, weakness and tenderness. Claimant also had pain with extreme cervical spine extension with some recreation of the shoulder pain symptoms. She complained of fatigue in her arm with mild activities. Dr. Yamaguchi felt that she had right rotator tendonitis with possible cervical spine radiculopathy. The area was injected, physical therapy was prescribed, and she was referred to Dr. Heidi Prather.

Dr. Prather evaluated Claimant on March 11, 1999, and diagnosed cervical segmental dysfunction and to rule out cervical radiculopathy and rotator cuff tendonitis. Claimant was prescribed Lodine for pain control, physical therapy for flexibility, and strengthening exercises for her cervical spine. X-rays of the cervical spine taken on March 11, 1999 revealed mild degenerative disc disease at the C4-5 levels.

On March 17, 1999, Claimant, through her counsel, notified Employer that she was seeking medical treatment on her own and would look to Employer for reimbursement.

Between March 11 and May 13, 1999, Claimant had eight sessions of physical therapy. Although her right shoulder pain improved, her right lateral neck pain continued.

On April 30, 1999, Claimant suffered a work-related injury when she jolted her mid back when pulling a bread rack from the walk-in refrigerator at work. She was seen at BJC Corporate Health on April 30, 1999. X-rays of her thoracic spine were negative, and Ibuprofen was prescribed. Claimant was diagnosed with a parathoracic sprain. Claimant was off work until May 3, 1999, at which time she was returned to full duty.

On July 27, 1999, Claimant was in tears when she was seen by Dr. Josyula complaining of worsening of her right shoulder discomfort. Claimant was unable to elevate her shoulder above her head and was having difficulty ambulating normally. Claimant was given a Toradol shot and referred back to Dr. Prather. An MRI of the cervical spine performed on August 17, 1999 revealed focal kyphosis with surrounding muscle spasm from C4-C5 intervertebral disc herniation, with extruded disc material.

Claimant came under the care of Dr. Daniel Riew on August 31, 1999. According to his records, she complained of neck and arm pain for approximately 1-½ years, which she related to lifting at work. She also reported having problems picking up small objects. She reported her worst position was standing, and lying down eased her pain. Dr. Riew diagnosed interscapular pain, shoulder pain, radiculopathy secondary to herniated disc at 4-5, cervical kyphosis and foraminal stenosis at 4-5 and to a lesser extent at 5-6. He recommended epidural steroid injections and, if they failed to resolve the problem, surgery.

On September 22, 1999, Claimant was seen at the BJC Pain Management Center by Dr. Karanikolas complaining of pain in the neck, right shoulder, and right upper extremity radiating into the fingers since April 1997. Initially, the pain was sharp in her neck and shoulder and became a continuous dull pain down her right arm and into her fingers. Associated symptoms included nausea, dizziness, blurred vision, numbness, tingling, noise sensitivity, and irritability. Examination of the neck showed muscle spasms and trigger points with tenderness over the cervical vertebrae. Dr. Karanikolas diagnosed bilateral foraminal C4-5 and C5-6 stenosis, chronic right sided neck and upper extremity pain, with significant myofascial pain components, right sided radiculopathy, and slight weakness of the right upper extremity, apparently related to radiculopathy. The recommended treatment plan included physical therapy, epidural injections, Medrol dose pack, and trigger point injections.

On January 11, 2000, Claimant was putting chicken wraps into the oven when she knocked over a bucket of grease, slipped, and fell, burning her left hip on hot grease. Claimant was treated at Barnes Care where x-rays were taken of the low back and left hip. Left hip films revealed mild bilateral hip osteoarthritis without fracture. Low back films were negative. Cervical spine films showed: a straightening of the cervical spine without evidence of fracture, incomplete visualization of the C7 vertebral body and mild cervical spondylosis at the C4-5. Claimant was prescribed physical therapy and medications and given a ten-pound lifting restriction. Claimant was referred to Dr. Wayne who diagnosed right worse than left sacroiliitis, lumbosacral sprain, cervical sprain, and status post left elbow contusion, and continued Claimant's conservative treatment.

On February 28, 2000, Dr. Wayne recorded that Claimant had moderate improvement with therapy, but continued to

experience pain in her neck and low back. Her cervical range of motion was approximately 80% of normal. She was 75% of normal on left rotation with most of the pain being in the right lower neck, left rotation. Lumbosacral range of motion showed 75% of normal on flexion. Dr. Wayne prescribed three more weeks of physical therapy and limited duty. On March 14, 2000, Claimant reported that she continued to have difficulty performing her job because of her pain in the trapezius region with stirring and overhead lifting. Lumbosacral range of motion was within normal limits. Cervical range of motion was approximately 80% of normal for extension and in flexion. Dr. Wayne found her to be at maximum medical improvement and released her to full duty. As of April 5, 2000, Dr. Wayne felt that Claimant sustained a 5% permanent disability of the neck, but no disability to the lumbar region as a result of her work accident of January 11, 2000.

Claimant continued her medical treatment with Drs. Josyula and Riew. On November 17, 2000, she reported to Dr. Josyula that she had complaints of pain and discomfort involving her right shoulder area and that her arm strength was diminished. Medications were prescribed and she was referred to Dr. Riew for possible surgical intervention. She next saw Dr. Josyula on December 4, 2000 for pain in the upper neck and shoulders and asked to be taken off work because of her problems.

On January 23, 2001, she was seen by Dr. Riew. A repeat MRI of the cervical spine was performed on February 5, 2002, which revealed cervical kyphosis, cord compromise at C4-5 and to a lesser extent, at C5-6. Dr. Riew suggested surgery.

Claimant was referred for a second opinion to Dr. Christina Lenk, who recommended an EMG and nerve conduction study, and prescribed medications for her pain symptoms. The March 1, 2001 EMG nerve conduction studies were consistent with C4-5 radiculopathy and milder underlying median nerve lesion at the right wrist. Dr. Lenk suggested it was likely that surgery would be needed, but recommended a more conservative approach, including another course of physical therapy and pain medications.

According to the Barnes Jewish Hospital medical records, on March 12, 2001, Dr. Riew performed a carpectomy of the C5, and fusion of the C4-C6 with anterior cervical plate mesh cages, and right iliac crest bone grafting. The postoperative diagnosis was cervical herniated disc and spondylosis causing mild radiculopathy at the C4-5 and C5-6 levels.

Claimant was taken off of work while she recuperated from her surgery. When Claimant followed up with Dr. Riew on April 24, 2001, she stated that she continued to have upper trapezial pain, but that her arm symptoms had resolved. On June 19, 2001, she continued to complain of trapezial pain and occasional pain in her arm, although her tingling and numbness had improved. Dr. Riew felt that there were two explanations for her continued problems: (1) that she was beginning to heal; and, (2) there was a possibility that she was having problems at the C4-5 and C6-7 levels. He recommended that Claimant continue to wear her cervical collar and try to increase her aerobic exercise. On July 24, 2001, Dr. Riew referred Claimant to Dr. Galatz for treatment of her right shoulder pain.

Claimant complained to Dr. Galatz that she could not sleep at night, and she had trouble lifting her right arm over her head. Claimant was diagnosed with rotator cuff tendonitis and was injected with Cortisone and Lidocaine.

Claimant was next seen by Dr. Galatz on September 18, 2001. She reported that her shoulder felt good after the injection, however the pain had returned in moderate intensity. Dr. Riew ordered physical therapy.

Between January 1999 and September 18, 2001, Claimant incurred medical expenses for treatment of her right shoulder and neck while under the treatment of Drs. Josyula, Yamaguchi, Prather, Riew, Karanikolas, Lenk and Galatz in the sum of \$40,052.80.

Claimant returned to work with Employer on October 1, 2001. On October 9, 2001, she was seen by Dr. Josyula for complaints of numbness in her fingers and left hand for the past four or five days, and weakness in her hand muscles. On October 25, 2001, Claimant had electro diagnostic studies performed by Dr. John P. Metzler and an MRI. The MRI showed a disc herniation at the L3-4, and a bulge at the C6-7 levels. Dr. Riew referred Claimant to Dr. Greg Smith for nerve root injections, which were performed in November and December 2001.

On January 2, 2002, Claimant returned to see Dr. Josyula, who referred her to Dr. Riew. It was Dr. Riew's opinion that Claimant's symptoms arose from problems at the C3-4 and C6-7 levels. He recommended a circumferential fusion at both levels. He also stated, "she is going to need to get workers' compensation approval for this and then she will return to see me." At the request of Employer, Claimant was seen by Dr. Dennis M. McGraw on January 28, 2002. Dr. McGraw felt that her ruptured disc was not work related because there was "no specific injury associated", and referred her back to Dr. Riew as soon as possible for treatment.

On March 19, 2002, Claimant underwent a myelogram CT scan which showed a large disc herniation at the C3-4 on the right that compressed the spinal cord. Dr. Riew recommended urgent surgery to remove the old plate and to do an anterior cervical discectomy and fusion at C3-C4, using autograft and a cross plate. On March 25, 2002, surgery was performed. The post-operative diagnoses were herniated nucleus pulposus, C3-4 with myeloradiculopathy, post C4-6 anterior cervical decompression and fusion.

Following her surgery, she continued to treat with Dr. Riew. Claimant's x-rays taken on August 20, 2002 showed a small disc protrusion at C6-7, which was causing some neck pains and numbness and tingling in the left long finger on the left side. Dr. Riew recommended that she should consider surgery if her symptoms worsened. Dr. Riew restricted her lifting to not more than 10 pounds and pushing or pulling to not more than 20 pounds. Claimant testified that the last time she saw Dr. Riew was on February 18, 2003. She was unable to see him because she no longer had insurance. Claimant testified that Dr. Nester is her physician now and he prescribes Hydrocodone for neck and shoulder pain and a muscle relaxant. She uses a cane for foot pain, and for low back pain, which she attributes to her slip and fall on January 11, 2000.

Between October 25, 2001 and February 18, 2003, Claimant incurred medical expenses for treatment while under the care of Drs. Josyula, Smith, Metzler and Riew for treatment of her right and left upper extremities and neck pain in the sum of \$29,989.00.

Dr. Thomas Lee, an orthopedic surgeon, testified on behalf of Employer. Dr. Lee examined Claimant on November 10, 2003. On physical examination, Dr. Lee noted Claimant's forward flexion of the neck was 35 degrees compared to 65 degrees in a normal patient her age. Extension of her neck was limited to 25 degrees compared to normal of 55-65 degrees. Rotation of the neck was limited to 35 degrees in each direction compared to normal of 80-85 degrees. Claimant's limitations were consistent with her two spinal surgeries. Impingement sign and internal rotation testing showed a slightly decreased internal rotation on the right with internal rotation to the L3 verses the T12, suggesting adhesive capsulitis on the right. On testing of the wrist, Phalen's was positive on the right, which suggested that there was some residual from the carpal tunnel syndrome.

Based upon a reasonable degree of medical certainty, Dr. Lee opined that Claimant's right carpal tunnel syndrome was causally related to her work activities as a Head Cook. He ascribed a 6% permanent partial disability to her right wrist, but no disability to her left wrist because of the lack of symptoms at the time of the examination. Dr. Lee did not believe that Claimant's right shoulder and neck complaints were work related, and therefore did not offer an opinion on nature and extent of disability.

On cross-examination, Dr. Lee acknowledged that Dr. Ollinger and BJC treated Claimant for right shoulder and cervical complaints. Dr. Lee further acknowledged that tendonitis and adhesive capsulitis, as a secondary response to tendonitis, could be caused by repetitive motion. Likewise, under some circumstances, herniation of the cervical disc could be caused by repetitive trauma to the neck.

According to the medical records reviewed by Dr. Lee, on April 30, 1999, Claimant sustained a parathoracic strain which required conservative medical treatment. Dr. Lee described her injury to the upper back between the shoulder blades. Further, the record showed that Claimant sustained a work injury on January 11, 2000 that required medical treatment provided by Dr. Andrew Wayne. According to the medical records, Claimant sustained a cervical strain, which could have weakened the integrity of the cervical spine temporarily, including the neck, which could have made her more vulnerable to cervical disc herniation. The cervical x-rays taken by Dr. Wayne and the August 17, 1999 MRI were consistent in that both showed wear and tear changes in the spine. Finally, Dr. Lee acknowledged that the medical treatment provided Claimant was reasonable and necessary to help relieve Claimant's shoulder and neck complaints, and that the charges for such treatment were reasonable.

Dr. David Volarich testified on behalf of Claimant. When Dr. Volarich saw Claimant in March 2003, she continued to have problems with diminished motion and pain at the base of the skull in both trapezius muscles, right more left. She was having problems with radiating pain into the index and long fingers of both hands. She also reported headaches that occurred two or three days of the week, which were located in the temple portion of the skull, the forehead, and at the base of the skull and neck. She reported that fixed positions aggravated her neck pain, and that she could only sit for 30 minutes. Overhead use of her arms was difficult because of the diminished motion of her neck, and that she could not look up without having neck pain. Claimant has difficulty performing any repetitive hand activities. If she writes one letter, her hand fatigues. Dexterity is diminished to the point where she is unable to work on the computer. Her grip strength is diminished and she has difficulty using tools.

On physical examination, Claimant's cervical spine range of motion was severely restricted. Palpation of the neck

elicited pain in the trapezius muscles at the insert of the dorsal junction, the right being worse than the left. Dr. Volarich also found trigger points at the C6-7 midline. There was also loss of range of motion of the thoracic spine. Palpation of the mid back elicited pain in the paraspinal muscles, the right being worse than the left, from the T4 to the T8. Further, there was loss of range of motion in the lumbar spine. Dr. Volarich also found a right trigger point in the right sacrospinous notch. Straight leg raising was accomplished at 70 degrees on the left with back pain and on the right at 45 degrees with back pain that radiated into the right thigh and calf. In the right shoulder, there was a 10% loss of motion as evaluated by the Apley Scratch Test. There was also a similar loss of motion in the left shoulder and trapezius pain with weakness.

Examination of the hands showed the dexterity to the fingers was slow bilaterally. There was a one-centimeter scar over the ventral surface of the right wrist from her carpal tunnel release. Grip strength in the right as compared to the left was weak. Further, Dr. Volarich found asymmetric bulk loss in the upper extremities. Strength in both shoulders was weak to confrontational testing of the deltoid and rotator cuff. The tricep on the right was also weak. Finally, Dr. Volarich noted that Claimant walked with forward flexion at the waist by approximately 15 degrees and she moved about the examination room slowly.

After reviewing the medical records and taking a detailed job description from Claimant, Dr. Volarich concluded that her work activities were a substantial contributing factor in causing bilateral carpal tunnel syndrome, which required right endoscopic carpal tunnel release and cervical disc herniations at the C4-5 and C5-6 that required a two level discectomy and fusion with instrumentation. Further, Claimant's repetitive activities also aggravated her right shoulder AC joint, degenerative arthritis, and caused some rotator cuff tendonitis. Specifically, Dr. Volarich felt that these conditions were a result of her having to lift heavy objects at work, work in awkward positions, and perform a lot of bending, twisting, stooping and overhead work. Dr. Volarich also testified that the medical treatment offered by Drs. Josyula, Yamaguchi, Prather, Riew and Lenk was reasonable and necessary to alleviate the effects of her work-related injuries to her right upper extremity, shoulder and neck. Dr. Volarich further testified, based upon a reasonable degree of medical certainty, the normal recuperative period following an endoscopic release of carpal tunnel was approximately six weeks.

Dr. Volarich testified that after her first neck surgery, Claimant was vulnerable to further herniation of the disc space above or below the fusion. Dr. Volarich explained that when a patient bends her head forward, for example, all of the stress is going to be at the C3-4 level, or at the C6-7 level. After she returned to work as a Head Cook on October 1, 2001, Claimant herniated the cervical disc space above the fused disc as a result of her repetitive work activities.

With respect to the May 7, 1998 claim, based upon a reasonable degree of medical certainty, Dr. Volarich opined that there is a 35% permanent partial disability of the right upper extremity rated at the right wrist due to the carpal tunnel syndrome that required endoscopic carpal tunnel release. The rating accounts for her pain, paresthesias and weakness in her dominant hand. Additionally, there was a 20% permanent partial disability of the left upper extremity rated at the wrist due to mild carpal tunnel syndrome. The rating accounted for pain, paresthesias and weakness in the non-dominant hand. Further, there is a 15% permanent partial disability of the right upper extremity of the shoulder due to aggravation of the AC joint, degenerative arthritis, and rotator cuff tendonitis, that required conservative care. The rating takes into account her pain, paresthesias and weakness in the dominant shoulder. There is also a 40% permanent partial disability of the body as a whole, rated at the cervical spine, due to the cervical disc herniation at the C4-5, and at the C5-6, which required discectomy and fusion with instrumentation. The rating accounted for the injury's contribution to neck pain, loss of motion and headaches.

Dr. Volarich opined as a result of the November 14, 2001 injury, there is an additional 25% permanent partial disability to the body as a whole, rated at the cervical spine due to the disc herniation at C3-4 (above the prior fusion), which required discectomy and fusion with instrumentation. The rating takes into account the injury's contribution to her neck pain and loss of motion.

Pertaining to the April 30, 1999 injury, he attributed is a 15% permanent partial disability of the body as a whole rated at the thoracolumbar spine due to the sprain/strain injury that required conservative care. The rating takes into account claimant's ongoing pain and loss of motion.

With respect to the January 2000 injury, he found a 10% permanent partial disability referable to the body as a whole, rated at the lumbosacral spine due to the sprain/strain injury that required conservative care, and a 5% permanent partial disability of the body as a whole rated at the cervical spine due to the sprain/strain injury that required conservative care. Dr. Volarich further concluded that the disabilities suffered by Claimant were greater than their simple sum and that a loading factor should be added to the disability ratings.

Dr. Volarich advised Claimant to limit repetitive bending, twisting, lifting, pushing, pulling, carrying and climbing and other similar tasks to an as-needed basis. He recommended that she not handle any weight greater than 10 to 15 pounds

and to limit this task to an occasional basis assuming proper lifting techniques. He recommended against handling weight over her head and away from her body, and/or carrying weight over long distances or on uneven terrain. She was advised to avoid remaining in fixed positions for longer than 15 to 30 minutes, including both sitting and standing, and to change positions frequently to maximize comfort and to rest when needed. Claimant was directed not to handle any weights greater than 1 to 2 pounds with either upper extremity alone, particularly with her arms extended away from her body. Close to the body, he recommended against lifting more than 3 to 5 pounds. Finally, he recommended appropriate stretching, strengthening and range of motion exercise programs, in addition to non-impact aerobic conditioning such as walking, biking or swimming to tolerance daily.

Based upon his May 2003 examination, he felt Claimant had reached maximum medical improvement as a result of her work accidents, but cautioned that she may require additional care for her disc protrusions at the C3-4 and C6-7 as well as the reported lumbar spine disc herniations. Further, in order to maintain her current state, Dr. Volarich opined that she would require ongoing care for her pain syndrome using narcotics and non-narcotic medications (NSAIDS), muscle relaxants, other such similar treatments for symptomatic relief.

Finally, Dr. Volarich recommended that Claimant undergo vocational evaluation and assessment to determine if she might be able to return to work. Claimant was evaluated by Mr. Timothy Lalk on September 25, 2003.

Mr. Lalk testified on behalf of Claimant. Based upon a reasonable degree of professional certainty, Mr. Lalk concluded Claimant is not able to secure and maintain employment in the open labor market, and is not able to compete for any position because of her medical conditions.

In summary, Mr. Lalk described Claimant as having basically worked in entry-level positions, primarily in food service. Considering the restrictions given to her by Dr. Volarich, Claimant would not be able to function in an unskilled sedentary position on a regular basis. At the time of her evaluation, she had been out of school for approximately 30 years. Mr. Lalk explained persons in Claimant's position often have difficulty getting back into the discipline of a formal education program. Based upon her physical restrictions and problems, Claimant is not a candidate for vocational rehabilitation.

Based upon Dr. Volarich's review of the report of Dr. Lalk, he determined that Claimant was permanently and totally disabled as a result of the combination of her work related injuries leading up to May 7, 1998, April 30, 1999, January 11, 2000, and November 14, 2001.

Claimant last worked on January 31, 2002. She does not believe she can return to any form of work because of her chronic pain. She has limitation of motion in her neck and shoulders. She habitually rubs her right hand because of numbness and tingling in her fingers. She has difficulty gripping and firmly holding onto objects. She has difficulty standing and sitting for prolonged periods of time and uses a cane. During the hearing she frequently changed positions, had difficulty rising from a seated position, and asked for water to take pain medication. The pain medication interferes with her ability to concentrate, and makes her drowsy. Throughout the day, she needs to lie down or sit in a reclined position using a pillow to support her neck. She has a pain in her neck at night that interferes with sleep. She is continuously fatigued. Although she has a driver's license and a handicap license plate, she relies upon her daughters to drive her, except when traveling short distances. She also relies upon her daughters to perform housework, daily chores, and cooking. Claimant also needs assistance getting in and out of the shower.

As a result of the two neck surgeries, Claimant is left with a large surgical scar across her neck. Claimant has been asked if she was attacked, causing her embarrassment. Claimant is not, however, bothered by her right wrist surgical scar.

Claimant testified in a credible and truthful manner.

### **RULINGS OF LAW**

Based upon my observations of Claimant at hearing, my comprehensive review of the medical evidence, and the application of Missouri law, I find:

As a result of the May 7, 1998 injury, Claimant sustained a 17 ½% permanent partial disability of the right upper extremity rated at the wrist. Claimant failed to prove that she sustained any permanent partial disability as a result of her left carpal tunnel syndrome. I further find Claimant has a 10% permanent partial disability of the right upper extremity at the shoulder due to aggravation of the AC joint, degenerative arthritis, and rotator cuff tendonitis. Further, Claimant sustained a 25% permanent partial disability of the body as a whole, rated at the cervical spine due to a disc herniation of the C4-5 and C5-6, which required surgery in 2001. A load factor of 10% should be applied. Accordingly, Claimant is entitled to 169 weeks of permanent partial disability benefits from Employer. Further, she is entitled to an additional 6 weeks of disfigurement for her neck scar. No disfigurement is awarded for her right wrist scar.

As a result of the May 7, 1998 injury, Claimant is awarded \$40,052.80 which are reasonable necessary medical expenses to help cure and alleviate the effects of her work related injury. Further, Claimant is owed temporary total disability benefits as a result of her surgery on the right wrist from June 5, 1998 to August 26, 1998 (11 5/7 weeks), and from January 31, 2001 to October 1, 2001 as a result of her first neck surgery (34 4/7 weeks).

Claimant failed to prove that she sustained any permanent partial disability as a result of her April 30, 1999 injury, and no permanent partial disability benefits are awarded. The claim against the Second Injury Fund is dismissed.

Claimant has a 5% permanent partial disability of the body as a whole rated at the lumbar spine due to a sprain/strain injury, and no additional permanent partial disability at the cervical spine due to her sprain/strain injury resulting from her January 11, 2000 work accident, for a total of 20 weeks of permanent partial disability. Because it does not rise to the requisite level of permanent partial disability to trigger Second Injury Fund liability, no benefits are awarded, and the claim against the Second Injury Fund is dismissed.

Claimant's repetitive work activities are a substantial factor in causing her diagnosed herniated disc in October 2001, her subsequent medical treatment and resulting disability. As a result of the November 14, 2001 work related injury, Claimant sustained a 25% permanent partial disability of the body as a whole rated at the cervical spine due to the disc herniation at the C3-4 that required a discectomy and fusion with instrumentation. Additionally, Claimant is entitled to recovery of 6 weeks of disfigurement for her second surgical scar. Further, Claimant is entitled to recover her reasonable and necessary medical expenses incurred to alleviate the effects of her work related injury in the total sum of \$29,989.00 for treatment rendered between October 25, 2001 and February 18, 2003. As a result of this last injury, Claimant was temporarily and totally disabled from January 17, 2002 through January 25, 2002, and from January 31, 2002 through February 18, 2003, when she last saw Dr. Riew (55 6/7 weeks).

Claimant has failed to meet her burden of proving that Employer is liable for future medical benefits, and none are awarded.

Claimant's employment as a Head Cook was hand intensive, and she was required to lift heavy objects on a frequent and routine basis, in awkward positions, at and above her head. Based upon the well-reasoned opinions of Dr. Volarich, and taking into consideration the repetitive nature of her work over a period of more than 20 years, I conclude her work activities were a substantial factor in causing her diagnosed conditions referable to her wrists, right shoulder, and neck, resulting in substantial medical treatment, lost time from work, and severe permanent disabilities.

In arriving at my decision, I note Employer failed to promptly respond to Claimant's requests for medical treatment and refused her requests for a step stool to avoid having to stand on her toes and lift at or above her shoulders. Claimant had been experiencing problems for more than a year before her supervisor completed a report of injury and referred her for treatment. A report was not completed until after Claimant lost control of her right hand and spilled soup on a customer. According to the medical records, Claimant's complaints were not limited simply to her right and left wrists. She also complained of right shoulder and neck pain. Dr. Ollinger, Employer's authorized medical provider, treated her with prescription medications for her right shoulder complaints. Despite the recommendations of Dr. Ollinger, Employer refused to refer Claimant to an orthopedist.

Drs. Ollinger, Volarich and Lee agree that Claimant's diagnosed carpal tunnel syndrome is work related. Dr. Lee disagrees, however, with Dr. Volarich on the causal relationship between claimant's work activities and her diagnosed right shoulder and neck problems. I find Dr. Lee's opinion on the issues of causation with regard to the neck and shoulder unpersuasive.

Dr. Lee's conclusion that Claimant's right shoulder problems are not work related lacks explanation. Dr. Lee's conclusionary opinion overlooks the fact that Dr. Ollinger provided treatment for Claimant's shoulder. Dr. Lee's opinion on causation also ignores the repetitive nature of Claimant's work and is inconsistent with his own testimony that tendonitis and adhesive capsulitis, as a secondary response to tendonitis, can be caused by repetitive motion.

For similar reasons, I reject Dr. Lee's causation opinion regarding Claimant's multi-level cervical disc herniations. Dr. Lee attributes Claimant's neck problems to degenerative changes in the spine. Dr. Lee's opinion, however, disregards the cause of the degenerative changes. By his own description, the August 17, 1999 MRI findings and the x-rays taken by Dr. Wayne showed wear and tear change. Furthermore, Dr. Lee admitted that Claimant's disc herniations could have been caused by repetitive trauma.

With respect to the November 2001 claim, I find Dr. McGraw's causation opinion is unsupported by a rational

explanation and is otherwise unconvincing. Following her first neck surgery, and within days after returning to work, Claimant began to experience new problems with her neck and right upper extremity. As explained by Dr. Volarich, her first spinal fusion made her vulnerable to additional cervical disc herniations above or below the fused disc space. Although Claimant was returned to work with restrictions, it is clear that Claimant's work activities were a substantial factor in causing the large disc herniation at the C3-4 level on the right requiring medical treatment, including surgery, and resulting in additional disability.

Finally, as a result of the last injury in combination with her preexisting disabilities, Claimant was rendered permanently and totally disabled under the Workers' Compensation Act. Accordingly, the Second Injury Fund is liable for the payment of permanent total disability benefits for the rest of Claimant's life.

Claimant suffered disabilities as a result of her May 7, 1998, January 11, 2000, and November 14, 2001 work injuries. These disabilities constituted a hindrance or obstacle to employment. Following her last injury, she has not been able to return to work because of her intractable pain. I find Claimant's testimony to be credible. The record also shows that Claimant suffers from disabling pain that severely limits her ability to perform her daily activities, let alone unskilled sedentary work on a sustained basis. Accordingly, based upon

Claimant's credible testimony and the expert reports and testimony of Dr. Volarich and Mr. Lalk, I find that Claimant is unable to compete in the open labor market and, thus, is permanently and totally disabled.

This award is subject to an attorney's lien of 25% in favor of Claimant's attorney, Mr. Charles Bobinette.

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

Margaret D. Landolt  
*Administrative Law Judge*  
*Division of Workers' Compensation*

A true copy: Attest:

\_\_\_\_\_  
Patricia "Pat" Secret  
*Director*  
*Division of Workers' Compensation*

Issued by THE LABOR AND INDUSTRIAL RELATIONS COMMISSION

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

Injury No.: 00-005912

Employee: Diane Smith  
Employer: The Board of Education of the City of St. Louis  
Insurer: Self-Insured  
Additional Party: Treasurer of Missouri as Custodian  
of Second Injury Fund  
Date of Accident: January 11, 2000  
Place and County of Accident: St. Louis, 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 November 14, 2005. The award and decision of Administrative Law Judge Margaret D. Landolt, issued November 14, 2005, is attached and incorporated by this reference.

The Commission further approves and affirms the administrative law judge's allowance of attorney's fee herein as being fair and reasonable.

Any past due compensation shall bear interest as provided by law.

Given at Jefferson City, State of Missouri, this 24<sup>th</sup> day of August 2006.

LABOR AND INDUSTRIAL RELATIONS COMMISSION

\_\_\_\_\_  
William F. Ringer, Chairman

\_\_\_\_\_  
Alice A. Bartlett, Member

\_\_\_\_\_  
John J. Hickey, Member

Attest:

\_\_\_\_\_  
Secretary

**AWARD**

Employee: Diane Smith Injury No.: 00-005912  
Dependents: N/A Before the  
**Division of Workers'**  
Employer: The Board of Education of the City of St. Louis **Compensation**  
Department of Labor and Industrial  
Additional Party: Second Injury Fund Relations of Missouri  
Jefferson City, Missouri  
Insurer: Self-Insured  
Hearing Date: August 8, 2005 Checked by: MDL:tr

**FINDINGS OF FACT AND RULINGS OF LAW**

1. Are any benefits awarded herein? Yes
4. 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
8. Date of accident or onset of occupational disease: January 11, 2000
9. State location where accident occurred or occupational disease was contracted: St. Louis
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
- 11. 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:  
Employee slipped on grease and fell.
- 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: Low back
- 16. Nature and extent of any permanent disability: 5% permanent partial disability of the body as a whole related to the lumbar spine
- 15. Compensation paid to-date for temporary disability: -0-
- 16. Value necessary medical aid paid to date by employer/insurer? \$1,976.93

Employee: Diane Smith Injury No.: 00-005912

- 17. Value necessary medical aid not furnished by employer/insurer? -0-
- 20. Employee's average weekly wages: \$434.94
- 19. Weekly compensation rate: \$289.96/\$289.96
- 20. Method wages computation: Stipulation

**COMPENSATION PAYABLE**

- 21. Amount of compensation payable:  
20 weeks of permanent partial disability from Employer \$5,779.20
- 22. Second Injury Fund liability: No
- TOTAL: \$5,799.20
- 23. Future requirements awarded: N/A

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:

Mr. Charles Bobinette

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

Employee: Diane Smith Injury No.: 00-005912  
Dependents: N/A Before the  
Employer: The Board of Education of the City of St. Louis **Division of Workers' Compensation**  
Additional Party: Second Injury Fund Department of Labor and Industrial Relations of Missouri  
Jefferson City, Missouri  
Insurer: Self-Insured Checked by: MDL:tr

### **PRELIMINARIES**

A hearing was held on August 8, 2005, at the Division of Workers' Compensation in the City of St. Louis. Diane Smith ("Claimant") was represented by Mr. Charles Bobinette. The Board of Education of the City of St. Louis ("Employer"), which was self-insured, was represented by Ms. Robin Higgins. The Second Injury Fund was represented by Assistant Attorney General Rachel Paul. Claimant filed four claims: 98-068375 (date of injury May 7, 1998); 99-054526 (date of injury April 30, 1999); 00-005912 (date of injury January 11, 2000); and 01-161057 (date of injury November 14, 2001). By agreement, the claims were consolidated and tried together. Claimant's attorney requested a fee of 25% of Claimant's awards.

In Injury Number 98-068375, the parties stipulated that Claimant's average weekly wage is \$359.06, and the permanent partial and temporary total disability rate is \$239.37. Employer paid \$6,780.65 in medical expenses. The issues in this claim are occupational disease, medical causation, past due temporary total disability benefits, past medical expenses, disfigurement, and nature and extent of permanent partial disability referable to the right and the left wrists, right upper extremity, shoulder and neck.

In Injury Number 99-054526, the parties stipulated that as of April 30, 1999, Claimant's average weekly wage was \$416.21, yielding a permanent partial disability rate of \$277.47. Employer paid \$342.13 in medical expenses, and no temporary total disability benefits. The issues presented are nature and extent of permanent partial disability referable to the back, and liability of the Second Injury Fund.

In Injury Number 00-005912, the parties stipulated Claimant's average weekly wage is \$434.94 and the permanent partial disability rate is \$289.96. Employer paid \$1,976.93 in medical expenses, and no temporary total disability benefits. The issues are nature and extent of permanent partial disability of the neck and lower back, and liability of the Second Injury Fund.

In Injury Number 01-161057, the parties stipulated Claimant's average weekly wage is \$460.18, and the total disability and permanent partial disability rate is \$306.79. Employer paid \$1,005.11 in medical expenses, and no temporary total disability benefits. The issues presented for resolution are occupational disease, medical causation, past due temporary total disability benefits, disfigurement, past and future medical expenses, nature and extent of permanent partial disability, permanent total disability, and liability of the Second Injury Fund.

### **FINDINGS OF FACT**

Claimant is 50 years old and is right-handed. In 1972, after completing the eleventh grade at Sumner High School, she dropped out of school. In the early 1980s, she obtained her GED. Claimant has no vocational training, office

experience, or computer or typing skills. In the early 1970s, Claimant worked at a McDonald's restaurant as a food service worker for a couple of months. She then moved to Michigan where she worked at a factory assembling toys for about a year. In 1973, she returned to St. Louis.

In 1978, Employer hired Claimant as a food service worker preparing lunches. She was promoted to Baker, and eventually to a Head Cook II. She worked from 6:00 a.m. to 2:30 p.m., Monday through Friday, ten months a year. She prepared approximately 200 breakfasts and 600 lunches each day as a Head Cook. She supervised ten to eleven workers. She was not required to plan menus, order food, or perform personnel work. Sometimes, she had to help serve the food as a fill-in when another worker was absent. She spent most of her time on her feet, and performed paperwork at the end of the day. Daily, she used both hands for slicing, dicing, peeling, scooping, pulling, cutting and stirring. When cooking, the heaviest she had to lift were pans, which weighed between 35 and 40 pounds when filled. She was required to reach overhead and use her upper extremities constantly. Claimant continuously looked down as she cooked, and raised her head backwards when she lifted. When lifting, she had to stand on her toes holding the pans in her hand and reach overhead to put them into the oven or rack. Claimant asked her supervisor for a step stool, but was never provided with one.

Claimant began experiencing problems with her hands, right shoulder and neck in late 1996 or early 1997. Although she requested medical treatment on several occasions, her supervisor did not prepare a report until Claimant lost control of her hand and spilled hot soup on a customer. On April 7, 1998, Claimant was seen by her private physician, Dr. Josyula, who suspected bilateral carpal tunnel syndrome and diagnosed cervical strain. Dr. Josyula felt that her condition was work related.

Eventually, on April 29, 1998, Employer referred Claimant to Dr. Ollinger, who diagnosed possible bilateral carpal tunnel syndrome substantially related to her work activities, and a small ganglion volar of the right wrist (not work related). Nerve conduction studies performed on the same day were abnormal on the right hand and normal on the left. On May 7, 1998, Dr. Ollinger prescribed medications and hand splints to be worn at night. Dr. Ollinger suggested that if she did not respond to medical treatment, she should be referred to an orthopedist for her shoulder complaints.

On June 11, 1998, Claimant continued to complain of bilateral numbness and tingling of her hands, and right shoulder pain. Dr. Ollinger recommended surgery on the right wrist, and an orthopedic referral for her right shoulder problem if her symptoms continued after her carpal tunnel syndrome surgery and post op rest.

Surgery was performed at Missouri Baptist Hospital on June 23, 1998. On July 6, 1998, Dr. Ollinger recommended alternative work with light use of the right hand, no power gripping, and a five-pound lifting restriction. Dr. Ollinger released Claimant to regular work on September 24, 1998. On December 3, 1990, Dr. Ollinger gave Claimant a 0% permanent partial disability rating on both wrists, and found no symptoms or signs of left carpal tunnel syndrome. He noted that her NCVs were normal. He did not feel that Claimant required any additional evaluation, care or work restrictions, and felt Claimant was at maximum medical improvement. On January 7, 1999, Employer refused to authorize any additional medical treatment for Claimant based upon Dr. Ollinger's report.

Claimant planned to work during the summer school break cleaning offices with her sister. Because of the planned surgery and her recovery, she remained unemployed between June 5 and the start of school on August 26, 1998. On September 24, 1998, Dr. Ollinger released Claimant for regular work.

Claimant continues to have difficulty with her right hand following her surgery. She frequently rubs her right hand to alleviate her pain. She has reduced strength, which results in difficulty with such tasks as opening jars, combing her hair, vacuuming, and grasping items. She frequently drops things.

On January 15, 1999, Claimant was seen by Dr. Josyula for right shoulder problems. Claimant reported that for the past several months, she had been having progressive discomfort in her right shoulder area, and that her work involved picking up steam table pans on a regular basis. At the time of her examination, she could not raise her arm above her head. She was diagnosed with a history of rotator cuff strain versus tear. She was prescribed medications, and referred to Dr. Kenneth Yamaguchi, an orthopedic surgeon.

On February 22, 1999, Claimant was seen by Dr. Yamaguchi. On physical examination, she had pain with increased internal rotation, weakness and tenderness. Claimant also had pain with extreme cervical spine extension with some recreation of the shoulder pain symptoms. She complained of fatigue in her arm with mild activities. Dr. Yamaguchi felt that she had right rotator tendonitis with possible cervical spine radiculopathy. The area was injected, physical therapy was prescribed, and she was referred to Dr. Heidi Prather.

Dr. Prather evaluated Claimant on March 11, 1999, and diagnosed cervical segmental dysfunction and to rule out cervical radiculopathy and rotator cuff tendonitis. Claimant was prescribed Lodine for pain control, physical therapy for

flexibility, and strengthening exercises for her cervical spine. X-rays of the cervical spine taken on March 11, 1999 revealed mild degenerative disc disease at the C4-5 levels.

On March 17, 1999, Claimant, through her counsel, notified Employer that she was seeking medical treatment on her own and would look to Employer for reimbursement.

Between March 11 and May 13, 1999, Claimant had eight sessions of physical therapy. Although her right shoulder pain improved, her right lateral neck pain continued.

On April 30, 1999, Claimant suffered a work-related injury when she jolted her mid back when pulling a bread rack from the walk-in refrigerator at work. She was seen at BJC Corporate Health on April 30, 1999. X-rays of her thoracic spine were negative, and Ibuprofen was prescribed. Claimant was diagnosed with a parathoracic sprain. Claimant was off work until May 3, 1999, at which time she was returned to full duty.

On July 27, 1999, Claimant was in tears when she was seen by Dr. Josyula complaining of worsening of her right shoulder discomfort. Claimant was unable to elevate her shoulder above her head and was having difficulty ambulating normally. Claimant was given a Toradol shot and referred back to Dr. Prather. An MRI of the cervical spine performed on August 17, 1999 revealed focal kyphosis with surrounding muscle spasm from C4-C5 intervertebral disc herniation, with extruded disc material.

Claimant came under the care of Dr. Daniel Riew on August 31, 1999. According to his records, she complained of neck and arm pain for approximately 1-½ years, which she related to lifting at work. She also reported having problems picking up small objects. She reported her worst position was standing, and lying down eased her pain. Dr. Riew diagnosed interscapular pain, shoulder pain, radiculopathy secondary to herniated disc at 4-5, cervical kyphosis and foraminal stenosis at 4-5 and to a lesser extent at 5-6. He recommended epidural steroid injections and, if they failed to resolve the problem, surgery.

On September 22, 1999, Claimant was seen at the BJC Pain Management Center by Dr. Karanikolas complaining of pain in the neck, right shoulder, and right upper extremity radiating into the fingers since April 1997. Initially, the pain was sharp in her neck and shoulder and became a continuous dull pain down her right arm and into her fingers. Associated symptoms included nausea, dizziness, blurred vision, numbness, tingling, noise sensitivity, and irritability. Examination of the neck showed muscle spasms and trigger points with tenderness over the cervical vertebrae. Dr. Karanikolas diagnosed bilateral foraminal C4-5 and C5-6 stenosis, chronic right sided neck and upper extremity pain, with significant myofascial pain components, right sided radiculopathy, and slight weakness of the right upper extremity, apparently related to radiculopathy. The recommended treatment plan included physical therapy, epidural injections, Medrol dose pack, and trigger point injections.

On January 11, 2000, Claimant was putting chicken wraps into the oven when she knocked over a bucket of grease, slipped, and fell, burning her left hip on hot grease. Claimant was treated at Barnes Care where x-rays were taken of the low back and left hip. Left hip films revealed mild bilateral hip osteoarthritis without fracture. Low back films were negative. Cervical spine films showed: a straightening of the cervical spine without evidence of fracture, incomplete visualization of the C7 vertebral body and mild cervical spondylosis at the C4-5. Claimant was prescribed physical therapy and medications and given a ten-pound lifting restriction. Claimant was referred to Dr. Wayne who diagnosed right worse than left sacroiliitis, lumbosacral sprain, cervical sprain, and status post left elbow contusion, and continued Claimant's conservative treatment.

On February 28, 2000, Dr. Wayne recorded that Claimant had moderate improvement with therapy, but continued to experience pain in her neck and low back. Her cervical range of motion was approximately 80% of normal. She was 75% of normal on left rotation with most of the pain being in the right lower neck, left rotation. Lumbosacral range of motion showed 75% of normal on flexion. Dr. Wayne prescribed three more weeks of physical therapy and limited duty. On March 14, 2000, Claimant reported that she continued to have difficulty performing her job because of her pain in the trapezius region with stirring and overhead lifting. Lumbosacral range of motion was within normal limits. Cervical range of motion was approximately 80% of normal for extension and in flexion. Dr. Wayne found her to be at maximum medical improvement and released her to full duty. As of April 5, 2000, Dr. Wayne felt that Claimant sustained a 5% permanent disability of the neck, but no disability to the lumbar region as a result of her work accident of January 11, 2000.

Claimant continued her medical treatment with Drs. Josyula and Riew. On November 17, 2000, she reported to Dr. Josyula that she had complaints of pain and discomfort involving her right shoulder area and that her arm strength was diminished. Medications were prescribed and she was referred to Dr. Riew for possible surgical intervention. She next saw

Dr. Josyula on December 4, 2000 for pain in the upper neck and shoulders and asked to be taken off work because of her problems.

On January 23, 2001, she was seen by Dr. Riew. A repeat MRI of the cervical spine was performed on February 5, 2002, which revealed cervical kyphosis, cord compromise at C4-5 and to a lesser extent, at C5-6. Dr. Riew suggested surgery.

Claimant was referred for a second opinion to Dr. Christina Lenk, who recommended an EMG and nerve conduction study, and prescribed medications for her pain symptoms. The March 1, 2001 EMG nerve conduction studies were consistent with C4-5 radiculopathy and milder underlying median nerve lesion at the right wrist. Dr. Lenk suggested it was likely that surgery would be needed, but recommended a more conservative approach, including another course of physical therapy and pain medications.

According to the Barnes Jewish Hospital medical records, on March 12, 2001, Dr. Riew performed a carpectomy of the C5, and fusion of the C4-C6 with anterior cervical plate mesh cages, and right iliac crest bone grafting. The postoperative diagnosis was cervical herniated disc and spondylosis causing mild radiculopathy at the C4-5 and C5-6 levels.

Claimant was taken off of work while she recuperated from her surgery. When Claimant followed up with Dr. Riew on April 24, 2001, she stated that she continued to have upper trapezial pain, but that her arm symptoms had resolved. On June 19, 2001, she continued to complain of trapezial pain and occasional pain in her arm, although her tingling and numbness had improved. Dr. Riew felt that there were two explanations for her continued problems: (1) that she was beginning to heal; and, (2) there was a possibility that she was having problems at the C4-5 and C6-7 levels. He recommended that Claimant continue to wear her cervical collar and try to increase her aerobic exercise. On July 24, 2001, Dr. Riew referred Claimant to Dr. Galatz for treatment of her right shoulder pain.

Claimant complained to Dr. Galatz that she could not sleep at night, and she had trouble lifting her right arm over her head. Claimant was diagnosed with rotator cuff tendonitis and was injected with Cortisone and Lidocaine.

Claimant was next seen by Dr. Galatz on September 18, 2001. She reported that her shoulder felt good after the injection, however the pain had returned in moderate intensity. Dr. Riew ordered physical therapy.

Between January 1999 and September 18, 2001, Claimant incurred medical expenses for treatment of her right shoulder and neck while under the treatment of Drs. Josyula, Yamaguchi, Prather, Riew, Karanikolas, Lenk and Galatz in the sum of \$40,052.80.

Claimant returned to work with Employer on October 1, 2001. On October 9, 2001, she was seen by Dr. Josyula for complaints of numbness in her fingers and left hand for the past four or five days, and weakness in her hand muscles. On October 25, 2001, Claimant had electro diagnostic studies performed by Dr. John P. Metzler and an MRI. The MRI showed a disc herniation at the L3-4, and a bulge at the C6-7 levels. Dr. Riew referred Claimant to Dr. Greg Smith for nerve root injections, which were performed in November and December 2001.

On January 2, 2002, Claimant returned to see Dr. Josyula, who referred her to Dr. Riew. It was Dr. Riew's opinion that Claimant's symptoms arose from problems at the C3-4 and C6-7 levels. He recommended a circumferential fusion at both levels. He also stated, "she is going to need to get workers' compensation approval for this and then she will return to see me." At the request of Employer, Claimant was seen by Dr. Dennis M. McGraw on January 28, 2002. Dr. McGraw felt that her ruptured disc was not work related because there was "no specific injury associated", and referred her back to Dr. Riew as soon as possible for treatment.

On March 19, 2002, Claimant underwent a myelogram CT scan which showed a large disc herniation at the C3-4 on the right that compressed the spinal cord. Dr. Riew recommended urgent surgery to remove the old plate and to do an anterior cervical discectomy and fusion at C3-C4, using autograft and a cross plate. On March 25, 2002, surgery was performed. The post-operative diagnoses were herniated nucleus pulposus, C3-4 with myeloradiculopathy, post C4-6 anterior cervical decompression and fusion.

Following her surgery, she continued to treat with Dr. Riew. Claimant's x-rays taken on August 20, 2002 showed a small disc protrusion at C6-7, which was causing some neck pains and numbness and tingling in the left long finger on the left side. Dr. Riew recommended that she should consider surgery if her symptoms worsened. Dr. Riew restricted her lifting to not more than 10 pounds and pushing or pulling to not more than 20 pounds. Claimant testified that the last time she saw Dr. Riew was on February 18, 2003. She was unable to see him because she no longer had insurance. Claimant testified that

Dr. Nester is her physician now and he prescribes Hydrocodone for neck and shoulder pain and a muscle relaxant. She uses a cane for foot pain, and for low back pain, which she attributes to her slip and fall on January 11, 2000.

Between October 25, 2001 and February 18, 2003, Claimant incurred medical expenses for treatment while under the care of Drs. Josyula, Smith, Metzler and Riew for treatment of her right and left upper extremities and neck pain in the sum of \$29,989.00.

Dr. Thomas Lee, an orthopedic surgeon, testified on behalf of Employer. Dr. Lee examined Claimant on November 10, 2003. On physical examination, Dr. Lee noted Claimant's forward flexion of the neck was 35 degrees compared to 65 degrees in a normal patient her age. Extension of her neck was limited to 25 degrees compared to normal of 55-65 degrees. Rotation of the neck was limited to 35 degrees in each direction compared to normal of 80-85 degrees. Claimant's limitations were consistent with her two spinal surgeries. Impingement sign and internal rotation testing showed a slightly decreased internal rotation on the right with internal rotation to the L3 versus the T12, suggesting adhesive capsulitis on the right. On testing of the wrist, Phalen's was positive on the right, which suggested that there was some residual from the carpal tunnel syndrome.

Based upon a reasonable degree of medical certainty, Dr. Lee opined that Claimant's right carpal tunnel syndrome was causally related to her work activities as a Head Cook. He ascribed a 6% permanent partial disability to her right wrist, but no disability to her left wrist because of the lack of symptoms at the time of the examination. Dr. Lee did not believe that Claimant's right shoulder and neck complaints were work related, and therefore did not offer an opinion on nature and extent of disability.

On cross-examination, Dr. Lee acknowledged that Dr. Ollinger and BJC treated Claimant for right shoulder and cervical complaints. Dr. Lee further acknowledged that tendonitis and adhesive capsulitis, as a secondary response to tendonitis, could be caused by repetitive motion. Likewise, under some circumstances, herniation of the cervical disc could be caused by repetitive trauma to the neck.

According to the medical records reviewed by Dr. Lee, on April 30, 1999, Claimant sustained a parathoracic strain which required conservative medical treatment. Dr. Lee described her injury to the upper back between the shoulder blades. Further, the record showed that Claimant sustained a work injury on January 11, 2000 that required medical treatment provided by Dr. Andrew Wayne. According to the medical records, Claimant sustained a cervical strain, which could have weakened the integrity of the cervical spine temporarily, including the neck, which could have made her more vulnerable to cervical disc herniation. The cervical x-rays taken by Dr. Wayne and the August 17, 1999 MRI were consistent in that both showed wear and tear changes in the spine. Finally, Dr. Lee acknowledged that the medical treatment provided Claimant was reasonable and necessary to help relieve Claimant's shoulder and neck complaints, and that the charges for such treatment were reasonable.

Dr. David Volarich testified on behalf of Claimant. When Dr. Volarich saw Claimant in March 2003, she continued to have problems with diminished motion and pain at the base of the skull in both trapezius muscles, right more left. She was having problems with radiating pain into the index and long fingers of both hands. She also reported headaches that occurred two or three days of the week, which were located in the temple portion of the skull, the forehead, and at the base of the skull and neck. She reported that fixed positions aggravated her neck pain, and that she could only sit for 30 minutes. Overhead use of her arms was difficult because of the diminished motion of her neck, and that she could not look up without having neck pain. Claimant has difficulty performing any repetitive hand activities. If she writes one letter, her hand fatigues. Dexterity is diminished to the point where she is unable to work on the computer. Her grip strength is diminished and she has difficulty using tools.

On physical examination, Claimant's cervical spine range of motion was severely restricted. Palpation of the neck elicited pain in the trapezius muscles at the insert of the dorsal junction, the right being worse than the left. Dr. Volarich also found trigger points at the C6-7 midline. There was also loss of range of motion of the thoracic spine. Palpation of the mid back elicited pain in the paraspinal muscles, the right being worse than the left, from the T4 to the T8. Further, there was loss of range of motion in the lumbar spine. Dr. Volarich also found a right trigger point in the right sacrospinous notch. Straight leg raising was accomplished at 70 degrees on the left with back pain and on the right at 45 degrees with back pain that radiated into the right thigh and calf. In the right shoulder, there was a 10% loss of motion as evaluated by the Apley Scratch Test. There was also a similar loss of motion in the left shoulder and trapezius pain with weakness.

Examination of the hands showed the dexterity to the fingers was slow bilaterally. There was a one-centimeter scar over the ventral surface of the right wrist from her carpal tunnel release. Grip strength in the right as compared to the left was weak. Further, Dr. Volarich found asymmetric bulk loss in the upper extremities. Strength in both shoulders was weak.

to confrontational testing of the deltoid and rotator cuff. The tricep on the right was also weak. Finally, Dr. Volarich noted that Claimant walked with forward flexion at the waist by approximately 15 degrees and she moved about the examination room slowly.

After reviewing the medical records and taking a detailed job description from Claimant, Dr. Volarich concluded that her work activities were a substantial contributing factor in causing bilateral carpal tunnel syndrome, which required right endoscopic carpal tunnel release and cervical disc herniations at the C4-5 and C5-6 that required a two level discectomy and fusion with instrumentation. Further, Claimant's repetitive activities also aggravated her right shoulder AC joint, degenerative arthritis, and caused some rotator cuff tendonitis. Specifically, Dr. Volarich felt that these conditions were a result of her having to lift heavy objects at work, work in awkward positions, and perform a lot of bending, twisting, stooping and overhead work. Dr. Volarich also testified that the medical treatment offered by Drs. Josyula, Yamaguchi, Prather, Riew and Lenk was reasonable and necessary to alleviate the effects of her work-related injuries to her right upper extremity, shoulder and neck. Dr. Volarich further testified, based upon a reasonable degree of medical certainty, the normal recuperative period following an endoscopic release of carpal tunnel was approximately six weeks.

Dr. Volarich testified that after her first neck surgery, Claimant was vulnerable to further herniation of the disc space above or below the fusion. Dr. Volarich explained that when a patient bends her head forward, for example, all of the stress is going to be at the C3-4 level, or at the C6-7 level. After she returned to work as a Head Cook on October 1, 2001, Claimant herniated the cervical disc space above the fused disc as a result of her repetitive work activities.

With respect to the May 7, 1998 claim, based upon a reasonable degree of medical certainty, Dr. Volarich opined that there is a 35% permanent partial disability of the right upper extremity rated at the right wrist due to the carpal tunnel syndrome that required endoscopic carpal tunnel release. The rating accounts for her pain, paresthesias and weakness in her dominant hand. Additionally, there was a 20% permanent partial disability of the left upper extremity rated at the wrist due to mild carpal tunnel syndrome. The rating accounted for pain, paresthesias and weakness in the non-dominant hand. Further, there is a 15% permanent partial disability of the right upper extremity of the shoulder due to aggravation of the AC joint, degenerative arthritis, and rotator cuff tendonitis, that required conservative care. The rating takes into account her pain, paresthesias and weakness in the dominant shoulder. There is also a 40% permanent partial disability of the body as a whole, rated at the cervical spine, due to the cervical disc herniation at the C4-5, and at the C5-6, which required discectomy and fusion with instrumentation. The rating accounted for the injury's contribution to neck pain, loss of motion and headaches.

Dr. Volarich opined as a result of the November 14, 2001 injury, there is an additional 25% permanent partial disability to the body as a whole, rated at the cervical spine due to the disc herniation at C3-4 (above the prior fusion), which required discectomy and fusion with instrumentation. The rating takes into account the injury's contribution to her neck pain and loss of motion.

Pertaining to the April 30, 1999 injury, he attributed is a 15% permanent partial disability of the body as a whole rated at the thoracolumbar spine due to the sprain/strain injury that required conservative care. The rating takes into account claimant's ongoing pain and loss of motion.

With respect to the January 2000 injury, he found a 10% permanent partial disability referable to the body as a whole, rated at the lumbosacral spine due to the sprain/strain injury that required conservative care, and a 5% permanent partial disability of the body as a whole rated at the cervical spine due to the sprain/strain injury that required conservative care. Dr. Volarich further concluded that the disabilities suffered by Claimant were greater than their simple sum and that a loading factor should be added to the disability ratings.

Dr. Volarich advised Claimant to limit repetitive bending, twisting, lifting, pushing, pulling, carrying and climbing and other similar tasks to an as-needed basis. He recommended that she not handle any weight greater than 10 to 15 pounds and to limit this task to an occasional basis assuming proper lifting techniques. He recommended against handling weight over her head and away from her body, and/or carrying weight over long distances or on uneven terrain. She was advised to avoid remaining in fixed positions for longer than 15 to 30 minutes, including both sitting and standing, and to change positions frequently to maximize comfort and to rest when needed. Claimant was directed not to handle any weights greater than 1 to 2 pounds with either upper extremity alone, particularly with her arms extended away from her body. Close to the body, he recommended against lifting more than 3 to 5 pounds. Finally, he recommended appropriate stretching, strengthening and range of motion exercise programs, in addition to non-impact aerobic conditioning such as walking, biking or swimming to tolerance daily.

Based upon his May 2003 examination, he felt Claimant had reached maximum medical improvement as a result of her work accidents, but cautioned that she may require additional care for her disc protrusions at the C3-4 and C6-7 as well

as the reported lumbar spine disc herniations. Further, in order to maintain her current state, Dr. Volarich opined that she would require ongoing care for her pain syndrome using narcotics and non-narcotic medications (NSAIDS), muscle relaxants, other such similar treatments for symptomatic relief.

Finally, Dr. Volarich recommended that Claimant undergo vocational evaluation and assessment to determine if she might be able to return to work. Claimant was evaluated by Mr. Timothy Lalk on September 25, 2003.

Mr. Lalk testified on behalf of Claimant. Based upon a reasonable degree of professional certainty, Mr. Lalk concluded Claimant is not able to secure and maintain employment in the open labor market, and is not able to compete for any position because of her medical conditions.

In summary, Mr. Lalk described Claimant as having basically worked in entry-level positions, primarily in food service. Considering the restrictions given to her by Dr. Volarich, Claimant would not be able to function in an unskilled sedentary position on a regular basis. At the time of her evaluation, she had been out of school for approximately 30 years. Mr. Lalk explained persons in Claimant's position often have difficulty getting back into the discipline of a formal education program. Based upon her physical restrictions and problems, Claimant is not a candidate for vocational rehabilitation.

Based upon Dr. Volarich's review of the report of Dr. Lalk, he determined that Claimant was permanently and totally disabled as a result of the combination of her work related injuries leading up to May 7, 1998, April 30, 1999, January 11, 2000, and November 14, 2001.

Claimant last worked on January 31, 2002. She does not believe she can return to any form of work because of her chronic pain. She has limitation of motion in her neck and shoulders. She habitually rubs her right hand because of numbness and tingling in her fingers. She has difficulty gripping and firmly holding onto objects. She has difficulty standing and sitting for prolonged periods of time and uses a cane. During the hearing she frequently changed positions, had difficulty rising from a seated position, and asked for water to take pain medication. The pain medication interferes with her ability to concentrate, and makes her drowsy. Throughout the day, she needs to lie down or sit in a reclined position using a pillow to support her neck. She has a pain in her neck at night that interferes with sleep. She is continuously fatigued. Although she has a driver's license and a handicap license plate, she relies upon her daughters to drive her, except when traveling short distances. She also relies upon her daughters to perform housework, daily chores, and cooking. Claimant also needs assistance getting in and out of the shower.

As a result of the two neck surgeries, Claimant is left with a large surgical scar across her neck. Claimant has been asked if she was attacked, causing her embarrassment. Claimant is not, however, bothered by her right wrist surgical scar.

Claimant testified in a credible and truthful manner.

### **RULINGS OF LAW**

Based upon my observations of Claimant at hearing, my comprehensive review of the medical evidence, and the application of Missouri law, I find:

As a result of the May 7, 1998 injury, Claimant sustained a 17 ½% permanent partial disability of the right upper extremity rated at the wrist. Claimant failed to prove that she sustained any permanent partial disability as a result of her left carpal tunnel syndrome. I further find Claimant has a 10% permanent partial disability of the right upper extremity at the shoulder due to aggravation of the AC joint, degenerative arthritis, and rotator cuff tendonitis. Further, Claimant sustained a 25% permanent partial disability of the body as a whole, rated at the cervical spine due to a disc herniation of the C4-5 and C5-6, which required surgery in 2001. A load factor of 10% should be applied. Accordingly, Claimant is entitled to 169 weeks of permanent partial disability benefits from Employer. Further, she is entitled to an additional 6 weeks of disfigurement for her neck scar. No disfigurement is awarded for her right wrist scar.

As a result of the May 7, 1998 injury, Claimant is awarded \$40,052.80 which are reasonable necessary medical expenses to help cure and alleviate the effects of her work related injury. Further, Claimant is owed temporary total disability benefits as a result of her surgery on the right wrist from June 5, 1998 to August 26, 1998 (11 5/7 weeks), and from January 31, 2001 to October 1, 2001 as a result of her first neck surgery (34 4/7 weeks).

Claimant failed to prove that she sustained any permanent partial disability as a result of her April 30, 1999 injury, and no permanent partial disability benefits are awarded. The claim against the Second Injury Fund is dismissed.

Claimant has a 5% permanent partial disability of the body as a whole rated at the lumbar spine due to a sprain/strain injury, and no additional permanent partial disability at the cervical spine due to her sprain/strain injury resulting from her

January 11, 2000 work accident, for a total of 20 weeks of permanent partial disability. Because it does not rise to the requisite level of permanent partial disability to trigger Second Injury Fund liability, no benefits are awarded, and the claim against the Second Injury Fund is dismissed.

Claimant's repetitive work activities are a substantial factor in causing her diagnosed herniated disc in October 2001, her subsequent medical treatment and resulting disability. As a result of the November 14, 2001 work related injury, Claimant sustained a 25% permanent partial disability of the body as a whole rated at the cervical spine due to the disc herniation at the C3-4 that required a discectomy and fusion with instrumentation. Additionally, Claimant is entitled to recovery of 6 weeks of disfigurement for her second surgical scar. Further, Claimant is entitled to recover her reasonable and necessary medical expenses incurred to alleviate the effects of her work related injury in the total sum of \$29,989.00 for treatment rendered between October 25, 2001 and February 18, 2003. As a result of this last injury, Claimant was temporarily and totally disabled from January 17, 2002 through January 25, 2002, and from January 31, 2002 through February 18, 2003, when she last saw Dr. Riew (55 6/7 weeks).

Claimant has failed to meet her burden of proving that Employer is liable for future medical benefits, and none are awarded.

Claimant's employment as a Head Cook was hand intensive, and she was required to lift heavy objects on a frequent and routine basis, in awkward positions, at and above her head. Based upon the well-reasoned opinions of Dr. Volarich, and taking into consideration the repetitive nature of her work over a period of more than 20 years, I conclude her work activities were a substantial factor in causing her diagnosed conditions referable to her wrists, right shoulder, and neck, resulting in substantial medical treatment, lost time from work, and severe permanent disabilities.

In arriving at my decision, I note Employer failed to promptly respond to Claimant's requests for medical treatment and refused her requests for a step stool to avoid having to stand on her toes and lift at or above her shoulders. Claimant had been experiencing problems for more than a year before her supervisor completed a report of injury and referred her for treatment. A report was not completed until after Claimant lost control of her right hand and spilled soup on a customer. According to the medical records, Claimant's complaints were not limited simply to her right and left wrists. She also complained of right shoulder and neck pain. Dr. Ollinger, Employer's authorized medical provider, treated her with prescription medications for her right shoulder complaints. Despite the recommendations of Dr. Ollinger, Employer refused to refer Claimant to an orthopedist.

Drs. Ollinger, Volarich and Lee agree that Claimant's diagnosed carpal tunnel syndrome is work related. Dr. Lee disagrees, however, with Dr. Volarich on the causal relationship between claimant's work activities and her diagnosed right shoulder and neck problems. I find Dr. Lee's opinion on the issues of causation with regard to the neck and shoulder unpersuasive.

Dr. Lee's conclusion that Claimant's right shoulder problems are not work related lacks explanation. Dr. Lee's conclusionary opinion overlooks the fact that Dr. Ollinger provided treatment for Claimant's shoulder. Dr. Lee's opinion on causation also ignores the repetitive nature of Claimant's work and is inconsistent with his own testimony that tendonitis and adhesive capsulitis, as a secondary response to tendonitis, can be caused by repetitive motion.

For similar reasons, I reject Dr. Lee's causation opinion regarding Claimant's multi-level cervical disc herniations. Dr. Lee attributes Claimant's neck problems to degenerative changes in the spine. Dr. Lee's opinion, however, disregards the cause of the degenerative changes. By his own description, the August 17, 1999 MRI findings and the x-rays taken by Dr. Wayne showed wear and tear change. Furthermore, Dr. Lee admitted that Claimant's disc herniations could have been caused by repetitive trauma.

With respect to the November 2001 claim, I find Dr. McGraw's causation opinion is unsupported by a rational explanation and is otherwise unconvincing. Following her first neck surgery, and within days after returning to work, Claimant began to experience new problems with her neck and right upper extremity. As explained by Dr. Volarich, her first spinal fusion made her vulnerable to additional cervical disc herniations above or below the fused disc space. Although Claimant was returned to work with restrictions, it is clear that Claimant's work activities were a substantial factor in causing the large disc herniation at the C3-4 level on the right requiring medical treatment, including surgery, and resulting in additional disability.

Finally, as a result of the last injury in combination with her preexisting disabilities, Claimant was rendered permanently and totally disabled under the Workers' Compensation Act. Accordingly, the Second Injury Fund is liable for the payment of permanent total disability benefits for the rest of Claimant's life.

Claimant suffered disabilities as a result of her May 7, 1998, January 11, 2000, and November 14, 2001 work injuries. These disabilities constituted a hindrance or obstacle to employment. Following her last injury, she has not been able to return to work because of her intractable pain. I find Claimant's testimony to be credible. The record also shows that Claimant suffers from disabling pain that severely limits her ability to perform her daily activities, let alone unskilled sedentary work on a sustained basis. Accordingly, based upon

Claimant's credible testimony and the expert reports and testimony of Dr. Volarich and Mr. Lalk, I find that Claimant is unable to compete in the open labor market and, thus, is permanently and totally disabled.

This award is subject to an attorney's lien of 25% in favor of Claimant's attorney, Mr. Charles Bobinette.

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

Margaret D. Landolt  
*Administrative Law Judge*  
*Division of Workers' Compensation*

A true copy: Attest:

\_\_\_\_\_  
Patricia "Pat" Secret  
*Director*  
*Division of Workers' Compensation*

Issued by THE LABOR AND INDUSTRIAL RELATIONS COMMISSION

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

Injury No.: 01-161057

Employee: Diane Smith

Employer: The Board of Education of the City of St. Louis

Insurer: Self-Insured

Additional Party: Treasurer of Missouri as Custodian  
of Second Injury Fund

Date of Accident: November 14, 2001

Place and County of Accident: St. Louis, 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 November 14, 2005. The award and decision of Administrative Law Judge Margaret D. Landolt, issued November 14, 2005, is attached and incorporated by this reference.

The Commission further approves and affirms the administrative law judge's allowance of attorney's fee herein as being fair and reasonable.

Any past due compensation shall bear interest as provided by law.

Given at Jefferson City, State of Missouri, this 24<sup>th</sup> day of August 2006.

LABOR AND INDUSTRIAL RELATIONS COMMISSION

\_\_\_\_\_  
William F. Ringer, Chairman

\_\_\_\_\_  
Alice A. Bartlett, Member

\_\_\_\_\_  
John J. Hickey, Member

Attest:

\_\_\_\_\_  
Secretary

**AWARD**

Employee: Diane Smith Injury No.: 01-161057  
Dependents: N/A Before the  
**Division of Workers'**  
Employer: The Board of Education of the City of St. Louis **Compensation**  
Department of Labor and Industrial  
Additional Party: Second Injury Fund Relations of Missouri  
Jefferson City, Missouri  
Insurer: Self-Insured  
Hearing Date: August 8, 2005 Checked by: MDL:tr

**FINDINGS OF FACT AND RULINGS OF LAW**

1. Are any benefits awarded herein? Yes
5. 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
10. Date of accident or onset of occupational disease: November 14, 2001
11. State location where accident occurred or occupational disease was contracted: St. Louis
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
12. 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:  
Employee used neck in a repetitive fashion.
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: Cervical spine

17. Nature and extent of any permanent disability: 25% permanent partial disability of the body as a whole referable to the cervical spine
15. Compensation paid to-date for temporary disability: -0-
16. Value necessary medical aid paid to date by employer/insurer? \$1,005.11

Employee: Diane Smith Injury No.: 01-161057

17. Value necessary medical aid not furnished by employer/insurer? \$29,989.00
21. Employee's average weekly wages: \$460.18
19. Weekly compensation rate: \$306.79/\$306.79
20. Method wages computation: Stipulation

#### COMPENSATION PAYABLE

21. Amount of compensation payable:

Unpaid medical expenses: \$29,989.00

55 6/7 weeks of temporary total disability (or temporary partial disability) \$17,134.74

100 weeks of permanent partial disability from Employer \$30,679.00

22. Second Injury Fund liability: Yes

Permanent total disability benefits from Second Injury Fund:  
\$306.76 payable for the life of Claimant. Payment shall begin 100 weeks  
after February 19, 2003. \*

TOTAL: INDETERMINATE

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:

Mr. Charles Bobinette

### FINDINGS OF FACT and RULINGS OF LAW:

Employee: Diane Smith Injury No.: 01-161057

Dependents: N/A Before the

**Division of Workers'**

Employer: The Board of Education of the City of St. Louis **Compensation**  
Department of Labor and Industrial  
Additional Party: Second Injury Fund Relations of Missouri  
Jefferson City, Missouri  
Insurer: Self-Insured Checked by: MDL:tr

**PRELIMINARIES**

A hearing was held on August 8, 2005, at the Division of Workers' Compensation in the City of St. Louis. Diane Smith ("Claimant") was represented by Mr. Charles Bobinette. The Board of Education of the City of St. Louis ("Employer"), which was self-insured, was represented by Ms. Robin Higgins. The Second Injury Fund was represented by Assistant Attorney General Rachel Paul. Claimant filed four claims: 98-068375 (date of injury May 7, 1998); 99-054526 (date of injury April 30, 1999); 00-005912 (date of injury January 11, 2000); and 01-161057 (date of injury November 14, 2001). By agreement, the claims were consolidated and tried together. Claimant's attorney requested a fee of 25% of Claimant's awards.

In Injury Number 98-068375, the parties stipulated that Claimant's average weekly wage is \$359.06, and the permanent partial and temporary total disability rate is \$239.37. Employer paid \$6,780.65 in medical expenses. The issues in this claim are occupational disease, medical causation, past due temporary total disability benefits, past medical expenses, disfigurement, and nature and extent of permanent partial disability referable to the right and the left wrists, right upper extremity, shoulder and neck.

In Injury Number 99-054526, the parties stipulated that as of April 30, 1999, Claimant's average weekly wage was \$416.21, yielding a permanent partial disability rate of \$277.47. Employer paid \$342.13 in medical expenses, and no temporary total disability benefits. The issues presented are nature and extent of permanent partial disability referable to the back, and liability of the Second Injury Fund.

In Injury Number 00-005912, the parties stipulated Claimant's average weekly wage is \$434.94 and the permanent partial disability rate is \$289.96. Employer paid \$1,976.93 in medical expenses, and no temporary total disability benefits. The issues are nature and extent of permanent partial disability of the neck and lower back, and liability of the Second Injury Fund.

In Injury Number 01-161057, the parties stipulated Claimant's average weekly wage is \$460.18, and the total disability and permanent partial disability rate is \$306.79. Employer paid \$1,005.11 in medical expenses, and no temporary total disability benefits. The issues presented for resolution are occupational disease, medical causation, past due temporary total disability benefits, disfigurement, past and future medical expenses, nature and extent of permanent partial disability, permanent total disability, and liability of the Second Injury Fund.

**FINDINGS OF FACT**

Claimant is 50 years old and is right-handed. In 1972, after completing the eleventh grade at Sumner High School, she dropped out of school. In the early 1980s, she obtained her GED. Claimant has no vocational training, office experience, or computer or typing skills. In the early 1970s, Claimant worked at a McDonald's restaurant as a food service worker for a couple of months. She then moved to Michigan where she worked at a factory assembling toys for about a year. In 1973, she returned to St. Louis.

In 1978, Employer hired Claimant as a food service worker preparing lunches. She was promoted to Baker, and eventually to a Head Cook II. She worked from 6:00 a.m. to 2:30 p.m., Monday through Friday, ten months a year. She prepared approximately 200 breakfasts and 600 lunches each day as a Head Cook. She supervised ten to eleven workers. She was not required to plan menus, order food, or perform personnel work. Sometimes, she had to help serve the food as a fill-in when another worker was absent. She spent most of her time on her feet, and performed paperwork at the end of the day. Daily, she used both hands for slicing, dicing, peeling, scooping, pulling, cutting and stirring. When cooking, the heaviest she had to lift were pans, which weighed between 35 and 40 pounds when filled. She was required to reach overhead and use her upper extremities constantly. Claimant continuously looked down as she cooked, and raised her head backwards when she lifted. When lifting, she had to stand on her toes holding the pans in her hand and reach overhead to put them into the oven or rack. Claimant asked her supervisor for a step stool, but was never provided with one.

Claimant began experiencing problems with her hands, right shoulder and neck in late 1996 or early 1997. Although she requested medical treatment on several occasions, her supervisor did not prepare a report until Claimant lost control of her hand and spilled hot soup on a customer. On April 7, 1998, Claimant was seen by her private physician, Dr. Josyula, who suspected bilateral carpal tunnel syndrome and diagnosed cervical strain. Dr. Josyula felt that her condition was work related.

Eventually, on April 29, 1998, Employer referred Claimant to Dr. Ollinger, who diagnosed possible bilateral carpal tunnel syndrome substantially related to her work activities, and a small ganglion volar of the right wrist (not work related). Nerve conduction studies performed on the same day were abnormal on the right hand and normal on the left. On May 7, 1998, Dr. Ollinger prescribed medications and hand splints to be worn at night. Dr. Ollinger suggested that if she did not respond to medical treatment, she should be referred to an orthopedist for her shoulder complaints.

On June 11, 1998, Claimant continued to complain of bilateral numbness and tingling of her hands, and right shoulder pain. Dr. Ollinger recommended surgery on the right wrist, and an orthopedic referral for her right shoulder problem if her symptoms continued after her carpal tunnel syndrome surgery and post op rest.

Surgery was performed at Missouri Baptist Hospital on June 23, 1998. On July 6, 1998, Dr. Ollinger recommended alternative work with light use of the right hand, no power gripping, and a five-pound lifting restriction. Dr. Ollinger released Claimant to regular work on September 24, 1998. On December 3, 1990, Dr. Ollinger gave Claimant a 0% permanent partial disability rating on both wrists, and found no symptoms or signs of left carpal tunnel syndrome. He noted that her NCVs were normal. He did not feel that Claimant required any additional evaluation, care or work restrictions, and felt Claimant was at maximum medical improvement. On January 7, 1999, Employer refused to authorize any additional medical treatment for Claimant based upon Dr. Ollinger's report.

Claimant planned to work during the summer school break cleaning offices with her sister. Because of the planned surgery and her recovery, she remained unemployed between June 5 and the start of school on August 26, 1998. On September 24, 1998, Dr. Ollinger released Claimant for regular work.

Claimant continues to have difficulty with her right hand following her surgery. She frequently rubs her right hand to alleviate her pain. She has reduced strength, which results in difficulty with such tasks as opening jars, combing her hair, vacuuming, and grasping items. She frequently drops things.

On January 15, 1999, Claimant was seen by Dr. Josyula for right shoulder problems. Claimant reported that for the past several months, she had been having progressive discomfort in her right shoulder area, and that her work involved picking up steam table pans on a regular basis. At the time of her examination, she could not raise her arm above her head. She was diagnosed with a history of rotator cuff strain versus tear. She was prescribed medications, and referred to Dr. Kenneth Yamaguchi, an orthopedic surgeon.

On February 22, 1999, Claimant was seen by Dr. Yamaguchi. On physical examination, she had pain with increased internal rotation, weakness and tenderness. Claimant also had pain with extreme cervical spine extension with some recreation of the shoulder pain symptoms. She complained of fatigue in her arm with mild activities. Dr. Yamaguchi felt that she had right rotator tendonitis with possible cervical spine radiculopathy. The area was injected, physical therapy was prescribed, and she was referred to Dr. Heidi Prather.

Dr. Prather evaluated Claimant on March 11, 1999, and diagnosed cervical segmental dysfunction and to rule out cervical radiculopathy and rotator cuff tendonitis. Claimant was prescribed Lodine for pain control, physical therapy for flexibility, and strengthening exercises for her cervical spine. X-rays of the cervical spine taken on March 11, 1999 revealed mild degenerative disc disease at the C4-5 levels.

On March 17, 1999, Claimant, through her counsel, notified Employer that she was seeking medical treatment on her own and would look to Employer for reimbursement.

Between March 11 and May 13, 1999, Claimant had eight sessions of physical therapy. Although her right shoulder pain improved, her right lateral neck pain continued.

On April 30, 1999, Claimant suffered a work-related injury when she jolted her mid back when pulling a bread rack from the walk-in refrigerator at work. She was seen at BJC Corporate Health on April 30, 1999. X-rays of her thoracic spine were negative, and Ibuprofen was prescribed. Claimant was diagnosed with a parathoracic sprain. Claimant was off work until May 3, 1999, at which time she was returned to full duty.

On July 27, 1999, Claimant was in tears when she was seen by Dr. Josyula complaining of worsening of her right shoulder discomfort. Claimant was unable to elevate her shoulder above her head and was having difficulty ambulating normally. Claimant was given a Toradol shot and referred back to Dr. Prather. An MRI of the cervical spine performed on August 17, 1999 revealed focal kyphosis with surrounding muscle spasm from C4-C5 intervertebral disc herniation, with extruded disc material.

Claimant came under the care of Dr. Daniel Riew on August 31, 1999. According to his records, she complained of neck and arm pain for approximately 1-½ years, which she related to lifting at work. She also reported having problems picking up small objects. She reported her worst position was standing, and lying down eased her pain. Dr. Riew diagnosed interscapular pain, shoulder pain, radiculopathy secondary to herniated disc at 4-5, cervical kyphosis and foraminal stenosis at 4-5 and to a lesser extent at 5-6. He recommended epidural steroid injections and, if they failed to resolve the problem, surgery.

On September 22, 1999, Claimant was seen at the BJC Pain Management Center by Dr. Karanikolas complaining of pain in the neck, right shoulder, and right upper extremity radiating into the fingers since April 1997. Initially, the pain was sharp in her neck and shoulder and became a continuous dull pain down her right arm and into her fingers. Associated symptoms included nausea, dizziness, blurred vision, numbness, tingling, noise sensitivity, and irritability. Examination of the neck showed muscle spasms and trigger points with tenderness over the cervical vertebrae. Dr. Karanikolas diagnosed bilateral foraminal C4-5 and C5-6 stenosis, chronic right sided neck and upper extremity pain, with significant myofascial pain components, right sided radiculopathy, and slight weakness of the right upper extremity, apparently related to radiculopathy. The recommended treatment plan included physical therapy, epidural injections, Medrol dose pack, and trigger point injections.

On January 11, 2000, Claimant was putting chicken wraps into the oven when she knocked over a bucket of grease, slipped, and fell, burning her left hip on hot grease. Claimant was treated at Barnes Care where x-rays were taken of the low back and left hip. Left hip films revealed mild bilateral hip osteoarthritis without fracture. Low back films were negative. Cervical spine films showed: a straightening of the cervical spine without evidence of fracture, incomplete visualization of the C7 vertebral body and mild cervical spondylosis at the C4-5. Claimant was prescribed physical therapy and medications and given a ten-pound lifting restriction. Claimant was referred to Dr. Wayne who diagnosed right worse than left sacroiliitis, lumbosacral sprain, cervical sprain, and status post left elbow contusion, and continued Claimant's conservative treatment.

On February 28, 2000, Dr. Wayne recorded that Claimant had moderate improvement with therapy, but continued to experience pain in her neck and low back. Her cervical range of motion was approximately 80% of normal. She was 75% of normal on left rotation with most of the pain being in the right lower neck, left rotation. Lumbosacral range of motion showed 75% of normal on flexion. Dr. Wayne prescribed three more weeks of physical therapy and limited duty. On March 14, 2000, Claimant reported that she continued to have difficulty performing her job because of her pain in the trapezius region with stirring and overhead lifting. Lumbosacral range of motion was within normal limits. Cervical range of motion was approximately 80% of normal for extension and in flexion. Dr. Wayne found her to be at maximum medical improvement and released her to full duty. As of April 5, 2000, Dr. Wayne felt that Claimant sustained a 5% permanent disability of the neck, but no disability to the lumbar region as a result of her work accident of January 11, 2000.

Claimant continued her medical treatment with Drs. Josyula and Riew. On November 17, 2000, she reported to Dr. Josyula that she had complaints of pain and discomfort involving her right shoulder area and that her arm strength was diminished. Medications were prescribed and she was referred to Dr. Riew for possible surgical intervention. She next saw Dr. Josyula on December 4, 2000 for pain in the upper neck and shoulders and asked to be taken off work because of her problems.

On January 23, 2001, she was seen by Dr. Riew. A repeat MRI of the cervical spine was performed on February 5, 2002, which revealed cervical kyphosis, cord compromise at C4-5 and to a lesser extent, at C5-6. Dr. Riew suggested surgery.

Claimant was referred for a second opinion to Dr. Christina Lenk, who recommended an EMG and nerve conduction study, and prescribed medications for her pain symptoms. The March 1, 2001 EMG nerve conduction studies were consistent with C4-5 radiculopathy and milder underlying median nerve lesion at the right wrist. Dr. Lenk suggested it was likely that surgery would be needed, but recommended a more conservative approach, including another course of physical therapy and pain medications.

According to the Barnes Jewish Hospital medical records, on March 12, 2001, Dr. Riew performed a carpectomy of the C5, and fusion of the C4-C6 with anterior cervical plate mesh cages, and right iliac crest bone grafting. The postoperative diagnosis was cervical herniated disc and spondylosis causing mild radiculopathy at the C4-5 and C5-6 levels.

Claimant was taken off of work while she recuperated from her surgery. When Claimant followed up with Dr. Riew on April 24, 2001, she stated that she continued to have upper trapezial pain, but that her arm symptoms had resolved. On June 19, 2001, she continued to complain of trapezial pain and occasional pain in her arm, although her tingling and numbness had improved. Dr. Riew felt that there were two explanations for her continued problems: (1) that she was beginning to heal; and, (2) there was a possibility that she was having problems at the C4-5 and C6-7 levels. He recommended that Claimant continue to wear her cervical collar and try to increase her aerobic exercise. On July 24, 2001, Dr. Riew referred Claimant to Dr. Galatz for treatment of her right shoulder pain.

Claimant complained to Dr. Galatz that she could not sleep at night, and she had trouble lifting her right arm over her head. Claimant was diagnosed with rotator cuff tendonitis and was injected with Cortisone and Lidocaine.

Claimant was next seen by Dr. Galatz on September 18, 2001. She reported that her shoulder felt good after the injection, however the pain had returned in moderate intensity. Dr. Riew ordered physical therapy.

Between January 1999 and September 18, 2001, Claimant incurred medical expenses for treatment of her right shoulder and neck while under the treatment of Drs. Josyula, Yamaguchi, Prather, Riew, Karanikolas, Lenk and Galatz in the sum of \$40,052.80.

Claimant returned to work with Employer on October 1, 2001. On October 9, 2001, she was seen by Dr. Josyula for complaints of numbness in her fingers and left hand for the past four or five days, and weakness in her hand muscles. On October 25, 2001, Claimant had electro diagnostic studies performed by Dr. John P. Metzler and an MRI. The MRI showed a disc herniation at the L3-4, and a bulge at the C6-7 levels. Dr. Riew referred Claimant to Dr. Greg Smith for nerve root injections, which were performed in November and December 2001.

On January 2, 2002, Claimant returned to see Dr. Josyula, who referred her to Dr. Riew. It was Dr. Riew's opinion that Claimant's symptoms arose from problems at the C3-4 and C6-7 levels. He recommended a circumferential fusion at both levels. He also stated, "she is going to need to get workers' compensation approval for this and then she will return to see me." At the request of Employer, Claimant was seen by Dr. Dennis M. McGraw on January 28, 2002. Dr. McGraw felt that her ruptured disc was not work related because there was "no specific injury associated", and referred her back to Dr. Riew as soon as possible for treatment.

On March 19, 2002, Claimant underwent a myelogram CT scan which showed a large disc herniation at the C3-4 on the right that compressed the spinal cord. Dr. Riew recommended urgent surgery to remove the old plate and to do an anterior cervical discectomy and fusion at C3-C4, using autograft and a cross plate. On March 25, 2002, surgery was performed. The post-operative diagnoses were herniated nucleus pulposus, C3-4 with myeloradiculopathy, post C4-6 anterior cervical decompression and fusion.

Following her surgery, she continued to treat with Dr. Riew. Claimant's x-rays taken on August 20, 2002 showed a small disc protrusion at C6-7, which was causing some neck pains and numbness and tingling in the left long finger on the left side. Dr. Riew recommended that she should consider surgery if her symptoms worsened. Dr. Riew restricted her lifting to not more than 10 pounds and pushing or pulling to not more than 20 pounds. Claimant testified that the last time she saw Dr. Riew was on February 18, 2003. She was unable to see him because she no longer had insurance. Claimant testified that Dr. Nester is her physician now and he prescribes Hydrocodone for neck and shoulder pain and a muscle relaxant. She uses a cane for foot pain, and for low back pain, which she attributes to her slip and fall on January 11, 2000.

Between October 25, 2001 and February 18, 2003, Claimant incurred medical expenses for treatment while under the care of Drs. Josyula, Smith, Metzler and Riew for treatment of her right and left upper extremities and neck pain in the sum of \$29,989.00.

Dr. Thomas Lee, an orthopedic surgeon, testified on behalf of Employer. Dr. Lee examined Claimant on November 10, 2003. On physical examination, Dr. Lee noted Claimant's forward flexion of the neck was 35 degrees compared to 65 degrees in a normal patient her age. Extension of her neck was limited to 25 degrees compared to normal of 55-65 degrees. Rotation of the neck was limited to 35 degrees in each direction compared to normal of 80-85 degrees. Claimant's limitations were consistent with her two spinal surgeries. Impingement sign and internal rotation testing showed a slightly

decreased internal rotation on the right with internal rotation to the L3 versus the T12, suggesting adhesive capsulitis on the right. On testing of the wrist, Phalen's was positive on the right, which suggested that there was some residual from the carpal tunnel syndrome.

Based upon a reasonable degree of medical certainty, Dr. Lee opined that Claimant's right carpal tunnel syndrome was causally related to her work activities as a Head Cook. He ascribed a 6% permanent partial disability to her right wrist, but no disability to her left wrist because of the lack of symptoms at the time of the examination. Dr. Lee did not believe that Claimant's right shoulder and neck complaints were work related, and therefore did not offer an opinion on nature and extent of disability.

On cross-examination, Dr. Lee acknowledged that Dr. Ollinger and BJC treated Claimant for right shoulder and cervical complaints. Dr. Lee further acknowledged that tendonitis and adhesive capsulitis, as a secondary response to tendonitis, could be caused by repetitive motion. Likewise, under some circumstances, herniation of the cervical disc could be caused by repetitive trauma to the neck.

According to the medical records reviewed by Dr. Lee, on April 30, 1999, Claimant sustained a parathoracic strain which required conservative medical treatment. Dr. Lee described her injury to the upper back between the shoulder blades. Further, the record showed that Claimant sustained a work injury on January 11, 2000 that required medical treatment provided by Dr. Andrew Wayne. According to the medical records, Claimant sustained a cervical strain, which could have weakened the integrity of the cervical spine temporarily, including the neck, which could have made her more vulnerable to cervical disc herniation. The cervical x-rays taken by Dr. Wayne and the August 17, 1999 MRI were consistent in that both showed wear and tear changes in the spine. Finally, Dr. Lee acknowledged that the medical treatment provided Claimant was reasonable and necessary to help relieve Claimant's shoulder and neck complaints, and that the charges for such treatment were reasonable.

Dr. David Volarich testified on behalf of Claimant. When Dr. Volarich saw Claimant in March 2003, she continued to have problems with diminished motion and pain at the base of the skull in both trapezius muscles, right more left. She was having problems with radiating pain into the index and long fingers of both hands. She also reported headaches that occurred two or three days of the week, which were located in the temple portion of the skull, the forehead, and at the base of the skull and neck. She reported that fixed positions aggravated her neck pain, and that she could only sit for 30 minutes. Overhead use of her arms was difficult because of the diminished motion of her neck, and that she could not look up without having neck pain. Claimant has difficulty performing any repetitive hand activities. If she writes one letter, her hand fatigues. Dexterity is diminished to the point where she is unable to work on the computer. Her grip strength is diminished and she has difficulty using tools.

On physical examination, Claimant's cervical spine range of motion was severely restricted. Palpation of the neck elicited pain in the trapezius muscles at the insert of the dorsal junction, the right being worse than the left. Dr. Volarich also found trigger points at the C6-7 midline. There was also loss of range of motion of the thoracic spine. Palpation of the mid back elicited pain in the paraspinal muscles, the right being worse than the left, from the T4 to the T8. Further, there was loss of range of motion in the lumbar spine. Dr. Volarich also found a right trigger point in the right sacrospinous notch. Straight leg raising was accomplished at 70 degrees on the left with back pain and on the right at 45 degrees with back pain that radiated into the right thigh and calf. In the right shoulder, there was a 10% loss of motion as evaluated by the Apley Scratch Test. There was also a similar loss of motion in the left shoulder and trapezius pain with weakness.

Examination of the hands showed the dexterity to the fingers was slow bilaterally. There was a one-centimeter scar over the ventral surface of the right wrist from her carpal tunnel release. Grip strength in the right as compared to the left was weak. Further, Dr. Volarich found asymmetric bulk loss in the upper extremities. Strength in both shoulders was weak to confrontational testing of the deltoid and rotator cuff. The tricep on the right was also weak. Finally, Dr. Volarich noted that Claimant walked with forward flexion at the waist by approximately 15 degrees and she moved about the examination room slowly.

After reviewing the medical records and taking a detailed job description from Claimant, Dr. Volarich concluded that her work activities were a substantial contributing factor in causing bilateral carpal tunnel syndrome, which required right endoscopic carpal tunnel release and cervical disc herniations at the C4-5 and C5-6 that required a two level discectomy and fusion with instrumentation. Further, Claimant's repetitive activities also aggravated her right shoulder AC joint, degenerative arthritis, and caused some rotator cuff tendonitis. Specifically, Dr. Volarich felt that these conditions were a result of her having to lift heavy objects at work, work in awkward positions, and perform a lot of bending, twisting, stooping and overhead work. Dr. Volarich also testified that the medical treatment offered by Drs. Josyula, Yamaguchi, Prather, Riew and Lenk was reasonable and necessary to alleviate the effects of her work-related injuries to her right upper extremity, shoulder and neck. Dr. Volarich further testified, based upon a reasonable degree of medical certainty, the normal

recuperative period following an endoscopic release of carpal tunnel was approximately six weeks.

Dr. Volarich testified that after her first neck surgery, Claimant was vulnerable to further herniation of the disc space above or below the fusion. Dr. Volarich explained that when a patient bends her head forward, for example, all of the stress is going to be at the C3-4 level, or at the C6-7 level. After she returned to work as a Head Cook on October 1, 2001, Claimant herniated the cervical disc space above the fused disc as a result of her repetitive work activities.

With respect to the May 7, 1998 claim, based upon a reasonable degree of medical certainty, Dr. Volarich opined that there is a 35% permanent partial disability of the right upper extremity rated at the right wrist due to the carpal tunnel syndrome that required endoscopic carpal tunnel release. The rating accounts for her pain, paresthesias and weakness in her dominant hand. Additionally, there was a 20% permanent partial disability of the left upper extremity rated at the wrist due to mild carpal tunnel syndrome. The rating accounted for pain, paresthesias and weakness in the non-dominant hand. Further, there is a 15% permanent partial disability of the right upper extremity of the shoulder due to aggravation of the AC joint, degenerative arthritis, and rotator cuff tendonitis, that required conservative care. The rating takes into account her pain, paresthesias and weakness in the dominant shoulder. There is also a 40% permanent partial disability of the body as a whole, rated at the cervical spine, due to the cervical disc herniation at the C4-5, and at the C5-6, which required discectomy carpectomy and fusion with instrumentation. The rating accounted for the injury's contribution to neck pain, loss of motion and headaches.

Dr. Volarich opined as a result of the November 14, 2001 injury, there is an additional 25% permanent partial disability to the body as a whole, rated at the cervical spine due to the disc herniation at C3-4 (above the prior fusion), which required discectomy and fusion with instrumentation. The rating takes into account the injury's contribution to her neck pain and loss of motion.

Pertaining to the April 30, 1999 injury, he attributed is a 15% permanent partial disability of the body as a whole rated at the thoracolumbar spine due to the sprain/strain injury that required conservative care. The rating takes into account claimant's ongoing pain and loss of motion.

With respect to the January 2000 injury, he found a 10% permanent partial disability referable to the body as a whole, rated at the lumbosacral spine due to the sprain/strain injury that required conservative care, and a 5% permanent partial disability of the body as a whole rated at the cervical spine due to the sprain/strain injury that required conservative care. Dr. Volarich further concluded that the disabilities suffered by Claimant were greater than their simple sum and that a loading factor should be added to the disability ratings.

Dr. Volarich advised Claimant to limit repetitive bending, twisting, lifting, pushing, pulling, carrying and climbing and other similar tasks to an as-needed basis. He recommended that she not handle any weight greater than 10 to 15 pounds and to limit this task to an occasional basis assuming proper lifting techniques. He recommended against handling weight over her head and away from her body, and/or carrying weight over long distances or on uneven terrain. She was advised to avoid remaining in fixed positions for longer than 15 to 30 minutes, including both sitting and standing, and to change positions frequently to maximize comfort and to rest when needed. Claimant was directed not to handle any weights greater than 1 to 2 pounds with either upper extremity alone, particularly with her arms extended away from her body. Close to the body, he recommended against lifting more than 3 to 5 pounds. Finally, he recommended appropriate stretching, strengthening and range of motion exercise programs, in addition to non-impact aerobic conditioning such as walking, biking or swimming to tolerance daily.

Based upon his May 2003 examination, he felt Claimant had reached maximum medical improvement as a result of her work accidents, but cautioned that she may require additional care for her disc protrusions at the C3-4 and C6-7 as well as the reported lumbar spine disc herniations. Further, in order to maintain her current state, Dr. Volarich opined that she would require ongoing care for her pain syndrome using narcotics and non-narcotic medications (NSAIDS), muscle relaxants, other such similar treatments for symptomatic relief.

Finally, Dr. Volarich recommended that Claimant undergo vocational evaluation and assessment to determine if she might be able to return to work. Claimant was evaluated by Mr. Timothy Lalk on September 25, 2003.

Mr. Lalk testified on behalf of Claimant. Based upon a reasonable degree of professional certainty, Mr. Lalk concluded Claimant is not able to secure and maintain employment in the open labor market, and is not able to compete for any position because of her medical conditions.

In summary, Mr. Lalk described Claimant as having basically worked in entry-level positions, primarily in food service. Considering the restrictions given to her by Dr. Volarich, Claimant would not be able to function in an unskilled sedentary position on a regular basis. At the time of her evaluation, she had been out of school for approximately 30 years.

Mr. Lalk explained persons in Claimant's position often have difficulty getting back into the discipline of a formal education program. Based upon her physical restrictions and problems, Claimant is not a candidate for vocational rehabilitation.

Based upon Dr. Volarich's review of the report of Dr. Lalk, he determined that Claimant was permanently and totally disabled as a result of the combination of her work related injuries leading up to May 7, 1998, April 30, 1999, January 11, 2000, and November 14, 2001.

Claimant last worked on January 31, 2002. She does not believe she can return to any form of work because of her chronic pain. She has limitation of motion in her neck and shoulders. She habitually rubs her right hand because of numbness and tingling in her fingers. She has difficulty gripping and firmly holding onto objects. She has difficulty standing and sitting for prolonged periods of time and uses a cane. During the hearing she frequently changed positions, had difficulty rising from a seated position, and asked for water to take pain medication. The pain medication interferes with her ability to concentrate, and makes her drowsy. Throughout the day, she needs to lie down or sit in a reclined position using a pillow to support her neck. She has a pain in her neck at night that interferes with sleep. She is continuously fatigued. Although she has a driver's license and a handicap license plate, she relies upon her daughters to drive her, except when traveling short distances. She also relies upon her daughters to perform housework, daily chores, and cooking. Claimant also needs assistance getting in and out of the shower.

As a result of the two neck surgeries, Claimant is left with a large surgical scar across her neck. Claimant has been asked if she was attacked, causing her embarrassment. Claimant is not, however, bothered by her right wrist surgical scar.

Claimant testified in a credible and truthful manner.

### **RULINGS OF LAW**

Based upon my observations of Claimant at hearing, my comprehensive review of the medical evidence, and the application of Missouri law, I find:

As a result of the May 7, 1998 injury, Claimant sustained a 17 ½% permanent partial disability of the right upper extremity rated at the wrist. Claimant failed to prove that she sustained any permanent partial disability as a result of her left carpal tunnel syndrome. I further find Claimant has a 10% permanent partial disability of the right upper extremity at the shoulder due to aggravation of the AC joint, degenerative arthritis, and rotator cuff tendonitis. Further, Claimant sustained a 25% permanent partial disability of the body as a whole, rated at the cervical spine due to a disc herniation of the C4-5 and C5-6, which required surgery in 2001. A load factor of 10% should be applied. Accordingly, Claimant is entitled to 169 weeks of permanent partial disability benefits from Employer. Further, she is entitled to an additional 6 weeks of disfigurement for her neck scar. No disfigurement is awarded for her right wrist scar.

As a result of the May 7, 1998 injury, Claimant is awarded \$40,052.80 which are reasonable necessary medical expenses to help cure and alleviate the effects of her work related injury. Further, Claimant is owed temporary total disability benefits as a result of her surgery on the right wrist from June 5, 1998 to August 26, 1998 (11 5/7 weeks), and from January 31, 2001 to October 1, 2001 as a result of her first neck surgery (34 4/7 weeks).

Claimant failed to prove that she sustained any permanent partial disability as a result of her April 30, 1999 injury, and no permanent partial disability benefits are awarded. The claim against the Second Injury Fund is dismissed.

Claimant has a 5% permanent partial disability of the body as a whole rated at the lumbar spine due to a sprain/strain injury, and no additional permanent partial disability at the cervical spine due to her sprain/strain injury resulting from her January 11, 2000 work accident, for a total of 20 weeks of permanent partial disability. Because it does not rise to the requisite level of permanent partial disability to trigger Second Injury Fund liability, no benefits are awarded, and the claim against the Second Injury Fund is dismissed.

Claimant's repetitive work activities are a substantial factor in causing her diagnosed herniated disc in October 2001, her subsequent medical treatment and resulting disability. As a result of the November 14, 2001 work related injury, Claimant sustained a 25% permanent partial disability of the body as a whole rated at the cervical spine due to the disc herniation at the C3-4 that required a discectomy and fusion with instrumentation. Additionally, Claimant is entitled to recovery of 6 weeks of disfigurement for her second surgical scar. Further, Claimant is entitled to recover her reasonable and necessary medical expenses incurred to alleviate the effects of her work related injury in the total sum of \$29,989.00 for treatment rendered between October 25, 2001 and February 18, 2003. As a result of this last injury, Claimant was temporarily and totally disabled from January 17, 2002 through January 25, 2002, and from January 31, 2002 through February 18, 2003, when she last saw Dr. Riew (55 6/7 weeks).

Claimant has failed to meet her burden of proving that Employer is liable for future medical benefits, and none are awarded.

Claimant's employment as a Head Cook was hand intensive, and she was required to lift heavy objects on a frequent and routine basis, in awkward positions, at and above her head. Based upon the well-reasoned opinions of Dr. Volarich, and taking into consideration the repetitive nature of her work over a period of more than 20 years, I conclude her work activities were a substantial factor in causing her diagnosed conditions referable to her wrists, right shoulder, and neck, resulting in substantial medical treatment, lost time from work, and severe permanent disabilities.

In arriving at my decision, I note Employer failed to promptly respond to Claimant's requests for medical treatment and refused her requests for a step stool to avoid having to stand on her toes and lift at or above her shoulders. Claimant had been experiencing problems for more than a year before her supervisor completed a report of injury and referred her for treatment. A report was not completed until after Claimant lost control of her right hand and spilled soup on a customer. According to the medical records, Claimant's complaints were not limited simply to her right and left wrists. She also complained of right shoulder and neck pain. Dr. Ollinger, Employer's authorized medical provider, treated her with prescription medications for her right shoulder complaints. Despite the recommendations of Dr. Ollinger, Employer refused to refer Claimant to an orthopedist.

Drs. Ollinger, Volarich and Lee agree that Claimant's diagnosed carpal tunnel syndrome is work related. Dr. Lee disagrees, however, with Dr. Volarich on the causal relationship between claimant's work activities and her diagnosed right shoulder and neck problems. I find Dr. Lee's opinion on the issues of causation with regard to the neck and shoulder unpersuasive.

Dr. Lee's conclusion that Claimant's right shoulder problems are not work related lacks explanation. Dr. Lee's conclusionary opinion overlooks the fact that Dr. Ollinger provided treatment for Claimant's shoulder. Dr. Lee's opinion on causation also ignores the repetitive nature of Claimant's work and is inconsistent with his own testimony that tendonitis and adhesive capsulitis, as a secondary response to tendonitis, can be caused by repetitive motion.

For similar reasons, I reject Dr. Lee's causation opinion regarding Claimant's multi-level cervical disc herniations. Dr. Lee attributes Claimant's neck problems to degenerative changes in the spine. Dr. Lee's opinion, however, disregards the cause of the degenerative changes. By his own description, the August 17, 1999 MRI findings and the x-rays taken by Dr. Wayne showed wear and tear change. Furthermore, Dr. Lee admitted that Claimant's disc herniations could have been caused by repetitive trauma.

With respect to the November 2001 claim, I find Dr. McGraw's causation opinion is unsupported by a rational explanation and is otherwise unconvincing. Following her first neck surgery, and within days after returning to work, Claimant began to experience new problems with her neck and right upper extremity. As explained by Dr. Volarich, her first spinal fusion made her vulnerable to additional cervical disc herniations above or below the fused disc space. Although Claimant was returned to work with restrictions, it is clear that Claimant's work activities were a substantial factor in causing the large disc herniation at the C3-4 level on the right requiring medical treatment, including surgery, and resulting in additional disability.

Finally, as a result of the last injury in combination with her preexisting disabilities, Claimant was rendered permanently and totally disabled under the Workers' Compensation Act. Accordingly, the Second Injury Fund is liable for the payment of permanent total disability benefits for the rest of Claimant's life.

Claimant suffered disabilities as a result of her May 7, 1998, January 11, 2000, and November 14, 2001 work injuries. These disabilities constituted a hindrance or obstacle to employment. Following her last injury, she has not been able to return to work because of her intractable pain. I find Claimant's testimony to be credible. The record also shows that Claimant suffers from disabling pain that severely limits her ability to perform her daily activities, let alone unskilled sedentary work on a sustained basis. Accordingly, based upon

Claimant's credible testimony and the expert reports and testimony of Dr. Volarich and Mr. Lalk, I find that Claimant is unable to compete in the open labor market and, thus, is permanently and totally disabled.

This award is subject to an attorney's lien of 25% in favor of Claimant's attorney, Mr. Charles Bobinette.

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

Margaret D. Landolt  
*Administrative Law Judge*  
*Division of Workers' Compensation*

A true copy: Attest:

\_\_\_\_\_  
Patricia "Pat" Secrest  
*Director*  
*Division of Workers' Compensation*