

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

Injury No.: 05-132393

Employee: Patricia Thomas
Employer: Pemiscot Memorial Health Systems (Settled)
Insurer: Self-Insured (Settled)
Additional Party: Treasurer of Missouri as Custodian
of Second Injury Fund

The above-entitled workers' compensation case is submitted to the Labor and Industrial Relations Commission (Commission) for review as provided by § 287.480 RSMo. Having reviewed the evidence and considered the whole record, the Commission finds that the award of the administrative law judge is supported by competent and substantial evidence and was made in accordance with the Missouri Workers' Compensation Law. Pursuant to § 286.090 RSMo, the Commission affirms the award and decision of the administrative law judge dated September 18, 2013, and awards no compensation in the above-captioned case.

The award and decision of Chief Administrative Law Judge Lawrence C. Kasten, issued September 18, 2013, is attached and incorporated by this reference.

Given at Jefferson City, State of Missouri, this 26th day of February 2014.

LABOR AND INDUSTRIAL RELATIONS COMMISSION

John J. Larsen, Jr., Chairman

James G. Avery, Jr., Member

Curtis E. Chick, Jr., Member

Attest:

Secretary

ISSUED BY DIVISION OF WORKERS' COMPENSATION

FINAL AWARD

Employee: Patricia Thomas Injury No. 05-132393
Dependents: N/A
Employer: Pemiscot Memorial Health Systems (settled)
Additional Party: Second Injury Fund
Insurer: Self c/o Cannon Cochran Management Services (settled)
Appearances: Jim Turnbow, attorney for the employee.
Jennifer Kornblum, attorney for the Second Injury Fund.
Hearing Date: June 24, 2013 Checked by: LCK/rf

SUMMARY OF FINDINGS

1. Are any benefits awarded herein? No.
2. Was the injury or occupational disease compensable under Chapter 287? No.
3. Was there an accident or incident of occupational disease under the Law? No.
4. Date of accident or onset of occupational disease? N/A
5. State location where accident occurred or occupational disease contracted: N/A
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?
No.
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 happened or occupational disease contracted: N/A
12. Did accident or occupational disease cause death? N/A.
13. Parts of body injured by accident or occupational disease: N/A
14. Nature and extent of any permanent disability: N/A
15. Compensation paid to date for temporary total disability: None.
16. Value necessary medical aid paid to date by employer-insurer: \$500.00.
17. Value necessary medical aid not furnished by employer-insurer: N/A
18. Employee's average weekly wage: \$323.03.
19. Weekly compensation rate: \$214.69.
20. Method wages computation: By agreement.
21. Amount of compensation payable: None.
22. Second Injury Fund liability: None.
23. Future requirements awarded: None.

Said payments shall be payable as provided in the findings of fact and rulings of law, and shall be subject to modification and review as provided by law.

The Compensation awarded to the employee shall be subject to a lien in the amount of 25% of all payments hereunder in favor of the following attorney for necessary legal services rendered to the employee: N/A

STATEMENT OF THE FINDINGS OF FACT AND RULINGS OF LAW

On June 24, 2013, the employee, Patricia Thomas, appeared in person and with her attorney, Jim Turnbow, for a hearing for a final award. The Second Injury Fund was represented by Assistant Attorney General Jennifer Kornblum. The parties agreed on certain undisputed facts and identified the issues that were in dispute. These undisputed facts and issues, together with a statement of the findings of fact and rulings of law, are set forth below as follows:

UNDISPUTED FACTS:

1. Pemiscot Memorial Health Systems was operating under and subject to the provisions of the Missouri Workers' Compensation Act, and was duly qualified as a self-insured employer care of Cannon Cochran Management Services.
2. On or about June 30, 2005, Patricia Thomas was an employee of Pemiscot Memorial Health Systems and was working under the Workers' Compensation Act.
3. On or about June 30, 2005, the employee sustained an occupational disease arising out of and in the course of her employment.
4. The employer had notice of the employee's occupational disease.
5. The employee's claim was filed within the time allowed by law.
6. The employee's average weekly wage was \$323.03. The rate for temporary total disability, permanent total disability and permanent partial disability is \$214.69 per week.
7. The employer paid \$500.00 in medical aid.
8. The employee reached maximum medical improvement on April 16, 2006.

ISSUES:

1. Medical causation.
2. Liability of the Second Injury Fund for permanent total or permanent partial disability.

EXHIBITS:

Employee Exhibits:

- A. Medical records of Baptist Memorial Hospital.
- B. Medical records of Cape Radiology Group.
- C. Medical records of DAEOC Women's Health Care Clinic.
- D. Medical records of Dr. Fitzwater.
- E. Medical records of Pemiscot Memorial Hospital.
- F. Records of Dr. Arshad/Pemiscot Primary Care Center.
- G. Medical records of Dr. Ray.
- H. Medical records of Semmes Murphy Neurologic and Spine Institute.
- I. Medical records of St. Francis Medical Center.
- J. Records of Sikeston Rehab.
- K. Medical records of Twin Rivers Regional Medical Center.
- L. Medical report of Dr. Volarich.

- M. Vocational Rehabilitation Evaluation of James England.
- N. Deposition of Dr. Volarich.

Second Injury Fund Exhibits:

- 1. Vocational and Rehabilitation Assessment of Stephen Dolan.
- 2. Medical report of Dr. David Robson.
- 3. Deposition of Patricia Thomas.

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

WITNESS:

Patricia Thomas, the employee.

BRIEFS:

The employee and the Second Injury Fund filed briefs on July 24, 2013.

STATEMENT OF THE FINDINGS OF FACT:

The employee was born on June 18, 1962. She is divorced and has four children who are all girls. Her two youngest children live with her. The employee has been on Social Security disability since December of 2007. In 1980, she graduated from high school in Hawaii. She went to vocational technical school to become a CNA and to perform EKG monitoring. She was in the United States Army from November of 1981 through February of 1982. She had almost completed basic training when she was honorably discharged. She performed EKG monitoring for nine years where she sat at a desk and watched monitors in the ICU unit. She performed monitoring and charted EKG rhythms. She was a secretary for the ICU and telemetry units and transcribed lab and doctor notes. She worked six years in Hawaii and three years in Missouri. The employee received her CNA license in 1998 and is licensed in both Arkansas and Missouri. She worked as a CNA for about 15 years and worked for Hayti Health Systems. For seven years she did not work and took care of her home when she was married to her second husband. She worked at Fred's as an apparel clerk, an assistant manager, and a manger. She worked on the floor and unloaded and loaded trucks, stocked shelves, worked on payroll, and did scheduling.

The employee testified that she first worked for Pemiscot Health Systems around 1993 for a year as a certified nurse's assistant. She moved to Georgia. She returned to work at Pemiscot in 1996 and worked again as a certified nurse's assistant there for about a year and then in 2001 for a year at a nursing home in Caruthersville. In between the home health jobs, she worked at Fred's and at Casino Aztar.

The employee testified that she started having back problems in 1996. She had an accident at the Casino Aztar when she slipped and fell on her bottom. She received treatment for her back. In 2002, she was working as a certified nurse's assistant and had back pain, numbness

and spasms more on the right side. She had an MRI, was diagnosed with degenerative disc disease, and had physical therapy which did not help. She was put on pain medication and muscle relaxers. She continued to receive medication once a month and her problems continued up until her neck injury in 2005. Around 2001 she started having problems with headaches, weakness, numbness and tingling in her arms.

On April 2, 2002, the employee went to Dr. Fitzwater's office due to back spasms and leg numbness. The records noted that she had an x-ray six years ago and had osteoarthritis. The Celebrex and Lodine did not work. A lumbar MRI performed on April 25 showed degenerative changes involving the discs at L3-4, L4-5, and L5-S1 with disc space narrowing and minimal midline posterior protrusion at L3-4, and to a lesser extent minimal posterior protrusion at L5-S1 with no disc space narrowing. Osteophytes were present at L3-4.

On April 30, 2002, the employee had a physical therapy assessment for degenerative spine disease and minimal L3-4 protrusion ordered by Dr. Fitzwater. In 1996, while working at the casino she hurt her back and had a slipped disc. The employee started having pain and numbness in her back and legs in December of 2001 which got progressively worse. She worked as a CNA for a number of years and had to quit her job due to back problems. The employee had pain of 2-9 out of 10 with constant aching, throbbing, stabbing, and sometimes sharp numbness that went down both legs; right worse than left. She had cramping on the right side in the lumbar area with tightness; numbness and tingling sensations in the bilateral thigh and knee area. She had pain, loss of motion, weakness, and functional difficulty.

On May 15, 2002, the employee stated that she needed the Skelaxin changed. On May 28, 2002 Dr. Fitzwater noted that physical therapy was finished. Due to the back pain being unresponsive to the therapy he prescribed Tylenol #3 and referred the employee to Dr. Ray, a neurosurgeon.

The employee testified that she does not recall being referred to Dr. Ray, was never informed of it, and did not see Dr. Ray at that time.

In June of 2002, the employee saw Dr. Fitzwater for persistent pain in the back and legs. The medications were not helping so Flexeril and Lortab were prescribed. In August and September of 2002, Dr. Fitzwater prescribed Zanaflex, Bextra and Lortab for back pain. In October of 2002, the employee saw Dr. Fitzwater for back pain. Prescribed were Flexeril and Lortab. In November of 2002, the employee saw Dr. Fitzwater for back pain. Prescribed were Flexeril, Lortab and Bextra.

In January of 2003, Dr. Fitzwater prescribed Flexeril and Lortab for back pain. In March, the employee saw Dr. Fitzwater for back pain. Prescribed were Mobic and hydrocodone. Diagnosed was arthritis. In April of 2003, the employee saw Dr. Fitzwater for back pain. He diagnosed arthritis and prescribed Mobic and hydrocodone. In August of 2003, the employee saw Dr. Fitzwater for back pain. Mobic, hydrocodone, and Zanaflex were prescribed.

The employee in February and March of 2004 saw Dr. Fitzwater for back pain and he prescribed Flexeril, Mobic, and hydrocodone.

The employee testified that the last time she was employed by Pemiscot Health she began on August 4, 2004. She told her employer that she had prior back problems. She had difficulty performing her job including lifting patients out of bed or pulling them up in bed. She asked for assistance in lifting which was not always available because a lot of times they were short-handed. She adjusted how she lifted to get it done but it took longer than with two people. She rested in the patient's room and was taking more breaks than the average certified nurse assistant. At home, she had a lot of weakness in her back and arms and would sit in a chair and relax. She took the narcotic medications after work. In the summer of 2004, she quit all of her hobbies except crocheting. She stopped doing physical things because it was too much on the body including her back and shoulders. She worked in the nursing home for the hospital and was involved in cleaning the residents up, getting them out of bed, dressing them, transporting them to the dining room and to the bathroom, giving them baths or showers, and taking them to doctor appointments. She worked 32-40 hours a week. Some patients needed total care where she changed the bed sheets, pulled the patients up in bed, fed them, and performed other tasks including moving patients to and from the bed to a chair. Some patients weighed 120 pounds but a total-care patient could be 200 pounds of dead weight. Her job was physically demanding. On an average shift, she took care of 12-18 patients.

On December 14, 2004, the employee saw the nurse at Dr. Fitzwater's for back pain. On December 16, the employee saw Dr. Arshad who noted she was on hydrocodone.

On February 18, 2005, the employee saw Dr. Fitzwater for back pain and arthritis. There was not a change and no injury was noted; Lorcet was prescribed.

The employee testified that in May of 2005 she had difficulty with one of the patients who had soiled the bed. There was no one else that could help and she cleaned the patient up. She changed the bed sheets, and with the pushing, pulling and tugging, later on everything in her body was hurting. She reported that incident to Tina, the charge nurse, and told her that she felt like something snapped in her back. She continued working but was hurting all over her neck, shoulder, arms, and her legs were tingling.

On May 12, 2005, the employee saw Dr. Fitzwater for back pain, dizziness, weakness, and blurred vision. Her pain was controlled by medications. She had stiffness of the entire lower back. There were muscle spasms of the lower back in the right and left paraspinal regions. Dr. Fitzwater prescribed Lorcet.

The employee testified that she had problems with her neck before June of 2005. She complained to Dr. Fitzwater that she was having cramping in the back of the neck and her shoulders felt tight. She had muscle spasms. In her arms she had a lot of weakness and tingling. She had major headaches all of the time. Dr. Fitzwater thought the headaches were caused by stress and the weakness in the arms was due to lack of oxygen from smoking but he never treated her for that. She had headaches and numbness and tingling in the arms since 2000 which had gotten progressively worse over time. She went to Dr. Arshad in June of 2005 due to back and neck pain with tingling in her hands. She stopped working in the middle of June of 2005 when her muscle spasms got worse and she was unable to continue working. Dr. Arshad told her that she could not lift more than 10 pounds.

The employee saw Dr. Arshad on June 1, 2005, for back pain and muscle spasms, and being dizzy and light-headed. She had a lot of muscle cramps and had pain in the hands and the lateral three fingers. The examination showed L5-S1 spasm, L5-S1 tenderness, positive Tinel's and positive Phalan's signs. Dr. Arshad diagnosed degenerative disc disease, dizziness, vertigo, and bilateral carpal tunnel syndrome. He scheduled a lumbar MRI and prescribed Meclizine.

The June 12, 2005 lumbar MRI showed mild levoscoliosis, mild spondylosis, and moderate lumbar facet arthropathy; mild central canal stenosis at L3-4 and L4-5; and multi-level foraminal narrowing. The right L3 exiting nerve root was posteriorly displaced, and the left L5 nerve root was possibly compressed within the foramen.

On June 15, 2005, the employee saw Dr. Arshad who noted that the MRI showed multiple areas of disc prolapse with spinal stenosis and foraminal narrowing. She had severe back pain and neck pain which radiated down into her arms. The employee had L5-S1 spasms, L5-S1 tenderness and C6-7 spasms. Dr. Arshad diagnosed degenerative disc disease, dizziness, vertigo, lumbar spinal canal stenosis, L3-4 radiculopathy, L3-4 nerve compression, and cervical spasm. Dr. Arshad ordered a cervical MRI and referred her to a neurosurgeon.

The employee testified that she stopped working on June 15, 2005. Her back got worse up to time she left work but has not changed since she left work.

The June 23, 2005 cervical MRI showed a Chiari I malformation; multi-level spondylosis with a right posterolateral disc protrusion at C6-7; central disc protrusion at C5-6; and osteophyte and disc protrusion at C4-5.

The employee saw Dr. Arshad on June 27, 2005. On examination, the employee had L5-S1 and C6-7 tenderness and spasms. Dr. Arshad diagnosed L3-4 radiculopathy and nerve compression; C5-6 radiculopathy and nerve compression; cervical and lumbar spinal canal stenosis; and vertigo. He prescribed Lorcet, Soma, Naprelan, and Norvasc; and referred her to Semmes Murphy Clinic.

The employee testified that when she went to Semmes Murphy she filled out paperwork that stated that her symptoms were not related to workers' compensation. At first, she did not think her problems had anything to do with work. She has known that she has had degenerative disc disease since 2001.

The employee saw Dr. Carro at Semmes Murphy on July 8, 2005. The employee filled out and signed an information sheet. The form asked if the appointment was related to a workers' compensation injury, a motor vehicle accident, or any other type of injury; the employee circled no. The employee's chief complaint was a lot of pain in her right arm and hand and severe pain in her lower back and right leg. Dr. Carro noted that the employee had back and right lower extremity pain for the past few years which had gotten worse in the past few weeks. The pain in the right proximal lower extremity felt like charley horses. The employee had pain going all the way from the elbow into her hand with hand weakness and decreased fine motor coordination. Dr. Carro reviewed the lumbar and cervical MRIs. On examination, she kept her head and shoulders forward. There was trace weakness in the right triceps, the right hip flexors,

and knee extensors. Dr. Carro diagnosed right C7 radiculopathy; Chiari I malformation; cervical spondylitic disease; L3-4 disc protrusion and foraminal stenosis on the right; L4-5 ligamentum flavum hypertrophy and mild central stenosis at L5-S1; and foraminal stenosis bilaterally. Dr. Carro ordered an EMG/nerve conduction study of the upper and lower right extremities which was performed on July 8 and was normal.

The employee was referred to Dr. Frankel on July 25, 2005, for neck and arm pain. She reported leg and back pain since 2001. The neck pain had been progressive over the last one-and-a-half months. The arm pain, right greater than left, went into all the fingers on the right and the last two digits on the left. She reported posterior suboccipital headaches with occasional Valsalva augmentation. Her leg pain was primarily in the hip to the knee on the right and not on the left. Past medical history showed degenerative joint disease. Sensory examination was equal and symmetric to light touch and pinprick except in the C6 and C7 dermatomes on the right. Dr. Frankel stated that the cervical MRI showed herniated discs, soft and hard components at C5-6 and C6-7 with right-sided foraminal stenosis greater than left. The lumbar MRI showed spondylosis, degenerative spondylolisthesis at L3-4 and L4-5. Flexion films demonstrated an increase in L3-4 listhesis. Dr. Frankel diagnosed neck pain with C6 and C7 radiculopathy and recommended an anterior cervical discectomy and fusion at C5-6 and C6-7.

On August 18, 2005, Dr. Frankel performed a C5-6 and C6-7 anterior cervical discectomy and fusion, micro-dissection, C5-6 and C6-7 struts, and C5-7 anterior cervical plating. The post-operative diagnoses were C6 and C7 radiculopathy and C5-6 and C6-7 cervical spondylosis.

The employee saw Dr. Arshad on September 14, 2005, with a lot of neck pain and pain with lateral movement, flexion, and extension. Dr. Arshad diagnosed cervical spinal stenosis, status post surgery, L3-4 nerve compression and radiculopathy, cervical spasm, and vertigo.

The employee saw Dr. Frankel on September 23, 2005. X-rays showed good position of the graft and hardware with fusion occurring.

On November 3, 2005 the employee saw Dr. Arshad with a lot of neck pain and muscle spasms, and numbness going down her arms. She stated that the surgery did not help a lot. She had lower back pain and pain going down her legs. On examination there were spasms at L5-S1 and C6-7; and tenderness, and pain on flexion and extension of the neck. Lorcet was refilled and the employee was to see a neurosurgeon for her lower back problems.

The employee saw Dr. Frankel on December 5, 2005. She had developed right hand pain with numbness and tingling in the first three digits. An EMG and nerve conduction study showed moderate to severe carpal tunnel on the right. A cervical CT showed incomplete incorporation of the bone at C5-6 and C6-7. Dr. Frankel recommended a wrist splint for the right-sided carpal tunnel, and referred her to Dr. Fernandez for follow up of the carpal tunnel. Dr. Frankel discussed her smoking. Due to the incomplete fusion, Dr. Frankel prescribed a bone growth stimulator. With regard to the low back, Dr. Frankel diagnosed degenerative lumbar spondylolisthesis. She was taking Lortab. He recommended that when she saw Dr. Fernandez they discuss if lumbar surgery was warranted.

On December 9, 2005, the employee had severe pain that was radiating down her arms. Dr. Arshad diagnosed cervical spasms, L3-4 radiculopathy and nerve compression; and continued Lorcet.

The employee filed her claim for compensation on December 15, 2005, alleging that she injured her cervical and lumbar spine performing her duties as a certified nurse's assistant. The date was listed as beginning in or about June of 2005 and included was occupational disease. The employer-insurer filed an answer on January 16, 2006, denying the employee sustained an accidental injury or occupational disease.

The employee saw Dr. Arshad on January 17, 2006, with a lot of neck pain. She had L5-S1 tenderness and spasms. He diagnosed lumbar and cervical disc disease and refilled Lorcet.

The employee saw Dr. Fernandez on February 16, 2006. Her neck pain had improved and the hand and radiculopathy had improved quite significantly. She had some bony fusion at the level below C6-7, but the level above C5-6 had some lucency. Dr. Fernandez was concerned because she continued to smoke and recommended a bone growth stimulator.

Dr. Arshad, on February 24, 2006, diagnosed lumbar and cervical disc disease and continued the Lorcet. On March 24, the employee had severe joint aches and pains and neck pain. Lorcet was continued. On April 24, Dr. Arshad noted that she could not see her Memphis neurosurgeon because she got Missouri Medicaid. She had a lot of neck pain and muscle spasms. He refilled the Lorcet and ordered x-rays of the cervical spine which were done on May 18, 2006, and showed post surgical changes. On June 2, 2006, the employee saw Dr. Arshad with a lot of neck pain and muscle spasms, and pain on flexion of the neck. Dr. Arshad diagnosed cervical disc disease, lumbar disc disease, cervical spine fusion, and lumbar radiculopathy. An MRI of the lumbar spine was ordered.

Dr. Arshad noted that on June 30, 2006, the employee had a lot of back pain and muscle spasms. She was prescribed Lorcet and a lumbar MRI was ordered. On July 27, 2006, Dr. Arshad noted that the employee had severe neck pain.

The August 4, 2006 lumbar MRI showed the worse level was L3-4 with a right asymmetric lateral disc abutting the exiting right nerve root causing moderate to severe lateral recess and neural foraminal stenosis. There was moderate degenerative disc disease at L4-5 with moderate narrowing of the left lateral recess.

On August 17, 2006, the employee saw Dr. Arshad with back pain and right leg pain. On examination, the employee had C6-7 and L5-S1 spasms and tenderness and pain on back flexion. Dr. Arshad diagnosed cervical and lumbar disc disease and lumbar radiculopathy. On September 18 Dr. Arshad wrote a letter that the employee had multiple medical problems including hypertension, hyperlipidemia, cervical disc disease, lumbar disc disease, and lumbar radiculopathy; and takes multiple medicines. She has pain whenever she walks or undergoes any physical activity. Dr. Arshad noted on September 26, the employee had a lot of back pain and muscle spasms. Lorcet was prescribed.

On October 24, 2006, the employee had severe pain in the neck and was very depressed. Cymbalta was added and Lorcet was continued. In November and December of 2006, Dr. Arshad continued the Lorcet.

On January 16, 2007, the employee saw Dr. Arshad with joint aches and pains with back pain. There was L5-S1 spasms and Lorcet was continued. In February of 2007, the employee saw Dr. Arshad with severe back pain with spasms and tenderness. Lorcet was prescribed. In March of 2007, Dr. Arshad prescribed Lorcet and Soma. In April of 2007, Dr. Arshad noted that the employee had severe neck pain. When her blood sugar drops she gets very dizzy. On exam, there was L5-S1 spasm, pain on flexion of the back, and bilateral knee crepitus. Hypoglycemia was added as a diagnosis. Lorcet and Soma were refilled. In May and June of 2007, Lorcet and Soma were refilled by Dr. Arshad. In July of 2007, the employee had joint aches and pains and back pain. The diagnosis was osteoarthritis, lumbar disc disease, cervical disc disease, depression, and restless leg syndrome. She was prescribed Requip, Soma, and Lorcet. In August of 2007, she had a lot of joint aches and pain, back pain and was in distress. Lorcet and Soma were prescribed by Dr. Arshad. In October, Dr. Arshad diagnosed anxiety disorder, back pain, muscle spasms, and fatigue. In November, the employee was prescribed Lorcet. In December of 2007, Dr. Arshad prescribed Lorcet and the employee was referred to Dr. Ray for severe lumbar disc disease.

On January 22, 2008, Dr. Arshad ordered an MRI of the lumbar spine and cervical spine which were performed on February 1, 2008. The cervical MRI showed a bulging disc involving the C4-5, C6-7, C7-T1, and T1-2 discs. There was degenerative arthritis and mild stenosis of the cervical spinal canal at the C5-6 and C6-7 levels. Stenosis of the neuroforamen bilaterally was seen at C4-5 and C6-7 and on the right at C5-6. There was degenerative disc disease of the C2-3 through the T2-3 discs. Post-op changes with plate and screws were seen anteriorly at C5-6 and C6-7. The lumbar MRI showed diffuse bulging L3-4 disc. A lateral herniated disc to the right could not be ruled out. There was diffuse bulging involving at L4-5 and posterior bulging at L5-S1. Degenerative disc disease was seen at T10-11, T11-12, T12-L1, L2-3, L3-4, L4-5, and L5-S1. There was degenerative arthritis and stenosis of the lumbar spinal canal at L3-4 and L4-5, scoliosis, and degenerative endplate changes at L3-4.

The employee was seen by Dr. Ray on March 12, 2008, who noted that the employee was totally disabled and on Medicare due to her degenerative back. On examination, she had a fairly limited range of motion of her neck and a lot of pain in the posterior aspect of her cervical spine. She was uncomfortable when walking due to her back and leg pain. Her back was tender across the lumbosacral spine going down into the right sciatic notch and along the sciatic nerve distribution. Her straight leg raise was positive on the right. The left straight-leg raise was normal but it caused back pain at approximately 60 degrees. Light touch was intact other than the first three fingers of her right hand. Dr. Ray diagnosed multi-level lumbar degenerative changes, in particular, a right lateralizing L3-4 disc with spinal stenosis of L3-4 and L4-5; carpal tunnel syndrome in the right hand; and a history of Chiari malformation. The employee had failed neck problems with headaches. All of her conditions had been progressing, in particular, the low back and right leg pain and she was virtually incapacitated. The employee had mild weakness in the leg but was mainly having back and right leg pain down the knee and towards the foot. Dr. Ray wanted a lumbar MRI and a CT of the neck. Dr. Ray thought that the

employee should have physical therapy but if conservative measures failed, she would be a candidate for some type of decompression surgery of L3-4, and possibly L4-5. With regards to her neck, Dr. Ray hoped for adequate improvement without surgery.

In March, Dr. Arshad prescribed Lorcet. In April, Dr. Arshad continued Lorcet for cervical degenerative disc disease and Requip for the restless leg syndrome.

The April 23, 2008 cervical CT noted the prior fusion at C5-6 and C6-7. There was degenerative disc disease at C4-5 with degenerative changes in the uncovertebral joints resulting in moderate left and mild right neural foraminal stenosis. Additional neural foraminal stenosis was seen at the C5-6 and C6-7 levels.

The April 23, 2008 lumbar MRI showed at L3-4 a small concentric disc bulge more prominent in the right which caused mild to moderate central stenosis and foraminal stenosis. At L4-5, there was a moderate concentric disc bulge with disc extrusion that caused mild to moderate central canal stenosis and foraminal stenosis. At L5-S1, there was a small disc that touched the right S1 nerve root but did not displace it and no direct compression of the thecal sac and foraminal stenosis. There was moderate rotatory lumbar levoscoliosis, mild/moderate spondylosis, moderate facet arthropathy, and multi-level disc disease.

Dr. Ray noted on April 23, 2008, that the employee had significant lower back pain with pain mainly going down the right lower extremity. The employee had significant neck pain with symptoms in her right upper extremity which are much worse than the low back with positive radiographic findings. Dr. Ray noted that the lumbar MRI showed a lateralizing disc on the right side of L3-4 with significant lateral recess stenosis and central disc bulge/protrusion at L4-5 with stenosis. There was degenerative disc disease at L5-S1 without evidence of neural compression. Dr. Ray recommended a partial C2, complete C3, C4, C5, C6, and partial C7 decompressive laminectomies with foraminectomies. After her recovery, he anticipated she would need a right L3-4 and L4-5 fusion with possible bilateral segmental decompression at L4. On May 6, 2008, Dr. Ray performed the recommended cervical surgery.

The employee testified that the May of 2008 surgery did not help and there was no change in her condition.

The employee saw Dr. Arshad on May 30, 2008, for severe neck and back pain. The Lorcet and Requip were continued and Flexeril for the muscle spasm were prescribed. Dr. Ray, on June 18, continued therapy.

The employee saw Dr. Arshad on July 2, 2008, with low-back shooting pain, lumbar spasms and tenderness, restricted range of motion, and neck spasm with pain on neck flexion. On November 3, 2008, the employee saw Dr. Arshad with a new onset of dull, constant neck pain. Ibuprofen was added, and Lorcet and Flexeril were continued.

The employee saw a physical therapist on November 5, 2008, with her neck still bothering her. She was unable to stand for any length of time without it hurting more. She was using a TENS unit daily and medication. She did not want to have surgery on her back. Noted

was a forward flexion head posture. The employee was disappointed at not being able to do much without pain. The employee had reached a plateau and was to continue her home program.

The employee saw Dr. Ray on November 5, 2008, and stated that for the most part she continued to do well with her neck pain but if she tried to do any particular activity for any length of time she had increased muscle pain and spasms. She reported relief with her TENS unit. She wanted to hold off on surgical intervention of her lumbar spine. She was discharged back to her primary care physician, Dr. Arshad. The employee saw Dr. Arshad on November 7 with low back pain with a lot of numbness in the lower legs. Lorcet, Requip, and Flexeril were continued, and Neurontin for the leg neuropathy was started. At the end of December of 2008, the medications were continued by Dr. Arshad.

The employee saw Dr. Arshad on February 2, 2009. The employee rated her neck and back pain at 8. The medications were continued. In March and April of 2009, the employee continued to have persistent back and neck pain.

The employee testified that Dr. Landry performed carpal tunnel surgery on the right in April of 2010 and on the left in June of 2010, but the surgeries did not help. She stopped going to Dr. Arshad in 2011 when she moved to Arkansas. She had surgery on her back in January of 2011 by Dr. Quiershi which did not change her back condition at all.

On January 10, 2012, the employee settled her claim against the employer-insurer for 12.5% permanent partial disability of the body as a whole referable to the cervical spine. The employer-insurer paid \$500.00 in medical expenses and no temporary total disability. The employer-insurer paid the Medicaid Lien of \$1,352.54 as part of the settlement. The disputes included compensability; occupational disease; notice; accident; nature and extent of temporary total disability, temporary partial disability, and permanent partial disability; and responsibility for any and all medical expenses.

The employee testified her neck is the same since the first surgery in 2005. Her neck causes physical limitations. She has no problems standing or walking or lifting due to her neck but it limits her ability to sit. It is hard to hold her head upright and when sitting her head leans over. She can only sit for about 30 minutes. Her equilibrium is off due to the neck which affects climbing stairs. She has a lot of dizziness and problems bending, reaching, pulling, or doing anything overhead. The neck pain radiates down both shoulders more on the right, and her neck feels like gristle if she is holding her head up. She has pain all of the time. Her average neck pain is 3-4 and the worst is about 8. The pain is aggravated if she lifts something. She is taking Percocet and Neurontin for her neck.

The employee testified that with regard to the low back, she has trouble standing and can stand 20 minutes or so. She can sit for about 20-25 minutes, and can only walk about a block. She can lift about ten pounds. She has trouble with stairs, bending, stooping, stretching, pushing and pulling. The pain in her lower back is from the waist and goes down both legs, mostly on the right side. The pain is constant, sharp and throbbing. The average pain is 4-5 and the worst is 8-9. Almost everything causes her lower back to hurt including lifting, carrying, sitting or standing too long. She is taking Percocet and Neurontin for her back.

The employee testified she is able to do all of her housework including some light cooking except for mopping, sweeping and vacuuming, which one of her daughters does. Her daughters help with the laundry. Her daughters make the bed and go grocery shopping. The yard work is done by her two son-in-laws. Her two oldest daughters also help with the housework. Due to the pain she does not sleep well and gets maybe four hours a night. On a typical day, she will get up, take her medication, and will sit in her recliner. She helps get her 11-year-old to school and then gets back in the recliner. She will occasionally do clothes or dishes, and will then cook dinner. She will play on her iPhone, crochet, or watch murder shows on television. She reads a little bit. She is in her recliner 75-80% of the day which helps with the back and neck. She does very little driving and it is difficult to get on and off the interstate due to her inability to turn her neck to see traffic. She is not really socially active but goes to school events for her daughter and granddaughter. If her back was the only thing that was just bothering her she would be able to do some work such as being a unit secretary, which was the easiest job she ever had. However, with the combination of the neck and back she could not work as a unit secretary due to her head, neck, arms, and back.

The employee saw Dr. Volarich on December 14, 2009. His deposition was taken on June 26, 2012. The employee was employed at Pemiscot Memorial Hospital as a certified nurse's assistant and had to repetitively lift patients. She developed symptoms in her back in 1996 without injury. On one particular day she worked with a 190-pound patient for an hour-and-a-half while bent over her and cleaning her. She believes it was either the end of May or first week of June 2001. The patient was combative and as she rolled the patient from side-to-side to clean up the mess; she had to duck and dodge fists. After this, her back and legs became numb. Her symptoms increased in 2002. She developed headaches in 2003. In August of 2004, she returned to Pemiscot Hospital and worked, lifting patients on a regular basis. She worked for about 10 months until June 15, 2005.

On examination, the employee was somewhat depressed and her affect was flat. She talked in a monotone and moved very slowly. The employee had weakness in the bilateral biceps, triceps, and forearms. Deep tendon reflexes were absent in the left C6 reflex. She was only able to squat to about 75% of normal because of back pain. She had some difficulty pushing off to stand upright because of back discomfort. In the cervical spine, the employee had loss of flexion, extension, right and left lateral flexion, and left and right rotation. In the lumbar spine, the employee had loss of flexion, extension, right and left lateral flexion. Straight-leg raise was accomplished to 80° bilaterally without radicular symptoms but with an increase in back pain.

It was Dr. Volarich's opinion that pre-existing June of 2005 the employee had chronic lumbar syndrome secondary to degenerative disc disease and degenerative joint disease, including disc protrusions at L3-4 and L5-S1 without persistent radicular symptoms; mild cervical syndrome and headaches; and historic carpal tunnel syndrome - essentially asymptomatic prior to June of 2005; and depression.

The employee had significant prior problems with her lumbar spine. The prior headaches were attributable to her neck syndrome. It was really not that much of a problem and she really did not know that she had a problem with the cervical spine until she was evaluated and found to

have significant compression mostly at C5-6 and C6-7. Prior to her work injury the primary problems were with her lumbar spine.

It was Dr. Volarich's opinion that the employee's pre-existing disabilities were a hindrance to her employment or re-employment; and that the employee had a 25% permanent partial disability of the body as a whole rated at the lumbosacral spine due to the disc protrusions at L3-4 and L5-S1 as well as the underlying spondylosis. The rating accounts for back pain, lost motion, and occasional lower extremity paresthesias prior to the worsening of her symptoms leading up to June of 2005. The employee had a 5% permanent partial disability of the body as a whole rated at the cervical spine due to the mild cervical spine stiffness and headaches leading up to June of 2005. Disability from carpal tunnel syndrome is not found since those symptoms resolved and disability exists as a result of her depression, but he would defer to psychiatric evaluation for that assessment.

It was Dr. Volarich's opinion that leading up to the injury of June of 2005 the employee's diagnoses were repetitive trauma cervical spine causing disc protrusions and aggravation of spondylosis C5-6 and C6-7 in turn causing upper extremity radiculopathy; status post anterior cervical discectomy with fusion and instrumentation C5-6 and C6-7; post laminectomy syndrome cervical spine with persistent radiculopathy; status post posterior cervical decompression laminectomies and foraminotomies C2-C; persistent post laminectomy syndrome cervical spine; aggravation lumbar spine degenerative disc disease; and degenerative joint disease including protrusions at L3-4 to the right and L4-5 to the left and L5-S1 to the left with an unstable spondylolisthesis at L3-4 causing recurrent intermittent bilateral extremity radiculopathy.

It was Dr. Volarich's opinion that the repetitive nature of the employee's work particularly the lifting, moving, and caring for patients on a daily basis are the substantial contributing factors as well as the prevailing or primary factors causing the disc protrusions at C5-6 and C6-7 as well as the aggravation of underlying degenerative disc disease and degenerative joint disease that required two extensive surgical procedures including an anterior cervical discectomy with fusion at two levels and a posterior decompression, laminectomy, and foraminotomies at six levels. As a result of the repetitive lifting trauma, she aggravated her underlying lumbar syndrome including the disc protrusions and degenerative changes at L3-4, L4-5, and L5-S1, as well as causing an unstable spondylolisthesis at L3-4 all of which required nonoperative treatment.

Dr. Volarich diagnosed an aggravation of the lumbar spine from all the repetitive lifting, pushing, and pulling caring for patients. It was his opinion that prior to June of 2005 the problems she was having with her back and neck would have been a hindrance or obstacle to employment or reemployment. It was Dr. Volarich's opinion that the employee's neck problems that necessitated the two surgeries was caused by her work at Pemiscot Memorial Health Systems.

It was Dr. Volarich's opinion that as a direct result of the injuries sustained leading up to June of 2005 while in the employ of Pemiscot Memorial Hospital that the following industrial disabilities exist that are a hindrance to her employment or re-employment:

A 60% permanent partial disability of the body as a whole rated at the cervical spine due to the disc protrusions at C5-6 and C6-7 as well as the aggravation of underlying degenerative changes that required two extensive surgical repairs, including anterior fusion with instrumentation and posterior decompression laminectomies. The rating accounts for this injury's contribution to neck pain, lost motion, headaches, and persistent recurrent upper extremity paresthesias, and radicular symptoms.

A 15% permanent partial disability of the body as a whole rated at the lumbosacral spine due to the aggravation of her lumbar syndrome including degenerative disc disease, degenerative joint disease, and disc protrusions at L3-4, L4-5, and L5-S1 as well as the development of her unstable L3-4 spondylolisthesis. The rating accounts for this injury's contribution to back pain, lost motion, and recurrent lower extremity paresthesias and radicular symptoms.

It was Dr. Volarich's opinion that the combination of her disabilities creates a substantially greater disability than the simple sum or total of each separate injury/illness, and a loading factor should be added.

Dr. Volarich stated that the employee may be able to perform some work activities on a limited basis with the following restrictions:

With regard to work and other activities referable to her spine prior to June of 2005, she would have been advised to bend, twist, lift, push, pull, carry, climb and perform similar tasks to tolerance; she would have been advised to handle weights to tolerance using proper lifting techniques; she would have been advised to handle weight over her head or away from her body, and carry weight over distances or uneven terrain to tolerance; she would have been advised to maintain fixed positions including both sitting and standing to tolerance; and she would have been advised to change positions as needed to maximize comfort and rest when needed. Dr. Volarich stated that those restrictions would have been to both the neck and low back but primarily the low back because she was not having major symptoms with her neck prior to June of 2005.

Dr. Volarich stated with regard to work and other activities referable to the spine after June of 2005, he advised the employee to avoid all bending, twisting, lifting, pushing, pulling, carrying, climbing and other similar tasks to an as needed basis; not handle any weight greater than 15 pounds, and limit this task to an occasional basis assuming proper lifting techniques; not handle weight over her head or away from her body, nor carry weight over long distances or uneven terrain; avoid remaining in a fixed position for any more than about 30 minutes at a time including both sitting and standing; and change positions frequently to maximize comfort and rest when needed including resting in a recumbent fashion.

It was Dr. Volarich's opinion that the employee is unable to engage in any substantial gainful activity nor can she be expected to perform in an ongoing working capacity in the future. It was his opinion that she cannot be reasonably expected to perform in an ongoing basis eight hours per day, five days per week throughout the work year. It was his opinion that she is unable to continue in her line of employment that she last held as a CNA for Pemiscot Memorial Hospital nor can she be expected to work on a full-time basis in a similar job. Based on his

medical assessment alone, it was Dr. Volarich's opinion that the employee is permanently and totally disabled as a result of the work-related injury leading up to June of 2005 in combination with her preexisting medical conditions including her psychiatric illnesses.

It was his opinion that the employee was not able to return to any work due to the problems that she had when he saw her. She had significant difficulties with fixed positions; with any kind of lifting; limiting herself now to about 10 pounds. He did not know what jobs are available and a vocational assessment would be needed to make that final determination. The factors that negatively impact her ability to work are primarily physical including significant losses in motion on the spine, ongoing radicular symptoms, weakness in the extremities both upper and lower. The depression is also going to limit her ability due to perception of pain and ongoing difficulties with motivation. The employee is taking narcotic pain medicines. Her smoking can accelerate the degenerative processes.

The employee saw James England for a vocational rehabilitation evaluation on September 8, 2010. His report was dated September 13, 2010. Mr. England noted that the employee appeared tired and admitted that she does not rest well at night. The employee seemed to be physically uncomfortable and needed to move about periodically and to get up to walk around after about 30 minutes. Her medications include Percocet, Neurontin, Tramadol, Flexeril, and ibuprofen. The employee's primary complaint is pain in her low back going down into her legs with the right side being worse than the left. The next worse pain was in her neck and she continues to have a feeling of her head being very heavy and pressing down into her shoulders. She has numbness and tingling in her hands virtually all the time.

The employee completed high school in Hawaii in 1980. She later had CNA training in Arkansas in about 1998 and had undergone EKG monitoring classes in Hawaii in 1989. She served in the Army briefly from October 1981 to February of 1982 and was medically discharged because of inability to handle the physical training involved in basic. She is familiar with basic computer entry and retrieval and has worked with Windows. She has done some charting and payroll as well as inventory control. She has experience scheduling and has supervised up to 24 people in a retail setting. She does have some transferable skill that would be usable down to a light level of exertion involving her knowledge of retail management as well as some knowledge that could potentially be utilized in doctors' offices as an assistant. Mr. England stated that it did not appear that she would have any clear transferable skills at a sedentary level of exertion, however. The employee was given the Wide-Range Achievement Test, Revision 3, and scored at the post high school level on reading and at the fifth-grade level on math which would be adequate for a number of different vocational alternatives.

Mr. England stated that the employee is 48 years old with a high school education and some additional technical training on the job. She comes across as tired, depressed, and physically uncomfortable. Her hands are also noticeably problematic for her in that she wears braces on them to try to help with some of the discomfort. It was Mr. England's opinion that as the employee presented, she would have grave difficulty trying to convince an employer to pick her over alternative candidates. Even more importantly, Mr. England did not know of any job setting that would allow her to recline periodically or to doze off when she gets into a

comfortable position. As she appears to be functioning, Mr. England believed that the employee is likely to remain totally disabled from a vocational standpoint.

Dr. Robson performed a records review and issued a report on November 15, 2012. Dr. Robson reviewed the medical records of the employee from the various health care providers and the report and deposition of Dr. Volarich, and the deposition of the employee. Dr. Robson stated that from a review of the medical records that it was clear that the employee had problems involving her neck going back to 1996 and low back going back to at least 2002 pre-dating anything that may or may not have happened in the middle of 2005 to her neck or low back. She was on chronic narcotics for years. Dr. Robson stated that he did not see any evidence to any work that caused her disability whatsoever involving her neck or her low back. He completely disagreed with any testimony of Dr. Volarich that any work activity had anything to do with the employee's degenerative problems in her neck and lumbar spine.

Stephen Dolan performed a records review and issued a vocational and rehabilitation assessment of the employee. His report was issued on January 29, 2013. Mr. Dolan reviewed the March of 2006 and September of 2009 depositions of the employee; the various medical records of the employee; the vocational rehabilitation evaluation report from Mr. England; the report and deposition of Dr. Volarich; and the report of Dr. Robson. Mr. Dolan stated that the employee graduated from high school in Honolulu, Hawaii. After high school, she had training as an EKG technician and later had training as a certified nurse aide (CNA). Mr. England tested the employee and she was above the high school level in reading and at the 5th grade level in math. In her deposition, the employee testified that she had worked for a year as a unit secretary in a hospital in Georgia and Mr. England did not mention that in his report. Mr. Dolan stated that the unit secretary job would have involved considerable computer work. Mr. England did not mention her first two jobs at Pemiscot Memorial from 1995 to 1997 and from 1999 to 2001. Mr. Dolan stated that it was not clear in the material he saw what types of jobs they were. The work dates the employee gave Mr. England sometimes conflict with one another.

The employee is familiar with basic computer operation. She has worked with Windows. She has experience, he said, with payroll and with inventory. Mr. England said she has skills that would transfer to light exertion jobs, but not to sedentary exertion jobs. Mr. Dolan stated that it was not clear to him why her computer skills, payroll skills, inventory skills, sales skills, etc. would not transfer to sedentary jobs, particularly since she has worked as a unit secretary which is a sedentary job.

According to Dr. Volarich's report the employee had back pain going back to 1996. In her deposition, she testified that she first saw a doctor, Dr. Fitzwater, for back pain in 2001. She testified that he would not operate on her back because it was not bad enough and she began taking narcotic pain medication. She had no physician imposed restrictions until June 2005. She had no idea she had neck problems until May or June of 2005, while last working at Pemiscot Memorial nursing home. She had no symptoms that she attributed to her neck. The employee had a two-level anterior cervical fusion on August 18, 2005 which evidently made her neck symptoms worse. She had a C2 through C7 laminectomy and foraminotomy on May 6, 2008. Dr. Arshad put her on light duty on June 15, 2005 with no lifting more than 10 pounds and no bending or stooping. Dr. Ray, on November 5, 2008, indicated his rationale for doing neck

surgery that the employee was totally disabled due to her back and had a failed neck problem. Dr. Volarich testified that the employee is totally and permanently disabled due to her June 2005 work injury in combination with her pre-existing medical problems. Dr. Robson indicated that the employee's problems are because of degeneration and not related to work activities.

Mr. Dolan stated that the employee had well documented lumbar and neck symptoms (although she did not realize them as neck symptoms) prior to June of 2005. She was, none the less, doing a heavy exertion level job successfully without any restrictions, according to her own testimony, until June 2005. From a vocational point of view it appears clear that if the employee is now not employable it is because of the injury culminating in her being taken off work as a nurse aide in June 2005, because she was successfully working at the heavy exertion level immediately prior to that.

RULINGS OF LAW:

Issue 1. Medical causation.

The Second Injury Fund is disputing that medical conditions, injuries and disability were medically causally related to the occupational disease.

Under Section 287.067.2 RSMO, an occupational disease is compensable if it is clearly work related and meets the requirements of an injury which is compensable as provided in Section 287.020.2 and 287.020.3 RSMo. An occupational disease is not compensable merely because work was a triggering or precipitating factor.

Section 287.020.2 RSMo states that "An injury is compensable if it is clearly work related. An injury is clearly work related if work was a substantial factor in the cause of the resulting medical condition or disability. An injury is not compensable merely because work was a triggering or precipitating factor." An injury arises out of and in the course of the employment if it is reasonably apparent that employment is a substantial factor in causing the injury. See Section 287.020.3(2) (a) RSMo.

Section 287.020.3 defines the term "injury" as an injury which has arisen out of and in the course of employment. The injury must be incidental to and not independent of the relation of employer and employee. An injury shall be deemed to arise out of and in the course of the employment only if: (a) It is reasonably apparent, upon consideration of all the circumstances, that the employment is a substantial factor in causing the injury; and (b) It can be seen to have followed as a natural incident of the work; and (c) It can be fairly traced to the employment as proximate cause; and (d) It does not come from a hazard or risk unrelated to the employment to which workers would have been equally exposed outside of and unrelated to the employment in normal non-employment life.

The burden of proof is on the employee to prove all material elements of her claim. See *Marcus v. Steel Constructors, Inc.*, 434 S.W.2d 475 (Mo. 1968) and *Walsh v. Treasurer of the State of Missouri*, 953 S.W.2d 632,637 (Mo. App. 1997). The employee has the burden to prove

that her injuries arose out of and in the course of employment. See *Smith v. Donco Construction*, 182 S.W.3d 693, 699 (Mo. App. 2006).

The employee must prove a direct causal connection between the injury and some distinctive feature of the job that is common to all jobs of that sort by competent and substantial evidence. See *Lytle v. T-Mac, Inc.*, 931 S.W.2d 496 (Mo. App. 1996). The employee has the burden of proof that occupational exposure from the employment was a substantial contributing factor to the disease. See *Jacobs v. City of Jefferson*, 991 S.W.2d 693 (Mo. App. 1999). The employee must prove a direct causal link between the job duties or his workplace and the disease. See *Decker v. Square D Co.*, 974 S.W.2d 667 (Mo. App. 1998).

The employee's claim for compensation is substantially affected by her prior medical history, diagnoses, and treatment for conditions that she is claiming occurred as a result of her employment with Pemiscot Memorial Health Systems from August of 2004 through June of 2005.

The employee began having back problems in 1996 and started to have numbness in her legs in December of 2001 which got progressively worse. Around 2000-2001 she started having problems with headaches, weakness, numbness and tingling in her arms; and had problems with her neck which has gotten progressively worse over time. In 2002, she had back pain, spasms and leg numbness more on the right side. She was diagnosed with degenerative disc disease. In June of 2002 due to persistent problems, the employee was prescribed pain medication, anti-inflammatories and muscle relaxers including Flexeril, Lortab, hydrocodone, Mobic, Zanaflex, and Bextra. In 2002 the employee had a lumbar MRI that showed degenerative changes involving the discs at L3-4, L4-5, and L5-S1. The employee had physical therapy assessment for degenerative spine disease. She had constant aching, throbbing, stabbing, and sometimes sharp numbness that went down both legs; right worse than left. She had pain, loss of motion, weakness, and functional difficulty. Dr. Fitzwater recommended a neurosurgeon. After 2002, the employee continued to have medical treatment and continued to be prescribed with prescription pain medication and muscle relaxers up until she started working at Pemiscot in August of 2004. After she started work she continued to be prescribed Hydrocodone and Lorcet for back pain and arthritis that was noted not to have changed as of February of 2005. Lorcet was continued in May of 2005. Even when she went to see Dr. Carro, a neurosurgeon, in July of 2005, the employee did not think that her problems had anything to do with work and therefore did not state her symptoms were not related to her job duties. In March of 2008, Dr. Ray stated that the employee was totally disabled due to her degenerative back. Dr. Ray diagnosed multi-level lumbar degenerative changes, in particular, a right lateralizing L3-4 disc with spinal stenosis of L3-4 and L4-5.

It was Dr. Volarich's opinion that the repetitive nature of the employee's work, particularly the lifting, moving, and caring for patients on a daily basis are the substantial contributing factors as well as the prevailing or primary factors causing the disc protrusions at C5-6 and C6-7 as well as the aggravation of underlying degenerative disc disease and degenerative joint disease and the two surgical procedures. It was his opinion that as a result of the repetitive lifting, pushing and pulling at work, the employee aggravated her underlying

lumbar syndrome including the disc protrusions and degenerative changes at L3-4, L4-5, and L5-S1 as well as causing an unstable spondylolisthesis at L3-4.

Dr. Robson stated that it was clear that the employee had problems involving her neck going back to 1996 and low back going back to at least 2002 pre-dating anything that may or may not have happened in the middle of 2005 to her neck or low back. The employee was on chronic narcotics for years. It was Dr. Robson's opinion that there was no evidence that the employee's work caused any disability to her neck or her low back. Dr. Robson completely disagreed with the testimony of Dr. Volarich that the employee's work activity had anything to do with the employee's degenerative problems in her neck and lumbar spine.

Based on a thorough review of the evidence, I find that the opinion of Dr. Robson is very persuasive and more persuasive than the opinion of Dr. Volarich regarding whether the employee's problems and conditions to her neck and low back were caused by her work activities.

I find that the employee's work activities and job duties were not a substantial factor in causing the employee's neck and low back conditions or aggravating the employee's pre-existing neck and low back conditions. I further find that the employee has failed to prove that her work activities and job duties caused an injury that was clearly work related and that the work activities and job duties were a substantial factor in the cause of the resulting medical conditions or disability. I find that the employee's medical conditions did not follow as a natural incident of the work activities and job duties and cannot be fairly traced to the work activities and job duties as the proximate cause. I find that the employee's conditions, injuries, disability and the need for medical treatment were not medically causally related to the employee's work activities, job duties or occupational disease.

Given the employee's failure to prove to prove a medical causal connection between her medical conditions and symptoms and the occupational disease, the employee's claim for compensation against the Second Injury Fund is denied. Therefore, the remaining issue which is liability of the Second Injury Fund is moot and will not be ruled upon.

Made by:

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