

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

Injury No.: 07-119197

Employee: Cheryl Whitfield
Employer: Ferguson-Florissant School District (Settled)
Insurer: Missouri United School Insurance
c/o Gallagher Bassett Services, Inc. (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 February 27, 2012. The award and decision of Administrative Law Judge John K. Ottenad, issued February 27, 2012, 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 15th day of August 2012.

LABOR AND INDUSTRIAL RELATIONS COMMISSION

V A C A N T

Chairman

James Avery, Member

Curtis E. Chick, Jr., Member

Attest:

Secretary

AWARD

Employee: Cheryl Whitfield

Injury No.: 07-119197

Dependents: N/A

Employer: Ferguson-Florissant School District (Settled)

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

Additional Party: Second Injury Fund

Insurer: Missouri United School Insurance
C/O Gallagher Bassett Services (Settled)

Hearing Date: August 30, 2011

Checked by: JKO

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: December 10, 2007
5. State location where accident occurred or occupational disease was contracted: St. Louis County
6. Was above employee in employ of above employer at time of alleged accident or occupational disease? Yes
7. Did employer receive proper notice? Yes
8. Did accident or occupational disease arise out of and in the course of the employment? Yes
9. Was claim for compensation filed within time required by Law? Yes
10. Was employer insured by above insurer? Yes
11. Describe work employee was doing and how accident occurred or occupational disease contracted: Claimant worked as an elementary school teacher for Employer and injured her left wrist, when a student smashed her left hand into the table as she was helping him with a writing assignment.
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: Left Wrist and Body as a Whole—Psychiatric
14. Nature and extent of any permanent disability: 5% of the Left Wrist and
35% of the Body as a Whole—Psychiatric
15. Compensation paid to-date for temporary disability: \$0.00
16. Value necessary medical aid paid to date by employer/insurer? \$930.15

Employee: Cheryl Whitfield

Injury No.: 07-119197

- 17. Value necessary medical aid not furnished by employer/insurer? N/A
- 18. Employee's average weekly wages: Sufficient to result in the maximum applicable rates of compensation
- 19. Weekly compensation rate: \$742.72 for TTD/ \$389.04 for PPD
- 20. Method wages computation: By agreement (stipulation) of the parties

COMPENSATION PAYABLE

21. Amount of compensation payable:

Employer previously settled its risk of liability in this case

22. Second Injury Fund liability:

\$353.68 per week for 148.75 weeks from 07/30/08 until 06/07/11	\$52,609.90
-----------------------------------------------------------------	-------------

\$742.72 per week for Claimant's lifetime starting 06/08/11, subject to review and modification by law

TOTAL: \$52,609.90 THROUGH 06/07/11 PLUS CONTINUING WEEKLY BENEFITS AS DESCRIBED

23. Future requirements awarded: As 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: Robert J. Keefe.

FINDINGS OF FACT and RULINGS OF LAW:

Employee:	Cheryl Whitfield	Injury No.: 07-119197
Dependents:	N/A	Before the
Employer:	Ferguson-Florissant School District (Settled)	Division of Workers'
Additional Party:	Second Injury Fund	Compensation
		Department of Labor and Industrial
		Relations of Missouri
		Jefferson City, Missouri
Insurer:	Missouri United School Insurance C/O Gallagher Bassett Services (Settled)	Checked by: JKO

On August 30, 2011, the employee, Cheryl Whitfield, appeared in person and by her attorney, Mr. Robert J. Keefe, for a hearing for a final award on her claim against the Second Injury Fund. The employer, Ferguson-Florissant School District, and its insurer, Missouri United School Insurance C/O Gallagher Bassett Services, were not present or represented at the hearing since they had previously settled their risk of liability in this case. The Second Injury Fund was represented at the hearing by Assistant Attorney General Kristin M. Frazier.

Along with this Claim [Injury Number 07-119197, with a date of injury of December 10, 2007, alleging injury to the left wrist], Claimant also tried her three other open companion claims at the same time. Injury Number 06-099118, with a date of injury of October 11, 2006, alleges injury to the left wrist. Injury Number 07-034087, with a date of injury of April 10, 2007, alleges injury to the right wrist and left wrist. Injury Number 07-102006, with a date of injury of October 12, 2007, alleges injury to the right ankle. Separate awards have been issued for each of these other cases.

At the time of the hearing, the parties agreed on certain stipulated facts and identified the issues in dispute. These stipulations and the disputed issues, together with the findings of fact and rulings of law, are set forth below as follows:

STIPULATIONS:

- 1) On or about December 10, 2007, Cheryl Whitfield (Claimant) sustained an accidental injury arising out of and in the course of her employment.
- 2) Claimant was an employee of Ferguson-Florissant School District (Employer).
- 3) Venue is proper in the City of St. Louis.
- 4) Employer received proper notice.
- 5) The Claim was filed within the time prescribed by the law.

- 6) At the relevant time, Claimant earned an average weekly wage sufficient to result in the maximum applicable rates of compensation of \$742.72 for total disability benefits and \$389.04 for permanent partial disability (PPD) benefits.
- 7) Employer paid no temporary total disability (TTD) benefits.
- 8) Employer paid medical benefits totaling \$930.15.

ISSUES:

- 1) Are Claimant's injuries and continuing complaints, as well as any resultant disability, medically causally connected to her accident at work on December 10, 2007?
- 2) What is the nature and extent of Claimant's permanent partial and/or permanent total disability attributable to this injury?
- 3) What is the liability of the Second Injury Fund?

EXHIBITS:

The following exhibits were admitted into evidence:

Employee Exhibits:

- A. Stipulations for Compromise Settlement between Claimant and Employer for Injury Numbers 02-005713, 06-093405, 06-099118, 07-034087, 07-102006 and 07-119197
- B. Deposition of Dr. David Volarich, with attachments, dated April 16, 2010
- C. Deposition of Mr. James England, Jr., with attachments, dated April 20, 2010
- D. Deposition of Dr. Jay Liss, with attachments, dated March 24, 2011
- E. Certified medical treatment records of Dr. Joyce Boehmer
- F. Medical treatment records of Dr. Kent Campbell, Metro Imaging and Dr. Sandra Tate for the January 30, 2002 work injury
- G. Medical treatment records of DePaul Health Center dated May 16, 2005
- H. Certified medical treatment records of Florissant Open MRI
- I. Certified medical treatment records of Excel Imaging
- J. Certified medical treatment records of PRORehab
- K. Surgical note dated February 23, 2007 from Timberlake Surgery Center for Claimant's left wrist surgery performed by Dr. David Brown on February 23, 2007
- L. Certified medical treatment records of The Orthopedic Center of St. Louis (Dr. David Brown)

Second Injury Fund Exhibits:

- I. Accident reports filed with Employer regarding the December 10, 2007 injury
- II. HealthSouth physical therapy records dated July 16, 18, 20 and 23, 2007
- III. Medical treatment records of Concentra Medical Centers dated October 3, 2006 through April 15, 2008
- IV. Certified medical treatment records of NEI of St. Louis (Dr. David Peeples)

Notes: 1) Unless otherwise specifically noted below, any objections contained in the exhibits are overruled and the testimony is fully admitted into evidence in this case.

2) Any stray marks or handwritten comments contained on any of the exhibits were present on those exhibits at the time they were admitted into evidence, and no other marks have been made since their admission into evidence on August 30, 2011.

FINDINGS OF FACT:

Based on a comprehensive review of the substantial and competent evidence, including Claimant's testimony, the expert medical opinions and depositions, the vocational expert opinion and deposition, the medical records, the other records, and the Stipulations for Compromise Settlement between Claimant and Employer for various injuries including this case, as well as based on my personal observations of Claimant at hearing, I find:

- 1) **Claimant** is a 58-year-old, currently unemployed individual, who worked for Ferguson-Florissant School District (Employer) as an elementary school teacher (K-4) at or around the time of this injury. Claimant testified that she had worked for Employer from 1998-2008, but worked as an elementary school teacher for various districts, all total, from 1975 to 2008 (33 years of teaching). Claimant admitted that she always wanted to be a teacher because her mother was a teacher. Claimant currently receives a monthly payment from the school district from a disability pension.
- 2) Claimant testified that she graduated from high school. Claimant then graduated from Harris-Stowe Teacher's College in 1975 with a BS in Elementary Education. She eventually obtained her Masters in Education degree, with an emphasis in social science and elementary education, in 2001 from Webster University.
- 3) Claimant testified that she has had asthma as long as she can remember. She has treated at various times over the years with inhalers, breathing tents and machines, and medications. She indicated that she has also been hospitalized because of the asthma. She said that over the years she missed time from work as a result of this condition. She said that she would sometimes use all of her sick or leave days per year because of having to miss work on account of the asthma. She noted that certain things like perfume, dust, pollen or animals would trigger an asthma attack,

sometimes even during the school day. Claimant noted that stress also triggered her asthma, and could set off a coughing spell.

- 4) Medical treatment records from Claimant's family physician, **Dr. Joyce Boehmer** (Exhibit E) document the extensive visits and treatment Claimant has received from Dr. Boehmer from at least 1999 through 2008. The records contain a number of visits to DePaul Health Center for severe persistent asthma, abdominal pain, heart palpitations, and left and right facial numbness, to name a few of the conditions. The records confirm that early on in this treatment, Claimant was given Singulair and a rescue inhaler for the asthma. On May 31, 2006, she was noted to have severe obstructive lung disease, with components of asthma and COPD, with a history of noncompliance and missed appointments, by Dr. Richard Summa. There are also references to treatment for pulmonary nodules. In 2004 and into 2006, Claimant was complaining of shortness of breath and receiving treatment.
- 5) Claimant described her job duties as an elementary school (K-4) teacher for Employer. She said that she had to create bulletin boards for the classroom, take care of the books and chairs, and create and perform science and art activities. She said that there was a lot of writing involved in her position, including daily reports, schedules, report cards and lesson plans for each day. Claimant indicated that she performed all of the writing by hand. She did not use a computer for it. She had to perform lifting, including books, chairs and boards. Her job required pushing, kneeling, squatting and being up on her feet most of the day. Claimant testified that she earned \$62,000.00 per year while working for Employer.
- 6) According to the records and testimony, Claimant's first claimed injury while working for Employer occurred on January 30, 2002. Claimant testified that she was walking down the hall with her class, when she slipped on some water on the floor and fell onto her buttocks. She said that she hurt her low back, neck and right foot. She said that she received treatment at Concentra and from Dr. Tate, and had an MRI of the neck. She eventually settled her Workers' Compensation case with Employer for this injury.
- 7) Medical treatment records from **Dr. Kent Campbell** (Exhibit F) document Claimant's initial treatment on February 1, 2002 following this January 30, 2002 accident at work. The record contains a consistent history of injury at work and complaints of back, neck and right ankle pain. Dr. Campbell diagnosed neck pain, back pain and a right ankle sprain, for which he prescribed medications. Claimant next began treating with **Dr. Sandra Tate** (Exhibit F) on February 5, 2002. Dr. Tate diagnosed low back pain, neck pain or a cervical strain, right SI joint dysfunction and a Grade I right ankle strain. She prescribed medication and physical therapy. Claimant's low back and right ankle seemed to be improving, but the neck was not, so Dr. Tate performed a couple of trigger point injections in the left upper trapezius muscle. When Claimant complained of some numbness and tingling radiating from her neck into her hand, Dr. Tate ordered a cervical MRI. The cervical MRI performed on March 12, 2002 at **Metro Imaging** (Exhibit F) showed mild degenerative hypertrophic ridging at C5-6, more severe on the right side, but no evidence of a focal

- disc protrusion. By March 13, 2002, Dr. Tate placed Claimant at maximum medical improvement for the low back and right ankle, but she injected the left AC joint because of ongoing neck complaints. Despite ongoing left upper trapezius pain and myofascial pain syndrome, Dr. Tate also placed Claimant at maximum medical improvement for her neck injury on March 20, 2002. Dr. Tate examined Claimant one last time on May 16, 2002 because of ongoing neck, low back and right ankle pain, but she did not believe any additional treatment was needed for these conditions.
- 8) Claimant and Employer entered into an agreement to resolve the January 30, 2002 claim (Injury No. 02-005713) by **Stipulation for Compromise Settlement** (Exhibit A) for \$14,500.00, or 10% permanent partial disability of the body as a whole referable to the neck and back and 2.5% permanent partial disability of the right ankle. The Second Injury Fund claim was voluntarily dismissed by Claimant on the Stipulation. This Stipulation was approved by Administrative Law Judge Jennifer L. Schwendemann on August 25, 2003.
 - 9) Claimant testified that she had continued problems following her treatment from this accident at work in 2002. She said that it was difficult to turn her neck to the left, which made driving tough. She said that she had continued pain in her back and developed arthritis in her right foot. She testified that these problems from this injury affected her ability to perform squatting, kneeling or sitting for a long period of time.
 - 10) Claimant testified that in 2005, she noticed her right hand was swelling and she had pain shooting up her forearm to her elbow. She sought treatment and Dr. Glogovac performed surgery on her right arm for a diagnosis of tendinitis.
 - 11) The medical treatment records from **DePaul Health Center** (Exhibit G) document the surgical treatment Claimant received from **Dr. Vic Glogovac** on May 16, 2005 for her right wrist. Dr. Glogovac performed a tenolysis reconstruction of the sixth dorsal compartment to treat Claimant's diagnosed tenosynoviopathy of the sixth dorsal compartment of the right wrist.
 - 12) **Dr. David Brown** at **The Orthopedic Center of St. Louis** (Exhibit L) first examined Claimant for an independent medical examination on September 26, 2005. Claimant provided a history of writing out 23 report cards by hand, which took a few hours, and then having to redo 10-15 of them in early January 2005. She also began using a PalmPilot for teaching. She reported waking up on January 28, 2005 in excruciating pain, but could not recall a specific injury. Dr. Brown characterized this as "a very unusual history," in that she reports hand-related activities that she believes caused her problem, but no gradual onset of complaints. Instead, an acute onset, but no specific injury. Even though she had had surgery from Dr. Glogovac months ago and was still in therapy, she still reported severe subjective complaints, but her exam revealed diffuse tenderness not well localized. He found that her limited range of motion and her resistance at attempts of passive range of motion pointed to voluntary, self-limited behavior on her part. Dr. Brown did not believe that her ruptured extensor retinaculum, which Dr. Glogovac surgically treated, was related to her work as a teacher, because that type of injury is typically due to a traumatic event and there

- was no such traumatic event described. He had no further recommendations for treatment and did not see any objective reason why she could not return to her work as a teacher.
- 13) Claimant said that she was able to go back to teaching school in September 2005, but she could not return to her regular job teaching fourth graders. Instead, she was assigned to the Mark Twain Student Support Center (MTSSC) to teach reading to kindergartners and first grade students. She said the MTSSC was where the district sent children with disruptive behavior issues or other such problems. She said there were only ten children per class, which was less than a regular sized elementary school class that she used to teach. Claimant testified that she has had severe pains in the right hand since 2005/2006, but she did her job. She admitted that she could not do the writing she used to have to do, so the MTSSC placement was good for her, because she did not have to write as much there. She admitted that it was difficult not being able to do what she used to be able to do.
- 14) Claimant testified that she began to have emotional problems by not being able to return to teaching fourth graders, a position she truly enjoyed. She said that a board member and the principal sent her home at one point because she just could not perform the writing that was expected of her, since she is right-hand dominant. She said that she was an emotional mess. She cried a lot and kept to herself. She said that she was unable to be a wife to her husband, and, so, they got divorced.
- 15) Medical treatment records from **Dr. Joyce Boehmer** (Exhibit E) during this period of time confirm that Claimant reported she was under a lot of stress on February 7, 2006, when she and her husband both lost their jobs and she went back to teaching at a resource center. By June 8, 2006, Claimant was at the doctor's office asking for an STD test because she was going through a divorce after a three-year marriage to a verbally and physically abusive man, and she was concerned she had gotten an STD. On June 5, 2007, she had more complaints of stress related to her daughter's wedding, but was not interested in starting any medication for her anxiety at that time.
- 16) On or about October 2, 2006, Claimant was walking down the hallway at school when she was struck on the right forearm by a door, as a fellow teacher opened it to step into the hallway. She treated with Dr. Glogovac for a forearm contusion.
- 17) Claimant and Employer entered into an agreement to resolve the October 2, 2006 claim (Injury No. 06-093405) by **Stipulation for Compromise Settlement** (Exhibit A) for \$1,882.75, or 2.5% permanent partial disability of the right forearm. The Second Injury Fund claim was voluntarily dismissed by Claimant on the Stipulation. This Stipulation was approved by Administrative Law Judge Karla Boresi on January 22, 2009.
- 18) Claimant testified that she suffered her next injury on the job working for Employer on October 11, 2006. Claimant testified that she was trying to stop a child from running out of the classroom, when he grabbed and twisted her left wrist, causing immediate pain. She said that she treated at Concentra and then with Dr. Glogovac.

- 19) Claimant testified that six weeks later, she was again injured when the same child became agitated while she was reading to the class. She said that he twisted her left wrist and slid down the wall with his whole body weight, while holding onto her wrist. Claimant testified that she was diagnosed with torn ligaments in the wrist and she eventually had surgery performed by Dr. Brown in February 2007. She said that she was off work for awhile and eventually settled her Workers' Compensation case for this injury.
- 20) **Dr. David Brown at The Orthopedic Center of St. Louis** (Exhibit L) examined Claimant on January 9, 2007. He took a history from her of a student twisting her left wrist on October 11, 2006, as well as a past medical history of surgery on her right wrist, with pain, numbness and tingling radiating from the right hand/wrist up to the elbow. Abnormalities on the X-rays suggested a possible TFCC injury. Dr. Brown recommended an MRI arthrogram to further evaluate the wrist. The MRI arthrogram confirmed a severe TFCC injury to the left wrist with widening between the end of the ulna and distal radius. Dr. Brown recommended surgery for the TFCC injury.
- 21) Dr. Brown took Claimant to surgery at the **Timberlake Surgery Center** (Exhibit K) on February 23, 2007. He performed a left wrist diagnostic arthroscopy, arthroscopic debridement of a large central left wrist TFCC tear, repair of an ulnar-sided peripheral TFCC tear both arthroscopically and convergent to an open repair, and a left wrist synovectomy. He performed this surgery to treat Claimant's left wrist triangular fibrocartilage complex tear.
- 22) Following surgery, Claimant seemed to be progressing well. She still had wrist pain, but showed some improvement through her visit on April 2, 2007, at which point Dr. Brown recommended supervised physical therapy and continued one-handed work with the uninjured extremity. Her treatment, however, was interrupted by a new injury at work on April 10, 2007.
- 23) Claimant and Employer entered into an agreement to resolve the October 11, 2006 claim (Injury No. 06-099118) by **Stipulation for Compromise Settlement** (Exhibit A) for \$16,474.06, or 25% permanent partial disability of the left wrist. According to the Stipulation, Employer paid \$33,949.07 in medical expenses and \$3,183.55 for a period of 4 3/7 weeks of temporary total disability benefits. The Second Injury Fund claim was left open on the Stipulation. This Stipulation was approved by Administrative Law Judge Karla Boresi on January 22, 2009.
- 24) Claimant testified that she had continued problems that she associated with this left wrist work injury. She said that she was in a great deal of pain and she had to wear a wrist splint. Claimant noted that after the earlier right wrist injury, she relied more on her left hand and wrist, but now that both wrists were injured, it was devastating. Claimant testified that she begged Dr. Brown to remove the splint so she could go back to work. She returned to work following the left wrist injury and surgery on March 19, 2007.

- 25) On April 10, 2007, Claimant suffered her next injury on the job for Employer when a student from her class started to come after the other students with a metal-legged chair, in an attempt to harm or injure them. She stepped between him and the other students to try to protect them, and he put the metal chair into the wall over her head. When she went to the telephone on the wall to call for help, the student twisted and snapped her right hand back making it impossible for her to make the call. She then reached into her purse to try to retrieve her cell phone to make the call with her left hand, and he once again twisted and snapped her left wrist to stop her from making the call. Claimant said that he was beating her in her arms and hands, resulting in excruciating pain in both wrists.
- 26) **Dr. David Brown** (Exhibit L) once again provided treatment for Claimant following this injury. He examined her on April 16, 2007. Claimant provided a consistent history of the re-injury to her wrist at work on April 10, 2007. Dr. Brown hoped that it was nothing more than an aggravation of her wrist, which would improve with medications and physical therapy. He sent her back to work with no use of the left upper extremity and only working with kindergartners. Three days later, on April 19, 2007, Dr. Brown once again examined Claimant for her right wrist complaints associated with the April 10, 2007 incident at school. She provided the prior history of surgery to the right wrist in 2005, followed by injury to the right wrist in 2006 when she was struck by a door. She reported increased pain in the right wrist and treatment since the April 10, 2007 injury for the right wrist with Concentra and Dr. Glogovac. Dr. Brown diagnosed ulnar-sided right wrist pain, for which he recommended medication, therapy and use of a wrist splint. Claimant was kept in therapy for a significant period of time, but Dr. Brown found in his follow-up examinations through July 31, 2007 that she was continuing to improve. The physical therapy note from July 23, 2007 at **Select Physical Therapy** (Exhibit SIF II) indicates that Claimant can roll her hair on curlers, lift full quarts and do her own laundry now. She was noted to have had slower than anticipated progress with strengthening due to her own self-limiting behavior.
- 27) Dr. Brown (Exhibit L) recommended nerve conduction studies to evaluate her complaint of numbness in the right upper extremity. The nerve conduction studies performed on August 14, 2007 by **Dr. David Peeples** (Exhibit SIF IV) were normal, so Dr. Brown next recommended an MRI of the right wrist. The MRI taken on September 4, 2007 revealed some subluxation of the distal radioulnar joint with lack of continuity of the volar radial ulnar ligament, but he thought these findings were chronic in nature. Dr. Brown did not believe they were related to the April 10, 2007 injury. He explained that a surgery may be in order for the chronic condition, but the results would be unpredictable. He provided a steroid injection for the right wrist and noted that her left wrist continued to improve. He released her to full duty, with no restrictions as of September 10, 2007.
- 28) Claimant and Employer entered into an agreement to resolve the April 10, 2007 claim (Injury No. 07-034087) by **Stipulation for Compromise Settlement** (Exhibit A) for \$13,179.25, or 15% permanent partial disability of the right wrist and 5% permanent partial disability of the left wrist. According to the Stipulation, Employer paid

\$3,450.43 in medical expenses and \$5,032.09 for a period of 7 weeks of temporary total disability benefits. The Second Injury Fund claim was left open on the Stipulation. This Stipulation was approved by Administrative Law Judge Karla Boresi on January 22, 2009.

- 29) Claimant testified that her hands/wrists were worse after this last incident with the student. She described pains that would wake her up at night that went all the way from her wrist to her shoulder in both arms. Claimant noted that these additional problems and complaints affected her ability to lift, push and pull objects. Claimant admitted that Dr. Brown further limited her leading up to the last injury at work. She had a helper coming into the classroom to help her, and, specifically, to help with some of the writing.
- 30) On October 12, 2007, Claimant was once again injured on the job for Employer. She was on the playground during recess playing kickball with her students. She said that the concrete was cracked and in need of repair. While playing with them, she twisted her right ankle. She was given a wrap for the ankle and medications. She said that between her first right ankle injury in 2002 and her new one in 2007, she had some pain, but the pain became more severe after the 2007 injury.
- 31) X-rays of the right foot and ankle taken on October 15, 2007 at **Excel Imaging** (Exhibit I) revealed mild degenerative joint space narrowing, but no discrete fracture, subluxation or significant soft tissue swelling. An addendum report the next day after the X-rays were reviewed again (which errantly says "left" instead of "right" foot even though it is an addendum based on the X-rays taken the prior day), indicates that there might be a subtle linear lucency in the superior portion of the navicular, which could represent a non-displaced stress fracture. Therefore, an MRI was recommended. An MRI of the right ankle taken on October 24, 2007 at **Florissant Open MRI** (Exhibit H) revealed mid and hind foot degenerative changes, but no evidence of a definite fracture. Medical treatment records from **Concentra Medical Centers** (Exhibit SIF III) showed no deformity, ecchymosis or swelling in the right foot, with a full range of motion. She was diagnosed with ankle/foot pain.
- 32) Claimant and Employer entered into an agreement to resolve the October 12, 2007 claim (Injury No. 07-102006) by **Stipulation for Compromise Settlement** (Exhibit A) for \$4,522.59, or 7.5% permanent partial disability of the right ankle. According to the Stipulation, Employer paid \$1,205.85 in medical expenses and no temporary total disability benefits. The Second Injury Fund claim was left open on the Stipulation. This Stipulation was approved by Administrative Law Judge Karla Boresi on January 22, 2009.
- 33) Claimant testified that she had some continued problems that she associated with the 2007 right ankle injury. She said she had some problems walking, using the right ankle for driving and she also had to stop taking baths because it was hard to get in and out of the bathtub. Claimant also testified that she used to be a good dancer, but after the right ankle injuries, she was unable to bop anymore.

- 34) Claimant returned to **Dr. David Brown** (Exhibit L) on November 12, 2007. She said the right wrist steroid injection helped, but she still had pain over the ulnar aspect of the wrist. She also had pain over the ulnar aspect of the left wrist. She said the pain was worse with writing and gripping. He suggested that an ulnar shortening osteotomy surgery might help, but her prognosis was guarded in terms of significant improvement in her complaints. Claimant was not interested in further surgery and instead requested another steroid injection in the right wrist. Dr. Brown again released her to full duty with no restrictions.
- 35) Finally, Claimant suffered her last injury while working for Employer on December 10, 2007. She was helping a 100-pound first grader, who was trying to learn how to write his name. He apparently became upset and smashed her left wrist into the desk with his fist, as hard as he could. Based on Claimant's testimony, it seemed as though this incident was "the last straw" for Claimant, in that she said she had been attacked three prior times by students and so she was afraid of being attacked again. She recognized that she had both hands injured, and so she felt as though she could not protect herself or "the babies" [her students].
- 36) Claimant testified that Dr. Brown and Dr. Glogovac both provided injections and indicated that she needed to go to light-duty work as a result of her left wrist. She said that Dr. Brown talked to her about surgery, but he said there was only a 50% chance of improvement, so she did not have the surgery. Claimant was sent for a functional capacity evaluation which indicated her lifting and pushing were limited, so she could not work in the classroom. Therefore, she was placed in the lunchroom to work with one child at a time. She finished the school year and last worked in May 2008.
- 37) **Dr. David Brown** (Exhibit L) examined Claimant on December 19, 2007. Claimant provided a consistent history of the new injury at work on December 10, 2007. Claimant reported increased pain, swelling and bruising since the injury, but Dr. Brown found no obvious bruising or swelling on the left wrist compared to the right in his examination. He diagnosed a contusion of the left wrist, for which he provided a wrist splint and released her to work with a 5 pound lifting limit on the left upper extremity. By January 7, 2008, Claimant was still complaining of bilateral wrist pain. Dr. Brown again believed that she had bilateral ulnar impaction syndrome, for which he could do surgery. Claimant was not interested in further surgery. She told him that she did not feel like she could do her normal job, so he sent her for a functional capacity evaluation to determine her capabilities and appropriate restrictions.
- 38) Dr. Brown ordered a functional capacity evaluation (FCE) to determine Claimant's ability to return to work in the classroom. The FCE was performed at **PRORehab** (Exhibit J) on January 22, 2008. The report from the therapist indicates that Claimant failed 10 out of 11 validity criteria, reflecting inconsistencies between her subjective pain reports and displayed functional abilities, as well as the presence of submaximal/inconsistent effort with testing. Because of her symptom magnification behaviors, the therapist noted that it was difficult to accurately identify her current abilities and limitations. Claimant displayed the ability to function at least in the

- sedentary work demand level, which she said would not meet her self-reported job demands for Employer. She also noted a fear of re-injury to the therapist because she cannot protect or defend herself, so she was considering disability retirement.
- 39) **Dr. David Brown** (Exhibit L) examined Claimant last on January 30, 2008, following the completion of the FCE. He confirmed that she could work in a sedentary work demand level, but not at the light work demand level necessary for her normal job duties in the classroom. She told Dr. Brown that she was looking at retiring and applying for disability. Since Claimant did not want any surgical treatment, Dr. Brown released her at maximum medical improvement. He placed permanent work restrictions on her that would limit her to a sedentary work demand level, including occasional lifting from floor to waist, waist to shoulder or shoulder to overhead of 10 pounds; occasionally bilaterally carry 5 pounds; more restrictive lifting, carrying, pushing or pulling with each arm individually; no handwriting continuously for over a minute and twelve seconds at a time; and no use of scissors for over one minute and fifteen seconds at a time.
- 40) The medical treatment records from **Dr. Joyce Boehmer** (Exhibit E) show that on January 18, 2008, Claimant was complaining of bilateral wrist pain from her work injuries involving both wrists. She reported being fearful of more injuries and Dr. Boehmer suggested that she apply for disability. She filled out disability forms for Claimant on March 10, 2008, noting that Claimant had chronic pain in both wrists, hands and up to the elbows from recurrent injuries at work. She said that Claimant was unable to use her hands/wrists for anything and was, therefore, disabled. After reporting a lot of stress and anxiety in her life as a result of having to quit teaching, Claimant was given Paxil on June 26, 2008, which she never took, and then a prescription for Xanax on July 23, 2008. It is unclear from the subsequent records if she ever actually took that medication either.
- 41) She said that because of the attacks, she could not go back to the classroom, so she decided to retire. She testified that in her heart, she wanted to teach, but physically, she could not handle it. She admitted that this sentiment started setting in after the April 2007 injury. Claimant admitted that fear was a part of her decision to retire. She subsequently received her disability pension through the school district. Claimant testified that she was unable to go back to teaching because she was unable to protect herself or the children anymore.
- 42) Claimant and Employer entered into an agreement to resolve the December 10, 2007 Claim (Injury No. 07-119197) by **Stipulation for Compromise Settlement** (Exhibit A) for \$1,702.05, or 2.5% permanent partial disability of the left wrist. According to the Stipulation, Employer paid \$930.15 in medical expenses and no temporary total disability benefits. The Second Injury Fund Claim was left open on the Stipulation. This Stipulation was approved by Administrative Law Judge Karla Boresi on January 22, 2009.
- 43) The deposition of **Dr. David Volarich** (Exhibit B) was taken by Claimant on April 16, 2010 to make his opinions in this case admissible at trial. Dr. Volarich is an

osteopathic physician, who is board certified in nuclear medicine, occupational medicine and as an independent medical examiner. He examined Claimant on one occasion, July 29, 2008, at the request of Claimant's attorney. Dr. Volarich took an extensive history from Claimant of her pre-existing problems and complaints, as well as of her various work injuries. He also reviewed extensive medical records regarding treatment she received for her various injuries. His physical examination revealed that she was depressed with a flat affect. He found asymmetric bulk in the upper and lower extremities, with strength decreasing as he moved down the arms, and right leg weakness because of ankle pain. He found significant wheezing, rhonchi and rales throughout the lung fields, left worse than right. There was significantly restricted range of motion and a trigger point found on the cervical examination, but very minor lost range of motion, with no spasm or trigger points, in the low back. He found some lost range of motion in the shoulders, minimal lost range of motion in the elbows and the most significant losses in the left wrist. He confirmed that Claimant had instability in the right wrist and pain consistent with ulnar impaction syndrome. At the right ankle, there was only a difference of 5 degrees of less inversion between the right and left ankles in range of motion testing.

- 44) Referable to the October 2, 2006 injury, Dr. Volarich diagnosed a right forearm contusion, for which he rated Claimant as having 15% permanent partial disability of the right forearm. Referable to the October 11, 2006 injury, Dr. Volarich diagnosed a left wrist strain, for which he rated Claimant as having 15% permanent partial disability of the left wrist. Referable to the injury on approximately November 28, 2006, Dr. Volarich diagnosed internal derangement of the left wrist causing a TFCC tear, which was surgically treated, for which he rated Claimant as having 35% permanent partial disability of the left wrist. Referable to the April 10, 2007 injury, Dr. Volarich diagnosed right wrist internal derangement (TFCC tear) not surgically repaired and a left wrist strain, for which he rated Claimant as having permanent partial disabilities of 25% of the right wrist and 10% of the left wrist. Referable to the October 12, 2007 injury, Dr. Volarich diagnosed a right ankle strain and aggravation of talonavicular degenerative arthritis, for which he rated Claimant as having 15% permanent partial disability of the right ankle. Finally, referable to the December 10, 2007 injury, Dr. Volarich diagnosed a left wrist contusion, for which he rated Claimant as having 20% permanent partial disability of the left wrist. Dr. Volarich opined that the work accidents described above were the substantial contributing factors to each of the above-referenced diagnoses and the attendant disability for each injury. He opined that she had reached maximum medical improvement based on the medical treatment she had received up through his examination on July 29, 2008.
- 45) Dr. Volarich also rated permanent partial disabilities pre-existing all of the above-referenced work injuries of 20% of the body as a whole referable to her pulmonary system for her chronic asthma, 15% of the body as a whole referable to the neck for her chronic cervical syndrome, 15% of the body as a whole referable to the low back for her chronic lumbar syndrome, 7.5% of the right ankle for her ankle strain, and 30% of the right forearm for the tenosynovitis and extensor carpi ulnaris tendon injury that was surgically repaired in 2005. Dr. Volarich noted that he made no attempt to rate her disability regarding her depression and he deferred to a psychiatric evaluation

for that assessment. He noted that each of her rated disabilities, as described, represented a hindrance or obstacle to employment. Dr. Volarich further opined that the combination of the disabilities creates a substantially greater disability than the simple sum or total of each separate injury or illness, and so a loading factor should be added. Finally, Dr. Volarich opined that Claimant was permanently and totally disabled as a direct result of the combination of all of her work injuries, as well as in combination with all of her pre-existing medical conditions. He opined that she was unable to return to teaching and he did not believe she could engage in any substantial gainful activity, nor could she be expected to work on a full-time basis. He also placed significant physical restrictions on her activities based on her arms, spine, lower extremities and pulmonary condition.

- 46) The deposition of **Mr. James England, Jr.** (Exhibit C) was taken by Claimant on April 20, 2010 to make his opinions in this case admissible at trial. Mr. England is a certified rehabilitation counselor. He met with Claimant on one occasion, August 21, 2009, at the request of Claimant's attorney. He reviewed extensive medical treatment records; took a family, social, educational and vocational history from Claimant; determined her functional restrictions/limitations; and then issued his report dated August 26, 2009. Mr. England concluded that Claimant is well-educated and has a very well-established work history and career as an elementary school teacher. He commented that if not for the degree of her impairments, she would be highly marketable in the open labor market. However, taking into consideration the combination of her problems, including difficulties with both upper extremities, her back, neck, and her depression, he did not believe she could successfully sustain any type of work in the open labor market. He testified that he believed she would have trouble even performing at a sedentary level of exertion because of the problems she has with her upper extremities. Absent significant improvement in her overall functioning, he opined that her lack of employability was likely to remain permanent.
- 47) On cross-examination, Mr. England opined that even with Dr. Brown's restrictions on her writing, it would be difficult to perform sedentary work, but in any event, emotionally, she would have to be in a better frame of mind. He admitted that although theoretically there may be a job, like a garage attendant, that does not violate her restrictions, the numbers are "pretty limited" and her fragile emotional state was a significant part of why he believed she was unemployable.
- 48) The deposition of **Dr. Jay Liss** (Exhibit D) was taken by Claimant on March 24, 2011 to make his opinions in this case admissible at trial. Dr. Liss is board certified in psychiatry and as a forensic examiner. He examined Claimant on one occasion, November 19, 2010, at the request of Claimant's attorney. He also reviewed extensive medical treatment records and provided Claimant with self-reporting questionnaires, such as the Beck Depressive Inventory, Beck Anxiety Inventory, Short Michigan Alcohol Screening Test, Yale-Brown Obsessive-Compulsive Symptom Checklist, General Adult ADD Symptom Checklist and the Post Trauma Stress Disorder Symptom Checklist, which Claimant completed and he reviewed. He found that Claimant had poor sleep, poor concentration, anxiety, social anxiety, poor self-

esteem, compulsive behaviors, mood swings, memory trouble, impulsive behavior, hopelessness and flashbacks. He diagnosed:

Axis I: A. Post Trauma Stress Disorder with associated anxiety and depression, related to multiple incidents prior to her injuries in 2006 and 2007.

B. Post Trauma Stress Disorder as a result of physical disability with associated anxiety and major depression, with the prevailing cause being the physical and psychiatric disabilities caused by the work injury.

Axis II: No personality disorder

Axis III: Major medical problems, history of asthma and persistent orthopedic problems

Axis IV: Major stress is her disability

Axis V: GAF as it relates to severity of psychiatric illness 40, which indicates the need for treatment

Dr. Liss opined that Claimant is permanently disabled and not capable of work in the open labor market, as a result of the combination of her work injuries and psychiatric injuries. He opined that Claimant had post trauma stress disorder with associated anxiety and depression, which pre-existed the 2006 and 2007 injuries, for which he rated Claimant as having 30% permanent partial disability of the body as a whole. He further opined that the 2006 and 2007 work injuries were the prevailing cause of additional post trauma stress disorder with associated anxiety and depression, for which he rated Claimant as having an additional 35% permanent partial disability of the body as a whole. In addition, he diagnosed major depression caused by her disability, for which he assigned another 35% permanent partial disability of the body as a whole. Combining all of her disabilities together, resulted in her permanent total disability, in his opinion.

- 49) Regarding her current complaints, Claimant testified that she has pain from both hands/wrists up to her elbows that wakes her up at night. She said that she wears splints all the time. In fact, I observed at trial that she was wearing braces on each wrist. She said that she is only able to write for approximately a minute before she gets a shooting pain, which causes her to have to stop writing. She used to like to write poetry, but she is unable to write poetry anymore. Claimant testified that her parents live next door to her and her father does all of the chores around her house. Since she cannot really cook anymore, her mother sends meals to her house, or Claimant may use the microwave for a meal. She said that she cannot take care of her own hair, so she either wears a wig or she goes to the beauty salon to have her hair done. Claimant noted that she is unable to even walk three blocks because she will get pain and swelling in her right foot.
- 50) On an average day, Claimant testified that she sits on the porch, watches television, visits with her parents or occasionally will go with her father to the Veterans' Administration center to watch a movie.
- 51) On cross-examination, Claimant was asked about another injury on April 15, 2008, when she was hit in the face with a toilet roll dispenser. She said that she did not

remember the specifics, but she probably reported it and went to Concentra. The records from **Concentra Medical Centers** (Exhibit SIF III) diagnosed her with a contusion of the face, when the dispenser cover came off the wall and struck her, as she was using the bathroom. She said that she did not think it necessarily aggravated her prior injuries or made anything worse. She said that she does not think she could even do the reading in the learning center because of her continued problems. She admitted that she has not thought about being a tutor because of the pains in her arms and the fact that she cannot protect herself. She is afraid of being in a teaching environment now as a result of all that has happened to her.

- 52) In terms of ongoing treatment, Claimant testified that she still gets injections from Dr. Glogovac four times per year. She said that the injections help some, but not entirely. Overall, her hands/wrists are about the same as when she was released by Dr. Brown. She has not received any specific psychiatric care before or after her visit with Dr. Liss. She only received a couple of weeks of medications from her personal (family) doctor, Dr. Boehmer.
- 53) Although on direct examination, when describing her work duties, she said that she was up on her feet all day, on cross-examination, she described trouble with her foot since 2002 and she said that she had a chair in which she would scoot around in the classroom. Despite this, she did still play kickball with the children. She said that it wasn't impossible for her to walk, it was just more difficult and caused pain. She also admitted that her ankle has gotten worse since 2009, because arthritis is setting into the ankle. She said that she received an injection in the foot from Dr. Glogovac last year.
- 54) The Second Injury Fund submitted no direct medical or vocational evidence into the record to dispute Claimant's experts' findings on medical causation or the nature and extent of permanent partial/total disability for the physical or psychiatric conditions at issue in this case.

RULINGS OF LAW:

Based on a comprehensive review of the substantial and competent evidence, including Claimant's testimony, the expert medical opinions and depositions, the vocational expert opinion and deposition, the medical records, the other records, and the Stipulations for Compromise Settlement between Claimant and Employer for various injuries including this case, as well as based on my personal observations of Claimant at hearing, and based on the applicable statutes of the State of Missouri, I find:

Claimant sustained a compensable injury to her left wrist on December 10, 2007, when she was helping a 100-pound first grader, who was trying to learn how to write his name. He apparently became upset and smashed her left wrist into the desk with his fist as hard as he could. Based on Claimant's testimony, I find that this incident was "the last straw" for Claimant, in that she said she had been attacked three prior times by students and so she was afraid of being

attacked again. She recognized that she had both hands injured, and so she felt as though she could not protect herself or “the babies” [her students]. The injury caused a left wrist contusion, which was treated conservatively. Claimant credibly testified that she had continued pain and problems with her left wrist. This finding on Claimant’s condition is supported by the records and reports of Dr. David Brown and the report and testimony of Dr. David Volarich.

Issue 1: Are Claimant’s injuries and continuing complaints, as well as any resultant disability, medically causally connected to her accident at work on December 10, 2007?

Given Claimant’s prior history of significant left wrist injuries, the Second Injury Fund questions whether Claimant’s December 10, 2007 accidental injury actually caused Claimant any additional problems, complaints or disability, specifically attributable to that new injury.

Considering the date of the injury, it is important to note that the new statutory provisions are in effect, including **Mo. Rev. Stat. § 287.800 (2005)**, which mandates that the Court “shall construe the provisions of this chapter strictly” and that “the division of workers’ compensation shall weigh the evidence impartially without giving the benefit of the doubt to any party when weighing evidence and resolving factual conflicts.” Additionally, **Mo. Rev. Stat. § 287.808 (2005)** establishes the burden of proof that must be met to maintain a claim under this chapter. That section states, “In asserting any claim or defense based on a factual proposition, the party asserting such claim or defense must establish that such proposition is more likely to be true than not true.”

Under **Mo. Rev. Stat. § 287.020.2 (2005)**, accident is defined as “an unexpected traumatic event or unusual strain identifiable by time and place of occurrence and producing at the time objective symptoms of an injury caused by a specific event during a single work shift.” Further, under **Mo. Rev. Stat. § 287.020.3 (1) (2005)**, “An injury by accident is compensable only if the accident was the prevailing factor in causing both the resulting medical condition and disability. ‘The prevailing factor’ is defined to be the primary factor, in relation to any other factor, causing both the resulting medical condition and disability.” Finally, under **Mo. Rev. Stat. § 287.020.3 (2) (2005)**, an injury is deemed to arise out of and in the course of the employment only if the accident is the prevailing factor in causing the injury and 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.

Claimant bears the burden of proof on all essential elements of her Workers’ Compensation case. *Fischer v. Archdiocese of St. Louis-Cardinal Ritter Institute*, 793 S.W.2d 195 (Mo. App. E.D. 1990) *overruled on other grounds by Hampton v. Big Boy Steel Erection*, 121 S.W.3d 220 (Mo. 2003). The fact finder is charged with passing on the credibility of all witnesses and may disbelieve testimony absent contradictory evidence. *Id.* at 199.

Based on Claimant’s credible testimony and the competent and credible testimony of Dr. David Volarich, I find that Claimant has met her burden of proving the presence of an accident that involved injury to her left wrist on December 10, 2007, which arose out of and in the course

of her employment as a school teacher for Employer. I find that Dr. Brown began a new course of treatment for the left wrist, for a diagnosed left wrist contusion, and provided additional work restrictions, based on this new injury to the left wrist on December 10, 2007. Dr. Volarich agreed with the diagnosis of a left wrist contusion being medically causally related to this December 10, 2007 accident, and he further credibly testified regarding the permanent partial disability he believed Claimant developed on account of this injury. While I may disagree with the numerical values of permanent partial disability he assigned for each of these injuries, the most important aspect of his testimony is that he was able to divide out an amount of permanent partial disability that he attributed to each such injury at work. In that respect, I find that Dr. Volarich's testimony supports Claimant's contention that she suffered some additional permanent partial disability medically causally related to the December 10, 2007 accident.

In addition to Claimant meeting her burden of proof that the left wrist contusion and some additional permanent partial disability on account of this injury is medically causally related to her accident at work on December 10, 2007, Claimant has also met her burden of proving that she sustained a psychiatric injury and disability, which is medically causally related to this accident on December 10, 2007.

Claimant credibly testified that she had significant anxiety and depression following the December 10, 2007 injury, when it became clear to her that she would be unable to continue functioning as a teacher, because she was unable to protect herself or her students anymore. Medical treatment records from Dr. Joyce Boehmer confirm these complaints and show that Claimant was prescribed medication for these complaints. Additionally, in the unrebutted testimony of Claimant's psychiatric expert, Dr. Jay Liss, he diagnosed major depression caused by her disability (inability to continue teaching following the last injury), for which he assigned 35% permanent partial disability of the body as a whole.

Therefore, in addition to Claimant meeting her burden of proof that she sustained a left wrist contusion with additional permanent partial disability referable to the left wrist, medically causally related to the December 10, 2007 accident, I find that she also met her burden of proving that she sustained major depression and an additional amount of permanent partial psychiatric disability referable to the body as a whole, medically causally related to the December 10, 2007 accidental injury at work for Employer.

Issue 2: What is the nature and extent of Claimant's permanent partial and/or permanent total disability attributable to this injury?

Issue 3: What is the liability of the Second Injury Fund?

Given that these two issues are so interrelated in this claim, I will address these two issues together.

Under **Mo. Rev. Stat. § 287.020.6 (2005)**, "total disability" is defined as the "inability to return to any employment and not merely ... inability to return to the employment in which the employee was engaged at the time of the accident." The test for permanent total disability is

claimant's ability to compete in the open labor market. The central question is whether any employer in the usual course of business could reasonably be expected to employ claimant in his present physical condition. *Searcy v. McDonnell Douglas Aircraft Co.*, 894 S.W.2d 173 (Mo. App. E.D. 1995) *overruled on other grounds by Hampton v. Big Boy Steel Erection*, 121 S.W.3d 220 (Mo. 2003).

In cases such as this one where the Second Injury Fund is involved, we must also look to **Mo. Rev. Stat. § 287.220 (2005)** for the appropriate apportionment of benefits under the statute. In order to recover from the Fund, Claimant must prove a pre-existing permanent partial disability existed at the time of the primary injury. Then to have a valid Fund claim, that pre-existing permanent partial disability must combine with the primary disability in one of two ways. First, the disabilities combine to create permanent total disability, or second, the disabilities combine to create a greater overall disability than the simple sum of the disabilities when added together.

In the second (permanent partial disability) combination scenario, pursuant to **Mo. Rev. Stat. § 287.220.1 (2005)**, the disabilities must also meet certain thresholds before liability against the Second Injury Fund is invoked, and they must have been of such seriousness so as to constitute a hindrance or obstacle to employment or re-employment should employee become unemployed. *Messex v. Sachs Electric Co.*, 989 S.W.2d 206 (Mo. App. E.D. 1999) *overruled on other grounds by Hampton v. Big Boy Steel Erection*, 121 S.W.3d 220 (Mo. 2003). The pre-existing disability and the subsequent compensable injury each must result in a minimum of 12.5% permanent partial disability of the body as a whole (50 weeks) or 15% permanent partial disability of a major extremity. These thresholds are not applicable in permanent total disability cases.

Where the Second Injury Fund is involved and there is an allegation of permanent total disability, the analysis of the case essentially takes on a three-step process:

First, is Claimant permanently and totally disabled?;

Second, what is the extent of Employer's liability for that disability from the last injury alone?; and

Finally, is the permanent total disability caused by a combination of the disability from the last injury and any pre-existing disabilities?

In determining this case, I will follow this three-step approach to award all appropriate benefits under the Statute.

Considering the competent and substantial evidence listed above, I find that Claimant is permanently and totally disabled. Claimant credibly described the continuing pain and problems she has attributable to her asthma, depression (psychiatric condition), her low back, neck, bilateral upper extremities and right ankle that keep her from functioning fully and normally on a daily basis. She is continuing to take medication on a daily basis to deal with these complaints and problems.

I find that the uncontradicted and uncontroverted reports and testimony in evidence from the medical and vocational experts support the conclusion that Claimant is permanently and totally disabled and unable to compete for work in the open labor market. I find that doctors have placed significant restrictions on Claimant's ability to function in the workplace. Dr.

Volarich, who provided the most comprehensive report on Claimant's condition, and Dr. Brown, the treating orthopedic doctor, placed significant restrictions on her physical activities from an orthopedic standpoint. Dr. Volarich concluded that from a medical standpoint, based on the combination of all of her conditions, injuries and disabilities, she was permanently and totally disabled. Dr. Volarich, however, did not provide any opinions regarding Claimant's psychiatric condition or disability.

Dr. Liss, specifically dealing with Claimant's mental condition, opined that Claimant was permanently disabled and not capable of work in the open labor market, as a result of the combination of her work injuries and psychiatric injuries. Claimant's GAF number was 40, indicating, according to the doctor, that Claimant would have serious symptoms and impairment and was in need of treatment. Dr. Liss credibly opined that Claimant not only had pre-existing psychiatric disability, but also had some psychiatric disability related to her injury claims, and also related specifically to her last claim on account of her inability to return to teaching. However, with regard to the psychiatric disability related to the various injury claims (except the last one), Dr. Liss did not divide out what amount of disability may be specifically attributable to each individual injury alone. Since he did not divide out the disability per injury, Claimant was unable to meet her burden of proof on the nature and extent of any psychiatric disability related to each individual injury. However, since I find his opinion is credible that some of the psychiatric disability is attributable to the work injuries collectively, then the mere fact that it cannot be assessed against Employer in any one case does not take away from the fact that the disability pre-existed the last injury, and, thus, is able to be used in a combination that makes Claimant permanently and totally disabled. In other words, I find that since the combination of her work injuries is responsible for the increased psychiatric problems, those problems are, thus, properly part of the pre-existing conditions/disabilities that can be combined with her physical injuries to ultimately make the finding that she is permanently and totally disabled.

Dr. Volarich's and Dr. Liss' opinions, and Claimant's allegation of permanent total disability, was further bolstered by the report and testimony of Mr. James England, a vocational rehabilitation counselor, who confirmed that Claimant was not employable in the open labor market given the totality of her condition, including her psychiatric disability.

Based on the totality of the evidence submitted at hearing, I find the opinions of Dr. Volarich, Dr. Liss and Mr. England to be credible and properly supported by the rest of the medical evidence in this case. I found no evidence in the record, either medical or vocational, to support the proposition that Claimant was only permanently partially disabled and able to work, when the totality of her condition was considered (including her psychiatric condition).

Since Claimant is found to be permanently and totally disabled, the next step of the inquiry then is to determine the extent of Employer's liability for the last injury alone, and specifically to determine if Employer is solely responsible for that permanent total disability.

Based on my review of the competent and substantial evidence, I do not believe the last injury alone caused Claimant to be permanently and totally disabled. I do not find any credible evidence to suggest that Claimant's permanent total disability is the result of the last injury on December 10, 2007 alone. None of the experts, who provided opinions on disability, or on her

ability to work, including Dr. Volarich, Dr. Liss or Mr. England, indicated that just the last injury alone was responsible for Claimant's permanent total disability.

Claimant has had a history of injuries to various parts of her body for which she received permanent partial disability payments going back to an injury at least in 2002. These pre-existing injuries to the low back, neck, right ankle and bilateral upper extremities caused Claimant to seek treatment, miss time from work and take medications for her complaints. Additionally, Claimant had some pre-existing health conditions, including asthma and some psychiatric issues, to which Dr. Volarich and Dr. Liss assigned some pre-existing permanent partial disability. I believe Claimant when she testified to the problems she experienced with her low back, neck, right ankle and bilateral upper extremities prior to the December 10, 2007 injury at work. Dr. Volarich and Dr. Liss testified that the combination of the primary and pre-existing injuries and conditions was the reason Claimant was permanently totally disabled. Mr. England also similarly opined that the combination of the disabilities rendered Claimant permanently and totally disabled. Quite simply, there is no medical or vocational evidence in the record to support a finding that the last injury alone caused the permanent total disability in the case.

Under **Mo. Rev. Stat. § 287.190.6 (1) (2005)**, “‘permanent partial disability’ means a disability that is permanent in nature and partial in degree...” The claimant bears the burden of proving the nature and extent of any disability by a reasonable degree of certainty. *Elrod v. Treasurer of Missouri as Custodian of the Second Injury Fund*, 138 S.W.3d 714, 717 (Mo. banc 2004). Proof is made only by competent substantial evidence and may not rest on surmise or speculation. *Griggs v. A.B. Chance Co.*, 503 S.W.2d 697, 703 (Mo. App. 1973). Expert testimony may be required when there are complicated medical issues. *Id.* at 704. Extent and percentage of disability is a finding of fact within the special province of the [fact finding body, which] is not bound by the medical testimony but may consider all the evidence, including the testimony of the Claimant, and draw all reasonable inferences from other testimony in arriving at the percentage of disability. *Fogelsong v. Banquet Foods Corp.*, 526 S.W.2d 886, 892 (Mo. App. 1975)(citations omitted).

Additionally, under the 2005 amendments to the Workers' Compensation Law, the Legislature added further provisions that have an impact on the determination of the nature and extent of permanent partial disability. **Mo. Rev. Stat. § 287.190.6 (2) (2005)** states,

Permanent partial disability... shall be demonstrated and certified by a physician. Medical opinions addressing compensability and disability shall be stated within a reasonable degree of medical certainty. In determining compensability and disability, where inconsistent or conflicting medical opinions exist, objective medical findings shall prevail over subjective medical findings. Objective medical findings are those findings demonstrable on physical examination or by appropriate tests or diagnostic procedures.

Therefore, according to the terms of this statute, it is incumbent upon the claimant to have a medical opinion from a physician that demonstrates and certifies claimant's permanent partial disability within a reasonable degree of medical certainty. Further, if there are conflicting opinions from physicians in a given case, then objective medical findings must prevail over subjective findings.

In awarding permanent partial disability for this injury under these new statutory provisions, it is, thus, necessary to deal with each of these sections. Considering the competent and substantial evidence listed above, I find that the medical opinions from Dr. Volarich and Dr. Liss demonstrate and certify, within a reasonable degree of medical certainty, that Claimant sustained permanent partial disability as a result of her pre-existing injuries, as well as the work-related injury on December 10, 2007. Although the Second Injury Fund questions the ratings and conclusions of Dr. Liss, since they are based on subjective complaints, I find no inconsistent or conflicting psychiatric opinion in the record to contradict the findings and conclusions offered by Dr. Liss.

In trying to assess the percentage of permanent partial disability related to this injury for which Employer would have responsibility, it is also necessary to take into account the pre-existing permanent partial disability to the same body part. With regard to the left wrist, I have found extensive medical treatment records confirming the treatment (conservative and surgical) that has been performed to treat her complaints and problems with the left wrist going back to the injury at work on October 11, 2006. Dr. Volarich testified to his opinion on the division of disability referable to her left wrist among these various injuries. I have also reviewed the Stipulations for Compromise Settlement for these injuries between Claimant and Employer that have been admitted into evidence in this case, which show the multiple payments of permanent partial disability for left wrist conditions. However, I must note that many of Claimant's left wrist injury cases are being resolved by virtue of the various awards being simultaneously issued with this one. Therefore, while the stipulated settlements between Claimant and Employer provide some evidence of the disability Claimant may have had in her left wrist leading up to the time of the December 10, 2007 injury, the findings of permanent partial disability which I have made in each award are what controls for the purposes of the final resolution of these cases.

Case law in this area has stood for the proposition that since pre-existing permanent partial disability to the same part of the body is conclusively presumed to continue undiminished, it is appropriate for the total amount of permanent partial disability to be reduced by the prior amount, leaving the balance to be paid by the Employer in the instant case. *Helm v. SCF, Inc.*, 761 S.W.2d 199 (Mo. App. 1988).

Based upon all of these findings, as well as based on Claimant's testimony and the medical evidence, I find that Claimant has a total of 50% permanent partial disability of the left wrist. I arrived at this number by comparing the findings on the physical examinations of the right and left wrists/forearms and finding that the left wrist had more restricted range of motion, and decreased grip strength and two-point discrimination, when compared to the right wrist/forearm. I find that Claimant's overall left wrist permanent partial disability is appropriately divided among her various injuries as follows: 10% of the left wrist attributable to the October 11, 2006 work injury; 30% of the left wrist attributable to the work injury on or about November 28, 2006; 5% of the left wrist attributable to the April 10, 2007 work injury; and 5% of the left wrist attributable to the December 10, 2007 work injury. Accordingly, I find that Employer was responsible for 5% permanent partial disability of the left wrist related to the December 10, 2007 injury.

In addition to the left wrist disability, as alluded to above, I find, based on the testimony and opinions of Dr. Liss, that Employer also had responsibility for permanent partial disability referable to Claimant's major depression (psychiatric condition) directly related to the December 10, 2007 injury at work. Accordingly, I find that Employer was responsible for 35% permanent partial disability of the body as a whole referable to her major depression and psychiatric conditions, medically causally related to the December 10, 2007 work accident.

The final step of the inquiry then is whether the permanent total disability is the result of the combination of the primary (last) injury and pre-existing disabilities so that the Second Injury Fund would have liability for the permanent total disability. As alluded to above, the medical opinions of Dr. Volarich and Dr. Liss, the vocational opinion of Mr. England, as well as the credible testimony of Claimant, all support the finding that Claimant is permanently and totally disabled as a result of the combination of her primary and pre-existing disabilities, and, thus, the Second Injury Fund has liability for that disability.

With regard to the pre-existing injuries and disabilities Claimant has alleged, I find Claimant has provided credible testimony and/or evidence to explain the nature of the injuries/disabilities to her low back, neck, right ankle, bilateral upper extremities, asthma and psychiatric condition. She also credibly explained the various ways in which these disabilities impacted her ability to work. In reviewing the medical records submitted into evidence, I did find notes regarding the low back, neck, right ankle, bilateral upper extremities and asthma to substantiate the extent of those injuries/conditions. It is clear to me from Claimant's testimony and from review of the medical records and opinions that the prior low back, neck, right ankle, bilateral upper extremities and asthma conditions were all disabling to some extent prior to the December 10, 2007 injury. Then, of course, there are the credible and uncontradicted medical opinions from Dr. Volarich and Dr. Liss, as well as the vocational opinion of Mr. England, all of whom opine Claimant is permanently and totally disabled as a result of the combination of her primary and pre-existing disabilities to multiple parts of her body.

The Second Injury Fund questions whether Claimant's permanent total disability truly came from a combination of her pre-existing disabilities and her last injury disability, by pointing to the fact that Claimant continued to work in some capacity for Employer through the end of the 2007/2008 school year, at which point she retired and took her pension disability. While it is true that she continued to work in some capacity until May 2008, I find that it was a markedly altered and accommodated capacity based on the results of the FCE performed on Claimant in January 2008 at the request of Dr. Brown. I find Claimant's testimony credible that after she was sent for the FCE, which indicated her lifting and pushing were limited, she was not allowed to work in the classroom. This testimony is supported by the report of Dr. Brown and the restrictions he placed on Claimant following the FCE. I find that she was placed in the lunchroom to work with one child at a time, which is a dramatic accommodation and departure from her regular teaching duties. I find that it was only with this accommodation that she was able to continue teaching through the end of the school year. Therefore, given these circumstances, I do not believe her teaching in some capacity through May 2008 (the end of the school year) negates a finding of permanent total disability based on the combination of her injuries and disabilities.

The Second Injury Fund also argues that the findings of inconsistent and submaximal effort on the FCE, as well as Dr. Brown's ultimate conclusion that Claimant could perform some

type of sedentary work, should negate a finding of permanent total disability from the Second Injury Fund. I am also unpersuaded by their argument in this regard. While it is true that the FCE pointed to inconsistent or submaximal effort by Claimant, Dr. Brown was well aware of those findings when he issued, what I find to be, very significant restrictions on her ability to use her upper extremities in the workplace. While he did technically indicate that she could perform sedentary work, I agree with Mr. England, that it would be difficult to imagine a job in the open labor market, even a sedentary job, that could accommodate such significant restrictions on the use of her hands, for even handwriting, for any period of time. I am also mindful of the fact that Dr. Brown only evaluated her and placed restrictions on her for her upper extremities, while Dr. Volarich evaluated and restricted her based on all of her injuries/conditions/disabilities. That is exactly why I found Dr. Volarich offered the most comprehensive and credible opinions on her overall condition, taking into account everything, not just her upper extremities.

Accordingly, based on all of this evidence, I find that Claimant has met her burden of proof to show that she is permanently and totally disabled as a result of the combination of her primary left wrist and body as a whole psychiatric disability with her pre-existing disabilities to the low back, neck, right ankle, bilateral upper extremities, and asthma, as well as including her psychiatric disability. Since the permanent total disability is the result of the combination of her disabilities, the Second Injury Fund has liability for this disability.

Having established the responsibility of the Second Injury Fund for the permanent total disability exposure in this Claim, there is yet one issue left regarding the amount and timing of the payments under the statute. It is necessary to determine a date of maximum medical improvement, before which Employer would have been responsible for temporary total disability payments, and after which the payment of permanent total disability benefits would commence.

Although Claimant was initially placed at maximum medical improvement by Dr. Brown on January 30, 2008, I do not believe she had reached the point of permanent total disability on that date, because Dr. Brown indicated that she was able to work at that time, and, in fact, she did continue working, albeit in a very accommodated position through May 2008. She also subsequently began to receive treatment from Dr. Boehmer in June and July 2008 for her anxiety and stress, which Dr. Liss ultimately concluded was related to the last injury and her physical disability and inability to work anymore. Therefore, I find that her point of maximum medical improvement and her date of permanent total disability must fall after the brief treatment for the anxiety concluded, as that was properly to be considered part of the last injury by virtue of Dr. Liss' opinions. When Claimant was examined by Dr. Volarich on July 29, 2008, he clearly opined that she was at maximum medical improvement for the December 10, 2007 injury, based on the treatment that had been provided to date.

Given the facts and circumstances described above, and in the absence of any more compelling date in the medical treatment records in evidence in this case, I find that Claimant reached the point of maximum medical improvement for her December 10, 2007 injury on July 29, 2008. Between her injury on December 10, 2007 and her date of maximum medical improvement on July 29, 2008, Employer had responsibility to pay temporary total disability benefits for any periods of time that Claimant was unable to work while she was receiving medical treatment related to the work injury on December 10, 2007. Employer's liability in that regard was extinguished by virtue of the settlement reached between Claimant and Employer on

January 22, 2009. Therefore, this date of maximum medical improvement is relevant only for the purpose of calculating Second Injury Fund liability.

Since Claimant reached maximum medical improvement on July 29, 2008 and Employer was responsible for all appropriate temporary total disability up through that date, I find that Claimant is permanently and totally disabled as of July 30, 2008.

By the terms of this award, Employer was responsible for 148.75 weeks of permanent partial disability at a rate of \$389.04. Therefore, from July 30, 2008 until June 7, 2011 (148.75 weeks), Employer had liability for \$389.04 per week, which Claimant and Employer settled by the terms of the Stipulation for Compromise Settlement that extinguished Employer's liability for this case.

Because the PTD and PPD rates are different, there is a differential due from the Second Injury Fund. Therefore, from July 30, 2008 until June 7, 2011 (148.75 weeks), Claimant is to receive \$353.68 per week, or the difference between the permanent partial and permanent total disability rates ($\$742.72 - \$389.04 = \$353.68$), from the Second Injury Fund.

Starting then on June 8, 2011, the Second Injury Fund is to pay \$742.72 per week for Claimant's lifetime, subject to review and modification by law.

CONCLUSION:

Claimant sustained a compensable injury to her left wrist arising out of and in the course of her employment on December 10, 2007, when she was helping a 100-pound first grader, who was trying to learn how to write his name. He apparently became upset and smashed her left wrist into the desk with his fist, as hard as he could. Claimant sustained a left wrist contusion, which was treated conservatively, medically causally related to this accident at work. Claimant also sustained major depression and an additional amount of permanent partial psychiatric disability referable to the body as a whole, medically causally related to the December 10, 2007 accidental injury at work for Employer. Claimant sustained permanent partial disability as a result of this December 10, 2007 injury in the amount of 5% of the left wrist and 35% of the body as a whole referable to her major depression and psychiatric conditions. Employer was responsible for 148.75 weeks of compensation (5% of the left wrist and 35% of the body as a whole) for permanent partial disability attributable to the December 10, 2007 injury.

Claimant is permanently and totally disabled as a result of the combination of the primary injury and pre-existing disabilities to the low back, neck, right ankle, bilateral upper extremities and asthma, as well as body as a whole disability for psychological conditions. Claimant reached maximum medical improvement for the December 10, 2007 injury on July 29, 2008 and became permanently and totally disabled as of July 30, 2008. Compensation from the Second Injury Fund is payable in the amount of \$353.68 per week from July 30, 2008 until June 7, 2011 (148.75 weeks), of \$52,609.90. Compensation from the Second Injury Fund is then payable from June 8, 2011 for the rest of Claimant's life in the amount of \$742.72 per week, subject to review and modification by law. Compensation awarded is subject to a lien in the amount of 25% of all payments in favor of Robert J. Keefe, for necessary legal services.

Made by: _____

JOHN K. OTTENAD
Administrative Law Judge
Division of Workers' Compensation