

TEMPORARY AWARD ALLOWING COMPENSATION
(Reversing Award and Decision of Administrative Law Judge)

Injury No.: 10-060138

Employee: Richard Yarbrough
Employer: Rural Metro Ambulance
Insurer: Ace American Insurance Company
Additional Party: Treasurer of Missouri as Custodian
of Second Injury Fund

This workers' compensation case is submitted to the Labor and Industrial Relations Commission (Commission) for review as provided by § 287.480 RSMo. We have reviewed the evidence, read the briefs, and considered the whole record. Pursuant to § 286.090 RSMo, we reverse the award and decision of the administrative law judge.

Introduction

The parties submitted the following issues for determination by the administrative law judge: (1) occupational disease arising out of and in the course of employment; (2) medical causation; (3) whether employer is liable to furnish medical care; and (4) whether employer is liable to provide temporary total disability benefits from February 18, 2011, through the present time.

The administrative law judge concluded that employee's work activity is not the prevailing factor in causing the medical conditions, disabilities, and symptoms affecting employee's right shoulder, right hip, and low back.

Employee filed a timely Application for Review with the Commission alleging the administrative law judge erred in concluding employee failed to prove he sustained an occupational disease.

For the reasons set forth herein, we reverse the administrative law judge's award and decision.

Findings of Fact

Employee was 62 years of age on the date of hearing. Employee worked as an EMT from 1992 until 2011 for employer or employer's predecessors (the company appears to have changed hands several times during employee's tenure). Employee's duties involved responding to the scene of a medical emergency, assessing the patient, providing emergency assistance, and transporting the patient. Employee responded to an average of three or four emergency calls per day. As the patients were typically incapacitated, employee and a partner would pull a stretcher weighing 81-87 pounds out of the ambulance, and carry or roll the stretcher to the patient.

Employee described carrying the stretcher while stepping over toys, auto parts, children, dogs, porches with missing boards, and multiple stairs. Employee indicated that, increasingly, many of the patients were obese; he estimated that in the last two

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years he worked for employer, at least 50% of the patients weighed over 300 pounds. Lifting and manipulating these individuals onto the stretcher involved significant physical strain. Employee described situations in which it was impossible to bring the stretcher into the area where the patient was located; in such cases, it was necessary to move the patient to the stretcher by any means available. Employee described rolling patients or placing them on blankets and dragging them, and explained that it was rarely possible to use proper lifting techniques in the far from ideal circumstances that he performed his duties.

Employee began to develop back and left leg pain in 2002. Employee underwent a lumbar laminectomy at L4-5 and L5-S1 performed by Dr. Joel Ray, and returned to normal duty without restrictions. Employee worked continuously following his release without severe back, hip, or lower extremity pain until July 2010. Employee experienced occasional aches and pains, and took over-the-counter pain medications, but he did not experience pain to a degree that interfered with his work for employer.

In July 2010, employee began to experience more severe pain in his right shoulder, right leg, right hip, and low back in the course of performing his work duties. At first, employee tried to work through the pain while taking over-the-counter pain medications. When his symptoms grew worse, however, employee decided to talk to his supervisor. Employee obtained authorized treatment for his right shoulder through employer with his own primary care physician, Dr. Caldwell, who ordered x-rays. Dr. Caldwell referred employee to an orthopedic surgeon, Dr. Houseworth, who ordered physical therapy for the low back and right shoulder, and who then performed surgery on the right shoulder on September 27, 2010. Employee answered a generalized leading question to indicate that he was off work after the right shoulder surgery, but employee did not identify any specific time periods that he was unable to work, nor did he indicate whether a doctor took him off work, or whether he personally believed he was capable of working at that time.

For employee's back complaints, employer sent him to Dr. Colle, who ordered diagnostic studies, prescribed narcotic pain medications, and concluded employee's back problems were not work-related.

On February 23, 2011, employer discharged employee from employment owing to employee's restrictions stemming from his medical treatment. Employee continues to suffer from right shoulder, low back, right hip, and right lower extremity complaints. Employee believes there are jobs that he could perform, although he does not believe he could go back to work as a paramedic. Employee did not offer any testimony that would support a finding that his complaints referable to his alleged work injuries render him unable to compete for work after February 23, 2011.

Expert medical testimony

Employee presents Dr. Dwight Woiteshek, who diagnosed traumatic internal derangement of the right shoulder with subsequent non-repairable rotator cuff tear with biceps tendon and glenoid labrum tear, and traumatic right sciatica with L4-5 herniation. Dr. Woiteshek opined that employee's work for employer over time lifting and transporting heavy patients

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is the prevailing factor in causing these injuries and diagnoses. Dr. Woiteshek opined that employee is in need of future medical treatment to address his complaints referable to his work injuries. Dr. Woiteshek opined employee has been unable to work as a result of his injuries since July 1, 2010, but the doctor agreed, on cross-examination, that employee did continue working up until March 2011.

Employer presents Dr. Bernard Randolph, who opined that preexisting degenerative conditions are the prevailing cause of employee's right shoulder, hip, and lumbar complaints. Dr. Randolph opined that employee sustained strain-type injuries of the right shoulder and low back in July 2010, but these injuries were superimposed upon preexisting degenerative and arthritic processes. Dr. Randolph did not identify any traumatic injury of the right hip, and opined that employee instead had severe arthritis of the right hip. Dr. Randolph believes that most arthritic disease, especially of the lumbar spine, is primarily influenced by things such as aging, smoking, and most importantly genetic factors; Dr. Randolph opined that exposure to lifting or bending plays only a minor role. Dr. Randolph also believed it significant that employee had arthritic changes throughout his whole body. Dr. Randolph rated some permanent partial disability referable to employee's right shoulder and his low back; Dr. Randolph somewhat incongruously attributed some of this permanent partial disability to employee's work activities for employer. Dr. Randolph believes employee does not need any additional treatment related to his duties for employer.

Employer also presents Dr. Colle, who opined that employee's work activity is not the prevailing factor in causing employee's back problems. Dr. Colle believes employee's risk factors, such as age, smoking, heart disease, and a family history of diabetes are the more significant factors in causing his current condition. Dr. Colle explained that he was looking for a traumatic problem, and that employee's low back did not become the way it is because of one lifting episode, but represented a chronic problem. It appears Dr. Colle did not consider the possibility that employee's work activities for employer over time caused a gradual onset injury; when asked, on cross-examination, whether he was aware employee was complaining of a gradual onset of low back pain, Dr. Colle responded, "I was not told that." *Transcript*, page 1087.

After careful consideration of each of the expert medical opinions in this matter, we find most persuasive the opinions from Dr. Woiteshek. We adopt his opinions (and so find) that employee's work for employer over time lifting and transporting heavy patients is the prevailing factor in causing traumatic internal derangement of the right shoulder with subsequent non-repairable rotator cuff tear with biceps tendon and glenoid labrum tear, and traumatic right sciatica with L4-5 herniation. We also adopt his opinion (and so find) that employee remains in need of additional medical treatment for his work injuries.

We do not, however, find persuasive Dr. Woiteshek's testimony regarding employee's inability to work after July 1, 2010. The doctor admitted that his opinion did not comport with the fact employee continued working for employer up to March 2011.

We note that employee did not provide any evidence to prove that his work activity is the prevailing factor causing his right hip complaints.

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Conclusions of LawOccupational disease arising out of and in the course of employment

Section 287.067.1 RSMo provides, as follows:

In this chapter the term "occupational disease" is hereby defined to mean, unless a different meaning is clearly indicated by the context, an identifiable disease arising with or without human fault out of and in the course of the employment. Ordinary diseases of life to which the general public is exposed outside of the employment shall not be compensable, except where the diseases follow as an incident of an occupational disease as defined in this section. The disease need not to have been foreseen or expected but after its contraction it must appear to have had its origin in a risk connected with the employment and to have flowed from that source as a rational consequence.

We have credited Dr. Woiteshek's opinion that employee suffers from traumatic internal derangement of the right shoulder with subsequent non-repairable rotator cuff tear with biceps tendon and glenoid labrum tear, and traumatic right sciatica with L4-5 herniation, and that employee's work activity of lifting and transporting heavy patients is the prevailing factor in causing these conditions. Dr. Woiteshek's findings demonstrate that employee sustained an occupational disease that appears to have had its origin in a risk connected with the employment, and that appears to have flowed from that source as a rational consequence. We conclude employee sustained an occupational disease arising out of and in the course of his employment for purposes of the foregoing section.

Because employee failed to provide any evidence to demonstrate that his right hip complaints are the product of his work activities for employer, we conclude that employee did not sustain an occupational disease affecting the right hip.

Medical causation

Section 287.067.2 RSMo provides, as follows:

An injury by occupational disease is compensable only if the occupational exposure 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. Ordinary, gradual deterioration, or progressive degeneration of the body caused by aging or by the normal activities of day-to-day living shall not be compensable.

In the context of occupational disease, the courts have clarified that:

A claimant must submit medical evidence establishing a *probability* that working conditions caused the disease, although they need not be the sole cause. Even where the causes of the disease are indeterminate, a single medical opinion relating the disease to the job is sufficient to support a decision for the employee.

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Vickers v. Mo. Dep't of Pub. Safety, 283 S.W.3d 287, 292 (Mo. App. 2009)(citations omitted)(emphasis in original).

Again, we have credited Dr. Woiteshek's opinion that employee suffers from traumatic internal derangement of the right shoulder with subsequent non-repairable rotator cuff tear with biceps tendon and glenoid labrum tear, and traumatic right sciatica with L4-5 herniation, and that his work is the prevailing factor in causing these conditions. Given Dr. Woiteshek's findings, we conclude that employee's occupational exposure was the prevailing factor in causing the resulting medical conditions of traumatic internal derangement of the right shoulder with subsequent non-repairable rotator cuff tear with biceps tendon and glenoid labrum tear, and traumatic right sciatica with L4-5 herniation.

Medical treatment

Section 287.140.1 RSMo provides: "In addition to all other compensation paid to the employee under this section, the employee shall receive and the employer shall provide such medical, surgical, chiropractic, and hospital treatment, including nursing, custodial, ambulance and medicines, as may reasonably be required after the injury or disability, to cure and relieve from the effects of the injury." Dr. Woiteshek identified a need for additional medical treatment referable to employee's work injuries. We have credited Dr. Woiteshek's testimony on this point. We conclude that employer is obligated to provide additional medical treatments that may reasonably be required to cure and relieve from the effects of employee's work injuries.

Temporary total disability

Section 287.170 RSMo provides for temporary total disability benefits to cover the employee's healing period following a compensable work injury. The test for temporary total disability is whether, given employee's physical condition, an employer in the usual course of business would reasonably be expected to employ him during the time period claimed. *Cooper v. Medical Ctr. of Independence*, 955 S.W.2d 570, 575 (Mo. App. 1997). Accordingly, we look to the evidence of employee's physical condition following the work injury.

Employee, in his testimony, did not identify his work injuries as a reason for his inability to work during any particular time period. Employee's expert provided testimony that we have deemed to lack persuasive force as to the issue of temporary total disability.

We conclude that employee has failed to meet his burden of proof with respect to this issue. We conclude that employee was not temporarily and totally disabled from February 18, 2011, through the present time. Accordingly, employer is not liable for temporary total disability benefits for the time period at issue.

Award

We reverse the award of the administrative law judge. Employer is ordered to provide employee with medical treatment that may reasonably be required to cure and relieve the effects of employee's work injuries. Employee's claim against the Second Injury Fund is reinstated.

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

This award is only temporary or partial. It is subject to further order, and the proceedings are hereby continued and kept open until a final award can be made. All parties should be aware of the provisions of § 287.510 RSMo.

The award and decision of Chief Administrative Law Judge Lawrence C. Kasten, issued May 11, 2012, is attached solely for reference.

Given at Jefferson City, State of Missouri, this 8th day of August 2013.

LABOR AND INDUSTRIAL RELATIONS COMMISSION



John J. Larsen, Jr., Chairman

DISSENTING OPINION FILED

James G. Avery, Jr., Member

Curtis E. Chick, Jr., Member

Attest:

Secretary

Employee: Richard Yarbrough

DISSENTING OPINION

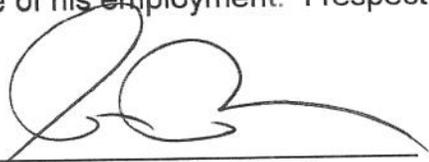
Based on my review of the evidence as well as my consideration of the relevant provisions of the Missouri Workers' Compensation Law, I am convinced that the award of the administrative law judge should be affirmed.

I disagree with the majority's choice to credit the testimony from Dr. Woiteshek over that provided by Drs. Randolph and Colle. Dr. Woiteshek did not explain his reasoning in finding that employee's low back and right shoulder conditions had their origin in a risk connected with the employment. Dr. Woiteshek did not even obtain a history as to when any of employee's pain complaints began. Instead, Dr. Woiteshek provided a conclusory and unsupported opinion of the type the courts have deemed to be insufficient to meet an employee's burden of proof. See, e.g., *Royal v. Advantica Rest. Group, Inc.*, 194 S.W.3d 371, 378 (Mo. App. 2006)(affirming the Commission's denial of workers' compensation benefits where the employee's expert "failed to provide any legitimate, persuasive explanation" for her opinions and made "only a conclusory and unsupported statement that was insufficient to carry [the employee's] burden of proof.")

On the other hand, Drs. Randolph and Colle explained that employee's current condition is the product of the degenerative arthritis that employee has throughout his entire body. Dr. Randolph explained that the diagnostic studies reveal extensive and severe preexisting degenerative disease in employee's right shoulder and low back. Dr. Randolph cited the latest medical studies, which suggest that the greatest risk factors for these arthritic processes are genetic. Both Drs. Randolph and Colle also noted that employee has numerous other risk factors, such as heart disease and a history of smoking. I find more persuasive the testimony from Drs. Randolph and Colle. I am convinced that employee has failed to meet his burden of proving that his work activity for employer is the prevailing factor in causing his low back and shoulder complaints.

Section 287.067.1 RSMo specifically states that: "Ordinary diseases of life to which the general public is exposed outside of the employment shall not be compensable ..." This 62-year-old employee's low back and shoulder conditions are the direct product of an ordinary disease of life: arthritis. Where the relevant statute specifically states that diseases of the type suffered by employee are not compensable, I believe the majority errs in reversing the administrative law judge.

For the foregoing reasons, I would affirm the award of the administrative law judge concluding that employee failed to meet his burden of proving he sustained an occupational disease arising out of and in the course of his employment. I respectfully dissent from the majority's award and decision.


James G. Avery, Jr., Member

ISSUED BY DIVISION OF WORKERS' COMPENSATION

FINAL AWARD

Employee: Richard Yarbrough Injury No. 10-060138
Dependents: N/A
Employer: Rural Metro Ambulance
Additional Party: Second Injury Fund
Insurer: Ace American Insurance Company c/o Gallagher Bassett Services
Appearances: Kim Heckemeyer, attorney for employee.
James Thoenen, attorney for the employer/insurer.
Hearing Date: January 9, 2012 (Commenced)
February 8, 2012 (Completed)

Checked by: LCK/kb

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: \$11,342.80
16. Value necessary medical aid paid to date by employer-insurer: \$31,435.83
17. Value necessary medical aid not furnished by employer-insurer: N/A
18. Employee's average weekly wage: \$616.87
19. Weekly compensation rate: \$411.25 for temporary total disability.
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 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: N/A

FINDINGS OF FACT AND RULINGS OF LAW

On January 9, 2012, Richard Yarbrough, appeared in person and with his attorney, Kim Heckemeyer for a temporary or partial award. The employer-insurer was represented at the hearing by their attorney, James Thoenen. Also present was Ryan Fugate the marketing general manger for Rural Metro Ambulance. The parties agreed on certain undisputed facts and identified the issues that were in dispute. These undisputed facts and issues, together with a summary of the evidence and the findings of fact and rulings of law, are set forth below as follows:

UNDISPUTED FACTS:

1. Rural Metro Ambulance was operating under and subject to the provisions of the Missouri Workers' Compensation Act, and its liability was fully insured by Ace American Insurance Company c/o Gallagher Bassett Services.
2. On or about July 1, 2010, Richard Yarbrough was an employee of Rural Metro Ambulance and was working under the Workers' Compensation Act.
3. The employer had notice of the employee's alleged occupational disease.
4. The employee's claim was filed within the time allowed by law.
5. The employee's average weekly wage was \$616.87. The rate of compensation for temporary disability was \$411.25 per week.
6. The employer-insurer paid \$31,435.83 in medical aid.
7. The employer-insurer paid \$11,342.80 in temporary total disability, the time periods covered were July 21, 2010 through February 23, 2011.

ISSUES:

1. Occupational disease.
2. Medical causation.
3. Claim for additional medical aid to the low back.
4. Claim for additional temporary total disability.

EXHIBITS:

The following exhibits were offered and admitted into evidence:

Employee's Exhibits:

- A. Medical records of Dr. Caldwell, Poplar Bluff Rehabilitation, Brain and NeuroSpine Clinic of Southeast Missouri, Dr. Houseworth, and Southeast Missouri Hospital.
- B. Medical records of Saint Francis Medical Center.
- C. Medical report and CV of Dr. Woiteshek.
- D. Deposition of the employee.
- E. Medical records from Saint Francis Medical Center and Dr. Ray.

Employer-Insurer's Exhibits:

1. Deposition of Dr. Randolph including his CV and report.
2. Deposition of Dr. Colle including his CV and medical reports.
3. Deposition of Dr. Woiteshek including his CV and medical reports.
4. Certified copy of the Division of Workers' Compensation Injury Numbers 01-166528 and 07-026238.
5. Medical records of Dr. Houseworth.
6. Medical records of Dr. Caldwell.
7. Medical records of Saint Francis Medical Center.
8. Medical records of Poplar Bluff Regional Rehabilitation.

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

The record was left open for the parties to stipulate and clarify the time period that the employer-insurer paid temporary total disability benefits or introduce evidence on this issue. On February 8, the court received a stipulation that the temporary total disability benefits were paid through February 23, 2011. The stipulation affected Issue 4 regarding the time period claimed for additional temporary total disability which will began on February 24, 2011. The record was closed on February 8, 2012.

WITNESS: Richard Yarbrough

BRIEFS: The employee's brief was received on February 8, 2012. The employer-insurer's brief was received on February 8, 2012.

FINDINGS OF FACT:

The employee testified that he was born in 1949, and left high school halfway through his senior year. He was a full time musician from 1969 until 1990 or 1991. He then received his GED and went to EMT school at Three Rivers Community College which was a four month course. He received an EMT certificate. Five years later he received a Paramedic Certificate which took three semesters of training. At that time he did not have any pain in his right shoulder, low back or lower leg. He went to work for Lucy Lee Hospital as an EMT and worked with a partner. He worked the same job at the same location but the name of the employer changed several different times.

In his July 28, 2011 deposition, the employee testified that due to the lifting, pulling and pushing, he started having pain when he started as an EMT in 1992. The employee testified at the hearing that he developed back and left leg pain in 2002, and saw Dr. Ray.

For the December 6, 2001 injury a Report of Injury was filed in Injury Number 01-166528. It noted that the employee injured his low back lifting a patient that weighed about 250 pounds.

On January 30, 2002 the employee saw Dr. Ray. In the initial questionnaire, the employee reported left hip and leg pain with bulging disc and nerve compression at L5-S1. The pain areas the employee noted was neck, right shoulder, low back and left leg; and occasional left leg numbness. Dr. Ray noted that the employee had no right leg pain. Dr. Ray reviewed the December 12, 2001 MRI and stated that it showed significant changes at L3-4, L4-5 and L5-S1 which was most significant at L5-S1 where the left neural foramina was completely occluded by a combination of soft tissue which was crushing the related nerve root. At L4-5 there was narrowing of the spinal canal due to a combined element of soft tissue, bone spurs, and possibly some disc material which caused at least a central stenosis if not a severe foraminal compression. On exam the straight leg raise was mildly positive at 60 degrees with back and left leg symptoms. Dr. Ray ordered an MRI.

The January 30, 2002 MRI was for low back pain and bilateral leg pain. At L3-4 there was degenerative disc disease with spurring and disc bulge which at most only flattened the thecal sac. At L4-5 there was marked degenerative disc disease with spurring and a broad-based disc bulge. There was a focal right lateral disc herniation superimposed which was likely causing significant mass effect upon the exiting right L4 nerve root. At L5-S1 there was a fairly large focal left lateral disc herniation superimposed upon marked degenerative disc disease and disc bulge. There was a marked narrowing of the left neural foramen with a mass effect upon the exiting left L5 nerve root.

On February 6, 2002, Dr. Ray noted that the MRI showed a near complete occlusion of the neural foramina of L5 on the left side due to a disc and spondylosis. At L4-5 there was at least mild central stenosis and there was more compression on the right side where the employee has no symptoms than on the left. Dr. Ray was concerned that the spur/disc area in the lateral recess may be playing a role in the employee's dramatically swollen L5 root on that side. Dr. Ray recommended L5-S1 surgery on the left side and thought that decompressing the L4-5 region would be important given the size of the swollen nerve root of L5.

On February 21, 2002, Dr. Ray performed a left L4-5 laminotomy with segmental decompression; L4-5 discectomy/fusion; left L5-S1 laminotomy; segmental decompression; and L5-S1 discectomy/fusion. Dr. Ray noted that the employee had a work related injury of December 6, 2001 which caused complex back pain and leg pain syndrome. There was an extruded left lateralizing and far lateral L5-S1 herniated nucleus pulposus completely occluding the left neural foramina and at L4-5 a left lateralizing herniated nucleus pulposus with central stenosis. Dr. Ray noted that the findings were consistent with the scans of discs and lateral recessed stenosis at L4-5 and large amounts of extruded fragment crushing the L5 root at L5-S1 as well as lateral recessed stenosis.

The employee treated with Dr. Ray until July 29, 2002. He noted multiple levels of lumbar disc surgery and had at least some mild discomfort. It was Dr. Ray's opinion the employee had an 11% impairment of the whole person and released the employee. The employee settled his claim for 20% permanent partial disability of the body as a whole referable to the low back.

The employee testified that after Dr. Ray released him in 2002, he returned to work full duty with no back or left leg pain, and worked continuously until July of 2010, without severe back, hip or lower extremity pain. He had occasional low back pain after that.

A Report of Injury was filed in Injury Number 07-026238 with a date of injury of March 23, 2007. The report stated that the employee was stepping out of a rear of an ambulance and felt pain in his lower back. There were no claims or settlements in that case.

In his deposition, the employee testified about transporting sick and injured people to the hospital. With regard to lifting, they might have to go upstairs; go down a narrow hallway without a stretcher and get the patient out as best as possible. Sometimes a soft stretcher which is like a tarp was used to roll the patient onto and carry them to the stretcher that had wheels. Sometimes the patients were rolled onto a blanket and dragged down the hallway to the stretcher. He worked with his partner who assisted in lifting the patients. In bad situations they would try to get help from other crews.

The employee testified to his job duties. The lifting portion got more difficult because patients became bigger and bigger. The stretcher with wheels weighed 80 pounds empty. To get the stretcher to the patient, they lifted, pushed or pulled it on different types of surface and locations. They carried the stretcher up and down ditches, up and down hills, and up and down stairs. They had to step over things, navigate porches with boards missing, and multiple stairs. After bringing the stretcher, they sometimes would have to get a jump bag that contained a lot of supplies and weighed 15-20 pounds; a cardiac monitor that weighed 20-25 pounds; and an oxygen tank that weighed 5 pounds. The calls were not consistent on a day to day basis. On occasional days there were no calls. There were usually several crews. The average calls for each crew on a shift were usually 4 or more. Sometimes there would be a trip to St. Louis or Memphis. Usually there were more than four calls a day, and if a crew was out of town, there would be more. They would get the patient on the stretcher the best way that they could. Most patients needed assistance. Sometimes they had to drag blankets with the patients on them; and sometimes would bend over the waist and pull them. They had calls when they needed more help and there was a list of known patients who were morbidly obese and weighed 300 pounds or more where two crews would be sent. He frequently moved 300 pound patients, and occasionally 400-500 pound patients. From 2008 through 2010, he thought about 50% of calls involved a patient that weighed over 300 pounds. His schedule was working 6 out of 7 days, and then being off for 7 days.

The employee testified that on a normal day, he had 3-4 runs in town which would average 45 minutes to an hour. Out of town runs would take longer. There would be about 10 minutes of lifting on each run. He always worked with someone else. The lifting process was getting on the stretcher, moving the stretcher, and putting it into an ambulance. One person had to help lift the stretcher out of the ambulance.

In his deposition, the employee testified that he developed right shoulder, low back, right hip and right leg problems from a combination of all the lifting and pulling and pushing. It was a gradual onset that became progressively worse and worse. From the spring of 2010, it got worse

until he told his supervisor in the first part of July that it was unbearable. In the spring or early summer there was a patient that weighed 500-600 pounds that had to be picked up at a hospital to be taken to a nursing home. They had a lot of help at the hospital but he and his partner had less help at the nursing home. Prior to that he was having occasional right shoulder pain and would take over the counter medication. The right shoulder and back were not constant until July. The hip pain came on that same time as shoulder pain. He thought the problems were from multiple incidents and not one incident but were not worse until the 500 pound person which was quite a strain and the condition got progressively worse into the early summer and July.

The employee testified that from 1992 until July 1, 2010, he had some occasional pain in right shoulder but it did not affect his job. In July of 2010, he developed a lot of pain to the right shoulder, right hip, lower back, and right leg which affected his ability to work. He started getting pain in the right shoulder, leg and back about the same time. The right shoulder pain was 7-8 out of 10. There was no specific incident that caused it. There was a large patient that they moved that weighed 500 pounds. The employee took over the counter medication and his pain got progressively worse. In July of 2010, he reported the injury at work to Brian Fugate and stated that he had pain in the low back, right hip, right leg and right shoulder which had gotten progressively worse. He was sent to Dr. Caldwell and was then referred to an orthopedist.

On July 21, 2010 the employee had x-rays of the right hip, right shoulder and low back ordered by Dr. Caldwell. The right hip showed moderate to severe degenerative changes. The right shoulder showed mild to moderate degenerative changes at the acromioclavicular joint. The low back showed extensive degenerative changes and fusion at L4-5 and L5-S1 with lesser degenerative changes elsewhere. On August 3, Dr. Caldwell referred the employee to Dr. Houseworth due to shoulder pain that was not improving.

On August 4 the employer filed a Report of Injury with a date of injury of July 1, 2010. The employee stated that the repetitive lifting and loading of patients caused pain in the right shoulder and lower back. The employer was notified July 1, 2010, and the last day at work was July 19.

On August 5 the employee saw Dr. Houseworth for right shoulder, right hip and low back pain. He felt like something had torn in his right shoulder about a month ago. He had right buttock and right groin pain that had gotten worse over the past month. The employee denied an overt injury to his right hip. The employee had daily low back pain. The prior back surgery at L4-5 and L5-S1 in 2002 was noted. On exam, the right shoulder impingement sign was positive and the resistant rotator cuff strength testing increased right shoulder pain. On exam of the right hip there was flexion to a 100 degrees and external rotation and abduction to 45 degrees. The low back exam showed no swelling or tenderness with palpations of the lumbar spine. X-rays of the right shoulder demonstrated AC degenerative joint disease. The right hip x-ray showed moderate degenerative joint disease and moderate decrease in the right hip joint space. Lumbar x-rays showed degenerative changes at L4-5 and L5-S1 with significantly decreased disc spaces at both levels. Dr. Houseworth diagnosed rotator cuff tendinitis, and possible rotator cuff tear; right hip moderate degenerative joint disease; and lumbar spine degenerative joint disease with degenerative disc disease and was status post lumbar spine surgery from 2002. A right shoulder

MRI could not be done due to the employee's pacemaker. Dr. Houseworth injected the subacromial bursa of the right shoulder; and ordered therapy for the right rotator cuff tendonitis and low back degenerative joint disease.

On August 10, 2010 the physical therapist noted the employee denied any incident producing mechanism of injury for the right shoulder and low back. The employee was convinced that the repeated nature of lifting clients at work produced his pain.

On August 12, the employee had increased right shoulder pain after feeling a loud crack at physical therapy yesterday. An x-ray of the right shoulder showed mild degenerative changes at the AC joint. Dr. Houseworth recommended continued therapy. The employee was attempting to claim an injury on workup. Dr. Houseworth stated that it remained to be seen if the claim was accepted. Dr. Houseworth discussed the possibility of right shoulder arthroscopy with subacromial decompression and rotator cuff repair.

The employee testified that he was sent by the insurer to Dr. Colle and gave an accurate history. Dr. Colle advised him that it was not a work related condition.

On August 18, 2010, the employee was sent to Dr. Colle to evaluate back pain. The employee reported that on approximately July 1, 2010 while lifting a heavy patient he had an episode of back pain and had intermittent leg pain. The employee had a thyroid disorder and had radioactive iodine treatment with ongoing pain in his joints. The increase of pain on July 1 was different from the joint pain from the iodine treatment. The employee had a secondary injury of his right shoulder with limited range of motion secondary to rotator cuff tear. The prior back surgery by Dr. Ray in 2002 with good resolution of his back and leg pain and returning to work at full duty was noted. X-rays of the lumbar spine revealed severe disc desiccation with complete collapse of L4-5 disc space. Dr. Colle ordered a myelogram/post myelogram CT of the lumbar spine; and a full body bone scan due to the severe collapse of the L4-5 disc space to rule out an ongoing process. Dr. Colle kept the employee off work until the studies determined if it was degenerative or acute.

On September 2, Dr. Houseworth noted the therapy was not helping his right shoulder and recommended surgical intervention. On September 9, Dr. Caldwell noted the employee was scheduled to have right shoulder surgery and had an injury lifting a heavy patient onto a stretcher.

The whole body bone scan ordered by Dr. Colle was performed on September 9 and showed increased activity involving the right hip joint consistent with degenerative disease. There was mildly increased activity in the right shoulder joint representing arthritic change. There was increased activity involving both knee joints and left midfoot representing degenerative changes. The impression was chronic degenerative joint changes most pronounced in the right hip.

The CT myelogram and post myelogram CT scan ordered by Dr. Colle was performed on September 13. The myelogram showed moderate loss of disc height with associated degenerative disc disease including vacuum disc phenomena at L4-5 and L5-S1. There was evidence of

disc/osteophyte impressions in the ventral thecal sac contributing to spinal canal stenosis, most notable at L3-4 and L4-5. The impression was marked degenerative disc disease with severe loss of disc height, vacuum disc foramina and spondylosis at L4-5 and L5-S1 and lesser changes at other levels. There was significant central canal stenosis at L3-4 and L4-5. The post myelogram CT scan showed mild to moderate loss of disc height which is asymmetrically more severe on the right and central vacuum disc phenomenon at L3-4. At L4-5 there was severe loss of disc height, vacuum disc phenomena, extensive endplate sclerosis and spondylosis. At L5-S1 there was less severe but still significant loss of disc height, vacuum disc phenomena, endplate sclerosis and spondylosis. There is multilevel central canal stenosis, more severe at L2-3, L3-4 and L4-5. The analysis of L2-L3 showed a broad based disc bulge with stenosis of the central canal. There was mild foraminal stenosis. At L3-4 there was stenosis of the canal and subarticular spaces resulting from a combination of disc bulge, facet arthropathy and thickening of the ligament flava; and mild to moderate foraminal stenosis. At L4-5 there was the prior left hemilaminectomy with the thecal sac modestly displaced to the left. There was evidence of prominent disc/osteophyte intrusion into the canal with extrusion into the right subarticular space and lateral recess and foramen resulting in stenosis of the lateral recess and foramen. There is moderately severe stenosis of the left foramen due to facet arthropathy and disc/osteophyte intrusion. At L5-S1 there was a modest disc bulge which abuts, but does not displace or compress the thecal sac or S1 nerve roots. There is moderately severe to severe bilateral foraminal stenosis resulting from loss of disc height, facet arthropathy and disc/osteophyte intrusion. The impression of the radiologist was multilevel degenerative disc disease in the mid to lower spine, the most severe stenoses occurring at L4-5 and L5-S1. There was multilevel central canal stenosis, the more severe stenoses occurring at L2-3 and L4-5 and to a lesser degree at L3-4. The examination showed the prior decompressive laminectomy on the left at L4-5 and an apparent right posterolateral/foraminal disc extrusion contributing to right foraminal stenosis and stenosis of the subarticular space and lateral recess. There was multilevel foraminal stenosis, the more severe from L3-4 through L5-S1.

The employee returned to Dr. Colle on September 21, 2010. The interim history noted back pain for several years but on approximately July 1, 2010 while lifting a heavy patient he had an episode of back pain with intermittent leg pain. The employee's current pain was ten out of ten with the pain worsening. On exam, there was a normal range of motion; no focal tenderness on palpation or evidence of a paraspinal spasm; and straight leg raising sign was negative in sitting and supine position bilaterally. There was tenderness to palpation of the diffuse lumbar spine in the right SI joint. Dr. Colle stated that the whole body bone scan showed the most change was the right hip. The myelogram of the lumbar spine revealed degenerative changes and severe stenosis at multiple levels. Dr. Colle's diagnosis was lumbago. Dr. Colle did not feel his pain was caused by a work related injury. According to his myelogram and whole body bone scan the employee had no acute fracture and has a degenerative spine. He has multiple level degenerative changes and spinal stenosis which was not determined to be caused by a work related injury. The employee had significant degenerative changes shown on his whole body bone scan. His right hip should be evaluated by an orthopedic surgeon. From a neurosurgical standpoint, the employee was at maximum medical improvement; and had no acute work related injury in the lumbar spine. The employee had severe to significant foraminal stenosis.

On September 27, 2010 Dr. Houseworth performed a right shoulder arthroscopy with extensive debridement, subacromial decompression, distal clavicle resection, and mini open repair of the long head of biceps tenodesis. The indication for operation was right shoulder pain and weakness that developed over a long period of time. The operative record showed a degenerative tear of the superior glenoid labrum consistent with a type II tear; fraying in the anterior inferior glenoid labrum; and a grade III chondromalacia of the humeral head and anterior inferior aspect of the glenoid. A SLAP tear extended from 10 o'clock to 2:30; the labrum could be lifted off the glenoid in this area; and significant fraying of the long head of the biceps tendon. There was a large, retracted rotator cuff tear that was extensive with absent tissue extending from the glenoid to the tuberosity involving both the supraspinatus and infraspinatus. Despite the extensive effort at mobilization as well as the absence of the tissue Dr. Houseworth did not feel that a rotator cuff repair was possible. The post operative diagnosis was large, retracted, non repairable rotator cuff tear involving supraspinatus and infraspinatus, grade III chondromalacia, significant tear of the long head of the biceps, acromioclavicular joint degenerative joint disease, and degenerative tear of the glenoid labrum.

Dr. Houseworth on September 30 discussed with the employee the nature of the non repairable rotator cuff with significant absence of tissue at the time of the surgery. Dr. Houseworth thought the employee should have considered right shoulder surgery at least two years ago.

On October 13 the employee saw Dr. Caldwell who noted the recent shoulder surgery with pain and decreased range of motion. The employee had increased pain and decreased range of motion in the low back; with chronic pain in the low back and hips. On October 19, Dr. Houseworth ordered more therapy for the irreparable rotator cuff tear and bicep tenodesis.

On November 2 the employee saw Dr. Caldwell for lower back, right hip and right knee pain. He had sharp burning across the back and into the pelvis area. He had difficulty raising his legs with an increase in weakness. He had pain in his pelvis and right hip that radiated down the right leg in the knee. Dr. Caldwell ordered a CT scan of the right hip which was performed the same day. The findings were severe osteoarthritic degenerative changes at L4-5 and L5-S1 with vacuum disc present at L4-5 and L5-S1. The diffuse disc bulge at L4-5 extended into the neural foramina bilaterally causing impingement on the L4 nerve root. Images of L5-S1 are not in the plane of the disc but there was probable impingement on the L5 nerve roots bilaterally. A vacuum joint was present at the left sacroiliac joint and moderate to severe degenerative changes in the right hip. There was a complete loss of joint space in the right hip and mild degenerative changes in the left hip with small osteophyte cyst.

On November 11 the employee stated his shoulder was doing pretty good and continued to have right buttock, right groin, right leg, and right medial knee pain. Dr. Houseworth noted that the CT scan of the right hip showed moderate to severe degenerative changes in the right hip and degenerative disc disease in the left hip. There are severe degenerative changes as well as degenerative disc disease in the lower lumbar spine. It was Dr. Houseworth's opinion that the right buttock, groin and knee pain were related to degenerative joint disease. Dr. Houseworth discussed the prospect of right total hip arthroplasty but the employee was not interested. The

employee had an intra-articular right hip injection at Bluff Radiology. Therapy on the right shoulder was continued.

On December 8, 2010 Dr. Houseworth diagnosed right shoulder surgery; right hip moderate to severe degenerative joint disease; and lumbar spine severe degenerative joint disease and degenerative disc disease. He prescribed four additional weeks of right shoulder therapy. Dr. Houseworth noted he was leaving the Polar Bluff area and the employee had been given copies of his records in order to facilitate continuing care. The employee testified that after Dr. Houseworth left town he saw Dr. Schafer twice.

On December 22, the employee saw Dr. Caldwell with right hip and right shoulder pain. The hip injection gave some temporary relief. He was still undergoing physical therapy for his shoulder.

On February 15, 2011 the therapist performed a functional capacity evaluation for the right shoulder. The employee did not fail any validity criteria and gave maximum effort. Based on the employee's physical performance the employee is able to perform all physical tasks in the heavy work demand level with the exception of overhead lifting which was limited to light material handling capacity. The findings indicate the employee physical performance does not meet the essential job demands of a paramedic. The active range of motion of the right shoulder showed loss of range of motion in flexion, abduction, adduction, external rotation and internal rotation. The employee would be discharged from therapy.

The employee testified that since the release by Dr. Houseworth he has had a dull ache in his shoulder, and does not have strength to pick up things. He has some range of motion problems which interferes with some daily activities. He has pain which is worse with activity including yard work and sometimes driving. Since July of 2010, his low back, right hip and right lower extremity was getting worse all of the time. He worked for 3-4 weeks on light duty at Metro which included restocking and vacuuming, and was terminated from employment the first part of March of 2011 since they could not accommodate light duty work.

On March 21 the employee saw Dr. Caldwell for chronic back and hip pain with degenerative joint disease. On June 23 the employee saw Dr. Caldwell for upper and lower back pain. The employee was taking Vicodin which was almost out. The review of systems showed chronic upper and lower back pain and hip pain. Neurontin and Flexeril were prescribed. On August 22, 2011 the employee saw Dr. Caldwell and stated his life was shot after hurting his back. The employee had decreased range of motion in the lumbar spine, right hip and minimally in the right shoulder. The employee was referred to Dr. Soeter for pain management and medications were prescribed.

The employee testified that he has occasional neck pain but does not remember when it started. He has knee pain which might be arthritis. He still has right hip pain, and occasional left hip pain, and no left shoulder pain to speak of. He has more low back pain with sitting longer, standing too long, and doing yard work. He walks with a limp. He has had those problems only since July of 2010. The severity of pain comes and goes. Due to his back he can only stand for

15-20 minutes before looking for a place to sit. He can sit comfortably for about 15-20 minutes, and then has to move around due to increased pain. He recently saw Dr. Soeter for pain management for the low back. His family doctor, Dr. Caldwell, is still prescribing Vicodin and Flexeril. The employee has not applied for work since he lost his job. There are probably jobs he could do such as a dispatcher but has not had a job since he was terminated. He does some cleaning and some yard maintenance including cutting grass but no trimming. The employee is requesting further medical treatment on the right hip, low back and right lower extremity; and temporary total disability.

Opinions:

The employee saw Dr. Woiteshek on June 18, 2011. His deposition was taken on September 14, 2011. Dr. Woiteshek noted that the employee had work related repetitive traumatic injuries leading up to and including July 1, 2010. Leading up to July 1, 2010 the employee developed pain in his right shoulder, right hip and lower back area. Approximately on July 1, 2010 he felt something tear in his right shoulder while lifting a heavy patient. Dr. Woiteshek's report did not have when the right shoulder and low back pain actually began but thought the symptoms probably began over the 6 months prior to July of 2010.

On examination, the employee had pain and tenderness with muscle spasms in the low back. The right ankle reflex was less than the left. Straight leg test was positive on the right at 60 degrees. There was 20% loss of motion in flexion, extension, and right and left lateral flexion. The right shoulder had crepitus; pain and tenderness; loss of motion and loss of strength. The right hip had pain, tenderness and loss of motion. Dr. Woiteshek reviewed the September of 2010 whole body scan and CT myelogram. He agreed with the radiologist that the bone scan showed chronic degenerative joint changes which were most pronounced in his right hip and the CT/Myelogram showed the prior laminectomy at L4-5 and an apparent right posterolateral/foraminal disc extrusion contributing to foraminal stenosis, and stenosis of the subarticular space and lateral recess.

Dr. Woiteshek diagnosed pre-existing herniated nucleus pulposus on the left at L4-5 and was status post surgery in February 2002 which was completely asymptomatic; and moderate osteoarthritis of the right hip joint which was relatively asymptomatic. Dr. Woiteshek diagnosed traumatic internal derangement of the right shoulder with subsequent non repairable rotator cuff tear with biceps tendon and glenoid labrum tear and was status post surgery; and diagnosed traumatic right sciatica with a new herniated nucleus pulposus on the right at L4-5 seen on the September 2010 CT/myelogram.

It was Dr. Woiteshek's opinion that the employee had reached maximum medical improvement for his right shoulder condition; and that as a direct result of the repetitive trauma leading up to and including July 1, 2010 while employed as a paramedic the employee sustained a 35% permanent partial disability of the right upper extremity at the shoulder. Dr. Woiteshek placed restrictions for the shoulder.

It is Dr. Woiteshek's opinion that the employee's right shoulder and back conditions were due to repetitive trauma over a period of time. It was Dr. Woiteshek's opinion that the repetitive traumatic injury leading up to and including July 1, 2010 where the employee injured his right shoulder, right hip and lower back transporting heavy patients as a paramedic were the prevailing factors in the cause of the traumatic internal derangement of the right shoulder with subsequent non repairable rotator cuff tear with glenoid labrum tear and his traumatic right sciatica with a new L4-5 herniated nucleus pulposus seen on the September 13, 2010 CT/ myelogram. The repetitive traumatic injuries leading up to and including July 1, 2010 while working as a paramedic were the prevailing factors in the cause of the right shoulder disability, the subsequent need for the treatment including surgery by Dr. Houseworth; and Dr. Woiteshek's recommended treatment for the new right L4-5 herniated nucleus pulposus.

Dr. Woiteshek stated that based on his diagnosis it was not possible that the natural degeneration process could be the cause of the right shoulder and his back symptoms. It was his opinion that it was not from the natural degeneration process because the employee developed right leg pain which matched up with the September of 2010 CT/myelogram that showed a right posterolateral extrusion to the right. It was his opinion that was a new injury. Dr. Woiteshek agreed that smoking can be a factor in the development of degenerative conditions and that the films of the right shoulder and back showed degenerative changes. Dr. Woiteshek stated that sometimes distinguishing changes on films related to aging versus work activity is done by tying them with symptoms. The CT myelogram showed a right posterior lateral foraminal disc extrusion to the right which matched the right-sided right leg pain. Those findings matched the examination of a positive straight leg raise and decreased reflex on the right. It was Dr. Woiteshek's opinion that the L4-5 disc extrusion on the right was tied to work.

It was Dr. Woiteshek's opinion that the employee had not reached maximum medical improvement for his back pain with right sciatica condition; and needed future medical care for that condition including but not limited to surgical repair of his herniated nucleus pulposus at L4-5. It was Dr. Woiteshek's opinion that the employee should avoid all bending, twisting, lifting, pushing, pulling, carrying, and climbing and other similar tasks as needed; avoid remaining in a fixed position for any more than 20-30 minutes at a time including sitting and standing; limit prolonged weight bearing including standing and walking to tolerance; and should change positions frequently to maximize comfort and rest in a recumbent fashion when needed.

It was Dr. Woiteshek's opinion that the employee has been unable to work as a result of his back and right shoulder since July 1, 2010. He was aware that the employee returned to work light duty and worked up until March of 2011. Dr. Woiteshek did not think that the employee could perform work in the medical field as a receptionist, dispatcher or technician due to his restrictions.

The deposition of Dr. Colle was taken on December 13, 2011. On exam the employee had diffuse tenderness to his lumbar spine and right sacroiliac joint which could be due to a lumbar strain. Due to the prior low back surgery, Dr. Colle ordered a CT/myelogram and not an MRI because it would better delineate if there was any acute pathological process instead of trying to look through scar tissue in an MRI. Since there was such a significant collapse of the

L4-5 disc space he ordered a whole body bone scan to determine if there was an acute process in the disc space or the vertebral bodies or a fracture that could occur from lifting of patients. Dr. Colle stated that based on the review of the whole body scan and the lumbar myelogram/CT along with his exam findings, the employee had no acute fractures, no weakness or myelopathy. The employee had a degenerative spine including multilevel degenerative changes and spinal stenosis which was not caused by a work related injury. It was Dr. Colle's opinion that the employee's pain was not caused by a work related injury. The significant degenerative changes were chronic in nature and were not an acute finding. It was Dr. Colle's opinion that the employee had ongoing lumbar stenosis and foraminal stenosis and severe degenerative disc disease which was not an acute problem. It was a chronic problem that may have been exacerbated by an acute lumbar strain.

The employee did not tell Dr. Colle that he had a gradual onset of back complaints and it was not until July 2010 that they became so severe that he felt like he could no longer perform his job due to his back. However, that would not change his opinion as to whether he had an acute problem.

Dr. Colle stated that to determine if there was a work related injury was to see if there was an acute problem such as a herniated disc, or fracture that could cause severe stenosis due to a slip or something of that nature. It was Dr. Colle's opinion that the employee had significant degenerative changes that did not occur over night and his spine did not become that way due to one lifting episode. It was a chronic problem and the work related injury did not cause his back to be the way it was. It was a chronic issue and not an acute issue from his work related injury. Dr. Colle stated that his current lumbar condition was not due to any one incident that occurred on or around July 1, 2010. It was Dr. Colle's opinion that the employee did not need any additional treatment; and was able to go back to work without any restrictions.

Dr. Colle was aware that the employee's job required him to place patients on stretchers, maneuvering them upstairs and downstairs, up and down ditches and into emergency medical vehicles. He was aware that involved maneuvering patients in excess of three to four hundred pounds occasionally on a routine basis. When asked if the employee's paramedic work activities were a prevailing factor in the conditions that he diagnosed, Dr. Colle could not state that his paramedic work activities were his complete problem to his lumbar spine. Lumbar stenosis can occur for many different reasons including smoking, obesity, diabetes, arthritis, and family history. Dr. Colle did not feel that the employee's lumbar stenosis was all because of his work. Other risk factors for his condition were his age, being a smoker, his body mass index, medical history, and his age. The more significant risk factors for the lumbar stenosis were his age and smoking.

On August 23, 2011 the employee saw Dr. Randolph. His deposition was taken November 30, 2011. The employee claimed injuries to his low back, right hip and right shoulder in the course of work activities during the early part of July 2010. The employee did not give a history of a specific injury occurring in July 2010 and did not recall a specific incident which led to the onset of pain. He claimed that work activities such as lifting and carrying patients contributed to the development of pain. The low back surgery by Dr. Ray in 2002 was noted.

After the employee received a settlement, he returned to work and worked steadily from 2002 until 2010.

Dr. Randolph reviewed the myelogram and post myelogram CT scan from September 2010. It showed severe multilevel degenerative disc disease/arthritis of the lumbar spine most evident at L5-S1 but also at L4-5 and L3-4 and degenerative spinal stenosis with no acute abnormalities identified. The post-op laminectomy defect of the left L5-S1 was observed. Severe facet arthrosis was noted at multiple levels. Vacuum defects were noted at the L5-S1, L4-5 and L3-4 disc spaces. Vacuum defects are disc space narrowing phenomenon which is air in the disc space and is an advanced characteristic of degenerative disease. There was severe arthritic disease in the facet joints of the lower three levels. The degenerative disease was superimposed on post operative changes from 2002.

Dr. Randolph stated that the right shoulder surgical findings showed a chronic injury to the rotator cuff as opposed to an acute tear and advanced arthritic disease of the glenohumeral joint, acromioclavicular joint and secondary effects on the glenoid labrum and the biceps tendon. The large non-repairable rotator cuff tear with retraction found during the surgery was chronic because a retracted cuff is a sign of chronic injury. Surgery was performed on the arthritic diseases in the shoulder including the glenoid labrum and the acromioclavicular joint; a procedure was performed to help decompress any cuff impingement; and the long head of the bicep tendon was repaired; and were related to the effects of the degenerative disease.

Dr. Randolph examined the right shoulder and lumbar spine. The right shoulder had loss of flexion, abduction, external rotation and internal rotation. Adduction was minimally reduced. All movements were accompanied by mild pain. Rotator cuff, biceps and deltoid strength was reduced. Crepitus was noted on movement which is consistent with arthritic disease. The examination of the lumbar spine showed some loss of motion. The straight leg raising and femoral stretch test was negative. Right hip abductor flexor strength was reduced. Lower extremity strength was normal and sensation was intact in the lower extremities. The mechanical pain was due to severe multilevel degenerative disc disease and to some degree degenerative spinal stenosis with no acute radicular abnormalities identified. The right hip evaluation revealed evidence of severe degenerative joint disease and no acute abnormalities were identified.

Dr. Randolph stated that at most the employee sustained strain injuries to the right shoulder and lumbar spine superimposed upon significant pre-existing disease. With respect to the right hip, the findings were completely degenerative in nature. Dr. Randolph stated that it appeared that around July of 2010, the employee strained his right shoulder which was superimposed on the pre-existing arthritic process. Dr. Randolph stated the employee sustained a lumbar strain type injury on or about July 2010 which was superimposed upon a severe pre-existing disease, including post op changes, degenerative disc disease, facet arthrosis, and degenerative lumbar spinal stenosis. The right hip had severe arthritis and Dr. Randolph did not identify any right hip injury on or around July 2010. Dr. Randolph rated the right shoulder at 20% permanent partial disability due to the limited range of motion and weakness in the shoulder and related to arthritis as well as the chronic rotator cuff tear. He apportioned 3% to the effects of the shoulder strain occurring on or about July 2010 from work activities at Rural Metro and

apportioned the remaining 17% to the previous effects of the disease not related to his work at Rural Metro. With respect to the lumbar spine, he estimated 28% permanent partial disability of the body. He attributed 20% that was related to the prior settlement. Of the remaining 8%, 2% was attributed to the effects of the strain on or about July 2010 and 6% was attributed to the effects of progressive degenerative disease and deteriorating lumbar spinal stenosis.

Dr. Randolph gave right shoulder restrictions of avoiding overhead reaching or lifting and lifting more than 10 pounds above the shoulder level; and low back restrictions of avoiding frequent or continued bending or twisting; and lifting of 70 pounds from floor to waist and 50 pounds from the waist level. The restrictions on the right hip were to avoid frequent stooping or squatting and avoid continually walking. The restrictions are due to the effects of his pre-existing disease and are not the result of or related to the work activities at Rural Metro.

Dr. Randolph did not have any recommendations for additional treatment related to the work duties and did not believe the employee required any additional work up or treatment of his medical problems.

Dr. Randolph was aware that the employee's job consisted of lifting, carrying and transporting patients; and included maneuvering stretchers downstairs and upstairs; up ditches; and up and down driveways. The employee had heavy patients that he lifted. A paramedic had episodes that were moderate to heavy in nature and on occasion had to perform tugging and pulling. There was down time.

Dr. Randolph stated that the arthritic disease at the lumbar level was primarily influenced by aging, exposure to smoking which accelerates degenerative changes of the spine and most importantly genetic factors. Those are the most significant things that influence the development of degenerative disc disease. The employee is a long time heavy smoker which is a significant risk for the progressive degenerative disease. Dr. Randolph stated that it was significant that the employee has arthritis throughout his whole body and supports the conclusion that there is a disease process such as osteoarthritis primarily affecting his joints both at the peripheral level and in the spine. People with a disease process causing arthritic disease will have it in multiple areas and not just one isolated area.

It was Dr. Randolph's opinion that the prevailing factor in the employees right shoulder, lumbar and right hip conditions are pre-existing and degenerative in nature. It was his opinion that the arthritic disease in joints and the spine develop primarily due to aging and genetic factors; and that exposure to lifting or bending have a minor role but not a prevailing or prominent role in development of those problems. It was his opinion that the any alleged accident or incident that occurred on or around July 2010 was not the prevailing factor in the back, right shoulder or right hip conditions, complaints or current clinical presentation. It was Dr. Randolph's opinion that the employee's work activities including repetitive lifting as a paramedic over the course of his career with Rural Metro were not the prevailing factor in any of his current back, right shoulder or hip conditions.

RULINGS OF LAW:

Issue 1. Occupational disease and Issue 2. Medical causation

It was disputed that on or about July 1, 2010 the employee sustained an occupational disease arising out or in the course of employment and that the employee's injuries were medically causally related to the alleged occupational disease.

The burden of proof is on the employee to prove all material elements of his 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 his injuries arose out of and in the course of employment. See Smith v. Donco Construction, 182 S.W.3d 693, 699 (Mo. App. 2006).

Under Section 287.067.2 and 287.067.3 RSMo, an injury by occupational disease is compensable only if the occupational exposure was the prevailing factor in causing both the resulting medical condition and disability. An injury due to repetitive motion is recognized as an occupational disease. An occupational disease due to repetitive motion is compensable only if the occupational exposure 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. Ordinary, gradual deterioration, or progressive deterioration caused by aging or by the normal activities of day to day living shall not be compensable.

Black's Law Dictionary 621 (Abridged Fifth Edition 1983) defines primary as "First; principal; chief, leading." Webster's College Dictionary 1071 (1991) defines primary as "First in rank or importance; chief;"

In order to be a compensable injury under repetitive motion/occupational disease, the employee has the burden to prove that the occupational exposure was the prevailing factor in causing the resulting medical condition and disability.

Dr. Woiteshek diagnosed traumatic internal derangement of the right shoulder with subsequent non repairable rotator cuff tear with biceps tendon and glenoid labrum tear; and traumatic right sciatica with a new herniated nucleus pulposus on the right at L4-5. It is Dr. Woiteshek's opinion that the employee's right shoulder and back conditions were due to repetitive trauma over a period of time. It was Dr. Woiteshek's opinion that the prevailing factor in the cause of the traumatic internal derangement of the right shoulder with subsequent non repairable rotator cuff tear with glenoid labrum tear and his traumatic right sciatica with a new L4-5 herniated nucleus pulposus was transporting heavy patients as a paramedic. Dr. Woiteshek stated that it was not possible that the natural degeneration process could be the cause of the right shoulder and back symptoms.

It was Dr. Colle's opinion that employee had chronic significant degenerative changes in the lumbar spine including multilevel degenerative changes, degenerative disc disease and spinal

stenosis which were not caused by a work related injury; and were not acute. When asked if the employee's work activities were a prevailing factor in the conditions he diagnosed, Dr. Colle could not state that they were all because of his work activities. Dr. Colle stated that lumbar stenosis can occur for many different reasons including smoking, age, obesity, diabetes, arthritis, family history, and medical history. It was Dr. Colle's opinion that the more significant risk factors for lumbar stenosis were his age and smoking.

It was Dr. Randolph's opinion that the right shoulder surgical findings showed a chronic and not acute injury to the rotator cuff; and advanced arthritic disease of the glenohumeral joint, acromioclavicular joint and secondary effects on the glenoid labrum and the biceps tendon. It was his opinion that the surgery was related to the effects of the degenerative disease. It was Dr. Randolph's opinion that the low back pain was due to severe multilevel degenerative disc disease and to some degree degenerative spinal stenosis with no acute radicular abnormalities identified. The right hip had severe degenerative joint disease and no acute abnormalities. Dr. Randolph stated that the arthritic lumbar disease and the degenerative disc disease was primarily influenced by aging, exposure to smoking which accelerates degenerative changes of the spine and most importantly genetic factors. The employee's long time heavy smoking was a significant risk factor for progressive degenerative disease; and it was significant that the employee has arthritis throughout his whole body.

It was Dr. Randolph's opinion that the prevailing factor in the employee's right shoulder, low back and right hip conditions were pre-existing and degenerative in nature; and developed primarily due to aging and genetic factors. Exposure to lifting or bending had a minor role but not a prevailing or prominent role in development of those conditions. It was Dr. Randolph's opinion that the employee's work activities including repetitive lifting as a paramedic over the course of his career with Rural Metro was not the prevailing factor in any of his current back, right shoulder or hip conditions, complaints or current clinical presentation.

Based on a thorough review of the evidence, I find that the opinions of Dr. Randolph and Dr. Colle are very credible and persuasive and are more credible and persuasive than the opinion of Dr. Woiteshek. I find that the employee's work activities and job duties were not the prevailing factor in causing the resulting medical conditions, disabilities and symptoms to the employee's right shoulder, right hip and low back. I find that the employee failed to satisfy his burden of proof on the issues of occupational disease and medical causation. I find that the employee did not sustain a compensable work-related occupational disease or injury that arose out of and in the course of his employment, and the employee's right shoulder, right hip and low back conditions, disabilities and complaints are not medically causally related to the alleged occupational disease.

Given the employee's failure to prove that he sustained an occupational disease and his failure to prove a medical causal connection between his right shoulder, low back, and right hip conditions, disabilities and symptoms; and the alleged occupational disease, the employee's claim for compensation is denied. Given the denial of the employee's claim on the issues of occupational disease and medical causation, the remaining issues of Additional Medical Aid and Temporary Total Disability are moot and will not be ruled upon.

Second Injury Fund

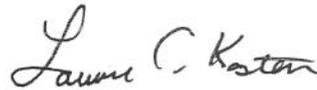
Since the claim against the employer-insurer is denied, the employee's claim for compensation against the Second Injury Fund is also denied.

Although the case was heard as a temporary hearing, based on the denial of the claim against the employer-insurer and the Second Injury Fund, this is a final award.

Made by:

I certify that on 5/11/12 I mailed a copy of the foregoing award to the following entities at their address of record: 1) parties by certified mail, and 2) counsel for the parties by first-class mail.

By mp



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