SOUTH DAKOTA DEPARTMENT OF LABOR & REGULATION
DIVISION OF LABOR AND MANAGEMENT

SUSAN ROBERTS, **HF No. 76, 2012/13**

Claimant,

v. **DECISION**

CASEY'S GENERAL STORES, INC.,

Employer,

and

EMCASCO,

Insurer.

This is a workers' compensation case brought before the South Dakota Department of Labor & Regulation, Division of Labor & Management pursuant to SDCL 62-7-12 and ARSD 47:03:01. The case was heard by Donald W. Hageman, Administrative Law Judge, on March 26, 2015, in Yankton, South Dakota. Claimant, Susan Roberts was represented by Kerri Cook Huber. The Employer, Casey's General Stores, Inc. and Insurer, EMCASCO were represented by Sarah K. Kleber.

Legal Issues:

The legal issue presented at hearing is stated as follows:

1. Whether the RSD which resulted from Roberts' March 2007 work injury has resolved?

2. Whether Roberts' October 26, 2011, work injury is a major continuing cause of her neck condition and need for surgery?

3. Whether Roberts gave timely notice to Employer of her October 2011 work injury?

4. Whether Roberts is permanently and totally disabled due to her work-related injuries?

Facts:

The Department finds the following facts by a preponderance of the evidence:

March 6, 2007 Injury:

1. Susan Roberts (Roberts) was employed by Casey's General Stores, Inc. (Employer) and Employer was insured by EMCASCO (Insurer) for workers' compensation purposes during all times relevant in this case.

2. On March 6, 2007, Roberts suffered a work-related injury. She struck her hand against a counter/stainless steel sink. Her hand bounced and slammed between a door jam and a door. As a result, Roberts injured her right hand, right ring finger and right long finger.

3. Employer and Insurer admitted liability of the injury to Roberts' right hand and fingers.

4. After the injury to her hand and fingers, Roberts had immediate pain and was unable to move her right ring finger without it locking. She had to physically straighten her right finger when it locked. She had decreased range of motion with locking and snapping.

5. Roberts' initially sought treatment at Yankton Medical Clinic in Yankton, SD. From there, she was referred to Dr. Verdun at Yankton Bone, Joint and Sports Medicine.

6. Roberts had no previous history of triggering or locking of her fingers and had no previous pain in her right hand. Dr. Verdun took Roberts to surgery in June 2007 where she underwent a right finger tenovaginotomy A1 pulley release. She then underwent occupational therapy and ultrasound treatment.

7. In November 2007, Roberts was referred to hand specialist Dr. Timothy LeeBurton at Sanford because of the continued pain, problems and triggering involving the right long finger and right ring finger. He determined she would need a revision of the A1 pulley release on the right ring finger and have an A1 pulley release of the right middle finger.

8. On February 25, 2008, Roberts underwent A1 pulley release of the ring and long fingers by Dr. LeeBurton.

9. After her February 2008 surgery, Roberts reported popping and hand pain, but the triggering had ceased.

10. In June 2009, Roberts complained of right hand numbness and weakness. Repetitive motions made her symptoms worse. She was diagnosed with work-related carpal tunnel syndrome and underwent a right carpal tunnel release in September 2009.

11. After her carpal tunnel surgery, Roberts did not have any recurrent triggering. However, the pain continued to worsen.

12. Roberts complained of her palm getting bright red and hard. She described pain that spread up her arm and tingling in the side of her right hand and fingers, spreading across the palm toward the thumb.

13. After Roberts' pain increased, Dr. LeeBurton referred Roberts to Dr. Genoff at CNOS in Dakota Dunes. Dr. Genoff noted Roberts' symptoms as consistent with a chronic pain syndrome. Dr. Genoff recommended Roberts seek treatment with a pain specialist and undergo an evaluation for the sympathetic mediated symptoms.

14. Roberts then was directed to Dr. Cook at Midwest Pain Clinic. Roberts' pain continued.

15. Roberts worked through occupational therapy with therapist Tammy Adam at Avera Sacred Heart Hospital in Yankton. She reported to Adams that the pain shot from the base of her palm to her elbow, as if she had hit her funny bone. Roberts was prescribed Tramadol.

16. On December 28, 2009, Roberts reported that she was having difficulty sleeping. She became very sensitive to cold weather. Adam noted that there was a significant difference between the palmar surface of Roberts' hand and the back of her hand.

17. Roberts tried the recommended methods of conservative treatments for Reflex Sympathetic Dystrophy (RSD), also known as Complex Regional Pain Syndrome (CRS). She followed through with different types of therapies and ultrasound. She tried different medications and nerve blocks. Despite these treatments Roberts' pain continued.

18. Dr. Genoff noted on February 8, 2010, that Roberts is not a surgical candidate.

19. Both Dr. Cook and Dr. Johnson from CNOS opined that Roberts suffered from CRS, Type 1.

20. In February 2010, Dr. Johnson thought that a cervical MRI would provide some answers to Roberts' continual pain and problems. He thought that there may have been a cervical component to her complaints.

21. Dr. Blow conducted an IME on behalf of the insurer in June 2010. His report states "Based on her physical exam, her range of motion of her shoulder and neck, her history, and clinical course, I feel that there is no component of the cervical spine". He noted her continual pain and problems and the significant level of pain that she was suffering. He noted her sensitivities to the temperature

and her difficulties sleeping. An MRI of Roberts cervical spine was denied based on Dr. Blow's IME.

22. Dr. Blow opined that the trigger finger was directly related to the trauma to the right hand, both the ring finger and the middle finger. He stated it is very frequent to have carpal tunnel syndrome with trigger finger and have trigger fingers with carpal tunnel. He further opined, "The subsequent carpal tunnel release by Dr. Timothy LeeBurton resulted in development of RSD".

23. Dr. Blow conducted another IME on November 11, 2010. His report states, "I think although she may have had RSD in the past, it has completely resolved. She is at the end of healing for her work injuries of 3/06/07 including the trigger finger, right carpal tunnel and RSD. Dr. Blow's opinion was based on the fact that some of Roberts' RSD symptoms were not evident at that exam. Her hand strength was symmetrical. Her color, texture and temperature were symmetrical. Her nail and nail beds looked good.

24. Roberts continued her treatment at Midwest Pain Clinic with Dr. Cook. In July 2011, Dr. Cook sought approval of a spinal cord stimulator to treat Roberts' RSD and her conditions associated with it. On July 11, 2011, Dr. Cook stated in a letter that he had been treating Roberts for more than a year for CRS. He stated that the treatment that had shown the most effect was steroid injections to her stellate ganglion nerve. However, he noted that any improvement Roberts has enjoyed had been temporary and that any improvement had been minimal in pain and in her ability to function. He also stated that the effects of the medications she was taking affected her abilities.

25. Dr. Cook's request for a spinal cord stimulator was denied by the Insurer based on Dr. Blow's June 2010 IME.

26. Dr. Blow noted on an exam on October 5, 2011, that Roberts had symmetrical and full strength in her upper extremities. Dr. Blow specifically noted on exam of the right upper extremity that texture, color, moisture and nail growth were symmetrical. Roberts was claiming that the palmar surface of her hand was swollen, but Dr. Blow did not see any swelling and did not detect any swelling on the left either. Muscle tone was noted to be symmetrical. Additionally, Dr. Blow did some palpation over the palmar surface of the metacarpal phalangeal joint. He did not detect any change on the left versus the right.

27. Despite knowledge of Dr. Blow's opinion, Dr. Cook continued to diagnose and treat Roberts for chronic pain after Dr. Blow's November 2010 and October 2011 exams. To date, Roberts' treating physicians have continued to treat her for chronic pain on nearly a monthly basis.

October 26, 2011 Injury:

28. Roberts suffered another work-related injury on October 26, 2011, when a stack of totes fell on her while she was trying to retrieve them.

29. Prior to Roberts' October 26, 2011 work injury, Roberts suffered from degenerative disc disease in her cervical spine.

30. She was initially treated at the Yankton Medical Clinic by Dr. Scott Weber, D.O. on the day of the injury. There she reported that multiple totes fell on her, hitting the "top of her right foot, left knee, and left arm." She reported that she was able to walk afterwards. She also denied any paresthesias and "just complains of pain to her left forearm, left knee, and right foot. The exam also noted diffuse tenderness in the left elbow, but full range of motion and no paresthesias with grip strength and elbow flexion and extension strength full and equal. The claimant had a mild abrasion on her left forearm. Her left knee had mild crepitate and range of motion increased pain to the inferior patellar pole. Ligaments were noted to be intact and other testing was negative in the lower extremity, except for a positive patellar grind test. There was no edema, abrasions, contusions or ecchymosis noted of the lower extremities. The right foot was tender over the first metatarsal with no paresthesias, but the ankle and all digits had complete and symmetric range of motion. No other issues were noted. X-rays were taken of the left knee and right foot, but these were unremarkable except for mild medial degenerative joint disease. Roberts was instructed to rest and ice as needed and to use over the counter medications including a pain reliever and anti-inflammatory, as needed. She was advised to return to activities as tolerated and she was released to work without any restrictions. Roberts was told to "follow up if pain persists or worsens." There was no neck pain identified in the medical records at that time.

31. A Department of Occupational Medicine form was completed at the Yankton Medical Clinic for Roberts' October 26, 2011, evaluation. There is nothing noted in the history, exam, or diagnosis of that document to suggest that there was a neck injury as a result of the injury on October 26, 2011.

32. On October 31, Roberts had an appointment with Dr. Cook. The medical records from that visit do not mention the injury on October 26th or any neck pain.

33. Roberts testified at hearing that she told the physician at Yankton Medical Clinic on October 26, 2011, that she had an upcoming appointment with Dr. Cook and they agreed Dr. Cook should evaluate the injury to her neck due to the medications she was currently taking. This testimony is not credible because none the medical records from Roberts' October, 26, 2011, visit to the Yankton Medical Clinic or Dr. Cook's October 31, 2011, appointment mention anything about a neck injury or pain.

34. In the follow up at Yankton Medical Clinic on November 17, 2011, Roberts reported no new issues related to the falling totes or the previous reported and

diagnosed contusions of her left knee, right foot and left arm. Roberts sought treatment noting a history of RSD in her right arm. She reports that she had 3 syncopal episodes on the date before and was seeking authorization to be off work. There was no mention of neck pain.

35. Roberts' syncopal episodes were noted in her medical records prior to October 26, 2011.

36. When Roberts returned to the Yankton Medical Clinic on November 20, 2011, it was again noted that she was being seen for problems with the RSD in her right upper extremity and additional syncopes were noted. There was no mention of neck pain.

37. During a doctor's appointment on November 28, 2011, Roberts stated that she thought that her frequent syncopal episodes were from the pain. The doctor noted: "I spoke to the patient and told her, in my opinion this is not work-related."

38. Further follow ups continued on the syncopal spells, again nothing related to an alleged neck injury or anything else from the October 26, 2011, date of injury.

39. Dr. Raval noted on December 28, 2011, his assessment of syncopal spell, "etiology is not known."

40. Roberts was seen by Dr. Raval on March 21, 2012. It was noted that she was being seen for "neck pain." She again reported the syncopal events. There is noted a variety of treatment for the neck including injections and therapy.

41. Roberts was referred to Dr. Cook in March of 2012 for her neck pain. On March 22, 2012, Dr. Cook administered cervical injections. He noted that she came in on referral from Dr. Genoff with "neck pain that radiates down from the right side of her neck down through the deltoids, through the posterior aspect of her triceps over into the lateral aspect of her forearm and into the ulnar distribution other right hand." It was noted that Roberts was having right arm pain "that radiates down her right arm through the deltoid muscle, down the posterior aspect of her triceps into her forearm and into the ulnar distribution of her right hand." Dr. Cook also noted: "The patient has pain that radiates down the right side of her neck into the right trapezius over into the right deltoid and into the posterior aspect of her triceps. She has very little numbness or tingling associated with this discomfort. She has no weakness of her right upper extremity." This right arm pain and issue is coming from the cervical area and is not coming from a right hand or arm complex regional pain syndrome as was previously noted from the March 6, 2007 injury.

42. By April 4, 2012, Dr. Cook assessed Roberts with "cervical radiculopathy C5-6 with right sided symptomology." Dr. Cook states that Roberts "obviously has radicular pain consistent with degenerative disc disease." Dr. Cook referred the

claimant for a consultation for evaluation of a cervical radiculopathy. Roberts was referred for physical therapy in May of 2012.

43. Roberts underwent a C5-6, C6-7 anterior cervical discectomy and fusion with instrumentation and left carpal tunnel release by Dr. Durward on November 15, 2012. She continued to seek pain treatment after the fusion with a history of "chronic regional pain syndrome and cervical radiculopathy." Therapy also continued for her degenerative and chronic conditions of "cervical fact arthrosis and cervical spondylosis".

44. Dr. Durward opined that Roberts, cervical problems were caused by her October 26, 2011 work injury. However, he provided no rationale to explain how he came to that conclusion. He also failed to explain why the injury on October 2011 took nearly five months to manifest any pain symptoms.

Permanent Total Disability:

45. Rick Ostrander, a Vocational Rehabilitation Expert of MVR Consulting Services, Inc. provided a vocational evaluation of Roberts on or about April 23, 2014. Mr. Ostrander reviewed her treatment history for both the work injuries of March 2007 and October 2007. He consulted with Roberts and concludes, "If one accepts at accurate Susan Roberts' description of her capacity for physical function as she describes it and as is documented in the medical records...she would be unable to return to any of her past employment, even sedentary work. She simply would not have the ability to attend and concentrate in a work setting consistent with competitive employment". "Additionally, there would be no work existing in significant numbers in the regional or national economy which she would be capable of performing. This would be due to the significant difficulty she experiences with pain in her right arm up to her head as well as her migraine headaches, her periods of dizziness and passing out as well as significantly decreased physical function including clumsiness when walking, problems with grip, strength and finger dexterity."

46. Additional facts may be discussed in the analysis below.

Analysis:

RSD:

"In a workers' compensation dispute, a claimant must prove all elements necessary to qualify for compensation by a preponderance of the evidence ... A claimant need not prove his work-related injury is a major contributing cause of his condition to a degree of absolute certainty. Causation must be established to a reasonable degree of medical probability, not just possibility. The evidence must not be speculative, but must be precise and well supported" Darling v West River Masonry, Inc., 2010 SD 4, 11-13.

Employer and Insurer accepted responsibility for Roberts' March 2007 hand injury and acknowledge that she possibly suffered from RSD as a result of that injury. However, their position is that Roberts' RSD was resolved as of Dr. Blow's November 2010 and October 2011 IMEs. Dr. Blow's opinion was based on the fact that some of Roberts RSD symptoms were not evident at those exams. Her hand strength was symmetrical. Her color, texture and temperature were symmetrical. Her nail and nail beds looked good, etc.

Nevertheless, the Department is of the opinion that Roberts' RSD persists. Dr. Blow ignored Roberts' most dominant RSD symptom, her pain. Robert experienced immediate pain after the injury and her medical records indicate that the pain has continued mostly unabated since that time. Dr. Cook explained that the treatment that had shown the most effect was steroid injections to her stellate ganglion nerve. However, he noted that any improvement Roberts has enjoyed had been temporary and that any improvement had been minimal. Roberts has met her burden of showing entitlement for her chronic pain which resulted from her March 2007 hand injury.

Neck:

The Department next turns to the question of whether Roberts' October 26, 2011 work injury is a major continuing cause of her neck pain and need for surgery. Claimant has the burden to establish by a preponderance of the evidence all of the facts essential to compensation. Davidson v. Horton Industries, Inc., 641 N.W.2d 138, 144 (SD 2002); Titus v. Sioux Valley Hospital, 658 N.W.2d 388, 390 (SD 2003). Claimant must prove that [her] injury arose out of [her] employment by showing a causal connection between [her] employment and the injury sustained. Claimant must prove by a preponderance of medical evidence that the employment or employment related injury was a major contributing cause of the impairment or disability. SDCL 62-1-1(7).

When Roberts sought treatment after her October 2011 injury, her medical records indicated treatment to the "top of her right foot, left knee, and left arm." There is no mention of an injury to her neck or resulting pain. In fact, Roberts' medical records do not reflect any neck pain until March of 2012.

Dr. Durward has offered an opinion that Roberts' neck condition is work related. However he offers no explanation of how he came to that conclusion. Most importantly, there is no explanation provided why an injury on October 2011 took nearly five months to manifest any pain symptoms. Absent such explanations, the Department is unconvinced that Roberts' neck pain is work-related.

Notice:

In light of the decision above, it is unnecessary for the Department to determine whether Roberts gave timely notice to Employer of her October 2011 work injury.

Odd Lot:

Roberts seek "odd-lot benefits" claiming that she is permanently and totally disabled as a result of her work-related injuries.

> An employee is permanently totally disabled if the employee's physical condition, in combination with the employee's age, training, and experience and the type of work available in the employee's community, cause the employee to be unable to secure anything more than sporadic employment resulting in an insubstantial income.

Fair v. Nash Finch Co., 2007 S.D. 16, ¶ 18, 728 N.W.2d 623.

Rick Ostrander, Roberts' vocational expert, offered a report in which he opined that Roberts was permanently and totally disabled. However a review of that report indicates that his opinion was based on Roberts' condition as a whole, including her RSD, her neck pain, her dizziness, her "passing out" episodes and her migraine headaches.

It is noteworthy that Roberts has only proven here that her RSD is work-related. She has not shown that her neck pain, her "passing out" episodes, or her migraine headaches are work-related. In addition, she continued to work with the RSD which resulted from the March 2007 injury and only ceased working after her October 26, 2011 injury. Therefore, the Department concludes that Roberts failed to carry her burden of showing that she is permanently and totally disabled as a result of her work-related injuries.

C*onclusion:*

Employer and Insurer shall submit Findings of Fact and Conclusions of Law and an Order consistent with this Decision, and if desired Proposed Findings of Fact and Conclusions of Law, within 20 days after receiving this Decision. Roberts shall have an additional 20 days from the date of receipt of Employer and Insurer's Findings of Fact and Conclusions of Law to submit Objections and/or Proposed Findings of Fact and Conclusions of Law. The parties may stipulate to a waiver of formal Findings of Fact and Conclusions of Law. If they do so, Employer and Insurer shall submit such stipulation together with an Order consistent with this Decision.

Dated this 25th day of September, 2015.

/s/ Donald W. Hageman
Donald W. Hageman
Administrative Law Judge