BEFORE THE DIVISION OF WORKERS COMPENSATION
STATE OF KANSAS

Anab Hassan,

Claimant,

vs. Docket No. 1,062,808

Tyson Fresh Meats, Inc.,

Respondent,

and

Self-Insured,

Insurance Carrier.

AWARD

Decision rendered this 17th day of September, 2015.

APPEARANCES

The Claimant appears in person and by her attorney, Stanley R. Ausemus; the Respondent, Tyson Fresh Meats, Inc., appears by their attorney, Thomas G. Munsell.

RECORD

The record consists of Deposition of C. Reiff Brown, M.D. dated May 12, 2015; Regular Hearing Transcript dated June 1, 2015; Deposition of Kelly Worthley dated July 22, 2015; Evidentiary Deposition of Anab Hassan dated September 1, 2015; Evidentiary Deposition of Ida Aguilar dated September 1, 2015; the exhibits entered into evidence by each party and the pleadings and correspondence contained in the administrative file.

STIPULATIONS

1. Claimant met with personal injury by accident arising out of and in the course of her employment on February 16, 2009 in Finney County, Kansas.

2. Notice was received.

3. The relationship of employer and employee existed.

4. The parties are covered by the Kansas Workers' Compensation Act.

5. The claimant's average weekly wage was $452.68 without fringe benefits.

6. The respondent has not furnished any temporary total disability compensation and none is claimed.

7. The respondent has furnished hospital and medical expenses in the sum of $323.91.

8. The report of Doug Lindahl and the report of Steve Benjamin may be entered without further foundation.

ISSUES

1. Was written claim timely and if so, nature and extent of disability?

2. Unauthorized medical treatment.

3. Future medical treatment.

FINDINGS

Having reviewed the entire evidentiary record in addition to the stipulations, it is found as follows:

1.

The claimant alleged a fall injury on February 16, 2009 which was docketed and received on October 19, 2012. Claimant's Exhibit 1 to the Regular Hearing Transcript is a demand letter sent to the respondent and received on October 19, 2012. Treatment was provided in 2009. Then the claimant was provided treatment in 2011. Dr. Hunsberger considered it a new case and repetitive. The claimant contends it is the same areas and it grew out of the fall.

The claimant has 4 children. She has not gone to school, does not speak or write English. She speaks Somalian but does write it. She is illiterate. She can not read or write any language. She doesn't have any special job skills. She spoke with Mr. Lindahl and Mr. Benjamin. She told them every place she had worked in the past 15 years as well as described the work she performed.

On February 16, 2009, while working for the respondent, the claimant fell. She

stepped on fat that was on the floor which made her fall on her back. She felt immediate pain in her whole body. She was instructed to stay where she was. Then they helped her up. At that time she began to feel pain in her neck head, both shoulders, her back and her right leg, foot and ankle. She was taken to the nurses' station. She was informed that they could not give her any medication because she was pregnant. She gave birth on June 29, 2009 and was off work for 45 days. When she returned to work, she was still having pain and discomfort from her fall.

The claimant went to the nurses's station a few times requesting treatment. Ultimately she was sent to a doctor but it was almost a year after the accident. The claimant saw Dr. Hunsberger on October 6, 2011. The claimant stated that there was not an interpreter present so she didn't respond to a lot of his questions. She stated that she was never pain free from her fall in 2009 until she was sent back to Dr. Hunsberger in 2011. She had pain in her back, neck and shoulders. She said she told him it was from her fall in 2009. The claimant said the only accident report she filled out was the one in 2009.

The claimant stated that she still has pain from the fall. That the pain is worse when she is working. It has been constant since the fall. The pain also increases in her shoulders during daily activities such as shopping, picking up her babies or taking a shower. She also has a lot of pain in her neck. She does not know if it is because of her back or shoulders, but she has a lot of pain. None of the treatment she has received has helped her.

The claimant's employment was terminated about September 30, 2013. She has looked for work but no one has offered her a job. She did file for and receive unemployment.

On cross examination, the claimant stated that she saw Dr. Hunsberger on 2 occasions in 2009 for her fall. Then she didn't see a doctor for quite some time after that. She was pregnant when she fell and then was off of work for 45 days after her child was born in June of 2009. When she returned to work, she returned to her regular job. She worked at that job until her termination. Also, it was her understanding that the court ordered physician, Dr. Pratt assigned her a 10% disability to the body as a whole for her 2009 fall. The claimant didn't file for benefits until after she met with Mr. Ausemus in October of 2012 which is more than 3 years after her injury in February of 2009.

The claimant denied reporting an injury in 2011. Respondent's Exhibit 1 to the Regular Hearing Transcript is certified records from the Division. There are Employer's Report of Accident forms. One form shows repetitive motion to multiple body parts with a date of accident of September 6, 2011 and September 27, 2011 as the date it was reported to the employer. The claimant admitted that September of 2011 was about 2 years after she had returned to work after the birth of her child. That she did not file a claim until a year after that. She stated that she never reported an accident other than

her fall in 2009 and then lower extremity claims of 2013.

The claimant was deposed in September of 2015. The claimant was shown Deposition Exhibit 1 which purports to be a report of an injury or illness with the date of injury being September 6, 2011. She admitted it was her signature on the bottom of the form although she doesn't remember signing it. Then she said the form was not explained to her, they just asked her to sign it. She said the only injury she had while working for the respondent was in 2009. She didn't report a new injury in 2011. After she returned from maternity leave she was returned to her regular job. She kept requesting treatment but they didn't send her for any. Finally after 4 or 6 weeks they sent her to a doctor. She was sent to Dr. Hunsberger, Dr. Baughman and Dr. Woodward.

On cross, the claimant stated that when she went to the plant nurse, she told them what the problem was and they did write things down. After they finished writing, she would sign the forms. She admitted that she can read dates. Some of the times there was an interpreter.

Ida Aguilar is a nurse manager for the respondent and has held that position since November of 2014. Her duties include managing the nurses, reviewing records and complying with OSHA guidelines. She is also responsible for the documentation and records in the health department. She was shown Deposition Exhibit 1 which contained 7 pages. She was familiar with those documents. She stated that when an employee presents to the occupational health clinic with an illness or injury, an OSHA 301 First Report of Injury is prepared. Page 1 of the exhibit is one of those reports. The second page is an Authorization for Release of Protected Health Information and page 3 is an Authorization for Release of Protected Health Information for a job injury claim. Page 4 is another OSHA 310 first Report form. Page 5 and 6 are authorizations for release of medical information to the respondent. Page 7 is an OSHA 301 First Report of injury form.

Contained in the exhibit is 3 OSHA first report forms. One has a date of injury of September 6, 2011; another has a date of injury of November 9, 2009; and the third has a date of injury of February 19, 2008. The first page was signed on September 27, 2011. The name shown is Anab Hassan. When a team member reports to health services, they tell what happened and what the injury is. The injury report is prepared at that same time. They obtain the team member's information, name, address, phone number, date of birth, marital status, sex, job code and title and where they sustained the injury of illness. They also obtain information as to the number of children they have, number of exemptions, hire date, time on the job that they were injured, and their rate of pay. They inquire how the incident occurred and what body parts were affected. They get the date of injury if they were treated at the ER and the date it was reported to the respondent. They also get the start shift time, injury time if it can be determined, and who it was reported to. Then they list the accident location, fill out Section Four where it states where it happened. They determine the type of injury or illness and then

have the team member review it and sign it along with the nurse and interpreter if one was used.

On cross examination, Ms. Aguilar stated that if a team member came in and requested additional medical treatment, they would inquire as to what body part and what case. Then they would contact the adjustor to see if they were able to send them for more treatment. She stated on the 2011 form the claimant listed a right thumb, right forearm, left rib and back which is not listed on the 2009 form. Both forms did have shoulders and neck.

Kelly Worthley is the Workers' Compensation Administrator for the respondent. She has worked for the respondent since 1998. Her duties are to investigate and take care of any injuries that are reported to the respondent. Also to pay medical bills, document the medical, determine compensability and do settlements. He receives the report of injury electronically from the nurses' department. Ms. Worthley was shown Respondent's Exhibit 1 to the Regular Hearing Transcript. It reflected a claim number for the date of injury of 2-16-09. Respondent Exhibit 1 to his deposition is an affidavit of records attached which is a payment screen of all the payments made on the case for the claimant. The date of the last payment on account of that injury was April 3, 2009 to Saint Catherine's for date of service of February 20, 2009.

Ms. Worthley stated that the claimant came in on September 27, 2011 and reported a new injury with a date of injury of September 6, 2011. Treatment was provided for the new injury. She stated that a Report of Injury will not be generated unless there is an employee statement.

Claimant's Exhibit 1 is a medical report from Dr. Hunsberger dated December 21, 2011. It indicates that the accident date is September 6, 2011. The date of accident could have been provided to him by the respondent according to Ms. Worthley.

A medical record of Dr. Steffen, Respondent Exhibit 3 indicates that the claimant was injured in 2008. That she has struggled with bilateral shoulder, neck, back, arm and hand pain since that time. That she had MRIs that were normal but she still had multiple pain generators. He stated that it was very clear that there was no evidence that the claimant's problems emanate from any work related injury. He thought it could possibly be a neurological or autoimmune disorder. This report was from December of 2012.

Dr. Hunsberger did see the claimant on December 15, 2009 for bilateral neck and shoulder pain and left elbow pain. The report shows a date of accident of November 9, 2009. Dr. Hunsberger stated that the claimant was not better with ibuprofen and Naprosyn. She continued to have bilateral neck and shoulder pain and left elbow pain. On exam, the claimant barely moves her shoulders, barely moves her neck although she can put her jacket off and on and walks with out problem. She looks

left to right when she does not think he is looking. Dr. Hunsberger placed the claimant at MMI. He stated he would keep her on alternate duty for one week while she bids for a different job. Then the claimant would be back to her normal duty. She was placed at MMI that day but returned to her normal duty without limitations or disabilities in one week.

Dr. Brown saw the claimant at claimant counsel's request. He initially evaluated the claimant in June of 2013. He reviewed medical records provided and conducted a physical examination. The claimant gave a history of a first injury occurring February 16, 2009. She fell and then had pain in both hands, left wrist, and right wrist which began in the last few months. (It should be noted that the date of examination was June of 2013.) The claimant related a second injury involving her left leg with a date of accident of March 25, 2013.

On examination, Dr. Brown found tenderness posteriorly in the neck that extended to the lower areas of the neck and outward to the upper trapezius and to the front and upper aspect of both shoulders and extends to both hands. He noted that in the lumbar spine there were no muscle spasm or arrhythmia and that she ambulated with a normal gait. For the February 2009 injury, Dr. Brown determined that the claimant's shoulder injury consisted of rotator cuff tendinitis and acromial impingement syndrome. That she most likely has a sprained neck and lumbar sprain resulting in symptoms in both areas. He stated that he was uncertain as to the origin of the right hand and arm pain and the left wrist and hand pain. He suggested additional studies. He stated that in his opinion, the February 2009 injuries are repetitive trauma injuries and the result of her work activity. The nature of her work was described to him and he believes the injuries to be true repetitive trauma syndromes.

The claimant was again examined in December of 2013. For her injuries of February of 2009, she was rated utilizing the 4th Edition of the AMA Guides and given a 5% whole body impairment based on the DRE Lumbosacral Category II. For loss of range of motion of the right shoulder, she was given a 6% right upper extremity impairment and for the left shoulder, a 4% left upper extremity impairment. Those were converted to a 6% impairment to the body as a whole and combined with the 5% whole person impairment for the lumbosacral problem and an additional 5% for her cervical problem for a total of 15% permanent partial impairment to the body as a whole. He also gave her permanent work restrictions.

Dr. Brown was provided a task list prepared by Mr. Lindahl. He stated that in his opinion, the claimant was unable to perform any of the tasks that were based on her employment with the respondent. There were 3 tasks. There was a 4th task that was performed for a different employer which he believes the claimant could still perform. Therefore, Dr. Brown determined the claimant suffers a 75% task loss. He was also provided a task list prepared by Mr. Benjamin. Of the tasks listed that the claimant performed for the respondent, he determined the claimant was able to perform 2 of the 5 tasks listed. There was one task listed that she performed at two different employers

which he felt she could still perform. Of the 7 tasks listed, he felt she could perform 4 of those. That would be a 43% task loss.

On cross examination, Dr. Brown stated that for the date of accident of February 16, 2009, the history given was of a single traumatic event injuring the left wrist and to some extent, the right wrist. The claimant expressed having pain in both hands extending outward into her fingers. That in the medical records he reviewed, there were records indicating that the claimant had sustained some type of accident in 2008. As a consequence of that event, the claimant reported having shoulder difficulties, neck, back, arm and hand pain since that injury. He admitted that the only pain complaints the claimant voiced to him on his initial examination was concerning her right hand and arm pain and left wrist and hand pain which were attributed to her February 2009 incident. In his conclusions he stated that he was uncertain as to the origin of those pains. He did not attribute any of her injuries to a single traumatic event. He also stated that his task reduction opinions were based on a global assessment of all her injuries and physical complaints which included her shoulder, neck back, arm and hand pain that she related to 2008 as well as any complaints she relates to 2013.

On redirect, Dr. Brown stated that rotator cuff tendinitis and acromial impingement as well as a sprain of the neck and lumbar sprain could be the result of a single traumatic event. That his ratings are possibly consistent with a single event. Then he stated that the claimant would have noticed an increase in her symptoms as she did her work activity even though that work may not have caused the problems.

Dr. Pratt evaluated the claimant pursuant to a court order. He saw her on August 4, 2014 at which time he took a history, reviewed medical records provided and conducted a physical examination. Dr. Pratt stated that the claimant was only a fair historian. The claimant gave a history of cervical symptoms as continuous, sharp electric involvement bilaterally radiating to the shoulders with discomfort of both shoulders. She complained of weakness bilateral upper extremities and reported the symptoms can radiate from the forearms to the hands. She reported numbness of the hands and the cervical region. The symptoms are exacerbated when she stands straight or walks a lot. Her low back symptoms are continuous with radiating laterally into the lower extremities. She has numbness of both lower extremities. The claimant reported vocationally related activities resulting in a number of symptoms in 2009 and bilateral lower extremities in 2013. The claimant was diagnosed with cervicothoracic discomfort; low back pain; bilateral shoulder syndrome; and diffuse upper and lower extremity symptoms of undetermined etiology.

Dr. Pratt stated that in relationship to the shoulders, cervicothoracic and lumbosacral involvement, he did not have the MRI reports available for consideration and would like them prior to determining permanency.

Dr. Pratt prepared an addendum to his independent medical evaluation. He received the additional information that had been requested. He received

documentation from imaging including June 3, 2013, the left knee, left ankle and lumbar spine were normal. The August 27, 2012 left shoulder MRI revealed a type II acromion. There was partial thickness tear of the articular surface at the supraspinatus footprint attachment and supraspinatus muscle had mild volume loss but without fatty degeneration. The cervical MRI was noted to show loss of lordosis probably secondary to muscle spasm but otherwise essentially unremarkable. There was disk bulging which was minimal at C4-5 with minimal left neural foraminal stenosis, C5-C6 again minimal bulging and bilateral neural foraminal stenosis. He noted that there was documentation from Dr. Baughman's office from August 6, 2012 noting cervical, bilateral shoulders, bilateral hands, and wrist plain films did not reveal acute bony abnormalities.

Dr. Pratt noted that he had documentation that the claimant had 3 claims. The initial claim was from February 16, 2009 with injury to her back, neck, both shoulders, left wrist, right arm and right hand. He was asked to address the amount of permanency for the accidents and whether work restrictions should apply. In relationship to the 2009 claim, the claimant was only a fair historian. Dr. Pratt noted that the claimant had significant limitations in active movements of her shoulders. Motor function was limited by giveaway weakness and she had some inappropriate responses on lumbosacral assessment. The claimant does have a cervicothoracic syndrome, low back pain, and bilateral shoulder syndrome with evidence of partial rotator cuff tear on the left and diffuse upper and lower extremity symptoms of undetermined etiology. He could not state that she had significant evidence of lumbosacral radiculopathy or cervical radiculopathy. The claimant's evaluation was limited by the inappropriate responses. When he compared range of motion during the evaluation with prior assessments, there was significant differences to the degree that it was not possible to consider range of motion findings as a true indication of her functional abilities. Dr. Pratt stated that there was evidence in the records of lumbosacral involvement and it appeared to be consistent. The claimant was given a 5% impairment of the whole person for her lumbosacral involvement. For the cervical involvement she was given a 0%. For the left shoulder she was given an 8% to the left upper extremity. For the right shoulder she was not given a rating. The 8% left shoulder was converted to a 5% to the whole person. The whole person ratings were combined for a 10% of the whole person. Dr. Pratt stated that in relationship to her reported wrist, arm and hand involvement, he could not state that he identified to a reasonable degree of medical certainty findings that results in permanent partial impairment for those areas. She was given permanent restrictions.

K.S.A. 44-520a states in relevant part that written claim shall be served upon the employer within 200 days after the date of accident or within 200 days after the date of the last payment of compensation. Here, the claimant alleged a specific date of accident of February 16, 2009. Two hundred days from that date would be September 04, 2009. The evidence presented shows the last payment for medical services rendered was tendered on April 3, 2009. Two hundred days from that date would be October 20, 2009. The claimant made claim for benefits on October 19, 2012 which is

well outside either of the 200 days.

K.S.A.44-534(b) states: "No proceeding for compensation shall be maintained under the workers compensation act unless an application for a hearing is on file in the office of the director within three years of the date of the accident or within two years of the date of the last payment of compensation, whichever is later." Here, the application for hearing was filed October 19, 2012 for a specific date of accident of February 16, 2009. Three years from that date is February 16, 2012. The last payment of medical treatment was April 3, 2009. Two years from that date is April 3, 2011.

In 2011 the claimant did receive treatment for some of the same body parts that were claimed in the 2009 injury. There was a new report of injury form filled out that listed body parts as injured that were not claimed in the 2009 report. The claimant denied ever filing a new accident report in 2011 although she signed a report of injury form for an injury of September 6, 2011. This was signed on September 27, 2011. It shows a repetitive motion injury to multiple body parts including a right thumb, right forearm, left rib and back which was not listed on the 2009 form.

There is a medical report from Dr. Steffen indicating that the claimant had struggled with bilateral shoulder, neck, back, arm and hand pain since 2008. He saw the claimant in December of 2012 and determined that her problems were not from any work related injury. Dr. Hunsberger saw the claimant in December of 2009 for bilateral neck and shoulder pain and left elbow pain showing a date of accident of November of 2009. He determined she was at MMI with no limitations or disabilities.

Dr. Brown determined the claimant had a 15% permanent partial impairment to the body as a whole but found that her injuries were repetitive trauma injuries, not specific traumatic event injuries. The claimant gave a history of injury of a fall that occurred on February 16, 2009 resulting in pain in both hands, left wrist and right wrist which began a few months prior to the examination. For those complaints, Dr. Brown was uncertain as to the origin. Dr. Pratt noted that the claimant was only a fair historian and the claimant's evaluation was limited by inappropriate responses. She was given a 5% whole person impairment for her lumbosacral involvement and a 5% whole person impairment for her left upper extremity for a 10% whole person impairment. It should be noted that Dr. Pratt was informed of what body parts related to what date of injury.

The claimant claims that treatment she received in December of 2012 and was paid for in January of 2013, extends her statute of limitations. The evidence presented shows that treatment was for a different reported date of injury. Two medical providers saw the claimant after her February 16, 2009 accident. One determined her to be at MMI and the other determined that any problems she was having was not related to a work injury.

The claimant failed to provide timely written claim. The claimant failed to prove that the statute of limitations should be extended based on treatment provided in

December of 2012 and paid for in January of 2013. Therefore, her application for hearing was not timely filed. The claimant's requests for benefits should be and the same are hereby denied.

2. Based on the ruling as to Issue No. 1, Issue No. 2 need not be addressed.

3. Based on the ruling as to Issue No. 1, Issue No. 3 need not be addressed.

AWARD DENIED

WHEREFORE, an award of compensation is hereby denied for the date of accident of February 16, 2009 in accordance with the above findings.

Claimant's contract of employment with her attorney is approved subject to the provisions of K.S.A. 44-536.

Fees and expenses of administration of the Kansas Workers Compensation Act are assessed against the Respondent to be paid direct as follows:

Kelley, York & Associates LTD.	
Deposition of C. Reiff Brown, M.D.	Unknown
Jennifer N. Overland	
Regular Hearing Transcript	$336.75
Western Kansas Reporting	
Evidentiary Deposition of Anab Hassan	$213.89
Evidentiary Deposition of Ida Aguilar	$213.90
Midwest Litigation Services	
Deposition of Kelly Worthley	$199.00

IT IS SO ORDERED.

Pamela J. Fuller
ADMINISTRATIVE LAW JUDGE

Original to: Larry Karns, Director
Copies to: Stanley R. Ausemus; Thomas G. Munsell