

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

Injury No.: 99-013898

Employee: Pamela Bates (formerly Vester)
Employer: Ponderosa
Insurer: Liberty Mutual Fire Insurance Company
Additional Party: Treasurer of Missouri as Custodian
of Second Injury Fund

Date of Accident: February 22 or 23, 1999

Place and County of Accident: St. Charles County, Missouri

The above-entitled workers' compensation case is submitted to the Labor and Industrial Relations Commission (Commission) for review as provided by section 287.480 RSMo. Pursuant to section 286.090 RSMo, subsequent to reviewing the evidence and considering the entire record, the Commission modifies the award and decision of the administrative law judge dated September 1, 2005. The award and decision of Administrative Law Judge Leslie E. H. Brown, issued September 1, 2005, is attached and incorporated by this reference.

I. Preliminary Matters

The Commission affirms all findings and conclusions of the administrative law judge, but for the determination of the appropriate rate for temporary total disability. The administrative law judge concluded the proper rate was \$82.02. The Commission modifies that determination, by concluding the proper rate for temporary total disability is \$79.67 per week.

II. Calculation of Compensation Rate for Temporary Total Disability

Section 287.250 RSMo, sets forth the manner of computing an injured employee's average weekly earnings and corresponding compensation rate.

Section 287.250.2 RSMo, defines gross wages, and part of the definition includes the following: "The term 'wages', as used in this section, includes the value of any gratuities received in the course of employment from persons other than the employer to the extent that such gratuities are reported for income tax purposes" (emphasis added).

Employee was a waitress for employer, and her gross wages consisted of her earnings based on an hourly wage of \$2.13, plus her tips reported for income tax purpose.

Employer and insurer's Exhibit No. 29 (employee's wage statement) was the only competent and substantial evidence adduced at the hearing from which the Division of Workers' Compensation (Division) or Commission could possibly calculate employee's average weekly earnings and corresponding compensation rate. Employer and insurer's Exhibit No. 29, in summary fashion, revealed the following:

<u>Period Ending Date</u>	<u>Gross Wage</u>	<u>Tips Reported for Income Tax Purposes</u>
11-23-98	\$336.18	\$185.00
12-07-98	\$246.08	\$163.00
12-21-98	\$155.45	\$105.00

01-04-99	\$196.76	\$129.00
01-18-99	\$228.27	\$155.00
02-01-99	\$222.62	\$163.00
02-15-99	<u>\$287.72</u>	<u>\$191.00</u>
	\$1,673.08	\$1,091.00

As stated above, there is no additional evidence in this entire record reflecting actual wages earned while employee was working for employer. Employee's evidence as to her earnings was based on speculation, surmise, and guess work. As to earnings from tips, the legislature has limited consideration of gratuities (tips) to the extent reported for income tax purposes.

In order to calculate employee's average weekly earnings and her corresponding compensation rate, the Commission is of the opinion that section 287.250.1(4) RSMo, is the appropriate subsection to use. (The Commission notes and emphasizes again that the Commission is only modifying the temporary total disability rate, not the permanent partial disability rate, which the Commission believes was appropriately computed by the administrative law judge utilizing section 287.250.6 RSMo). As an aside, the Commission is of the further opinion that the only other statutory provision that could possibly be applicable, to determine the correct rate for temporary total disability, would be section 287.250.4 RSMo, and the Commission would come to the same conclusion if either of these two provisions were used, as further discussed below.

Section 287.250.1(4) RSMo, provides in part as follows: "If the wages were fixed by the day, hour, or by the output of the employee, the average weekly wage shall be computed by dividing by thirteen the wage earned while actually employed by the employer in each of the last thirteen calendar weeks immediately preceding the week in which the employee was injured ..."

Section 287.250.1(4) RSMo further provides in pertinent part: "For purposes of computing the average weekly wage pursuant to this subdivision, absence of five regular or scheduled work days, even if not in the same calendar week, shall be considered as absence for a calendar week."

There was no evidence adduced showing employee missed any regular or scheduled work days for the fourteen-week pay period itemized on Employer and Insurer's Exhibit No. 29. There is no statutory basis to exclude any wages earned in any of the weeks depicted.

In the instant case, employee was paid every two weeks, and it is not possible to discern from the evidence adduced, the exact wages earned in any particular one-week time frame. The Commission can only ascertain the gross wages earned every two weeks. From the evidence presented, it is not possible to apportion the wages between the two-week incremental payments.

Section 287.800 RSMo, provides as follows: "All of the provisions of this chapter shall be liberally construed with a view to the public welfare, and a substantial compliance therewith shall be sufficient to give effect to rules, regulations, requirements, awards, orders or decisions of the division and the commission, ..."

Based upon the exceptional facts presented, the Commission is of the opinion that it can only fairly and justly determine employee's actual average weekly earnings by utilizing the fourteen weeks immediately preceding the week in which the employee was injured. In so doing the gross wages are \$1,673.08 equating to an average weekly wage of \$119.51, and a corresponding compensation rate for temporary total disability of \$79.67 ($\$119.51 \times \frac{2}{3}$).

Section 286.250.1(4) RSMo, requires the Commission to use the thirteen weeks immediately preceding the date of injury. In the instant case it is not possible to ascertain the wages earned representing the thirteen calendar weeks immediately preceding the week in which the employee was injured. The twelve-week period can be ascertained; and the fourteen-week period can also be ascertained.

The Commission is of the opinion that it would be fair and just to use the fourteen-week time frame in lieu of the twelve-week time frame since the fourteen-week time frame obviously encompasses the thirteen weeks immediately preceding the week of the accident. The Commission is also of the opinion that in so doing it is in

conformance with sections 287.250.1(4), 287.250.4 RSMo, and 287.800 RSMo.

III. Conclusion

Based on the above modification, the Commission ascertains and determines employee's average weekly earnings to be \$119.51, resulting in a compensation rate for temporary total disability benefits of \$79.67. Consequently, the amount of compensation payable is modified to the following amounts: \$91.05 temporary total disability representing 1 and 1/7 weeks ($\$79.67 \times 1 \text{ and } 1/7 \text{ weeks}$); and underpayment of temporary total disability in the amount of \$611.99 [$(\$79.67 \times 15 \text{ and } 3/7 \text{ weeks}) - \617.20].

The award and decision of Administrative Law Judge Leslie E. H. Brown dated September 1, 2005, as modified is attached and incorporated by reference.

The Commission further approves and affirms the administrative law judge's allowance of attorney's fee herein as being fair and reasonable.

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

Given at Jefferson City, State of Missouri, this 26th day of April 2006.

LABOR AND INDUSTRIAL RELATIONS COMMISSION

William F. Ringer, Chairman

Alice A. Bartlett, Member

DISSENTING OPINION FILED

John J. Hickey, Member

Attest:

Secretary

DISSENTING OPINION

I have reviewed and considered all of the competent and substantial evidence on the whole record. Based on my review of the evidence as well as my consideration of the relevant provisions of the Missouri Workers' Compensation Law, I believe the decision of the administrative law judge should be affirmed. As the Commission majority has affirmed all findings and conclusions of the administrative law judge, but for the appropriate rate for temporary total disability, I dissent on that issue alone.

The Commission majority concludes that the rate for temporary total disability set by the administrative law judge of \$82.02 per week should be modified to \$79.67 per week. I disagree. Section 287.250.1 RSMo (2000) reads as follows:

(4) If the wages were fixed by the day, hour, or by the output of the employee, the average weekly wage shall be computed by dividing by thirteen the wages earned while actually employed by the employer in each of the last thirteen calendar weeks immediately preceding the week in which the employee was injured or if actually employed by the employer for less than the thirteen weeks, by the

number of calendar weeks, or any portion of a week, during which the employee was actually employed by the employer. For the purposes of computing the average weekly wage pursuant to this subdivision, absence of five regular or scheduled work days, even if not in the same calendar week, shall be considered as absence for a calendar week. If the employee commenced employment on a day other than the beginning of a calendar week, such calendar week and the wages earned during such week shall be excluded in computing the average weekly wage pursuant to this subdivision.

In computing claimant's average weekly wage for the purposes of determining her rate for temporary total disability, the administrative law judge did not consider claimant's earnings during the period of December 21, 1998. As the evidence showed that claimant worked less than her normal weekly hours during that period, the administrative law judge, in accordance with section 287.250.1(4) RSMo, considered claimant absent during that time. The majority, however, was unmoved by the substantial disparity in claimant's earnings during that period compared to the other periods. As such, the majority considered claimant's earnings during that time when making its determination regarding claimant's average weekly wage.

I find that the administrative law judge properly applied section 287.250.1(4) RSMo by disregarding claimant's earnings for the December 21, 1998 period. I would affirm the award of the administrative law judge in its entirety.

As the Commission majority has decided otherwise, I must respectfully dissent.

John J. Hickey, Member

AWARD

Employee: Pamela Bates (formerly Vester) Injury No. 99-013898

Dependents: ~~Before the~~

DIVISION OF WORKERS'

Employer: ~~COMPENSATION~~

Department of Labor and

Industrial Relations of Missouri

Additional Party: State Treasurer, as custodian of the Second Injury Fund
Jefferson City, Missouri

Insurer: Liberty Mutual Fire Insurance Company

Hearing Date: 10/5/04, 12/2/04 (finally submitted 1/27/05) Checked by: LEHB/bfb for df

FINDINGS OF FACT AND RULINGS OF LAW

1. Are any benefits awarded herein? Yes
2. Was the injury or occupational disease compensable under Chapter 287? Yes
3. Was there an accident or incident of occupational disease under the Law? Yes
4. Date of accident or onset of occupational disease: February 22 or 23, 1999
5. State location where accident occurred or occupational disease was contracted: St. Charles County, Missouri
6. Was above employee in employ of above employer at time of alleged accident or occupational disease?
Yes

7. Did employer receive proper notice? Yes

8. Did accident or occupational disease arise out of and in the course of the employment? Yes

9. Was claim for compensation filed within time required by Law? Yes

10. Was employer insured by above insurer? Yes

11. Describe work employee was doing and how accident occurred or occupational disease contracted:
Employee was carrying tubs of dishes, twisted, and suffered injury.

12. Did accident or occupational disease cause death? No Date of death? ----

13. Part(s) of body injured by accident or occupational disease: low back (body as a whole); and psych condition
aggravation (body as a whole)

14. Nature and extent of any permanent disability: 20% body as a whole referable to the low back; and 5% body
as a whole (referable to psych aggravation)

15. Compensation paid to-date for temporary disability: \$617.20

16. Value necessary medical aid paid to date by employer/insurer? See Award/Exhibits

17. Value necessary medical aid not furnished by employer/insurer? liability for past medical treatment, See
Award

18. Employee's average weekly wages: -----

19. Weekly compensation rate: \$82.02/\$127.00

20. Method wages computation: by Award

COMPENSATION PAYABLE

21.Amount of compensation payable: ----

Unpaid medical expenses: Liability for past medical treatment, See Award

1 1/7 weeks of temporary total disability (or temporary partial disability) \$ 93.74

Underpayment of temporary total disability \$ 648.25

20% body as a whole referable to the low back; and 5% body as a whole referable
to psych condition aggravation permanent partial disability from Employer . . . \$12,700.00

-----weeks of disfigurement from Employer

-----Permanent total disability benefits from Employer beginning , for
Claimant's lifetime

22. Second Injury Fund liability: Yes No Open

and, thereafter, for Claimant's lifetime

TOTAL: \$13,441.99; AND
LIABILITY FOR PAST
MEDICAL EXPENSES
(SEE AWARD)

23. Future requirements awarded: None

Said payments to begin as of the date of this Award and to be payable and be subject to modification and review as provided by law.

The compensation awarded to the claimant shall be subject to a lien in the amount of 25% of all payments hereunder in favor of the following attorney for necessary legal services rendered to the claimant:

Ray Gerritzen, Attorney for Claimant

FINDINGS OF FACT and RULINGS OF LAW:

Employee: Pamela Bates (formerly Vester)

Injury No: 99-013898

Before the
DIVISION OF WORKERS'
COMPENSATION
Department of Labor and Industrial Relations of Missouri
Jefferson City, Missouri

Dependents: ----

Employer: Ponderosa

Additional Party State Treasurer, as custodian of the Second Injury Fund

Insurer: Liberty Mutual Fire Insurance Company
Checked by: LEHB/bfb for df

This is a hearing involving the claimant, Pamela Vester (now Pamela Bates), with four cases being presented today in this hearing: Injury Numbers 98-126746, 98-174599, 99-013898, and 99-120559. In each of the cases, the claimant appeared in person and by counsel, Attorney Ray A. Gerritzen. In each of the first three cases (Injury Numbers 98-126746,

98-174599, 99-013898), the employer/insurer, Ponderosa/Liberty Mutual Insurance Company, appeared by and through counsel, Attorney Mary Flanagan-Dean; as to the last case, Injury Number 99-120559, that case against the employer/insurer was previously settled and the employer/insurer will not be present. In each of the four cases, the Second Injury Fund appeared by and through Assistant Attorney General Barbara Toepke.

The parties entered into certain stipulations, and agreements as to the issues and evidence to be presented in these cases.

STIPULATIONS – Injury Number 99-013898:

On or about February 22nd or 23rd, 1999: a. the claimant while in the employment of Ponderosa sustained an injury by accident arising out of and in the course of her employment occurring in St. Charles County, Missouri; b. the employer and employee were operating under and subject to the provisions of the Missouri Workers' Compensation Law; c. the employer's liability was insured by Liberty Mutual Fire Insurance Company.

d. The employer had notice of the injury. e. A Claim for Compensation was filed within the time prescribed by law.

f. Temporary total disability benefits have been paid; the payments of the temporary total disability benefits in this case are set forth in Joint Exhibit 1-A offered by the employee and employer/insurer; this exhibit also sets forth the payments made as a result of the temporary total disability benefits.

ISSUES – Injury Number 99-013898:

1. Liability of past medical expenses
2. Future medical care
3. Wage and rate
 - a. Whether or not there was an underpayment of the temporary total disability benefits based upon the computed rate
4. Nature and extent of past temporary total disability for two periods - first period is March 29, 1999 through April 5, 1999, and second period is August 28, 1999 through September 19, 1999
5. Nature and extent of permanent disability, whether partial or total
6. Liability of the Second Injury Fund.

EXHIBITS – Injury Number 99-013898:

The following exhibits were admitted into evidence^[1]:

Claimant's Exhibits:

No. A: Deposition transcript of Robert P. Poetz, D.O. taken on behalf of the claimant on September 23, 2004 (with deposition exhibits attached – his curriculum vitae, Deposition Exhibit A; his report of August 30, 2001, Deposition Exhibit B; his report of May 15, 2003, Deposition Employee Exhibit C; and his report of September 15, 2004, Deposition Exhibit D) (Admitted subject to the employer/insurer objections therein)

No. B: Certified medical records of Barnes Jewish St. Peters Hospital, certified May 8, 2000 (13 pages)

No. B-1: Certified medical records of Barnes Jewish St. Peters Hospital, certified May 15, 2002 (8 pages)

No. B-2: Certified medical records of Barnes Jewish St. Peters Hospital, certified April 14, 2000 (20 pages)

No. C: Certified medical records of Thomas Cabrera, M.D., certified February 12, 2002 (13 pages)

No. D: NOT ADMITTED (November 7, 2002 report of Richard A. Koelling, D.C.)

No. E: 05/07/99 MRI of the lumbar spine from Open MRI of America

No. F: 01/30/02 MRI of the lumbar spine without contrast from Open MRI of America

No. G: Certified medical records of St. Joseph Health Center, St. Charles, certified March 27, 2002 (149 pages)

No. G-1: Certified medical records of St. Joseph Health Center in St. Charles, certified October 7, 2002 (9 pages)

No. H: Itemized list of medical bills as to Ponderosa, totaling \$10,059.73

No. I: WITHDRAWN

No. J: Certified medical records of Susan Albers, D.C., certified 9-30-99 (11 pages)

No. K: Certified medical records of HealthSouth in Cave Springs, certified April 26, 2000 (68 pages)

No. L: Certified medical records of Saaid Khojasteh, M.D., certified March 20, 2002 (5 pages)

No. M: St. Charles County Ambulance report of 6-11-99

No. N: Certified medical records of St. Peters Bone and Joint Surgery/Terrence Piper, M.D., certified January 13, 2000 (2 pages)

- No. N-1: 03-14-01 report of Terrence Piper, M.D.
- No. O: Certified medical records of Robert Yanover, M.D., certified November 26, 2001 (5 pages)
- No. 0-1: Certified medical records of Robert Yanover, M.D., certified September 22, 2003 (3 pages)
- No. P: Copies of pay checks (Admitted only in 99-013898)

Joint Exhibit:

- No. 1-A: Document entitled – “Work Missed Due to Injury at Ponderosa Steak House” (with redactions)

Employer/Insurer’s Exhibits:

- No. 1: Dr. Randolph’s reports
- No. 2: Dr. Randolph’s curriculum vitae
- No. 3: Dr. Stillings’ report
- No. 4: Dr. Stillings’ curriculum vitae
- No. 5: Dr. Albers’ records (Duplicative of CI’s J)
- No. 6: Barnes Jewish Hospital St. Peters records (Duplicative of CI’s B, B-1 and B-2)
- No. 7: BJC Corporate Health St. Peters records (Duplicative of CI’s B, B-1 and B-2)
- No. 8: Dr. Thomas Cabrera’s records (Duplicative of CI’s C)
- No. 9: Dr. Saaid Khojasteh record (Duplicative of CI’s L)
- No. 10: Dr. Catherine Dean’s records
- No. 11: HealthSouth’s records
- No. 12: Dr. Koelling’s treatment records (the November 7, 2002 report is withdrawn and will not be considered in this Award)
- No. 13: (**Ruling:** It is found that this exhibit described as Dr. Lange’s treatment records consists mainly of examination reports with conclusions written by doctors to the workers’ compensation insurance company; the claimant’s objections to this portion of the exhibit on grounds of hearsay are sustained, and these reports are not admitted into evidence. It is further found that the remainder of the exhibit of treatment entries and physical therapy daily notes are admitted into evidence.)
- No. 14: NYDIC Open MRI of America St. Peters records
- No. 15: St. Charles County Ambulance records
- No. 16: St. Joseph Health Center records
- No. 17: Records of Dr. Paul M. Spezia, D.O.
- No. 18: WITHDRAWN
- No. 19: Dr. Weber’s records
- No. 20: Records of The Work Center, Inc.
- No. 21: Dr. Yanover’s records
- No. 22: (WITHDRAWN)
- No. 23: (WITHDRAWN)
- No. 24: Deposition transcript of Dr. Bernard Randolph, M.D. taken on behalf of the employer/insurer on July 29, 2004 (and attached exhibits) (Admitted subject to the objections therein)
- No. 25: Deposition transcript of Dr. Wayne A. Stillings, M.D. taken on behalf of employer Ponderosa on March 22, 2004 (with attached exhibits) (Admitted subject to the objections therein)
- No. 26: (**Ruling:** It is found that this exhibit described as Dr. Lange’s certified records consists mainly of examination reports with conclusions written by doctors to the workers’ compensation insurance company; the claimant’s objections on grounds of hearsay to this portion of the exhibit is sustained, and these reports are not admitted into evidence. It is further found that the remainder of the exhibit of treatment entries and physical therapy daily notes are admitted into evidence.)
- No. 27: Records of Parkcrest Surgical Associates, Inc. (**Ruling:** Claimant’s objection to the admission of the last sentence of June 30, 1999 report on grounds – have a right to cross examine – is overruled)
- No. 28: W-2 forms of the employee with a business records affidavit (Claimant’s objection was withdrawn)
- No. 29: Wage information
- No. 30: Medical bills paid by employer and insurer (STIPULATION BY THE EMPLOYER/INSURER: As I mentioned submitting Employer-Insurer’s Exhibit Number 30, I’m willing to hold claimant harmless on behalf of my client for the medical bills listed in Exhibit 30 because it is our understanding that these have been paid.)

Second Injury Fund Exhibits:

- Roman Numeral I: Stipulation for Compromise Settlement for Injury Number 99-120559. (Admitted into evidence in all four cases)
- Roman Numeral II: Deposition transcript of Dr. Randolph (duplicative of Number 24 that was offered by the employer in

the first three cases; offered by Second Injury Fund in Injury Number 99-120559 for the Second Injury Fund) (Admitted subject to the objections therein)

Roman Numeral III: Report of James England (Claimant's stipulation: James England would testify per his report, but does not agree to the contents of the report) (Admitted into evidence in all four cases)

Roman Numeral IV: Records of St. Peters Bone and Joint (Duplicative of Number 17 that was offered by the employer in the first three cases; offered by Second Injury Fund in fourth case, Injury Number 99-120559)

FINDINGS OF FACTS AND RULINGS OF LAW
Injury Number 99-013898

ISSUES – Injury Number 99-013898: Wage and rate, and Whether or not there was an underpayment of the temporary total disability benefits based upon the computed rate

Pamela Sue Bates (formerly Vester^[2]), the claimant, testified that she was born on 01/18/80. I graduated from high school in May, 1999, she said. I had no other training after that, Bates stated, no college or vocational school of any kind. I first went to work for Ponderosa in 1997, Bates testified, I was seventeen years old at the time. My job was server/back bar; I guess it was the salad bar area, Bates stated. She agreed that she was a trainee and there were adults that worked there that made more than she did. When I started I was part-time, the claimant said, I was in a program in high school where I had to have at least twenty hours of work.

In 1998 I was working roughly twenty hours a week; sometimes a little more, depending on if I had to work on the weekends, the claimant stated. I became eighteen in 1998, Bates agreed. Three months before November 1, 1998, I was making about \$1.19 an hour plus tips, the claimant said. But when I worked the salad bar, I made about \$6.25 because I wasn't making tips then, she said, but when I was serving I made roughly \$1.19 and tips; I probably, on a regular day, had maybe five or six tables that I would tend to, and I'd probably make about three to four dollars in tips, each table, Bates stated. I would say in a regular day I would come out with forty to fifty dollars in tips, the claimant testified. I got out of school early to go to work, so I worked roughly five to six hours, she said. Bates agreed that she therefore got about \$8.00 an hour in tips. We also got discounted food of ten percent off the regular price, but I didn't eat there very often, maybe once a week, the claimant said. She agreed that this had little or no value to her. Bates agreed that it would be fair to say that she thought she was making about \$9.19 an hour for twenty hours a week. I think some of the older people that worked there who did my same job worked forty hours a week, Bates stated. She was asked if it would be the same thing for them, would they make about the same amount in tips. They would make more, they had more hours there, but, yeah, Bates answered. She agreed that they got W-2's from Ponderosa. The claimant was asked if the W-2's properly reflected her tips. Actually, I was told -- the manager that was working with me, they told me not to claim all our tips, Bates stated. She agreed that the numbers on the W-2's did not really show her whole income. The tips were in cash, Bates said.

The claimant agreed that she and her attorney looked for her copies of W-2's and her attorney did not have any. Bates was shown Exhibit P, and she agreed that it was 13 pages of the paychecks she got from Liberty Mutual marked as TTD for the injury of 02/22/99; she agreed that the document indicated that they figured her TTD rate at \$40.00 per week, or saying she made only \$60.00 a week while working at Ponderosa. Bates agreed that she was testifying that she in fact made roughly \$50.00 a night in tips alone. When queried if this would be \$200.00 for four nights a week, Bates responded - It varied, but most of the time, yeah, four times a week, so that would be a fair average. She agreed that she was saying she earned \$200.00 in tips a week, and in addition to that she made \$2.13 an hour which was \$42.60 more for the twenty hours she worked. So, the claimant was asked, her actual gross pay then for a week in 1999 was \$242.60 a week. Yeah, I think so, regardless of what the W-2 says, she answered. Indicating that her rate should have been \$161.73 per week, Bates agreed that instead of paying her \$161.73 a week, they paid her \$40.00 a week, and thus they shorted her \$121.74 a week for every one of those weeks they paid her on that record.

Bates agreed that at the time of her third injury on February 23, 1999 she was making about the same wages and working the same hours as she was in 1998. The same was true regarding full-time people that were working there as opposed to me that was part-time, Bates agreed. I really don't know how much some of them were making, some of them didn't share that information with others, she further stated. I knew they were making more than me, Bates stated. She was asked, as a minor would she have made more as she got older doing that same job. Yeah, probably, Bates answered, because if I would have chosen to go full time, yes, I would have been making more. She was asked if full time people get more than the \$1.19 an hour. That I'm not sure; I don't know what they made an hour, Bates answered. She agreed that she thought they got more tips, and explained that it was because they're there longer during the day, they had more time to make more tips during the day. When asked how much would she expect her salary to go up if she worked forty hours versus twenty hours. It's hard to say because it all depends on the hours, Bates responded, I would say if they were working open to close,

then, probably double, at least. This Ponderosa where I worked is still there, the claimant said, when I worked there it was a pretty steady flow of customers. The claimant was asked, when you looked at your W-2's and you knew they were short, did you ever tell somebody - what the heck is going on, I made more than this? No, Bates answered, because being a teenager I really wasn't thinking about it, I didn't pay attention to it.

Bates stated that her salary was roughly the same in December of 1998 as it was in November 1998 -- \$1.19 an hour plus \$50.00 a week in tips working twenty hours a week. She later agreed, though, that she had made a mistake in her wages; Bates testified - I stated that I made \$1.19 an hour, but actually I made \$2.13 an hour plus the tips. I have no idea where the \$1.19 came from, to tell you the truth, the claimant stated, I am so sorry about that.

During cross examination, Bates agreed that she had stated she worked about twenty hours a week at Ponderosa, and worked as a server and as a filler of the salad bar. Also I worked another position there of host maybe every now and then, the claimant said, but nothing else really. I was a majority of the time a server, she said, about ninety, ninety-five percent of the time. Bates agreed that when she worked filling the salad bar, she did not receive tips. When asked if she had said she earned \$5.50 an hour filling the salad bar, Bates responded - I'm not positive on how much. Bates was shown W-2 forms marked as Employer-Insurer's Exhibit Number 28. She was asked if she had any reason to disagree with the figures that were reported on those W-2 forms. To tell you the truth, I don't know exactly what I'm looking at, Bates answered, I was a teenager, I didn't ever look at this stuff really. I guess they're fine, Bates stated after reviewing the exhibit. No, the claimant said, I don't have any reason to disagree with the amounts, the totals in those W-2 forms, I don't know.

During redirect examination, Bates admitted that she does not know how to read a W-2, so she cannot say if it is right or wrong. It was noted that the exhibit, No. 28, indicated that her total wages in 1999 were \$729.00. Bates stated that she really did not know how much that represented in time, or what it was supposed to represent in the way of hours. She agreed that her total wages were \$2.13 an hour. I do not really know how many hours I worked in 1999 for Ponderosa, Bates said. It was noted that exhibit No. 28 indicated Bates only had tips of \$409.79 for the whole year of 1999, which would translate to about \$8.00 a week. That does not at all make sense to me, I know that, Bates said. The claimant stated that she worked for Ponderosa all of January 1999 up to February 23, 1999. February 23, 1999 was the date I injured my back, she said. She agreed that, therefore she worked for Ponderosa about fifty-four days; she agreed that she worked roughly four days a week. I was off February 23, 1999 to --my first day back was April 6, 1999, Bates testified. That was actually the only date that I worked was April 6, 1999 until I had more back pain while at work; I left early and went back home again, she said. I went back to work again for Ponderosa on June 30, 1999, I think, and worked until August 27, 1999. So, she agreed, it was about the same length of time that she had done in the beginning of the year, July to August 27th, or about fifty-eight days again. I went to work on August 29, 1999 but was sent home right away, she stated, so I did not work at all that day. Then I resigned on 9-10-99. She was asked what happened August 29, 1999 up to September 10, 1999, and Bates responded -- I didn't work at all due to back pain, I couldn't. Bates agreed that, therefore, the 1999 represented at the most anywhere between fourteen and sixteen weeks of work. It was noted that if you took fourteen weeks into \$409.00 (dropping the cents), that calculates to about \$28.00 a week total in tips. That would sound accurate, Bates stated. The claimant then testified -- No, probably more like -- in a week, closer to about \$200.00 or so. She then agreed that the W-2 was way off as far as she was concerned. It is clear to me that this W-2 does not properly reflect what I made at Ponderosa, Bates stated.

It is found that, notwithstanding the claimant's testimony of the additional amount of money she made in salary and tips at Ponderosa (the claimant specifically stated that ten percent off the regular price of a meal for employees was of little or no value to her as she eat at Ponderosa very often, maybe once a week), the claimant presented no evidence in support of her allegations. Furthermore, during cross examination, the claimant stated that she had no reason to disagree with the amounts and totals in the W-2 form. It is found that the 1999 W-2 form (No. 28) and the wage statement (No. 29) are competent evidence of the claimant's wage at the pertinent time of the February 22 or 23, 1999 work related accident herein.

The parameters for determining a rate for benefits in Missouri Workers' Compensation Law are set forth in Section 287.250 RSMo., which states:

287.250. 1. Except as otherwise provided for in this chapter, the method of computing an injured employee's average weekly earnings which will serve as the basis for compensation provided for in this chapter shall be as follows:

(1) If the wages are fixed by the week, the amount so fixed shall be the average weekly wage;

(2) If the wages are fixed by the month, the average weekly wage shall be the monthly wage so fixed multiplied by twelve and divided by fifty-two;

(3) If the wages are fixed by the year, the average weekly wage shall be the yearly wage fixed divided by fifty-two;

(4) If the wages were fixed by the day, hour, or by the output of the employee, the average weekly wage shall be computed by dividing by thirteen the wages earned while actually employed by the employer in each of the last thirteen calendar weeks immediately preceding the week in which the employee was injured or if actually employed by the employer for less than thirteen weeks, by the number of calendar weeks, or any portion of a week, during which the employee was actually employed by the employer. For purposes of computing the average weekly wage pursuant to this subdivision, absence of five regular or scheduled work days, even if not in the same calendar week, shall be considered as absence for a calendar week. If the employee commenced employment on a day other than the beginning of a calendar week, such calendar week and the wages earned during such week shall be excluded in computing the average weekly wage pursuant to this subdivision;

(5) If the employee has been employed less than two calendar weeks immediately preceding the injury, the employee's weekly wage shall be considered to be equivalent to the average weekly wage prevailing in the same or similar employment at the time of the injury, except if the employer has agreed to a certain hourly wage, then the hourly wage agreed upon multiplied by the number of weekly hours scheduled shall be the employee's average weekly wage;

(6) If the hourly wage has not been fixed or cannot be ascertained, or the employee earned no wage, the wage for the purpose of calculating compensation shall be taken to be the usual wage for similar services where such services are rendered by paid employees of the employer or any other employer;

(7) In computing the average weekly wage pursuant to subdivisions (1) to (6) of this subsection, an employee shall be considered to have been actually employed for only those weeks in which labor is actually performed by the employee for the employer and wages are actually paid by the employer as compensation for such labor.

2. For purposes of this section, the term "gross wages" includes, in addition to money payments for services rendered, the reasonable value of board, rent, housing, lodging or similar advance received from the employer, except if such benefits continue to be provided during the period of the disability, then the value of such benefits shall not be considered in calculating the average weekly wage of the employee. The term "wages", as used in this section, includes the value of any gratuities received in the course of employment from persons other than the employer to the extent that such gratuities are reported for income tax purposes. "Wages", as used in this section, does not include fringe benefits such as retirement, pension, health and welfare, life insurance, training, Social Security or other employee or dependent benefit plan furnished by the employer for the benefit of the employee. Any wages paid to helpers or any money paid by the employer to the employee to cover any special expenses incurred by the employee because of the nature of his employment shall not be included in wages.

3. If an employee is hired by the employer for less than the number of hours per week needed to be classified as a full-time or regular employee, benefits computed for purposes of this chapter for permanent partial disability, permanent total disability and death benefits shall be based upon the average weekly wage of a full-time or regular employee engaged by the employer to perform work of the same or similar nature and at the number of hours per week required by the employer to classify the employee as a full-time or regular employee, but such computation shall not be based on less than thirty hours per week.

4. If pursuant to this section the average weekly wage cannot fairly and justly be determined by the formulas provided in subsections 1 to 3 of this section, the division or the commission may determine the average weekly wage in such manner and by such method as, in the opinion of the division or the commission, based upon the exceptional facts presented, fairly determine such employee's average weekly wage.

5. In computing the compensation to be paid to an employee, who, before the injury for which the employee claims compensation, was disabled and drawing compensation under the provisions of this chapter, the compensation for each subsequent injury shall be apportioned according to the proportion of incapacity and disability caused by the respective injuries which the employee may have suffered.

6. For purposes of establishing a rate of compensation applicable only to permanent partial disability, permanent total disability and death benefits, pursuant to this chapter, the average weekly wage for an employee who is under the age of twenty-one years shall be adjusted to take into consideration the increased earning power of such employee until she or he attains the age of twenty-one years and the average weekly wage for an employee who is an apprentice or a trainee, and whose earnings would reasonably be expected to increase, shall be adjusted to reflect a level of expected increase, based upon completion of apprenticeship or traineeship, provided that such adjustment

of the average weekly wage shall not consider expected increase for a period occurring more than three years after the date of the injury.

7. In all cases in which it is found by the division or the commission that the employer knowingly employed a minor in violation of the child labor laws of this state, a fifty percent additional compensation shall be allowed.

8. For an employee with multiple employments, as to the employee's entitlement to any temporary total or temporary partial disability benefits only pursuant to subsection 9 of section 287.220, and for no other purposes, the employee's total average weekly wage shall be equal to the sum of the total of the average weekly wage computed separately for each employment pursuant to the provisions of this section to which the employee is unable to return because of this injury.

9. The parties, by agreement and with approval of an administrative law judge, legal advisor or the commission, may enter into a compromise lump sum settlement in either permanent total or permanent partial disability cases which prorates the lump sum settlement over the life expectancy of the injured worker. When such an agreement has been approved, neither the weekly compensation rate paid throughout the case nor the maximum statutory weekly rate applicable to the injury shall apply. No compensation rate shall exceed the maximum statutory weekly rate as of the date of the injury. Instead, the prorated rate set forth in the approved settlement documents shall control and become the rate for that case. This section shall be retroactive in effect.

In light of the evidence presented, Subsection 3 must be considered. The claimant testified that she thought some of the older people that worked at Ponderosa who did her same job worked forty hours a week. They would make more, they had more hours there, yeah, Bates said. No further evidence was presented. It is found that a determination that Ponderosa had full-time employees or that the claimant was not a regular employee would be speculative, and thus this section of the statute cannot be used.

There is competent evidence presented, it is found, to make a determination of the temporary total disability benefit rate under Subsection 1(6) by the wage statement (Employer/Insurer's No. 29). Considering the weeks preceding the week of the 02/22 or 23/99 work related injury, it is found that the wage statement reveals:

<u>Period Ending Date</u>	<u>Wage Amount</u>
11/09/98 (1/2)	\$81.69
11/23/98	\$336.18
12/07/98	\$246.08
01/04/99	\$196.76
01/18/99	\$228.27
02/01/99	\$222.62
02/15/99	<u>\$287.72</u>
TOTAL:	\$1599.32

Period 12/21/98 was dropped as it showed less than the normal number of weekly work hours (27.99 – 40.35 hours per bi-weekly), thus the claimant is considered absent for that calendar week. Thus, \$1599.32 divided by 13 weeks = \$123.03/week; \$123.03/week x 2/3 = \$82.02/week. It is found that the competent and substantial evidence establishes a rate for temporary total disability of \$82.02/week.

It is found that the competent evidence indicates that a determination of a permanent partial disability rate should be made under Subsection 6. The claimant gave undisputed testimony that she was born on January 18, 1980. Thus on the day of the February 22 or 23, 1999 work related injury herein, the claimant was nineteen (19) years old. In discussing an injury at her employer, Developmental Learning Center, on September 30, 1999, Bates testified about the settlement of this case, and read from the copy of the Stipulation for Compromise Settlement which was admitted into evidence (Roman Numeral I). This Stipulation for Compromise Settlement, which was approved by an administrative law judge, reflects a weekly compensation rate of \$127.00. An approval of a settlement by the commission or an ALJ is a prerequisite to its validity; a settlement approved by the ALJ is conclusive. *Conley v. Treasurer of Missouri*, 999 S.W.2d 269, 274 (Mo.App. E.D., 1999). Even under the most liberal determination of a rate under Subsection 1 (i.e. considering the preceding weeks of 02/15/99 back to 11/09/98 (the last discernable week on CI's No 29) and dropping the two-week periods of 12/21/98 and 12/07/98 where it was indicated the claimant worked less than her usual full week, the rate would be: \$1434.93 divided by 12 weeks = \$119.58/week; \$119.58/week x 2/3 = \$79.725/week rate), the law per Subsection 6 allows for consideration of an increased earning power of an employee who is under the age of twenty-one on the date of the work related injury up to three years

subsequent. It is found that there is competent evidence establishing an increased earning power for the claimant in September 1999 when the claimant was nineteen years old; it is found that the substantial competent evidence establishes a rate for permanent partial disability of \$127.00/week.

ISSUE – Injury Number 99-013898: Nature and extent of past temporary total disability for two periods - first period is March 29, 1999 through April 5, 1999, and second period is August 28, 1999 through September 19, 1999; and Whether or not there was an underpayment of the temporary total disability

I do not really know how many hours I worked in 1999 for Ponderosa, Bates said. The claimant stated that she worked for Ponderosa all of January 1999 up to February 23, 1999. February 23, 1999 was the date I injured my back, she said. I was off February 23, 1999 to --my first day back was April 6, 1999, Bates testified. That was actually the only date that I worked was April 6, 1999 until I had more back pain while at work; I left early and went back home again, she said. I went back to work again for Ponderosa on June 30, 1999, I think, and worked until August 27, 1999. I went to work on August 29, 1999 but was sent home right away, she stated, so I did not work at all that day. Then I resigned on 9-10-99. She was asked what happened August 29, 1999 up to September 10, 1999, and Bates responded -- I didn't work at all due to back pain, I couldn't.

Testifying further as to how long she was off work after the February 23, 1999 injury, Bates stated - I know I missed fifteen days of school, I wasn't able to get out of bed really very well, so, I guess, I missed at least fifteen days of work then also. Bates stated that she was not paid the whole time she was off of work. I didn't have any vacation time or anything like that, I was just a part-time employee, so I didn't have any benefits, she said. The periods placed in issue by the parties were noted as - March 29, 1999 through April 5, 1999, and August 28, 1999 through September 19, 1999. Bates stated that she was off during those periods due to her back injuries. The second time it was flaring up again, same thing, she said. I couldn't work in those periods because of my back, I wasn't able to move very well, she said. I was off because my neck was also hurting, Bates stated.

Bates testified that she quit her employment at Ponderosa. I didn't want to but I quit, she said, I felt harassed. I went back to work, Dr. Spezia released me for light duty or off work, but I wanted to go back to work, so I went back on light duty and light duty ended up being the biggest section in the restaurant, she said. I was all by myself in the biggest section of the restaurant; and I was the closer, which the closer ends up having more duties to clean up; I was responsible to do that; so in my opinion that is being harassed, Bates testified. It was not at all light duty, she stated. Agreeing that she told them about it, Bates testified - I said something to Jo Garcia, I asked her if this was light duty, and she said, yes, if you need help, just let us know. When asked if she had asked for help, Bates answered - I was doing alright for a while without having much pain in my back until towards the end when it started hurting again, and by that time I figured, well, I only got an hour left to work, I'll just do it and go home. So I didn't -- I said something to her, I said it was bothering me, but by that time most of the employees had left to go home, so there wasn't too many people to help me, the claimant said. Bates agreed that this happened just one night only. I did resign, I'm not sure of the date; it was 1999, Bates stated.

The claimant testified about problems and treatment she had for her back which she related to the 02/22 or 23/99 work related injury. The Summer of 1999 I was nineteen, Bates said, and because of my back I barely made it to my prom. In fact, I couldn't go shopping for a dress because it was too much walking, it was too soon after the injury, and my mom ended up making my dress, she said. Once I got to the dance, I wasn't able to dance, I was just kind of sitting there like a bump on the log, Bates stated. I was lucky to stand much less dance at my high school prom, Bates testified, because of the problem with my back, it was still hurting way too much at that time. Also in the Summer of 1999, a couple girlfriends and myself planned our own little senior trip and we were going to go there for two weeks, I think, and stay in a friend of mine's aunt's place there; the day before we were supposed to leave, I hurt my back again, so I was unable to go for the full two weeks, Bates stated. Explaining what she meant by hurt her back again, Bates stated that they had gone grocery shopping for the weeks to come; I went with them but I didn't help them put groceries in the cart, they knew what my problem was, too, she said. Shopping was quite a bit of walking but I was feeling okay enough to keep going, but when I finally got home I kind of laid down on the floor to rest my back for a little while, and I had put my knees up, laying down on the floor with my back on the floor, and I raised my knees and I just lifted my right foot just an inch off the floor and I was screaming in pain; it was just as though it was all over again, the claimant said. So I missed a lot of our trip because of that, she stated. My family was going on a family vacation to Table Rock Lake, and there we usually we spend a lot of time in the water water-skiing and tubing, things of that sort; I am unable to do those things now because of the injury, Bates testified. I was a slalomer, too, one ski, the claimant said. I have not done any water-skiing since February at Ponderosa, Bates said. I use to exercise, but because of the injury at Ponderosa in February of 1999 I'm scared of even trying to exercise now because I don't want the bad pain anymore, the claimant said. There are a few back exercises that the doctor gave me that I've tried, didn't really seem to help though very much, she stated.

It was agreed and stipulated by the employee and employer/insurer that temporary total disability benefits have been paid as set forth in Joint Exhibit 1-A. This document was entitled "Work Missed Due to Injury at Ponderosa Steak House" (Joint Exhibit No. 1-A), and reflected two periods of temporary total disability benefit payments: a. 02/26/99 – 03/28/99, total paid \$177.20; and b. 04/15/99 – 06/30/99, total paid \$440.00. The document indicated a total of \$617.20 paid in temporary total disability benefits to the claimant. There was a discussion at the hearing that in the February, 1999 case there was a total of \$1,230.54 in benefits paid, but it is found that the evidence reflects and the stipulation is as set forth in Joint Exhibit No. 1-A, again a total of \$617.20 paid in temporary total disability benefits to the claimant. It should be noted that Claimant's Exhibit No. P reflects the same dates and amounts of payments of temporary total disability payments as reflected in Joint Exhibit No. 1-A, except No. P does not include the final pay period of 6/24/99-6/30/99=\$40.00 reflected in No. 1-A (?dropped page?).

It is found that based on the determination of the temporary total disability rate in this Award, there has been an underpayment of the temporary total disability periods not in dispute. It is found that for the agreed and stipulated periods of temporary total disability benefits of 02/26/99 – 03/28/99 and 04/15/99 – 06/30/99, the correct benefit payment should be, respectively: $(4 \frac{3}{7} \text{ weeks} \times \$82.02/\text{week} = \$363.23) + (11 \text{ weeks} \times \$82.02/\text{week} = \$902.22) = \1265.45 . The stipulated-to document, Joint Exhibit No 1-A, was found to be controlling, and reflects that a total of \$617.20 was paid to the claimant for these periods. Thus it is found that there was an underpayment of temporary total disability benefits for the periods not in issue of: $\$1265.45 - \$617.20 = \$648.25$.

Also at issue is whether or not there is temporary total disability owed for two periods – a. 03/29/99 through 04/05/99, and 08/28/99 through 09/19/99. Section 287.020.7 RSMo defines the term "total disability" as an "inability to return to any employment and not merely mean inability to return to the employment in which the employee was engaged at the time of the accident". "Temporary total disability" is not defined by the workers' compensation statute, but is intended to be an award to cover a healing period and is a benefit granted only for the time prior to when the employee can return to work; an award for temporary total disability is not intended to encompass disability after the condition has reached the point where further progress is not expected. *See, Williams V. Pillsbury Co.*, 694 S.W.2d 488, 489 (Mo.App. E.D. 1985). The claimant's testimony of an inability to work during treatment for the work-related injury with corroborating medical evidence constitutes substantial evidence on which to award temporary total disability benefits. *See, generally, Patterson v. Engineering Evaluations*, 913 S.W.2d 344, 347 (Mo.App. E.D. 1995).

The claimant, admittedly a poor historian, gave various dates as to when she was unable to work after the February 22 or 23, 1999 work related accident, but ultimately testified that the periods of March 29, 1999 through April 5, 1999 and August 28, 1999 through September 19, 1999 were the days she was off due to her back injuries. The second time it was flaring up again, same thing, she said. I couldn't work in those periods because of my back, I wasn't able to move very well, Bates stated. I was off because my neck was also hurting, the claimant said. I went to work on August 29, 1999 but was sent home right away, Bates testified, so I did not work at all that day. Then I resigned on 9-10-99. I didn't work at all between August 29, 1999 up to September 10, 1999 due to back pain, the claimant said, I couldn't.

Bates testified that she quit her employment at Ponderosa because she felt harassed. I went back to work, Dr. Spezia released me for light duty or off work, but I wanted to go back to work, so I went back on light duty and light duty ended up being the biggest section in the restaurant, she said. I was all by myself in the biggest section of the restaurant; and I was the closer, which the closer ends up having more duties to clean up; I was responsible to do that; so in my opinion that is being harassed, Bates testified. It was not at all light duty, she stated. Agreeing that she told them about it, Bates testified - I said something to Jo Garcia, I asked her if this was light duty, and she said, yes, if you need help, just let us know. I was doing alright for a while without having much pain in my back until towards the end when it started hurting again, and by that time I figured, well, I only got an hour left to work, I'll just do it and go home. So I didn't -- I said something to her, I said it was bothering me, but by that time most of the employees had left to go home, so there wasn't too many people to help me, the claimant said. Bates agreed that this happened just one night only. I did resign, she said.

Considering the medical evidence, medical records of **Barnes Jewish St. Peters Hospital** (No. B-2; See, also No. 6) included records of emergency room treatment of Bates on 02/26/99, and 06/11/99. The 02/26/99 record noted a relayed history of injury from Bates of: "Fell 3 wks ago @ work –landing on butt. Has had back pain off & on since then. On 2/21/99 @ work while carrying 'bus tubs' back pain became severe. C/o (increased) pain (with) movement or ambulation. The doctor's written examination findings were somewhat illegible, but appeared to include: Low back midline tenderness plus right SI area; straight leg was negative on the left and positive on the right at about 80 degrees; reflexes, sensory and toe ??? within normal limits. Dr. Pinto's diagnosis was: Low back pain. An excuse from work for 2 days was included in the record as well as instruction to follow up with private physician.

Records of **Dr. Paul M. Spezia, D.O. of St. Peters Bone & Joint Surgery** (No. 17) indicated that the doctor saw

Bates for the first time on 03/01/99. The doctor wrote that Bates had back pain; it was written that Bates had fallen at work at Ponderosa in October of 1998, and had fallen again, apparently slipping, about 3 weeks earlier, and then had a third episode of back pain the Tuesday before when she went to pick up a bus tub and she felt some pain in her back. Dr. Spezia further wrote; "Denies numbness or tingling. Denies any bowel or bladder problems. She denies any fevers or chills. Full orthopedic history was reviewed and signed by myself. She is active and likes to do crunches. Leg raises and push ups. She has no bad habits." Physical exam findings included: in no acute distress; sitting in a wheel chair, states she has not been able to walk well since the last episode of back pain; x-rays from prior Friday taken at the emergency room were negative; minimal paravertebral muscle spasm; some point tenderness in the PSIS joints right greater than left; negative seated straight leg raise; negative lying straight leg raise; 5+/5+ strength quads, hamstrings, foot inversion, eversion, dorsiflexion, plantar flexion; DTR's were 2+/4+ and equal bilaterally; sensation was intact to light touch. Dr. Spezia's assessment on 03/01/99 was: mechanical low back strain, acute. Treatment plans included trigger point injection, and physical therapy. A 03/19/99 entry stated that the appointment had been cancelled because Bates the facility was not a provider for the work comp company.

Medical records of **Susan Albers, D.C.** (No. J; See, also No. 5) indicated that Bates was a new patient treated on 04/30/99 for complaints of low back pain; in a form completed by Bates, she indicated other complaints of - neck pain. In an Ancillary Treatment Summary, the doctor noted the Chief Complaint as: "LBP & @ leg pain (constant) since last night". A General History was also written in the Ancillary Treatment Summary sheet, and included: "Feb. lifted a big tub of dishes & felt immediate pain in L/B - after LB tx from P.T. (20 visits) pt. gets better for awhile then exacerbates Pt. had 'shot' @ Dr's office 1 time." The record indicated treatment consisted of x-rays, and with manipulation and ultrasound. In a prescription form dated 04/30/99, the doctor wrote her recommendation of changing medication from Aleve to Ibuprofen, ice and wear a back support at all times except in bed. A 05/01/99 record reflected that Bates was again treated on that date; it as noted in the entry that the doctor had a conversation with Bates and her mother to explain the x-rays; in the final entries of 05/04/99 and 05/05/99, it was written that Bates missed an appointment, and when called the next day her mother relayed that Bates was following treatment recommendations of Dr. Long and that Dr. Long had returned Bates to work on light duty, though the employer had given her the longest area with lifting. Dr. Albers completed a form in which she indicated Bates had lower back pain and swelling in lower back, and that an accident had occurred on 02/30/99, the accident being - lifting a heavy tub of dishes at work.

Records of **Parkcrest Surgical Associates, Inc.** (No. 27) indicated that Bates was seen for the first time on May 18, 1999; Bates' chief complaint was - low back pain. It was noted that Bates was evaluated in the presence of her mother. The doctor wrote:

Patient denies significant problems with her back prior to the alleged work-related injury of 02/23/1999. She had fallen approximately 1 year prior to this while employed at Ponderosa. She apparently had some very minimal difficulties at that time. She currently works as a waitress at Ponderosa 20 hours weekly, and she is a senior in high school. She reports that on the date of the injury, she picked up a heavy bus tub and when someone called her name, she twisted and developed a sharp shooting pain in the right side of her low back.

The doctor's assessment on 05/18/99 was:

Patient has continued complaints of low back pain with a small disc extrusion at the L5-S1 level. She does not appear to be a surgical candidate. Her symptoms are improving with physical therapy. We discussed other alternative therapies including epidural steroid injections and continued anti-inflammatory medication on a regular basis. The risks and benefits of each were discussed. The patient elected to continue in physical therapy and begin anti-inflammatory medications. She currently is not interested in any epidural steroid injections. She's graduating from high school in approximately 2 ½ weeks. She'll continue in physical therapy for 2 weeks and be off work for another 2-3 weeks. At that time, I anticipate the restrictions for 2 weeks and eventually to full duty within approximately 4-5 weeks.

In the next entry of June 8, 1999, it was written that Bates had undergone physical therapy and was making good improvement. The assessment on June 8, 1999 was that Bates had made marked improvement with physical therapy and could currently return to work with restrictions of no lifting greater than 30 lbs. However, we're recommending functional capacity evaluation to assess whether she's going to be able to return to full duties as a waitress, the doctor wrote.

The Barnes Jewish St. Peters Hospital 06/11/99 emergency room record noted that Bates was working at Ponderosa. The patient history/nursing assessment indicated Bates presented with back pain, and had a history of back problems; it was noted that the back pain had increased that day, and that Bates had come via ambulance^[3]. Further written was: c/o severe low back pain, worsened today. Radiates down (right) leg. Denies numbness; tingling. States pain worsened when attempted

to cross leg. Rates pain 10 in series 1-10. Crying/shaking.” The doctor’s written history basically was:

19 year old white female with complaints of back pain with pain greatest right side of midline with radiation to right buttock and right leg posteriorly; history of back injury with work with recent MRI, with finding of disc bulging, patient laying on floor today with left leg bent at knee supported on floor with foot, lifting right leg up to place over left leg with sudden onset of radicular pain. Pain intense with increase with slight movement. Patient in ambulance on way to St. Joseph’s Hospital with inability to tolerate level of pain and diverted to this hospital for evaluation. Original injury in February of this year, prior had been active with dance, soft ball etc.

The doctor’s diagnosis after exam on 06/11/99 was slightly illegible, but appeared as: lumbar disc ????? & radiculating pain. The record included an authorization for treatment signed by Bates’ mother, and an instruction sheet by Bates’ father which indicated that Bates was instructed to follow up with private doctor Monday if pain persists, modified bed rest, and medication was prescribed.

Parkcrest Surgical Associates, Inc. records indicated that Bates was next seen on June 15, 1999 after a functional capacity evaluation, and the following was noted:

“Patient had a functional capacity evaluation performed last Thursday. She was lying on the floor Friday with her left knee up, attempted to lift her right knee to cross it over, and after 2 inches developed severe low back pain radiation to the right low back region. Patient reports that she was seen in the ER at Barnes West Hospital....She continues to have pain in the low back region radiating into the right hip and right lateral thigh to just above the knee. There’s no associated numbness/tingling or bowel/bladder difficulty.”

The assessment on June 15, 1999 after examination was: Low back pain with herniated disc. The assessment was: Low back pain with herniated disc. In the next entry of June 24, 1999, it was written that Bates had undergone an additional 5 sessions of ½ day work hardening and had made some improvement in her ability to lift on a more frequent basis. Patient reports that overall she continues to have some pain, but she has good days and bad days; today is a particularly good day, it was noted. It was further written that Bates did continue to take pain medication on an occasional basis, that Bates felt the work hardening had been beneficial, and that she had no numbness/tingling or bowel/bladder difficult. The assessment on June 24, 1999 was – L5-S1 small disc protrusion and low back pain. In the final treatment note of June 30, 1999, the following was written:

Patient participated well in work hardening until yesterday. Under the advice of her attorney who told her that perhaps work hardening was too early, they did not participate yesterday. However, patient denies specific difficulty with work hardening except the first day 2 weeks ago. Since that time, she’s had no significant increased pain, has been able to progress with her therapy, and is lifting up to 35 lbs. She continues to have pain in the left and right side of her back. She has radiation of pain in the lateral aspect of the leg to the knee only. This occurs mostly after sitting and driving for more than an hour. She reports that she’s had to have friends drive for her. She has no bowel/bladder difficulty or muscle weakness. She’s been taking ibuprofen for the last few days but otherwise has had no medication at all. She reports the only difficulty she had with work hardening was just being really afraid of re-injuring herself or straining.

The doctor’s assessment on June 30, 1999 was:

Patient had disc protrusion at the L5-S1 level. She’s currently able to perform the activities of her job s a waitress as noted by the physical therapist and his job-site evaluation. She is able to lift 35 lbs without increasing difficulty. Both the patient and her mother feel that returning to work would possibly be too early at this tie; however, I told them that we have no objective evidence that going back to work would cause any difficulty. They have requested a neurological opinion. At the current time, I think the patient’s at maximum medical improvement and could return to work without restrictions.

Records of **The Work Center, Inc.** (No. 20) began with a June 11, 1999 Functional Capacity Report (FCE) in which it was noted that the objective was to determine current abilities and limitation with regard to vocation. The record indicated that the service was ordered by Dr. Tate, the employer was Ponderosa, and the insurance adjuster and insurance company (Liberty Mutual) was noted. The next document was a Work Hardening Report dated June 24, 1999. It was noted that Vester attended 5 out of 5 sessions, and attendance was 100%. The Overall Impression was:

Ms. Vester is a pleasure to work with, displaying the utmost in compliance and puts forth maximum effort in her daily performance.

Ms. Vester reported that following her FCE she experienced a significant symptom flare-up. Upon initiating the work hardening program, her daily program was modified. Since initiating the program, she has demonstrated noted improvement in her overall functional capabilities and is tolerating increase in her overall activity levels. Despite her subjective symptoms, Ms. Vester demonstrates the ability to perform and complete her program on a daily basis, tolerating increases well.

Currently in the work hardening program, Ms. Vester is functioning within the light work demand level.

The last report in the record, a Work Hardening Report dated June 24, 1999, noted that Vester had participated in 7 of the possible 8 sessions. It was noted that on 06/29/99 Vester arrived with her mother and reported that she was under advisement that she should not participate in the work hardening program until she saw her physician and a neurologist. Listed in the Significant Findings was: Based upon an on-site job analysis conducted on 06-29-99, Ms. Vester is currently functioning within the work demand level required of her usual and customary employment position based primarily on load handling requirements. The Overall Impression was:

Ms. Vester continued to be a pleasure to work with, putting forth maximum effort in her daily performance. Since her last report date she has displayed continued improvement with regard to load handling ability, general strength and endurance and her tolerance to increased activity levels. She also tolerated the addition of a conditioning program (06-25-99) performed on Cybex equipment and in conjunction with her daily work hardening program.

Ms. Vester continued to perform and complete her program on a daily basis with no apparent difficulty, tolerating increases well and maintaining a consistent pace.

Dr. Spezia's records indicate that he next saw Bates on 07/14/99, and the doctor wrote:

Pamela presents today with some complaints of some low back pain radiating down to her left hip now. She was doing better. She was seen by her work comp doctor and she was also seen by her chiropractor for some manipulation. An MRI has been obtained since the last visit since I saw her. This reveals a small disc extrusion with inferior migration at L5-S1, but mostly central. There appears to be a small ovarian cyst as well. She complains of no numbness or tingling in her legs. She does have some Mittelschmerz findings. With questioning she does complain of the low back pain that was aggravated with a work hardening type of location which they were evaluating her for a return to job. She doesn't feel that she can go back to work full duty at this time because of her back pain.

Dr. Spezia's assessment on 07/14/99 was: 1. Resolved mechanical low back pain; 2. MRI evidence of an L5-S1 HNP left side; and 3. ovarian cyst. The doctor wrote the following treatment recommendations:

Her findings on MRI were fairly defuse and not pathologic to the point that she didn't need orthopedic surgery. We discussed epidural steroid injections. They do not want to do that. She is not active enough to have any real manipulations today. I think that this will eventually resolve over the ensuing 6 to 8 weeks. I think that light duty is a reasonable alternative in the mean time. Apparently some leg pain is involved when she drives for long periods of time and this disc herniation that is somewhat central may be causing some of the symptoms. I think epidural steroid would be my recommendation at this stage.

In a Report to Employer form, Dr. Spezia wrote that the diagnosis was L5-S1 HNP; the doctor noted work restrictions of - no carrying food trays, ice buckets, silverware or bust tubs; and no lifting greater than 10 pounds, and 4-hour shifts. At the 08/04/99 visit, Dr. Spezia wrote that Bates reported she was 65% better. After examination, Dr. Spezia's diagnosis was - Mechanical low back strain with an L5-S1 disc protrusion; the doctor again wrote that Bates at this stage was non-surgical and did not need any type of aggressive conservative measures, and that he didn't think physical therapy would be worthwhile. We'll follow her up as needed, the doctor wrote. In an August 4, 2000 letter, Dr. Spezia wrote that an MRI performed subsequent to Bates' initial visit on 03/01/99 "showed a protruded L5-S1 HNP but without any evidence of impingement on nerve root." "She certainly had a non-surgical exam at that time, both by MRI findings as well as by clinical findings", the doctor wrote. Dr. Spezia further wrote:

After July 14, 1999 the patient returned for further care August 4, 1999. She states that she was 65% better, did not feel like she had enough pain for any type of treatment to include epidural steroid injection. Neurologically she was negative.

I again spent time telling her at length that this was a non-surgical problem and that sub-specialty orthopedic care would not be needed any further. In the meantime in April of 1999 a maximum medical disability evaluation was given by myself and a rating of 5% was given stating that the disability was based upon her history of back pain that is still intermittent in nature but that this would not affect her choice of gainful employment.

I have not seen my patient, Pamela Vester, since August 4, 1999 and my opinion has not changed, since that last exam, in terms of requiring surgery or requiring further work-up.

The next treatment records in evidence were medical records of **Barnes Jewish St. Peters Hospital** (No. B; See, also No. 7) concerning emergency room treatment of Bates on 09/30/99 after a fall at work at Developmental Learning Center causing injury to her left eyebrow area, neck and lower back. Physical exam findings were noted and x-ray results for the elbow, lumbar and cervical areas were noted. The clinical impression after evaluation on 09/30/99 was - neck strain and lumbar strain. It was indicated that Bates and her family were counseled, that there was a need for follow up; the record included a work excuse form indicating no work for two days.

Dr. Terrence Piper, M.D., in a March 14, 2001 report to the claimant's attorney (No. N-1), wrote that he first saw Bates in May 2000. Noting that he had been asked to answer numerous questions concerning events that transpired in 1998 and 1999, Dr. Piper further wrote: "Suffice it to say at this juncture that I have reviewed Dr. Spezia's letter dated August 4, 2000 concerning Mrs. Vester, which I completely concur with."

Considering the medical evidence on the issue of whether or not there is temporary total disability owed for the two periods of 03/29/99 through 04/05/99 and 08/28/99 through 09/19/99, **it is found** the medical evidence indicates that the claimant was still under active medical care to cure her from the effects of the February 22 or 23, 1999 work related injury. Dr. Spezia indicated that he felt Bates was at maximum medical improvement *in April of 1999*. (emphasis added) Dr. Spezia's reveal that at a 03/01/99 visit, the treatment recommendation was a trigger point injection and physical therapy. A 03/19/99 entry stated that the appointment had been cancelled because Bates the facility was not a provider for the work comp company, but the next treatment record (those of Dr. Susan Albers, D.C. of 04/30/99) noted a General History – "after LB tx from P.T. (20 visits) pt. gets better for awhile then exacerbates Pt. had 'shot' @ Dr's office 1 time." It is found that the substantial competent evidence indicates that the claimant remained at the same physical status and was active treatment subsequent to the agreed and stipulated period of temporary total disability benefits of 02/26/99 – 03/28/99 and into April of 1999. It is found that the substantial and competent evidence supports an award of temporary total disability benefits for the period in issue of 03/29/99 – 04/05/99. This would be: $1 \frac{1}{7} \text{ weeks} \times \$82.02 = 93.74$.

It is further found that there is no medical opinion supporting the claimant's allegation that during the time period 08/28/99 – 09/19/99 she was temporarily totally unable to work as a result of injuries sustained in the 02/22 or 23/99 work related accident. Dr. Spezia indicated in his medical records that he felt Bates was at maximum medical improvement for injuries sustained in the 02/22 or 23/99 work related accident as of April 1999; the doctor had noted, though, that the claimant complained of an aggravation of her symptoms with work hardening. The Work Center, Inc. record, the work hardening record, noted the claimant's report of experiencing a significant symptoms flare-up at the beginning of the program, and it was further written that her daily program was modified. The Parkcrest Surgical Associates, Inc. record reflected that work hardening was ordered by this facility for the claimant, and the claimant experienced some physical difficulties during work hardening; the written opinion in this treatment record was that Bates reached maximum medical improvement and could return to work without restrictions as of June 30, 1999. It is found that the substantial competent evidence establishes that the claimant was at maximum medical improvement for the February 22 or 23, 1999 work related injury as of June 30, 1999. Therefore temporary total disability benefits for the period of 08/28/99 – 09/19/99 is denied.

ISSUE – Injury Number 99-013898: Nature and extent of permanent disability, whether partial or total

Considering the medical evidence, **Barnes Jewish St. Peters Hospital** records (No. B-2; See, also No. 6) of 02/26/99 noted the work related injury a few days earlier where the claimant had increased back pain while carrying 'bus tubs' at work. Bates's complaints were noted as: "C/o (increased) pain (with) movement or ambulation. Denies numbness tingling to LE's." The doctor's diagnosis on 02/26/99 was: Low back pain.

Records of **Dr. Paul M. Spezia, D.O. of St. Peters Bone & Joint Surgery** (No. 17) indicated that the doctor saw Bates for the first time on 03/01/99. The doctor wrote that Bates had back pain; it was written that Bates had fallen at work at Ponderosa in October of 1998, and had fallen again, apparently slipping, about 3 weeks earlier, and then had a third episode of back pain the Tuesday before when she went to pick up a bus tub and she felt some pain in her back. Dr. Spezia further wrote; "Denies numbness or tingling. Denies any bowel or bladder problems. She denies any fevers or chills. Full

orthopedic history was reviewed and signed by myself. She is active and likes to do crunches. Leg raises and push ups. She has no bad habits.” Physical exam findings included: in no acute distress; sitting in a wheel chair, states she has not been able to walk well since the last episode of back pain; x-rays from prior Friday taken at the emergency room were negative; minimal paravertebral muscle spasm; some point tenderness in the PSIS joints right greater than left; negative seated straight leg raise; negative lying straight leg raise; 5+/5+ strength quads, hamstrings, foot inversion, eversion, dorsiflexion, plantar flexion; DTR’s were 2+/4+ and equal bilaterally; sensation was intact to light touch. Dr. Spezia’s assessment on 03/01/99 was: mechanical low back strain, acute.

Medical records of **Susan Albers, D.C.** (No. J; See, also No. 5) indicated that Bates was a new patient treated on 04/30/99 for complaints of low back pain; in a form completed by Bates, she indicated other complaints of - neck pain. In an Ancillary Treatment Summary, the doctor noted the Chief Complaint as: “LBP & @ leg pain (constant) since last night”. A General History was also written in the Ancillary Treatment Summary sheet, and included: “Feb. lifted a big tub of dishes & felt immediate pain in L/B – after LB tx from P.T. (20 visits) pt. gets better for awhile then exacerbates Pt. had ‘shot’ @ Dr’s office 1 time.” The record reflected that Bates was again treated on 05/01/99; it as noted in the entry that the doctor had a conversation with Bates and her mother to explain the x-rays; in the final entries of 05/04/99 and 05/05/99, it was written that Bates missed an appointment, and when called the next day her mother relayed that Bates was following treatment recommendations of Dr. Long and that Dr. Long had returned Bates to work on light duty, though the employer had given her the longest area with lifting. Dr. Albers completed a form in which she indicated Bates had lower back pain and swelling in lower back, and that an accident had occurred on 02/30/99, the accident being - lifting a heavy tub of dishes at work.

A report of a **May 7, 1999 MRI** of the lumbar spine by Dr. Allan McCown, M.D. of Open MRI of America to Dr. Lange (No. E; See, also, No. 14) noted the following findings and impression:

FINDINGS: There is some disc space narrowing at L5-S1. There is a central disc extrusion of moderate size at L5-S1 with some inferior migration through the extruded portion of the disc. A minor subligamentous bulge of the L2-L3 disc on the left paracentral area is noted. There is no evidence of spinal stenosis. The conus extends to approximately L1 and ends normally. No compression fractures or marrow replacement abnormalities and the neural foramina appear patent.

On the sagittal fast spin echo images, there is a fluid filled structure in the posterior aspect of the pelvis. It could represent an ovarian cyst. It is probably about 4 cm in size.

IMPRESSION: 1. Central disc extrusion with slight inferior migration at L5-S1.
2. Some disc space narrowing and minor dessication at L5-S1
3. Minor subligamentous bulge of the L2-L3 disc in the left paracentral area.
4. Probable ovarian cyst.

Records of **Parkcrest Surgical Associates, Inc.** (No. 27) indicated that Bates was seen for the first time on May 18, 1999; Bates’ chief complaint was - low back pain. It was noted that Bates was evaluated in the presence of her mother. The doctor wrote:

Patient denies significant problems with her back prior to the alleged work-related injury of 02/23/1999. She had fallen approximately 1 year prior to this while employed at Ponderosa. She apparently had some very minimal difficulties at that time. She currently works as a waitress at Ponderosa 20 hours weekly, and she is a senior in high school. She reports that on the date of the injury, she picked up a heavy bus tub and when someone called her name, she twisted and developed a sharp shooting pain in the right side of her low back.

Medical treatment subsequent to back injury with the heavy bus tub was discussed, and the doctor noted that he had a copy of the report of the MRI performed on 05/07/99. Examination findings on 05/18/99 included: flexion only to 50 degrees with complaints of pain with flexion, extension to 20 degreeed, side bending and lateral rotation are within normal limits; tenderness of right pyriformis muscle; no active trigger points; straight leg raises are negative to 90 degrees in the sitting/lying positions; PSISs and pelvic landmarks appear symmetrical; no significant hamstring tightness identified; muscle strengths are 5/5 throughout; lower deep tendon reflexes are 2+ and symmetrical for patella, Achilles, and hamstring tendons bilaterally; lower sensation is intact to light touch, pinprick and vibratory sense throughout. The doctor’s assessment on 05/18/99 was:

Patient has continued complaints of low back pain with a small disc extrusion at the L5-S1 level. She does not appear to be a surgical candidate. Her symptoms are improving with physical therapy. We discussed other alternative therapies including epidural steroid injections ad continued anti-inflammatory medication on a regular basis. The risks and benefits of each were discussed. The patient elected to continue in physical therapy and begin

anti-inflammatory medications. She currently is not interested in any epidural steroid injections. She's graduating from high school in approximately 2 ½ weeks. She'll continue in physical therapy for 2 weeks and be off work for another 2-3 weeks. At that time, I anticipate the restrictions for 2 weeks and eventually to full duty within approximately 4-5 weeks.

In the next entry of June 8, 1999, it was written that Bates had undergone physical therapy and was making good improvement. Bates' complaints were: with heavy activity such as prolonged driving or twisting she has some low back pain; able to walk only about ½ mile without limping; occasional pain into her right upper thigh but no numbness/tingling or bowel difficulty. The assessment on June 8, 1999 was that Bates had made marked improvement with her physical therapy and could currently return to work with restrictions of no lifting greater than 30 lbs. However, we're recommending functional capacity evaluation to assess whether she's going to be able to return to full duties as a waitress, the doctor wrote.

Records of **The Work Center, Inc.** (No. 20) began with a June 11, 1999 Functional Capacity Report (FCE) in which it was noted that the objective was to determine current abilities and limitation with regard to vocation. The record indicated that the service was ordered by Dr. Tate, the employer was Ponderosa, and the insurance adjuster and insurance company (Liberty Mutual) was noted. It was written that the duration of the FCE was 3.5 hours. Bates was noted to have reported subjective complaints of intermittent ache in the right aspect of her lumbar region and right hip, and lateral aspect of her right lower extremity. Bates was noted to display a positive attitude and was compliant during the FCE; primary limitations were noted as subjective symptoms increased with the duration of the FCE, decrease in general work endurance per increase in right gait deviation with the duration of the FCE, and decrease in load handling tolerance in comparison to the physical demands of her job. Recommendations were: reconsultation with Dr. Tate to assess significance of Vester's subjective symptoms and current functional status using the FCE report as a supplement. Further written was: "Based on data obtained during this FCE and the job description provided by Vester, she is currently not functioning within the work demand level required of her job. According to Jeff at Ponderosa, Ms. Vester may be required to lift 35 lb. tubs on a frequent basis, in contrast to her reporting increase in symptoms when lifting 30 lbs. on an occasional basis. Written was that it was felt Vester could benefit with participating in a work hardening program for one to two weeks.

The 06/11/99 Barnes Jewish St. Peters Hospital record, in the patient history/nursing assessment indicated Bates presented with back pain, and had a history of back problems; it was noted that the back pain had increased that day, and that Bates had come via ambulance. Further written was: c/o severe low back pain, worsened today. Radiates down (right) leg. Denies numbness; tingling. States pain worsened when attempted to cross leg. Rates pain 10 in series 1-10. Crying/shaking." The doctor's written history basically was:

19 year old white female with complaints of back pain with pain greatest right side of midline with radiation to right buttock and right leg posteriorly; history of back injury with work with recent MRI, with finding of disc bulging, patient laying on floor today with left leg bent at knee supported on floor with foot, lifting right leg up to place over left leg with sudden onset of radicular pain. Pain intense with increase with slight movement. Patient in ambulance on way to St. Joseph's Hospital with inability to tolerate level of pain and diverted to this hospital for evaluation. Original injury in February of this year, prior had been active with dance, soft ball etc.

The doctor's exam findings on 06/11/99 included: speech clear and appropriate; back with pain on palpation right paralumbar area and right sacral area; pain over sciatic notch area; straight leg raise with intense pain to low back buttock and leg; DTR 1+ sensory intact with light touch and pin; elevation of left leg with pain at right not radicular. The doctor's diagnosis was slightly illegible, but appeared as: lumbar disc ????? & radiculating pain.

The next document in The Work Center record was a Work Hardening Report dated June 24, 1999. It was noted that Vester attended 5 out of 5 sessions, and attendance was 100%. Among the listed significant findings were: 1. "Initial" loads were decreased upon initiating the work hardening program secondary to a symptom flare-up following hr FCE; improved lifting tolerance to 30 lbs floor-waist for 3 reps and 20 lbs. waist shoulder for 3 reps; bilaterally carries a 25 lb. load a distance of 25 ft for 2 sets of 4 repetitions; pushes and pulls 280 lbs on four wheel cart; reports subjective symptoms of intermittent "pinching, pulling, and tightness" in her right low back area, and "throbbing and tightness" in her right hip and lateral aspect of right buttock and thigh musculature. The Overall Impression was:

Ms. Vester is a pleasure to work with, displaying the utmost in compliance and puts forth maximum effort in her daily performance.

Ms. Vester reported that following her FCE she experienced a significant symptom flare-up. Upon initiating the work hardening program, her daily program was modified. Since initiating the program, she has demonstrated noted improvement in her overall functional capabilities and is tolerating increase in her overall activity levels. Despite her

subjective symptoms, Ms. Vester demonstrates the ability to perform and complete her program on a daily basis, tolerating increases well.

Currently in the work hardening program, Ms. Vester is functioning within the light work demand level.

The last report in the record, a Work Hardening Report dated June 24, 1999, noted that Vester had participated in 7 of the possible 8 sessions. It was noted that on 06/29/99 Vester arrived with her mother and reported that she was under advisement that she should not participate in the work hardening program until she saw her physician and a neurologist. Listed in the Significant Findings was: Based upon an on-site job analysis conducted on 06-29-99, Ms. Vester is currently functioning within the work demand level required of her usual and customary employment position based primarily on load handling requirements. The Overall Impression was:

Ms. Vester continued to be a pleasure to work with, putting forth maximum effort in her daily performance. Since her last report date she has displayed continued improvement with regard to load handling ability, general strength and endurance and her tolerance to increased activity levels. She also tolerated the addition of a conditioning program (06-25-99) performed on Cybex equipment and in conjunction with her daily work hardening program.

Ms. Vester continued to perform and complete her program on a daily basis with no apparent difficulty, tolerating increases well and maintaining a consistent pace.

The next entry in the Parkcrest Surgical Associates, Inc. record was a June 15, 1999 entry which included the following:

“Patient had a functional capacity evaluation performed last Thursday. She was lying on the floor Friday with her left knee up, attempted to lift her right knee to cross it over, and after 2 inches developed severe low back pain radiation to the right low back region. Patient reports that she was seen in the ER at Barnes West Hospital....She continues to have pain in the low back region radiating into the right hip and right lateral thigh to just above the knee. There’s no associated numbness/tingling or bowel/bladder difficulty.”

Exam findings again included decreased range of motion of the back with increased pain at end range of motion on both sides; other exam findings were the same. The assessment was: Low back pain with herniated disc. Patient would benefit from work hardening for ½ day 5 days a week and she will be continued on her medication, the doctor wrote. In the next entry of June 24, 1999, it was written that Bates had undergone 5 sessions of ½ day work hardening and had made some improvement in her ability to lift on a more frequent basis. She is right around 30 lbs at the current time, and her actual posture and repetitions are increasing but she is not felt to be able to do 30 lbs on a full 8-hour basis, according to her therapist, the doctor wrote. Patient reports that overall she continues to have some pain, but she has good days and bad days; today is a particularly good day, it was noted. It was further written that Bates did continue to take pain medication on an occasional basis, that Bates felt the work hardening had been beneficial, and that she had no numbness/tingling or bowel/bladder difficult. Exam findings on June 24, 1999 included: gait is within normal limits; patient able to walk in a heel/toe fashion; also able to walk on heels and toes and to perform tendem gait; range of motion was improved with side bending and lateral rotation within normal limits; the remained of the exam was the same. The assessment was – L5-S1 small disc protrusion and low back pain. The plan was to continue Bates in work hardening as she was making improvement there. In the final treatment note of June 30, 1999, the following was written:

Patient participated well in work hardening until yesterday. Under the advice of her attorney who told her that perhaps work hardening was too early, they did not participate yesterday. However, patient denies specific difficulty with work hardening except the first day 2 weeks ago. Since that time, she’s had no significant increased pain, has been able to progress with her therapy, and is lifting up to 35 lbs. She continues to have pain in the left and right side of her back. She has radiation of pain in the lateral aspect of the leg to the knee only. This occurs mostly after sitting and driving for more than an hour. She reports that she’s had to have friends drive for her. She has no bowel/bladder difficulty or muscle weakness. She’s been taking ibuprofen for the last few days but otherwise has had no medication at all. She reports the only difficulty she had with work hardening was just being really afraid of re-injuring herself or straining.

Examination findings on June 30, 1999 were the same. The doctor’s assessment on June 30, 1999 was:

Patient had disc protrusion at the L5-S1 level. She’s currently able to perform the activities of her job as a waitress as noted by the physical therapist and his job-site evaluation. She is able to lift 35 lbs without increasing difficulty. Both the patient and her mother feel that returning to work would possibly be too early at this time; however, I told

them that we have no objective evidence that going back to work would cause any difficulty. They have requested a neurological opinion. At the current time, I think the patient's at maximum medical improvement and could return to work without restrictions.

Dr. Spezia next saw Bates on 07/14/99, and the doctor wrote:

Pamela presents today with some complaints of some low back pain radiating down to her left hip now. She was doing better. She was seen by her work comp doctor and she was also seen by her chiropractor for some manipulation. An MRI has been obtained since the last visit since I saw her. This reveals a small disc extrusion with inferior migration at L5-S1, but mostly central. There appears to be a small ovarian cyst as well. She complains of no numbness or tingling in her legs. She does have some Mittelschmerz findings. With questioning she does complain of the low back pain that was aggravated with a work hardening type of location which they were evaluating her for a return to job. She doesn't feel that she can go back to work full duty at this time because of her back pain.

Exam findings on 07/14/99 included: ROM – fingertips to knees, any further causes pain; extension 20 degrees, side bend left and right fingertips to knees; deep tendon reflexes are 2+/4+ and equal bilaterally; negative seated straight leg raise; palpatory exam lumbosacral spine reveals mild paravertebral muscle spasm. Dr. Spezia's assessment on 07/14/99 was: 1. Resolved mechanical low back pain; 2. MRI evidence of an L5-S1 HNP left side; and 3. ovarian cyst. The doctor wrote the following in his treatment recommendations:

Her findings on MRI were fairly defuse and not pathologic to the point that she didn't need orthopedic surgery. We discussed epidural steroid injections. They do not want to do that. She is not active enough to have any real manipulations today. I think that this will eventually resolve over the ensuing 6 to 8 weeks. I think that light duty is a reasonable alternative in the mean time. Apparently some leg pain is involved when she drives for long periods of time and this disc herniation that is somewhat central may be causing some of the symptoms. I think epidural steroid would be my recommendation at this stage.

In a Report to Employer form, Dr. Spezia wrote that the diagnosis was - L5-S1 HNP.

Records of **Dr. Catherine Dean of Women's Healthpartners, Inc.** (No. 10) indicated that by referral of Dr. Cabrera, Bates was seen three separate times at this facility; intake sheets completed by Bates reflected – appeared for treatment/evaluation on 07/26/99 (Bates indicated employed at Ponderosa), appeared for treatment on 09/21/00 (Bates indicated that she was unemployed), and appeared for treatment on 10/15/01 (Bates indicated that she was employed at True Manufacturing).

A Gynecologic Problem Evaluation and Management Report form, dated 07/26/99, noted Bates' comments problems with her periods, including pelvic pain. A copy of the May 7, 1999 MRI of the lumbar spine was in the record (this MRI noted findings of a probable ovarian cyst). A Dr. Jeffrey M. Dicke, M.D. of Washington University School of Medicine, Department of Obstetrics and Gynecology wrote an 08/17/99 exam report in which he noted that Bates had complaints of lower abdominal pain, and that an MRI of the lower back had revealed a probable ovarian cyst; Dr. Dicke wrote that ultrasound correlation was requested. The results of the ultrasound were discussed by the doctor. Dr. Dicke's impression was: 1. Sonographically normal uterus; 2. Normal-sized ovary containing small simple cyst of probable functional origin; and 3. Sonographically normal left ovary. The record indicated that Bates was treated with medications.

Dr. Spezia's record indicated that he next saw Bates on 08/04/99 at which time it was written that Bates reported she was 65% better. After examination, Dr. Spezia's diagnosis was - Mechanical low back strain with an L5-S1 disc protrusion. Dr. Spezia's/St. Peters Bone & Joint Surgery record indicated that Bates was examined by another doctor at the 05/30/00 exam. It as noted that Bates had had problems with her back for the past year and was treated by Dr. Spezia, and that apparently a ruptured disc had been diagnosed. Exam findings were: neurologically okay; lots of paravertebral muscle spasm; tender at 4-5, 5-1; motor strength is good over all muscle groups; reflexes are symmetric; positive straight leg raise bilaterally at about 45 degrees; no pain with flexion and passive rotation left hip; pain with flexion and rotation of right hip. The doctor further wrote:

Other than the spina bifida occulta of L5, as I said, there's not much on x-ray. Maybe a little discogenic type of scoliosis convexed to the left. Might be from perhaps a disc problem. She has a history of having a 5-1 prolapsed disc by Dr. Spezia's note in the spring of 1999. This has happened now multiple times. It happened as a waitress. It happened as a daycare worker and now it's happened working in a furniture company. She's just turned 20 here recently and she's plagued with chronic back pain. Doesn't have much in the way of leg pain.

In an August 4, 2000 letter, Dr. Spezia wrote that an MRI performed subsequent to Bates' initial visit on 03/01/99 "showed a protruded L5-S1 HNP but without any evidence of impingement on nerve root." "She certainly had a non-surgical exam at that time, both by MRI findings as well as by clinical findings", the doctor wrote. The doctor noted that he had reviewed additional medical records. Dr. Spezia further wrote:

After July 14, 1999 the patient returned for further care August 4, 1999. She states that she was 65% better, did not feel like she had enough pain for any type of treatment to include epidural steroid injection. Neurologically she was negative.

I again spent time telling her at length that this was a non-surgical problem and that sub-specialty orthopedic care would not be needed any further. In the meantime in April of 1999 a maximum medical disability evaluation was given by myself and a rating of 5% was given stating that the disability was based upon her history of back pain that is still intermittent in nature but that this would not affect her choice of gainful employment.

I have not seen my patient, Pamela Vester, since August 4, 1999 and my opinion has not changed, since that last exam, in terms of requiring surgery or requiring further work-up.

Additional medical records from **Barnes Jewish St. Peters Hospital** (No. B; See, also No. 7) concerned the 09/30/99 emergency room treatment of Bates after a fall at work at Developmental Learning Center with injury to her left eyebrow area, neck and lower back. Severity of pain was noted as "moderate", and it was also indicated that Bates had an associated symptom of - not loss of consciousness, but possibly dazed. Physical exam findings included: alert, no acute distress, swelling and tenderness at left eyebrow area; symptoms in low mid back area.

X-rays were taken, and reports stated the following findings: a. Elbow: negative. b. Lumbar: vertebral heights are well maintained, no fractures or acute osseous abnormality is identified; there is scoliosis with the convexity to the left in the mid lumbar spine; intervertebral disc spaces are well preserved; no spondylolisthesis or spondylolysis is identified. c. Cervical: mild reversal of lordotic curve; vertebral body heights are well maintained; no fracture or acute osseous abnormality is identified; no malalignment is seen; the neural foramina are patent; there is levoscoliosis in the thoracic spine, but no significant scoliosis in the cervical spine.

The clinical impression after evaluation was neck strain and lumbar strain; the section included an area about concussion, and no notations were made. It was indicated that Bates and her family were counseled, that there was a need for follow up; the record included a work excuse form indicating no work for two days.

BJC Corporate Health – St. Peters records (No. 7) indicated treatment for the 09/30/99 work related injury. The record included physical therapy records indicating treatment to the neck and back into November 1999. In a November 18, 1999 Discharge Summary by the doctor, the final diagnoses were: Resolved Sprain Neck; Resolved Torticollis; Resolved Contusion Right arm; Resolved Contusion Lumbar; and Improving sprain lumbosacral. It was written that Bates was released for return to full duty.

Medical records of **Barnes Jewish St. Peters Hospital** (B-1; See, also No. 6) consisted of a 07/18/2000 evaluation/consultation at the Pain Center by a Dr. Gerald Joyce, M.D., apparently on referral by Dr. Terrence Piper, M.D. The record included a 06/05/00 report of an MRI of the lumbar spine by radiologist Sandy A. Ruhs, M.D. which stated:

Findings: Sagittal alignment is within normal limits with no evidence of spondylolisthesis. The vertebral body height are maintained. There is loss of the T2 disc signal at L5-S consistent with disc desiccation. The conus terminates at the L1-2 level. The cauda equina is grossly normal. Marrow signal is uniform with no evidence of focal replacement. No obvious paravertebral soft tissue is seen.

There is minimal disc bulge at L4-5, though no effacement of the anterior epidural fat or neural foraminal compromise.

There is a central and left paracentral disc protrusion at L5-S1, broad based and moderate severity. This does efface the anterior epidural fat, though does not appear to abut the exiting left L5 nerve root. Incidentally note is made of lack of fusion of the posterior elements of S1 consistent with spina bifida occulta.

SUMMARY:

1. Moderate central/left paracentral disc protrusion, L5-S1, with mild effacement of the thecal sac.
2. Minimal disc bulge at L4-5.
3. Incidental spina bifida occulta of S1.

A pain history noted for Bates was: "About 18 months – she was carrying a heavy load of dishes – when turning to the right she felt a sudden pain – all the way to her knee". Dr. Joyce, in his 07/18/2000 Consultation Note, noted the following History of Present Illness:

Ms. Vester is a 20 year old woman with an 18 month history of low back pain with occasional right leg pain which would radiate down to her mid-thigh. The leg pain is intermittent, low back pain has been constant. Usually, it has been at a fairly low level but on third time, it was been so severe it sent her to the emergency Room. She saw Dr. Piper and he did an MRI of her lumbar spine which was noteworthy for a moderate disc protrusion at L5, S1 and a minimal disc bulge at L4-5 with some spina bifida. Ms. Vester says that she's been very sensitive to pain medications and muscle relaxants and has had a hard time tolerating them because of her sensitivity.

The good news for Ms. Vester is that she's finally begun to do her Physical Therapy about three weeks ago, that is her home exercise program. She had Physical Therapy 18 months ago but she was resistant to doing her home exercises because of fear that she might injure herself. Supposedly, the Workmen's Comp nurse frightened her enough about the prospect of an epidural steroid injection that she resolved to finally try doing her home exercises and she's not been doing them for about three weeks. The good news is that for the past two weeks, she's been pain free. She still has had very limited activity in this time but she has been pain free for the first time in the last year and a half. (sic)

Examination findings on 07/18/2000 were: general – pleasant 20 year old woman in no acute distress; neurological – motor and sensory exams are essentially normal, straight leg raising is normal, Patrick's test is normal; myofascial exam in also unremarkable. Dr. Joyce's assessment on 07/18/2000 was – "she has had chronic low back pain but appears to be responding well to home exercise program and today will be to continue her home exercise program and slowly increase her activity at home.

Certified medical records of **Thomas Cabrera, M.D.**, (No. C; See, also, No. 8) consisted of treatment entries (08/16/00 – 11/13/01) for various ailments of Bates (i.e. allergic rhinitis, pharyngitis with note for work, 08/16/00; Cardiopulmonary lab Echo/Doppler report, dated 05/25/2001, which reflected was performed due to indication of mitral valve disease, the report noted normal findings). A 10/06/00 entry (the second entry in the record) was the first to note complaints from Bates of back pain; it was written that Bates was referred to Dr. Piper. The next entry of 12/11/00 reflected that Bates' mother called and relayed that Bates had pain in sides, more towards the back, for several weeks now getting worse; it was noted that Bates had no burning, frequency or fever, and that she did have a herniated disc; it was written that the doctor had advised Bates to take Tylenol or go to the emergency room. The next entry of 02/06/01 reflected that Bates had fainted at work, True Manufacturing. The entry included: "Near syncopal episode – Has ??? work-up but no neuro consult. – Possible migraine headaches". It was written that Bates was to see Dr. Yanover, Dr. Wood. The next entry of 02/20/01 noted – bad headaches. Further written was: - "Possible depression, - Migraine headaches, - Crys, sleeps ok". It was indicated that samples of Celexia and Maxalt were given; the next entry reflected that Bates mother called and said Bates said the Maxalt worked and she would like a prescription called in to Walgreens. A Disability Certificate dated 02/20/01 indicated that Bates was totally incapacitated 02/06/01 to 02/07/01, and then would be sufficiently recovered to resume a normal workload. Another Disability Certificate dated 02/20/01 indicated that Bates was totally incapacitated on 02/20/01, and would be sufficiently recovered to resume a normal workload after that date.

Dr. Terrence Piper, M.D., in a March 14, 2001 report to the claimant's attorney (No. N-1), wrote that he first saw Bates in May 2000. Noting that he had been asked to answer numerous questions concerning events that transpired in 1998 and 1999, Dr. Piper further wrote: "Suffice it to say at this juncture that I have reviewed Dr. Spezia's letter dated August 4, 2000 concerning Mrs. Vester, which I completely concur with."

Medical records of **Robert Yanover, M.D.** (No. O; See, also, No. 21) included a March 26, 2001 examination report by Dr. Yanover in which the doctor noted that he had examined Bates on March 21, 2001 regarding headaches. It was noted that Bates did experience photophobia, at times felt like she was moving even a spinning sensation and periods where she has felt faint, and that on one occasion actually passed out for 5 seconds. After examination, the doctor's impression was: The patient has a common form of migraine. On occasion she may have a basilar form of migraine. They clearly seem to be influenced by stress and anxiety. There may be an underlying depressive feature to this as well." Dr. Yanover wrote that he would recommend further follow-up and evaluation. It was noted that Bates was started on daily Paxil, and that other medicines would be considered if the Paxil was not beneficial.

Included in the record was a report of a CT scan of the head performed on 05/30/00. The history was noted as: Syncope, hypoglycemia episode. The findings summary was: normal.

The entry of 05/22/01 in the medical records of Dr. Cabrera indicated that a prescription for Maxalt was phoned in to Walgreens. The next entry of 08/28/01 included: - wants Paxil, - hypoglycemia. Further written in the entry was: "Hypoglycemia, ?Depression?; - Stop Maxalt will try Paxil".

A final treatment entry was in the Dr. Spezia's/St. Peters Bone & Joint Surgery record (No. 17), and indicated that Bates was examined by a different doctor on 09/26/01. The following was written:

Presents today with complaints of back pain. She's had a long history of back pain dating to well over three years ago. Incidentally, it used to be right-sided complaints, low back, and a little in her legs. Now, about a week ago, had stood up, felt a pop on her left side. It's primarily all left-sided at this point. Low back pain only. She denies any loss of bowel or bladder control. No leg pain. She's treated herself with Ibuprofen really with no significant improvement.

Exam findings on 09/26/01 included: in no apparent distress; straight leg exams are negative at 90 degrees with the exception of a little back pain on the left; dorsal and plantar flexion are strong and intact; quadriceps muscles are strong and intact; hip flexors are a little weaker on the left, but primarily due to her low back causing her pain, actually on the other side are pretty strong and intact; rotation of the hips are without deficit; gait is antalgic in nature; slightly tearful on exam; nothing too neurologically focal. The doctor's assessment was:

1. Low back strain. Treat her conservatively with physical therapy. I'll start her on Vioxx 50 mg 1 a day for a couple of days and titrate to 25. Samples provided. She was cautioned not to use any other nonsteroidals concomitantly.
2. Depression. She's chronic and on medication at this time.
3. Seizure history, unknown etiology. I'd like to avoid muscle relaxers given that they can lower the seizure threshold and make her situation even worse than it already is. I'll see her back in a couple of weeks after she's had some therapy.

The 09/28/01 entry in Dr. Cabrera's record indicated it was a follow-up for on Paxil; also noted was complaints of back pain. The entry reflected that Paxil was refilled.

The 10/15/01 Dr. Dean/Women's Healthpartners, Inc. record again indicated that Bates was there for annual well woman exam; the initial form included comments of - Migraine headaches/syncope. Irregular menstrual cycle was noted in the record. In an 02/07/02 Gynecological Problem Evaluation and Management Report, Bates described her problem:

About a month ago I was committed to the hospital in the psych-ward. I was having feelings of harming myself. When I started the B.C. is about the time I had started my major headaches, depression and the suicidal thoughts I chose to stop taking these pills about mid time last month. I have been feeling much better now. My psychiatrist told (as well as many other doctors in the past) that I may be very sensitive to drugs. (sic)

In Dr. Cabrera's record was an 11/12/01 work excuse form by Dr. Cabrera stated: "Pamela Vester called our office today to let us know that she was not able to report to work last Wednesday, Nov. 7, 2001 because of irregular menstrual period". The last treatment entry of 11/13/01 noted complaints from Bates of - has a bad migraine, over the counter migraine meds not working, can the doctor call something to Walgreens; a prescription of Fiorinal was phoned to Walgreens

Medical records of **St. Joseph Health Center, St. Charles** (No. G^[4]; See, also No. 16) concerned the hospitalization of Bates from 12/29/01 through 01/12/02 because of increased depression symptoms and thoughts of cutting her wrists. In the admitting sheet, Dr. Saaid Khojasteh, M.D. wrote the following History of Present Illness:

Patient recently has been experiencing symptoms of depression and anxiety, she has not been able to sleep very well. She has been also feeling overwhelmed at work. She also has had a problem at work, specifically she has been given a hard time because some of her co-workers have been passing rumors about her and her boyfriend and other boyfriend. She has been upset about this. She has been feeling despondent, depressed. She initially participated impartial hospital program but was not doing well and as a result was switched to the inpatient program where she started to express thoughts of cutting her wrists and feeling depressed. She has been also experiencing some migraine. When patient as asked about any other reason related to the depression she only mention job stress and the problem she has had with the boyfriend. Of note is also that the boyfriend has asked for sometime off from each other and that has been causing the patient to feel more distress.

Past medical history was: Bates has been on Celexia and Xanax recently; has a history of migraines once a twice a week; and had had also a question of herniated disc three years ago. Bates' family history was noted as: for psychiatric disorder, patient's father and brother have experienced depression. A Dr. D. Kliman performed a consultation exam of Bates on

12/13/01 during her hospitalization. Dr. Kliman noted in the History of Present Illness that Bates had been admitted for mood stabilization; it was noted that Bates had been having days where she is very depressed and then days when she is doing well. Dr. Kliman noted the same past medical history and family history. Dr. Kliman's assessment after examination was: 1. Depression; Migraines; 3. Question of herniated disc in the past, asymptomatic; and 4. Nicotine abuse, ongoing. In the Discharge Summary, Dr. Khojasteh wrote the following:

LABORATORY DATA: Included in the body of the chart. She had an EKG, an MRI of the back, and C-Spines that all came back to be normal^[5]. The Ct of the head did not reveal any abnormality. All of these were done in preparation for ECT.

HOSPITAL COURSE: The patient was continuously despondent, depressed, and had a lack of energy and motivation. Her medications were changed several times. These included Zoloft, Effexor, Ritalin and Prozac. Ultimately, ECT was discussed with her and her family. The patient declined ECT. At that time, the patient indicated that there was a history of abuse of her and the patient has been very despondent about this. Ultimately, the family indicated that Dr. had seen the patient and had stated that the patient had herniation of the disk. As a result, the ECT was put on hold until the MRIs were done. The patient, however, later wanted to stop all medication. After that, she started to feel better. Mother thought that change of birth control pill might have had an impact on patient's mood. She did well and denied any further suicidal ideations. The patient was discharged on Celexa 20 mg ½ q. AM. She is to see Dr. Michele Wood and myself or Dr. Larice in the office. She is to start counseling with respect to the history of abuse with Dr. Cardesz or Holly Carson. I asked that the parents hold the bottles of medication away from her. At the time of discharge, her mood and affect had improved. She denied any suicidal or homicidal ideation.

The final diagnosis was: Axis I: 1. Major affective disorder, depression with anxiety feature, 2. Possible posttraumatic stress disorder. Axis II: Deferred. Axis II: Migraines. Axis IV: Moderately severe. Axis V: 28 on admission and 36 on discharge. A 01/12/02 Discharge Summary form indicated that Bates was discharged with no restrictions on activities permitted.

Treatment records of **Dr. Koelling of Koelling and Turnbull Chiropractic Center** (No. 12) began with a 01/29/02 Examination Form in which examination findings for Bates included: lumbar range of motion – severe restriction in all motions; sensory – hyperesthesia. In a 01/29/02 treatment entry was written: “acute LBP hx of herniated disc at L5 S1”. An MRI was recommended as well as a follow up in 2 days. An Authorization for Absence form signed by the doctor and dated 01/29/02 indicated that Bates was under the doctor's care, and in order to avoid aggravation of a health condition it was recommended that Bates be off work until 02/07/02. The report of the January 30, 2002 MRI of the lumbar spine by Julian N. Verde, M.D., Interpreting Radiologist, of Open MRI of America (See, also, No. F) was in Dr. Koelling's record. Dr. Koelling's next and last treatment entry of 02/05/02 was illegible.

A report of a **January 30, 2002 MRI of the lumbar spine** by Julian N. Verde, M.D., Interpreting Radiologist, of Open MRI of America (No. F) to Dr. Koelling noted a patient history of – low back pain radiating to the right leg. Examination findings were: “posterior central bulge of the L5-S1 intervertebral disc previously described on examination of 5-7-00. There is no significant impingement upon the thecal sac or foramina. The vertebral bodies and intervertebral discs are otherwise normally aligned and of normal intensity. Foramina are patent and symmetrical. The bony spinal canal is normal in size.” The impression was: “There is a posterior central bulge of the L5-S1 intervertebral disc previously described on an examination of 5-7-99. The lumbar spine is otherwise normal in appearance.

Medical records of **St. Joseph Health Center in St. Charles** (No. G-1; See, also, No. 16) concerned the 06/10/02 emergency room treatment of Bates for complaints of: Migraine headache – woke up with it this am. In the Notes section, the following was included: Time 0850 – female to ED, complaints of migraine HA pain 9/10 that started when woke this AM. Pt very light-sensitive and states pain is a 9/10. Denies nausea and vomiting. Family @ bedside; Time 0855 – MD at bedside; Time 0935 – Pt states that her pain is “totally gone”. She states that she is “just tired”. The clinical impression was: Migraine headache. A Return to Work Instructions form indicated that Bates was discharged on 6/10/02; it was written that she should be able to return to work in 2 days, and that Bates needed no work limitations.

Considering medical opinions, **Dr. Robert Poetz, D.O.** testified by deposition on behalf of the claimant. (CI's A) At the deposition, Dr. Poetz's reports of August 30, 2001, May 15, 2003, and September 15, 2004 were offered into evidence without objection, and it was stipulated and agreed to that Dr. Poetz would testify per these reports. In his August 30, 2001 report, Dr. Poetz noted that he was evaluating Bates for injuries at Ponderosa on November 1, 1998, December 5, 1998 and February 23, 1998, and for injuries at Developmental Learning Center on September 30, 1999 and October 22, 1999. The doctor noted Bates' chief complaints: “I experience pain occasionally in my lower back which increases with lifting,

bending, and prolonged sitting or standing. Occasionally the pain travels to my right thigh. I also have increase lower back pain when I am on my menstrual cycle. My neck is painful and stiff and pops at times.” Dr. Poetz discussed the work related accident of February 23, 1999: patient indicates was carrying a heavy tub of dirty dishes to the kitchen when a customer called her and as she turned to the right with the tub she developed a severe sharp pain in her lower back which progressively worsened; treatment was discussed which included x-rays, trigger point injection in the lower back, physical therapy, work restrictions and an MRI. Bates’ past medical history was noted by Dr. Poetz as – significant for depression since the February 23, 1999 back injury, no previous symptoms before that time; also migraines and occasional syncope since December 2000; and motor vehicle accident on September 18, 1993 where she hit the left side of her face and was diagnosed with TMJ and experiences occasion popping and pain at the left jaw. Examination findings on August 30, 2001 included the following:

Neck: Carotid pulses are equal bilaterally, no venous pulse. Thyroid contour, size and shape within normal limits

Upper Extremities: The patient moves all the joints of her upper extremities well without deformity. The hands are neurovascularly intact with good capillary refill

Lower Extremities: There is crepitus exhibited in the knees bilaterally which may indicate chondromalacia. The feet are neurovascularly intact.

Spine: There is no evidence of kyphosis, lordosis, scoliosis or pelvic list. The cervical spine has decreased range of motion with crepitus. The patient reports right sciatic pain occasionally and pain in the right lumbosacral area. There is tenderness exhibited in the right lumbosacral area with mild to moderate myospasms. The patient flexes to 60 degrees and complains of lower back pain and pain upon arising. There were no radicular signs at the time of our examination. Straight leg raising was negative, however, she describes a dermatome pattern of radicular pain that comes from time to time while sitting, and that dermatome pattern is consistent with L5-S1 radiculopathy. The patient exhibits a butterfly tattoo at the lower back.

Neuro: Cranial nerves II-XII are grossly intact. Deep tendon reflexes intact; no motor or sensory deficits noted.

Dr. Poetz wrote: “It would be difficult to ascertain the exact injury date of the disc because the patient states that the lower back symptoms resolved several weeks after the December 5, 1998 injury with no residual effects. It is therefore attributed to the February 23, 1999 incident as she remained symptomatic from that date on.

Dr. Poetz’ diagnoses after the August 30, 2001 exam included: 1. Lumbar strain, coccalgia and pre-sacral ecchymosis, 12/5/98; 2. Lumbar strain and herniated nucleus pulposus with exacerbation of previous lumbar strain, 2/23/99; 3. Depression, 2/23/99; 4. Closed head trauma with loss of consciousness resulting in cerebral concussion syndrome, and cervical/lumbar strain with exacerbation of previous lumbar condition, 9/30/99; 5. Lumbar strain with exacerbation of previous lumbar condition, 10/22/99; and 6. Left temporomandibular joint syndrome, 1993. The doctor’s conclusion as to any permanent disability after his August 30, 2001 evaluation included: 1. 35% permanent partial disability to the body as a whole at the lumbar spine directly resultant from the December 5, 1998, February 23, 1999, September 30, 1999 and October 22, 1999 (work related injuries). 2. 20% permanent partial disability to the body as a whole at the cervical spine directly resultant from the September 30, 1999 work related injury. 3. 20% permanent partial disability to the body as a whole at the head directly resultant from the September 30, 1998 work related injury. 4. 5% permanent partial disability to the body as a whole due to TMJ, 1993. Dr. Poetz further wrote: “The combination of the present and prior disabilities results in a total which exceeds the simple sum by 15%.”

Dr. Poetz’ recommendations included: range of motion exercises, nonsteroidal anti-inflammatory medication, avoid heavy lifting and strenuous activity, if no response to conservative care and continued low back pain then consider lumbar myelogram and post myelogram, surgical intervention if indicated.

In his second report of May 15, 2003, Dr. Poetz wrote that Bates had returned to his office on March 24, 2003 accompanied by her parents to re-evaluate her disability status. Bates chief complaints were noted as: “I always have some lower back pain. Occasionally I have pain into my right leg when my lower back flares up. I wake up with migraines at least once a week.” In the History of Present Illness section of the report, Dr. Poetz noted that from the time the patient was last examined in our office on May 24, 2001 she has continued to experience residual lower back pain. The doctor further wrote: “A repeat MRI of the lumbar spine was obtained on January 30, 2002 which was reported to show a posterior central bulge of the L5-S1 intervertebral disc previously described on exam of May 7, 1999. The patient indicates that she continues to follow up with a chiropractor for her lower back pain.” It was noted that Bates’ medical history was significant for depression and migraine headaches and Bates denied having symptoms for these conditions prior to her injuries; she indicated she developed stress and depression following the February 23, 1999 injury and then as a result of this began experiencing migraines sometime in late 2000. Further written was:

During this examination the patient presented with an active migraine. She had difficulty answering questions

throughout the exam due to pain and she cried intermittently. The patient indicates that since the last exam in our office her depressive symptoms have increased. She was hospitalized in January 2002 for this condition after an attempt to slit her wrists. Her mother noted that Pamela has tried a number of medications for depression, which have caused unfavorable side effects. Prior to her hospitalization she was placed on birth control pills for cramping and shortly thereafter she developed mood swings and personality changes which her parents feel were related to the birth control medication. The birth control pills were discontinued during her hospitalization. Her parents also indicate that she has discontinued all medication for depression. She is unable to remain gainfully employed because of poor attendance at work due to lower back pain, depression and migraines. During the exam she expressed concern that she was going to be terminated soon and several weeks after this appointment she called to notify us that she had once again been terminated from her employment.

Examination findings on May 15, 2003 were similar or the same as on August 30, 2001, particularly as to the neck, upper extremities, and neuro. The lower extremities now included popping in the knees bilaterally. The spine now included:

The patient was unable to sit up squarely from a supine position. She flexes to 45 degrees and complains of lower back pain and pain upon arising. Straight leg raising and Fabere-Patrick testing were positive for lower back pain, but not radicular.

Dr. Poetz' opinion continued to be that Bates' lower back symptoms were attributable to the February 23, 1999 incident as she remained symptomatic from that date on. The doctor's diagnoses remained the same as in August 2001 with the addition of - Migraine headaches, 2/23/99. The recommendations remained the same with the addition of - Migraine management with Triptan class, and Stress management counseling with psychiatrist. Dr. Poetz' conclusions as to any permanent disability after his May 15, 2003 evaluation remained the same with the addition of: 1. 20% permanent partial disability to the body as a whole due to depression which is directly resultant from the February 23, 1999 work related injury; and 2. 10% permanent partial disability of the body as a whole due to migraine headaches which is directly resultant from the February 23, 1999 work related injury. The doctor's opinion on the synergistic effect from the work related injuries with the prior disabilities remained that it exceeded the simple sum by 15%.

On cross examination by Ponderosa, Dr. Poetz indicated that "(N)ot to my knowledge" did Bates injure her cervical spine in any of the incidents at Ponderosa. (Poetz Dp. pg. 11) The doctor agreed that he attributed his rating for the low back to four different accidents, and that he did not break down the percentage of disability among those accidents; he agreed that among these accidents is the 12/05/98 incident which occurred at Ponderosa. Dr. Poetz stated that he did not attribute one rating for four accidents because he was unable to divide the permanency among the four accidents. Dr. Poetz agreed that he had noted in his report that no treatment was rendered for the 12/05/98 accident, and that Bates' symptoms had resolved after two weeks. When queried if a person's symptoms resolved, was it his opinion that there was no permanent injury from the accident, Dr. Poetz responded - "That is not my opinion". (Poetz Dp. pg. 11) Dr. Poetz agreed that there was maybe a week or two weeks that Bates' low back pain subsided since February of 1999, testifying - "I believe so, yes." (Poetz Dp. pg. 18)

Dr. Poetz stated, during cross examination, that he "did not make a judgment on" whether or not the depression was attributable to any of the injuries at Ponderosa. (Poetz Dp. pg. 19) The doctor stated that he had assessed a rating at the head, but that he "did not make a judgment on" whether or not that permanency was due to the accidents at Ponderosa, specifically prior to March of 1999. (Poetz Dp. pg. 19)

On cross examination by the Developmental Learning Center, Dr. Poetz agreed that when he initially saw Bates in August 2001 she was working as a receptionist for True Manufacturing; the doctor stated "(A)s far as I know" at that time Bates was working without restrictions. (Poetz Dp. pg. 32) It was noted that in his August 2001 report Dr. Poetz had diagnosed cerebral concussion syndrome, and the doctor was asked to explain what cerebral concussion syndrome: "A blow to the head that results in either loss of consciousness or dazed", Dr. Poetz answered. (Poetz Dp. pg. 33) Dr. Poetz was further queried as to why he had not broken down the 35% percentage of permanent partial disability of the lumbar spine he had assessed for the four incidents. "I wasn't asked to break it down", Dr. Poetz explained. (Poetz Dp. pg. 37)

On redirect, Dr. Poetz stated that a ruptured disc was a more severe injury than a sprain in a lumbar spine. The doctor agreed that a ruptured disc would have a greater weight of the percentage of disability than a sprain, and explained: "A ruptured disc is more permanent. A ruptured disc causes more symptoms, longer symptoms, and more inability to perform functions of the lower back than a sprain." (Poetz Dp. pp. 37-38) Dr. Poetz agreed that in his August 30, 2001 report he had attributed the herniated nucleus pulposus to the 02/23/99 accident. Agreeing that a patient can have a ruptured disc and have intermittent pain as opposed to constant pain, Dr. Poetz further testified: "In fact, that's more typical of ruptured discs, that patients may have periods of remission and periods of exacerbation." (Poetz Dp. pg. 39)

Dr. Poetz agreed, during redirect, that if a person is unconscious at all, that is one of the factors for diagnosing a brain concussion. The doctor explained that a brain concussion is “(A) bruise to the brain” that occurs “(B) blunt trauma”. (Poetz Dp. pg. 42) Dr. Poetz gave the following testimony about how a permanent partial disability manifests from a brain concussion:

Q. And how does that give a percentage of permanent partial disability?

A. The area of bruise, impact to the brain and the coverage of the brain undergo physiologic change in the form of microscopic hemorrhage, edema, tissue remodeling. Those areas may be more subject to develop in the future seizure activity, stroke, have both embolic and hemorrhagic stroke, and may be the source of chronic headaches.

Q. And can those things show up years later post concussion?

A. They can. (Poetz Dp. pp. 42-43)

Dr. Bernard C. Randolph, M.D. testified by deposition on behalf of the employer/insurer (Emp/Ins 24). The doctor stated that he specializes in physical medicine and rehabilitation. I examined Ms. Vester on two occasions - July 7, 2003 on behalf of the Developmental Learning Center, and on October 16, 2003 for Ponderosa, Dr. Randolph testified. At the deposition, Dr. Randolph’s reports were offered into evidence without objection at the deposition on the stipulation that the doctor would testify in accordance with his report and not that the claimant was agreeing with the content of the report. (See, Randolph Dp. pp. 7-8; and Randolph Dp. pp. 14-15 and 22)

Dr. Randolph noted in the July 7, 2003 report that he reviewed diagnostic studies, including a May 1999 MRI of the lumbar spine and a June 2000 MRI of the lumbar spine. It was noted that Bates’ past medical history was significant for treatments of anxiety and depression, and that these treatments had been managed by her family physician, Dr. Thomas Cabrera, by psychiatrists at various facilities, and that she had been admitted to the hospital on at least 2 occasions for treatment of depression and other mood disorders. Dr. Randolph stated the following in the July 7, 2003 report as to his examination findings:

She was observed to be a well-developed and well-nourished white female looking her stated age of 23 and in no acute distress. Her mother was in attendance at the time of the interview and examination. She was alert and oriented times three. Mood was even and her affect was appropriate. She was cooperative.

The face was symmetric. Pupils were equal. Extraocular movements were full. The tongue was in the midline. Voice quality was normal.

Cervical examination revealed full active and pain free range of motion. Palpation revealed no discrete spasm or trigger points at the cervical or proximal shoulder areas.

Upper extremity mobility was normal at the shoulders, elbows, and wrists bilaterally. No pain complaints were voiced. Muscle bulk and strength grades in the arms were normal throughout. Reflexes were brisk. Pinprick was intact. Peripheral circulatory findings were normal. Adson’s tests were negative. No deformities or discoloration were identified in the upper extremities.

Examination of the lumbar spine revealed normal alignment. She had full range of motion with some very slight pain reported on the extreme of flexion and extension. Lateral flexion and rotational movements were pain free. Her Straight leg raising and femoral stretch tests were negative bilaterally. Reflexes were 2+ and symmetric. Babinski responses were downgoing. Pinprick was intact in all peripheral nerve distributions and dermatomes of the lower extremities. Muscle bulk and strength grades were normal in both lower extremities throughout. Mobility at the ankles, knees, and hips was normal bilaterally. Peripheral pulses were 2+. There was no edema. Palpation revealed some minimal tenderness in the right lumbar paraspinals at about the L4-5 level. Changes in muscle texture or tone were not appreciated. No tenderness noted in the sciatic notches. Gaeaslen’s tests were negative. She was able to stand and walk with a normal gait pattern. She was able to walk on toes and heels without difficulty. All movements were very smooth and there were outward signs of discomfort during the course of the evaluation. The chest was clear to auscultation and percussion. The heart had a regular rate and rhythm and no murmurs. The abdomen was soft and non-tender with positive bowel sounds. No masses were palpable.

Dr. Randolph testified that there was a typographical error in the last sentence of the paragraph on page 5. “It should be no outward signs (of discomfort during the course of the evaluation)”, the doctor stated. (Randolph Dp. pp. 9-10) Dr. Randolph was asked, in terms of the physical exam were there any positive objective findings. “No”, the doctor answered. (Randolph Dp. pg. 9) Discussing his review of the May 1999 MRI, Dr. Randolph testified:

“From my reading, it showed some degenerative disc disease at L5-S1 which was mild. There was a posterior prominence of the disc at that level, but I did not see a lateralized disc herniation. There was no stenosis. There was

also a very slight prominence of the disc at the L2-3 disc.” (Randolph Dp. pp. 10-11)

The doctor agreed that the June 2000 MRI he reviewed would have been performed after Vester’s September 30, 1999 and October 22, 1999 incidents. Dr. Randolph was asked if he had found any difference in comparing the June 2000 MRI film with the May 1999 film. “No, the films were basically the same”, Dr. Randolph answered. (Randolph Dp. pg. 11)

Dr. Randolph testified as to his opinion of a diagnosis as a result of the September 30, 1999 incident: “In my opinion, she had sustained a sprain injury to the cervical and lumbar spine and a contusion to the right elbow and forehead.” (Randolph Dp. pg. 12) The doctor testified as to his diagnosis in regards to the October 1999 incident: “...a minor exacerbation of the low back pain when she picked up an infant....And I think I really couldn’t say anything more than that.” (Randolph Dp. pg. 12)

The doctor was asked his opinion of whether or not Vester was in need of any surgical intervention, and Dr. Randolph answered: “She did not need any surgical intervention.” (Randolph Dp. pg. 12) “She had met or reached maximum medical improvement” at the time of my examination in July of 2003, Dr. Randolph said. (Randolph Dp. pg. 12) The doctor stated his opinion as to whether or not Vester was capable of working without restrictions: “Yes, she was capable of working full duty and without restrictions at that time.” (Randolph Dp. pp. 12-13)

Dr. Randolph testified as to his opinion of any permanent partial disability Vester had sustained as a result of the September 1999 and October 1999 incidents:

“In my opinion, she had 0 percent permanent partial disability of the right arm related to the elbow contusion. She had 0 percent permanent partial disability of the person related to the facial contusions occurring on 9/30/99. She had 0 percent permanent partial disability of the person due to the minor cervical sprain occurring on 9/30/99. Additionally, I estimated 9 percent permanent partial disability of the person as a whole due to lumbar spine disease. And I attributed approximately 2 percent of this to the sprain injury occurring on or about 9/30/99. I did not find any additional disability related to the minor exacerbation occurring on 10/22/99.” (Randolph Dp. pg. 13)

Dr. Randolph agreed that he evaluated Vester a second time on October 16, 2003 on behalf of Ponderosa in regards to three accidents alleged to have occurred at Ponderosa on 11/01/98, 12/05/98 and 02/22/99. Dr. Randolph agreed that he reviewed medical records as part of his evaluation. “I don’t recall seeing Dr. Yanover’s records”, Dr. Randolph said. (Randolph Dp. pg. 17) Dr. Randolph discussed Vester’s complaints at the 10/16/03 exam, which were: episodic mild low back pain, the pain at about two on a scale of 0 to 10; the pain was aching in quality and tended to occur with bending or twisting; some occasional numbness in the front of the right thigh, especially with prolonged sitting such as driving a car or prolonged standing; some discomfort with walking down an incline; occasional pain with coughing or sneezing; no weakness in the legs. The doctor discussed his findings upon examination of Vester’s low back and coccyx:

“She had normal alignment to the back. She reported no pain with flexion, extension or lateral flexion. She had normal reversal of the lumbar curve when she bent forward. Straight leg raising was negative. Strength grades and muscle bulk in the legs were normal. Basically, the findings were minimal except for some tenderness which she reported in the right lumbar paraspinal. And I didn’t detect any other significant findings really.” (Randolph Dp. pg. 20)

Dr. Randolph testified about the percentage of disability he had assessed to each of these injuries:

“What I attributed, or what I opined in my report in that she had approximately 5 percent permanent partial disability of the person related to the injury occurring to the lumbar spine on 2/23/99. Additionally, 1 percent permanent partial disability to the person as a whole due to the injury of the lumbar spine occurring on 12/5/98. I attributed 1 percent permanent partial disability of the person as a whole due to early degenerative disc disease of the lumbar spine which was constitutional or hereditary in nature.” (Randolph Dp. pp. 21-22) (**Ruling:** Claimant’s objections are overruled. Randolph Dp. pp. 20 and 21)

Dr. Randolph stated that he would not impose any restrictions on Vester’s ability to work as of his 10/16/03 examination.

It was noted in the October 16, 2003 evaluation report that Bates had recently become engaged (about 2 days before the 10/16/03 exam). Dr. Randolph wrote the following in the Summary and Conclusions section of the 10/16/03 report:

In summary, Ms. Vester was involved in 3 work-related incidents as described above. These occurred while working at Ponderosa Steak House. The initial incident is best defined as a contusion to the right elbow. She states that she

recovered without any significant intervention. The current findings on exam are within normal limits. She reported no ongoing symptoms at the level of the right elbow. Therefore, I would conclude that she has 0% permanent partial disability of the right upper extremity related to the contusion to the right elbow occurring on or about 11/01/98.

She also sustained a contusion and sprain to the lumbar spine on or about 12/09/98. She states that this occurred when she was closing up the store as previously described. She states that she had no specific treatments for this injury and that her symptoms gradually went away.

Her third injury occurred on or about 02-23-99. This represents a sprain injury to the lumbar spine which resulted in some discogenic low back pain. The mechanism of injury – i.e. carrying a heavy load and twisting at the lumbar level – is consistent with a lumbar sprain likely involving the segmental level of the low back. Imaging studies revealed a small central disc protrusion in the context of some early degenerative changes at the L5-S1 level of the lumbar spine. Pamela was treated with conservative measures and appears to have made a very good recovery overall. She continues to have some episodic low back pain. Current physical findings show no deficits in motion. She has normal strength and normal sensory function. No radicular findings are noted on examination. Pamela is at MMI with regard to this injury. She requires no additional work-up or treatment.

Of note, she sustained some subsequent injuries to the lumbar spine which I detail in my earlier report.

I previously opined that Pamela had approximately 9% permanent partial disability of the person as a whole due to lumbar spine disease. I attributed about 2% of that disability to the lumbar injuries occurring at the Developmental Learning Center. The remaining 7% I consider to be essentially preexisting. My opinion is about the same with regard to her total lumbar disability. She has normal motion and no neurological deficits. She has normal strength and flexibility in her lower extremities. Therefore, my analysis is that she had approximately 9% permanent partial disability of the person as a whole due to lumbar spine disease. As I stated, I attribute 2% of this disability to injuries occurring at the Developmental Learning Center. I apportion 5% of this disability to the injury occurring on or about 02/23/99 at Ponderosa Steak House. Additionally, I apportion 1% permanent partial disability of the person as a whole to the injury to the lumbar spine occurring on or about 12-05-98 at Ponderosa Steak House. Finally, I attribute approximately 1% permanent partial disability of the person as a whole due to early degenerative disc disease of the lumbar spine which is constitutional or hereditary in nature.

On cross examination by the claimant, Dr. Randolph stated that he has had training in reading MRIs; the doctor agreed that there is a difference between an extruded disc and a prominent disc. It was noted that in his July 7, 2003 report, page 5, Dr. Randolph opined that an MRI revealed mild degenerative disc disease at L5-S1 characterized by posterior prominence of the disc at that level, and very slight prominence of the disc at L2-3 was also appreciated. “That’s correct”, the doctor answered. (Randolph Dp. pg. 28) When queried – that’s entirely different than extrusion isn’t it, Dr. Randolph responded – “That’s correct.” (Randolph Dp. pg. 28) It was noted that in his October 16, 2003, page 4, the doctor wrote that imaging studies revealed a small central disc protrusion in the context of some early degenerative changes at the L5-S1 level of the lumbar spine. “Yes”, Dr. Randolph answered. (Randolph Dp. pg. 29) Dr. Randolph stated that he had seen the report of the radiologist concerning the May 17, 1999 MRI; the following testimony then occurred:

- Q. So we’re clear on that, the MRI on May 17, 1999 was officially read as follows, quote, there was some disc space narrowing at the L5-S1. There is a central disc extrusion of moderate size at L5-S1 with some inferior migration through the extruded portion of the disc; that’s what it reads doesn’t it?
- A. It does say that.
- Q. That’s entirely different than your interpretation, isn’t it?
- A. It’s different.
- Q. It’s much more serious, isn’t it?
- A. Not necessarily from a clinical stand point.
- Q. I see. And there’s also a minor subligamentous, S-U-B-L-I-G-A-M-E-N-T-O-U-S, bulge of the L2-L3 disc on the left paracentral area; correct?
- A. That’s what the doctor wrote. (Randolph Dp. pp. 29-30)

Dr. Randolph agreed that the radiologist’s impression for the May 7, 1999 MRI was: 1. central disc extrusion with slight inferior migration at L5-S1; 2. some disc space narrowing in moderate desiccation at L5-S1; 3. minor subligamentous bulge at the L2-L3 disc on the left paracentral area; and 4. an unrelated findings of probable ovarian cyst. It was indicated that Dr. Randolph did not have the 01/03/02 MRI report, and a portion of the radiologist’s findings was noted – “there is no significant impingement upon the thecal sac or foramina”. Dr. Randolph responded that such a finding does not necessarily mean there is an impingement.

Dr. Wayne A. Stillings, M.D. testified by deposition on behalf of employer Ponderosa (No. 25). The doctor agreed that he evaluated Vester as to any psychiatric injuries that may have resulted from the alleged incidents at Ponderosa on November 1, 1998, December 5, 1998 and February 23, 1999. Dr. Stillings listed the records he had reviewed. Dr. Stillings noted Vester's relayed complaints at the evaluation: "She reported that occasionally, 'My back flames up (increased low pain),' mostly during her menses which are regular. The duration of the flare-up is from two to 14 days per month, lasting an average of seven days. Miss Vester also stated, 'When this does occur, I tend to slip into a bit of depression, noting severe, nothing major.'" (Stillings Dp. pg. 9) (**Ruling:** Claimant's objections on grounds of repetitious during the deposition are overruled, i.e. Dp. pp. 8, 13, 31) Dr. Stillings stated that he discussed with Bates her family history; the doctor noted that Vester's father drove her to the evaluation; abuse issues of sexual abuse when a child by a friend's father, and mental/verbal/emotional abuse by men she dated subsequent to her back injury were discussed by Dr. Stillings. "Miss Vester admitted that she is a poor historian, especially in regard to her relational history, work history, psychiatric history, et cetera. . . .", Dr. Stillings noted. (Stillings Dp. pg. 16) Discussing Vester's relayed history of her experience in school, Dr. Stillings testified:

"In school, she was an average student, but at age five, was diagnosed with ADHD, which caused her to be held back from the first grade.

She was treated with Ritalin for one year but her mother insisted that this medication be stopped and she had never had further treatment for this condition.

She graduated late from high school, at age 19 in '05-99." (Stillings Dp. pg. 17)

The doctor was asked what information Vester had provided regarding a work history, and Dr. Stillings initially responded:

"An attempt was made to chronologically construct further history including employment history, psychiatric history and psychosocial history.

When comparing some aspects of the history provided by Miss Vester to that in the medical records, it becomes clear that her self-report that she has a poor memory, like her father, is probably accurate.

Miss Vester stated, 'My memory is not very good,' but she made a genuine effort to provide chronologic historic information as best she could

At age 16, she worked as a counter person in a fast food restaurant for six months.

She quit this job after an ankle sprain.

Thereafter, she worked as 'Chuckie' for about eight months at Chuckie Cheese, stating, 'That was cool.'

She quit this job.

She is not sure of the year she was hired as a waitress at Ponderosa....."

"Miss Vester last worked at Ponderosa in the spring of 1999.

She believed she worked for one day and become upset when she was assigned work duties outside of her limited duty restrictions.

As a result, she apparently quit.

In the summer of 1999, she functioned as a clerk at Rothman Furniture for six months, but injured her back there, stating 'But I don't recall how.'

She was out of work for two weeks and upon return she was assigned the job of a telephone operator from which she was terminated due to poor performance and excessive bathroom breaks, which she explained were necessitated by heavy menses that month.

Thereafter, she worked as a telephone operator at True Manufacturing for a little more than a year.

This is where she met Jason and the 'gossip and rumors' started.

A group of employees who also comprised somewhat of a social group decided to take a bus tri to the wine country in the fall of 1999.

She alleged that a female coworker started rumors about her alleging that she had cheated on Jason who, in response to hearing the rumor, began making out with a married woman at the winery.

She threw her water bottle at Jason.

When she got on the bus, Jason stated, 'You're a fucking bitch.'

When she sat down, several coworkers hovered over her in a threatening and intimating fashion and began verbally attacking her.

As she was getting off the bus, she had words with the married lady and pushed her out of the way.

She found a police officer and asked for a ride home from Augusta to St. Peters.

After this incident, Miss Vester stated, 'I was ashamed to show my face. I was embarrassed,' and 'I felt stupid.'

She was reluctant to go to work but continued at work for a couple of weeks and then quit, alleging that she was feeling that her employer was trying to force her out because they changed her job duties.

Thereafter, she functioned as a receptionist at Superior Home Products for five months. She was fired when she didn't show up for work.

Currently she works as an order clerk for Reliv Corporation.

In summary, she has held at least seven jobs and been fired twice during the past seven years or so." (Stillings Dp. pp. 17-18 and 21-23)

The doctor discussed the information he had received concerning Vester's mental health care:

"Miss Vester reported that her first lifetime mental health care contact when she consulted a psychiatrist, Dr. Khojasteh in 12-01 for an assessment to arrange for psychiatric hospitalization for suicidal ideation.

She reported that she had been depressed for one to one-and-a-half years, but she wasn't really sure when her depression began.

At the time of the 2-99 work incident at age 17, Miss Vester was engaged to Chad.

In fact, over the course of that two-and-a-half year tumultuous relationship, they were engaged and broken up four times.

Miss Vester stated, 'I had a battle with him.' 'My head saying no, my heart saying yes,' with respect to the relationship, and 'He was kind of a pain,' and 'He was a liar, a thief.'

Miss Vester stated that Chad lied about being fired from multiple jobs, at least once for stealing and possibly from others.

As a characterization of the relationship, she said, 'It was young, stupid.'

She noted that the relationship had 'up and down emotions.'

She was sad when they broke up or had problems, and happy when they got back together, and this was a cycle.

She was rather nonspecific as to the dates when she and Chad were having problems.

She could not recall when they actually broke up, but it was sometime in 1999, after her back injury.

She reported the relationship was quite stressful at times.

In fact, Chad jilted her sometime in 1999 and a couple weeks later, she found out from his brother that he was engaged to a girl in Chicago.

She stated that he might have been engaged before he broke off their relationship.

Miss Vester was admitted to the psychiatric unit at St. Joseph's Hospital for approximately two weeks.

With respect to her recall and memory of the hospitalization, Miss Vester stated, 'Not much.'

After discharge, she had no follow-up psychiatric care because she felt better after going off the birth control pill and her back felt better.

She stated spontaneously that she was 'feeling more like myself.'" (Stillings Dp. pp. 19-21)

It was noted that Dr. Stillings had indicated in his report reviewing a substantial number of medical treatment records, and the doctor was asked what he had gathered from this review. Dr. Stillings answered:

"The record review is from the top of page seven to the top of page 14, so it is quite extensive.

You know, in a brief summary, I would say that in general there aren't very many objective findings that support her subjective complaints, and I think many of her complaints are rather hysterical in nature, and also demonstrate a pattern of dependency on the medical system.

And also would be consistent with a pattern where this person has some psychosocial stresses in her life, and tends to express them as physical complaints, thereby getting the attention of her doctors and her parents, and I think through that process she is able to sort of not deal with her personal problems and deal with them indirectly through her medical complaints." (Stillings Dp. pg. 24) (**Ruling:** Claimant's objection on grounds of hearsay is overruled. Stillings Dp. pg 24)

Vester's family psychiatric history was discussed by Dr. Stillings: "She reported that her father and brother have been treated for depression with antidepressants, and her paternal grandfather was psychiatrically hospitalized." (Stillings Dp. pg. 25)

Dr. Stillings testified as to Vester's mental status exam:

"Mental status, Miss Vester was an alert, cooperative, polite, young, casually but neatly attired white female.

There was no evidence of psychomotor retardation nor acceleration.

She walked with an odd limp on the right side.

Initially she placed an icepack behind her low back but as the evaluation proceeded, she removed this.

Speech was normal in rate and rhythm.

There was no formal thought disorder.

She did not appear to be in significant pain nor preoccupied with pain.
He tends to minimize the emotional impact of significant psychosocial stressors on her.
On the other hand, she tends to impute her depression primarily to the 2-99 work incident.
No psychological distress nor physiologic reactivity was manifest in regard to the 2-23-99 work incident nor its sequelae.
She displaced psychological distress when discussing her history of sexual abuse, the recent deaths of her grandmothers, her termination at Rothman Furniture, her difficult and conflicted relationship with Jason, and her two-and-a-half year relationship with her sometimes fiancé, Chad.
Her affect was pleasant and somewhat labile.
She had rapid shifts of mood.
She was slightly dramatic at times and overall is immature.
She laughed cheerily about the sleeping arrangement with her parents after her back injury.
Her mood was euthymic.
She was not depressed.
Miss Vester denied hallucinations, obsessions, compulsions, phobias, suicidal and homicidal ideation.
She was fully oriented to time, place and person.
Recent and remote memory functions are intact.
Cognitively she functions in the normal range.
Verbal comprehension and concentration were good.
Her general fund of knowledge is adequate.
Proverb interpretation was appropriate and accurate.
Her intellectual ability is in the normal range.
Insight and judgment are questionable.” (Stillings Dp. pp. 25-27)

The MMPI test was performed on Vester, the doctor said, and discussed the results:

“This is a valid profile, however this individual’s approach to the test is defensive and therefore psychopathology could be missed.

This individual tends to overlook faults in herself, her family and her life situation with a corresponding lack of insight and resistance to psychiatric evaluation.

Although extremely concerned that she present a positive image to others, nonetheless, she is not accurately aware of many impressions others have of her weakness.

She is defensively minimizing conflicts she might have in an attempt to look good.

The overall profile manifests the ‘characterological V,’ that’s a term of art.” (Stillings Dp. pp. 27-28)

Dr. Stillings gave an explanation:

“It is just a profile configuration on the ten major clinical scales which indicates the presence of may be some maladaptive personality traits.

And to that extent, people with this characterological V often are brooding, distrustful, irritable, self-centered, possibly hostile and usually unable to form close relationships.

They have a significant level of social maladjustment often related to blaming others for her personal faults and problems in life.

This style of blaming prevents them from developing insight into their own feeling and behavior since they are constantly focused on other’s behavior rather than their own.

She lacks self-criticism.

People with this profile are highly sensitive to real or imagined criticism from others, often inferring hostility or rejection when this was not intended.

In order to avoid rejection and maintain a level of security, they become adept at manipulating others.

People with this profile have a paranoid flare to their personality and are likely to feel that they are getting a raw deal from life and to feel misunderstood.

They have passive-aggressive personality features, and excessive needs for attention and affection.

The PD-S scale is highly elevated.

The constructs underlying individual with this profile involve rebelliousness and rationalization.

They are self-indulgent and have a persistent disposition to derogate authority figures.

They will not readily admit to their own responsibility for difficulties and rationalize these difficulties in an attempt to make them appear reasonable and justifiable.

They readily project blame and responsibility for their trouble onto others or external situations.

They resent, and are especially sensitive to anything that may be construed to be a demand made upon them.

At the same time, they demand sympathy from others.

People with this profile are in general immature, insecure, indecisive and passively manipulative.

They exhibit poor judgment.

These needs and the egocentric self-indulgent behavior already indicated is consistent with narcissism ascribed to these individuals by clinicians.

Relationships and occupations seem to be areas particularly effected by these individual's disorders.

Somatic symptoms most often reported include headaches, black out spells, amnesia and pain. (Stillings Dp. pp. 28-30)

Dr. Stillings testified as to his opinion of how the MMPI test results were consistent with other findings with regard to Vester:

"I think when you look at the MMPI, and this is an actuarial interpretation for this code type, this person does have excessive needs for attention and affection, and I think that it is demonstrated by her very, very close relationship with her mother, more than just a best friend, but really a dependent relationship.

Her mother was still waiting on her hand and foot and taking her to the bathroom and letting her sleep in her bed and things like that.

I also think that clearly the MMPI results shows that she is immature and that is readily apparent on mental status examination as well, and I think that is buttressed by her rather rocky occupational history, having multiple jobs where she quit or terminated or something has disrupted her occupational history and that is an immature profile. She also has had a lot of immature relationships which she would I think frankly admit, she said she was dating some guys were real jerks, and again this is really consistent with the MMPI where she has some poor judgment, she is insecure, she is immature, and I think this causes her relational problems and also occupational problems which are validated by her own history.

The other thing, she is a bit self-centered, and that shows up on the MMPI and people who are dependent, have dependent personality features are very self-centered and a bit narcissistic, and she I think controls, she is adept in a passive-aggressive way at controlling situations around her, like her parents and deflecting away from her own struggles of growing up by focusing on her medical problems, which is just a way of putting off her growing up. I think she is afraid to grow up.

I think she would like to grow up and be independent, she just doesn't know how to do that, and I think she needs some help with that." (Stillings Dp. pp. 31-33)

Dr. Stillings testified as to his diagnoses of Vester:

"AXIS I:

Number one, parent-child relational problem (dependency and codependency issues with her parents).

Number two, ADHD by history.

Number three, undifferentiated somatoform disorder.

Number four, major depressive disorder, single episode, in remission.

AXIS II:

Personality disorder, NOS, with dependence, hysteroid, and narcissistic personality features.

AXIS III (the physical diagnoses, physical problems):

No diagnosis.

AXIS IV:

Psychosocial stressors, in her case, when I saw her dependency on her parents, particularly her mother, financial and recent deaths of her two grandmothers.

AXIS V:

Global assessment of functional 55 which means moderate symptoms (it is a scale from zero to a hundred)"

(Stillings Dp. pp. 33-34)

Dr. Stillings gave his opinions as to any permanent psychiatric problem from the alleged incidents at Ponderosa:

"From my perspective, my opinion is that in relation to those incidents, she has no permanency from a psychiatric standpoint."

"Well, number two, Miss Vester has no psychiatric illness related to which I have enumerated on AXIS I and II, they are not related to the work incident, the three incidents you have enumerated.

Number three, Miss Vester has multiple psychiatric diagnoses which I have listed on AXIS I and II, and problems related to nonoccupational factors, and then number four, it is possible that the work injury of 2-22-99 mildly

contributed to the major depressive episode.” (Stillings Dp. pg. 35)

I did not recommend any further psychiatric treatment for any conditions stemming from the incident at Ponderosa, Dr. Stillings said, and I did not find any restrictions on Vester’s ability to work from a psychiatric perspective as a result of the incidents alleged at Ponderosa.

On cross examination by the claimant, Dr. Stillings gave the following testimony:

Q. And you still hold to the opinion that depression is not a psychiatric disorder?

A. Depression is the term for low moods it is not classified in DSM-IV as a psychiatric disorder.

Q. So your answer is you still maintain depression is not a psychiatric disorder, right?

A. Psychiatric symptoms, yes.

Q. I didn’t ask you that.

You say it is not a psychiatric disorder?

A. Per DSM-IV, that’s correct.

Q. Have you ever found people, have you ever diagnosed people with depression?

A. I would use – not really.

I would use the classification of DSM-IV. (Stillings Dp. pg. 49)

Dr. Stillings stated, during cross examination, that he usually interprets his own MMPIs. I used the original, the old MMPI on Vester, the doctor said. Agreeing that he had interpreted Vester’s MMPI test results, Dr. Stillings stated – “Well, you can say that, but that is based on actuarial statements taken out of MMPI textbooks and things like that.” (Stillings Dp. pg. 55)

On cross examination by Developmental Learning Center, Dr. Stillings agreed that he conducted his interview with Vester in August of 2003 and determined a fairly extensive employment and history of her work injuries. Vester did not give any history of having been employed by the Developmental Learning Center in the fall of 1999, the doctor said. When queried if Vester had given any history of having sustained any injuries while employed by the Developmental Learning Center in September, 1999 or October, 1999, Dr. Stillings answered that Vester had not. The doctor agreed that he did not attribute any disability to any injuries Vester had sustained at the Developmental Learning Center. It was noted that Dr. Stillings had indicated that it was possible that the February 1999 injury may have mildly contributed to Vester’s major depression episode, and Dr. Stillings agreed; when queried wasn’t it correct that he did not indicate in his report that it was possible that any injuries that Vester sustained at the Developmental Learning Center may have mildly contributed to her major depression episode, Dr. Stillings responded – “I certainly didn’t, I didn’t know about them.” (Stillings Dp. pt. 64)

On further cross examination by the claimant, the doctor was asked if he had known about or been supplied information about the Developmental Learning Center. Dr. Stillings answered: “In terms of the records review?”...I probably did see it in there.” (Stillings Dp. pg. 65) The doctor was further queried, didn’t Vester have a history of the Developmental Learning Center claims existing. “You are right, it was in the records, in the medical records, that’s right”, Dr. Stillings answered. (Stillings Dp. pg. 65) The employer/insurer, Ponderosa/Liberty Mutual, just told me about the pending claims against them, the doctor indicated. Concerning a claim history, Dr. Stillings testified: “it was in the medical records. The only thing I was directed to was the Ponderosa claim.” (Stillings Dp. pg. 66)

James England, Jr., vocational rehabilitation counselor, performed a records review to evaluate Vester’s employability in the open labor market on behalf of the Second Injury Fund. In his evaluation report of September 21, 2004 (Roman Numeral III), England discussed his review of medical records as well as any functional restrictions/limitations recommended by any doctors. England discussed his review of Vester’s deposition testimony, noting her physical complaints and limitations, her recent treatment for depression; it was noted that at the time of her deposition Vester was working at a sedentary job; England discussed Vester’s educational background and vocational history gleaned from Vester’s deposition testimony. England wrote the following summary and conclusions:

Ms. Vester is a younger worker under U.S. Department of Labor guidelines.

She has performed work in the past which would be considered sedentary to light from an exertional standpoint.

I did not see any information in the medical records that would contraindicate her ability to perform the types of work she has in the past.

Obviously her position in customer service and skip tracing would be the easiest from a physical standpoint. The

last job of which I was aware she was performing would have been the skip-tracing position and as of the time of the deposition she was performing that type of work adequately.

There is nothing I have seen in the medical records I reviewed that would lead me to believe that she is unable to perform at least sedentary to light work as she has in the past. These types of jobs are readily available in the open labor market and there is actually more demand for them than the supply of people to perform them.

It is found, considering the evidence, that the competent and substantial evidence establishes all of the following:

1. The substantial, competent medical evidence establishes that as a result of the February 22 or 23, 1999 work related accident, the claimant suffered the injury of acute lumbar strain, central disc extrusion with slight inferior migration at L5-S1 with some disc space narrowing and minor dessication at L5-S1 (i.e. 5/7/99 MRI report) and as of on 03/01/99 the protruded L5-S1 HNP was without any evidence of impingement on nerve root (i.e. Dr. Spezia's 08/04/00 report). And with aggravation during work hardening for the February 22 or 23, 1999 work related injury, the claimant suffered intermittent ache in the lateral aspect of her right lower extremity (i.e. 6/11/99 reports of The Work Center and Barnes Jewish St. Peters Hospital). Injuries sustained during authorized medical treatment of a prior compensable injury are the natural and probable consequence of the compensable injury and the employer is liable for all resulting disability. *See, generally, Lahue v. Missouri State Treasurer*, 820 S.W.2d 561, 563 (MO.App. W.D. 1991).

Considering the all of the evidence, it is found that there is substantial, competent evidence establishing permanent partial disability as a result of the low back injury sustained in the February 22 or 23, 1999 work related accident. It is found, though, that Dr. Poetz' opinion is not competent as to any permanent partial disability in regards to the February 22 or 23, 1999 work related low back injury in that the doctor assesses one percentage of disability for four separate low back injuries (one before and two after the February 22 or 23, 1999 injury) and does not break down the percentage as to each.

"In a workers' compensation case, it is the claimant's burden to prove "not only causation between the accident and the injury but also that a disability resulted and the extent of such disability." *Griggs v. A.B. Chance Co.*, 503 S.W.2d 697, 703 (Mo.App. W.D.1973). Further, "proof of permanency of injury requires reasonable certainty." *Id.* This proof must be based on competent and substantial evidence and not merely on speculation. *Id.* "Failure to offer expert testimony regarding the percentage of disability derived from the compensable injury bars the claimant from recovering permanent partial disability benefits." *Miller v. Wefelmeyer*, 890 S.W.2d 372, 376 (Mo.App. E.D.1994) (overruled on other grounds, *Hampton*, 121 S.W.3d 220); *see also, Goleman v. MCI Transporters*, 844 S.W.2d 463, 466 (Mo.App. W.D.1992) (overruled on other grounds, *Hampton*, 121 S.W.3d 220) (finding it was claimant's burden to prove the extent of the pre-existing injury if he was to receive permanent partial disability benefits for the additional injury)." *Moriarty v. Treasurer of State of Missouri*, 141 S.W.3d 69, 73 (Mo.App. E.D.,2004)

It is found that the competent and substantial evidence supports an award of 20% permanent partial disability of the body as a whole at the lumbar spine as a result of the February 22 or 23, 1999 work related low back injury of - acute lumbar strain, central disc extrusion with slight inferior migration at L5-S1 with some disc space narrowing and minor dessication at L5-S1 without any evidence of impingement on nerve root, and subsequent intermittent ache in the lateral aspect of her right lower extremity. This would be: 400 weeks x 20% = 80 weeks; 80 weeks x \$127.00 = \$10,160.00

2. The substantial, competent medical evidence does not establish a psychiatric diagnosis as a result of the February 22 or 23, 1999 work related injury, but does establish that the work related injury contributed to a major depressive episode (i.e. Dr. Stillings opinion). It is found that both Dr. Poetz and Dr. Stillings offered competent opinions on any disability in this instance, and it is found, considering all of the evidence, that the competent and substantial evidence supports an award of 5% permanent partial disability of the body as a whole in regards to the contribution to the major depressive disorder as a result of the February 22 or 23, 1999 work related injury. This would be: 400 weeks x 5% = 20 weeks; 20 weeks x \$127.00 = \$2540.00.

3. It is found that there is no medical opinion/diagnosis of an injury to the cervical spine as a result of the February 22 or 23, 1999 work related accident [i.e. a. Dr. Susan Albers, D.C. in her 04/30/99 record indicated that Bates was a new patient treated for complaints of low back pain; in a form completed by Bates was indicated other complaints of - neck pain. Dr. Albers noted a history of: "Feb. lifted a big tub of dishes & felt immediate pain in L/B - after LB tx from P.T. (20 visits) pt. gets better for awhile then exacerbates Pt. had 'shot' @ Dr's office 1 time."; Dr. Albers completed a form in which she indicated Bates had lower back pain and swelling in lower back, and that an accident had occurred on 02/30/99, the accident being - lifting a heavy tub of dishes at work. b. Dr. Poetz indicated on cross examination by Ponderosa, that "(N)ot to my knowledge" did Bates injure her cervical spine in any of the incidents at Ponderosa. Poetz Dp. pg. 11. c. the first diagnosis concerning the cervical spine was in the 09/30/00 emergency room treatment record of Barnes Jewish St. Peters Hospital in which it was noted that Bates was being seen after a fall at work at

Developmental Learning Center with injury to her left eyebrow area, neck and lower back, also with an associated symptom of - not loss of consciousness, but possibly dazed.].

4. It is found that Dr. Poetz' opinion that migraine headaches was an injury as a result of the February 22 or 23, 1999 work related accident is not supported by the medical records. The treatment records first reflect complaints of and treatment for a diagnosis of migraine headaches in Dr. Cabrera's record of 02/06/01, which is subsequent to the 09/30/00 work related injury that involved a fall with left eyebrow area injury, neck injury as well as an associated symptom of - possibly dazed (additionally, Dr. Poetz diagnosed the subsequent 09/30/00 work related injury as - Closed head trauma with loss of consciousness resulting in cerebral concussion syndrome, and cervical/lumbar strain with exacerbation of previous lumbar condition).

ISSUE – Injury Number 98-126746: Liability of the Second Injury Fund

Parameters for Second Injury Fund liability are set forth in Section 287.220 RSMo. This section requires that not only the compensable injury result "in additional permanent partial disability so that the degree or percentage of disability, in an amount equal to a minimum of fifty weeks compensation, if a body as a whole injury or, *if a major extremity injury only, equals a minimum of fifteen percent permanent partial disability*" (emphasis added), but also that the preexisting disability reaches the same threshold. Permanent partial disability for prior injuries has been assessed at or found to be less than the required threshold level for consideration of Second Injury Fund liability, consequently Second Injury Fund liability is denied.

ISSUE – Injury Number 99-013898: Liability of past medical expenses

The claimant testified - the next morning after February 23, 1999 when I got up I just wasn't able to move, my lower back hurt really bad, and my parents, you know, they called Ponderosa and told them that I wouldn't be in, that I was unable to come in to work because of my back hurting; I think they spoke to Jo Garcia, the manager, the claimant said. We decided to ride it out that day to see if I felt better and the next morning I still didn't feel any better, so my parents called my primary care doctor, Dr. Cabrera, and he said to take me to the emergency room, so that's where we went, Bates stated. We went to the emergency room at Barnes St. Peters, the claimant said, and I believe then they gave me a shot of -- I forget what it's called, I'm sorry. Testifying to the best of her memory of her medical treatment since February 23, 1999 up to the first accident she had at Developmental Learning Center on September 30, 1999, Bates stated – I was constantly going to the doctor. After going to the emergency room, we went to see Dr. Spezia, a back specialist, I think a bone and joint specialist, that Dr. Cabrera had recommended, she said. And I saw him and he recommended that I stay off work for a while; I think he was the one that also started me on physical therapy, I believe, she said. But I saw a few doctors in between there, Bates stated, I think I saw Dr. Spezia, Dr. Lange, and Dr. Tate also, she's the one that started me on the work-hardening program. The first time I went to the work-hardening program I actually hurt my back again, the claimant said, it was the same feeling, same thing in the same place, my lower back. They had me carrying some buckets down to my side; I had some buckets with, I think, a little bit of sand in it; they wanted to see how much I could carry and could tolerate, but that actually hurt my back doing that, it was just too heavy for me, I guess, Bates stated. I felt the same sharp pain that I had experienced before in my right lower back, she said, it went a little bit into my hip area, didn't go all the way down my leg that time. The claimant agreed that this was the work-hardening prescribed by Liberty Mutual's doctor. When it started hurting, I dropped the buckets, Bates said, I told the work-hardening people that it hurt, and they said okay, that was the end of that session that day.

Bates was shown Exhibit H described as a list of the medical bills; it was noted that the exhibit included a summary on the front sheet, and that noted in the exhibit were the bills paid by Liberty Mutual as best they could ascertain. Bates was asked if all of the bills, including the ones paid by Liberty Mutual, because of her injuries to her back at Ponderosa. Yeah, it looks like it, she answered. Bates agreed that she was asking for an award of these bills.

Bates stated that she had never had any CT Scans or MRI's of her back before February 23, 1999. She agreed that she had an MRI done May 7, 1999, and that after that someone told her she had a ruptured disc in her low back. Before I had gotten my MRI, Bates added, I went to see a chiropractor, Susan Albers, and she told us, my parents and I, that she would recommend getting an MRI. So we asked Dr. Lange for an MRI, we requested it ourselves, and he's the one that ordered it, and then he's the one that told me that it did come back with the results of a herniated disc, the claimant said. After the diagnosis of a herniated disc, my medical treatment was a series of things, Bates said, I tried several months of physical therapy, they had recommended taking steroid epidural shots but I actually was scared of that, so I didn't do it. They basically prescribed Ibuprofen to help the inflammation, ice on my back; just things that I could do for myself at home, she said. Since 2000, in the last four years, I haven't really had very much medical treatment, Bates said. I've seen several doctors about this, they all tell me the same thing, Ibuprofen and ice, the claimant stated, they've all said I'm too young in

their opinion as a candidate for surgery. If it gets worse I would be willing to have surgery, Bates said. She agreed that she is asking for an award of future medical treatment for her back injury. Currently for my back I am doing the same things, the claimant testified, Ibuprofen and ice, and just taking it easy really.

Bates was questioned about her testimony in regards to the medical bills marked as No. H during cross examination. The claimant stated that she remembered looking at these bills, and stated that she believed she had testified all of the bills were related to/had arose out of accidents at Ponderosa. She was asked if she was aware that the dates of treatment in some of the records were September 30, 1999. I was aware there were some earlier things, Bates responded. When asked if she aware that that particular date was the date of her injury at Developmental Learning Center, Bates responded - I'm not positive on the dates, I think so. She was queried if, in light of that fact that that treatment occurred on the date of the injury at Learning Developmental Center, may this treatment have arisen out of the injury at Developmental Learning Center? No, I don't think so, Bates answered, because I know when it happened. I know when my back injury happened, there's no question about that, she further stated. I believe the September 30, 1999 injury at Developmental Learning Center may have made the incident worse; does that answer your question, the claimant said. When further queried - do you think it was also the incident at Developmental Learning Center that might have been a substantial cause of your need for treatment on the date of the September 30, 1999 injury, Bates answered that it may have. Bates admitted that she flipped through these medical bills, that she did not get a very thorough look, so it's possible that she may have overlooked some dates of treatment that were not in fact related to the Ponderosa incident.

It has previously been determined in this Award that the records of The Parkcrest Surgical Associates, Inc. reflected that Bates reached maximum medical improvement and could return to work without restrictions as of June 30, 1999; it is found that this is the date the claimant reached maximum medical improvement for injuries sustained in the February 22 or 23, 1999 work related accident^[6].

Thus considering treatment records prior to June 30, 1999 (please see **Issue – Temporary total disability** section of this Award for a discussion of these medical records), along with the claimant's list of bills (CI's H) and the employer/insurer's list of medical bill payments (Emp/Ins's. No. 30), the following is found:

1. It is found that there is a sufficient factual basis upon which to award compensation for the Barnes-Jewish St. Peters Hospital bill of 02/26/99, as well as the 06/11/99 bill which concerned the emergency room treatment of Bates on that date for increase in pain of her back injury as well as radiating pain into the right leg; this was subsequent to the exacerbation during work hardening at The Work Center. *See, generally, Martin v. Mid-America Farm Lines, Inc.*, 769 S.W.2d 105, 111-112 (Mo.banc 1989).

It is found that the Washington University School of Medicine bill for an x-ray performed on 02/26/99 is compensable.

It is found that the Kingsway Emergency Physicians bill for treatment at Barnes-Jewish St. Peters on 06/11/99 is compensable.

It is found that the St. Charles County Ambulance District bill for service on 06/11/99 is compensable.

2. It is found that there is a sufficient factual basis upon which to award compensation for the bills of HealthSouth for service in March – June, 1999. Medical records of **HealthSouth** in Cave Springs (No. K; See, also, No. 11) indicated that Bates was sent to the facility for physical therapy for low back pain in March 1999, April 1999, May 1999, June 1999 and July 1999. The physical therapy record indicated a date of injury of 02/23/99. (NOTE: Emp/Ins. Exh. No. 30 reflects payment of this bill.)

3. It is found that there is a sufficient factual basis upon which to award compensation for the May 7, 1999 MRI performed at NYDIC (No. E; See, also, No. 14), and referred to by treating physicians.

4. It is found that there is an insufficient factual basis upon which to award compensation for the bills from Dr. David Lange/St. Louis Orthopedic Inst. Inc. in that there are no supporting medical records in evidence. (NOTE: CI's No. H and Emp/Ins. Exh. No. 30 both indicate that this bill was paid by the workers' compensation insurance carrier, thus the bill may not be in dispute.)

5. It is found that Emp/Ins. Exh. No. 30 indicate that The Work Center bill was paid by the workers' compensation insurance carrier.

6. It is found that the substantial weight of the evidence supports an award of compensation for Dr. Spezia's bill of 03/01/99 in that the evidence indicates that the employer was aware of and condoned this treatment of Dr. Spezia. It is found that the substantial and competent evidence is the claimant's testimony indicating that the employer was aware of her injury

and informed of her need for treatment, the stipulation between the employee and employer/insurer that the claimant was temporarily and totally disabled as a result of the February 22 or 23, 1999 work related injury during the time period of 02/26/99 – 03/28/99, and the fact that the only medical record of treatment during this time period was Dr. Spezia's record.

7. It is found that any bill in Claimant's Exhibit No. H subsequent to June 30, 1999 (the determined date of maximum medical improvement for the February 22 or 23, 1999 work related injury) is not compensable.

ISSUE – Injury Number 99-013898: Future medical care

It has been determined in this Award that the competent and substantial evidence establishes the injuries suffered by the claimant that as a result of the February 22 or 23, 1999 work related accident, the claimant suffered injuries of acute lumbar strain, central disc extrusion with slight inferior migration at L5-S1 with some disc space narrowing and minor desiccation at L5-S1, and also that the February 22 or 23, 1999 work related injury contributed to a major depressive episode.

Bates stated that after the diagnosis of a herniated disc, her medical treatment was a series of things. I tried several months of physical therapy, they had recommended taking steroid epidural shots but I actually was scared of that, so I didn't do it. They basically prescribed Ibuprofen to help the inflammation, ice on my back; just things that I could do for myself at home, she said. Since 2000, in the last four years, I haven't really had very much medical treatment, Bates said. I've seen several doctors about this, they all tell me the same thing, Ibuprofen and ice, the claimant stated, they've all said I'm too young in their opinion as a candidate for surgery. If it gets worse I would be willing to have surgery, Bates said. She agreed that she is asking for an award of future medical treatment for her back injury from the February 22 or 23, 1999 work related accident.

Bates was queried at the hearing as to who did she plan to go to for treatment for her back for the immediate future, what was she doing medical-wise. I'm not really doing a whole lot right now, Bates answered. Anytime I have an episode with my back, my parents usually come out to my house and take care of the baby for me, and I usually lay in bed with ice on, and I take Ibuprofen, she testified. It's happened three times that my parents have come to my house because of my back since the baby's been born, and my baby is five months old, Bates stated. My parents stay all day until my husband gets off work, and then he takes over for them, and then they'll come back the next day, she said.

On cross examination by Ponderosa, Bates agreed that she injured her back a number of times subsequent to her injuries alleged against Ponderosa. She agreed that she injured her back at home carrying bags up stairs in January of 2002, and she injured her low back while working for Development Learning Center on September 30, 1999. When queried that she had also injured her low back on October 22, 1999 while working for Developmental Learning Center, Bates responded - I think so, yes. She stated that the primary injury from the incidents at Developmental Learning Center was to her low back. In the incident where I was injured at Developmental Learning Center on September 30, 1999 on the playground equipment, I was knocked unconscious for a little while, I was taken by ambulance to Barnes St. Peters Hospital, Bates agreed. She agreed that she continued to treat following that incident for her low back. The subsequent incident at Developmental Learning Center was an injury where I was picking up a child, Bates agreed. She stated that when this incident occurred she immediately felt a sharp pain in your low back like the same one as before. Bates stated that she believed she was working at True Manufacturing when she had the incident at home in January of 2002 carrying bags upstairs. She was queried wasn't it true that this was the incident that immediately preceded her leave from True Manufacturing. I believe that incident happened and then I was off work for a while and went to the hospital for mental reasons, Bates answered. Bates agreed that her back was injured again at True Manufacturing on the first day she was assigned to clerical duties because of the up and down motion while filing.

Parkcrest Surgical Associates, Inc. treatment records in the final treatment note of June 30, 1999 included that Bates denied specific difficulty with work hardening except the first day 2 weeks ago and since that time, she's had no significant increased pain, has been able to progress with her therapy, and is lifting up to 35 lbs. She continues to have pain in the left and right side of her back. She has radiation of pain in the lateral aspect of the leg to the knee only. This occurs mostly after sitting and driving for more than an hour. She reports that she's had to have friends drive for her. She has no bowel/bladder difficulty or muscle weakness. She's been taking ibuprofen for the last few days but otherwise has had no medication at all. She reports the only difficulty she had with work hardening was just being really afraid of re-injuring herself or straining.

Examination findings on June 30, 1999 were the same. The doctor's assessment on June 30, 1999 was:

Patient had disc protrusion at the L5-S1 level. She's currently able to perform the activities of her job as a waitress as noted by the physical therapist and his job-site evaluation. She is able to lift 35 lbs without increasing difficulty.

Both the patient and her mother feel that returning to work would possibly be too early at this time; however, I told them that we have no objective evidence that going back to work would cause any difficulty. They have requested a neurological opinion. At the current time, I think the patient's at maximum medical improvement and could return to work without restrictions.

In an August 4, 2000 letter, a treating doctor, Dr. Spezia, wrote that an MRI performed subsequent to Bates' initial visit on 03/01/99 "showed a protruded L5-S1 HNP but without any evidence of impingement on nerve root." "She certainly had a non-surgical exam at that time, both by MRI findings as well as by clinical findings", the doctor wrote. Dr. Spezia further wrote:

After July 14, 1999 the patient returned for further care August 4, 1999. She states that she was 65% better, did not feel like she had enough pain for any type of treatment to include epidural steroid injection. Neurologically she was negative.

I again spent time telling her at length that this was a non-surgical problem and that sub-specialty orthopedic care would not be needed any further. In the meantime in April of 1999 a maximum medical disability evaluation was given by myself and a rating of 5% was given stating that the disability was based upon her history of back pain that is still intermittent in nature but that this would not affect her choice of gainful employment.

I have not seen my patient, Pamela Vester, since August 4, 1999 and my opinion has not changed, since that last exam, in terms of requiring surgery or requiring further work-up.

Dr. Spezia, in his August 4, 2000 letter, listed the medical records he described as "(A) large packet of information' and noted that they had been reviewed at length. "This additional information does not change my current opinion of Pamela Sue Vester's evaluation and final diagnosis as noted on my last office note", Dr. Spezia wrote.

Dr. Terrence Piper, M.D., in a March 14, 2001 report to the claimant's attorney, wrote that he first saw Bates in May 2000. Noting that he had been asked to answer numerous questions concerning events that transpired in 1998 and 1999, Dr. Piper further wrote: "Suffice it to say at this juncture that I have reviewed Dr. Spezia's letter dated August 4, 2000 concerning Mrs. Vester, which I completely concur with."

Dr. Randolph evaluated the claimant on behalf of the employer/insurer and wrote in an October 16, 2003 evaluation report the following in the Summary and Conclusions section of the 10/16/03 report:

In summary, Ms. Vester was involved in 3 work-related incidents as described above. These occurred while working at Ponderosa Steak House. The initial incident is best defined as a contusion to the right elbow. She states that she recovered without any significant intervention. The current findings on exam are within normal limits. She reported no ongoing symptoms at the level of the right elbow. Therefore, I would conclude that she has 0% permanent partial disability of the right upper extremity related to the contusion to the right elbow occurring on or about 11/01/98.

She also sustained a contusion and sprain to the lumbar spine on or about 12/09/98. She states that this occurred when she was closing up the store as previously described. She states that she had no specific treatments for this injury and that her symptoms gradually went away.

Her third injury occurred on or about 02-23-99. This represents a sprain injury to the lumbar spine which resulted in some discogenic low back pain. The mechanism of injury – i.e. carrying a heavy load and twisting at the lumbar level – is consistent with a lumbar sprain likely involving the segmental level of the low back. Imaging studies revealed a small central disc protrusion in the context of some early degenerative changes at the L5-S1 level of the lumbar spine. Pamela was treated with conservative measures and appears to have made a very good recovery overall. She continues to have some episodic low back pain. Current physical findings show no deficits in motion. She has normal strength and normal sensory function. No radicular findings are noted on examination. Pamela is at MMI with regard to this injury. She requires no additional work-up or treatment.

Of note, she sustained some subsequent injuries to the lumbar spine which I detail in my earlier report.

Dr. Poetz' diagnoses after his initial examination of Bates on the claimant's behalf on August 30, 2001 exam were: 1. Contusion right elbow, 11/1/98; 2. Lumbar strain, coccalgia and pre-sacral ecchymosis, 12/5/98; 3. Lumbar strain and herniated nucleus pulposus with exacerbation of previous lumbar strain, 2/23/99; 4. Depression, 2/23/99; 5. Closed head

trauma with loss of consciousness resulting in cerebral concussion syndrome, and cervical/lumbar strain with exacerbation of previous lumbar condition, 9/30/99; 6. Lumbar strain with exacerbation of previous lumbar condition, 10/22/99; and 7. Left temporomandibular joint syndrome, 1993. The doctor gave a general recommendation on future medical care of: range of motion exercises, nonsteroidal anti-inflammatory medication, avoid heavy lifting and strenuous activity, if no response to conservative care and continued low back pain then consider lumbar myelogram and post myelogram, surgical intervention if indicated. Dr. Poetz had opined: "It would be difficult to ascertain the exact injury date of the disc because the patient states that the lower back symptoms resolved several weeks after the December 5, 1998 injury with no residual effects. It is therefore attributed to the February 23, 1999 incident as she remained symptomatic from that date on." In his third and final report of September 15, 2004, Dr. Poetz noted that he had seen Bates again on September 10, 2004 for re-evaluation, and that after that evaluation he had received additional medical record for review. Dr. Poetz wrote:

Overall, the patient had no significant complaints and seems somewhat better in regards to her migraines and depression. However, with the chronicity of her lower back pain it is almost certain that future medical care will be needed. She has a herniated nucleus pulposus with symptoms that continue. It is more probable than not that surgical intervention will be needed at a later time.

In conclusion, after examination of the patient and review of the additional medical records it is my opinion that the determinations in my previous report dated May 15, 2003 remain unchanged.

At his deposition, Dr. Poetz was asked his opinion as to why he felt Bates will need future medical treatment, and the doctor answered:

"Well, the answer is, as to why I think that she will require surgical intervention in the future, I feel it's more probable than not that she will because of the natural progression of ruptured discs. She has a ruptured disc in the lower back, and a ruptured disc in the lower back secondary to degenerative disc disease or to trauma typically progresses with time and with age, plus the fact that she continues to be symptomatic of a ruptured disc in the lower back, so I feel it's just a matter of time until her ability to tolerate the ruptured disc comes to an end and she'll require surgical intervention." (Poetz Dp. pg. 8) (**Ruling:** Second Injury Fund's and Employer/Insurer's objections on grounds of seven day rule are overruled. See, Poetz Dp p. 7 and 8)

The doctor was asked if there was any medical care Bates was going to need in the future other than surgical intervention, and Dr. Poetz testified:

"Well, she would certainly continue under conservative care for her low back pain and her other diagnoses until such time as surgical intervention were necessary, so the conservative care of perhaps intermittent therapy, perhaps anti-inflammatories which I think she had recommended as well, perhaps pain management, perhaps epidural steroid injections. These can all be relieving temporary symptoms of ruptured discs, so those treatments may or are very likely to be necessary in the future." (Poetz Dp. pp. 8-9)

On cross examination, Dr. Poetz agreed that the May 2003 physical examination was pretty much the same as it had been when he had seen Bates earlier in 2001. The doctor was asked if in any of the medical records he had reviewed were there any doctors who recommended surgical intervention for the lumbar spine. "Not to my knowledge", Dr. Poetz answered. (Poetz Dp. pg. 36)

Dr. Stillings evaluated the claimant on behalf of the employer/insurer and noted in his discussion as to any permanent psychiatric problem from the alleged incidents at Ponderosa:

"Well, number two, Miss Vester has no psychiatric illness related to which I have enumerated on AXIS I and II, they are not related to the work incident, the three incidents you have enumerated. Number three, Miss Vester has multiple psychiatric diagnoses which I have listed on AXIS I and II, and problems related to nonoccupational factors, and then number four, it is possible that the work injury of 2-22-99 mildly contributed to the major depressive episode." (Stillings Dp. pg. 35)

Dr. Stillings further testified - I did not recommend any further psychiatric treatment for any conditions stemming from the incident at Ponderosa, and I did not find any restrictions on Vester's ability to work from a psychiatric perspective as a result of the incidents alleged at Ponderosa.

"A worker is entitled to medical treatment as may reasonably be required to cure and relieve from the effects of the injury. Section 287.140.1; *Williams*, 982 S.W.2d at 311.....The claimant is not required to present evidence

[5] It should be noted that a careful review of this record (both No. G and No. 16) did not reveal a report of an MRI of the lumbar spine.

[6] It should be noted that Dr. Stillings' testimony "it is possible that the work injury of 2-22-99 mildly contributed to the major depressive episode" is found to be referring to the hospitalization of Bates from 12/29/01 through 01/12/02 because of increased depression symptoms reflected in St. Joseph Health Center, St. Charles medical records. As it was determined in this Award that the substantial, competent medical opinions did not establish a psychiatric diagnosis as a result of the February 22 or 23, 1999 work related injury, but only established that the work related injury contributed to the major depressive episode, it is found that the treatment for the major depressive episode was not as a result of the February 22 or 23, 1999 work related accident and injury.