

Issued by THE LABOR AND INDUSTRIAL RELATIONS
COMMISSION

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

Injury No.: 04-092537

Employee: Lisa Bowman

Employer: Radnor Holdings, L. P., d/b/a Wincup

Insurer: Insurance Company of the State of Pennsylvania

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. Having reviewed the evidence and considered the whole record, the Commission finds that the award of the administrative law judge is supported by competent and substantial evidence and was made in accordance with the Missouri Workers' Compensation Act. Pursuant to section 286.090 RSMo, the Commission affirms the award and decision of the administrative law judge dated July 30, 2008, and awards no compensation in the above-captioned case.

The award and decision of Administrative Law Judge Carl Mueller, issued July 30, 2008, is attached and incorporated by this reference.

Given at Jefferson City, State of Missouri, this 13th day of March 2009.

LABOR AND INDUSTRIAL RELATIONS COMMISSION

William F. Ringer, Chairman

Alice A. Bartlett, Member

John J. Hickey, Member

Attest:

Secretary

FINAL AWARD

Employee: Lisa Bowman Injury No: 04-092537
Dependents: N/A
Employer: Radnor Holdings, L.P., d/b/a Wincup
Additional Party: None
Insurer: Insurance Company of the State of Pennsylvania
Hearing Date: June 30, 2008 Checked by: RCM/rm

FINDINGS OF FACT AND RULINGS OF LAW

1. Are any benefits awarded herein? Only those already provided; no additional benefits are awarded.
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: June 13, 2004
5. State location where accident occurred or occupational disease was contracted: Higginsville, Lafayette 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 bent over to pick debris off floor and as she came up she struck her head on a metal object.
12. Did accident or occupational disease cause death? No Date of death? N/A
13. Part(s) of body injured by accident or occupational disease: Body as a whole (head)
14. Nature and extent of any permanent disability: zero (0%) disability of the body as a whole
15. Compensation paid to-date for temporary disability: \$9,812.25
16. Value necessary medical aid paid to date by employer/insurer? \$9,788.66
17. Value necessary medical aid not furnished by employer/insurer? \$0.00

18. Employee's average weekly wages: \$420.52
19. Weekly compensation rate: \$280.35
20. Method wages computation: By stipulation
21. Amount of compensation payable:

Medical Expenses

Medical Already Incurred \$9,788.66
 Less credit for expenses already paid (\$9,788.66)
 Total Medical Owing \$0.00

Temporary Disability

TTD Already Incurred \$9,812.25
 Less credit for benefits already paid (\$9,812.25)
 Total TTD Owing \$0.00

Permanent Partial Disability

0% whole body disability (.00 x 400 weeks) x \$280.35/week \$0.00

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 Total Award: \$0.00

22. Second Injury Fund liability: N/A
23. Future requirements awarded: None

FINDINGS OF FACT and RULINGS OF LAW:

Employee: Lisa Bowman Injury No: 04-092537

Dependents: N/A

Employer: Radnor Holdings, L.P., d/b/a Wincup

Additional Party: None

Insurer: Insurance Company of the State of Pennsylvania

Hearing Date: June 30, 2008 Checked by: RCM/rm

On June 30, 2008, the employee and employer appeared for a final hearing. The Division had jurisdiction to hear this case pursuant to §287.110. The employee, Ms. Lisa Bowman, appeared in person and with counsel, Jerry Kenter. The employer, Radnor Holdings, L.P., d/b/a Wincup (“Wincup”) and its insurer appeared through William G. Belden. The Second Injury Fund was not a party to the case. The issues the parties requested the Division to determine was whether or not Ms. Bowman has reached maximum medical improvement, whether Wincup must reimburse the employee for past medical expenses totaling \$6,386.20, whether Wincup must provide the employee with additional medical care, whether the employee is entitled to additional TTD and if the employee has reached maximum medical improvement, the nature and extent of disability, if any. For the reasons noted below, I find that the employee has reached maximum medical improvement, that the requests for additional medical treatment, payments of past medical expenses and TTD are denied and that the employee has not proven she sustained permanent partial disability from the

work-related injury of June 13, 2004.

STIPULATIONS

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The parties stipulated that:

- On or about June 13, 2004 (“the injury date”), Wincup was an employer operating subject to Missouri’s Workers’ Compensation Law with its liability fully insured by Insurance Company of the State of Pennsylvania;
- Ms. Bowman was Wincup’s employee working subject to the law in Higginsville, Lafayette County, Missouri;
- Ms. Bowman sustained an accident arising out of and in the course of her employment with Wincup on the injury date;
- Ms. Bowman both notified Wincup of her injury and filed her claim within the time allowed by law;
- On the injury date, Ms. Bowman’s average weekly wage was \$420.52, resulting in a compensation rate of \$280.35 for both temporary total and permanent partial disability compensation;
- Wincup has paid Ms. Bowman Temporary Total Disability Compensation totaling \$9,812.25 from June 15, 2004 through September 17, 2004, and from December 20, 2004 through May 8, 2005;
- Wincup provided Ms. Bowman with medical care costing \$9,788.66. This sum includes the bills from Lafayette Regional and Mid-America Radiology that are contained in Exhibit B; and
- If Ms. Bowman has reached maximum medical improvement, the nature and extent of disability, if any, is an issue for today’s hearing.

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ISSUES

The parties requested the Division to determine:

- Whether Ms. Bowman has reached maximum medical improvement?

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- Whether Wincup must reimburse the employee for medical expenses totaling \$6,386.20?
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- Whether Wincup must provide the employee with additional medical care?
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- Whether Ms. Bowman is entitled to additional TTD from May 9, 2005 through today and into the future until she reaches maximum medical improvement? And,
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- If Ms. Bowman has reached maximum medical improvement, then determining whether she has suffered any disability and, if so, the nature and extent of her disability?

FINDINGS OF FACT

Ms. Bowman testified on her own behalf, and called one additional witness, Stacey Bowman. Ms. Bowman also presented the following exhibits, all of which were admitted into evidence without objection:

Exhibit A – Medical records documenting treatment Ms. Bowman received, including the following:

- Higginsville Medical Clinic/Dr. Singh
- Lafayette Regional Health Center
- Dr. Kathryn Hedges
- NYDIC MRI
- Higginsville Physical Therapy
- Kansas City Bone & Joint
- Dr. Thomas Whittaker
- Dr. Neal Deutch
- Crutchfield Chiropractic, P.C.
- Family Practice Associates/Dr. Pulliam
- The Headache & Pain Center
- PainCare
- Dr. Vicki Folsom

Exhibit B – Medical bills of Crutchfield Chiropractic, P.C.

Exhibit C – Narrative report of Allen J. Parmet, M.D., dated January 24, 2006

Exhibit D – Medical records since June 16, 2006, including the following:

- Health Center of America/Dr. Ryser
- University of Kansas Medical Center Radiology
- Columbia Center for Neurology & Multiple Sclerosis/Dr. Batchu
- Midwest Neurosurgery Associates/Dr. Chilton

Exhibit E – Narrative report of Allen J. Parmet, M.D., dated June 20, 2007

Exhibit F – Temporary Award, dated July 5, 2006

Exhibit G – Deposition of Allen J. Parmet, M.D., taken November 21, 2007, including Parmet Deposition Exhibits 1 through 5. After reviewing the transcript, all objections to the introduction of Exhibits 1 through 5 are overruled.

Exhibit H – Deposition of Reginald W. Dusing, M.D., taken June 17, 2008, including Dusing

Deposition Exhibits 1 through 4 and the correction sheet completed by Dr. Dusing. After reviewing the transcript, the objections to the introduction of Exhibit 4 and all questions based on Exhibit 4 are overruled.

Exhibit 1 – Medical bills received by the Employee since June 16, 2006

Although the employer did not call any witnesses, it did present the following exhibits, all of which were admitted into evidence without objection:

Exhibit 1 – Narrative report of Michael E. Ryan, M.D., dated February 24, 2005

Exhibit 2 – Narrative report of Patrick L. Hughes, M.D., dated May 13, 2005

Exhibit 4 – Deposition of Michael E. Ryan, M.D, taken December 18, 2007, including Ryan Deposition Exhibits 1 through 4

Exhibit 5 – Request for Hearing – Final Award, filed April 18, 2008

The employer offered as Exhibit 3 the narrative report of J. Michael Smith, M.D., dated December 22, 2004. The employee objected to the introduction of the exhibit on the grounds that it was a narrative report addressing nature and extent of permanent partial disability that was furnished to counsel for the employee and was not submitted properly under Section 287.210.7, RSMo., that the deposition of Dr. Smith had not been taken and that Dr. Smith was not present to testify live at the hearing. The Court sustained the objection and Exhibit 3 was not admitted into evidence.

A hearing for a temporary award for this matter was held on June 16, 2006. The Court has been provided the Transcript of Temporary Proceedings, and its file contains the exhibits that were previously admitted into evidence at the hearing of June 16, 2006. The Court takes judicial notice of the Transcript of Temporary Proceedings and the exhibits that were admitted into evidence at the hearing of June 16, 2006.

Based on the above exhibits and the testimony of Ms. Bowman and the other witness, I make the following findings:

Lisa Bowman is 45 years of age, and lives in Higginsville, Missouri. Ms. Bowman finished the 10th grade in high school and never obtained a GED. Ms. Bowman started working at Wincup on November 15, 2002 through a temporary agency, and became a regular employee of Wincup in January 2003. At the time of accident, Ms. Bowman worked as a Pac-Tech, which required her to operate production equipment. Ms. Bowman testified that her job required her to watch eight or nine machines for jams and to change plastic rolls weighing 50-75 pounds.

Ms. Bowman's medical history includes a prior head injury that occurred in childhood, for which Ms. Bowman was unconscious for a week. *Transcript of Temporary Proceedings*, pp. 20-21. Ms. Bowman also had a medical history of headaches. The medical records of Family Practice Associates document an office visit on March 27, 2003, where Ms. Bowman gave a history of intermittent headaches. See Exhibit A, p.33. On March 27, 2003, Ms. Bowman reported severe headache with vision loss. *Id.*

On June 13, 2004, Ms. Bowman bent over to pick up Styrofoam from the floor, and as she came up she struck the top of her head on a metal box and fell to the ground. Loss of consciousness was denied. Ms. Bowman testified that at the time of the accident, she heard a crack in her neck and her neck felt "crunched." Ms. Bowman also testified that the box took some of her hair out, and that her ears hurt and felt like they were bleeding. Ms. Bowman also testified to experiencing loss of vision, which she initially testified to not feeling before the accident. Ms. Bowman also reported headaches, and felt "dazed" after the accident. Ms. Bowman took a moment to compose herself and continued working her regular job that day. Ms. Bowman did not seek medical treatment from the employer that day. See *Transcript of Temporary Proceedings*, pp. 20-22.

The following day, Ms. Bowman felt like her head was full of pressure, with her symptoms

unchanged from the prior day. Ms. Bowman contacted her family physician, Dr. Brockhaus, for additional medical treatment. Ms. Bowman testified that Dr. Brockhaus would not see her because she had a workers compensation injury. Ms. Bowman contacted Wincup and was referred to Dr. Singh for medical treatment. See *Transcript of Temporary Proceedings*, pp. 22-23

Dr. Singh first saw Ms. Bowman on June 15, 2004. Ms. Bowman testified that she was truthful with Dr. Singh about her symptoms. Ms. Bowman reported that she struck the top of her head. Dr. Singh documents a severe headache and blurring of vision. See Exhibit A, p.157. The blurring of vision had cleared up. *Id.* Other symptoms were denied. *Id.* A CT scan of the head was recommended. *Id.* The CT scan of the head was performed on June 22, 2004, and was interpreted as negative. See Exhibit Z, pp. 147, 157. On June 25, 2004, Ms. Bowman returned to Dr. Singh, and reported that her headache persisted. See Exhibit A, p.157. Ms. Bowman was referred to a neurologist, Dr. Hedges, for evaluation. *Id.*

During the time that Ms. Bowman was receiving treatment from Dr. Singh, the authorized treating physician, she also commenced treatment with Crutchfield Chiropractic. See Exhibit A, pp. 43-70. Ms. Bowman testified that she went to Crutchfield Chiropractic on her own while she was receiving authorized medical treatment from providers selected by Wincup. Ms. Bowman testified that no authorized medical provider referred her to Crutchfield Chiropractic. Ms. Bowman received treatment at Crutchfield Chiropractic from June 14, 2004 through July 8, 2005. See Exhibit A, pp. 44-47. Some of these services were paid by Ms. Bowman. *Id.* Included in the record are treatment records for June 14, 2004 through May 13, 2005. See Exhibit A, pp. 48-61.

Ms. Bowman saw Dr. Hedges, based on Dr. Singh's referral, on June 30, 2004. See Exhibit A, pp. 110-11. Ms. Bowman testified that she was truthful when she saw Dr. Hedges. As part of the examination, Ms. Bowman completed and signed an intake form reporting headaches for the past 18 days. See Exhibit A, p.114. No other symptoms were noted on the form that Ms. Bowman completed. *Id.* Ms. Bowman reported a blow to the top of her head. See Exhibit A, p.110. Dr. Hedges reports headache and photophobia, and that the initial blurry vision went away. See *id.* Dr. Hedges did not record neck pain during her examination. See Exhibit A, p.111. Dr. Hedges diagnosed post-traumatic headache, and possible occipital neuralgia, and prescribed medication. *Id.* An MRI was recommended if the headaches persisted. *Id.*

On July 12 and 16, 2006, Ms. Bowman returned to Dr. Singh, and reported ongoing headaches. See Exhibit A, p.158. An MRI of the brain was performed on July 22, 2004. See Exhibit A, p.150. This study was interpreted as negative. See Exhibit A, p.159. Ms. Bowman was sent back to Dr. Hedges. *Id.*

On August 19, 2004, Ms. Bowman returned to Dr. Hedges. During this visit, Ms. Bowman reported severe pain in the head, and daily neck and spine pain. See Exhibit A, p.112. Ear infections, shakiness of the extremities and dizziness were also reported. *Id.* Dr. Hedges noted that although Ms. Bowman said the dizziness persisted since the accident, it was not noted on the initial intake form that Ms. Bowman completed. *Id.* Dr. Hedges performed an examination, and found nothing on physical exam that led her to think there was anything other than post-traumatic syndrome. *Id.* Dr. Hedges made referrals to other specialists for evaluation, including an ophthalmologist and rehabilitation physician, and an MRI of the cervical spine was ordered. See Exhibit A, p.113. The MRI of the cervical spine was performed on August 24, 2004, and was interpreted as showing minor bulging at C4-5 and C6-7 without impingement or stenosis, and straightening of the cervical lordosis. See Exhibit A, p.102.

On September 14, 2004, Ms. Bowman was seen for a physical therapy evaluation at Higginsville Physical Therapy. See Exhibit A, pp. 96-100. Ms. Bowman testified that Dr. Hedges referred her to Higginsville Physical Therapy, and that Wincup refused to authorize physical therapy. Dr. Hedges' records, however, state that she did not order physical therapy. See Exhibit A, p.122.

Ms. Bowman was seen by a physical medicine specialist, Dr. Patel, based on Dr. Hedges' referral to a rehabilitation specialist, on September 15, 2004. See Exhibit A, pp. 91-95. Ms. Bowman reported "pain about the whole head," and pain in the entire spine, after she sustained a blow to the top of her head. See Exhibit A, p.93. Dr. Patel diagnosed an injury to the head from the accident of June 13, 2004, and pain in the head and entire spine, unclear etiology. See Exhibit A, p.95. Dr. Patel did not think Ms. Bowman required additional treatment, and had reached maximum medical improvement. *Id.* Dr. Patel also noted some inconsistencies between formal and informal observation during the physical examination. *Id.*

Ms. Bowman was also seen by a neuro-ophthalmologist, Dr. Whittaker, on December 20, 2004, based on Dr. Hedges' referral. See Exhibit A, pp. 82-90. Ms. Bowman reported constant headaches, changes in vision, difficulty concentrating and difficulty finding words, after she sustained a blow to the top of her head. See Exhibit A, p.82. Subjective complaints of hearing loss were also noted. *Id.* Dr. Whittaker diagnosed a history of closed head injury with mild post-concussive syndrome with significant headache. See Exhibit A, p.83. Dr. Whittaker recommended neuropsychological testing and reevaluation by a neurologist. *Id.*

In December 2004, Ms. Bowman was seen by Dr. J. Michael Smith by referral of her attorney. Although Ms. Bowman provided very specific testimony concerning her symptoms and their progression since the injury date, Ms. Bowman could not recall what happened during the examination with Dr. Smith. Ms. Bowman thought that Dr. Smith issued a permanent disability rating, with which she disagreed. See *Transcript of Temporary Proceedings*, p.77.

Ms. Bowman underwent the neuropsychological assessment by Dr. Neal Deutch on February 4, 2005. See Exhibit A, pp. 71-80. Ms. Bowman reported that she struck the top and center of her head. See *id.*, p.71. Ms. Bowman testified that she did not complete some of the forms that were required for the testing because she did not have time because of another appointment. *Transcript of Temporary Proceedings*, pp. 64-65. Dr. Deutch noted average functioning with regard to Ms. Bowman's short-term and overall memory. See Exhibit A, pp. 75-76. Dr. Deutch also noted normal executive functioning, satisfactory temper control and satisfactory social adaptability and sensitivity. *Id.*, pp. 78-79. Dr. Deutch thought there could be adjustment disorder and pain disorder. *Id.*, p.80. A psychiatric consultation was recommended.

Ms. Bowman underwent the neurological reevaluation by Dr. Ryan on February 24, 2005. See Exhibit 1. Ms. Bowman reported a blow to the top of her head. See *id.*, p.1. Ms. Bowman reported ongoing head pain, loss of vision, dizziness, nausea, hearing loss, numbness in the arms, difficulty finding words and pain down the spine. See *id.*, p.2. Ms. Bowman also stated she was not prone to headaches prior to the accident. *Id.* Dr. Ryan thought Ms. Bowman had a minor closed-head injury, and noted significant symptom magnification. *Id.*, p.3. Dr. Ryan thought Ms. Bowman reached maximum medical improvement and opined that Ms. Bowman has sustained no permanent disability from a neurological perspective. *Id.*

Ms. Bowman testified that she went to the Headache & Pain Center on her own on March 2, 2005. See Exhibit A, pp. 25-28. Ms. Bowman testified that the physician examined her and provided treatment choices. Ms. Bowman was not satisfied with this, and testified that she did not want a physician to provide her treatment choices. Instead, Ms. Bowman wanted a physician to tell her what he or she would do to make her symptoms go away. Ms. Bowman's friend, Diana Pfaff, paid for the appointment.

Ms. Bowman also went to PainCare on her own, and received treatment from March 14, 2005 to March 21, 2005. See Exhibit A, pp. 9-23. Ms. Bowman received injections at PainCare that she did not think were effective in reducing her symptoms.

Ms. Bowman underwent the psychiatric consultation on May 13, 2005. See Exhibit 2. Dr. Hughes performed the psychiatric consultation. Dr. Hughes reviewed the accident, Ms. Bowman's reported symptoms and the prior course of medical treatment. Dr. Hughes did not believe that Ms. Bowman suffered

from pain order, and thought that the multitude of subjective complaints constituted malingering. See *id.*, p.7. Dr. Hughes did not think that additional treatment was indicated, and thought Ms. Bowman sustained no permanent disability from a psychiatric standpoint. *Id.* p.8.

Ms. Bowman went to a new primary care physician, Dr. Folsom, on June 15, 2005; June 30, 2005 and August 23, 2005. See Exhibit A, pp. 3-8. On August 23, 2005, Dr. Folsom's records diagnose neuralgia, and state that Dr. Folsom had little else to offer, other than a recommendation against using narcotics to treat Ms. Bowman's symptoms. See Exhibit A, p.3.

Ms. Bowman was seen by Dr. Parmet by referral of her attorney on January 24, 2006. See Exhibit C. Dr. Parmet diagnosed post-traumatic headache. *Id.*, p.8. Dr. Parmet acknowledged that Ms. Bowman was scrutinized thoroughly, and her subjective complaints were not suggestive of serious neurological injury. *Id.* Dr. Parmet recommended a bone scan, but admitted that for an optimum outcome such a study should have been done less than 12 months after the injury date. *Id.* No other tests were recommended. *Id.* Dr. Parmet deferred specific treatment recommendations pending the outcome of the test. *Id.*

Ms. Bowman requested additional medical treatment, and a temporary hearing was held on June 16, 2006. At that time, Ms. Bowman testified that she did not have headaches, but had pain in her head. *Transcript of Temporary Proceedings*, p.31. Ms. Bowman also reported pain and swelling in the neck. *Id.* Nausea and dizziness were also reported, along with pain in the spine with walking or sitting too long. *Id.*, pp. 31-32. Ms. Bowman testified that none of the health care providers she has seen have made her symptoms better, except for the modalities received at Crutchfield Chiropractic. *Id.*, p.75. Ms. Bowman, however, also indicated that her symptoms had worsened since the accident date. See *id.*, p.85.

Following the hearing of June 16, 2006, the Court issued its Temporary Award dated July 5, 2006. Ms. Bowman's course of authorized and unauthorized medical treatment was reviewed. See Exhibit F, pp. 5-7. The request for additional medical treatment was denied because the course of authorized medical treatment was exhaustive, because Ms. Bowman's testimony concerning her symptoms was not credible and because Dr. Parmet's testing recommendation was not reasonable. *Id.*, pp. 9-10. The request for reimbursement of unauthorized medical expenses incurred by Ms. Bowman was also denied. *Id.*, p.9.

Since the hearing of June 16, 2006, Ms. Bowman saw Dr. Carol Ann Ryser on her own on August 11, 2006. See Exhibit D, pp. 23-93. Ms. Bowman reported pain in the head, back, neck and spine. *Id.*, p.40. Dizziness, problems with balancing and ear problems were also noted in Dr. Ryser's records. *Id.* Dr. Ryser recommended Ms. Bowman undergo a bone scan and brain SPECT imaging. *Id.* Dr. Ryser also noted that Ms. Bowman was "aggressive about needing narcotics." *Id.* After those tests were administered, Dr. Ryser referred Ms. Bowman to Dr. Jonathan Chilton. *Id.*, p.44.

Ms. Bowman underwent the radiological tests at the Radiology Department of the University of Kansas Hospital on September 18 and 22, 2006. The tests were administered by Dr. Reginald Dusing. Dr. Dusing interpreted the bone scan as a negative study. Exhibit D, p.20. Dr. Dusing interpreted the brain SPECT scan as showing signal changes of the anterior temporal lobes and supraorbital gyri. See Exhibit D, p.22. Dr. Dusing testified that based on these findings, he could not state they had nothing to do with a closed head injury. See Exhibit H, p.28. Dr. Dusing also confirmed that the bone scan revealed no evidence of skeletal trauma to the head. *Id.*, p.33. Dr. Dusing also testified that the brain SPECT scan, alone, is not a complete diagnostic tool, and should be done in conjunction with a CT or MRI scan. *Id.*, p.42. Dr. Dusing also testified the brain SPECT scan cannot determine the date of a traumatic brain injury or the mechanism of injury. *Id.*, pp. 43-44.

After the radiological studies were completed, Ms. Bowman went to Dr. Chilton on her own, and was seen on December 12, 2006. Ms. Bowman reported whole head pain, neck pain radiating down the spine,

occasional tingling of the arms and fingers and an off-balance sensation. See Exhibit D, p.2. Dr. Chilton wanted to review the prior CT and MRI scans before providing final recommendations. *Id.*, p.3. It does not appear Ms. Bowman returned to Dr. Chilton.

Dr. Parmet reviewed the bone scan and brain SPECT scan reports, and prepared a supplemental report dated June 20, 2007. Dr. Parmet changed his prior opinions, and stated that Ms. Bowman required additional evaluation for her closed head injury, rather than for the neck. See, Exhibit E, p.2. Dr. Parmet testified at his deposition that his opinions were premised on the mechanism of injury being a “coup-contre coup” head injury, with Ms. Bowman sustaining a blow to the back of head, which caused the brain to bounce against the front of the head. See Exhibit G, pp. 14-15. Dr. Parmet admitted he was not an expert in interpreting brain SPECT scan images. See *id.*, p.51.

Dr. Ryan also reviewed the bone scan and brain SPECT scan reports, and prepared a supplemental report dated October 1, 2007. See Exhibit 4, pp. 41-42. Dr. Ryan indicated that no one could state that the abnormalities identified on the brain SPECT scan were related to Ms. Bowman’s rather minor closed head injury. *Id.*, p.41. Dr. Ryan confirmed that Ms. Bowman did not sustain permanent neurologic deficit, had reached maximum medical improvement and required no additional testing or treatment. *Id.* Dr. Ryan also testified that it remained his opinion that Ms. Bowman did not sustain permanent disability for the work-related injury. *Id.*, p.14.

Ms. Bowman has also been evaluated on her own accord by Dr. Batchu at the Columbia Center for Neurology & Multiple Sclerosis on February 21, 2007. Ms. Bowman reported constant pain inside her head that felt different at different times. See Exhibit D, p.9. Neck, swelling, crunches and cracks were also reported. *Id.* Physical examination of the neck, however, revealed full range of motion. *Id.* Dr. Batchu’s impressions included chronic headache, remote history of head injury, possible sleep apnea and sensory loss with an uncertain etiology. See *id.*, p.10. Dr. Batchu wanted to review the past records and radiology reports, and might consider further evaluation once the records and reports were reviewed. See *id.* It does not appear Ms. Bowman returned to Dr. Batchu.

A second hearing took place on June 30, 2008 at the request of the Employer. See Exhibit 5. At the hearing, Stacey Bowman, Ms. Bowman’s daughter, testified that since the hearing of June 2006 Ms. Bowman has demonstrated personality changes and seemed depressed. Ms. Bowman’s daughter provided her mother narcotic medication. Stacey Bowman also testified that Ms. Bowman’s complaints of head, neck and spine pain were the same, along with the dizziness. Stacey Bowman admitted on cross-examination that she did not have the necessary background or training to render an expert psychological opinion.

Ms. Bowman also testified at the second hearing. Ms. Bowman testified that her symptoms have been the same since the hearing of June 2006. Ms. Bowman also testified that she used the narcotic pain medication that her daughter provided, but it did not improve her symptoms. Ms. Bowman was unable to describe the pain sensation in her head, apart from it making one want to kill oneself. Ms. Bowman admitted a medical history of headaches, which caused her to miss time from work.

Ms. Bowman testified she has not worked since June 13, 2004. Ms. Bowman did make an application for unemployment compensation, which she stated was denied. Ms. Bowman confirmed that she was struck on the top of her head on June 13, 2004. Ms. Bowman testified that she performs activities of daily living, including driving, cooking and cleaning. Ms. Bowman also testified she dictated a two-page narrative concerning her medical history, which is contained in the medical records. See Exhibit D, pp. 59-60. Ms. Bowman stated that sitting and standing causes her head pain.

RULINGS OF LAW

At the outset of the second hearing, an issue arose whether the setting was a second temporary hearing or a final hearing. The second hearing was set in response to a request for a final hearing filed by Wincup, after no written objection to the request for hearing was filed. Wincup argues that under the local rules adopted by the Missouri Division of Workers' Compensation the case should proceed as a final hearing. Ms. Bowman argues that if the Court were to find that she has not reached maximum medical improvement and required additional medical treatment, that she could not receive an award of medical treatment if the case was heard as a final hearing. I rule that I have authority to issue a temporary award, should the facts of the case dictate such a result. I find, however, that Ms. Bowman has reached maximum medical improvement and that it is appropriate to issue a final award in this matter.

First, I find that Ms. Bowman has reached maximum medical improvement. Ms. Bowman's course of authorized medical treatment has been exhaustive. Ms. Bowman initially treated with Dr. Singh, who ordered a CT scan of the head that was interpreted as negative and referred Ms. Bowman to Dr. Hedges. Dr. Hedges ordered an MRI of the brain that was interpreted as negative and referred Ms. Bowman to Dr. Patel and Dr. Whittaker for additional treatment recommendations. Dr. Patel declared Ms. Bowman at maximum medical improvement from a physical medicine standpoint. Dr. Whittaker referred Ms. Bowman to Dr. Deutch for neuropsychological evaluation. Dr. Whittaker also recommended reevaluation by a neurologist. Although Dr. Whittaker is associated with the University of Kansas Medical Center, which is where Dr. Dusing is located, he did not recommend a brain SPECT scan or refer Ms. Bowman to Dr. Dusing. Dr. Deutch performed an extensive neuropsychological evaluation, and recommended a referral to a psychiatrist. Dr. Hughes, a psychiatrist, declared Ms. Bowman at maximum medical improvement. Dr. Ryan, a neurologist, declared Ms. Bowman at maximum medical improvement. Dr. Ryan reviewed the subsequent brain SPECT scan report and confirmed that Ms. Bowman reached maximum medical improvement.

Ms. Bowman's medical evidence supporting her claim that she is not at maximum medical improvement is not credible. Dr. Parmet initially stated that Ms. Bowman did not require additional testing or treatment for her head complaints, and recommended a bone scan to evaluate the neck. Dr. Parmet did not recommend a brain SPECT scan initially. After those tests were completed, Dr. Parmet indicated that his initial statements were incorrect, and recommended additional testing and treatment for the head. Dr. Parmet acknowledged he does not have the training to interpret brain SPECT scans. Dr. Parmet's new opinions are premised on Ms. Bowman sustaining a coup-countre coup injury. Ms. Bowman did not sustain a coup-countre coup injury. According to Ms. Bowman's testimony and the treatment records, Ms. Bowman sustained a blow to the top of her head. Dr. Dusing was unable to provide an opinion as to whether Ms. Bowman had reached maximum medical improvement. Both Dr. Chilton and Dr. Batchu wanted to review additional medical records before issuing opinions as to whether Ms. Bowman required additional medical treatment or testing.

Despite seeing several authorized and unauthorized health care providers, Ms. Bowman testified that her condition has not improved, and has remained the same. Ms. Bowman reported that medication has not improved her symptoms. Ms. Bowman previously testified that her symptoms have not improved despite numerous office visits at Crutchfield Chiropractic. I previously found, and still find, that Ms. Bowman has been exaggerating her symptoms. Maximum medical improvement is reached when the medical condition has reached the point where further progress is not expected. See *Cardwell v. Treasurer of State of Missouri*, No. ED 90226, p.6 (Mo. App. E.D. Apr. 15, 2008). Based on the credible medical evidence, and Ms. Bowman's testimony concerning the state of her head symptoms, I conclude that Ms. Bowman reached maximum medical improvement effective May 9, 2005.

Second, I deny the request for temporary total disability benefits from May 9, 2005 and continuing. The more

credible medical evidence from the chain of authorized medical providers indicates that maximum medical improvement was reached May 9, 2005. Ms. Bowman's medical evidence addressing temporary total disability is Dr. Parmet's testimony. Dr. Parmet's opinions conflict and are not credible. It is not appropriate to award temporary total disability benefits after an employee has reached maximum medical improvement, because the medical condition is permanent. See *Cardwell*, p.6. In this case, because I find that Ms. Bowman reached maximum medical improvement May 9, 2005, the request for temporary total disability benefits on or after that date is denied.

Third, the request for payment of unpaid medical expenses contained in Exhibits B and I are denied. Ms. Bowman previously requested payment of the unauthorized medical expenses contained in Exhibit B at the first hearing of June 16, 2006, and that request was denied. No additional evidence has been presented to lead to a different result now.

It is incumbent upon the employer to provide such medical treatment as may reasonably be necessary to cure or to relieve the effect of the injury. See §287.140.1, RSMo. While the employer retains the statutory right to select the authorized treating physician, See §287.140.1, RSMo., this opportunity must be exercised affirmatively at the first opportunity. See *Banks v. Springfield Park Care Center*, 981 S.W.2d 161, 164-65 (Mo. App. S.D. 1998). *If an employee is sent to a company doctor for treatment and the employee thereafter receives additional medical treatment from another physician without notifying the employer, this can constitute an election by the employee to select his or her own doctor at his or her own expense. Id. at 165 (citing Anderson v. Parrish, 472 S.W.2d 452, 457 (Mo. App. K.C. 1971)).*

Ms. Bowman's course of authorized medical treatment has been exhaustive. Upon receiving notice from Ms. Bowman that she required medical treatment, Wincup referred Ms. Bowman to Dr. Singh for the headaches she reported. An MRI of the brain and CT of the head were negative, and an MRI of the cervical spine was felt to be non-contributory to the symptoms Ms. Bowman reported. Dr. Singh referred Ms. Bowman to Dr. Hedges, who rendered additional treatment and referred Ms. Bowman to Dr. Patel and Dr. Whittaker. Dr. Patel indicated Ms. Bowman reached maximum medical improvement. Dr. Whittaker referred Ms. Bowman to Dr. Deutch, who performed a neuropsychological assessment. Dr. Deutch referred Ms. Bowman to a psychiatrist, Dr. Hughes, who indicated that Ms. Bowman reached maximum medical improvement from a psychiatric standpoint. Ms. Bowman was also referred to another neurologist, Dr. Ryan, for a second opinion, and he declared Ms. Bowman at maximum medical improvement.

With regard to the chiropractic modalities at Crutchfield Chiropractic, no authorized medical provider referred Ms. Bowman to that facility. Ms. Bowman went to Crutchfield Chiropractic on her own, without notifying Wincup, which was undergoing authorized medical treatment from the providers listed above. I do not find that the multiple visits to Crutchfield Chiropractic constitute emergency treatment. I find that Ms. Bowman's conduct constitutes an election by Ms. Bowman to select her own health care provider at her own expense. Moreover, according to Ms. Bowman's own testimony, her symptoms either worsened or stayed the same. I do not find that the modalities at Crutchfield Chiropractic reasonably necessary.

With regard to the medical expenses listed in Exhibit I, these expenses appear to correspond to the treatment documented in Exhibit D. These expenses were incurred by Ms. Bowman on her own after the first hearing, were not authorized and do not constitute emergency treatment. As stated above, the more credible medical opinions establish that Ms. Bowman reached maximum medical improvement before those expenses were incurred. Dr. Parmet's testimony regarding the reasonableness of brain SPECT scan or additional treatment is not credible because of his conflicting opinions. Moreover, Ms. Bowman's testimony concerning her current symptoms, which apparently led to the expenses contained in Exhibit I, contradict the contemporaneous medical records of Dr. Singh and Dr. Hedges, as well as the initial intake form Ms. Bowman completed for Dr. Hedges. I do not find Ms. Bowman's testimony concerning her current symptoms reliable. The request for payment of the medical expenses contained in Exhibit I is denied, because those

expenses do not reflect reasonably necessary medical treatment. In addition, it is not reasonable to order an employer to provide or to pay for additional treatment to attempt to relieve symptoms that are being exaggerated.

Fourth, because Ms. Bowman has reached maximum medical improvement, it is appropriate to address the issue of nature and extent. The opinions of Dr. Smith are not considered because his report was not admitted into the record. Ms. Bowman's blow to the top of her head did not break the skin and did not result in a loss of consciousness. The MRI and CT scan revealed no change in the physical structure of Ms. Bowman's head. Dr. Dusing was unable to attribute the signal changes from the brain SPECT scan to the injury of June 13, 2004. The treatment records indicate that Ms. Bowman's reported symptoms do not correspond to objective clinical findings. Dr. Ryan testified that Ms. Bowman did not sustain permanent disability, from a neurological standpoint, for her relatively minor closed head injury. Dr. Hughes stated that from a psychiatric standpoint Ms. Bowman did not sustain permanent disability.

Ms. Bowman's testimony concerning her current symptoms contradict the contemporaneous treatment records of the authorized physicians. In addition, Ms. Bowman had a medical history of headaches prior to the date of injury, as evidenced by her family physician. Ms. Bowman subsequently applied for unemployment compensation. Moreover, Ms. Bowman testified that although she does not work, she does cooking and cleaning. Ms. Bowman's complaints of memory loss are not supported by the neuropsychological test. Although Ms. Bowman's daughter reported personality changes at the second hearing, no personality issues or changes are reported in the contemporaneous treatment records. No abnormalities concerning Ms. Bowman's personality are noted in the neuropsychological test. The testimony of Ms. Bowman's daughter concerning her mother's symptoms was contradicted by Ms. Bowman.

Based on the weight of the whole record, I conclude that the expert opinions of Dr. Ryan and Dr. Hughes should control, and I rule that Ms. Bowman has sustained no permanent disability as a result of the relatively minor closed head injury. Accordingly, no permanent disability benefits are awarded.

Finally, the request for an award of future medical is considered, and is denied. It is appropriate to award future medical, notwithstanding a declaration of maximum medical improvement, upon a showing of a reasonable probability that future medical treatment will be necessary. See *Williams v. City of Ava*, 982 S.W.2d 307, 312 (Mo. App. S.D. 1998)(citing *Mathia v. Contract Freighters, Inc.*, 929 S.W.2d 271, 277 (Mo App. S.D. 1996)). Dr. Ryan and Dr. Hughes both stated that no additional medical treatment was needed. Dr. Parmet indicated that Ms. Bowman would require additional testing and treatment, but his conflicting opinions are not credible. The only other physician to comment on future medical is Dr. Batchu, who stated that Ms. Bowman "may" require additional testing after he has reviewed the prior treatment records. It does not appear this was accomplished. Stating that future medical treatment may be a possible need is insufficient to establish a reasonable probability that future medical treatment will be necessary. See *id.* Accordingly, the request for an award of future medical treatment is denied.

Date: _____

Made by: _____

Carl Mueller
Administrative Law Judge
Division of Workers' Compensation

A true copy: Attest:

Jeffrey Buker
Director
Division of Workers' Compensation

Although medical bills from Lafayette Regional and Mid-America Radiology are included in Exhibit B, the parties stipulated that the Employer already paid those medical bills.

SPECT is an acronym for “Single Positron Emission Computerized Tomography”. *See*, Employer’s Exhibit 4 at 21:8.