

AWARD

(Modifying our January 14, 2014, Award)

Injury No.: 01-144965

Employee: Tina Collins
Employer: Aztar Corporation
Insurer: Commerce & Industry Insurance Company
Additional Party: Treasurer of Missouri as Custodian
of Second Injury Fund

On January 14, 2014, we issued an award of compensation in this matter. The Second Injury Fund appealed the award to the Missouri Court of Appeals for the Southern District. While the matter was pending before the court, the parties reached an agreement for settlement of this case. By order dated July 29, 2014, the court held its appeal in abeyance to afford the parties an opportunity to present their settlement to us. The parties filed a Joint Motion to Modify our January 14, 2014, award. We grant the Joint Motion and we modify our award to include additional findings and conclusions as requested by the parties. The modifications appear bolded and underlined.

This workers' compensation case is submitted to the Labor and Industrial Relations Commission (Commission) for review as provided by § 287.480 RSMo. We have reviewed the evidence, read the parties' briefs, and considered the whole record. Pursuant to § 286.090 RSMo, we modify the award and decision of the administrative law judge. We adopt the findings, conclusions, decision, and award of the administrative law judge to the extent that they are not inconsistent with the findings, conclusions, decision, and modifications set forth below.

Preliminaries

The parties asked the administrative law judge to resolve the following issues: (1) whether employee sustained a motor vehicle accident on May 13, 2002, that was compensable as part of this claim; (2) whether employee sustained a fall on October 30, 2009, that is compensable as part of this claim; (3) whether employee provided notice to employer of the alleged motor vehicle accident of May 13, 2002; (4) whether employee provided notice to employer of the alleged fall of October 30, 2009; (5) average weekly wage and rate of compensation; (6) medical causation of employee's claimed psychiatric and/or psychological injury; (7) medical causation as to the alleged May 13, 2002, motor vehicle accident; (8) medical causation as to the alleged October 30, 2009, fall; (9) employer's claim for a credit for overpayment of temporary total disability benefits; (10) past medical expenses in the amount of \$44,757.29; (11) mileage or other medical expenses; (12) future medical aid; (13) nature and extent of disability; (14) Second Injury Fund liability; and (15) whether employer is entitled to a subrogation credit for a third-party settlement in the amount of \$3,743.00.

The administrative law judge rendered the following findings and conclusions: (1) employee's alleged injuries to the low back, neck, upper back, and shoulders from the motor vehicle accident on May 13, 2002, are not medically causally related to the

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December 15, 2001, accident; (2) the October 30, 2009, accident is not compensable as part of employee's claim and her injuries resulting from that accident are not medically causally related to the December 15, 2001, accident; (3) employee's average weekly wage was \$282.88 and employee's rate of compensation is \$188.59 per week; (4) employer is entitled to a credit for overpaid temporary total disability in the amount of \$50.89; (5) employee's December 15, 2001, work accident aggravated employee's preexisting dysthymic disorder; (6) employee's claim for previously incurred medical bills is denied; (7) employee is not in need of additional psychiatric treatment to cure and relieve her from the effects of her December 15, 2001, work-related injury; (8) employee is in need of additional treatment to cure and relieve her from the effects of her December 15, 2001, work-related injury to her back and SI joint; (9) employee is not entitled to any additional temporary total disability benefits; (10) employee is permanently and totally disabled due to subsequent accidents and substantial worsening of her condition after December 15, 2001; (11) as a result of the work injury, employee suffered a 25% permanent partial disability of the body as a whole referable to the lumbosacral spine and a 2.5% permanent partial disability of the body as a whole referable to aggravation of her preexisting psychiatric condition; and (12) the Second Injury Fund is liable for 21.25 weeks of permanent partial disability benefits.

Employee filed a timely Application for Review with the Commission alleging the administrative law judge erred in finding that employee's permanent total disability was neither from the last accident alone nor from a combination of the employee's preexisting psychiatric conditions and the injuries resulting from the accident at work on December 15, 2001.

Findings of Fact

The administrative law judge's award sets forth the stipulations of the parties and the administrative law judge's findings of fact as to the issues disputed at the hearing. We adopt and incorporate those findings to the extent that they are not inconsistent with the modifications set forth in our award. Consequently, we make only those findings of fact pertinent to our modifications herein.

Post-injury return to work

Employee performed light duty work for employer after the December 2001 work injury until her unrelenting low back pain prompted Dr. Landry to take her off work beginning January 28, 2002. On April 17, 2002, Dr. Byrd permitted employee to return to work with a 10-pound lift restriction, as well as restrictions against repetitive bending, twisting, or stooping, and the requirement that employee be permitted to change positions frequently. When employee returned to work, employer assigned her to a stationary post watching the crew entrance and vault where employee could sit or stand as she felt necessary. Employee held the crew entrance and vault post for about a year, then started driving the shuttle bus, which was an easier task for her to perform, because she was able to get out and walk around occasionally, which she couldn't do while watching the crew entrance or vault.

Employer's witness Rhonda Gooch, a human resources manager, testified that the vault and crew entrance post and the shuttle driver position were not special jobs that

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employer created for employee, implying that these were not really "light duty" positions. But the record reveals that before her work injury, employee rotated amongst various patrols or posts, some of which involved prolonged standing and walking, performed bicycle patrols lasting 8 hours, and was also responsible for pushing casino patrons in wheelchairs. There is no indication that employee was expected to perform any of these tasks after her injury.

The medical records suggest employee continued to suffer considerable back pain after returning to work, for which she received a total of eight injections from Dr. Chiu from May through July 2002. Employee was also using a TENS unit and taking an array of pain medications and muscle relaxers including Neurontin, Ultracet, and Flexeril. On July 11, 2002, Dr. Byrd noted employee had missed the last two days of work owing to severe back pain. On August 28, 2002, Dr. Gibbs determined that employee was at maximum medical improvement, and released employee to continue working with a 25-pound lift restriction.

From October 2002 through January 2003, employee saw a chiropractor, Dr. Burnett, for severe low back pain. On February 21, 2003, Dr. Burns recorded a history of severe low back pain, diagnosed chronic pain syndrome referable to the work injury, and recommended employee continue her heavy regimen of medications, which then included the narcotic hydrocodone. As of July 2003, when employee stopped working for employer, employee was still treating with Dr. Burns, who imposed ongoing restrictions that he referred to as "modified" or "light" duty which included no running or climbing, no lifting more than 25 pounds, and no climbing any more than three steps. Dr. Burns's most recent records from November 2004 reveal that he never lifted the light duty restriction.

Given the medical record and the fact that employee no longer rotated patrols but instead performed dedicated tasks such as guarding the crew entrance and vault or driving the shuttle bus, we find that employee never returned to full duty work for employer following the work injury.

Employee's decision to quit working

Employee suffers from a preexisting migraine condition which causes intermittent severe headaches. Employee had seen doctors and taken medications for this condition, and had not experienced a migraine headache for several years before the work injury. After the work injury, employee experienced migraine headaches while undergoing physical therapy for her low back in February and March 2002, and complained of headaches to the chiropractor, Dr. Burnett, in October 2002. On July 21, 2003, employee sought treatment with Dr. Prasad for migraines. On July 22, 2003, employee stopped reporting for work, and on August 29, 2003, employee's coworker delivered her uniform to employer.

At her deposition of August 18, 2003, employee revealed that she planned to quit working for employer, and when asked whether she was going to seek other employment, she testified that she didn't believe she was capable of working eight hours because she hurt all the time, and specifically identified constant low back and right leg pain. Elsewhere in the same deposition, employee testified that she was currently off work owing to her treatment

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with Dr. Prasad for migraines, and indicated she was not claiming she had been off work since the end of July because of the work injury. Both employer and the Second Injury Fund point to this as inconsistent with employee's testimony at the hearing that she quit working because of her ongoing chronic pain condition referable to her low back.

Especially when we take into account employee's preexisting psychiatric disability and her hearing loss and speech deficit, we are not persuaded that employee's testimony at her August 2003 deposition is in material conflict with her testimony at the hearing. At her deposition, employee acknowledged that she was *then* off work because of her treatment with Dr. Prasad; this is not at all inconsistent with her testimony she didn't think she could go *back* to work because of her unrelenting low back pain. The medical records certainly corroborate employee's complaints of chronic disabling low back pain.

On September 11, 2003, Dr. Burns (who employee was still seeing for chronic low back pain) reported that employee quit working because of pain with prolonged sitting, while noting employee was seeing a neurologist for headaches. Other medical records (many of which are summarized above or in the administrative law judge's opinion) show that employee's chronic low back pain never substantially improved despite the fact she was performing light duty work for employer and was receiving pain management treatment in the form of physical therapy, injections, a TENS unit, and a heavy regimen of medications including narcotics. At the hearing, employee testified she continues to rely on daily use of hydrocodone and other pain medications, as well as a TENS unit and SI belt, and she extensively described the effect of her low back injury on her physical capabilities. In light of these factors, we find employee's testimony regarding her limitations and the reason she left work to be credible.

Expert opinion regarding permanent total disability

We acknowledge that this case is both factually and legally complex and that the record contains ample evidence to support the administrative law judge's decision to credit the vocational expert Gary Weimholt, who opined that employee is not permanently and totally disabled. However, after careful consideration and review of the extensive medical record, and in light of our finding that employee provided credible testimony regarding her limitations, we find most persuasive the opinions from Mr. England and Dr. Volarich that employee is permanently and totally disabled as a result of the effects of the work injury in combination with employee's preexisting disability.

We find appropriate and adopt the administrative law judge's finding that employee reached maximum medical improvement on August **28**, 2002. We also deem appropriate and adopt the administrative law judge's findings with respect to the nature and extent of employee's preexisting psychiatric disability as well as the permanent partial disability employee sustained as a result of the work injury.

Correction

In the fifth full paragraph on page 8 of his award, the administrative law judge states: "The employee started physical therapy on February 1, 2012." This is an apparent typographical error. We correct the foregoing to read instead as follows: "The employee started physical therapy on February 1, 2002."

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Conclusions of Law

Second Injury Fund liability

Section 287.220 RSMo creates the Second Injury Fund and provides when and what compensation shall be paid in "all cases of permanent disability where there has been previous disability." As a preliminary matter, the employee must show that she suffers from "a preexisting permanent partial disability whether from compensable injury or otherwise, of such seriousness as to constitute a hindrance or obstacle to employment or to obtaining reemployment if the employee becomes unemployed..." *Id.* The Missouri courts have articulated the following test for determining whether a preexisting disability constitutes a "hindrance or obstacle to employment":

[T]he proper focus of the inquiry is not on the extent to which the condition has caused difficulty in the past; it is on the potential that the condition may combine with a work-related injury in the future so as to cause a greater degree of disability than would have resulted in the absence of the condition.

Knisley v. Charleswood Corp., 211 S.W.3d 629, 637 (Mo. App. 2007)(citation omitted).

We have adopted the administrative law judge's findings that employee suffered from a preexisting permanent partially disabling psychiatric condition at the time she sustained the work injury. We are convinced this condition was serious enough to constitute a hindrance or obstacle to employment. This is because we are convinced employee's preexisting psychiatric condition had the potential to combine with a future work injury to result in worse disability than would have resulted in the absence of the condition. See *Wuebbeling v. West County Drywall*, 898 S.W.2d 615, 620 (Mo. App. 1995).

Having found that employee suffered from a preexisting permanent partially disabling condition that amounted to a hindrance or obstacle to employment, we turn to the question whether the Second Injury Fund is liable for permanent total disability benefits. In order to prove her entitlement to such an award, employee must establish that: (1) she suffered a permanent partial disability as a result of the last compensable injury; and (2) that disability has combined with a prior permanent partial disability to result in total permanent disability. *ABB Power T & D Co. v. Kempker*, 236 S.W.3d 43, 50 (Mo. App. 2007). Section 287.220.1 requires us to first determine the compensation liability of the employer for the last injury, considered alone. If employee is permanently and totally disabled due to the last injury considered in isolation, the employer, not the Second Injury Fund, is responsible for the entire amount of compensation. "Pre-existing disabilities are irrelevant until the employer's liability for the last injury is determined." *Landman v. Ice Cream Specialties, Inc.*, 107 S.W.3d 240, 248 (Mo. 2003).

We have adopted the administrative law judge's finding that employee sustained permanent partial disability as a result of the work injury, and found persuasive the expert opinions from Mr. England and Dr. Volarich that employee's permanent total disability results from a combination of her preexisting disability with the effects of the primary injury. We find that employee is not permanently and totally disabled as a result of the last injury considered in isolation.

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We conclude employee is permanently and totally disabled owing to a combination of her preexisting disability in combination with the effects of the work injury. The Second Injury Fund is liable for permanent total disability benefits.

Conclusion

We modify **our January 14, 2014, award and** the award of the administrative law judge as to the issues of permanent total disability and Second Injury Fund liability.

As a result of the work injury, employee suffered a 25% permanent partial disability of the body as a whole referable to the low back and a 2.5% permanent partial disability of the body as a whole referable to her psychiatric condition, for a total of 110 weeks of compensation for permanent partial disability attributable to the primary injury. Employee reached maximum medical improvement on August 28, 2002. Employee's permanent partial disability and permanent total disability rates are the same. Consequently, the Second Injury Fund owes no differential payment for the 110-week period of permanent partial disability attributable to the primary injury, which period ended on October 13, 2004.

The Second Injury Fund is liable for permanent total disability benefits beginning **October 14, 2004**, at the weekly rate of \$188.59. The weekly payments shall continue thereafter for employee's lifetime, or until modified by law.

The award and decision of Chief Administrative Law Judge Lawrence C. Kasten, issued November 15, 2012, is attached hereto and incorporated herein to the extent not inconsistent with this decision and award.

The Commission approves and affirms the administrative law judge's allowance of an 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 27th day of August 2014.

LABOR AND INDUSTRIAL RELATIONS COMMISSION

John J. Larsen, Jr., Chairman

James G. Avery, Jr., Member

Curtis E. Chick, Jr., Member

Attest:

Secretary

ISSUED BY DIVISION OF WORKERS' COMPENSATION

FINAL AWARD

Employee: Tina Collins Injury No. 01-144965
Dependents: N/A
Employer: Aztar Corporation
Additional Party: Second Injury Fund
Insurer: Commerce & Industry Insurance Company
Appearances: James Turnbow, attorney for employee.
Amy Young, attorney for the employer-insurer.
Gregg Johnson, Assistant Attorney General for Second Injury Fund.
Hearing Date: Commenced August 30, 2011
Completed September 29, 2011 Checked by: LCK/rm

SUMMARY OF FINDINGS

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? December 15, 2001.
5. State location where accident occurred or occupational disease contracted: Pemiscot 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 happened or occupational disease contracted: The employee slipped and fell.
12. Did accident or occupational disease cause death? No.
13. Parts of body injured by accident or occupational disease: Body as a whole referable to the lumbosacral back and psychiatric condition.
14. Nature and extent of any permanent disability: 25% of the body as a whole referable to the lumbosacral spine and 2.5% permanent partial disability of the body as a whole referable to psychiatric condition.
15. Compensation paid to date for temporary total disability: \$2,666.65.
16. Value necessary medical aid paid to date by employer-insurer: \$95,607.28.
17. Value necessary medical aid not furnished by employer-insurer: None.
18. Employee's average weekly wage: \$288.88.
19. Weekly compensation rate: \$188.59.
20. Method wages computation: See Rulings of Law.
21. Amount of compensation payable:

Permanent partial disability: \$20,744.90 less a credit in the amount of \$50.89 for overpayment of temporary total disability.

Total: \$20,694.01
22. Second Injury Fund liability: \$4,007.54.
23. Future requirements awarded: Future medical. See Rulings of Law.

Said payments shall be payable as provided in the findings of fact and rulings of law, and shall be subject to modification and review as provided by law.

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

FINDINGS OF FACT AND RULINGS OF LAW

On August 30, 2011, the employee, Tina Collins, appeared in person and with her attorney, James Turnbow for a final award. The employer-insurer was represented at the hearing by its attorney, Amy Young. Present for the employer was Ronda Gooch, its Human Resource Manager. The Second Injury Fund was represented by Assistant Attorney General Gregg Johnson. The parties agreed on certain undisputed facts and identified the issues that were in dispute. These undisputed facts and issues, together with the findings of fact and rulings of law, are set forth below as follows:

UNDISPUTED FACTS:

1. Aztar Missouri Riverboat Gaming Corporation L.L.C. was operating under and subject to the provisions of the Missouri Workers' Compensation Act, and its liability was fully insured by Commerce & Industry Insurance Company.
2. On December 15, 2001, Tina Collins was an employee of Aztar Missouri Riverboat Gaming Corporation L.L.C. and was working under the Workers' Compensation Act.
3. On December 15, 2001, the employee sustained an accident arising out of and in the course of her employment.
4. The employer had notice of the employee's accident.
5. The employee's claim was filed within the time allowed by law.
6. The employee's injury to her lumbar spine was medically causally related to the December 15, 2001 accident.
7. The employer-insurer paid \$95,607.28 in medical aid.
8. The employer-insurer paid \$2,666.65 in temporary disability benefits for 13 6/7 weeks. The time periods paid were December 20, 2001; January 14, 2002 through April 18, 2002; and July 9, 2002 through July 10, 2002. The rate paid was \$192.26 per week.

ISSUES:

1. Alleged motor vehicle accident on May 13, 2002.
2. Alleged fall on October 30, 2009.
3. Notice in the alleged motor vehicle accident on May 13, 2002.
4. Notice of the alleged fall on October 30, 2009.
5. The average weekly wage and rate of compensation.
6. Medical causation with regard to the employee's psychiatric and/or psychological injury as a result of the December 15, 2001 accident.
7. Medical causation as to the alleged May 13, 2002 motor vehicle accident.
8. Medical causation as to the alleged October 30, 2009 fall.
9. The employer-insurer is claiming an overpayment for previously paid temporary total disability based on an incorrect rate of compensation. The employer-insurer is seeking credit on any amount awarded in the case.
10. Claim for previously incurred medical.
11. Claim for mileage or other medical expenses under section 287.140 RSMo.
12. Claim for additional or future medical aid.
13. Nature and extent of disability.

14. Liability of the Second Injury Fund for permanent partial disability or permanent total disability.
15. Alleged subrogation credit by the employer-insurer for the third party settlement in the May 13, 2002 alleged motor vehicle accident.

With regard to issue 11 the record was left open for the employer-insurer to submit evidence of payment for the medical mileage. On September 15, 2011, a facsimile was received by the court from the employer-insurer. Attached to the letter was correspondence between the employee's attorney and the employer-insurer's attorney. The parties stipulated that the employee had received mileage reimbursement in full and that Issue 11 was being withdrawn.

EXHIBITS:

Employee's Exhibits:

- A. Deposition on Dr. Volarich including CV and reports.
- B. Deposition of James England including CV and reports.
- C. Numerous medical records.
- D. Medical bills.
- E. AIG wage statement.
- F. Office note of Brain and Neurospine Clinic. (At the hearing this exhibit was not admitted because the record was not certified. The record was left open for the employee to get a certified copy of the records. A certified record of the medical report was received on September 7, 2011 and the exhibit was admitted into evidence.)

Employer-Insurer's Exhibits:

1. Deposition of Dr. Chabot including his CV and report.
2. Deposition of Dr. Stillings including his CV and reports.
3. Deposition of Gary Weimholt including his report, CV and letter from the employer-insurer's attorney.
4. Deposition of Tina Collins.
5. Deposition of Tina Collins.
6. Crew member record of Tina Collins.
7. Human resources crew member action form.
8. Human resources crew member action form.
9. Wage statement of Tina Collins.

The Second Injury Fund did not offer any exhibits.

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

WITNESSES: The employee, Tina Collins; her husband Jackie Collins; and Ronda Gooch.

BRIEFS: The employee and the employer-insurers briefs were received on October 14, 2011. The Second Injury Funds brief was received on October 17, 2011.

FINDINGS OF FACT:

The employee testified that she lives in Bragg City, was born in 1958, and is 52 years old. She is five foot five inches tall and weighs 140 pounds. Prior to the December 15, 2001 accident she weighed 115 pounds. She attributes her weight gain to less activity. The last grade she completed was the 9th grade and she dropped out of high school to marry her husband. She received a GED in 1995. She went to trade school but is not licensed as a cosmetologist. She went to a community college and took basic courses.

The employee testified that she worked in high school part time for about a year at an ice cream parlor. She chopped and weeded cotton before the age of 20. She worked at Brown Shoe Company for three to four months and stopped working to be home with her children. She worked at Loxscreen for several months and then quit to have a baby. She worked for four to five years at a convenience store/truck stop as a working manager until it went out of business in 1989. She worked at Plastene Supply Company for about 10 months. She was laid off and had some problems doing her job due her elbow and wrist burning. Her carpal tunnel syndrome got better after that and she had no ongoing problems. The last employer before Casino Aztar was the Peach Orchard Gin where she worked on a seasonal basis weighing products and fertilizer. There was a three to four year gap before going to work at Casino Aztar and she was a stay at home mother.

The employee testified that she was born in St. Louis and moved to Dunklin County when she was 10 years old. Her parents were abusive and alcoholics who went out drinking and left the employee and her four siblings by themselves. She was the second oldest child. All of the children got whipped pretty regularly. As a child she was hit in her head numerous times and beaten frequently around her ears. It started when she was about eight until she ran away from home when she was 15. She was placed in a foster home and never again lived with her parents. She has had problems with hearing since she was a child and received speech therapy in school. She has hearing loss in both ears and had several ear surgeries with tubes. She received medical treatment for hearing loss including surgery in Memphis which helped cut down on infections but did not help with hearing problem. She had speech problems before the December of 2001 accident and it is hard to understand her.

The employee testified that due to her traumatic childhood she has dealt with depression for most of her adult life. She had depression and anxiety and was treated by a psychologist which helped. She treated with Dr. Hunt her primary care doctor and took Elavil and Xanax. Since the December of 2001 work accident, both her mother and father have died.

The employee testified that she had migraines and was light headed and dizzy. She had blackouts and was passing out which was part of the reason for treatment in Memphis. She had migraine headaches and took medication which made her headaches go away. At the time of the accident, she was not having any migraine headaches.

In January of 1993, the employee went to the neurology clinic at University Hospital for headaches and difficulty in walking secondary to imbalance and hearing impairment. The employee used to get occasional dizzy spells associated with vertigo. She had an episode of

black out spells in February of 1992 when she lost consciousness after her extremities became cold and clammy. An MRI showed no lesions. The employee had similar episodes of dizziness and vertigo for many years and hearing impairment of many years. In March of 1993, the employee went to ENT Clinic. It was noted for the past 15-16 years she had intermittent drainage from both ears, and has a long history of decreased hearing. She has had intermittent dizziness for the past 15 years with it being worse in December; and occasionally completely blacked out. She had some tinnitus. An audiogram showed moderate mixed hearing loss bilaterally with a larger conductive component in the right. Diagnosed was bilateral hearing loss with history of intermittent draining and vague history of dizziness.

In April of 1993, the employee went to University Clinic for depression and Amitriptyline was increased. In April of 1993, the employee went to the ENT Clinic at University Hospital and was diagnosed with conductive hearing loss and history of dizziness. In November of 1993, the ENT Clinic noted a long standing problem with dizziness described as lightheadedness and unsteadiness. There was a history of head trauma and being a victim of child abuse from her parents. The employee had bilateral conductive hearing loss. A CT scan of the temporal bones showed abnormality on both sides with loss of contact with the tympanic membrane. A left middle ear exploration and tympanoplasty was recommended.

In December of 1993 the employee went to Malden Medical Center. She was taking Xanax and wanted to replace it with Valium which was prescribed. In July of 1993 the employee requested a prescription for Amitriptyline, and was to be treated at the mental health unit in Columbia. Elavil and Xanax were prescribed, and were refilled in August and November of 1993. In March of 1994, the employee went to the ENT clinic at University Hospitals for bilateral conductive hearing loss with a left TM perforation.

The employee testified that she injured her low back in 1994 from a lawn mower which got stuck in a ditch. She went to the doctor for a few visits and was diagnosed with a back strain. After treatment she had no problems with her low back.

On May 26, 1994 the employee saw Dr. Hunt. Two days ago she was using a riding mower and it got stuck in a hole. She tried to lift the mower out and hurt her lower back and between her shoulders. She was diagnosed with an acute low back strain and medications were prescribed. On July 12, 1994 the employee had pain and tingling in her right leg. In September 1994 Dr. Hunt prescribed Valium in lieu of Elavil.

On July 7, 1995, the employee went to Malden Medical Center. She was not taking her medicine but has been seeing a counselor who told her that she needed to be on depression medication. Dr. Hunt diagnosed depression and prescribed Zoloft. On December 8, 1995, the employee was at Malden Medical Clinic and discussed a change in medication. Diagnosed was panic disorder and Prozac was prescribed.

In March of 1996, the employee was treated at UT Medical Group in Memphis for dizziness, hearing loss and tinnitus. On April 15, 1996, the employee's Prozac was refilled. On August 11, 1997, the employee went to the Malden Medical Center due to pain in the right shoulder, side of neck and hip and thought she may have pinched a nerve. An x-ray of the

thoracic spine was performed. The employee was diagnosed with a back strain; and prescribed Ultram and Darvocet.

The employee testified that she started working at the Casino Aztar in April of 2000 as a security guard. She quit working there for a period of time because she wanted to work a different shift and not a lot of weekends. She then was rehired at the same job with better hours. As a security guard she worked different posts including the turn stall and was patrolling on the shuttle bus. The only pushing requirement was pushing wheelchairs. In February of 2001, she quit for a period of time because did not agree on things with her boss, was unemployed for three months and then was rehired in May of 2001.

Ronda Gooch testified that she has been employed at Casino Aztar for 15 years. She started working in the industrial claims office, was the human resource supervisor for four years and the past three years she has been the human resource manager. The employee was hired on April 13, 2000. She had a leave of absence from October 11 through November 17 of 2000; and was on a medical leave of absence from January 4, 2001 to January 18, 2001. She quit on February 6, 2001 due to the shift she was working. She was rehired on May 7, 2001 working the same shift and same job.

2001:

The employee testified that on December 15, 2001, she was hurt at around 11:00 a.m. at the end of the shift. She was on the pavilion that had wet steps. Her feet went out from her and she fell. She hit her tailbone and fingers. When she got up, she was really hurting in her back and tailbone due to the severe impact with the steps. She went to the office and saw an EMT. Her right hand was bleeding but it healed up. Throughout the night her tailbone and legs were hurting. She went into work with her tailbone burning and pain shooting down her right leg. She worked for about 30 minutes and was told to go to the emergency room.

On December 16, 2001, the employee went to Pemiscot Memorial Hospital emergency room for pain in the tailbone and tingling in the anterior right thigh.

On December 17, 2001, the employee went to Doctors' Clinic due to back pain. X-rays at the hospital were negative. The employee was having severe lumbosacral pain and muscle spasms. Skelaxin and pain medication were prescribed.

2002:

The employee saw Dr. Landry an orthopedic surgeon on January 7, 2002, for persistent lower back and sacral pain which became worse after working for two hours; and numbness in the right lateral thigh and foot. The employee had tenderness at L5-S1 and in the mid-sacral area. Sitting straight leg rising was negative bilaterally and supine straight leg raising was positive at eighty degrees bilaterally with pulling and pain in the sacral area. The lower extremities had normal sensation, strength and muscle tone. There was no muscle atrophy and reflexes were symmetrical. X-rays from December showed some degenerative change with marginal erosions of the bilateral sacroiliac joints. Dr. Landry thought there might be an occult

fracture of the sacrum; and a lumbar disc protrusion was possible; and ordered a bone scan and a lumbar MRI. The employee could continue to work at light duty as long as she can alternate sitting and standing activity and not lift over twenty pounds.

The bone scan on January 11 showed a hot spot at the upper sacrum and it was noted that the possibility of an underlined fracture of the sacrum could not be ruled out. The January 12 lumbar MRI showed a right disc protrusion at L4-5 with effacement of the anterior thecal sac on the right and mild encroachment of the right neural foramina; and disc desiccation at L3-4 and L4-5.

Dr. Landry noted that the bone scan on January 11 showed an increased uptake in the upper and mid portions of the sacrum consistent with fracture. The January 12 MRI showed loss of signal intensity at L3-4 and L4-5; and a right sided disc protrusion encroaching into the neural foramen at L4-5. Dr. Landry recommended 2 weeks of bed rest with limited walking activities; and continued Vioxx and Darvocet.

The employee testified that she worked until January 15, 2002, and was then off work for three months.

On January 29, the employee saw Dr. Landry with right buttock pain that radiated down into her right leg to the foot with numbness and tingling; and muscle spasms in the lower back and buttock area. Sitting straight leg raising was positive on the right. Supine straight leg raising was 75 degrees on the right with right lower extremity and tailbone pain. There was normal strength sensation and reflexes in the lower extremities. Dr. Landry ordered therapy and returned the employee to half day light duty with no prolonged standing, no repetitive twisting, stooping and bending, and no lifting of over 15 pounds.

The employee started physical therapy on February 1, 2012. On February 12, Dr. Landry noted the employee had been unable to work because her job did not allow half day light duty work; and recommended a neurosurgical consultation.

On March 6, 2002 the employee saw Dr. Gibbs a neurosurgeon for low back and right leg pain. The employee had been off work since January 21 and had aching and stabbing in her low back, burning in her sacral region, aching in her buttock and numbness and tingling in her right leg. Dr. Gibbs reviewed the January 12 MRI which showed at L4-5 a broad based disc bulge more to the right with increased signal intensity along the posterior annulus which may represent an annular tear; and a broad based disc bulge at L5-S1. The January 11 bone scan showed increased uptake in the sacroiliac joint and upper sacrum. An MRI of the sacrum revealed no apparent abnormal signal intensity within the S1 or S2 vertebrae. Dr. Gibbs diagnosed back pain and right lower extremity numbness that may be due to a possible annular tear at L4-5 or sacral fracture with no evidence of radiculopathy or myelopathy. Dr. Gibbs ordered a CT scan.

The March 13 lumbar CT scan showed a mild concentric non-compressive disc bulge at L5-S1 with associated bilateral facet joint disease; mild degenerative changes at both sacroiliac joints; and no evidence of a sacral fracture or bony destructive process.

On March 13, Dr. Gibbs noted that the employee had low back pain with no leg pain and the numbness and tingling in the right thigh had significantly improved. Physical therapy helped. Dr. Gibbs noted that the lumbar CT showed that the disc height from L2 through S1 seemed relatively well preserved; there was no marked degenerative changes in the sacroiliac joint bilaterally and no apparent fracture. Dr. Gibbs diagnosed low back pain without radicular symptoms most likely due to sacroiliac joint dysfunction. He prescribed a Medrol Dosepak, therapy, and a TENS unit.

On April 17, 2002, Dr. Gibbs noted that the therapy gave only marginally improvement and the low back pain was due to the sacroiliac joint dysfunction. Dr. Gibbs prescribed sacroiliac joint/epidural steroid injection; and the employee was to return to work on limited duty with a 10 pound lifting restriction and no repetitive bending, twisting or stooping and to change positions frequently.

The physical therapist noted on April 17 that the employee was doing much better with a decrease in low back pain. The range of motion of the lumbar spine was within normal limits and no gait alteration was noted. The therapist recommended discontinuation of therapy.

The employee testified that on April 19, 2002, she started working on a light duty basis and was stationed at the crew entrance where she could sit and stand as she needed. She probably did that for about a year and then started driving a shuttle mini bus. She picked up customers from the parking lot and took them to the casino. Being a shuttle bus driver was easier than the crew entrance because she could move around.

On May 6 Dr. Chiu diagnosed right SI joint dysfunction, right iliolumbar ligament, and degenerative disc disease; and performed injections to the right SI joint and iliolumbar ligament.

On May 13, 2002, the employee had a visit scheduled with Dr. Gibbs' office. The employee's daughter called and stated that that they had a wreck on the way to the appointment.

The employee testified that around noon on May 13, 2002, she had a motor vehicle accident when her daughter was driving her to Dr. Gibbs for a scheduled appointment. Their vehicle was struck from behind by an 18 wheeler. She first stated that she did not notify the employer but then stated she might have told employer in the shift office. She went to the emergency room and then to a chiropractor. The accident hurt her neck and shoulders; and low back. The low back returned back to the way it was prior to the motor vehicle accident, and she had problems to her neck and shoulders. She no longer has any problems with her neck.

The employee testified in her August 18, 2003 deposition that when she had her motor vehicle accident she had neck and shoulder stiffness but did not have any problems with her back. The employee testified in her November 29, 2006 deposition that she did not have any symptoms in her low back after the motor vehicle accident and had no lasting problems due to the motor vehicle accident.

Ms. Gooch testified that the company was not made aware that the motor vehicle accident in May of 2002 was work related until the employee's deposition in August of 2003.

The company was aware of the motor vehicle accident but was never asked to provide medical treatment.

The employee went to Pemiscot Memorial Hospital emergency room on May 13, 2002, due to being involved in a motor vehicle accident with neck and shoulder stiffness.

On May 16 Dr. Chiu noted that the employee had neck and shoulder pain after being rear ended. Dr. Chiu performed a right SI joint injection and three trigger point injections to the right gluteus minimus. On May 29 and June 5 Dr. Chiu performed injections to the right SI joint and L4-5 and L5-S1 interspinous ligaments. On June 5 Dr. Gibbs noted that the injections by Dr. Chiu helped the right hip but not the low back. The employee was working full time. Dr. Gibbs diagnosed lumbosacral back pain and right SI joint tenderness. Dr. Gibbs prescribed a TENS unit, medication for muscle spasms and discomfort; and the employee was to continue working with a 20 pound lifting restriction and frequent position changes.

On June 11, 2002, Dr. Chiu performed an injection to the L4-5 region; and noted the right SI joint dysfunction was resolved. On June 13, Chiu performed injections to the right SI joint and L3-4 interspinous ligament. The employee noted that her neck was still a little sore after the motor vehicle accident. On June 21 Dr. Chiu performed injections at L4-5 and L5-S1. On June 28, Dr. Chiu performed injections to L5-S1 and right sacral ligaments; and noted that after her back pain under control her neck would be evaluated under her own insurance.

On July 11, 2002, Dr. Gibbs noted that the employee had approximately eight injections by Dr. Chiu; and the right sacroiliac joint was much improved. The employee had severe pain in the mid lumbar region and had been off work for the last two days. Dr. Gibbs prescribed Neurontin, Ultracet, Flexeril and Elavil.

Dr. Gibbs on August 28, 2002, noted that the back pain was likely due to sacroiliac joint dysfunction and the employee had significant leg length discrepancy. Dr. Gibbs discontinued the Neurontin and Flexeril; continued the Elavil, Vioxx and Ultracet; and prescribed a sacroiliac joint belt. Dr. Gibbs thought that the employee was at maximum medical improvement; had exhausted medical management; and did not see any indication for surgical intervention. Dr. Gibbs discharged the employee and stated that she can continue working with a 25 pound lifting restriction.

The employee began being treated by Dr. Burnett, a chiropractor on October 24, 2002. The employee had neck pain and an exacerbation of lower back pain that began shortly after being in an auto accident on May 13, 2002. The neck, lower back and pelvic region pain had been getting worse with a pain level of 5-6. She had constant sharp right sided lower back pain extending into both legs to the knees. She had constant dull neck pain which extended into both shoulders. She had headaches that began to the front of the head and extended to the back of the neck. The employee has a history of lower back pain that occurred while working; and was currently being treated. The lower back pain treatment by Dr. Burnett was noted to be secondary to her medical treatment and involved only the injury that occurred in the motor vehicle accident of May 13, 2002.

The employee saw Dr. Burnett on October 30, 2002, with continued spasms at C1-T1 and L1-L5. The cervical, headache, and lumbar/pelvic syndrome remained the same with moderate levels of pain. The employee treated with Dr. Burnett thirteen times in November 2002. On November 1, the employee had high levels of pain in her neck and lower back and an altered gait when walking. On November 15 the lower back pain continued to extend into her left leg above the knee. The employee saw Dr. Burnett ten times in December of 2002.

On December 6, 2002, the employee saw Dr. Diffine for low back pain and dizziness. Outpatient physical therapy was ordered. On December 19, Dr. Brunette noted that the employee continued to have spasms at C1-T1 and L1-L5. The employee went to the emergency room at Pemiscot Memorial Hospital on December 26, due to back pain; and a Toradol injection was given.

2003:

In January 2003 the employee was treated by Dr. Burnett six times. On January 3, the employee had increased lower back pain more to the left side extending to the upper leg above the knee. The employee's last visit was on January 22. She had mild back discomfort, the cervical syndrome was improving with minimal pain, and the thoracolumbar motion was restricted. Dr. Burnett released the employee from care but noted that she would remain under medical treatment for her low back until released for her work related injury.

On January 23, 2003, the employee saw Dr. Diffine who diagnosed depression, anxiety and low back pain. Dr. Diffine prescribed Wellbutrin for depression, Xanax for anxiety and Lorcet Plus for low back pain. On February 13, the employee saw Dr. Diffine with anxiety, depression and mood swings and Lexapro was prescribed.

The employee saw Dr. Burns on February 21, 2003, for low back pain that she related to a work related injury on December 15, 2001. Dr. Burns noted significant work up with a bone scan showing uptake at the sacrum and SI joint. A MRI demonstrated a mild increased uptake at several discs compatible with mild desiccation with possible annular tear at L4-5. Dr. Burns reviewed the physical examinations from multiple visits with the prior practitioners and the findings suggested a right SI dysfunction. The employee was on Hydrocodone, Neurontin, Vioxx, Alprazolam, Lexapro, and Carisoprodol. Dr. Burns diagnosed a work related fall with sacral fracture, SI dysfunction and L4-5 disc injury; which suggested the current pain syndrome was related to the fall at work. The employee demonstrated features of chronic pain with some secondary features suggesting an adjustment disorder or anxiety/depression in relation to treatment of her chronic pain. Dr. Burns recommended maintenance medications for chronic pain; and stated that while she was using the medications, that she was able to function at a modified work assignment performing normal work duty for the security department. Dr. Burns stated her prognosis for continued work at a modified work duty was excellent.

After a referral by Dr. Diffine, the employee went to Dr. Nasir on March 11, 2003, for chronic low back pain, right knee pain, right lower extremity pain down to the toes, and dorsal back pain; and complaints of restless leg. The employee had sleep disturbances due to pain and a poor appetite. She had irritation, anxiety, nervousness, depression, but denied any suicide

ideation. The pain was relieved with leaning forward, TENS unit, sacroiliac joint belt, and lying on her side. Aggravating factors include sitting up straight, standing, riding in a car, and weather changes. The employee was on Lorcet Plus, Soma, Xanax and Zoloft. The employee was working at Casino Aztar as a Security Guard. Dr. Nasir diagnosed chronic low back and right lower extremity pain status post fall; bilateral sacroiliac joint arthralgia; myofascial pain syndrome; right knee pain due to osteoarthritis; coccygodynia; chronic thoracic spine pain; depression; and pending litigation issues. Dr. Nasir prescribed Neurontin and Vioxx; and ordered x-rays of the lumbar spine and coccyx.

On April 10, 2003, Dr. Diffine diagnosed depression, anxiety and low back pain; and prescribed medication.

The employee went to Pemiscot Memorial Hospital emergency room on May 19, 2003, for low back pain. On May 25, the employee went to the emergency room due to increased low back pain that morning and pain radiating to the right leg. On May 27, the employee saw Dr. McPherson for back pain that she related to a fall at work. Dr. McPherson prescribed medications.

On June 12, 2003, Dr. Burns noted the employee has chronic pain from the sacral fracture, SI dysfunction and L4 disc injury related to a fall at work. Her symptoms have been well stabilized with medications and TENS unit. Her sleep and mood were quite disturbed when she was off her medications. The employee is on the casino security force and driving a bus with good tolerance for activity; and had a 25 pound lifting restriction with no running and climbing. Dr. Burns diagnosed chronic pain that was stable with current medication.

On July 15, 2003, Dr. Burns noted the employee had been doing about the same with good tolerance with her workplace. She was driving a shuttle bus allowing just three steps up into the bus. Current medications resulted in good pain control. Dr. Burns continued her current medications; and continued restricted work duty with no lifting greater than 25 pounds and no climbing greater than three steps.

The employee went to the Hubbard-Shea ENT Clinic on July 15, 2003, for headache pain. In review of systems, checked yes were neck pain, fatigue, weight loss, nausea, headaches, double vision, hearing loss, ear drainage, ear pain, ear noise and dizziness. A hearing testing was performed. Diagnosed was migraine headaches and a referral was made to Dr. Prasad.

The employee saw Dr. Prasad a neurologist on July 21, 2003, for headaches and neck pain which she developed two months ago. It was most severe on the right side with associated nausea and had been occurring at least two to three times a week. She was taking over the counter medication without benefit. She does not recall any injury such as a fall or head trauma but has a remote history of a car accident. The employee was on Soma, Hydrocodone, Lexapro, Vioxx and Xanax. Past medical history showed a remote history of motor vehicle accident a year ago causing back problems. She had chronic back pain which was apparently under control with the TENS unit. The CT of the head performed in the office appeared normal. Dr. Prasad stated that the headaches were likely a combination of migraine and tension; and prescribed Pamelor and Fioricet for severe headaches.

The employee testified that after returning to work in the middle of April of 2002, she continued to have problems doing her job. She continued to work full time on the shuttle bus until mid July of 2003 when she applied for FMLA. She left work at the end of August of 2003, and quit due to pain which was excruciating even with medication and walking around. She did not quit her job sooner because she liked the job and wanted to keep it.

The employee testified that she saw a doctor in July of 2003 and he took her off work. She remembers her deposition testimony in August of 2003 when she testified that her doctor was taking her off work due to headaches, nausea and vomiting. She is not claiming that was work related. She testified that she misunderstand the deposition question about why she quit working for Casino Aztar. She quit work due to severe back pain and cannot work due to the low back, tailbone and right leg. The reason she quit was due to hurting in her lower back and she could not get comfortable and was not due to migraine headaches.

The employee testified in her August 18, 2003 deposition that in the middle of July of 2003, Dr. Burns put her on restrictions and she returned to work in accordance with those restrictions. She first saw Dr. Prasad at the end of July of 2003 and he took her off work due to migraine headaches. She is not claiming that she had not worked since the end of July because of the work accident at the casino. It is solely because of the migraines and recommendations of Dr. Prasad. Since being off work her back improved and the leg and hip pain is less frequent. When asked if the only reason that she had not worked since the end of July was the instructions of Dr. Prasad she said no. When asked what other reason, the employee stated she is not going back to work and was going to resign that week. She did not feel she was up to 8 hours because she hurt all of the time and cannot rest. She was having constant pain and problems in the lower part of the middle of her back where the tailbone and back meet with sharp shooting pains down her leg which gets more severe as the day goes on. The employee is not claiming the migraines are related to the work injury but she gets light headed from the migraines. She is being treated for depression and believes it is related to the work injury.

The employee testified in her November 29, 2006 deposition that she stopped working for the casino because she could not work due to pain which got worse and was so bad she could not think straight.

Ms. Gooch testified that the employee was off work from January 15 through April 19, 2002 for workers' compensation. She worked at the Casino until she applied for FMLA. Her employment ended on July 22, 2003, and the employee was placed on FMLA because the employee said she had a stroke. The first time that the company was aware she had quit was after the employee's deposition in August of 2003, when their attorney informed them that the employee had quit for conditions unrelated to the work.

The Crew Member Record which is Employer-Insurer 6 showed that the employee was on FMLA from July 22, 2003 through August 15, 2003, and on August 29, 2003 there was a separation, and the employee voluntarily quit.

Ms. Gooch testified that on August 29, 2003, another security officer brought the employee's uniform in. When she quit, the employee was a security officer/shuttle driver.

Based on Dr. Burns' restrictions, they would have offered her a regular job within the restrictions which included the vault door job.

The employee saw Dr. Burns on September 11, 2003, and stated that about two weeks after her July visit she had a loss of pain control which came without any further injury or overall medical change. She had been working with a neurologist for headaches and placed on Butalbital about two months ago. Dr. Burns noted limited tolerance for walking and increased pain with prolonged sitting which prompted her to quit her job driving the shuttle bus. On examination, there was decreased lumbar motion and painful palpation of the sacrum and SI joints bilaterally. X-rays showed the right SI joint had an appearance of a complete fusion. Dr. Burns assessed chronic pain syndrome, history of sacral fracture with SI joint dysfunction and evidence of right SI fusion. Dr. Burns increased the Hydrocodone; added Ambien for sleep disturbance; and ordered a bone scan.

On October 2, 2003, Dr. Burns noted the bone imaging demonstrated a rib agent at the 9th right rib but since x-rays did not show the abnormality a clear diagnosis was not possible. The employee's sleep and mood problems were stabilized with medication. Dr. Burns assessed chronic pain syndrome secondary to trauma with possible rib fracture and known pelvic fracture. Dr. Burns continued the medications; noted the employee had been previously released to work with stable limitations.

On November 7, 2003, Dr. Burns noted the employee had increased pain in the right lateral leg after mopping and vacuuming; and the rib pain was more intermittent and not as severe. On November 21, Dr. Burns wrote a letter that the employee had evidence of an abnormality of the right ninth rib compatible with a contusion from the work injury with a suggestion of a healing fracture. The rib injury was thought to be related to her work injury.

On December 7, 2003, the employee went to Pemiscot Memorial Hospital for low back and right leg pain.

2004:

On January 7, 2004, the employee saw Dr. Burns with continued episodes of moodiness. The employee had a few episodes of pain severe enough to cause some right leg muscle tremoring and an episode of fainting associated with pain while standing and fell without injury. The employee had increased pain with housework and cooking. She had poor tolerance for standing more than fifteen to twenty minutes. Dr. Burns diagnosed chronic pain syndrome with worsen mood and stable SI dysfunction. The employee was encouraged to have her primary physician evaluate the episode of syncope. She was sent for an FCE at Mid America Rehab to determine the permanent activity restrictions. Dr. Burns thought the employee was at maximum medical improvement for the chronic pain related to a sacral fracture and chronic SI dysfunction but would need maintenance care for the chronic pain.

The employee had an EEG on January 19, 2004, with the clinical impression of moderately slow for her age suggesting a mild generalized cerebral disturbance but no evidence of a focal cerebral lesion and no epileptic findings. Part of the slow character could be secondary

to antidepressants, narcotics or sedatives the employee was taking. The January 19 brain MRI showed extensive high intensity nodular signals due to amyloid angiopathies, peripheral vascular sclerosis or obstruction; and can be seen in Alzheimer's and Binswanger's diseases. There was minimal cerebral atrophy which was rather early for her age with periventricular edema.

The employee saw Dr. Choudhari on February 4, 2004, after being referred by Dr. Diffine for seizures. It was noted that the employee had been passing out her whole life, however, for the last two years she had been having more frequent episodes. She is told by her family that when she passes out, she will shake sometimes up to 10-15 minutes, is confused and disoriented for a while. She has had about six or seven episodes in the last three months. When she has these symptoms she has numbness as well as visual symptoms but denied any previous history of stroke like symptoms or loss of vision. Past medical history was significant for depression, anxiety and back pain. She was on Hydrocodone, Xanax, Vioxx, Soma, Zoloft and Ambien. Dr. Choudhari diagnosed possible complex partial type of seizures with unclear etiology. The employee had an abnormal MRI which showed multiple hyper intense lesions which can be seen with small vessel disease but does not have any risk factors and the possibility of multiple sclerosis should be considered.

On February 11, 2004, Dr. Choudhari performed a lumbar puncture. The employee had lower back pain with an onset of two years ago which is relieved by medications and lying down. The pain affects her sleep, appetite and physical activity. The lumbar puncture showed support for a diagnosis of multiple sclerosis. On February 24, the employee had a bilateral carotid duplex ultrasound to check on the carotid arteries which showed no significant lesions.

On March 4, 2004, Dr. Burns noted the employee was about the same but had some episodes of blacking out. She had a neurological workup and is avoiding any material handling and steps. She had previously been released to light duty work which was felt to be appropriate level; and avoids material handling and steps. Dr. Burns noted that returning to work driving was not reasonable given the episodes of blacking out. Dr. Burns diagnosed chronic pain syndrome secondary to stable SI dysfunction.

On August 31 the employee had continued problems with lifting, bending and vacuuming. The pain was fairly well controlled with her current medications, Dr. Burns noted the employee was released at maximum medical improvement in February and placed on permanent restrictions of light to medium work. On November 30, 2004, Dr. Burns assessed chronic pain syndrome secondary to pelvic fracture; and light duty work was continued.

2005:

The employee saw Dr. Burns on February 24, 2005, who diagnosed chronic pain syndrome, pelvic fracture with SI dysfunction secondary to work fall, and a possible rib injury secondary to work fall. The employee was continued at light duty work with current medications.

On April 14, 2005 Dr. Choudhari noted that the employee was still having episodes of passing out. When she comes to she sweats and gasps for air but does not have confusion or

disorientation. She has had two episodes in three months. The past MRI showed significant white matter disease and he ordered a repeat MRI. On April 26, the brain MRI ordered for a history of multiple sclerosis showed multiple hyper intense foci were seen which can be caused by small vessel disease or other conditions such as multiple sclerosis.

On May 12, 2005, the employee saw Dr. Choudhari with fatigue, and he ordered another lumbar puncture. On June 9 the employee saw Dr. Choudhari with pain in her low back, legs and feet. Dr. Choudhari noted the based on the spinal tap and the MRI the employee most likely had multiple sclerosis; and sent her for a second opinion at the MS Clinic at Barnes Hospital.

On October 25, 2005, the employee saw Dr. Diffine for depression over several months. He prescribed Cymbalta and Xanax to help with anxiety.

On December 22, 2005, Dr. Choudhari noted that the employee had occasional blurred vision and difficulty with her balance. There was a concern about multiple sclerosis due to multiple lesions and small vessel disease on the MRI. The St. Louis MS Clinic did not think there was multiple sclerosis; and recommended repeat brain and cervical MRIs.

2006:

On January 3, 2006, the employee saw Dr. Diffine for back pain, anxiety, fatigue and depression.

The January 4, 2006 cervical MRI showed degenerative disc disease at multiple levels most prominent at C5-6 with a disc protrusion at that level slightly towards the left. The January 4 brain MRI showed multiple hyper intense lesions but when compared to the April 26, 2005 MRI there did not appear to be any significant new lesions. The lesions most likely were caused by small vessel disease but the possibility of multiple sclerosis cannot be excluded. On January 5 Dr. Choudhari noted the employee had neck pain with numbness and tingling of her hands. The cervical MRI showed degenerative disc disease and some disc protrusions. The brain MRI did not show any significant change from the previous MRI.

On January 18, 2006, the employee told Dr. Burns that she had good tolerance for all activities except for bending and lifting which were strictly avoided. Light house work was done with mild increase in pain. Dr. Burns noted that her sleep was stable and her mood was improved on Cymbalta. Dr. Burns diagnosed chronic pain syndrome, right SI dysfunction and mood disturbance related to chronic pain.

On March 1, 2006, the employee informed Dr. Diffine that the Cymbalta was working and the employee was not crying and was sleeping well. On April 5, Dr. Diffine stated that the Cymbalta was making a big difference and the employee had not felt that good for a long time.

Dr. Choudhari performed an EMG/NCS on April 20, 2006. The employee noted that she was numbness, tingling and pain in her hands worse on the right which radiated up her arm and shoulder. She had been having numbness and tingling of her fingers in both hands for six months; and neck pain. The nerve conduction studies of the median and ulnar nerves were

normal. Due to back pain and right leg numbness, Dr. Choudhari ordered an MRI which was done on April 28 and showed mild to moderate L4-5 central spinal canal stenosis secondary to a broad based disc protrusion to the right; a right L3-4 medial foraminal disc protrusion contributing to far right lateral recess stenosis and mild right L3-4 foraminal stenosis; the protruding disc contacts the exiting right L3 nerve root as well as right L4 nerve root; and there was a small posterior annular tear at L4-5.

In April and May of 2006, the employee had audio tests by Dr. Smith an ENT. In April the employee was having dizziness and a muffled sound in her right ear.

On May 18, 2006, the employee saw Dr. Burns with an increase in pain in the lower lumbar level which she thought was related to trying to get garage shelves together. On exam there was myofascial band and trigger point present in the low lumbar. Dr. Burns assessed myofascial pain syndrome with active trigger points secondary to chronic pain and performed trigger pointy injections. On May 31 the employee told Dr. Diffine that her anxiety and depression were better. On July 19 Dr. Diffine noted that the employee's depression was good but her anxiety was fluctuating a lot. On August 18, the employee saw Dr. Diffine for several things including anxiety and depression.

On August 23, 2006, the employee had new cervicospinal pain associated with increased activity. The trigger point injections performed in May resulted in fairly significant reduction in low back pain and it allowed her to do a lot of activities that she had not previously done. Dr. Burns assessed myofascial pain syndrome in the cervicospinal area bilaterally and mild degenerative joint disease in the cervical spine. Medications were continued for her chronic low back and hip pain which should benefit the cervical pain. Dr. Burns performed myofascial trigger point injections. On September 19, Dr. Burns diagnosed myofascial pain syndrome, right SI dysfunction, cervical degenerative joint disease, and chronic pain syndrome. Dr. Burns stated that the SI dysfunction directly related to her work related pelvis injury and recommended a right SI joint injection.

On September 28, 2006, the employee saw Dr. Choudhari with more problems including getting weak for few days where she could not do anything; and problems with balance. The employee requested medications for multiple sclerosis. Dr. Choudhari suspected that the employee had multiple sclerosis due to the spinal tap having positive oligoclonal bands. Barnes Hospital MS Clinic was not sure about the diagnosis of multiple sclerosis. Dr. Choudhari noted that the MRI would be repeated.

On October 6, 2006, Dr. Burns noted that the employee had chronic pain secondary to pelvic fractures. She had previous treatment for right SI dysfunction and recent exacerbation without further injury. There were positive provocative signs with radiation to the right SI joint. There was normal lower extremity strength and reflex. Dr. Burns performed a right sided SI joint injection.

The October 6 brain MRI stated that given the history of hypertension, a hyper intense region may be possibly due to small vessel disease. The possibility of multiple sclerosis should be considered due to multiple hyper intense regions. The employee saw Dr. Choudhari on

October 26, with continued episodes of dizziness and lightheadedness but not completely passing out. A spinal tap for multiple sclerosis was within normal limits. The employee did not have any clinical history of multiple sclerosis but there was a concern about the possibility of seizures.

On November 10, 2006, Dr. Burns prescribed physical therapy for SI dysfunction directly related to her previous pelvic fracture and secondary post traumatic degenerative joint disease. The initial physical therapy evaluation was on November 14. Her current complaints were right low back/SI pain with increased pain with prolonged standing or sitting, and decreased pain when sitting in her recliner. The employee had a mild limp on the right. The therapist noted in Waddell's testing she was positive for five out of seven tests. The therapist noted symptoms consistent with right SI joint dysfunction but cogwheeling and positive Waddell's signs indicate submaximal effort and possible symptom magnification. The employee had therapy through December 11 and continued to demonstrate signs of possible symptom magnification.

2007-2009:

The employee saw Dr. Burns in January, April, May, July, September and November of 2007 and was prescribed medications and injections. The employee continued treatment with Dr. Burns in February, May and August of 2008. It was noted that the employee was having more psychosocial stress due to her daughter being in a car accident.

On August 31, 2008, Dr. Burns noted the employee had an exacerbation due to overhead work and had right shoulder impingement. She had a fall secondary to her leg weakness and felt she strained her shoulder. The leg weakness has been occurring in episodes of short duration and resulted in a couple of near falls. The fall and injury to the shoulder was related to pain from her pelvic injury. Trigger point injections across the right trapezius and subacromial right shoulder injections were performed. Dr. Burns assessed pelvic fracture with right leg pain, right shoulder impingement secondary to fall and chronic pain syndrome.

On January 9, 2009, Dr. Burns noted the employee had a recent exacerbation of her SI pain, and performed a bilateral SI joint injection. Dr. Burns on July 30 refilled medications and ordered an SI injection which was performed on August 10.

The employee testified that on October 30, 2009, she was on the steps of her front porch and her right leg gave out as she went down the steps. She fell in the yard and landed on her left hand and broke her wrist in three places. She had problems with her right leg giving out only after the December of 2001 accident. She did not ask employer for treatment, and went on her own to Twin Rivers emergency room, and Dr. Burns referred her to Dr. Schafer.

Ms. Gooch testified that the employee's 2009 fall and left wrist fracture was not reported to her and the employee did not request medical treatment.

The employee went to Twin Rivers Regional Medical Center on October 30, 2009, for a wrist injury due to the night before falling and landing on her left hand and wrist. X-rays showed a comminuted fracture of the distal radius with moderate displacement. On November 2 the

employee saw a Nurse Practitioner in Dr. Burns' office and was referred to Dr. Schafer on November 4. On November 6, 2009, it was noted that the employee slipped, fell and fractured her left distal radius. Dr. Schafer performed a close treatment with manipulation of left distal radius fracture and application of external fixator at Southeast Missouri Hospital. The employee had follow-up visits with Dr. Schafer on November 13, November 20, December 4, and December 21 of 2012.

2010-2011

On January 5, 2010, the employee saw Dr. Schafer who noted that she lacked about ten to fifteen degrees of full extension and flexion of the wrist; and employee wanted to continue working on her own exercise program instead of therapy. Dr. Schafer noted that the employee will gradually work her way out of the wrist splint and return on an as needed basis.

The employee saw Dr. Burns on January 15, 2010, which was a month ahead of schedule due to an exacerbation of left hip and thigh pain beginning about two to three weeks ago. She did not immediately recall any new falls or injuries or change in activities. She had a wrist fracture with surgery when she misstepped and did a flip which resulted in a jar to the back and left hip. She later recalled running an errand and being at a place where she had to go up and down several flights of stairs and was in a hurry and considered that may have been the time that the pain started. Dr. Burns diagnosed pelvic fracture with SI dysfunction, chronic pain syndrome and recent hamstring strain; and ordered lab work.

On January 15, 2010, the employee filed an amended claim that included aggravation of pre-existing depression; and left arm fracture from the October 30, 2009 fall. The employee claimed on October 30, 2009, her right leg gave way due to the injuries from December 15, 2001.

On February 5, 2010, the employee saw Dr. Burns with increased left hip and left knee pain since her fall where she broke her wrist. She has had more radicular pain in the left hip and knee and has had two or three episodes of knee instability. Dr. Burns assessed fall with left radiculopathy; increased hip, back and knee pain; left knee instability; and remote pelvic fracture with chronic pain. Dr. Burns ordered a left knee MRI which was performed on February 20 and showed a sprain/low grade partial tear of the anterior cruciate ligament. On February 25, Dr. Burns noted that the MRI demonstrated primarily chronic appearing changes and an injection was given. Oxycodone was prescribed. On March 26, 2010, another prescription for Oxycodone was prescribed. The employee continued to treat with Dr. Burns in July of 2010.

On November 1, 2010, the employee had a psychiatric evaluation by Dr. Armas. The employee has had anxiety and panic attacks since she was thirty-five and has had depression off and on since her mid twenties. The employee had a history of back pain and was currently on Hydrocodone. Diagnosed was Axis I major depressive order, severe, recurrent and panic disorder. Axis II was deferred. Axis III was back pain. Axis IV was unemployment. Axis V was 50/55. The planned course of action was a mental health evaluation/management with a medical doctor. Dr. Armas prescribed several different medications with the goal of lessening

her panic attacks and other symptoms. The employee treated with Dr. Armas on November 15 and December 17, 2010.

On November 26, 2010, the employee filed an amended claim that added the May 13, 2002 motor vehicle accident on the way to Dr. Gibbs and that she sustained injuries to her neck and back.

On January 6, 2011, Dr. Burns diagnosed chronic pain syndrome; remote pelvic fracture secondary post traumatic degenerative joint disease which were all fairly stable and improved with current treatment. The employee treated with Dr. Armas in January, February, March and April 2011; and appeared to have a good response to the medications.

Current Symptoms:

The employee testified to the problems she was having from her work accident. She has continuous pain in the center of her low back, tailbone, and right hip, with pain and numbness in the right leg. Her tailbone feels like a carpet burn all the time and sitting makes it worse. She has numbness and tingling in her leg and it gives way. She has difficulty standing after 15-20 minutes, and then needs to sit down. She has problems sitting for 20-25 minutes and then needs to lay and get off her tailbone and back to get relief. At times alternating sitting and standing is not enough and on a daily basis she has to sit in a partial recliner. When she is sitting she leans forward to take weight off her tailbone and back. She cannot walk very far, has trouble lifting and the heaviest thing she can lift is a gallon of tea. She has a hard time going up stairs. She has difficulty bending over all of the way, cannot kneel or crawl, and cannot pull anything heavy. She is taking Hydrocodone 3 times a day, Artrotec twice a day; Soma 3 times a day, and Lidoderm patches. She continues to use the TENS unit every day for pain. She wears an SI belt all the time; uses a heating pad a lot and takes hot baths twice a day.

The employee testified that her daughter who is a licensed homemaker works at her house every day for three hours. Her daughter does the dusting, cooking and all of the heavy activities including vacuuming and mopping. Her husband and daughter will bring the clean laundry and the employee folds it. She can dust table tops and cook some. Her husband mows the yard, does housework quite a bit, cooks most of the meals, and gets clothes out for her. Her most comfortable position is partly reclining in a recliner. She reclines about half way back several times during the day. She has trouble sleeping more than five hours and sleeps on her back on a heating pad. She drives occasionally but has trouble controlling her right foot. She used to be a regular church attendee but cannot sit for the two hours of bible class and church services. She changed her hair style and cut her long hair because she could not hold her head back to wash it.

The employee testified that with regard to her left wrist that was broken, she cannot pick up an iron skillet. The most she can lift is three to four pounds and she has a loss of grip but it does not have to be that heavy to drop it.

The employee testified that prior to the accident, she enjoyed gardening, flowers, crochet, reading, walking and biking. She enjoyed mowing her yard and using a weed eater; and going to

church. Since the accident and her injuries, she does not do any hobbies. She still reads and goes to church once in a while. She does not do any mowing. The employee is on social security disability.

Jackie Collins testified that prior to the work accident, his wife had no problems with housekeeping. She did everything including cooking, cleaning, helping mow and grew flowers. She was very active and did physical things including walking and bicycling. Every now and then she was light headed. She had hearing problems and had a hard time understanding questions. After the work accident she just does a little house work and does dusting every now and then. She occasionally cooks, does the dishes and puts up laundry. On a typical day, she is up and down 24 hours a day. She goes to bed for three to four hours, wakes up, and watches TV, and goes back to bed, then wakes up again. During the day she is up and down, and lies down during the day in a recliner or in the bed on a hearing pad. She had good days and bad days depending on what she tries to do. She does not work with her flowers, and will go shopping and drives every so often. She does not use the lawn mower. There has been a big change in their life due to the accident. The employee has not been employed since 2006, and has been on social security disability since 2006 for COPD and vertigo.

Opinions:

The employee saw Dr. Volarich on December 6, 2005. The exam revealed the employee to be profoundly depressed and the employee appeared to be on the verge of crying throughout the examination. She talked in a low monotone and dwelled considerably on her pain syndrome. On examination, her deep tendon reflexes were symmetric in the lower extremities. Extensor hallucis longus strength was strong on the left and weak on the right. She walked slowly, stiffly and with short steps; held her right hand over her right hip and complained of low back and right sacroiliac joint pain. At times there was a slight limp. The employee's lumbar motion was restricted in flexion, extension, right lateral flexion and left lateral flexion. Trigger points were noted in the right sacroiliac joint and right sciatic notch. Straight leg raise on the right was positive at 45 degrees and was stopped due to significant increase in low back pain in the right sacroiliac joint.

With regard to the December 15, 2001 injury Dr. Volarich diagnosed a sacral fracture with residual right sacroiliac joint dysfunction, disc protrusion at L4-5 to the right with intermittent right leg radicular symptoms, and aggravation of degenerative disc disease at L3-4 and L4-5 and aggravation of degenerative joint disease in the bilateral sacroiliac joints. It was Dr. Volarich's opinion that as a direct result of the December 15, 2001 injury the employee sustained a 35% permanent partial disability of the body as a whole rated at the lumbosacral spine due to severe back pain syndrome, as well as ongoing right leg radicular symptoms and loss of motion.

Pre-existing to December 15, 2001, Dr. Volarich diagnosed a minor lumbar strain that had resolved, hearing loss, chronic headaches and severe depression. It was Dr. Volarich's opinion that the employee had pre-existing disability that existed as a result of her hearing loss but deferred to an ear, nose and throat evaluation for assessment. It was his opinion that the employee had disability as a result of her severe depression, child abuse and headaches with

fainting episodes and he deferred to a psychiatric evaluation for assessment. It was Dr. Volarich's opinion that there was no disability referable to her 1994 lumbar strain since the symptoms resolved and caused no hindrance in her ability to work up to December 15, 2001.

Subsequent to December 15, 2001, Dr. Volarich diagnosed cervical and bilateral shoulder girdle strains from the 2002 motor vehicle accident. It was Dr. Volarich's opinion that additional disability existed as a result of her motor vehicle accident; and that the employee had a 15% permanent partial disability of the body as a whole rated at the cervical spine and bilateral shoulder girdles due to her strain/sprain syndrome and ongoing myofascial pain.

It was Dr. Volarich's opinion that the combination of her disabilities created a substantially greater disability than the simple sum or total of each separate injury/illness and a loading factor should be added.

Dr. Volarich recommended the employee undergo a vocational evaluation and assessment to determine how she might best return to the open labor market. The employee was forty-six years old which is a younger individual, has an education limited to the tenth grade but achieved a GED. She has only worked in service or labor type jobs the majority of her work career and has been unable to go back to work since July of 2003. She received Social Security Disability in 2004. Dr. Volarich stated if the vocational assessment identified a job for which she was suited, he had no objection with her attempting to return to work based on the limitations listed in the report. If vocational assessment was unable to identify a job for which she was suited then it was his opinion that the employee is permanently and totally disabled as a result of a work related injuries of December 15, 2001, in combination with her pre-existing hearing loss and psychiatric impairments including those secondary to child abuse and severe depression with headaches and fainting spells. It was his opinion that the cervical and bilateral shoulder girdle strain injuries from the motor vehicle accident would also contribute to her permanent disability in a less substantial manner.

It was Dr. Volarich's opinion that the employee would require ongoing care for her pain syndrome including but not limited to narcotics and non-narcotic medications, muscle relaxants, physical therapy and similar treatments. It was his opinion that the employee would need ongoing treatment with a pain clinic for her severe back pain syndrome which would include epidural steroid injections, trigger point injections, nerve root blocks, TENS units and other similar treatments.

With regard to her spine, the employee should avoid all bending, twisting, lifting, pushing, pulling, carrying, climbing and other similar tasks to an as need basis. She should not handle any weight greater than 10-15 pounds and limit that to an occasional basis. She should not handle weight over her head or away from her body or carry weight over long distances or uneven terrain. She should avoid remaining in a fixed position for any more than 20-30 minutes including standing and sitting. She should change positions frequently to maximize comfort and recline in a recumbent fashion when needed.

On January 12, 2006, Dr. Volarich sent a letter to clarify whether the restrictions were referable to her work related injury of December 15, 2001, or due to the motor vehicle accident

in 2002. Dr. Volarich stated that is difficult to break out the restrictions other than to note the majority of them are the result of the work accident of December 15, 2001, that caused a stress fracture of the sacrum and disc protrusion of L4-5 or aggravated her underlying degenerative disc and degenerative joint disease. The motor vehicle accident of 2002 caused a strain injury to the cervical spine and shoulder girdles and the restriction of not handling weight over her head or away from her body would be directly attributable to the cervical spine injury. The remaining limitations are due to her December 15, 2001 work accident.

On August 9, 2007, Dr. Volarich noted that he had received additional medical records and after reviewing those he had no changes to his December 6, 2005 report. Dr. Volarich stated that it appeared that she had developed central nervous system difficulties consistent with early multiple sclerosis or possibly a degenerative neurological condition; and thought those conditions occurred after the work related injury of December 15, 2001.

Dr. Volarich's deposition was taken January 16, 2009. Dr. Volarich stated that he diagnosed degenerative disc disease at L3-4 and L4-5 and degenerative joint disease bilaterally at the sacroiliac joints which was pre-existing the December 15, 2001 accident. He did not assign any disability to the pre-existing conditions because she was asymptomatic. With regard to the motor vehicle accident he thought it created disability but did not think it was a significant as to her back and particularly her psychiatric illness. None of the work restrictions were for any injury sustained before December 15, 2001.

The history in the functional capacity evaluation was that the employee quit her job in June or July 2003 because of headaches and severe seizure disorder since her injury. She reported that she quit because she was scared she would hurt someone while driving the bus. The reason presented in the history to Mid-America Rehab as to why she quit her job is different than what she told Dr. Volarich. Dr. Volarich did not offer any opinion that headaches or seizures are anyway related to her low back injury of December 15, 2001.

Dr. Volarich stated that the employee told him that due to the subsequent motor vehicle accident in 2002 she developed neck and shoulder pain but denied any lumbar involvement. The report from Northgate Chiropractic on October 24, 2002, the employee told the chiropractor that she experienced exacerbation of her low back pain shortly after the motor vehicle accident of May 13, 2002. That history is inconsistent with the history she gave to Dr. Volarich that she had no back pain from the motor vehicle accident.

The employee saw James England for a vocational rehabilitation evaluation on September 6, 2006. Mr. England noted that the employee appeared in a great deal of discomfort and was up and down about every fifteen minutes during the evaluation. She looked extremely tired and had a very flat affect and appeared near tears on several occasions. The employee finished the tenth grade and got her GED around 1995. She completed about 24 hours of credit in general courses at a community college. Mr. England stated that it appeared that she had some transferability of skill down to a light level of exertion. On vocational testing results she scored at the end of the high school level in reading and at the fifth grade level on arithmetic which would be adequate for a variety of entry level types of work activity. She would need some remediation in math if she were planning to enter a more technical field.

In his summary and conclusion Mr. England stated that the employee was forty-seven years old which placed her in younger worker category. She comes across as extremely thin, frail, tired and depressed; and seemed to be in a great deal of physical discomfort. Mr. England stated just looking at her presentation he did not believe that an employer in a normal course would likely hire her over virtually any other candidate. Her combination of problems would be certainly observable in an interview setting. Mr. England did not know of any work setting that would allow someone with the employee's problems to lie down periodically through the day or have times when she is not able to concentrate or focus accurately. It was Mr. England's opinion that the employee was functioning at a level that would prevent her from being able to sustain even sedentary work on a consistent day to day basis. She came across as a very sincere woman that would like nothing better than to somehow improve significantly so she could go back to work. As she appears to be functioning it was Mr. England's opinion that he did not believe she would be a good candidate for vocational rehabilitation and would not recommend her to an employer as a dependable perspective employee. Absent significant improvement in her overall functioning Mr. England stated that she would likely remain permanently and totally disabled from a vocational standpoint.

On January 28, 2009, Mr. England sent a letter after reviewing the results of the functional capacity evaluation conducted at Mid-America Rehab on January 27, 2004. Mr. England stated that the therapist thought that the employee was capable of medium level work activity. If this were true Mr. England stated he would certainly see no reason why she would not be able to return to previous work activity as a security person from a physical standpoint. The physical measurements do not take into consideration her emotional limitations as described by Dr. Kamath. Mr. England stated that taking into consideration his psychiatric findings as well as physical limitations as described by Dr. Volarich, his opinion remained unchanged from initial report of September 6, 2006.

The deposition of Mr. England was taken on April 13, 2009. Mr. England did not believe that based on the restrictions by Dr. Volarich and her description of her typical day to day functioning that she would be capable of even sedentary work on a consistent day to day basis. It was Mr. England's opinion that the employee was not able to compete in the open labor market and thought it was from a combination of the physical problems that she exhibited as well as the emotional problems she seemed to be experiencing despite the medication and treatment. Mr. England was not aware that the employee told her physical therapist during her functional capacity evaluation that she quit work because she developed headaches and severe seizure disorder and was scared she could hurt someone driving the shuttle bus. That would be inconsistent with what she reported to him.

The employee told Mr. England that she tried to keep working on a light duty basis until July 2003 and at that point she told him she could no longer handle the pain. Mr. England testified that he did not know if the employee quit because of pain in her back, headaches or from the seizure disorder. If she quit due to the headaches that would be inconsistent with her reporting to him that she had not had problems with migraines since 2002 or 2003. The employee told him her headache problem was getting better.

Mr. England stated that the employee's intellect would not prevent her from re-employment. The employee has skills that would be usable to the light level exertion from her past experience in retail management.

Mr. England reviewed the functional capacity evaluation performed on January 27, 2004, which said that the employee was capable of medium level work. Mr. England was not aware that Dr. Gibbs had released the employee with a restriction of 25 pounds lifting. Mr. England stated that if the employee just had that restriction she would be employable in the open labor market. Mr. England was not aware that Dr. Burns stated that he thought the employee was capable of working in light to medium duty work with no climbing greater than three stairs. With only Dr. Burns restrictions she would be capable of working in the open labor market.

In reaching his conclusion he took into account that the employee told him that she must recline during the day to deal with pain. Mr. England stated that if the employee did not give him truthful and accurate information that could affect some of his opinions. When he evaluated her, he was not aware that she tested positive for four out of five Waddell signs, and that the physical therapist thought her movement patterns and effort during the test were inconsistent.

The employee saw Dr. Chabot on July 9, 2009. Dr. Chabot noted that the employee was alert and cooperative and did not appear to be in distress. She did not walk with a cane or walker. She was able to move from the seated to standing position without assistance. There was mild tenderness to palpation involving the right SI region. The employee was able to sit at ninety degrees without any discomfort. Straight leg raise testing was negative at both the seated and supine positions. There was minimal hamstring tightness. Her lower extremity and neurological examination revealed decreased sensation involving the anterior thigh, right medial calf and right first web space. Motor strength testing was normal and deep tendon reflexes were symmetric. Dr. Chabot's impression was a history of sacral contusion with increased signal uptake on bone scan but negative x-rays and CT scan; history of chronic SI dysfunction and chronic back pain. The employee had a history of depression and anxiety, SI joint degeneration, and seizure disorder, versus episodic syncope. The employee had a negative history of multiple sclerosis and a history of an L4-5 disc protrusion.

Dr. Chabot stated that the employee sustained a contusion type injury on December 15, 2001, which resulted in chronic SI dysfunction and low back pain. Dr. Chabot stated that the history of SI joint degeneration and the history of seizure disorder versus episodic syncope pre-existed the accident. The medical records documented the employee had degeneration involving the bilateral SI joints and lumbar spine.

Dr. Chabot stated that the medical records documented the employee developed neck and upper thoracic complaints as well as exacerbation of her low back complaints following the subsequent motor vehicle accident. The employee did not complain of significant neck pain. The employee has a history of chronic headache and migraines which are not related to her December 15, 2001 injury. It was Dr. Chabot's opinion that the employee's lumbar and lumbar sacral complaints are the only condition related to her December 15, 2001 injury.

With regard to additional medical treatment to cure and relieve the employee from the effects of the work related injury, Dr. Chabot stated that the employee would most likely need to continue ongoing treatment in the form of the use of medications to moderate her symptoms. Prior treatment rendered by Dr. Burns appeared to be reasonable and appropriate to address her persistent complaints. It was Dr. Chabot's opinion that the employee had reached maximum medical improvement regarding her December 15, 2001 injury and would need ongoing treatment in the form in the use of medications to moderate her symptoms.

It was Dr. Chabot's opinion that the employee sustained a 5% permanent partial disability of the body as a whole due to the persisting complaints associated with her injury and subsequent complaints including the associated disc herniation at L4-5 and aggravation of her pre-existing degenerative disease involving the lumbar spine. It was Dr. Chabot's opinion that the employee sustained a 10% permanent partial disability of the body as a whole for persisting complaints involving her chronic sacroiliac condition.

When asked whether the employee had any permanent disability relating to pre-existing degenerative or intervening or subsequent accidents unrelated to the December 15, 2001 accident, Dr. Chabot stated that the medical records did not indicate evidence of ongoing treatment for chronic back or lumbar sacral complaints prior to December 15, 2001 injury. The ratings take into consideration the employee's pre-existing degenerative disease. It was his opinion that the neck and prior thoracic complaints were related to involvement in the motor vehicle accident. The neurologic conditions; mainly episodic syncopal episodes and questionable seizure disorder; depression and anxiety are not related to the December 15, 2001 injury.

With regard to permanent restrictions as a result of the December 15, 2001 accident, it was Dr. Chabot's opinion that the employee could return to limited work duties in the light/medium classification with maximum lifts in the 30-35 pound range, and frequent lifts in the 5-10 pound range. Job duties that require repetitive squatting, bending, and crawling would not be tolerated. The functional capacity evaluation revealed that the employee could perform lifts in chest to overhead position in the light/medium classification. Job duties that require consistent sitting would not be tolerated by the employee and she would best tolerate job duties that would allow her to alternate sit and stand 20-30 minutes at a time.

It was Dr. Chabot's opinion that as a result of the December 15, 2001 accident the employee was not permanently and totally disabled. Her prior treating physicians have consistently felt she was able to return to work duties at a limited capacity.

The deposition of Dr. Chabot was on May 20, 2011. It was Dr. Chabot's opinion that on review of the records that the employee probably had a contusion and not a fracture to the sacrum. The MRI of January 12, 2002, showed a right disc protrusion to L4-5 and showed evidence of nerve root impingement. After her May 2002 car accident the employee was evaluated at the emergency room for increased back complaints. When he saw the employee, she was taking Hydrocodone and Soma for the low back and SI pain and Cymbalta which is used for pain, depression and anxiety. On physical exam the employee tested negative for nerve root impingement. On exam she did have evidence of sensory changes along the L5 nerve root distribution which could be radicular to some degree but he did not think it was a surgical

problem. With regard to the May 2002 motor vehicle accident it was Dr. Chabot's opinion that there was no indication of permanent partial disability to the cervical spine. It was Dr. Chabot's opinion that as a result of the work accident the employee sustained a 15% permanent partial disability of the body as a whole referable to the lumbar spine with 5% for the L4-5 disc protrusion and 10% for the chronic sacroiliac condition. It was Dr. Chabot's opinion that there was no restriction referable to the motor vehicle accident.

With regard to what was caused by the December 15, 2001 accident Dr. Chabot stated a sacral contusion with increased signal uptake on bone scan but negative x-rays and negative subsequent CT scan; chronic SI dysfunction; chronic back pain; and L4-5 disc protrusion. Dr. Chabot did not agree with Dr. Volarich that she had a sacral fracture but agreed that there was an SI contusion with chronic dysfunction, aggravation of the SI joint degeneration, and a disc protrusion. Dr. Chabot agreed that there was an aggravation of the degenerative joint disease in the sacroiliac joint on the right side. It was Dr. Chabot's opinion that there was no evidence that the employee had multiple sclerosis. She had abnormalities on her brain MRI but did not appear to correlate with her clinical examination or complaints.

With regard to the future treatment due to the work accident Dr. Chabot stated that using medications to moderate the symptoms was reasonable, and SI joint injections if they moderate the symptoms. With regard to the May 2002 motor vehicle accident he did not assign any permanent partial disability from that. Even though she has reached maximum medical improvement she should receive ongoing medical treatment in the future. It is Dr. Chabot's opinion that the employee can work within the capacity in his report. When asked if there would be any reason why the employee would need to recline periodically throughout the day given her diagnosis, Dr. Chabot did not see why she would have to as long as her job allows her to alternate from sitting to standing .

The employee saw Gary Weimholt on July 23, 2010, for a vocational rehabilitation evaluation, his report was dated October 6, 2010, and his deposition was on June 1, 2011. Mr. Weimholt noted that the employee was observed to stand up several times in the interview and said it was due to pain in her tailbone. The employee seemed very tired. She was observed leaving the room and she walked very slowly up a gentle ramp area held on to the railing. Her speech was very sluggish and she denied side effects from medication. Mr. Weimholt was concerned that her testing would be valid. He deferred testing and relied on previous testing by Dr. Stillings and Mr. England. Mr. England indicated a high school level reading and fifth grade arithmetic. Mr. Weimholt stated that the employee's speech appeared to be slower than the normal relay and rhythm, as was also described by Dr. Stillings. Mr. Weimholt stated the employee demonstrated the ability to work at a convenience store where she deposited money, cashiered, totaled the cash register and supervised persons. She did record keeping at a grain and gin company. The employee did post high school-college program and obtained a 3.14 grade point average.

With regard to the transferable skills that would allow her to return to work in a light, sedentary or medium category of employment, the employee has demonstrated abilities in administrative support/office work, banking deposits, general office work, sales work, supervision work, warehouse/production inspection work, cash handling and cashier work,

customer service and retail sales work, and security and protective services work. She has demonstrated the ability to obtain a semi-skilled level of work and performed semi-skilled work as a security guard and convenience store manager. There are other security guard jobs of an unarmed nature that can be performed within the restrictions of Dr. Chabot and Dr. Volarich (not considering the need to recline) where there is a mixture of standing and sitting and very limited lifting. There are cashier positions in which the worker would have the ability to sit and stand and lifting not exceeding 15-20 pounds including at parking garages, automotive service centers, cafeterias and service stations. Other positions within the restrictions are night auditor in a motel or hotel; as a dietary aide in hospitals or nursing homes; and some of the drive thru windows of fast food restaurants. The employee has rudimentary computer and typing skills required for clerk/receptionist type positions with changes in sitting and standing.

Mr. Weimholt stated that the employee in her depositions reported that she was attending work regularly and performing all of her duties without physical or emotional problems. She reported in the deposition of 2003 that she was taken off work by a physician due to symptoms unrelated to the 2001 work injury and otherwise had returned to her regular duties. After she quit her job in 2003 she began to present herself in such a manner that an employer would consider her to be unable to perform work which includes multi symptoms not all related to her 2001 work injury. Mr. Weimholt stated that none of the work restrictions even those of Dr. Volarich (with the exception of the need to rest on the job) would preclude her from the kinds of jobs that he has indicated in the report or from performing some of the previous kinds of work.

It was Mr. Weimholt's opinion that the employee has remained employable in the open competitive labor market following the December 15, 2001 injury and the time that she quit the employment in July 2003, and she is not totally vocationally disabled as a result of the accident or injury. Mr. Weimholt did not believe that the employee is vocationally disabled, either as a result of the injury of December 15, 2001, in and of itself, or in combination with previous physical or mental problems. It is his opinion considering her current presentation alone, he did not think she would be hired by any employer in a normal course of business.

Mr. Weimholt stated that the description of why she left her work that she gave during her deposition was different than what she told him. It was his understanding that she voluntarily quit her employment due to migraine headaches.

Dr. Chabot's restrictions fall into a medium level but not the full range of medium. Dr. Volarich's lifting restrictions are greater than sedentary and go into light range of work but not the full range of light. The restrictions that he based his opinion on did not include any restrictions from the seizure disorder or blacking out episodes. To his knowledge none of the doctors addressed restrictions referable to those conditions. The blacking out episodes that she described would be considered a hindrance or obstacle to employment or re-employment. Just considering restrictions related to the December 15, 2001 accident it was Mr. Weimholt's opinion that the employee would be able to return to employment in the open labor market.

The employee has not attempted to return to work since she quit her job at the casino. In his opinion just looking at her age, education, restrictions and transferable skills he believes an employer would be reasonably expected to hire her. Even taking into account the employee's

ongoing neck symptoms from the subsequent motor vehicle accident and Dr. Volarich's neck restrictions, it was Mr. Weimholt's opinion that the employee is employable in the open labor market.

Mr. Weimholt stated that it was his opinion that with Dr. Volarich's restrictions including the need to rest the employee is unemployable. If the employee has to take unscheduled breaks to recline some during the day, that would interfere with her ability to keep a job. Mr. Weimholt stated that someone just looking at the employee probably wouldn't hire her based upon her current appearance. Mr. Weimholt discussed that the need to rest on the job would be that same as needing to recline in a recumbent fashion. It was his opinion that if someone had to lie down during the day for a significant amount of time that they are not employable in the open labor market pretty much without exception. There was no indication when the need to recline began. It was his opinion that that if one were to consider her current presentation alone that nobody is going to hire her and most pronounced things would be her slow pattern of speaking and slow pattern of walking which would be very obvious to a potential employer.

The employee saw Dr. Stillings on August 3, 2009, for a psychiatric evaluation. Dr. Stillings diagnosed Axis I: pre-existing dysfunctional family origin; pre-existing parent-child relational problems (emotionally and physically abused by alcoholic mother and father); pre-existing victim of sexual abuse as a child; pre-existing dysthymic disorder, chronic, early onset. Axis II: pre-existing personality disorder, NOS, with some somatoform/histrionic, dependant, depressive, obsessive-compulsive, narcissistic personality traits. Axis III: Per medical records and including epilepsy. Axis IV: multiple and severe; chronic pre-existing emotional problems dating back to childhood; low motivation to return to work; change of identity for a worker to a non-worker; uneven and sporadic work history; adoption of the "invalid" role; and interaction with the legal system. Axis V: GAF of 68 (mild to no significant psychiatric symptoms/functioning adequately from an emotional standpoint).

It was Dr. Stillings opinion that the employee's psychiatric diagnosis are enumerated above in Axis I and II; the December 15, 2001 work accident is not a substantial factor in causing any of the conditions diagnosed; however, it substantially causally aggravated her pre-existing dysthymic disorder with an associated 2% permanent partial psychiatric disability. All of the above psychiatric conditions on Axis I and II are pre-existing and none of them are due to intravenous events or events subsequent to December 15, 2001; or substantially causally related to the December 15, 2001 work injury. The employee does not need psychiatric treatment to cure any condition causally related to the December 15, 2001 work injury, and has reached psychiatric maximum medical improvement.

It was Dr. Stillings opinion that the employee had pre-existing psychiatric conditions/disorders of dysfunctional family origin with an associated 5% permanent partial psychiatric disability; parent-child relational problem associated with 10% permanent partial psychiatric disability; victim of sexual abuse as a child with an associated 2.5% permanent partial psychiatric disability; dysthymic disorder with a associated 5% permanent partial psychiatric disability; and personality disorder with an associated 2.5% permanent partial psychiatric disability. It was Dr. Stillings opinion that the employee is able to work without restrictions from the psychiatric stand point and needs no restrictions outside the workplace.

It was Dr. Stillings opinion that the employee was not permanently and totally disabled as a result of the December 15, 2001 accident.

Dr. Stillings deposition was taken on June 13, 2011. Dr Stillings said that the employee had a traumatic and chaotic upbringing. The employee told him that she quit due to low back pain, headaches and seizures. The employee told him that she has a long standing seizure disorder but did not see any objective documentation in the records of a seizure disorder.

It was Dr. Stillings opinion that the employee had a total pre-existing 25% permanent partial disability of the body as a whole attributable to her psychiatric conditions. It was his opinion that the December 15, 2001 work accident substantially aggravated the pre-existing dysthymic disorder with an associated 2% psychiatric permanent partial disability of the body as a whole. In his opinion the prior psychiatric problems had a potential to be a hindrance or obstacle to her employment to her psychiatric problems created by her work injury. Due to her pre-existing conditions if she decided to return to work within her physical limitations from the psychiatric standpoint she should have a very low stress level of a job and probably would not be able to sustain full time employment.

It is Dr. Stillings opinion from the psychiatric perspective in all likelihood at this point in her life when he saw her she was fifty years old and given the caveat the complexity of psychiatric diagnosis tend to show deterioration over time in a downward drift and deterioration of their ability to function in life and solely on a psychiatric basis it is highly unlikely she could work. With regard to work restrictions she would need a very low stress job that was part time and she might be able to sustain it. He did not attribute the downward shift of her condition to her work accident. The employee does not have an anxiety disorder but she does have chronic depressive disorder which is another word for dysthymic disorder.

RULINGS OF LAW:

Rulings of Law regarding the May 13,2002 Motor Vehicle Accident:

Issue 1. Alleged motor vehicle accident on May 13, 2002 and Issue 7. Medical causation as to the alleged May 13, 2002 motor vehicle accident.

It is disputed that the employee sustained a motor vehicle accident on May 13, 2002, that was compensable as part of the claim in Injury Number 01-144965 and that the alleged injury to the low back, neck and upper back was medically causally related to the alleged motor vehicle accident on May 13, 2002, and was compensable and related to the claim in Injury number 01-144965.

The employee testified that on May 13, 2002, she had a motor vehicle accident as her daughter was driving her to Dr. Gibbs for a scheduled appointment. The medical records from Dr. Gibbs show that on May 13, 2002, the employee had a visit scheduled and the employee's daughter called and stated that they had a wreck on the way to the appointment. Based on the employee's testimony and the corroborating medical records of Dr. Gibbs, I find that on May

13, 2002, the employee was on her way to an appointment with Dr. Gibbs and was involved in a motor vehicle accident.

In *Bear v. Anson Implement Inc.*, 976 S.W.2d 553, 556 (Mo. App. 1998), the employee was injured as a result of an automobile accident on his way home from medical treatment that he was receiving for a workers' compensation injury. He had left work earlier and went to a doctor's appointment. On the way home from the doctor's office he was struck by a vehicle and injured his left leg and hip. The Court of Appeals held that the injuries resulting from an automobile accident on the way home from an employer-authorized medical appointment for a prior workers' compensation accident was not compensable. The Court held that even if the employee was deemed to be in the course and scope of his employment while receiving treatment at the doctor's office for the compensable injury, the going to and coming from rule prevented him from recovery in that accidents going to or coming from work are not considered compensable. There had to be a showing that the nature of the primary injury contributed to the subsequent injury in some way other than merely occasioning the journey during which harm from a totally unrelated source occurred.

Based on the *Bear* case, I find that the motor vehicle accident that occurred on May 13, 2002, while the employee was going to Dr. Gibbs to receive treatment for the December 15, 2001 accident and injury is not compensable as part of the claim in Injury Number 01-144965 and that the alleged injuries to the low back, neck, upper back and shoulders from that motor vehicle accident is not medically causally related to the December 15, 2001 accident.

Issue 3. Notice in the alleged motor vehicle accident of May 13, 2002.

Based on my rulings in Issue 1 and Issue 7 above, the issue of Notice is moot and shall not be ruled upon.

Issue 15. Alleged subrogation credit by the employer-insurer for the third party settlement in the May 13, 2002 alleged motor vehicle accident.

Based on my rulings in Issue 1 and Issue 7 above, the employer-insurer's request for subrogation credit is not applicable and therefore is denied.

Rulings of Law regarding the October 30, 2009 Incident:

Issue 2. Alleged fall on October 30, 2009 and Issue 8. Medical causation as to the alleged October 30, 2009 fall.

The employer-insurer stipulated that the employee's injury to her lumbar spine was medically causally related to the December 15, 2001 accident. The employer-insurer is disputing that on October 30, 2009 that the employee sustained a fall that was compensable as part of the claim in Injury Number 01-144465; and are disputing that the injury to the left wrist that occurred on October 30, 2009 was compensable and medically causally related to the December 15, 2001 accident.

The employee has the burden of proving that not only the employee sustained an accident that arose out of and in the course of employment, but also that there is a medical causal relationship between the accident and the injuries and the medical treatment for which the employee is seeking compensation. *Griggs v. A.B. Chance Company*, 503 S.W. 2d 697 (Mo.App. 1973). Medical causation, not within common knowledge or experience, must be established by scientific or medical evidence showing the cause and effect relationship between the complained of condition and the asserted cause. *Brundage v. Boehringer Ingelheim*, 812 S.W.2d 200, 202 (Mo. App. 1991). Expert testimony is required where the cause and effect relationship between a claimed injury or condition and the alleged cause is not within the realm of common knowledge. *McGrath v. Satellite Sprinkler Systems, Inc.*, 877 S.W.2d 704, 708 (Mo. App. E.D., 1994); *Brundage* at 202.

In *Manley v. American Packing*, 253 S.W.2d 165 (Mo. 1952) the Supreme Court held that injuries which follow the legitimate consequences of the original accident are compensable even though the accident was not the sole or direct cause of the condition. The chain of causation means original force and every subsequent force. The accident which set the first injury or force in motion is responsible for the final result and it is immaterial that the final result might not ordinarily be expected. In *Lahue v. Missouri State Treasurer*, 820 S.W.2d 561 (Mo.App.1991), the Court of Appeals held that where a employee has an injury that arises out of and in the course of their employment, every natural consequence that flows from the injury, including a distinct disability in another area of the body is compensable as a direct and natural result of the primary or original injury.

The employee testified that on October 30, 2009, she was on her front porch and her right leg gave out as she went down the steps, and she fell and broke her wrist; and that it was only after the December of 2001 accident that she had problems with her right leg giving out.

The medical records show that the employee went to the hospital on October 30, 2009, and stated that she fell and landed on her wrist. The medical record from Dr. Schafer on November 6 stated that the employee slipped and fell. The medical records from Dr. Burns on January 5, 2010, state that the employee had a wrist fracture when she misstepped. None of the medical records mention that her right leg gave out causing the fall.

The employee has the burden of proof that she fell as a direct and natural result of the primary or original injury; and there is a medical causal relationship between the December 15, 2001 accident and the October 30, 2009 fall. There is no medical evidence or medical opinion that the October 30, 2009 fall was a direct and natural result of the December 15, 2001 accident.

I find that the employee has failed to meet her burden of proof that the October 30, 2009 fall was a natural and probable consequence of the original injury to the employee's low back. I further find that the employee failed to meet her burden of proof that the injuries from the fall were a legitimate consequence of the original accident. I find that the employee failed to meet her burden of proof that the injuries from the fall were a natural and probable consequence that flowed from the original injury. I find that the October 30, 2009 accident was not compensable as part of the claim in Injury Number 01-144965; and that the injuries that occurred on October

30, 2009 were not compensable and were not medically causally related to the December 15, 2001 accident.

Issue 4. Notice of the alleged fall incident on October 30, 2009.

Based on my rulings in Issue 2 and Issue 8 above, the issue of Notice is moot and shall not be ruled upon.

Rulings of Law regarding the December 15, 2001 Accident:

Issue 5. The average weekly wage and rate of compensation.

Section 287.250.1(4)RSMo. states that the average weekly wage is computed by dividing by 13 the wages earned in each of the last 13 calendar weeks immediately preceding the week in which the employee was injured. Absence of 5 regular or scheduled work days shall be absence of a calendar week.

Employee Exhibit E is a wage statement and punch detail for the employee's wages. It showed each day the employee worked and how many hours she worked that day. Employer-Insurer Exhibits 7 and 8 show the employee was making \$7.00 an hour until November 7, 2001 when her rate increased to \$7.21 an hour. Employer-Insurer Exhibit 9 is a punch detail report which shows the 13 weeks prior to the injury date and breaks out each day.

The employee was injured on Saturday, December 15, 2001. The calendar week started on Sunday, December 9, 2001. The 13 weeks immediately preceding the week of the injury was Sunday, September 9 through Saturday, December 8, 2001.

After reviewing the evidence, I find that the employee's normal work week was Sunday, Monday, Thursday, Friday and Saturday. From Sunday, September 9 through Saturday, December 8, 2001, the employee earned \$3,111.64 and missed 10 regular work days. Those 10 days are Thursday, September 27; Thursday, October 11; Thursday, November 1; Thursday, November 8; Thursday, November 15; Monday, November 26; Thursday, November 29; Thursday, December 6; Friday, December 7; and Saturday, December 8. Since the employee had 10 absences the \$3,111.64 shall be divided by 11. I therefore find that the employee's average weekly wage was \$282.88, and the employee's rate of compensation is \$188.59 per week.

Issue 9. The employer-insurer is claiming an overpayment for temporary total disability previously paid based on an incorrect rate of compensation.

The employer-insurer is seeking credit on any amount awarded in the case. The employer-insurer paid \$2,666.65 in temporary disability benefits for 13 6/7 weeks at the rate of \$192.26 per week. Based on my rulings regarding the rate of compensation, I find that the employer-insurer overpaid previously paid temporary total disability. The difference between the rate previously paid of 192.26 and the correct rate of compensation is \$188.59 a week is \$3.67 per week. The employer-insurer is entitled to a credit in the amount of \$50.89 (\$3.67 per week for 13 6/7 weeks.)

Issue 6. Medical causation with regard to the employee's psychiatric and/or psychological injury as a result of the December 15, 2001 accident.

It is disputed the employee's psychiatric or psychological injury was medically causally related to the December 15, 2001 accident.

The employee had a very traumatic childhood and had psychiatric and/or psychological problems that pre-existed the December 15, 2001 that she received treatment for.

The aggravation of a preexisting symptomatic condition is compensable. See *Parker v. Mueller Pipeline*, 807 S.W. 2d 518 (Mo. App. 1991). (Aggravation of pre-existing depression). In *Kelly v. Banta and Stude Construction Company, Inc.*, 1 S.W.3d 43 (Mo. App. 1999), the Court of Appeals held that the employer-insurer was liable for hip replacements based on a finding that the employee's work activity aggravated the employee's pre-existing osteoarthritis. It is sufficient that causation be supported only by reasonable probability. See *Davis v. Brezner*, 380 S.W.2d 523 (Mo. App. 1964) and *Downing v. Willamette Industries, Inc.*, 895 S.W.2d 658 (Mo. App. 1995).

The only expert that addressed the psychiatric and/or psychological condition is Dr. Stillings. Dr. Stillings diagnosed pre-existing dysfunctional family origin; pre-existing parent-child relational problems(emotionally and physically abused by alcoholic mother and father); pre-existing victim of sexual abuse as a child; pre-existing dysthymic disorder, chronic, early onset; pre-existing personality disorder, NOS, with some somatoform/histrionic, dependant, depressive, obsessive-compulsive, narcissistic personality traits. It was Dr. Stillings opinion that the December 15, 2001 work accident was not a substantial factor in causing any of the above diagnosed psychiatric conditions. It was his opinion that the December 15, 2001 work accident substantially aggravated the pre-existing dysthymic disorder with an associated 2% psychiatric permanent partial disability of the body as a whole.

Based upon the evidence, I find that the opinion of Dr. Stillings on medical causation for the psychiatric and/or psychological conditions is credible and persuasive. I find that the employee's December 15, 2001 work accident aggravated the employee's pre-existing dysthymic disorder; and the aggravation of the pre-existing dysthymic disorder was medically causally related to the compensable December 15, 2001 work accident.

Issue 10. Claim for previously incurred medical.

At the hearing the employee withdrew the \$57.00 bill to Dr. Hazel. The employee is claiming \$44,757.29 in previously incurred medical bills contained in Employee Exhibit D. The employer-insurer is disputing that amount with regard to authorization, reasonableness, necessity and causal relationship.

With regard to the \$2,543.00 bill to St. Francis Medical Center, the date of service is February 20, 2010, and was a left knee MRI due to the October 30, 2009 fall. I find that the left knee MRI is not medically causally related to the December 15, 2001 accident. I find that the employer-insurer is not liable for the St. Francis Medical Center bill.

With regard to the \$3,405.00 bill to Orthopedic Associates, the employee is only requesting the portions of the bill that are highlighted. The other portions have been paid. The requested bills are for treatment from November 2, 2009 through January 15, 2010 for the left wrist fracture and other symptoms from the October 30, 2009 fall. I find that these bills are not medically causally related to the December 15, 2001 accident; and the employer-insurer is not liable for the Orthopedic Associates bill.

With regard to the \$19,986.21 bill to Southeast Missouri Hospital, there are several dates of service. The treatment on September 22, 2003 was for bone imaging. The corresponding medical records for this date of service are not in evidence and that bill is not recoverable. See *Martin v. Mid-America Farm Lines, Inc.* 769 S.W. 2d 105 (Mo. Banc 1989). There was treatment on November 4 and November 6, 2009 for the left wrist fracture on October 30, 2009. I find that these bills are not medically causally related to the December 15, 2001 accident and are not recoverable. There was treatment on January 15, 2010, for laboratory tests including blood work which was for treatment related to the October 30, 2009 fall which is not medically causally related to the December 15, 2001 accident, and is not recoverable. I find that the employer-insurer is not liable for the Southeast Missouri Hospital bill.

With regard to the \$14,685.88 bill to Twin Rivers Medical Center there are several dates of service. There was a brain MRI and an EEG performed on January 19, 2004, which was to check for seizures and Multiple Sclerosis. There was blood work performed on February 4, 2004, and a bilateral carotid duplex ultrasound on February 24, 2004, which was ordered for seizures. There was an MRI of the brain on April 26, 2005, and a lumbar puncture on May 12, 2005, to check for MS and blood work due to balance difficulty on December 22, 2005. There were MRIs of the neck and brain on January 4, 2006; and treatment on October 31, 2009, for the left wrist injury. I find that all of the medical bills to Twin Rivers Medical Center are not medically causally related to the December 15, 2001 accident; and that the employer-insurer is not liable for these bills.

With regard to the \$1,022.20 bill to Pemiscot Memorial Hospital there are dates of service for May 13, 2002, December 26, 2002, May 19, 2003, May 25, 2003 and December 7, 2003. The May 13, 2002 emergency room visit was due to the motor vehicle accident which is not compensable and is not medically causally related to the December 15, 2001 accident. The December 26, 2002 visit to the emergency room was for her low back and was after Dr. Gibbs released the employee but before the employer-insurer sent the employee to Dr. Burns. There was no evidence that the employee requested treatment after being released by Dr. Gibbs that was denied or that the visit was a true emergency situation. I therefore find that the treatment was unauthorized, and is not recoverable. With regard to the remainder of the dates of service for treatment, they were all after the employer-insurer authorized Dr. Burns to treat her. Section 287.140 RSMo. gives the employer the right to select the treating physician. The statute also gives the employee the option of selecting her own physician at her own expense. See *Anderson v. Parrish*, 472 S.W.2d 452 (Mo. App. 1971). I find that the remainder of the visits to the emergency room at Pemiscot Memorial Hospital was while the employer-insurer was providing treatment with Dr. Burns. I find that the medical treatment was unauthorized and the employee exercised her right under the statute to have treatment on her own; and that the emergency room

exception did not apply. I find that the employer-insurer is not liable for the Pemiscot Memorial Hospital bills.

With regard to the \$3,135.00 bill to Dr. Burnett, D.C. there are multiple dates of service from October 24, 2002 through January 22, 2003. Dr. Burnett treated the employee for neck pain and an exacerbation of her lower back pain from the May 13, 2002 motor vehicle accident. I find that the May 13, 2002 motor vehicle accident was not compensable and not medically causally related to the December 15, 2001 accident; and the employer-insurer is not liable for the bill to Dr. Burnett.

The employee's claim for previously incurred medical bills is denied.

Issue 12. Claim for additional or future medical aid.

Under Section 287.140 RSMo the employee is entitled to receive all medical treatment that is reasonably required to cure and relieve her from the effects of the injury. In *Landers v. Chrysler Corporation*, 963 S.W.2d 275 (Mo. App. 1997), the Court held that it is sufficient to award medical benefits if the employee shows by "reasonable probability" that he is in need of additional medical treatment by reason of his work related accident.

It was Dr. Volarich's opinion that the employee would require ongoing care for her pain syndrome including, but not limited to, narcotics and non-narcotic medications, muscle relaxants, physical therapy and similar treatments; and would need ongoing treatment with a pain clinic for her severe back pain syndrome and would include epidural steroid injections, trigger point injections, nerve root blocks, TENS units and other similar treatments. With regard to additional medical treatment to cure and relieve the employee from the effects of the work related injury, Dr. Chabot stated that the employee would most likely need to continue ongoing treatment in the form of the use of medications to moderate her symptoms. It was Dr. Burns' opinion that the employee was at maximum medical improvement for the chronic pain related to a complex sacral fracture and chronic SI dysfunction but would need maintenance care for the chronic pain.

It was Dr. Stillings opinion that the employee does not need psychiatric treatment to cure any condition including the condition causally related to the December 15, 2001 work injury, and she has reached psychiatric maximum medical improvement.

I find that opinions of Dr. Volarich, Dr. Chabot, Dr. Burns and Dr. Stillings are credible and persuasive with regard to the issue of additional medical treatment.

I find that the employee is not in need of additional psychiatric treatment to cure and relieve her from the effects of her December 15, 2001 work related injury. The employee's claim for future medical for the psychiatric condition is denied.

I find that the employee is in need of additional medical treatment to cure and relieve her from the effects of his December 15, 2001 work related injury to her lumbosacral back and SI joint. The employer-insurer is therefore directed to provide the employee with all of the medical

care that is reasonable and necessary to cure and relieve the employee from the effects of her work related injury pursuant to Section 287.140 RSMo.

Issue 13. Nature and extent of disability and Issue 14. Liability of the Second Injury Fund for permanent partial disability or permanent total disability.

Temporary Disability:

Temporary total disability benefits are intended to cover healing periods and are payable until the employee is able to return to work or until the employee has reached the point where further progress is not expected. See *Brookman v Henry Transportation*, 924 S.W.2d 286 (Mo.App.1996).

The employee was paid temporary disability benefits when she was off work. The employee went back to work full time on April 19, 2002, and worked until July 22, 2003, when she was put on FMLA through August 15, 2003. The employee was no longer employed as of August 29, 2003. On August 28, 2002, it was Dr. Gibbs' opinion that the employee was at maximum medical improvement.

Based on a review of the evidence, I find that through August 28, 2002, the employee was in her healing period and had not reached the point where further progress was not expected. I find that the employee reached the point where further progress was not expected on August 29, 2002, and was not entitled to any additional temporary total disability benefits. Since the employee had returned to work on April 19, 2002, and continued to work through July 21, 2003, the employee is not entitled to any additional temporary total disability.

Permanent Total Disability:

The first question that must be addressed is whether the employee is permanently and totally disabled.

On August 28, 2002, it was Dr. Gibbs' opinion that the employee could continue working with a 25 pound lifting restriction. On July 15, 2003, Dr. Burns noted the employee had good tolerance with her workplace, and was driving a shuttle bus. Dr. Burns continued the restrictions of no lifting more than 25 pounds and no climbing more than three steps.

In December of 2005, Dr. Volarich recommended the employee undergo a vocational evaluation to determine how the employee might best return to the open labor market. Dr. Volarich stated if the vocational assessment identified a job for which she was suited, he had no objection with her attempting to return to work based on his limitations. If a vocational assessment was unable to identify a job for which she was suited then it was his opinion that the employee is permanently and totally disabled.

In September of 2006, Mr. England stated that just looking at her presentation he did not believe that an employer in a normal course would likely hire her. It was his opinion that the employee was functioning at a level that would prevent her from being able to sustain even

sedentary work on a consistent day to day basis. Absent significant improvement in her overall functioning it was Mr. England's opinion that the employee would likely remain permanently and totally disabled from a vocational standpoint; and the employee was not able to compete in the open labor market.

In July of 2009, Dr. Chabot only addressed the December 15, 2001 accident. With regard to permanent restrictions from that accident, Dr. Chabot stated that the employee could return to limited work duties in the light/medium classification with maximum lifts in the 30-35 pound range, and frequent lifts in the 5-10 pound range. Repetitive squatting, bending, and crawling would not be tolerated. Job duties that require consistent sitting would not be tolerated and she would best tolerate duties that would allow her to alternate sitting and standing for 20-30 minutes at a time. It was Dr. Chabot's opinion that as a result of the December 15, 2001 accident the employee was not permanently and totally disabled; and sustained a 15% permanent partial disability of the body as a whole referable to the lumbar spine.

When he saw her in August of 2009, it was Dr. Stillings' opinion solely from a psychiatric basis that it was highly unlikely she could work. With regard to work restrictions she would need a very low stress part time job.

In July of 2010, it was Mr. Weimholt's opinion that considering the employee's current presentation alone, the employee was not employable and did not think she would be hired by any employer in a normal course of business.

Based on a review of the evidence, I find that no employer in the usual course of business would reasonably be expected to employ the employee in her present condition and reasonably expect the employee to perform the work for which she is hired. I find that at the time of the hearing the employee was unable to compete in the open labor market and is permanently and totally disabled.

The next issue that must be determined is whether the employee was permanently and totally disabled as a result of the December 15, 2001 accident alone; whether the employee was permanently and totally disabled from the pre-existing conditions in combination with the December 15, 2001 accident; or whether the employee was permanently totally disabled as a result of the subsequent non work related accidents and conditions and/ or subsequent deteriorations of pre-existing conditions.

For the employee to be awarded permanent total disability benefits from the employer-insurer or the Second Injury Fund, the employee has the burden to prove that she is permanently and totally disabled due either from the December 15, 2001 accident alone or from a combination of the December 15, 2001 accident and injury in combination with the employee's pre-existing conditions.

In order to find the Second Injury Fund liable for permanent total disability, there must be a pre-existing permanent partial disability combined with a disability from a subsequent injury to create permanent and total disability. In order to calculate Second Injury Fund liability, the percentage of disability that can be attributed solely to the pre-existing condition(s) at the

time of the last injury must be determined. See Carlson v. Plant Farm, 952 S.W.2d 369 (Mo. App. 1997).

I find that the employee's claim for permanent total disability against the employer-insurer and the Second Injury Fund is substantially affected by the following:

There is no credible evidence that the December 15, 2001 accident resulted in permanent total disability.

At the end of August of 2002, it was Dr. Gibbs' opinion that the employee could continue working with a 25 pound lifting restriction.

In February of 2003, Dr. Burns stated that with regard to the low back pain that was related to the December 15, 2001 accident, the employee was able to function at a modified work assignment performing normal work duty for the security department; and the prognosis for continued work at a modified work duty was excellent. In June of 2003, Dr. Burns noted the employee's symptoms have been well stabilized with medications and TENS unit; that she is on the casino security force driving a bus with good tolerance for activity; and had a 25 pound lifting restriction with no running and climbing. On July 15, 2003, Dr. Burns noted the employee had good tolerance with her workplace driving a shuttle bus allowing just three steps up into the bus. He continued restricted work duty with no lifting greater than 25 pounds and no climbing greater than three steps.

It was Dr. Volarich's opinion that as a direct result of the December 15, 2001 injury the employee sustained a 35% permanent partial disability of the body as a whole at the lumbosacral spine.

It was Dr. Chabot's opinion that as a result of the December 15, 2001 accident the employee was not permanently and totally disabled. As a result of the December 15, 2001 accident, it was Dr. Chabot's opinion that the employee could return to limited work duties in the light/medium classification with maximum lifting in the 30-35 pound range, and frequent lifts in the 5-10 pound range. It was Dr. Chabot's opinion that as a result of the work accident the employee sustained a 15% permanent partial disability of the body as a whole referable to the lumbar spine.

It was Mr. England's opinion that the employee was not able to compete in the open labor market from a combination of physical and emotional problems.

It was Mr. Weimholt's opinion that the employee remained employable in the open competitive labor market following the December 15, 2001 injury and when she quit the employment in July 2003, she was not totally vocationally disabled as a result of the accident or injury. Just considering restrictions related to the December 15, 2001 accident it was Mr. Weimholt's opinion that the employee would be able to return to employment in the open labor market.

It was Dr. Stillings' opinion that the December 15, 2001 work accident substantially aggravated the pre-existing dysthymic disorder with an associated 2% psychiatric permanent partial disability of the body as a whole. It was Dr. Stillings' opinion that the employee was not permanently and totally disabled as a result of the December 15, 2001 accident.

The employee had a non compensable motor vehicle accident on May 13, 2002, which caused an aggravation of the employee's low back condition and caused neck/shoulder problems.

The employee testified that the May 13, 2002 accident hurt her neck and shoulders; and her low back. On November 26, 2010, the employee filed an amended claim that added the motor vehicle accident and which noted that she sustained injuries to her neck and back.

The medical records note that the employee had head, neck, shoulder, low back, pelvis and leg pain after being rear ended by a semi. In October of 2002, Dr. Burnett began treating the employee for neck pain and an exacerbation of lower back pain that began after the auto accident. The neck, lower back and pelvic region pain had been getting worse and the employee had pain down both legs; a constant dull neck pain extending into both shoulders; and headaches that extended to the back of the neck. In January of 2006, a cervical MRI showed a C5-6 disc protrusion at that level slightly towards the left. The employee had neck pain with numbness and tingling of her hands. In August of 2006 the employee had a new problem of cervicospinal pain. Dr. Burns diagnosed myofascial pain syndrome in the cervicospinal area and mild degenerative joint disease in the cervical spine.

Dr. Volarich said that the employee told him that due to the subsequent motor vehicle accident in 2002 the employee developed neck and shoulder pain but did not have any back pain from the accident. That history is inconsistent with what the employee told Dr. Burnett. Subsequent to the December 15, 2001 accident, Dr. Volarich diagnosed cervical and bilateral shoulder girdle strains from the 2002 motor vehicle accident. It was Dr. Volarich's opinion that additional disability existed as a result of her 2002 motor vehicle accident; and that the employee had a 15% permanent partial disability of the body as a whole rated the cervical spine and bilateral shoulder girdles due to her strain/sprain syndrome and ongoing myofascial pain. His restriction of not handling weight over her head or away from her body was directly attributable to the cervical spine injury.

Subsequent to the December 15, 2001 accident the employee either developed a neurological condition or had a pre-existing condition that deteriorated and affected her ability to work.

The employee was noted to have dizziness when she saw Dr. Diffine on December 6, 2002. On July 15, 2003, the employee went to an ENT Clinic and had fatigue, nausea, headaches, double vision, and dizziness. She was diagnosed with migraine headaches and referred to Dr. Prasad, a neurologist. On July 21, 2003, Dr. Prasad noted that the employee had headaches and neck pain which she developed two months ago; with associated nausea that had been occurring at least two to three times a week.

An EEG in January of 2004 showed a clinical impression of moderately slow for her age suggesting a mild generalized cerebral disturbance. A January of 2004 brain MRI showed

extensive high intensity nodular signals which could be due to several different conditions; and there was minimal cerebral atrophy which was rather early for the employee's age. In February of 2004, Dr. Choudhari saw the employee for seizures. The employee had been passing out her whole life, however, for the last two years she had been having more frequent episodes which included new symptoms of numbness, loss of vision and stroke like symptoms. He diagnosed possible complex partial type of seizures and noted the employee had an abnormal MRI which showed multiple hyper intense lesions seen with small vessel disease but the possibility of multiple sclerosis should be considered. A lumbar puncture showed support for a diagnosis of multiple sclerosis. In March of 2004, Dr. Burns noted the employee had blacking out episodes and stated that returning to work driving was not reasonable given the episodes of blacking out.

In April of 2005, Dr. Choudhari noted the employee was still having episodes of passing out; and ordered a brain MRI which showed multiple hyper intense foci caused by small vessel disease or other possibilities such as multiple sclerosis. Dr. Choudhari noted the based on the spinal tap and MRI the employee most likely had multiple sclerosis. In December of 2005, Dr. Choudhari noted that the employee had blurred vision and difficulty with her balance. In September of 2006, Dr. Choudhari noted that the employee had weakness and balance problems. In October of 2006, the employee had dizziness and lightheadedness.

Mr. Weimholt stated that the blacking out episodes would be a hindrance or obstacle to employment or re-employment

In August of 2007, Dr. Volarich noted that it appeared that the employee had developed central nervous system difficulties consistent with early multiple sclerosis or possibly a degenerative neurological condition. Those conditions occurred after the work related injury of December 15, 2001; and the headaches and seizures were not related to the injury.

The employee continued to work until July 21, 2003.

It is significant that the employee continued to work until July 21, 2003, which was after the May 13, 2002 motor vehicle accident that caused an aggravation of the lumbosacral spine; and neck and shoulder problems; and after the development or deterioration of central nervous system difficulties consistent with early multiple sclerosis or a degenerative neurological condition.

The employee's testimony at the hearing concerning why she stopped working on July 21, 2003, is contradicted by other evidence.

The employee testified at the hearing that the reason she quit was due to lower back pain and not due to migraine headaches; and that she misunderstood the question in her deposition about why she quit working.

The employee testified in her August 18, 2003 deposition that in the middle of July of 2003, Dr. Burns put her on restrictions and she worked within those restrictions. Dr. Prasad at the end of July of 2003, took her off work due to migraine headaches that caused her to become lightheaded. She was not claiming that she stopped working due to the work accident and it was solely because of the migraines and recommendations of Dr. Prasad. Later in the deposition, she

testified that the recommendation of Dr. Prasad was not the only reason she stopped working in July of 2003; and that she was not up to working 8 hours due to lower back and tailbone pain with shooting pains down her leg.

Ms. Gooch testified that the employee was placed on FMLA on July 22, 2003, because the employee said she had a stroke. Mr. Collins testified that the employee has been on social security disability for COPD and vertigo.

Dr. Volarich stated that the history in the functional capacity evaluation was that the employee quit her job because she developed headaches and severe seizure disorder that occurred since her injury; and was scared she would hurt someone while driving the shuttle bus. That was inconsistent with what the employee told Dr. Volarich and Mr. England.

Mr. Weimholt stated that the description of why she left work during her deposition was different than what she told him. It was his understanding that she voluntarily quit her employment due to migraine headaches.

Deterioration of the Pre-existing Psychiatric Condition.

When he saw the employee in July of 2009, it was Dr. Stillings opinion from a psychiatric perspective that the complexity of psychiatric diagnoses tend to show deterioration over time in a downward drift and deterioration of the ability to function in life. Dr. Stillings stated that solely on a psychiatric basis it is highly unlikely that the employee could work. Dr. Stillings did not attribute the downward shift of her psychiatric condition to the work accident.

The employee had a non compensable injury on October 30, 2009 which caused additional physical problems.

The employee saw Dr. Burns in January of 2010 due to an exacerbation of left hip and thigh pain beginning about two to three weeks ago. When she fractured her wrist, she misstepped and did a flip which resulted in a jar to her back and left hip. In February of 2010, Dr. Burns noted that since her fall when she broke her wrist, the employee had increased left hip and left knee pain with knee instability. Dr. Burns diagnosed left radiculopathy; increased hip, back and knee pain; left knee instability; and remote pelvic fracture with chronic pain.

Conclusion:

All of these facts substantially affect the credibility of the opinion of the employee's expert Dr. Volarich that she is permanently and totally disabled from a combination of the December 15, 2001 accident and the employee's pre-existing conditions at the time of the December 15, 2001 accident; and the opinion of the employee's expert Mr. England that the employee was not able to compete in the open labor market from a combination of the physical problems that she exhibited as well as the emotional problems she seemed to be experiencing.

It was Mr. Weimholt's credible and persuasive opinions that the employee remained employable in the open competitive labor market following the December 15, 2001 injury; and at

the time she quit employment in July 2003, she was not totally vocationally disabled either as a result of the injury of December 15, 2001, in and of itself, or in combination with the previous physical or mental problems. It was Mr. Weimholt's opinion that the blacking out episodes would be a hindrance or obstacle to employment or re-employment.

I find that the opinions of Mr. Weimholt are more persuasive and more credible than the opinions of Dr. Volarich and Mr. England as to the cause of the employee's permanent total disability.

The evidence highlights an unavoidable conclusion: The employee is permanently and totally disabled but her inability to compete in the open labor market is due to subsequent accidents and substantial worsening of her condition after December 15, 2001, which includes the May 13, 2002 non compensable motor vehicle accident that aggravated her low back condition and caused neck and shoulder problems; the development of a neurologic condition and/or a deterioration of a pre-existing neurological condition; the deterioration of the pre-existing psychiatric condition; and the non compensable injury on October 30, 2009 that caused an aggravation of the employee's low back condition and caused hip, left sided radiculopathy, and left knee problems.

I find that there is no credible evidence to support a finding that the permanent total disability resulted from a combination of her pre-existing conditions as of December 15, 2001, and her December 15, 2001 accident and lumbosacral injury. I find that the employee's permanent total condition was the result of subsequent deterioration of the employee's condition and not the result of the pre-existing conditions as of December 15, 2001, combined with the December 15, 2001 accident.

I find that the employee failed in her burden of proof that either the employer-insurer or the Second Injury Fund is responsible for the employee's permanent total disability benefits. The employee's claim against the employer-insurer and the Second Injury Fund for permanent total disability is hereby denied.

Permanent Partial Disability:

Employer-Insurer:

I find that as a result of the December 15, 2001 accident and injury alone that the employee sustained permanent partial disability. Based upon the evidence, I find that as a direct result of the December 15, 2001 accident and injury alone, the employee sustained a permanent partial disability of 25% of the body as a whole referable to the lumbosacral spine and a 2.5% permanent partial disability of the body as a whole referable to the psychiatric condition. The employer-insurer is therefore ordered to pay to the employee 110 weeks of compensation at the rate of \$188.59 per week for a total award of permanent partial disability of \$20,744.90.

Second Injury Fund:

Primary Injury

I find that the primary injury caused an additional 2.5% permanent partial disability of the body as a whole referable to the psychiatric condition. Since that is less than 50 weeks for a body as a whole injury it does not meet the statutory minimum threshold set forth in Section 287.220.1 RSMo. I further find that the primary psychiatric condition did not combine synergistically with the pre-existing psychiatric condition. The primary psychiatric condition shall not be included for purposes of determining Second Injury Fund liability.

I find that the primary injury to the employee resulted in a 25% permanent partial disability of the body as a whole referable to the lumbosacral spine at the 400 week level for a total of 100 weeks of compensation.

Pre-Existing Psychiatric Condition as of December 15, 2001.

It was Dr. Volarich's opinion that the employee had disability existing as a result of her severe depression, child abuse and headaches with fainting episodes and deferred to a psychiatric evaluation for the assessment. It was Dr. Stillings' opinion that the employee had a total pre-existing 25% permanent partial disability of the body as a whole attributable to her psychiatric conditions.

Based on the evidence, I find that the employee's pre-existing psychiatric condition constituted a hindrance or obstacle to employment or obtaining re-employment. I find that the pre-existing psychiatric condition as of December 15, 2001, resulted in a 17.5% permanent partial disability of the body as a whole at the 400 level for a total of 70 weeks of compensation.

Pre-Existing Low Back Strain and Hearing Loss:

It was Dr. Volarich's opinion that there was no disability from the 1994 lumbar strain and it caused no hindrance in her ability to work. It was Dr. Volarich's opinion that the employee had pre-existing disability that existed as a result of her hearing loss but deferred to an ear, nose and throat evaluation for assessment. There was no opinion in evidence as to the extent of disability for the hearing loss and whether it created a hindrance or obstacle to employment.

I find that the employee did not meet her burden of proof that the low back strain or hearing loss met the statutory minimum threshold set forth in Section 287.220.1 RSMo; and that either condition created a hindrance or obstacle to employment. These conditions shall not be included for purposes of determining Second Injury Fund liability.

Conclusion:

I find that the employee's pre-existing psychiatric condition and the primary injury to the body as a whole referable to the lumbosacral spine combined synergistically to create a total disability of 191.25 weeks. This total disability is based on a loading factor of 12.5%. After

deducting the disability that existed prior to the last injury (70 weeks) and the disability resulting from the last injury considered alone (100 weeks) from the total disability attributable to all injuries or conditions existing at the time of the last injury (191.25 weeks), the remaining balance to be paid by the Second Injury Fund is equal to 21.25 weeks. The Second Injury Fund is therefore ordered to pay to the employee the sum of \$188.59 per week for 21.25 weeks for a total award of permanent partial disability equal to \$4,007.54.

ATTORNEY'S FEE:

James Turnbow, attorney at law, is allowed a fee of 25% of all sums awarded under the provisions of this award for necessary legal services rendered to the employee. The amount of this attorney's fee shall constitute a lien on the compensation awarded herein.

INTEREST:

Interest on all sums awarded hereunder shall be paid as provided by law.

Made by:

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