

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

Injury No.: 97-433205

Employee: Cheryl Jennings  
Employer: Station Casino St. Charles  
Insurer: Continental Casualty Company  
Additional Party: Treasurer of Missouri as Custodian  
of Second Injury Fund  
Date of Accident: September 16, 1997  
Place and County of Accident: St. Charles, Missouri

The above-entitled workers' compensation case is submitted to the Labor and Industrial Relations Commission (Commission) for review as provided by section 287.480 RSMo. Having reviewed the evidence and considered the whole record, the Commission finds that the award of the administrative law judge (ALJ) is supported by competent and substantial evidence and was made in accordance with the Missouri Workers' Compensation Act. Pursuant to section 286.090 RSMo, the Commission affirms the award and decision of the administrative law judge dated December 7, 2004. The award and decision of Administrative Law Judge Leslie E. H. Brown, as issued December 7, 2004, is attached and incorporated by this reference.

The Commission finds that the ALJ correctly weighed and evaluated the lay and medical testimony in reaching her conclusions as to the issues in this case, including disability, causation, past and future medical care and expense, and the liability of the Second Injury Fund. *Reese v. Gary & Roger Link, Inc.*, 5 S.W.3d 522 (Mo. App. E.D. 2002), *Sullivan v. Masters Jackson Paving Co.*, 35 S.W.3d 879 (Mo. App. S.D. 2001), *Landman v. Ice Cream Specialties, Inc.*, 107 S.W.3d 240 (Mo. banc 2003).

This matter is before the Commission on employee's review of a Final Award as above indicated. An earlier Temporary or Partial Award had been issued on March 4, 2002, by a different ALJ. The Temporary Award required employer/insurer to provide employee with a "specific medical procedure." Several medical experts presented testimony/opinions at the hearing for the Final Award that the "specific medical procedure" was not necessary nor recommended.

Employer/insurer complied with the requirements of the Temporary Award, provided medical treatment and made substantial payments. No party contends that the Temporary or Partial Award is res judicata. *Diallo v. City of Maryland Heights*, 996 S.W.2d 675 (Mo. App. E.D. 1999), rehearing and/of transfer denied.

The Final Award determined that the earlier ordered procedure was not causally related to the injury in question and held that the medical expenses and disability stemming from that procedure were not compensable. As indicated, we agree. *Putnam-Heisler v. Columbia Foods*, 989 S.W.2d 257, 261 (Mo. App. W.D. 1999).

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

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

Given at Jefferson City, State of Missouri, this 4<sup>th</sup> day of August 2005.

LABOR AND INDUSTRIAL RELATIONS COMMISSION

CONCURRING OPINION FILED  
William F. Ringer, Chairman

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Alice A. Bartlett, Member

DISSENTING OPINION FILED  
John J. Hickey, Member

Attest:

\_\_\_\_\_  
Secretary

CONCURRING OPINION

I submit this concurring opinion to disclose the fact that I was previously employed as a partner in the law firm of Evans & Dixon. While I was a partner, the instant case was assigned to the law firm for defense purposes. I had no actual knowledge of this case while a partner with Evans & Dixon. However, recognizing that there may exist the appearance of impropriety because of my previous status with the law firm of Evans & Dixon, I undertook no involvement or participation in the decision in this case until a stalemate was reached between the other two members of the Commission. As a result, pursuant to the rule of necessity, I am compelled to participate in this case as there is no other mechanism in place to resolve the issues in the claim. *Barker v. Secretary of State's Office*, 752 S.W.2d 437 (Mo. App. W.D. 1988).

Having reviewed the evidence and considered the whole record, I join in and adopt the award and decision of the ALJ awarding benefits.

\_\_\_\_\_  
William F. Ringer, Chairman

DISSENTING OPINION

I must respectfully disagree with the opinion of the majority of the Commission.

Following the issuance of the Temporary Award, employer/insurer undertook the ordered course of treatment in an effort to cure and relieve this employee's back injury. They are not to be applauded for fulfilling their statutory obligation. *Williams v. City of Ava*, 982 S.W.2d 307 (Mo. App. S.D. 1998).

Employer/insurer was ordered to provide a discogram. Unfortunately, the procedure resulted in extensive

infection, discitis, bone erosion and a lumbar fusion. This flowed from a lawful order of an administrative law judge (ALJ) and was undertaken to cure and relieve employee from the effects of her injury at the recommendation of a qualified physician. Section 287.140 RSMo. It is well settled law that where, without fault of employee, the primary injury is aggravated by medical treatment, there is a causal connection between the original injury and the resulting disability. *Wilson v. Emery Bird Thayer Co.*, 403 S.W.2d 953 (Mo. App. W.D. 1966).

The majority would disregard the impact of the Temporary Award on employee. Instead, they emphasize the effect upon employer/insurer. The majority would have us not penalize employer/insurer for providing the ordered treatment. Instead, they would penalize employee for undergoing the physician recommend and ALJ ordered course of treatment.

Undoubtedly, the procedure had a significantly injurious effect. Undoubtedly, employee is without fault in this aggravation of her primary injury by the medical treatment. To hold employee was wrong to follow her doctor's advice and the order of the ALJ is unconscionable.

Employer/insurer would have us believe that they expended over \$200,000.00 in medical treatment, all the while knowing that this was only a case of a low back sprain/strain.

The majority refers to several medical experts who did not recommend the procedure ordered by the initial ALJ, namely a discogram. The implication in that statement is that the physicians recommended against the procedure. This is not the case. Only after the procedure and subsequent infection did the second guessing begin. Before the first hearing, the physicians were concerned with a method to alleviate employee's pain complaints and define the problem. One recommended a discogram. This is the placing of a needle in the disc and pumping in fluid to demonstrate whether there is a tear. Another thought that myelogram could show bulging discs or a larger herniation. The myelogram procedure involves insertion of a needle and interthecal injection of radiopaque contrast medium. Another physician was leaning toward steroid injections and CT studies. All involve needles into the back and all carry the risk of infection.

The majority improperly places the burden on compliance with the initial award on employee. This is contrary to the spirit and letter of the Workers' Compensation law

which statutorily requires a liberal construction of the law with a view to the public welfare. Section 287.800 RSMo.

The focus, here, should not be on employer/insurer. Rather, the focus should be on employee who did as she was lawfully ordered with disastrous consequences. Do we now tell her that the law provides no avenue for redress? That she was wrong to do as ordered?

I would reverse the Award of Administrative Law Judge Brown and enter an Award for past and future medical aid and temporary and permanent disability in accord with the findings and decision of the Temporary Award in this matter.

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John J. Hickey, Member

## AWARD

Employee: Cheryl Jennings

Injury No. 97-433205

Dependents:

Before the  
DIVISION OF WORKERS'  
COMPENSATION

Employer: Station Casino St. Charles

Additional Party:

Insurer: Continental Casualty Company (formerly known as CNA Claims Plus)

Hearing Date:  
LEHB/bfb for df

July 8, 2004 (finally submitted 8/9/04)      Checked by:

#### FINDINGS OF FACT AND RULINGS OF LAW

1. Are any benefits awarded herein? Yes
2. Was the injury or occupational disease compensable under Chapter 287? Yes
3. Was there an accident or incident of occupational disease under the Law? Yes
4. Date of accident or onset of occupational disease: September 16, 1997
5. State location where accident occurred or occupational disease was contracted: St. Charles, Missouri
6. Was above employee in employ of above employer at time of alleged accident or occupational disease?  
Yes
7. Did employer receive proper notice? Yes
8. Did accident or occupational disease arise out of and in the course of the employment? Yes
9. Was claim for compensation filed within time required by Law? Yes
10. Was employer insured by above insurer? Yes
11. Describe work employee was doing and how accident occurred or occupational disease contracted:  
Employee was walking through casino boat construction on way to work on the casino boat and fell.
12. Did accident or occupational disease cause death? No Date of death? ----
13. Part(s) of body injured by accident or occupational disease: low back
14. Nature and extent of any permanent disability: 30% permanent partial disability referable to the low back
15. Compensation paid to-date for temporary disability: \$19,558.48
16. Value necessary medical aid paid to date by employer/insurer? \$200,548.19
  
17. Value necessary medical aid not furnished by employer/insurer? Past medical expenses, See Award
18. Employee's average weekly wages: \$380.00
19. Weekly compensation rate: \$253.34/\$253.34
20. Method wages computation: by agreement of the parties

COMPENSATION PAYABLE

21. Amount of compensation payable:

Unpaid medical expenses: . . . . . See Award

Future medical care : . . . . . See Award

---- weeks of temporary total disability (or temporary partial disability)

re: Body as a whole, 30% permanent partial disability from Employer, or . . . . . \$30,400.80

---- weeks of disfigurement from Employer

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

22. Second Injury Fund liability: Yes  No  Open . . . . . \$10,133.68

weeks of permanent partial disability from Second Injury Fund

Uninsured medical/death benefits

Permanent total disability benefits from Second Injury Fund:  
weekly differential ( ) payable by SIF for weeks beginning  
and, thereafter, for Claimant's lifetime

TOTAL: PAST MEDICAL EXPENSES;  
FUTURE MEDICAL CARE (SEE AWARD);  
AND \$40,534.40

23. Future requirements awarded: Yes, See Award

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

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

Dean L. Christianson, Attorney for Claimant

FINDINGS OF FACT and RULINGS OF LAW:

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

Dependents:

Employer: Station Casino St. Charles

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

Insurer: Continental Casualty Company (formerly known as CNA Claims Plus)  
Checked by: LEHB/bfb for df

This is a hearing for a Final Award in Injury Number 97-433205<sup>[1]</sup>. The claimant, Cheryl Jennings, appeared in person and by counsel, Attorney Dean L. Christianson; the employer/insurer appeared by and through counsel, Attorney Tim Tierney; the Second Injury Fund appeared by and through Assistant Attorney General Barb Toepke.

The parties entered into certain stipulations, and agreements as to the complex issues and evidence to be presented in this hearing.

**STIPULATIONS:**

On or about September 16, 1997: a. the claimant while in the employment of Station Casino St. Charles sustained an injury by accident arising out of and in the course of her employment occurring in St. Charles County, Missouri; b. the employer and employee were operating under and subject to the provisions of the Missouri Workers' Compensation Law; c. the employer's liability was insured by Continental Casualty Company, (at the prior hearing known as RSKCo and now known as CNA Claims Plus; d. the employee's average weekly wage was \$380.00, the being \$253.34 over \$253.34.

e. The employer had notice of the injury. f. Claims for Compensation were filed within the time prescribed by law.

g. Temporary total disability benefits have been paid to the employee in the total amount of \$19,558.48; those payments represent 77 1/4 weeks of benefits covering a period from April 22, 2002 through September 9, 2003. h. Medical aid has been provided in the total amount of \$200,548.19.

**ISSUES:**

1. Medical causation
2. Liability of past medical expenses
3. Future medical care
4. Nature and extent of permanent disability - whether partial or total
5. Liability of the Second Injury Fund

**EXHIBITS:**

The following exhibits were admitted into evidence:

**Claimant's Exhibits:**

Dean Christianson, Attorney for the Claimant: At the initial hardship hearing of this matter Exhibits A through K were offered and admitted into evidence; however, at that time the Second Injury Fund was not present and participating; at this point in time I am re-offering Exhibits A through K, subject to any objections that the Second Injury Fund might have.

Barbara Toepke, Attorney for the Second Injury Fund: I have no objection.

Tim Tierney, Attorney for the employer/Insurer: No objections other than those made at the prior hearing.

Claimant's Exhibits No. A, B, C, D, E, F, G, H, I, J, and K were re-admitted into evidence in this hearing, subject to any objections made at the first hearing.

No. L: Transcript of the testimony taken at the hearing of November 28, 2001

No. M: Records from Dr. Matthew Gornet. M.D.

No. N: Additional records from Dr. Matthew Gornet, M.D.

No. O: Records of Dr. Rasheed

No. P: Records from Barnes West Medical Consultants

- No. Q: Additional records from Barnes West Medical Consultants
- No. R: Medical records from Barnes West County Hospital
- No. S: Additional records from Barnes West County Hospital
- No. T: Medical records from St. Joseph's Hospital West
- No. U: Medical bills

(NOTE: Claimant's Attorney's comments (apparently re: No. K): There have been a substantial number of medical bills, and though some may have been paid, sometimes a few can slip through the cracks; my intention is not to get any sort of duplicate payment from the medical providers or payment to us for these medical bills, but just to be sure that any that might have fallen through the cracks are covered because my investigation showed that these offered bills seemed to be the ones that are still outstanding.

My intent is to get in the award whether or not these bills are the employer/insurer's responsibility, and if they are the employer/insurer's responsibility, an order saying that the employer/insurer is to resolve payment of these bills - either through payment through further negotiation, or whatnot; and that any bills they've already paid, they get a credit on that, but otherwise it's their duty to resolve it so that the medical provider does not come back later on and say to Cheryl Jennings that it is her responsibility for payment of these bills.

These bills do not encompass the bills offered as Claimant's Exhibit No. U at the first hearing in November 2001; these bills are since November 2001.)

- No. V: Deposition transcript of Dr. David Volarich (Admitted subject to the objections therein)
- No. W: Deposition transcript of Timothy Lalk (Admitted subject to the objections therein)
- No. X: Additional medical records of Dr. Rasheed
- No. Y: Copies of several letters between my office and the office of the Attorney for the Employer/Insurer in dealing with a request for medical treatment
- No. Z: Copy of a direct pay dispute form in this case from the Division file from Barnes West Hospital, and a release of that direct pay lien from Barnes West Hospital with the exhibit showing that those bills were paid

#### Employer/Insurer's Exhibits:

- No. 1: Re-offering of the first hearing deposition transcript of Dr. Wagner taken on behalf of the employer/insurer on October 26, 2001
- No. 2: Deposition transcript testimony of Dr. John R. Wagner, M.D. taken on behalf of the employer/insurer on May 13, 2004
- No. 3: Deposition transcript of Dr. Wayne Stillings taken on May 12, 2004

#### Second Injury Fund's Exhibits:

No exhibits offered

### **FINDINGS OF FACTS AND RULINGS OF LAW**<sup>[2]</sup>

#### **ISSUE: Medical causation**

In this second hearing, it is found that additional significant evidence has been presented and will be considered on the issue of medical causation; the prior Temporary Award is not res judicata on the issue of medical causation.<sup>[3]</sup>

In the Temporary Award issued after the first hearing in this case (hearing held on November 28, 2001), the Administrative Law Judge found that the claimant, Jennings, "has disc pathology medically caused by her work injury"; it had been agreed and stipulated to by the parties that the claimant suffered an injury arising out of and in the course of her employment with St. Charles Casino (Station Casino) on September 16, 1997. Noting that proof must be made by competent and substantial evidence, the Administrative Law Judge in the Temporary Award awarded future medical care to cure and relieve the claimant from the effects of the work related injury based on the October 4, 2001 deposition testimony of Dr. Matthew Gornet.

The claimant, in this second Hearing for final Award continues to contend, as she did in the first hearing for Temporary Award, that subsequent to the September 16, 1997 work related low back injury she continued with low back problems as a result of that work related injury, and that treatment suggested and provided by Dr. Gornet beginning in June of 2001 was reasonable and necessary to cure and relieve her from the effects of the work injury.

The claimant, it is found, admitted that she had a poor memory and was at times forgetful or confused during her hearing testimonies thus resulting in some inconsistencies, but Jennings' was found to be basically a credible witness. Curiously, the claimant testified at the first hearing that she treated with Dr. Levin off and on for four years after the September 16, 1997 work related accident (See Trans. pp. 20-21); at the second hearing the claimant agreed, during cross examination, that she actually had a period from sometime in 1998 up to the time she first saw Dr. Gornet in 2001 where she didn't receive any treatment or care; Dr. Volarich agreed during cross examination the history relayed to him by Jennings was that she had received no treatment from 5/1/98 through 3/23/2000. Considering the medical evidence in this case, it is found that it supports the claimant's testimony in the second

hearing of a period of approximately two years of no treatment for her low back; the medical evidence indicates that after treatment in September 1997 at Barnes Care West, Barnes-Jewish St. Peters Hospital and St. Joseph Health Center and treatment with Dr. Levin through March 19, 1998, Jennings was next treated by Dr. Prather beginning in March of 2000. There are bills of prescribed medication by Dr. Levin (See Claimant's Exhibit No. K), but, again, Dr. Levin's treatment records end at March 19, 1998, thus a determination of further treatment for low back complaints would be speculative. At the second hearing, Jennings testified that she began working for North Shore Yacht Club Bar and Grill, and worked there from April 24, 1998 through approximately September 4, 1998; Jennings agreed that she left this employment because she fractured her arm. The arm fracture happened at home, the claimant testified, I was carrying a laundry basket down the steps and the cat ran in front of me and I went down the last three steps. At the first hearing on November 28, 2001, Jennings was asked if she had had any accidents or falls or anything like that since September 16, 1997, and she answered – "No". (See Trans. Pg. 26) After the North Shore Yacht Club job, I went to work at Wal-Mart as a cashier, and at some point during my job at Wal-Mart I also started working for the St. Charles Princess, a dinner cruise ship, as a barmaid, Jennings agreed; she testified further in the first hearing that she began working for Wal-Mart in November 1999, and in July 2001 also began working at St. Charles Princess (See Trans. pp. 8 and 9). The claimant stated that when she was working at Wal-Mart and St. Charles Princess she was never disciplined for failure or inability to perform any of her job duties. Jennings admitted that her work at Wal-Mart and at St. Charles Princess caused her pain complaints to change; stating - somewhat, yes; it depended on how much I stood and worked. At the first hearing Jennings agreed that as a cashier at Wal-Mart, standing all day, lifting merchandise over the scanner (with assistance from customers with heavy items), and twisting made her back and leg worse; she agreed that as a bartender at St. Charles Princess standing and bending to get things out of the refrigerator made her back and leg worse. (See Trans. pp. 48 and 49) At some point in this time frame, when I was working for these places, I went to Dr. Heidi Prather for treatment, a doctor to the best of my knowledge I found on my own, Jennings testified. The claimant stated that it would be consistent with her recollection if Dr. Prather's notes indicated that her work at Wal-Mart would cause a progression of her pain throughout the day. Jennings agreed that at some point there was a progression of the pain to the point that she felt it was necessary to go see someone beyond Dr. Prather; the claimant explained that Dr. Prather had suggested that since the injections didn't help after thirty injections, the doctor could not give any more, and that she needed an orthopedic surgeon. That's when I found Dr. Gornet, the claimant said. On cross examination at the second hearing, Jennings was asked if she knew what caused her condition to become much worse in that year preceding the time she went to see Dr. Gornet, and she answered - it would be working and standing too long, doing activities, hobbies I liked doing. Jennings stated that it was consistent with her recollection that, as reflected in Dr. Gornet's file and the doctor's deposition testimony, the doctor had an intake sheet he had had her fill out and the sheet contained a history that her condition had gotten much worse in the last year.

The evidence reveals that the treatment provided by Dr. Gornet was further evaluation via a discogram. There is no dispute in the medical evidence, it is found, that as a result of the discogram that was performed by Dr. Gornet, the claimant developed infection in the disc space (discitis) and osteomyelitis, and had a lumbar fusion procedure: a. See the records of Dr. Matthew Gornet, M.D. (Claimant's Exhibit No. M) which reflected treatment of Jennings from 8/5/02 through 9/11/03, and included in an 8/8/02 follow up entry that a procedure had been performed on 6/3/02 of an open biopsy and discectomy L4-5 for the diagnosis of – disc space infection, status post discography. Dr. Gornet's record reflected that new erosions were subsequently noted and Jennings was admitted to Barnes-Jewish Hospital on 09/04/02, and Dr. Gornet performed the procedure of: Posterior fixation L4 to S1 with Sexton instrumentation. The pre- and post-operative diagnosis were: Discitis L4-5 and L5-S1 with bony erosions. b. Dr. Volarich, in his 3/11/04 deposition, testified –

“As part of her diagnostic workup, she underwent a diskogram and post-diskogram developed discitis, which is a disc space infection, at the L4-5 level that progressed to osteomyelitis at L4 and L5. As a result of this complication, she required two separate surgical repairs culminating in anterior and posterior fusions at L4-5 and L5-S1.” (Volarich 3/11/04 Dp. pg. 15)

Dr. Volarich further stated that the bacterial infection he had discussed, the discitis, came from the performance of the diskogram; the doctor agreed that by the time the infection was discovered the vertebrae had eroded, and this bone destruction was one of the sources of the instability in Jennings' spine that ultimately led to the fusion. Dr. Volarich agreed that therefore: no diskogram, no discitis and no erosion of the bone, no fusion, and no increase in disability. c. Dr. Wagner, at his 5/13/04 deposition, testified:

“She then had further workup with a discogram which was complicated by an infection. She had obviously infection at two levels. One level was biopsied or drained. This was done on 6-4-02. Three months later, she had a second operation to fuse these levels and she is in the process of healing.” (Wagner 5/13/04 Dp. pp. 10-14)

Dr. Wagner was asked about his opinion, based on his evaluation, as to the cause of the infections he had seen. “In my opinion, the cause was the discogram”, the doctor answered. (Wagner 5/13/04 Dp. pg. 15) Dr. Wagner further stated that Jennings “had a terrible complication from that discogram.” (Wagner 5/13/04 Dp. pp. 15-16)

Considering the medical evidence and opinions presented in this second hearing, it is found that the initial considerations is what physical injury, if any, to the claimant's low back was caused by the September 16, 1997 work related accident and whether or not the claimant's low back condition at the time of the discogram which was performed in early 2002 and subsequent problems from that discogram are causally related to the September 16, 1997 work related injury herein.

In its Memorandum of Law, the Employer/Insurer notes in its argument on the issue of medical causation the following:

“For an injury to be compensable, claimant must establish a causal connection between the accident and the injury. *Silman v. William Montgomery & Associates*, 891 S.W.2d 173, 175 (Mo.App.E.D.1995); *Griggs v. AB Chance Co.*, 503 S.W.2d 697, 704 (Mo.App.W.D.1973). It is claimant’s burden of proving, to a reasonable probability, that her injuries resulted from the accident to which she attributes them. *Davies v. Carter Carburetor*, 429 S.W.2d 738, 749 (Mo.1968). Claimant must produce evidence from which it reasonable may be found that her injury resulted from a cause for which the employer would be liable. *Griggs*, 503 S.W.2d at 704; *Dolen v. Bandera’s Café & Bar*, 800 S.W.2d 163, 164 (Mo.App.E.D.1990).

The testimony of claimant or other lay witness can constitute substantial evidence of the cause of an injury or disability when the facts fall within the realm of lay understanding. *Silman*, 891 S.W.2d at 175; *Knipp v. Nordyne*, 969 S.W.2d 236, 240 (Mo.App.W.D.1998). An injury may be of such a nature, however, that expert opinion is essential to show that it was caused by the accident to which it is ascribed. *Griggs*, 503 S.W.2d at 704; *Silman*, 891 S.W.2d at 175. Medical causation, which is not within the common knowledge or experience of lay understanding, must be established by medical evidence showing the cause and effect relationship between the complained of condition and the asserted cause. *Landers v. Chrysler*, 963 S.W.2d 275, 279 (Mo.App.E.D.1998). Where the condition presented is a sophisticated injury that requires surgical intervention or other highly scientific techniques for its diagnosis, and particularly where there is serious question of pre-existing disability and its extent, proof of causation is not within the realm of lay understanding. *Silman*, 891 S.W.2d at 175-176; *Griggs*, 503 S.W.2d at 704-705; *Knipp*, 969 S.W.2d at 240.

An annular disc tear, bulging disc, herniated disc, or discitis are clearly sophisticated injuries. Given this fact, the causal connection between claimant’s September 16, 1997 accident and her current condition must be proven by competent medical testimony. *Silman*, 891 S.W.2d at 173.”

It should be further noted:

“A medical expert’s opinion must have in support of it reasons and facts supported by competent evidence which will give the opinion sufficient probative force to be substantial evidence.” (citations omitted) *Pippin v. St. Joe Minerals Corp.*, 799 S.W.2d 898, 904 (Mo.App. 1990).

It is found, considering the voluminous medical records, testing (i.e. MRIs and CT scans) and opinions in this case, that the nature of the claimant’s injury as a result of the September 16, 1997 work related accident is indeed a sophisticated matter requiring competent medical opinion to establish the answer.

Considering the medical opinions in evidence:

A. It is found that Dr. Gornet was the only physician suggesting in June of 2001 further evaluation of the claimant in regards to her September 16, 1997 work related accident; Dr. Gornet testified that as of June 28, 2001 his working diagnosis was discogenic low back pain consistent with the diagnosis of an annular tear and further evaluation was needed in the form of a CT discogram to make a determination of treatment. Dr. Gornet testified that Jennings “does probably have a slight disc herniation.” (Gornet Dp. pp. 44-45) At his deposition in October 2001, Dr. Gornet agreed that Jennings was employed at Wal-Mart at the time of his June 2001 evaluation of her; the doctor admitted that he did not know Jennings’ position at Wal-Mart, and did not know if this position required her to lift, bend or stoop on a repetitive basis. Dr. Gornet admitted that since he had no knowledge as to how long Jennings had worked at Wal-Mart or her duties, he would not be able to rule out Jennings’ work at Wal-Mart exacerbating her pain. Dr. Gornet admitted that at her visit in June 2001 Jennings had indicated in his office Health Questionnaire form that her health condition had gotten worse in the last year; the doctor admitted that he made no inquiry to Jennings as to what had happened in that past year to make her much worse. Indicating that it was his belief the need for the CT discogram procedure goes back to the September 1997 incident irregardless of Jennings’ subsequent activities which might increase her symptomatology, Dr. Gornet testified – “If she didn’t have that annular tear and she was working at Wal-Mart and doing repetitive bending, then my belief would be that she wouldn’t have significant symptoms.” (Gornet Dp. pg. 37) Notwithstanding, Dr. Gornet agreed that it was his opinion, if Jennings was working as a secretary sitting she might not have symptoms even presuming she had an annular tear, and further testified: “She may not have symptoms that are significant enough for her to seek further medical treatment, that’s correct.” (Gornet Dp. pg. 37) Dr. Gornet agreed, that in that regard, Wal-Mart does play a role.

B. Dr. Volarich, who evaluated Jennings on her behalf on May 15, 1998, testified by deposition on July 16, 1998 that his diagnosis referable to injuries sustained by Jennings’ in the 9/16/97 accident was - small disc herniations, L4-5 and L5-S1 to the left with left leg radiculopathy; and chronic back pain syndrome. The doctor admitted, on cross examination, that he relied upon Dr. Wayne’s 2/12/98 and 4/98 records in regards to CT scans and he did not have the opportunity to review the actual radiology report or CT scan; Dr. Volarich agreed that he had relied upon the report of Dr. Wayne with regard to his diagnosis of herniated disc at L4-5 and L5-S1. Dr. Volarich further opined after the May 15, 1998 evaluation:

“Based on the treatment she had up to that point, I thought she had reached maximum medical improvement, but I did make some additional treatment considerations. In order to maintain her current state, she will require ongoing intermittent treatment for her back pain syndrome with anti-inflammatory medications, muscle relaxants, pain pills,

physical therapy, osteopathic manipulation, and other similar treatments for symptomatic relief. I did not feel surgery was indicated.” (Volarich Dp. pg. 16)

Dr. Volarich assessed a percentage of permanent partial disability as a result of the 9/16/97 accident and injuries after his May 15, 1998 evaluation of the claimant. It was noted that only after Dr. Volarich was subsequently contacted by the claimant and asked to provide an opinion on whether or not Jennings needed the additional medial treatment recommended by Dr. Wayne did he agree with the suggestion of a trial epidural steroid injections to see if that would help Jennings’ pain syndrome, and if that failed, then diagnostic testing in the form of a myelogram, postmyelogram CT. After two additional evaluations of Jennings on September 7, 1998 and November 26, 2003, Dr. Volarich testified at a second deposition on March 11, 2004 that in his 1999 evaluation report he had felt the treatment should be about the same as he had stated previously in 1998. Dr. Volarich further stated: “As far as additional diagnostic studies, I just mentioned treatment for pain, manipulation type things, physical therapy, but I didn’t recommend any additional scanning procedures, for example”. (Volarich 3/11/04 Dp. pg. 26) Dr. Volarich stated that after either of his last two exams he had not recommended Jennings to undergo a diskogram. Dr. Volarich was queried, in your review of records of Drs Sedgwick, Wayne, Guy and Levin did any of these doctors recommend that Jennings undergo a diskogram, and Dr. Volarich responded – “No. Nobody said that.” (Volarich 3/11/04 Dp. pg. 27) Dr. Volarich agreed that at the time of his 5/15/98 and 9/7/99 exams he had felt both times that as a result of the September 16, 1997 accident, Jennings had sustained disability to the low back of thirty percent of the body as a whole. At his second deposition in 2004, the doctor was asked to explain his deposition testimony in July 1998 – that Jennings was as good as she was going to get based upon the treatment she had received to date, and Dr. Volarich testified:

“I mean based on everything that had been done up to the point that I saw her the second time in 1999, which was the MRI scans, the pain management that she had had with Dr. Guy, everything conservative that had been done to that point which was basically conservative treatment for her discogenic pain, you know, she was as good as she was going to get. There’s nothing more to really do. I wouldn’t have made a recommendation that she get a pain stimulator, for example, because there was not that kind of a problem with her back or her legs at that time. I wouldn’t recommend that she be on narcotic medications at that time because she didn’t have the severity of the pain.

So again, from what had been done from day one of the accident up to the time that I saw her in ’99, it was all appropriate treatment. It was all reasonable treatment. It was all attempts to improve her symptoms. And she had more or less plateaued.” (Volarich 3/11/04 Dp. pp. 41-42)

Agreeing that it was his opinion after his 5/15/98 and 9/7/99 examinations of Jennings that the September 1997 incident at work didn’t cause a need for a diskogram, Dr. Volarich further stated - “Again, I didn’t see her at that the time. Dr. Gornet did again to see what change in her symptoms had occurred. You know, that’s one of the next steps in the diagnostic process. When a patient still has back pain radiating into the leg with an MRI, for example, that doesn’t show an obvious frank herniation, the diskogram is a very specific test for that level.” (Volarich 3/11/04 Dp. pg. 35) Notwithstanding this averment about the discogram, Dr. Volarich admitted that there was nothing in Dr Gornet’s record that would have changed his opinion as to permanent disability for Jennings. Dr. Volarich admitted that he did not have a copy of the self-reporting health questionnaire that Jennings filled out at the time she was first seen by Dr. Gornet in June 2001; Dr. Volarich agreed, though, that according to Dr. Gornet’s records the history was that Jennings worsened between the time he had seen her in 1999 and the time she went to Dr. Gornet. Dr. Volarich was queried - so, it was not the fall on September 16, 1997 in and of itself that caused the infection or the instability, and the doctor answered: “No. That’s correct....The fall, the problems with the disc protrusions as I’ve described, 4-5 and 5-1, and the symptoms associated, everything else now is the complications of the diagnostic study.” (Volarich 3/11/04 Dp. pg. 35)

Dr. Volarich was asked his opinion as to whether the work Jennings had performed at St. Charles Princess for a year in about 2001 or at Wal-Mart from about 1999 to 2003 had caused or aggravated her back condition, and Dr. Volarich answered: “I don’t think it did. It’s my opinion that it did not cause any new problems.” (Volarich 3/11/04 Dp. pg. 39) Notwithstanding this testimony, Dr. Volarich agreed during cross examination that repetitive activities cause deterioration in one’s back. Dr. Volarich stated that he specifically asked Jennings if her work activities at St. Charles Princess and Wal-Mart affected her low back condition, if she had any new injuries or any new problems and she didn’t report anything new. “She said that everything was just slowly getting worse as time went by..” (Volarich 3/11/04 Dp. pg. 36) Dr. Volarich had testified that he had put restrictions on Jennings the first time he saw her in 1998 “(T)o attempt to prevent further injury”. (Volarich 3/11/04 Dp. pg. 36) The doctor said that he did not know if Jennings had operated outside of his recommended restrictions at either St. Charles Princess or Wal-Mart as he did not ask her that question directly. “I think she probably worked within the weight limit, but she may have been upright more than thirty minutes at a time”, the doctor said. (Volarich 3/11/04 Dp. pg. 37) The doctor said that he did not know if Jennings had engaged in repetitive bending, twisting, lifting, pushing, pulling carrying, etc. at either St. Charles Princess or Wal-Mart. Dr. Volarich agreed, during cross examination, that repetitive activities over time can produce disability. Dr. Volarich stated that in 1999 Jennings was beginning to have problems in her right leg as well as her left, and further testified - “Well, again I think it shows that there’s still ongoing difficulties from the original accident. Some progression of symptoms, more pressure on the L4-5 nerve root, and more centrally now rather than just being localized to the left side.” Dr. Volarich stated that what caused the problem in the right leg to develop was “(J)ust life’s activities I think could make it progress to some degree. I think it’s just some ongoing progression of the original process, the original injury with two different disc levels being involved. (Volarich 3/11/04 Dp. pg. 40)

C. Dr. John R. Wagner, M.D. evaluated Jennings on behalf of the employer/insurer on March 19, 2001 and testified on October 26, 2001 that based on his March 2001 evaluation, Jennings was “capable of working”, and “there was no restriction in her

activity”. (Wagner 10/26/01 Dp. pg. 15) The doctor further opined that he felt no further treatment was indicated for Jennings, that she was “at maximum medical improvement”. (Wagner 10/26/01 Dp. pg. 16) Dr. Wagner further opined that based on his March 19, 2001 evaluation, that as a result of the September 16, 1997 work related incident “there is no evidence of any disability in the lumbar spine. She has zero percent disability secondary to the injury of 9-16-97”. (Wagner 10/26/01 Dp. pg. 17) Dr. Wagner testified by deposition again on May 13, 2004 after evaluating Jennings again March 17, 2003; the doctor stated that he had reviewed his previous deposition testimony and his opinions had not changed. Dr. Wagner noted that since he had seen Jennings on 3-19-01, she had been treated by Dr. Gornet and had had a discogram of the lumbar spine performed. Dr. Wagner further noted:

“At five weeks after the discogram, the diagnosis of an infection was made. The patient then underwent open biopsy of the disc and this confirmed the diagnosis. She was seen by Dr. L’Ecuyer....., the infectious disease specialist who treated her with IV antibiotics for a bout six weeks. Then in September of 2002 she had an anterior lumbar fusion and a posterior lumbar fusion with pedicle screws and cages anteriorly. The pedicle screws, of course, were put in posteriorly and the cages were put in anteriorly. The fusion was at L4-5 and L5-S1. She stated afterwards she was treated with antibiotics with a PIC line....which collapsed her left lung. She was then treated with a chest tube for about four days and then that cleared up.” (Wagner 5/13/04 Dp. pg. 6)

The doctor was asked, based on his evaluation, what was his opinion as to the cause of the infections he had seen. “In my opinion, the cause was the discogram”, Dr. Wagner answered. (Wagner 5/13/04 Dp. pg. 15) The doctor was asked his opinion as whether or not the discogram that was performed was indicated or required as a result of the work related injury of 1997. Dr. Wagner answered:

“In my opinion, the discogram was not indicated. She had a normal examination. She had a normal MRI. She had subjective complaints. And one must not do things that harm patients. And this discogram obviously harmed this lady. And you have to have a good reason to do any test, either a discogram or a blood test or so on, there’s got to be a good reason. Because I don’t care what you do, there’s always bad side effects. And this is a classic example of a discogram or a test that was, in my opinion, not indicated and the patient got in terrible trouble because of it. So in my opinion the discogram was not indicated and she had a terrible complication from that discogram. She had an excellent physical examination and she had no sign on her MRI, which is an excellent test for this kind of problem, three years after her injury. So if she had a significant injury in 1997, she certainly would have had a change on her MRI in three years.” (Wagner 5/13/04 Dp. pp. 15-16)

**It is found**, considering the medical opinions, that Dr. Gornet’s opinion in June of 2001 on the cause of the claimant’s back problems is found not to be controlling in that the doctor admitted he had less than an entire history of Jennings’ activities during the four years subsequent to the September 1997 work related injury and when he saw Jennings for the first time in June 2001. The evidence reveals that in that four year interim: a. the claimant admitted to exacerbations of her low back and leg complaints and to a worsening of this condition, which is corroborated by medical evidence; b. the claimant admitted to a fall down stairs of sufficient force to fracture her arm in approximately September 1998 (no medical records of treatment for this arm fracture were offered for further exploration of the injuries sustained in this fall); the claimant admitted to performing work duties beyond the restrictions placed on her by Dr. Volarich in May of 1998 which the doctor testified he had put these restrictions on Jennings to attempt to prevent further injury. Additionally, Dr. Gornet admits that Jennings indicated to him a worsening of her back complaints during 2000 and he made no inquiry into that history. It is found that with less than a complete history of the claimant, Dr. Gornet’s opinion on the cause of the claimant’s low back symptoms four years after the September 1997 work related injury would be speculative and not probative on the question of whether or not the September 1997 work related injury was a substantial cause for the symptoms seen in June 2001. It is found that Dr. Volarich’s opinion on causation is given some weight in that his opinion is based on a more complete history; it should be noted, however, that with Dr. Volarich’s admission that in making the diagnosis of small disc herniations, L4-5 and L5-S1 to the left he did not review CT scan films or reports and he relied upon examination reports of a Dr. Wayne (whose records are not in evidence in this case), Dr. Volarich’s opinion of a diagnosis for the work related injury is found to be attenuated. It is found that Dr. Wagner’s opinion on a diagnosis for the September 16, 1997 work related injury is most probative in that it is found to be supported by the treatment records: a. the 9/23/97 Barnes Jewish St. Peter’s emergency room record indicated that Jennings was treated on that date for complaints of pain in the left lower back and left buttock as a result of falling six days earlier at work, and the diagnosis was – lumbar strain/sprain; b. the 9/21/97 St. Joseph Health Center record reflected that Jennings was seen on that date for complaints of severe back pain, and after examination and an x-ray of the lumbar spine performed on that date which was reported as - negative lumbar spine, there is no change from 05/94 - the diagnosis was lumbosacral strain with muscle spasm. Dr. Wagner indicated his diagnosis by his testimony: that based on his March 19, 2001 evaluation, that as a result of the September 16, 1997 work related incident “there is no evidence of any disability in the lumbar spine”.

Additionally, in light of the evidence, there is medical opinion on the causal relationship of a psychiatric condition for the claimant and the September 16, 1997 work related accident: a. the 9/23/97 Barnes Jewish St. Peter’s emergency room record also noted complaints of stress from Jennings and that Jennings reported having been in an abusive relationship, and a diagnosis of anxiety secondary to stress was also made on that date; b. a 9/23/97 St. John’s Mercy Medical Center record reflected that Jennings had been sent from Barnes St. Peter’s with a suspicion of a psychiatric problem, though Jennings had reported upon arrival at St. John’s she had suffered a fall 2 weeks ago and had complaints of left hip and left upper quadrant pain, the discharge record of

9/25/97 noted a principal diagnosis of pyelonephritis and secondary diagnoses that included anxiety state, and orthopedic aftercare; c. a 9/26/97 record from Barnes Care West reflected treatment of Jennings for complaints of pain traveling all over her body, from her hips, to both legs, to her feet, to her hands, to her shoulders as a result of falling on concrete in the parking lot on 9-9-97 and that Jennings admitted to being in an abusive relationship and presently had a black eye, the Description of Treatment section included - "The patient needs evaluation for psychiatric problems", and the diagnosis was - "Psychiatric problems. This is not a work related condition.". The evidence, including the claimant's testimony, further reveals that the claimant has been diagnosed with and suffering for years with anxiety and depression prior to the September, 1997 work related accident. Dr. Stillings offered the only medical expert opinion of the question of causation in regards to a psychiatric condition. Testifying to his diagnoses after evaluation of Jennings on January 25, 1999, Dr. Stillings stated: "Number one, other conditions that may be a focus of clinical attention, that being histrionic personality traits. Number two, relational problems, not otherwise specified with a history of emotional and physical abuse. Number three rule out substance dependence." (Stillings Dp. pg. 25) Dr. Stillings testified as to his opinion on causation in relation to Jennings' diagnoses and the September 16, 1997 work related accident: "Ms. Jennings has no psychiatric illness causally related to nor aggravated by the 9/16/97 work accident." (Stillings Dp. pg. 28). Dr. Stillings was queried on cross examination by the claimant - when he said the claimant had histrionic complaints was he saying this was an intentional faking or malingering situation. The doctor answered:

"No, absolutely not. It just means this is her personality style. If she has an injury, her reaction and emotion to that injury is going to enhance the injury. It's going to be a greater injury than if she didn't have this personality. It's a subconscious process. It's not something that she's aware of." (Stillings Dp. pg. 35)

Dr. Stillings testified he was he was aware that the claimant had had back fusion surgery subsequent to his evaluation of her on January 25, 1999, and acknowledged that the medical records reflected that she had pain problems since the September 16, 1997 injury due to her back. When queried wouldn't chronic pain affect your work and cause one who had the propensity to be depressed to be even more so, Dr. Stillings responded - "Possibly." (Stillings Dp. pg. 48) The doctor was asked if it was still his opinion that the claimant suffered zero psychiatric disability as a result of the September 16, 1997 work related injury. "Well, without a chance to reevaluate her, I really don't have an opinion on that", the doctor answered. (Stillings Dp. pg. 48) Dr. Stillings agreed that it had been five years since he had seen the claimant. It is found that Dr. Stillings' opinion that Jennings had no psychiatric illness causally related to or aggravated by the September 16, 1997 work accident is probative and controlling; it is found that as it has been determined that the substantial weight of the pertinent medical opinions have established no causal connection between the claimant's low back condition in late 2001 and the discogram and subsequent complications of infection and fusion surgery, any opinion of Dr. Stillings' concerning the effect on Jennings' psychiatric illness as a result of these factors is not relevant.

It is found that the substantial weight of the competent medical evidence and opinions establish that as a result of the September 16, 1997 work related accident the claimant sustained the injury of lumbosacral strain and chronic back pain syndrome.

#### **ISSUE: Liability of past medical expenses; Future medical care**

It has been determined in this Award that the opinion of Dr. Wagner is controlling and Dr. Volarich's opinions are given some weight also; it was found that, for stated reasons above, Dr. Gornet's opinions have little probative force; it has been determined that the substantial weight of the competent medical evidence and opinions establish that as a result of the September 16, 1997 work related accident the claimant sustained the injury of a lumbosacral strain and chronic back pain syndrome, and the substantial weight of the competent medical evidence and opinions do not establish a causal connection between the September 16, 1997 work related accident and the claimant's low back condition that led to a discogram, infection and fusion surgery.

In its Memorandum of Law, the employer/insurer noted the following: For past medical expenses to be awarded, such medical care and treatment must flow from a work related accident. *See, Gill v. Massman Construction*, 495 S.W.2d 878, 881 (Mo.App. W.D. 1970); *Modlin v. Sunmark*, 699 S.W.2d 5, 7 (Mo.App. E.D. 1985). An employee who has not sustained a compensable injury is not entitled to medical treatment for a possible disability resulting from some other cause. *Beyer v. Howard Construction*, 736 S.W.2d 78, 82 (Mo.App. S.D. 1987). The medical fees for which reimbursement is sought must be reasonable and necessary to treat a work related injury. *Jones v. Jefferson City School District*, 801 S.W.2d 486, 490 (Mo.App. W.D. 1990).

It was Dr. Volarich's opinion as of his May 15, 1998 evaluation of Jennings on her behalf that she was at maximum medical improvement for injuries sustained in the September 16, 1997 work related accident; the doctor further stated that after a 1999 examination of Jennings his opinion remained that Jennings had plateaued from her work related injury. Dr. Volarich stated that after his May 15, 1998 evaluation he had recommended ongoing intermittent treatment for back pain of anti-inflammatory medications, muscle relaxants, pain pills, physical therapy, osteopathic manipulations and other similar treatments, and testified that treatment up to when he saw Jennings on September 7, 1999 "was all appropriate treatment. It was all reasonable treatment" (Volarich 3/11/04 Dp. pg. 41) The doctor stated he never recommended that Jennings undergo a discogram, and that from his review of the records of Drs. Sedgwick, Wayne, Guy and Levin, none of these doctors recommended this procedure. Dr. Volarich indicated his opinion that it was not the fall on September 16, 1997 that caused in Jennings' lumbar spine the infection, the instability and the ultimate fusion but rather these were the complications of the diagnostic discogram study. The doctor was queried - so, it was not the fall on September 16, 1997 in and of itself that caused the infection or the instability, and Dr. Volarich answered: "No. That's correct....The fall, the problems with the disc protrusions as I've described, 4-5 and 5-1, and the symptoms associated, everything

else now is the complications of the diagnostic study.” (Volarich 3/11/04 Dp. pg. 35) Dr. Wagner, who noted that he was not authorized to treat the claimant, testified that following his examination of Jennings on March 19, 2001 and his review of medical records and diagnostic studies he had the following opinion: “No treatment is indicated. She is at maximum medical improvement”. (Wagner 10/26/01 Dp. pg. 16) Dr. Wagner stated that the cause of the infection in Jennings’ lumbar spine and the September 2002 fusion surgery was the discogram. Dr. Wagner gave further testimony on his opinion as to whether or not the discogram that was performed was indicated or required as a result of the September 16, 1997 work related injury:

“In my opinion, the discogram was not indicated. She had a normal examination. She had a normal MRI. She had subjective complaints. And one must not do things that harm patients. And this discogram obviously harmed this lady. And you have to have a good reason to do any test, either a discogram or a blood test or so on, there’s got to be a good reason. Because I don’t care what you do, there’s always bad side effects. And this is a classic example of a discogram or a test that was, in my opinion, not indicated and the patient got in terrible trouble because of it. So in my opinion the discogram was not indicated and she had a terrible complication from that discogram. She had an excellent physical examination and she had no sign on her MRI, which is an excellent test for this kind of problem, three years after her injury. So if she had a significant injury in 1997, she certainly would have had a change on her MRI in three years.” (Wagner 5/13/04 Dp. pp. 15-16)

At the second hearing, the claimant offered into evidence bills for prescriptions and treatment (See Claimant’s Exhibit Nos. K and U). Jennings testified about the bills in Exhibit No. U, stating that they were related to prescription medication and treatment beginning in May of 2002 through June of 2004 for testing and treatment ordered by Dr. Gornet in relation to the discogram study and subsequent complications; the claimant noted that the exhibit included a bill for a mattress as Dr. Gornet wanted her to get a better mattress for support. Jennings further noted that Exhibit No. U included bills from Dr. Rasheed, her personal physician, from November 2003 through June 2004, and included a bill for a brain scan ordered by Dr. Rasheed.

Considering the evidence in light of the findings in this Award, it is further found that the substantial weight of the competent medical evidence establishes that the claimant was at maximum medical improvement for the September 16, 1997 work related accident as so stated by Dr. Volarich upon his May 15, 1998 evaluation; it is found that as the substantial weight of the competent medical evidence does not establish a causal link between the September 16, 1997 work related accident/injury and the discogram performed after June of 2001 and the subsequent complications, medical bills flowing from the treatment of the discogram and complications are not compensable. Thus, it is found that the medical bills encompassing Claimant’s Exhibit No. U are not compensable for these reasons.

It should further be noted, however, that at the time of his opinion in May 15, 1998 that the claimant was at maximum medical improvement for the September 16, 1997 work related injury, Dr. Volarich made a recommendation for future treatment as a result of the work injury; the doctor testified at his July 16, 1998 deposition:

“Based on the treatment she had up to that point, I thought she had reached maximum medical improvement, but I did make some additional treatment considerations. In order to maintain her current state, she will require ongoing intermittent treatment for her back pain syndrome with anti-inflammatory medications, muscle relaxants, pain pills, physical therapy, osteopathic manipulation, and other similar treatments for symptomatic relief. I did not feel surgery was indicated.” (Volarich Dp. pg. 16)

In her Memorandum of Law, the claimant wrote that Dr. Volarich made further future treatment recommendations. At his March 11, 2004 deposition, Dr. Volarich was asked to testify as to his opinion of whether Jennings would benefit from any future medical treatment attributable to the 9/16/97 accident:

“In general, I recommended that she’d require some ongoing care for her pain syndrome using modalities including, but not limited to, the narcotic and non-narcotic medications such as the non-steroidal anti-inflammatory drugs, muscle relaxants, physical therapy, and similar treatments as directed by current standard of medical practice for the symptomatic relief of her condition.

I also recommended that she be seen and evaluated at a pain clinic to help better control her pain syndrome. Epidural steroid injections, trigger point injections, foraminal blocks, nerve root blocks, TENS units, and possibly even a spinal cord stimulator would benefit her condition.” (Volarich 3/11/04 Dp. pg. 22)

Dr. Volarich was asked his opinion of whether or not Jennings was a candidate for surgery when he last saw her on November 26, 2003:

“When I saw her, I didn’t think that additional surgery was needed on that day. But I did make some notes that because of all the hardware that was placed in her low back, she could have a problem with that hardware, become reinfected as I talked about a little earlier, loosen or fail, and those pieces of hardware would need to be removed or replaced. The decision to perform any additional surgery on her back should be made in conjunction with her wishes, change in symptoms, and expert surgical opinion.” (Volarich 3/11/04 Dp. pp. 22-23)

It was Dr. Volarich's opinion, though, that the September 16, 1997 work related incident did not cause a need for the discogram, and the doctor further opined – therefore, no discogram, no discitis and no erosion of the bone, and no fusion. Dr. Volarich was queried - so, it was not the fall on September 16, 1997 in and of itself that caused the infection or the instability. Dr. Volarich answered: "No. That's correct. I think we've established that already. The fall, the problems with the disc protrusions as I've described, 4-5 and 5-1, and the symptoms associated, everything else now is the complications of the diagnostic study." (Volarich 3/11/04 Dp. pg. 35) The claimant wrote in her Memorandum of Law: "Dr. Wagner, testifying on behalf of the Employer and Insurer, stated that he did not have an opinion as to whether or not Claimant needed pain management. He simply said that if someone deemed that she should go to a pain management doctor, the cause of the need for that treatment would be the infection and surgeries following the discogram." Considering Dr. Wagner's May 13, 2004 deposition, the doctor was then asked what would be the cause of the need for pain management if Jennings needed it, and Dr. Wagner answered: "It would be the infection after her discogram and then subsequent surgeries. And she certainly didn't need it before her discogram." (Wagner 5/13/04 Dp. pg. 17) Again, Dr. Wagner's opinion was that the discogram that was performed was not indicated or required as a result of the September 16, 1997 work related injury. Dr. Wagner also testified that based on his March 2001 evaluation he felt no further treatment was indicated for Jennings, that she was "at maximum medical improvement". (Wagner 10/26/01 Dp. pg. 16)

As the Employer/Insurer notes in its Memorandum of Law, the claimant must show by a reasonable probability that she is in need of additional medical treatment by reason of her work related injury or accident. *See, Sifferman v. Sears Roebuck & Co.*, 906 S.W.2d 823, 828 (Mo.App. S.D. 1995).

Considering the evidence, including the medical records and competent medical opinions, **it is further found** that the substantial weight of it establishes a need for future medical care for the claimant's chronic back pain syndrome as a result of the work accident and injury of September 16, 1997. As repeatedly stated by Dr. Volarich and bears repeating here, this future medical treatment attributable to the 9/16/97 accident is to consist of:

"In general, I recommended that she'd require some ongoing care for her pain syndrome using modalities including, but not limited to, the narcotic and non-narcotic medications such as the non-steroidal anti-inflammatory drugs, muscle relaxants, physical therapy, and similar treatments as directed by current standard of medical practice for the symptomatic relief of her condition.

I also recommended that she be seen and evaluated at a pain clinic to help better control her pain syndrome. Epidural steroid injections, trigger point injections, foraminal blocks, nerve root blocks, TENS units, and possibly even a spinal cord stimulator would benefit her condition." (Volarich 3/11/04 Dp. pg. 22)

The employer/insurer are found to be liable to provide this future medical care. Section 287.140 RSMo.

It is found that the substantial weight of the competent medical opinions do not causally link any continuing problems or treatment needs as a result of the discogram, infection and fusion surgery to the September 16, 1997 work related accident, and consequently any treatment recommended but flowing from these factors is denied.

With the determination immediately above, consideration must be given of the bills encompassing Claimant's Exhibit No. K. It was agreed and stipulated to by the claimant and the employer/insurer at the beginning of the second hearing that medical aid has been provided by the employer/insurer in the total amount of \$200,548.19; the claimant additionally conceded that more than likely these bills have been paid and she is not seeking a double payment and the employer/insurer would be entitled a credit for any payments, the claimant is seeking a determination on the compensability of these bills. The claimant stated the following in her Memorandum of Law the following:

"In her Temporary Award Judge Karl found that Claimant's back problems were medically caused by her work injury. Judge Karl found the Employer and insurer had abandoned the right to control Claimant's medical care, *Wiedower v. ACF Industries, Inc.*, 657 S.W.2d 71, 74 (Mo.App. 1987), and were liable for payment of \$5,851.00 in medical bills submitted at trial. Employer and Insurer have since paid those bills, and no additional evidence has been offered which would tend to prove that they had no liability for them. As such, Judge Karl's decision on past medical bills should be affirmed."

The claimant is correct that in its Memorandum of Law, the Employer/Insurer made no argument concerning the bills encompassing Claimant's Exhibit No. K; their argument on the issue of reimbursement of past medical expenses referred to and concerned only the bills marked as Claimant's Exhibit No U. However, at the beginning of the second hearing, the claimant offered into evidence the bills encompassing Claimant's Exhibit No. K, and specifically requested in the Final Award a determination on the compensability of these bills.

In the first/Temporary Award, the Administrative Law Judge determined that the employer/insurer waived their right to control the claimant's medical care subsequent to September 23, 1997 and claimant was free to seek care from a physician of her choice as she did by treating with Drs. Levin, Prather and Gornet; the Administrative Law Judge noted the following as the actions that led to the employer/insurer's waiver:

“Immediately after the September 16, 1997 accident occurred, Employer took no actions to provide Claimant with medical care. Claimant had reported to her supervisor that she had fallen and that she was having difficulty in performing her job. Yet she was not offered any medical assistance. She was in fact left without help until Employer finally sent her to BarnesCare on September 23, 1997. And even then, the doctor at BarnesCare refused to provide her with medical treatment, determining that her problems were not ‘work related’.”

At the first hearing, the claimant testified that after she fell due to construction work for the boat while on her way into work on the boat, she worked that day up until an hour before the end of her shift and she went home; there is no indication in her testimony that she advised her employer that day of her fall. (See Trans. pp. 11-13) The claimant testified that the next day she went to her family physician, Dr. Levin. She next sought treatment four days later at St. Joseph’s hospital emergency room, and had not been working in the interim; there is no indication in the claimant’s testimony that she notified her employer of a work related injury. (See Trans. pp. 13-14) The claimant testified that she next went to the emergency room of Barnes St. Peters Hospital one to two days later. When queried if the employer/insurer sent her to BarnesCare after Barnes St. Peters emergency room, the claimant answered “No”, explaining: “That was after I was going back to work, and I did not know anything about workmen’s comp, that I was supposed to fill out anything. They – I had to fill out workmen’s comp, they had me to go to BarnesCare that day.” (Trans. pg. 15) The claimant testified that she returned to Dr. Levin for treatment for her back, and that the employer’s workers’ compensation insurance company paid for this treatment; the claimant stated that she continued to treat with Dr. Levin off and on for the next four years. (See Trans. pg. 20) The claimant testified that at some point she began treating with Dr. Prather; when asked how she got Dr. Prather’s name, the claimant first answered - “I don’t recall”, and then stated “I believe it was Dr. Wayne I think”. (Trans. pg. 21) In the second hearing during cross examination by the employer/insurer, the claimant was asked how she found Dr. Prather, and Jennings testified that while working for Wal-Mart and the St. Charles Princess she went to Dr. Heidi Prather for treatment; a doctor, to the best of my knowledge, I found on my own, Jennings stated. The claimant was queried during cross examination at the first hearing, prior to seeing Dr. Prather did she go to anybody at the Station Casino or contact anybody at the insurance company and say that she would like to see Dr. Prather for treatment of her back. “No”, the claimant answered. (Trans. pg. 44) The claimant agreed during cross examination at the first hearing that the employer/insurer sent her to Dr. Sherwyn Wayne and to Dr. Wagner for evaluation. (See Trans. pp. 39 and 44)

Considering the evidence, it is found that additional evidence was presented at the second hearing on the question of liability of the medical bills in Claimant’s Exhibit No. K in regards to Dr. Prather’s bills. (Without consideration on the determination in the first hearing by the Administrative Law Judge that the employer/insurer waived their right to control the medical treatment), it is found that there is substantial competent evidence to award compensation for Dr. Levin’s bills for treatment for the September work related injury from September 17, 1997 through March 19, 1998, in that: a. the claimant gave undisputed testimony that the employer/insurer paid the bills of Dr. Levin; b. it has been determined in this Final Award that the claimant is entitled to future medical care for management of her low back pain as a result of the September 16, 1997 work injury; c. Dr. Levin’s records of 9/17/97 through 3/19/98 indicate treatment of the claimant for low back pain; and d. the employer/insurer acknowledged paying a substantial amount in medical benefits and did not contest the payment of past medical bills encompassing Claimant’s Exhibit No. K, particularly those of Dr. Levin. It is found that there is an insufficient factual basis upon which to award compensation for the remainder of Dr. Levin’s bills in claimant’s Exhibit No. K (March 31, 1998 through November 21, 2001) in that Dr. Levin’s treatment records in evidence end with a March 19, 1998 entry. When a claimant’s testimony accompanies the bills, which the employee identifies as being related to and the product of her injury, and when the bills relate to the professional services rendered for the compensable injury as shown by the medical records in evidence, a sufficient factual basis exists for the commission to award compensation. *See, Martin v. Mid-America Farm Lines, Inc.*, 769 S.W.2d 105, 111-112 (Mo. banc 1989).

On the question of Claimant’s Exhibit No. K, Dr. Prather’s bills, it is found that there was additional evidence presented in the second hearing on the question of liability for these past medical expenses: a. the claimant’s admission that she sought treatment from Dr. Prather on her own as a result of a worsening of her back symptoms while working for Wal-Mart and the St. Charles Princess; and b. a March 24, 2000 letter from the employer/insurer’s attorney to the claimant’s attorney stating that pursuant to their last conversation, it was the employer/insurer’s understanding that the claimant was currently treating and would the claimant provide the name of the treating physician so the employer/insurer could obtain those records, and the claimant’s attorney’s response letter dated May 2, 2000 informing the employer/insurer that the claimant has been receiving medical care through Washington University Department of Orthopedic Surgery and that an MRI scan had been performed and the claimant was currently receiving physical therapy (See Claimant’s Exhibit No. Y). There is no dispute, it is found, in the evidence that upon notice of the work related injury, the employer/insurer complied with the workers’ compensation law and sent the claimant for treatment at BarnesCare. Under § 287.140.1: a. an employer is charged with the duty of providing the injured employee with medical care and is given control over the selection of the medical provider, and it is only when the employer fails to do so that the employee is free to pick his own provider and assess those costs against his employer; b. the employer is held liable for medical treatment procured by the employee only when the employer has notice that the employee needs treatment, or a demand is made on the employer to furnish medical treatment, and the employer refuses or fails to provide the needed treatment; c. medical services rendered by a physician of the employee’s choosing with no notice to the employer or request that the employer provide further medical treatment are to be at the expense of the employee. *See, Blackwell v. Puritan-Bennett Corp.*, 901 S.W.2d 81, 85 (Mo.App. E.D. 1995), and *Banks v. Springfield Park Care Center*, 981 S.W.2d 161, 164 (Mo.App. S.D. 1998). It is found that the substantial weight of the evidence establishes that upon notice of a work related injury, the employer/insurer complied with the workers’ compensation law and sent the claimant for medical treatment, and thus the employer/insurer did not waive their right to choose the treating physician.

It is found that the substantial weight of the evidence indicates that the claimant sought treatment from Dr. Prather on her own and made no attempt to inform the employer/insurer of or request treatment from the employer/insurer prior to beginning treatment on her own with Dr. Prather. Consequently, it is found that the treatment by Dr. Prather was unauthorized and the claimant's expense. It should be further noted that upon review of Dr. Prather's records, the records reflect that the treatment reports were cc'd to Dr. Levin. However, there are no records of Dr. Levin's in evidence at or near the time of Dr. Prather's treatment (Dr. Prather's treatment records are for the time period of March 23, 2000 through July 11, 2000, and Dr. Levin's treatment records end at March 19, 1998), thus no determination of a referral by an accepted or authorized treating doctor can be made. Dr. Prather's medical bills are found not to be compensable, and are found to consist of the following documents in Claimant's Exhibit No. K: the third and fourth pages – bills from Washington University and their doctor Dr. Prather (as well as doctors who had performed radiology studies per Dr. Prather's referral; see Dr. Prather's March 23, 2000 treatment record which indicates that she was going to have lumbar spine x-rays and MRI performed and the next treatment note of April 13, 2000 discusses the results of the MRI that had been performed). It is further found that there is an insufficient factual basis upon which to award Dr. Prather's bill for 7/21/00 in that no treatment records reflecting that date are in evidence. *See, Martin, 769 at 111-112.* It is found the second page of Exhibit No. K - a bill for an MRI scan and x-ray of the lumbar spine performed at BJC Health System on 04/05/00 (\$1363.00) – reflects no physician's name, but apparently are the charges of the facility for the lumbar MRI and x-rays Dr. Prather ordered; for the reasons stated in the discussion of Dr. Prather's bills, compensation for this bill is denied. For reason previously stated, it is found that there is an insufficient factual basis upon which to award compensation for the Wal-Mart and Walgreen prescription bills as these bills indicate the prescribing doctor was either Dr. Levin or Dr. Prather (thirteenth and fourteenth pages). It is found that there is a sufficient factual basis upon which to award compensation for the bill from Barnes-Jewish St. Peters Hospital (first page).

**ISSUE: - Nature and extent of permanent disability - whether partial or total:**

It has previously be determined in this Award that the substantial weight of the competent evidence established that as a result of the September 16, 1997 work related accident, the claimant suffered the injuries of lumbosacral strain and chronic back pain syndrome; it was determined that the substantial weight of the competent medical evidence did not establish a causal connection between the condition of the claimant's low back in or about June 2001 and the subsequent discogram, infection and fusion surgery.

Dr. Volarich's discussion of Jennings' complaints on May 15, 1998, it is found, were consistent with the claimant's recitation of her complaints and limitations as a result of the September 1997 work related injury testified to by the claimant in the first hearing (prior to the discogram). Dr. Volarich stated the following in his discussion of Jennings' complaints on May 15, 1998:

“On the day I examined her, she continued to have ongoing difficulties because of pain in her back and left lower extremity. The pain severity depends on the level of activity. If she carried any heavy weight, she had pain. She currently works as a waitress and tries not to handle any weight greater than about 20 pounds because it will increases her back pain.

Any repetitive activities cause her pain to worsen as does remaining in a fixed position for more than about 30 minutes at a time. Her left leg still goes numb and she continues to experience occasional radiating pain down the posterior aspect of the left leg into the calf. This occurs particularly with heavy lifting if she sits too long.

Her pain is diminished with heat, seeing her family physician who will perform manipulation, and taking some medications. She feels best when she rests on her side. She denies loss of bowel or bladder control.

Miss Jennings is able to perform most activities of daily living to care for herself as long as she does so within reason. As far as home activities, her mother performs most chores now. She tells me she cannot work out in the yard. She pursues no leisure activities.

Weather changes continue to cause her an increase in low back discomfort on a variable basis. She tells me that when her back is flared up she has difficulty sleeping where she is awakened several times at night needing to reposition. She is able to drive without difficulty for about an hour.” (Volarich Dp. pp. 10-11)

Dr. Volarich testified that examination findings on May 15, 1998 included: female in no acute distress; on neurological exam, mental status and cranial exam were normal; motor exam revealed symmetric bulk and tone; strength in the lower extremities – the quadriceps and hamstring strength were strong bilaterally; calf strength was strong with toe walking but weak with heel walking on the left at plus 4 over 5; sensory exam was normal; extensor hallucis strength on the right was strong with plus 5 over 5, but weak on the left at plus 4 over 5; toes were down going; able to walk across exam room without foot drop, limp or ataxia; musculoskeletal exam – lumbar motion was restricted with 17 percent loss of flexion, 40 percent loss in both right and left side bending and 25 percent loss in both right and left rotation; palpation of the low back elicited complaint of pain at left sacroiliac joint and to a lesser degree the left sciatic notch; straight leg raising was accomplished to 70 degrees bilaterally without radicular pain. Concerning diagnoses, Dr. Volarich testified after his evaluation of Jennings on May 15, 1998:

“Referable to the 9/16/97 accident, I had two diagnosis. The first was small disc herniations, L4-5 and L5-S1 to the left with left leg radiculopathy. The second was chronic back pain syndrome.

Had some diagnoses as well that were preexisting 9/16/97. First, bulging disc to the left at L4-5. Second, left pubic ramus fracture, well-healed.” (Volarich Dp. pg. 15)

(It has previously been determined in this Award that Dr. Volarich's diagnosis of - small disc herniations, L4-5 and L5-S1 to the left - is given little weight in that the doctor admitted this opinion was based on his review of examination reports of a Dr. Wayne whose records are not in evidence in this case, and Dr. Volarich admitted that he did not review CT scan films or reports in making this diagnosis.) Dr. Volarich testified about his opinion of current disability he felt Jennings was suffering from as a result of the 9/16/97 accident and injury after the May 15, 1998 exam: "...it's my opinion that there's a 30 percent permanent partial disability of the body as a whole rated at the lumbosacral spine due to the tiny disc herniations at L4-5 and L5-S1." (Volarich Dp. pg. 17) The doctor stated that there was additional disability in the low back, and testified: "...there's a 12.5 percent permanent partial disability of the body as a whole rated at the lumbosacral spine due to the historic strain/sprain injuries and bulging disc at L4-5 to the left." (Volarich Dp. pp. 17 -18) "I did not find disability from the pelvic fracture since she was asymptomatic", the doctor said. (Volarich Dp. pg. 18) Dr. Volarich further testified: "The combination of her impairment does create substantially greater disability than a simple total of each, and the loading factor should be added." (Volarich Dp. pg. 18) Dr. Volarich assigned work restrictions for the claimant after his May 15, 1998 evaluation.

Dr. John R. Wagner testified that his evaluation of Jennings was on March 19, 2001 in regards to the September 16, 1997 work related injury. Jennings stated that she has good days of light pain in the low back area near the sacrum, and bad days where there is pain like a knife stab and it shoots down both entire legs. The doctor was noted that Jennings relayed she was currently working as a cashier at Wal-Mart and also worked the floor, and been doing this for a year and a half; Jennings relayed that when she tries to sit or stand for an hour, she has back pain, the doctor noted. Dr. Wagner stated that that he took x-rays on that date and reviewed the actual films. Dr. Wagner testified about the findings reveal by his examination and review of films:

"Well, her examination is excellent. She has normal motion. She has excellent muscle relaxation. She has a normal neurological exam. Tugging on the nerves was straight leg raising and the knee flip test, so she has a normal examination and all of the films that I reviewed, except for that first film which showed a slight concave, are absolutely normal including her MRI." (Wagner 10/26/01 Dp. pp. 14-15)

Dr. Wagner testified that based on his March 19, 2001 evaluation of Jennings, as a result of the September 16, 1997 work related incident "there is no evidence of any disability in the lumbar spine. She has zero percent disability secondary to the injury of 9-16-97". (Wagner 10/26/01 Dp. pg. 17) Dr. Wagner further opined that based on his March 19, 2001 evaluation, Jennings was "capable of working", and "there was no restriction in her activity". (Wagner 10/26/01 Dp. pg. 15)

The employer/insurer noted the following in its Memorandum of Law:

"Harmonizing the testimony and findings of the medical experts, it is apparent that claimant sustained 30% permanent partial disability to the body as a whole, referable to the lumbar spine, as a result of the September 16, 1997 accident. (Volarich 1998 Deposition, 17); Volarich 2004 Deposition, 28). While Dr. Volarich found that claimant sustained an additional 45% permanent partial disability to the body as a whole, referable to the lumbar spine, this disability was the result of the unwarranted discogram and not the accident taking place on September 16, 1997. (Volarich 2004 Deposition, 32-33). Any permanent partial disability granted to claimant for the September 16, 1997 accident must be limited to 30% of the body as a whole. R.S.Mo. §287.19(0); *Landers*, 963 S.W.2d at 284; *Sifferman v. Sears Roebck & Co.*, 906 S.W.2d 823, 826 (Mo.App. S.D.1995). Such a disability findings would be in keeping with the nature of the 1997 work injury, the 1997 work injury's aggravation of claimant's ongoing back pain syndrome, limited motion, and the radiating pain in claimant's left leg. (Volarich 1998 Deposition, 17; Volarich 2004 Deposition, 6)

A finding of 30% permanent partial disability would reflect the undisputed evidence that claimant continued to work, despite the injury to her back from the 1997 accident, until she underwent the unwarranted discogram. Since claimant worked during the interval from April of 1998 until April of 2002, she could not have been permanently totally disabled due to her back injury from the 1997 event, as a matter of law. R.S.Mo. §287.020.7; *Minies v. Meadowbrook Manor*, 105 S.W.3d 529, 538 (Mo.App. E.D. 2003); *Sifferman*, 906 S.W.2d at 825."

The Second Injury Fund argues in its Memorandum of Law:

"Assuming Claimant's treatment subsequent to the temporary award was not related to the primary injury, as alleged by the employer, Claimant has not proved she is permanently and totally disabled. Ms. Jennings testified that after the primary injury and before the discogram she continued to work. No medical expert testified that the combined effect of the work injury before the discogram and any preexisting condition rendered Ms. Jennings unemployable in the open labor market. After the work injury, she worked first at North Shore Yacht Club and then later at both the St. Charles Princess and Wal-Mart. At one point she was even working up to 70 hours per week. While Ms. Jennings was working with restrictions after her work accident, she was employable in the open labor market, because she was able to obtain and maintain employment, up until her discogram. Only in the aftermath of that procedure did she become unable to work."

It is found that the substantial weight of the competent evidence supports the employer/insurer's and the Second Injury Fund's above arguments. Considering all of the evidence in light of this finding, it found that the substantial weight of the credible evidence supports an award of 30% permanent partial disability of the body as a whole referable to the lumbar spine as a result of the September 16, 1997 work related accident and injury. This would be: 400 weeks x 30% = 120 weeks; 120 weeks x

\$253.34/week = \$30,400.80.

### **ISSUE: Liability of the Second Injury Fund**

It has previously been determined in this Award that the competent medical evidence establishes preexisting disability for the claimant via the opinions of Dr. Volarich that the claimant had preexisting disability to the lumbar spine, and Dr. Stillings opinion that the claimant had preexisting psychiatric disability. Dr. Wagner indicated that he had reviewed records concerning treatment of Jennings prior to her injury in 1997, but the doctor limited his opinion as to the amount of disability to the low back, if any, as a result of the September 1997 work related injury.

It has previously been determined that in this Award that the substantial weight of the competent evidence does not establish that the claimant is permanently and totally disabled, thus consideration of Second Injury Fund liability is based upon any possible liability for permanent partial disability. The parameters for Second Injury Fund liability in such instances is set forth in Section 287.220.1 as follows:

All cases of permanent disability where there has been previous disability shall be compensated as herein provided. Compensation shall be computed on the basis of the average earnings at the time of the last injury. If any employee who has 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, and the preexisting permanent partial disability, if a body as a whole injury, equals a minimum of fifty weeks of compensation or, if a major extremity injury only, equals a minimum of fifteen percent permanent partial disability, according to the medical standards that are used in determining such compensation, receives a subsequent compensable injury resulting in additional permanent partial disability so that the degree or percentage of disability, in an amount equal to a minimum of fifty weeks compensation, if a body as a whole injury or, if a major extremity injury only, equals a minimum of fifteen percent permanent partial disability, caused by the combined disabilities is substantially greater than that which would have resulted from the last injury, considered alone and of itself, and if the employee is entitled to receive compensation on the basis of the combined disabilities, the employer at the time of the last injury shall be liable only for the degree or percentage of disability which would have resulted from the last injury had there been no preexisting disability. After the compensation liability of the employer for the last injury, considered alone, has been determined by an administrative law judge or the commission, the degree or percentage of employee's disability that is attributable to all injuries or conditions existing at the time the last injury was sustained shall then be determined by that administrative law judge or by the commission and the degree or percentage of disability which existed prior to the last injury plus the disability resulting from the last injury, if any, considered alone, shall be deducted from the combined disability, and compensation for the balance, if any, shall be paid out of a special fund known as the second injury fund, hereinafter provided for.

Reviewing the evidence, at the first hearing, the claimant testified that she had seen to Dr. Levin about two times prior to the September 1997 concerning low back complaints; she did not remember, however, over what period of time. Jennings further testified that she did not remember if she was having any lower back complaints in the year prior to the September 1997 work injury, did not remember if she had had leg complaints prior to September 1997 like she was presently having, and stated that prior to September 1997 she did not have back complaints like she was presently having or any trouble performing her job. At the second hearing, the claimant agreed that Dr. Levin had been her family doctor since about October 13, 1993; she stated that she guessed it was correct that from October 13, 1993 up until September 16, 1997, the date she fell at the casino, she saw the doctor for treatment and care sixty-eight times or approximately seventeen times a year and on most of those occasions the doctor would prescribe her some kind of medication. The claimant testified about suffering from anxiety and depression prior to the September 1997 work injury and receiving treatment for this condition. Jennings agreed that there were other occasions when she would call in to Dr. Levin and they would prescribe her medications without a visit, and agreed that this occurred in that same four-year period approximately twenty times a year. She agreed that in addition to this, in that same period of 1993 to 1997, she was also seen through a variety of emergency rooms or hospitals for other treatment and/or diagnostic studies or tests including in 1994 a CT scan of her low back and at St. Joseph's Hospital EMG and nerve conduction studies of her arm on two occasions. Jennings agreed that she has been seen through St. Joseph's emergency room for a variety of problems on at least five or six occasions from May of 1993 up to August 6, 1997, including for migraine headaches. Concerning the occasions prior to September 16, 1997 when her low back complaints became severe enough that the doctor thought it was appropriate for her to have a CT scan of her back, Jennings explained that what caused the onset of her low back pain at that point in time was that the casino opened and she was working with high heels ten plus hours a day. Jennings agreed that if the doctor's notes indicated that she had problems with pain in her legs and feet, she wouldn't have any reason to dispute that.

Considering the medical opinion of Dr. Volarich, the doctor testified about the history relayed to him by Jennings May 15, 1998 evaluation about prior injuries and treatment: "Ms. Jennings reports that leading up to 9/16/97 she recalls no ongoing difficulties with her low back. She never had radiating pain to the left leg and she was working under no restrictions." (Volarich Dp. pg. 8) Dr. Volarich was queried that he had mention Jennings had a prior history in 1994 of having a flare-up of back discomfort and was there a presumption that she did not have any radicular complaints at that point in time, and the doctor responded - "No. Because a CT scan was ordered, and you don't order a CT scan unless you have radicular complaints in the history." (Volarich Dp. pg. 26) Dr. Volarich opined that in addition to 30 percent permanent partial disability of the body as a whole rated at the

lumbosacral spine as a result of the 9/16/97 accident, "...there's a 12.5 percent permanent partial disability of the body as a whole rated at the lumbosacral spine due to the historic strain/sprain injuries and bulging disc at L4-5 to the left." (Volarich Dp. pp. 17 - 18) Dr. Volarich further testified: "The combination of her impairment does create substantially greater disability than a simple total of each, and the loading factor should be added." (Volarich Dp. pg. 18). Dr. Stillings, after evaluation of Jennings on January 25, 1999, testified as to his diagnoses: "Number one, other conditions that may be a focus of clinical attention, that being histrionic personality traits. Number two, relational problems, not otherwise specified with a history of emotional and physical abuse. Number three rule out substance dependence." (Stillings Dp. pg. 25) Testifying as to his opinion on causation in relation to Jennings' diagnoses and the September 16, 1997 work related accident, Dr. Stillings stated: "Ms. Jennings has no psychiatric illness causally related to nor aggravated by the 9/16/97 work accident." (Stillings Dp. pg. 28). Dr. Stillings testified. "Ms. Jennings has sustained 0 percent permanent partial psychiatric disability related to the 9/16/97 work accident", Dr. Stillings testified. (Stillings Dp. pg. 30) It was Dr. Stillings' opinion that the claimant's psychiatric condition preexisted the September 16, 1997 work related accident. Dr. Stillings was queried, when he said the claimant had histrionic complaints was he saying this was an intentional faking or malingering situation, and the doctor answered:

"No, absolutely not. It just means this is her personality style. If she has an injury, her reaction and emotion to that injury is going to enhance the injury. It's going to be a greater injury than if she didn't have this personality. It's a subconscious process. It's not something that she's aware of." (Stillings Dp. pg. 38)

Dr. Stillings assessed psychiatric disability for Jennings:

"I have three opinions. Number one, Ms. Jennings has a 15 percent preexisting permanent partial psychiatric disability in relation to her first diagnosis of relational problems NOS multiple with a history of emotional and physical abuse.

Opinion No. 2 is that Ms. Jennings has a 15 percent preexisting permanent partial psychiatric disability related to diagnosis number two, which is histrionic personality traits.

Opinion No. 3 is Ms. Jennings has a preexisting permanent partial psychiatric disability of 5 percent related to diagnose number three, which is substance abuse by history." (Stillings Dp. pg. 33)

The doctor further testified that all three of the diagnoses come together: "Well, they really have a synergistic phenomenon in that it's what we call co-morbidity. In other words, having three problems like this is worse than their simple sum." (Stillings Dp. pg. 35) Dr. Stillings addressed the synergistic effect of the claimant's preexisting psychiatric problems with her work related injury during his discussion of his interpretation of the claimant's MMPI results, including in his testimony:

"This is a valid profile. This person has a histrionic construct to her personality structure. She is likely to report subjective complaints well beyond those which can be physically or organically objectively confirmed.....All scales relevant to pain, including the low back pain scale, are elevated into the functional/exaggeration region. She is likely to present with a variety of vague and unusual complaints...." (Stillings Dp. pp. 22-23)

Dr. Stillings further testified as to a co-morbidity of his three diagnoses and how they had affected Jennings' employment; the doctor further testified as to the co-morbidity or a synergistic effect in the fact that Jennings has both psychiatric problems and a back injury so that she is worse off, and further testified:

"The principle of co-morbidity is applicable in psychiatry. It is also applicable between the presence of physical diseases in combination with psychiatric disorders, in that when you have both, you have a synergistic effect, and it is harder to treat the individuals and their outcomes are much poorer than if you have a person with just a single disorder.

"Say for Ms. Jennings, with her histrionic personality - let's just take one of the three psychiatric disorders. Her histrionic personality feature will cause her not to do as well physically. She will not feel as well. She will report higher levels of pain. She'll be functionally more limited in terms of her capacity from a physical standpoint due to that personality feature." (Stillings Dp. pp. 37 and 38).

In her Memorandum of Law, the claimant noted Stillings' assessment of pre-existing psychiatric disability and that the doctor indicated a synergistic effect between this preexisting psychiatric disability and the disability from the September 16, 1997 work related injury and disability: "He also testified that there is a synergistic effect between the Claimant's physical problems and psychiatric problems."

The determination of a specific amount or percentage of disability to be awarded to an injured claimant is a finding of fact within the unique province of the administrative law judge. *Landers*, 963 S.W.2d at 284. Permanency of disability must be show with reasonable certainty. *See, Matzker v. St. Joseph Minerals*, 740 S.W.2d 362, 363 (Mo.App. E.D. 1987)

It is found, in considering the evidence, that the substantial weight of the evidence establishes minimal hindrance or obstacle to the claimant's employment in regards to her preexisting low back in that the claimant could articulate only minimal interference with the performance of her work prior to the September 1997 work injury (i.e. there is no evidence that the claimant missed

extended periods of time from work prior to the September 1997 work injury due to low back problems) and minimal symptoms; it is found that the substantial weight of the evidence establishes a preexisting disability for the claimant's low back of 7.5%. Thus it is found that as the preexisting disability to the low back is below the threshold level set for consideration of Second Injury Fund liability, such consideration cannot be made.

It is further found, though, that the substantial weight of the evidence supports a finding of a preexisting psychiatric disability of 20% of the body as a whole for the claimant. It is found that the substantial weight of the evidence indicates a synergistic effect between the claimant's September 16, 1997 work related low back injury and her preexisting psychiatric disability; it is found that that synergistic effect is a 20%. Thus, Second Injury Fund liability is found to be: [(400 weeks x 30% = 120 weeks) + (400 weeks x 20% = 80 weeks)] x 20% = 40 weeks; 40 weeks x \$253.34/week = \$10,133.60.

### **SUMMARY OF THE EVIDENCE**

**Cheryl Lynn Jennings, the claimant**, testified in her own behalf and stated that she was born on August 9, 1958. Agreeing that she had taken medications today before the hearing, Jennings stated that she took Vicodin for her back and leg pain, and Valium. When asked if these medications would affect her ability to testify today, the claimant answered – My memory is not good, so the medication should not affect that much, as I am used to taking the pain medication, so, no, I wouldn't say. Jennings stated that she is not married. I have one child and he is not dependent on me at this time; he is twenty years old and is not in school, she said. My level of education is a graduate of high school, Jennings stated. I do not have any education beyond high school; I have not taken any sort of classes since high school for learning a skill or vocational training, she said. Jennings stated that she is not able to type, and does not know how to operate and does not own a personal computer.

Jennings testified about her employment history. When I first came out of high school, I worked at Town and Country at a fast food restaurant. I worked at fast food restaurants from twelfth grade through nineties, the claimant said. I also worked for Town and Country Supermarket where first I was a cashier and worked off and on for about ten years, and then I went to bakery, and then deli manager four years, and then I did various assorted things throughout the store - just wherever they needed me to work. I work for this grocery store around ten years, until 1991, she said. After leaving the grocery store I next worked at Station Casino St. Charles from 1994 to 1997 as a cocktail server, she stated. Jennings agreed that Station Casino St. Charles was where she was working when the accident of September 1997 happened, and agreed that she was terminated shortly after the accident occurred. The claimant talked about her duties at the Station Casino St. Charles as a cocktail server. It was like slicing fruit up for the bar, and then going out walking the floor, and asking the customers what they would like to drink - soda or mixed drinks - and then going and getting it for them and taking it back to them, she testified. After I left Station Casino St. Charles in 1997 I next worked at North Shore Yacht Club for about a year in, I believe, it was 2001, and my job was a bartender. It was a full time job, as I recall, and my duties as a bartender included mixing drinks, helping stock the coolers and ordering, and serving some food to my customers, she said. I also worked another casino boat, the St. Charles Princess, from 2001 to 2003 as a bartender, the claimant said. She agreed that it was the same sort of work she had done at the Yacht Club, but added that when the cruise started she would serve drinks, and then she would walk around and talk to her guests, and stated that it was just like up to two-hour cruises.

Jennings agreed that she was born and raised down in Southeast Missouri. She was asked, since you've moved up here to St. Charles in about the early nineties ha she had jobs anywhere else. I worked at Wal-Mart from 1999 to 2003 as a cashier, the claimant said, and agreed that it was the standard thing that we see -- someone standing there and moving items across a scanner of some sort. My other duties at Wal-Mart were that I would go out on the floor and hang up merchandise and stuff because I did have limitations from Dr. Prather saying that I had to stand and sit, alternate, or it would aggravate my back; I would have to go out on the floor and walk around, the claimant stated. Jennings agreed that all of these jobs took place before she underwent a discogram with Dr. Gornet in about March of 2002. I have not worked anywhere since March of 2002, the claimant testified, and further stated she has tried to work at St. Charles Princess, she thought, once. My boss called me and they said could I work it, and if I could he would help me and my co-workers would help me, it was just a cruise. It was one two-hour cruise where I was bartending, and it wasn't good because of my back and leg pains, Jennings testified. Other than that, I have not worked anywhere since March of 2002, she said.

The claimant stated that she understood the hearing today was because of the claim she filed for an accident from working at the Station Casino St. Charles back in September of '97. She stated that she remembered testifying in this matter at a hearing back in November of 2001. I have looked over the transcript of my testimony back in November 2001 and I would testify the same today, the claimant stated. There is a matter of a fractured arm that was in the transcript, that it happened at the Yacht Club when I worked there, but it did not happen at the Yacht Club, it happened at my home, Jennings noted.

Jennings testified about the medical treatment she has received since November of 2001, since that last hearing. She agreed that after the November 2001 hearing she began receiving medical care from Dr. Matthew Gornet, and one of the first things this doctor did was have her undergo a discogram. Agreeing that she noticed problems after the discogram, Jennings testified that for two days after she was doing fine but had a little pain; she went home and was going to go to work the third day, and she couldn't even get out of bed, she couldn't walk, and was in pain in her lower back where the discogram was. I went to the emergency room at Barnes West County Hospital, and they gave me pain medication, and that's about it, she said. This did not resolve my problems, Jennings stated, so then I got an appointment to see Dr. Gornet; and then, I believe, an MRI was taken and it showed an infection on

my spine. They admitted me to the hospital, started me on antibiotics, and then they took a piece of my spine, bone and tissue, to see what kind of infection it was, Jennings said this on in June of 2002. I had another surgery in September, 2002 which was the fusion of my spine, front and back; there has been no surgery since then, the claimant stated. Jennings agreed that after each of these surgeries she followed up with Dr. Gornet. I also followed up with the infectious disease doctor, Dr. L'Ecuyer, right there by the hospital; in his office, Jennings added. She stated that she is no longer treating with Dr. L'Ecuyer, but the doctor said if anything was to flare up, any infections or anything, he would want to see her again; to the best of my knowledge there have been no flare ups of the infection, she said. After the second surgery, Dr. Gornet's treatment consisted of pain medication, she stated, and agreed that the doctor also did Cat Scans and MRIs from time to time to make sure the fusion was coming along. Jennings agreed that Dr. Gornet eventually discharged her from his care in or about September of 2003. I am not treating with Dr. Gornet at this time, she said. It was noted that in his last note of September 11, 2003, Dr. Gornet wrote that he is going to see Jennings in a year for her standard two-year follow-up, and Jennings was asked if she had scheduled any appointments to see the doctor for September of 2004. No, the claimant answered. Since September of 2003 I have had medical treatment for my back and leg complaints of eight weeks of rehab at Lake St. Louis Hospital ordered by my family physician, Dr. Rasheed, Jennings testified. When asked if this helped in any way, the claimant answered - No. The claimant was asked her opinion of whether she was better, worse, or the same since she had the discogram. Worse, the claimant responded. Jennings stated that she sees Dr. Rasheed just about every month since September of 2003 for pain medications, MRI, rehab. I am scheduled to see Dr. Rasheed again for my back and legs in August of 2004. I have also been to the emergency room of St. Joseph's Hospital in Lake St. Louis, Mo for medical care about five times since I was discharged by Dr. Gornet and Dr. L'Ecuyer, the claimant said. Jennings explained that it gets to where the pain medicine will not work at all, and her legs just have no feeling and they go out underneath her. I called Dr. Rasheed's office, Jennings stated, and they told me - if the pain is that bad, you need to go to the emergency room.

I have not had any accidents since the last hearing, the claimant said.

Jennings was shown Claimant's Exhibit U, and explained that the first page is just kind of a summary of what's included. Page 2 is the bill from Washington University in St. Louis, and it's concerns treatment in August of 2002 and September 4, 2002 for an MRI, CT Scan, CT reconstruction, and anesthesia ordered by Dr. Gornet, she said. The claimant agreed that the next several pages were also from Washington University and concerned a June 2002 x-ray, some MRIs, a chest x-ray, and things of that sort, and this was also ordered by Dr. Gornet. It was noted that there were some documents there showing Barnes West County bills have been paid, and there are bills of doctors at Barnes West County; Jennings stated that she did not know if these are part of Barnes West County, or if they are separate physician charges for what was done at Barnes West County. The next page are Dr. Gornet's charges in this case, the claimant agreed, and after that is a bill from Midwest Radiological Associates for April 30, 2002. The next page are charges of Dr. Paul B. L'Ecuyer, the claimant said. After that are bills from Barnes Jewish West County Hospital for visits on May 8, 2002, May 6, 2002, March 3, 2002 and April 28, 2002; these are for the emergency room visits, Jennings stated, and agreed that these may be part of what Barnes West County indicated in Claimant's Exhibit Z had been fully paid then. After that is several pages from SSM St. Joseph's Hospital West, the first page of which shows in October of 2003 Jennings was there for a blood draw, lipid profile, CBC, etc; the claimant was asked if she knew what these things were done for. I don't understand really what the CBC and all that is for, but that was for the pain that I was having, she answered, I had to go in and they draw blood to make sure nothing was going bad. It was noted that this October 2003 service was after she had been discharged by Dr. Gornet a month earlier in September of 2003. That's when I was having pain still yet, and when I talked to Dr. Rasheed's secretary she said, well, if the pain's bad go to the emergency room, Jennings responded. The page after that reflects that again in November of 2003 the was another blood draw and a cervical spine x-ray, and this was ordered by Dr. Rasheed again, the claimant agreed. The page after that, concerning a January 2004 CT Scan of my brain, this was ordered by Dr. Rasheed for my headaches, Jennings stated. The next two pages are from Dr. Rasheed for visits I made to him, the claimant agreed, and further agreed that she was going to Dr. Rasheed before Dr. Gornet discharged her. I do not recall why I was going to Dr. Rasheed, the claimant said. Jennings was questioned about the next page which reflected a purchase of a mattress from the Orthopedic Center of St. Louis. Dr. Gornet wanted me to get a better back support mattress for my back, the claimant explained, and I paid for it myself and have not been reimbursed for this. The claimant agreed that after that there are a number of Wal-Mart prescription receipts making up about five pages. It was noted that a good deal of the prescription receipts have Dr. Gornet's name on them, but others have names of other doctors, and the claimant was asked to testify about these: a. the very first two have a Dr. Richard Tao, that was a doctor in the emergency room; b. the second page of Wal-Mart prescriptions shows a Dr. David Brown on several occasions, and was a partner with Dr. Gornet if Dr. Gornet was out of town or something, so sometimes I would have prescriptions filled by other doctors in Dr. Gornet's office, and the next doctor, a Dr. Bernardi, was a partner of Dr. Gornet at that time; d. the next two pages are three St. Charles Drug Company bills, and all indicate Dr. Gornet, and I do not recall if Dr. Gornet ever treated me for anything besides this work injury in September of 1997, he didn't treat me for colds or the flu or depression or anything like that nor for a broken arm; e. the last two pages are St. Charles Rexall Drug, and I put the lines on there because it was the pain medicine I was taking for my back and legs, and some of them was for depression ordered by Dr. Levin as I've been under a lot of stress since my surgery and stuff, and the Diazepam I have taken for a while and am taking that now. The claimant explained the medications she had underlined: Propoxephene, I believe, is a Darvocet, a pain medication; Effexor was an anti-depressant; Neurontin is for the dead nerves in my legs; Beubetel is for my headaches and pain; Sochloroprin is a muscle relaxer; Oxycodone is a pain pill and Percocet is under that; to the best of my knowledge, Lexapro is an anti-depressant or muscle relaxer; Tramadol was a pain medication. Jennings agreed that the bills she had just testified about were bills that she had received from the various treatment she testified to at the hearing. Concerning the medical bills she had talked about for treatment of headaches, Jennings stated that these bills had something to do with her back, and then when she was working, when you carry trays of full drinks, it's her neck and shoulders.

Jennings agreed even before she fell at Station Casino St. Charles she had treatment from Dr. Levin for problems up in these areas, and treatment by him was for headaches back then also, so the headaches, at least to some extent, go back before she even fell at the Station Casino St. Charles.

The claimant testified about her past medical history. I have been treated for problems with my back before September of 1997 like up in my neck and shoulders, she said. Dr. Levin sent me to St. Joseph Hospital and they put a heating pad on it; it might not have been very much in my lower back, but some -- one or two treatments on that, but they put that big old heating pad like on my back, from my middle back up. Jennings said that she did not recall if she had had any sort of studies done on her back such as x-rays or anything like that, but stated that she would not disagree if the records showed she had had a CT scan of her back in the past. I had never had surgery on my back in the past, she said. Agreeing that she had been involved in an auto accident in 1991, Jennings stated that the injuries she had from that accident was a fractured pelvis. It wasn't bad enough to have surgery, it was just very fine crack in it, the claimant stated, and all I had to do was lay in the hospital two or three weeks and let it heal; after taking it slower while working jobs and working on my life, it healed perfect, she said. Jennings agreed that she has had seven female-type surgeries in the past.

Jennings testified about her present physical status, like over the last four to six weeks or so. She was asked, since the last hearing did she think she was about the same, better or worse. Quite a bit worse, the claimant said. My back is worse; like right now I can feel the pain back there, and then my legs are like the numbing sensation right now, she said. I have back symptoms just about every day; there's not a day that goes by, Jennings stated. Sometimes it is worse than other, and it can be doing nothing and it will get worse, she said. Lately I've only been getting five hours of sleep; I twist, turn all night; I go from recliner to the bed; I just can't get comfortable, Jennings testified. There's pain in my back right now, but I'm coping with it because I took my pain medication, the claimant said. I have numbness in both of my legs in the front, back, the whole sides all the way down, she said, and it is very seldom that I don't have numbness in my legs. Recently, the numbness in my legs has been constant, every day, the claimant said, and it has gotten to where my legs if I even try to walk they go out underneath me. Jennings agreed that she notices frequently a difference in her concentration of her medication. My thought process is not okay when I am taking my medication because of the stress and every day/every other day pain I go through; the depression, anxiety, anxious, it's just ongoing; it's just took a really big toll on me, the claimant testified.

The claimant testified about what a day in her life is like and her limitations. Within the last two or three months, I get maybe five, six hours of sleep a night, she said, and it not straight sleep because I have to get up and move around, I can't lay. When I get up in the morning I usually drink coffee, sit around for a while, and then maybe go out and water flowers. I'm living with my mother right now because it's got so bad that I cannot do hardly any activities, and if I do it knocks me down, she said. Living with my mother helps a lot, Jennings stated, she will do things or help, such as with grocery shopping, she goes with me she does grocery shopping, takes care of the yard, the laundry. Jennings stated that she is able to drive as long as she drives her mother's car as it is an automatic while hers is a stick shift, and because with the clutch and brake and gas she had to use her leg lot. I can drive comfortably for about fifteen to twenty minutes and then my back and legs feel worse, she said. Concerning lifting, the claimant stated, at times I catch myself lifting heavier stuff, but I pay for it when I do that. The sort of things that I lift are like a little bit of groceries - bread - nothing very heavy, the claimant said. With standing, I can stand comfortably for a half hour, she said. I can sit comfortably for maybe fifteen minutes, then I have to twist to the left, twist on the right; I can't lay -- if I'm in a recliner I can lay back; I can't lay on my stomach at all, Jennings stated. I can walk around a block at times, but sometimes not even a block, she said, because my leg hurts. Jennings agreed that she is able to take care of her personal needs, such as dressing yourself, washing yourself, etc.

The claimant agreed that her past medical history includes psychiatric treatment. When asked what sort of psychiatric treatment she had had, Jennings stated that it had been quite a few years ago, and she really didn't recall. She agreed that among the medications she is taking is Valium. I don't recall how long I have been taking Valium, it's been quite a few years, Jennings said, I'm a very anxious and nervous person. She agreed that she has been taking Valium for more than ten years. The claimant was asked if she felt the medications that Dr. Rasheed gives her, which she termed either pain meds or muscle relaxers, did she think that these help her to deal with her symptoms in her back and legs. They don't relieve them, the claimant answered, they do maybe help take the edge off, but sometimes -- quite a few times -- I take more than I should to get my rest to where I'm just so tired and I can't handle the pain and I just need my rest, you know, I just can't deal with it, I just --. I have tried to be more active to get out and do more things around the house, but the result is not good, Jennings said, I have pain in my lower back. I can do it maybe for a day, then I'll be knocked down for a day or two, sometimes a week, she said.

On cross-examination, Jennings agreed that she had already indicated that her memory is not all that good. She agreed that prior to 9-16-97, the date of her fall at the casino, Dr. Levin was her family physician and had been for approximately four years. To the best of my knowledge, yes, Jennings said, during that time I was on Valium, Fioricet, Xanax, Diazepam, Respiral and Soma. She agreed that at least with regard to the Valium and the Fiorinal or Fioricet, she had been on those for quite some time.

Concerning the bills that I went through on direct examination, Jennings stated, I am not getting any kind of dunning notices through the mail from any of these physicians or facilities at this point, and it has been some time since I've gotten any kind of bills. No one is calling me up at this point and saying she has legal obligations we want you to take care of with regard to these bills, she said.

During cross examination, Jennings agreed that Dr. Gornet is the physician who performed her discogram. Prior to this I went to see, to the best of my knowledge, Dr. Wagner and Dr. Wayne, Dr. Sedgwick, and Dr. Volarich, the claimant said. Jennings agreed that prior to the discogram, Dr. Volarich had indicated that he thought she had a definable amount of permanent partial disability and provided a rating report, at that time he didn't recommend that she undergo a discogram. Neither did Drs. Wayne or Sedgwick or Wagner, none of those physicians, recommended that she undergo a discogram, the claimant agreed. She agreed that she actually had a period from sometime in 1998 up to the time she first saw Dr. Gornet in 2001 where she didn't receive any treatment or care. Jennings agreed that she had some concerns about whether she was in fact as good as she was going to get, she asked her attorney and he gave her a recommendation and she went to Dr. Gornet on her own. She agreed that Dr. Gornet ended up doing the discogram. The claimant was queried if Dr. Gornet's records indicated that he felt there was no pathology on the discogram that would warrant surgical intervention; would that be inconsistent with her recollection of any discussion she had with Dr. Gornet. Yes, Jennings answered. The claimant agreed that after she had the infection, Dr. Gornet treated her for a period of time and eventually released her from his care. I did not think it was appropriate at that time that he released me from his care, the claimant said, I wanted more treatment at that time. She agreed that she specifically asked Dr. Gornet for pain management treatment. Dr. Gornet advised that he didn't think it was necessary, and I disagreed with that so I went back to Dr. Rasheed, Jennings said. Dr. Rasheed, is the successor to my family physician Dr. Levin, so Dr. Rasheed is a family practitioner, she agreed, and further agreed that Dr. Rasheed is not a pain management specialist. The claimant was queried, if you had to do it all over again, if we were back at the first hearing, and you knew then what you know now, would you be asking the Judge to send you for a discogram. Not from what the outcome was, the infection setting in, I would not, Jennings answered.

Jennings agreed that she started going to Dr. Rasheed in October of 2003, and at that time Dr. Rasheed said that it was not only back pain but also neck pain that she was treating, and that the neck pain is a pre-existing problem. So, the claimant agreed, some of the charges from Dr. Rasheed would be for treatment of the neck pain. In addition to the neck pain, Dr. Rasheed has also treated me for the headaches, and that's what the CT Scan was for, Jennings agreed. She agreed that the headaches were also a pre-existing problem. The claimant agreed in addition to that, Dr. Rasheed has made a diagnosis of allergic rhinitis and has prescribed Nasanex or nasal spray; she agreed that she has also treated with Dr. Levin in the past for problems with her sinuses, and further agreed that she was not saying that her sinus problems are due to the injury to her back. Dr. Rasheed has prescribed some medications for me, including Fioricet, the nasal spray Nasanex, Valium, and Soma, the claimant agreed. She agreed that these medications - Fioricet, Fiorinal, the Valiums, Nasanex, Soma - those are all medications that Dr. Levin had her on prior to 9-16-97. Jennings agreed that she was also on a variety of psychiatric medications prior to 9-16-97.

During cross examination, the claimant agreed that Dr. Levin had been her family doctor since about October 13, 1993; she stated that she guessed it was correct that from October 13, 1993 up until September 16, 1997, the date she fell at the casino, she saw the doctor for treatment and care sixty-eight times or approximately seventeen times a year and on most of those occasions the doctor would prescribe her some kind of medication. She agreed that there were other occasions when she would call in and they would prescribe her medications without a visit, and agreed that this occurred in that same four-year period approximately twenty times a year. She agreed that in addition to this, in that same period of 1993 to 1997, she was also seen through a variety of emergency rooms or hospitals for other treatment and/or diagnostic studies or tests including in 1994 a CT scan of her low back and at St. Joseph's Hospital EMG and nerve conduction studies of her arm on two occasions. Jennings agreed that she has been seen through St. Joseph's emergency room for a variety of problems on at least five or six occasions from May of 1993 up to August 6, 1997. Migraine headaches is one of the things I treated for prior to September of 1997, the claimant agreed, and I have had problems with migraines for most of your life. I had migraines two to three times a week and with medications they resolved after two to three hours; if for some reason my medications aren't available at the onset of my migraines, they're no fun and I go to the emergency room, the claimant said. She agreed that at times prior to September of 1997 her migraines were severe enough that she was unable to work and had to stay home in a quiet, dark room. I was prescribed Fioricet and Imtrack for migraines, Jennings stated; she stated that she is not able to do things like drive when she takes these drugs. Jennings agreed that prior to September of 1997 she had some issues of physical abuse in her life, that she had been abused by two different men in her life. My second husband who I was with for ten years was physically and emotionally abusive, Jennings testified, he just hit me and yelled, verbal. I do not recall ever having to go to a emergency room or see a doctor as a result of the physical abuse, she said. When asked if she had ever had any legal problems as a result of that abuse, were the police ever involved in any of these altercations, the claimant responded - I don't recall. After that husband I became involved with a boyfriend for eight years beginning in 1990 or 1991, and he was also physically and emotionally abusive, she said. Jennings agreed that he had actually sent her to the emergency room on more than one occasion as a result of the physical abuse. Concerning the emotional abuse, Jennings agreed at least one occasion he accused her of infidelity and they ended up in the emergency room requesting a pelvic exam so that she could prove to him that she had not been unfaithful. On another occasion he sent me to St. Joseph's Hospital with a black eye, she agreed, and further agreed that as she recalled this was approximately three weeks before the fall at the casino. On that occasion when I showed up at the emergency room I was actually in handcuffs, the claimant admitted. It was because I was standing up by him, he hit me in the eye, and supposedly he went back in the bedroom after the cops got there and scratched his face, and they say they saw abuse on him, so they took him, too, and me, Jennings explained. The claimant agreed that she has been diagnosed with depression and anxiety, and as a result of these diagnoses she has been prescribed, among other things, Valium and Xanax. She agreed that she has been on some form of anti-depressant medication such as Valium and Xanax, continuously since at least October of 1993. Jennings stated that her father had had a nervous breakdown when he was in the Air Force, and continued to have problems as a result. Discussing the kind of problems her father continued to have, Jennings testified, from what I recall, it wasn't bad; it was just, you know, sick a

lot, took his medication; he was on quite a bit of medication; he became a hundred percent disabled. She agreed that he was unable to work as a result of it, and agree that he was hospitalized as a result of this. Jennings stated that she did not recall when she was first prescribed Fiorinal or Fioricet. She stated that she believes she is dependent upon Valium. I have been through two inpatient detox programs to try to get off of them, but I've gone back to them, she said. Jennings agreed that she had said when she was asked about her complaints on direct examination that she copes with her pain through her prescription medications; this has been an issue in my life prior to the discogram, she agreed. Jennings agreed that shortly after her accident she was hospitalized at St. John's Hospital in a psychiatric ward on 9-23-97 with a diagnosis at that time of major depressive disorder and an anxiety disorder. It was noted that the record indicated that she attributed her anxiety to relationship issues and job stress, and Jennings agreed.

Prior to September 16, 1997, Jennings agreed during cross examination, that she was treated for problems with her neck and low back and shoulders. To the best of my knowledge, she said, I had been to Dr. Bickmeyer on approximately four occasions for problems with tightness in my neck and shoulders. Concerning the occasions when her low back complaints became severe enough that the doctor thought it was appropriate for her to have a CT scan of her back, Jennings explained that what caused the onset of her low back pain at that point in time was that the casino opened and she was working with high heels ten plus hours a day. Jennings agreed that if the doctor's notes indicated that she had problems with pain in her legs and feet, she wouldn't have any reason to dispute that.

The claimant was asked during cross examination, when you saw Dr. Volarich the first time in May of 1998, to your recollection, did Dr. Volarich place any restrictions on her ability to engage in any physical activities. I don't recall, Jennings responded. After that exam, the claimant agreed, for short period of time she was on unemployment and subsequent to that she went to the North Shore Yacht Club Bar and Grill and worked there from April 24, 1998 through approximately September 4, 1998, or about a year. She agreed that she left there because she fractured her arm. This injury happened at home, the claimant stated, I was carrying a laundry basket down the steps, and the last three steps the cat ran in front of me and down I went. Up to the time of that fall no doctor that she'd been to had recommended that she undergo any discogram, the claimant agreed. Up to the time of that fall no doctor had recommended any surgery on my back, she agreed. After the North Shore Yacht Club job, I went to work at Wal-Mart as a cashier, Jennings agreed. At some point during my job at Wal-Mart I also started working for the St. Charles Princess, a dinner cruise ship that goes up and down the river, and worked there as a barmaid, she agreed. Jennings agreed that she had testified in her deposition that during the Summer of 2001 she worked approximately seventy hours a week, but further stated that she was not sure of that, she'd have to get her statements out. She stated that when she was working at Wal-Mart and St. Charles Princess she was never disciplined for failure or inability to perform any of her job duties. She was asked if her work at Wal-Mart or St. Charles Princess or the bar caused her pain complaints to change in any way. Somewhat, yes, she answered, it depended on how much I stood and worked. At some point in this time frame, when I was working for these places, I went to Dr. Heidi Prather for treatment, a doctor, to the best of my knowledge, I found on my own, Jennings said. The claimant was queried, if Dr. Prather's notes indicated that her work at Wal-Mart would cause a progression of her pain throughout the day; would that be consistent with her recollection. Yes, Jennings answered. She agreed that at some point there was a progression of the pain to the point that she felt it was necessary to go see someone beyond Dr. Prather. The claimant was queried, so if Dr. Prather's notes of 2-5-01 indicated that she had had a recent exacerbation of her pain complaints and she had requested a referral to a surgeon, would that be consistent with what she recalled. The doctor suggested that since the injections didn't help after thirty injections, she could not give me no more, and that I needed an orthopedic surgeon, Jennings said. She agreed that that's when she found Dr. Gornet. Jennings stated that it was consistent with her recollection that, as reflected in Dr. Gornet's file and the doctor's deposition testimony, the doctor had an intake sheet he had had her fill out and the sheet contained a history that her condition had gotten much worse in the last year. She was asked if she knew what caused her condition to become much worse in that year preceding the time she went to see Dr. Gornet. It would be working and standing too long, doing activities, hobbies I liked doing, Jennings answered.

On cross examination by the Second Injury Fund, Jennings was asked to describe in more detail the job she performed at the St. Charles Casino. As a cocktail server, Jennings testified, I walked the floor of my sections, and then I would go out take their drinks orders, and make sure they were doing okay, if they needed anything, go back up to the bar, get their drink orders and deliver them back to them. I was not on my feet all day in my job at the St. Charles Casino, the claimant said, in an eight hour shift, I got an hour lunch and two fifteen minute breaks. There were no parts of my job that I would sit down to do, she said. She agreed that she wore high heels in her job at Station Casino, and stated that she got the most comfortable and they were about an inch high. The claimant agreed that she would have to carry drink trays, and stated that the weight of the trays depended on how many drinks were on there, a full tray would be about twenty drinks. Sometimes I would carry two trays, she said.

Jennings agreed, during cross examination by the Second Injury Fund, that when she was testifying earlier about the restrictions and problems she had at Wal-Mart, those restrictions and problems related to her September 16, 1997 injury. Before my fall at Station Casino I was not having radiating pain and numbness down into my legs, she said. It was noted that Jennings had testified earlier that now she can only sit for about fifteen minutes comfortably; she stated that that she did not recall having difficulty with sitting before her fall at Station Casino. Before my fall at Station Casino I did not have difficulty with driving distances or standing for periods of time, the claimant said. The claimant was queried as to her testimony that she had had problems sleeping prior to September 16, 1997, what caused this problem. I don't recall that, Jennings stated.

On redirect examination, the claimant stated that during break in the hearing she took another Vicodin, a pain reliever, because her back and legs were hurting. It was noted that Jennings had testified on cross-examination that she had had some

medication in the past that she took for headaches and neck and upper back pain. If I did not have that medication to take now for my back and legs, I would not good at all, she said, I've tried to limit myself, buy the pain's there every day. The back and leg pain is worse if I don't take it, the claimant stated. It was noted that she had indicated earlier that if she had known the outcome of the discogram she wouldn't have done it; Jennings was asked why back in March of 2002 was she willing to undergo that discogram. Because I was hurting real bad and I needed to know what the problem was, I needed to know what was going on, she answered. It was noted that Jennings had testified about having a fall at home where she had fractured her arm; she was asked if that fall at home worsen her back or leg pain in any way. No, Jennings answered. It was not that Jennings had stated that prior to the discogram she was working at Wal-Mart and the St. Charles Princess; she was asked if she had had any difficulty in performing her job at Wal-Mart before she had the discogram. Answering yes, Jennings stated that she had difficulty with sitting and more with standing. I had a doctor's excuse from standing to sitting, I have to alternate every half hour; I would get help from other employees or my customers to help me, you know, like getting the UPC numbers for me, and my co-workers would help me out, she said. Jennings explained that with the UPC number, they were on the product underneath it, and if someone brought like a five or ten pound bag of dog food, they knew me, the problems I had, and they would help get the UPC number and I would just type them in, and they would have to put it back in the basket, too. If I had lifted the product out of the basket, because of the pounds that it was and my back, I would have been out probably for the rest of the day due to back and leg complaints, Jennings said. She was asked if she had ever missed any time from work while working at Wal-Mart because of back or leg complaints. Yes, I did, Jennings answered, there close to the end, anywhere from two to three times a week, and then I'd have doctor excuses from, as I recall, Dr. Levin. I had problems due to back and leg complaints at the St. Charles Princess with stooping or in serving the drinks or something; my bosses would hop in and my co-workers, I had somebody always there to help me, they would make me go sit down, she said. I would need help quite a bit because of my lower back and leg pain, she said. I missed time from work at St. Charles Princess due to back or leg complaints, she said, not as much as Wal-Mart because I had good co-workers with other bartenders and my bosses would just hop in there. They were very good to me, they helped me out; they knew my situation, and they would not let me do anything that would harm my back worse than, you know, and legs worse than what they were. Jennings stated when she went to Dr. Prather on her own, during that time she did not recall was being offered any medical treatment by any other doctors. Jennings agreed that she did try at that time to get in and treat with Dr. Bernardi who was in with Dr. Gornet, but he did not take work comp.

**Medical records** in evidence included the following:

**A. Records from St. Joseph Health Center** (Claimant's Exhibit No. C) reflected various visits to the emergency room by Jennings during the period of 05/26/93 through 09/21/97. 1993 and early 1994 entries concerned complaints of chest pain and female problems (i.e. abdominal bloating).

The record contained a 05/16/94 record indicating that Jennings was being seen for complaints of - chronic back pain. The record indicated that Jennings was unemployed, and that Dr. Yanover was her doctor. A 05/16/94 report of a CT of the lumbar spine ordered by a Dr. Yanover; the diagnosis was - minimal leftward disc bulging at L4-L5.

Jennings was next seen on 09/13/96 for complaints of neck and shoulder pain; a CT scan performed on that date reported - loss of cervical lordosis and unerupted right maxillary molar. Jennings was seen on 08/06/97 with a request to have a pelvic exam to prove she had not had sex as her husband (who was with her) had accused her of having sex with someone else; exam was denied; it was written that Jennings left the emergency room. The next record of 08/23/97 concerned treatment for an eye injury after Jennings was assaulted and hit in the eye with a fist; an x-ray of the orbit was reported as - negative for fracture; the record included an "Emergency Department Restraint Order/Flow Sheet" indicating that Jennings was in custody with the Sheriff's department and in handcuffs.

Jennings was next seen on 09/21/97 for complaints of severe back pain and abdominal bloating; the record reflected that Demerol and Vistaril was administered via the right hip. A 09/21/97 x-ray report stated a diagnosis of - negative lumbar spine, there is no change from 05/94. The diagnosis was: lumbosacral strain with muscle spasm.

**B. Records from Barnes-Jewish St. Peters Hospital** (Claimant's Exhibit No. E) reflected treatment of Jennings at various times in the 1990's. Initial records were of thoracic, pelvis and lumbar spine x-rays taken on 12/17/92 for the history of soreness and pain. The thoracic spine findings were - negative; the pelvis findings were - post traumatic change, left hemi-pelvis which appears well healed; and the lumbar spine findings were - mild levoscoliosis.

An 8/05/97 record reflected that claimant was seen for lower abdominal pain. It was noted that Jennings had chronic abdominal problems, and had had seven prior surgeries.

The next and last record indicated a 9/23/97 visit by Jennings for complaints of pain in the left lower back and left buttock; it was noted that Jennings had fallen six days earlier at work. Also noted were complaints of stress, and that Jennings reported having been in an abusive relationship. The diagnosis was: lumbar strain/sprain, and anxiety secondary to stress.

**C. A record from Barnes Care West** (Claimant's Exhibit No. D) concerned the treatment of Jennings on 9/26/97. The injury was noted as the following:

The patient report she fell on concrete in the parking lot on 9-9-97 in the morning. The patient reports that she landed on her left hip and outstretched hand. The patient worked that day, after falling in the morning, but now complains of pain all over her body. The patient is the fetal position on the exam table crying and moaning. She reports the pain is traveling all over her body, from her hips, to both legs, to her feet, to her hands, to her shoulders. The patient has been to five doctors since the fall. The patient reports she has been to the St. Joseph's emergency room, has been to her

private medical doctor, Dr. Milton Levin and is currently on Soma, Indomethacin, Valium and Fioricet. (sic)

In the description of treatment section, written was - "The patient needs evaluation for psychiatric problems". It was noted that Jennings was being transferred to St. John's Emergency room for further evaluation, and that the company was providing a security guard to take the patient. Further written on the second page of the record was that Jennings admitted to being in an abusive relationship and reported that he boyfriend gave her her black eye that she currently had. The assessment on 9/26/97 was: "Psychiatric problems. This is not a work related condition."

A **St. John's Mercy Medical Center** record (Claimant's Exhibit No. F) included a 9/23/97 entry which reflected that Jennings had been sent from Barnes St. Peters with a suspicion of a psychiatric problem, but Jennings reported upon arrival at St. John's she had suffered a fall 2 weeks ago and had complaints of left hip and left upper quadrant pain. The record reflected that Jennings was discharged on 9/25/97 with a principal diagnosis of - pyelonephritis and secondary diagnoses that included - anxiety state, and orthopedic aftercare.

**D. Records from Dr. Heidi Prather, D.O.** of Orthopedic Surgery at Washington University Medical Center (Claimant's Exhibit No. H) indicated that Jennings was seen for the first time on March 23, 2000 for complaints of low back pain and bilateral lower extremity symptoms. The history of present illness was noted as:

The patient is a 41-year-old female who presents today for management of a chronic problem. She fell at work at a casino in St. Charles in September 1997. She apparently was treated for discogenic pain and mild radiculopathy thought to be related to a bulging disc at L4-5 and L5-S1. I have some notes from a physician and an independent medical exam at that time, which diagnosed her with this. I do not have the actual pictures or reports of the imaging in front of me today. She had a long working diagnosis at that time which had included left-sided disc bulge at L4-5, a history of a previous pelvic fracture in 1991, history of physical abuse and reactive depression and a history of multiple groin surgeries. She is here today because she has had continued pain. She has had physical therapy a year ago. She is not sure of anything medicine-wise that has helped with her pain. She has had no recent imaging or diagnostic workup since 1998. Pain is worse with standing or sitting.

Noted was that Jennings reported no prior medical history. Also noted was that Jennings worked full time as a cashier at Wal-Mart. Dr. Prather's diagnosis was: right SI joint dysfunction; history of multilevel bulging disc, cannot rule out continued discogenic pain; probable myofascial component; and history of anxiety, depression. The plan was for an MRI of the lumbar spine, and medications for pain and sleep dysfunction were prescribed.

In an April 13, 2000 examination report, Dr. Prather wrote that she had reviewed a recent MRI of the lumbar spine which was normal. Dr. Prather's diagnosis after examination was: axial low back pain, flexion-based. The treatment plan was to start physical therapy and a refill of Darvocet.

In the next entry of June 29, 2000, Dr. Prather wrote that she had been following Jennings for SI joint dysfunction and a history of discogenic pain thought to be related to a bulging disc. She has continued working with the physical therapy and has moderate exacerbations of her pain intermittently, the doctor wrote, she reports that she had to miss work one time the last week because of increasing pain. She reports pain going into her lower extremities with occasional numbness and tingling but no give-away weakness, the doctor wrote. Physical exam findings on 6/29/00 were:

In general, an alert pleasant female in no acute distress. She demonstrates the pain with forward flexion. None with extension. She has pain with slump-sit but I am not able to reproduce lower extremity pain. Muscle stretch reflexes remain 1+ and symmetric for patella, medial hamstring and Achilles. Strength testing is intact for lower extremities test.

The diagnosis was: flexion based axial low back pain to rule-out radicular component. The doctor recommended an EMG nerve conduction study, noting that Jennings "truly has radiculitis within the setting of a normal MRI".

The last document in the record was a July 11, 2000 EMG/Nerve Conduction Study report reflecting that Dr. Prather had done the study. Numerous findings were reported as normal, except - Abnormal spontaneous activity is noted in bilateral spinals and medial heads of the gastroc bilaterally and gluteus maximus on the right. The doctor's written diagnosis was: electrodiagnostic evidence of bilateral S1 radiculopathy. An injection was recommended.

**E. Records of Dr. Paul B. L'Ecuyer, M.D.** (Claimant's Exhibit No. P) concerned the treatment of Jennings for vertebral discitis/osteomyelitis. The doctor noted in the first entry of the record, dated June 19, 2002, that Jennings had undergone a discogram several months earlier to further define chronic back pain, and shortly after the discogram she developed acute worsening of her back pain and was subsequently hospitalized.

Streptococcus was found and Jennings was placed on antibiotics, the doctor wrote, and she reports a resolution of her fever. The treatment plan was to continue antibiotic and obtain laboratory studies. In a July 19, 2002 note, it was written that Jennings had completed six weeks of antibiotic therapy and had done extremely well. She notes that she currently has "0" pain at rest; she does have some pain with activity. Dr. L'Ecuyer recommended an MRI and follow up with himself and with Dr. Gornet. Subsequent treatment notes reflected Jennings' complaints of severe low back pain; Jennings was followed with continued antibiotic therapy and occasional MRIs and CT scans as well as laboratory studies. In a final treatment note of May 14, 2003, Dr. L'Ecuyer wrote that Jennings was doing about the same; she continues to have her usual back pain, limiting most of the activities that she likes to be

doing such as gardening or work around the house. She continues to have numbness in her anterior thighs, the doctor wrote. It was noted that there was no wound inflammation and Jennings had been off antibiotics for months now without any signs of recurrence. The doctor noted that a CT scan of the spine revealed no significant lucency around the hardware to suggest infection, and there was possibly some increase in fusion but still not completely fused. "At this point", Dr. L'Ecuyer wrote, "no further followup necessary here; no role for antibiotic". The doctor wrote that Jennings would follow with Dr. Gornet.

**F. Records from Barnes West Medical Consultants** (Claimant's Exhibit No. Q) concerned the home care services of home infusion for Jennings from June 28, 2002 through November 5, 2002.

**G. Records of Dr. Matthew Gornet, M.D.** (Claimant's Exhibit No. M) the initial note of 8/5/02 reflected that the doctor had been contacted by the neuroradiologist who felt that the MRI scan indicated that possibly Jennings' infection had gotten worse. In an 8/8/02 follow up entry it was noted that a procedure had been performed on 6/3/02 of an open biopsy and discectomy L4-5 for the diagnosis of – disc space infection, status post discography. New erosions were subsequently noted and Jennings was admitted to Barnes-Jewish Hospital on 09/04/02, and Dr. Gornet performed the procedure of: Posterior fixation L4 to S1 with Sexton instrumentation. The pre- and post-operative diagnosis was the same: Discitis L4-5 and L5-S1 with bony erosions. Jennings was seen post-surgically through January 9, 2003, at which time Dr. Gornet wrote the following:

At this point, she continues to have pain in her back and legs. Her CT-Scan shows good early bone consolidation. I am confident that she is finally healing this process. I have given her a prescription for Neurontin and refilled her Vioxx and Ultram prescriptions. I have asked her to begin ambulating on her own. Again, our plan is to have her return to her sedentary position in approximately two months. I would like to repeat her scan in two months also.

Records from **Barnes-Jewish West County Hospital** (Claimant's Exhibit No. S) included hospital records of Jennings for 5/8/02 – 5/11/02 for the diagnosis of diskitis; it was noted that Jennings had been evaluated about 2 ½ weeks earlier with diskography. The remainder of the record consisted mainly of radiographic studies over time. The May 2002 hospital record noted that a CT scan revealed some mild erosion in the lumbar spine. Radiographic studies in 2003 concerned review of post status anterior and posterior spinal fusion.

**H. Additional records from Dr. Gornet** (Claimant's Exhibit No. N) concerned continued follow-up from the June and September 2002 procedures. In an entry entitled "Phone conversation 3-3-03", it was written by the doctor that a Barnes-Jewish Hospital emergency room doctor had called to discuss that Jennings had been seen that day for severe low back pain. It was written that after a discussion with Dr. Gornet, Jennings would be dispensed 20 Darvocet to be used minimally and otherwise she was to take over-the-counter medication. Further written was: "She is requesting narcotic medication and states that she cannot manage her symptoms without it. As Dr. Gornet requested, Darvocet will be issued and nothing else."

In a 3-13-03 treatment note, it was written that Jennings had reported a flare-up of pain several weeks ago and for obvious reason had some concern. It was noted that a CT scan showed some good bone consolidation; and noted by the doctor was that he saw no evidence of any structural related problem that could be causing new onset of pain. Physical therapy and rehab was to be started, the doctor wrote, as it was felt Jennings had adequately healed six months post surgery. The doctor wrote: "She may never be able to return to full duty activity, but obviously, in two months time, my plan, after rehab would be to release her to sedentary activity. I would probably not place her at MMI until one year."

The last treatment note in the record was a 9-11-03 entry in which it was written that Jennings continued with bilateral leg pain. The record indicated that a final CT scan had been performed prior to this visit; it was written that the fusion was solid, there was no evidence of infection or other problems, and that her hardware appeared to be in excellent position. "She does have some bilateral increasing sclerosis and air in the SI joints and this may account for some of her leg pain", the doctor wrote. Further written was:

At this point, she understands that I have placed her at maximum medical improvement and I have stated that I would recommend against any further treatment, including pain management. We talked about anti-inflammatories. I can follow up with her finally in one year's time for her standard two year follow up.

**I. Records from St. Joseph Hospital West** emergency room (Claimant's Exhibit No. T) consisted of treatment of Jennings on two occasions. On December 17, 2003 Jennings presented with complaints of low back pain and radiating pain to the right leg. The history of injury from Jennings was onset of symptoms 2 years earlier. Exam findings on December 17, 2003 included: back - paraspinal tenderness in the lower back, and otherwise normal; the neuro exam was noted as – motor exam normal, sensory exam normal. The diagnosis was – chronic lower back pain. The record reflected that medication was prescribed for Jennings, and included - Anaprox, Flexeril, and Percocet. It was written that Jennings was instructed to follow up with her family physician, Dr. Rasheed.

A January 8, 2004 emergency room record reflected that Jennings' complaints was lower and middle back pain and radiating pain to the left leg. The history of injury from Jennings was noted as: fall; onset was 1997 fell at work; lower back pain since despite surgery in 2002. It was noted that this was Jennings' second visit for this complaint. Exam findings on January 8, 2004 included: back - tenderness mid lumbar area, and otherwise normal; the neuro exam was noted as – motor exam normal, sensory exam normal. The diagnosis was – Acute and chronic lower back pain. The record reflected that medication was prescribed for Jennings, and included - Anaprox, Flexeril, and Vicodin. It was written that Jennings was instructed to follow up with her family

physician, Dr. Rasheed, and that Jennings might need pain clinic referral.

**J. Records from Dr. Nasir Rasheed** (Claimant's Exhibit No. O) began with a page reflected prescriptions of medications Fioricet and Estroproipate for Jennings on 02/27/03. The first treatment entry, a 10/13/03 note, reflected that Jennings was being seen for complaints of back pain status post surgery; the note reflected that medication was prescribed. An 11/03/03 x-ray report of the cervical spine stated findings of: degenerative changes at C5-6 and to a lesser degree at C4-5. An 11/10/03 note indicated Jennings' complaints of cervical pain, fever, runny nose, degenerative disc disease and headache; medication of 2 refills of Fioricet, Flexeril and Darvocet was prescribed. Jennings was seen on 01/20/04 and had complaints of – legs hurt, numb, and are weak. A separate sheet reflecting the treatment date of 01/0/04 included a note to get Dr. Gornet's notes. A report of a CT scan of the brain performed on 01/28/04 stated an impression of: unremarkable contrast/noncontrast of the brain. A last treatment note of 02/19/04 was in the record and reflected that Jennings had complaints of back pain that radiated to the leg; the written impression was: lumbar radiculopathy. The same medication was again prescribed for two refills with the addition of Percocet; it was written that Jennings would be referred to pain management.

The record included laboratory studies ordered by Dr. Rasheed for blood, liver, and cholesterol performed, respectively in, October 2003, November 2003 and February 2004.

Additional records of **Dr. Rasheed** (Claimant's Exhibit No. X) reflected treatment of Jennings in April – June 2004 for back pain and lumbar radiculopathy, headaches and for anxiety, depression and insomnia. Medications refilled for Jennings included Valium and Fioricet

**Prior medical records** pertaining exclusively to treatment prior to September 16, 1997 in evidence included the following:

**1. Records from Lucy Lee Healthcare System** (Claimant's Exhibit No. I) reflected treatment and hospitalizations in the late 1980's through the early 1990's for various female problems. A December 1991 record indicated that Jennings was hospitalized for about a week for fracture of the left superior pubic ramus as a result of a motor vehicle accident in which she was a passenger and the vehicle turned over. The record included x-ray studies of the right ankle, cervical spine and lumbar spine, however these studies were reported as normal or, in the case of the lumbar spine, no acute osseous trauma.

A 6/9/91 record reflected that Jennings was seen for complaints of headache for 5 days, dizziness, legs numb, back pain and neck pain. The diagnosis was – tension cephalgia. Medications prescribed included – Valium and Fioricet.

In a 9/14/92 record, the admitting diagnoses for Jennings included – severe pelvic pain/recurrent pelvic endometriosis and anxiety neurosis; the record reflected that Jennings was admitted to the hospital for a total abdominal hysterectomy.. It was noted that Jennings reported she had gone through a divorce. A 9/17/92 consultation report included the therapist's diagnosis of – Polysubstance dependence.

**2. The record of Dr. Levin** (Claimant's Exhibit No. G) was largely illegible, but reflected treatment of Jennings from 10/25/93 through 3/19/98. Initial entries indicated treatment for sinusitis and bladder problems. A 12/15/93 entry first reflected the treatment, including medication, for problems of nervousness and depression; these problems continued to be reflected in the next approximate fifty-six entries (most of which indicated refills of medications) up to April of 1995; the record appeared to reflect a prescription for Valium for the first time in a 4/27/95 entry. The record reflected treatment of Jennings, either by a visit or a refill of medication approximately 2 – 5 times a month through 8/14/97; the last of these entries reflected the following – 5/30/97, fioricet and valium refills; 6/11/90 valium, fioricet, and extendryl refills; 7/11/97 Darvocet refill and Macrochantin prescription; 7/14/97 valium and fioricet refills; 8/5/97 valium, fioricet and extendryl refills.

The next entry was date 9/17/97 and indicated that Jennings had had an injury on 9/16/97 due to a slip and fall; the entry indicated injury to the lumbar spine; medication was prescribed, including Indocin, Fioricet and Valium. The record indicated that Jennings was treated two more times in September 1997, six times in November 1997, twice in December 1997, and five more times through early March of 1998 for complaints of neck, back, left hip and leg pain. The last entry of March 19, 1998 reflected only refills of medications – Premarin, Valium and Fioricet.

**3. Records of Dr. Edward C. Bickmeyer, D.C.** (Claimant's Exhibit No. J) included treatment entries for Jennings from July 11, 1995 through July 13, 1995 for complaints of neck pain, left and right shoulder pain and frequent headaches due to overexertion. The July 1995 record reflected that the onset of these problems was: 1 to 2 years. It was noted that Jennings was currently on Fioricet and Valium. Objective findings were: tenderness in the cervical/thoracic spine. X-ray findings were noted to be straightening of the cervical spine. The diagnosis was: cervicocranial syndrome, cervical subluxation, and headache. Treatment consisted of spinal adjustment, electromuscle stimulation and cryotherapy.

The record included a Service Description form which indicated that after 7/13/95, Jennings was treated on 12/15/97 with electric muscle stimulation in one area, the cervical spine.

**Dr. Matthew F. Gornet, M.D.**, board certified orthopedic surgeon, testified by deposition on behalf of the claimant on October 4, 2001 (Claimant's Exhibit No. A) The doctor stated that he saw Jennings for the first time on June 28, 2001 for complaints of low back pain which radiated into both buttocks and pain and tingling down both legs which began after an incident at work on September 16, 1997. Concerning prior problems of low back pain, the doctor said, Jennings reported a rare history of low back pain treated by a chiropractor, but nothing significant, and no significant low back pain six months prior to the accident, and also some prior intermittent neck, shoulder and upper back pain. In discussing his review of medical records, Dr. Gornet noted that

“(T)he record’s long and illustrious’, but basically reflected “conservative measures”. (Gornet Dp. pg. 7) Discussing his findings after examination of Jennings, Dr. Gornet testified: “I think her general description of where her pain is....fairly classic of discogenic back pain”. (Gornet Dp. pg. 10) The doctor noted other pertinent findings: normal neurological exam from a strength standpoint; a slight decrease in ankle reflexes; sensation was normal; and some mild increased low back pain with straight leg raise, but not super significant. I reviewed radiographs obtained in my office as well as MRI scans from 10/24/00 and 4/5/00, the doctor stated, and “(I)n my opinion, both of them revealed a slight disc protrusion at L5-S1 and to a lesser extent at L4-L5”. (Gornet Dp. pg. 10) Dr. Gornet testified as to his diagnosis and opinions:

“My working diagnosis at this point, again given her history, her complaints and her MRI findings, was discogenic low back pain, again consistent with the diagnosis of an annular tear.

And at that point, I felt that those were similar conclusions to what Dr. Prather drew, and I think her options at this point are to essentially live with those symptoms or undergo further evaluation at this point. I don’t have a determination of treatment because I think she has to be evaluated further.” (Gornet Dp. pg. 13)

Discussing his recommendations, Dr. Gornet stated that he would first repeat an MRI scan , and second, obtain a CT discogram to see if there was a tear in a disc. “But of – more important, again beyond just the tear itself, is that that particular tear causes her back pain”, the doctor added. (Gornet Dp. pg. 14) Depending on the results of the discography and if her symptoms are disabling to her the current options are either IDET (an electric coil that is heated and seals the tear in the disc) or potentially an anterior interbody fusion. Concerning the IDET, Dr. Gornet stated: “The problem is is that at this point I think the results on that are not necessarily completed to the point that I have good degree of satisfaction with that.” (Gornet Dp. pg. 15) **(Ruling:** Employer/Insurer’s objections on grounds of Seven Day Rule is overruled. See, generally, *Sprung v. Interior Const. Service*, 752 S.W.2d 354, 358 (Mo.App. E.D. 1988). Gornet Dp. pp. 13, 14, 15)

Dr. Gornet was asked his as to whether Jennings’ problems with her back were substantially caused by her fall at work on September 16, 1997. The doctor answered:

“I base that on several things, the fact that she had no significant spinal abnormalities prior to this. She had a classic sort of twisting injury with a fall, which causes a shear on the disc. She had symptoms, which are again fairly classic of low back pain and bilateral buttock, bilateral leg pain. She has an MRI scan that is consistent with that. She has electrodiagnostic studies, which are consistent again the potential lesion at L5-S1, although as I stated earlier, that wouldn’t necessarily need to be.” (Gornet Dp. pp. 19-20)

Dr. Gornet stated that in his opinion, the treatment Jennings had received to date (of his October 4, 2001 deposition) had been reasonable and necessary to cure and relieve her condition. **(Ruling:** Employer/Insurer’s objections on grounds of Seven Day Rule is overruled. See, generally, *Sprung v. Interior Const. Service*, 752 S.W.2d 354, 358 (Mo.App. E.D. 1988). Gornet Dp. pg. 23) “I believe she is capable of working in a sedentary position”, the doctor said. (Gornet Dp. pg. 24)

On cross examination by the employer/insurer, Dr. Gornet agreed that at the time he saw Jennings she was employed at Wal-Mart, but stated that he did not now for how long. The doctor admitted that he did not know Jennings’ position at Wal-Mart, and did not know if the position required her to lift, bend or stoop on a repetitive basis. The doctor testified:

“Well, discogenic pain itself would not necessarily – as far as the causal incident would not be caused by that unless there was a trauma so to speak. Obviously repetitive bending and lifting can exacerbate those symptoms and make them worse, so I think there’s sort of two different issues there.” (Gornet Dp. pg. 31)

The doctor admitted that since he had no knowledge as to how long she worked there or her duties, he would not be able to rule out Jennings’ work at Wal-Mart exacerbating her pain. Dr. Gornet agreed that Jennings had indicated in his office Health Questionnaire form that her health condition had gotten worse in the last year. The doctor admitted that he made no inquiry to Jennings as to what had happened in that past year to make her much worse.

Dr. Gornet agreed, during cross examination, that symptomatology plays a roll in the determination as to whether or not surgery was appropriate for a person. When further queried, so it would be correct if a person is engaged in activities which increase their symptoms those activities would be a substantial factor in the determination of whether they actually need a procedure? Dr. Gornet answered:

“I don’t – my understanding was whether the event that occurred was a substantial factor in causing their – a requirement for further treatment. If she didn’t have that annular tear and she was working at Wal-Mart and doing repetitive bending, then my belief would be that she wouldn’t have significant symptoms. So in my opinion, it goes back to the initial injury.” (Gornet Dp. pg. 37)

Agreeing that it was his opinion, if Jennings was working as a secretary sitting she might not have symptoms even presuming she had an annular tear, Dr. Gornet further testified: “She may not have symptoms that are significant enough for her to seek further medical treatment, that’ correct.” (Gornet Dp. pg. 37) Dr. Gornet agreed, that in that regard, Wal-Mart does play a role.

During cross examination, Dr. Gornet agreed that his examination was four years after the work related incident, and his findings included that: Jennings was not in any acute distress when he saw her; that she had good range of motion with no complaint of radiation into the buttocks or legs on forward flexion, her pain complaint was essentially the same when she would bend which was low back to both buttocks and down both legs; she had no atrophy or weakness in the lower extremities; deep tendon reflexes were symmetrical at the knees and the ankles, sensation was normal in all dermatomes of the lower extremities; she did not have significant SI joint pain; straight leg testing was not productive for back pain or leg pain to about 60 degrees bilaterally; her gait was normal. The doctor noted that the only pertinent finding on exam of Jennings was “a slight decrease in her ankles, which may go with this subtle S1 radiculopathy. Again the significance of that with discogenic low back pain is not necessarily clear.” (Gornet Dp. pg. 39) When queried that wasn’t it correct that he was not able to find objectively the areas of paresthesia that Jennings had described to him, Dr. Gornet answered:

“It’s not a dermatomal pattern, again as I stated earlier in my testimony. Because there is irritation of the whole cauda equina itself as it passes over this disc lesion, it becomes a nonspecific. And that’s one of the things that determines that and makes it fairly classic for discogenic pain.” (Gornet Dp. pp. 39-40)

Dr. Gornet agreed that Jennings had indicated to him on her pain chart that she had stocking numbness and paresthesia from her hips all the way down to the toes. When queried if he had found objective evidence of this on his physical exam, Dr. Gornet responded: “That’s correct. In other words, she does not have persistent numbness. So when I touch her or pinprick her, I wouldn’t say that’s decreased over other areas of the skin.” (Gornet Dp. pg. 40) The doctor was asked if he would characterize Jennings’ as a normal neurological exam. “I would say that she has no focal deficit”, Dr. Gornet answered. (Gornet Dp. pg. 42) Explaining that an annular tear is disc pathology, Dr. Gornet testified:

“Well, again, she does probably have a slight disc herniation. In fact, if you – for instance, even the MRI report you just handed me says, causing slight compression of her thecal sac. Again I don’t feel that compression is her pathology. I believe that slight herniation or disc protrusion or however you want to term it is a sign of underlying annular pathology meaning a tear.” (Gornet Dp. pp. 44-45)

The doctor further stated: “I do not believe that her current symptoms are due to compression of her cauda equina or her nerves. I do not believe that she has significant compression, that’s correct.” (Gornet Dp. pg. 44)

Dr. Gornet agreed, during cross examination, that his only recommendation he noted in his June 28, 2001 report was a CT discogram; the doctor agreed that he had not prescribed any medications at that time, and that he had indicated Jennings could continue to work doing what she was doing. The doctor agreed that the discogram in and of itself would not provide him with an indication of when, where or how the tear occurred. Dr. Gornet indicated that he was aware Jennings had been in an abusive relationship for seven years prior to the September 1997 incident; the doctor stated that he did not make any inquiry as to the nature of the abuse Jennings had been through; the doctor admitted that abuse could cause an annular tear.

During cross examination, Dr. Gornet admitted that he was not aware Jennings had had CT scans of the lumbar spine prior to the September 1997 work related injury, and didn’t have the opportunity to review these films or the radiologist’s reports. The doctor admitted there was no history in his June 28, 2001 report of a 1994 diagnosis of a L4-5 disc bulge and chronic low back pain, or a May 9, 1996 admission with complaints of pain in the legs and feet bilaterally, or being seen by a physician on July 11, 1995 for complaints of low back pain. Dr. Gornet pointed out that he had asked Jennings at the June 28, 2001 exam if she had had any significant problems within the last six months. The doctor was asked if he had seen where Jennings had received any treatment from 1998 up until she saw Dr. Prather in March of 2000, and Dr. Gornet answered: “Again, it sounds like that she had been seeking treatment for along time and no one had offered anything more to her. So I don’t see that there was significant treatment in there”. (Gornet Dp. pg. 65) The doctor admitted, though, that he had not seen any treatment during this period.

On redirect, Dr. Gornet was referred to his record and a CT report of May 16, 1994 with findings of minimal leftward bulging of the L4-L5 laterally and no discrete herniation. Dr. Gornet stated that these findings did not change his opinion in any way that he September 1997 work related injury was the substantial cause of Jennings’ current symptoms. Explaining his opinion, the doctor stated that this was because the study indicated the L5-S1 space was unremarkable at that time, and “so would give further information to state that that’s a potentially new lesion after this particular date and time. Again we can’t say when, but after 5/16/94”. And further stated that he did not feel Jennings had a leftward disc bulging at L4-5 at the time he reviewed both of her MRI scan, so “again I would say that this pathology has no relevance on what her current scans are and her current complaints”. (Gornet Dp. pg. 69) Dr. Gornet agreed that medical records concerning Jennings’ abuse, a September 23, 1997 x-ray showed old healed fractures which indicated they were not fresh fractures at the time of the September 1997 work related accident.

**Dr. David T. Volarich, D.O.** board certified in nuclear medicine and as an independent medical examiner, testified on July 16, 1998 on behalf of the claimant, after evaluation of the claimant at the claimant’s request on May 15, 1998. The doctor discussed the history relayed to him by Jennings of the September 16, 1997 work related injury and subsequent treatment, prior injuries and treatment; the doctor noted – “Ms. Jennings reports that leading up to 9/16/97 she recalls no ongoing difficulties with her low back. She never had radiating pain to the left leg and she was working under no restrictions.” (Volarich Dp. pg. 8) Dr. Volarich stated the

following in his discussion of Jennings' complaints on May 15, 1998:

"On the day I examined her, she continued to have ongoing difficulties because of pain in her back and left lower extremity. The pain severity depends on the level of activity. If she carried any heavy weight, she had pain. She currently works as a waitress and tries not to handle any weight greater than about 20 pounds because it will increase her back pain.

Any repetitive activities cause her pain to worsen as does remaining in a fixed position for more than about 30 minutes at a time. Her left leg still goes numb and she continues to experience occasional radiating pain down the posterior aspect of the left leg into the calf. This occurs particularly with heavy lifting if she sits too long.

Her pain is diminished with heat, seeing her family physician who will perform manipulation, and taking some medications. She feels best when she rests on her side. She denies loss of bowel or bladder control.

Miss Jennings is able to perform most activities of daily living to care for herself as long as she does so within reason. As far as home activities, her mother performs most chores now. She tells me she cannot work out in the yard. She pursues no leisure activities.

Weather changes continue to cause her an increase in low back discomfort on a variable basis. She tells me that when her back is flared up she has difficulty sleeping where she is awakened several times at night needing to reposition. She is able to drive without difficulty for about an hour." (Volarich Dp. pp. 10-11)

Dr. Volarich noted Jennings' occupational history and educational history. The doctor said that examination findings on May 15, 1998 included: female in no acute distress; on neurological exam, mental status and cranial exam were normal; motor exam revealed symmetric bulk and tone; strength in the lower extremities – the quadriceps and hamstring strength were strong bilaterally; calf strength was strong with toe walking but weak with heel walking on the left at plus 4 over 5; sensory exam was normal; extensor hallucis strength on the right was strong with plus 5 over 5, but weak on the left at plus 4 over 5; toes were down going; able to walk across exam room without foot drop, limp or ataxia; musculoskeletal exam – lumbar motion was restricted with 17 percent loss of flexion, 40 percent loss in both right and left side bending and 25 percent loss in both right and left rotation; palpation of the low back elicited complaint of pain at left sacroiliac joint and to a lesser degree the left sciatic notch; straight leg raising was accomplished to 70 degrees bilaterally without radicular pain. Medical records reviewed were listed by Dr. Volarich. The doctor discussed his diagnosis after evaluation of Jennings on May 15, 1998:

"Referable to the 9/16/97 accident, I had two diagnosis. The first was small disc herniations, L4-5 and L5-S1 to the left with left leg radiculopathy. The second was chronic back pain syndrome.

Had some diagnoses as well that were preexisting 9/16/97. First, bulging disc to the left at L4-5. Second, left pubic ramus fracture, well-healed." (Volarich Dp. pg. 15)

The doctor testified as to his opinion of whether or not the 9/16/97 work related accident was a substantial cause of any of his diagnoses:

"It's my opinion that the work accident of 9/16/97 when Miss Jennings tripped and fell on the walkway while entering the workplace at the Station Casino St. Charles is the substantial contributing factor to the small disc herniation at L4-5 and L-S1 from which she continued to experience difficulties." (Volarich Dp. pp. 15-16)

Dr. Volarich was asked his opinion of whether Jennings was in need of any further medical care as a result of the 9/16/97 accident:

"Based on the treatment she had up to that point, I thought she had reached maximum medical improvement, but I did make some additional treatment considerations. In order to maintain her current state, she will require ongoing intermittent treatment for her back pain syndrome with anti-inflammatory medications, muscle relaxants, pain pills, physical therapy, osteopathic manipulation, and other similar treatments for symptomatic relief. I did not feel surgery was indicated." (Volarich Dp. pg. 16)

The doctor was further queried if he had an opinion on whether or not Jennings needed the additional medical treatment recommended by Dr. Wayne, and Dr. Volarich answered: "I would agree with his suggestion of a trial epidural steroid injections to see if that would help her pain syndrome. If that failed, then I would recommend diagnostic testing in the form of a myelogram, postmyelogram CT." (Volarich Dp. pp. 16-17)

Dr. Volarich was asked and testified about his opinion of current disability he felt Jennings was suffering from as a result of the 9/16/97 accident and injury: "...it's my opinion that there's a 30 percent permanent partial disability of the body as a whole rated at the lumbosacral spine due to the tiny disc herniations at L4-5 and L5-S1." (Volarich Dp. pg. 17) The doctor stated that there was additional disability in the low back, and testified: "...there's a 12.5 percent permanent partial disability of the body as a whole rated at the lumbosacral spine due to the historic strain/sprain injuries and bulging disc at L4-5 to the left." (Volarich Dp. pp. 17-18) "I did not find disability from the pelvic fracture since she was asymptomatic", the doctor said. (Volarich Dp. pg. 18) Dr. Volarich further testified: "The combination of her impairment does create substantially greater disability than a simple total of each, and the loading factor should be added." (Volarich Dp. pg. 18)

Dr. Volarich discussed restrictions he had put on Jennings which were: avoid all repetitive bending, twisting, lifting, pushing, pulling, carrying to an as-needed basis; no handling of weights greater than 15 to 20 pounds and limit this to an occasional basis; avoid remaining in a fixed position for more than 30 minutes at a time; frequently move about and rest when needed.

On cross examination by the employer/insurer, Dr. Volarich admitted that he relied upon Dr. Wayne's 2/12/98 and 4/98 records in regards to CT scans and he did not have the opportunity to review the actual radiology report or CT scan. When queried wasn't it true that he had relied upon the report of Dr. Wayne with regard to his diagnosis of herniated disc at L4-5 and L5-S1, Dr. Volarich answered –"Yes". (Volarich Dp. pg. 23) The doctor was questioned about the 8/23/97 Barnes Jewish St. Peter's emergency room record which reflected that Jennings had been in an altercation and whether or not this type of physical activity could cause a herniated disc. "Well, if she did and was pushed down or really exerted herself, it's possible", the doctor answered. (Volarich Dp. pg. 30) Dr. Volarich admitted that he did not have the entire record from BarnesCare.

Dr. Volarich stated, during cross examination, that Jennings was not under any active medical treatment at the time of his May 15, 1998 evaluation of her. Concerning his knowledge of when Jennings was last under active medical treatment, Dr. Volarich testified: "I believe after she saw Dr. Wayne. That would have been April 1, 1998." (Volarich Dp. pg. 25)

The doctor was queried, during cross examination, when he noted that Jennings had a prior history in 1994 of having a flare-up of back discomfort was there a presumption that she did not have any radicular complaints at that point in time. Dr. Volarich answered: "No. Because a CT scan was ordered, and you don't order a CT scan unless you have radicular complaints in the history." (Volarich Dp. pg. 26)

**Dr. Volarich** testified by deposition on behalf of the claimant a second time on March 11, 2004, after evaluation of the claimant at the claimant's request on September 7, 1998 and November 26, 2003. The doctor agreed that he had also reviewed additional records.

Concerning the September 7, 1998 exam, Dr. Volarich agreed that the physical examination showed no change from the earlier examination. Stating that his diagnoses also stayed that same at that time, Dr. Volarich further testified: "Consistent with small disc herniations at L4-5 and L5-S1 to the left with I now said bilateral lower extremity radiculopathy but it was still left worse than right. It was always left-sided. She also had chronic back pain syndrome. My pre-existing diagnoses stayed the same." (sic) (Volarich 3/11/04 Dp. pg. 6)

Dr. Volarich discussed the clinical findings at the November 26, 2003, and testified as to his diagnoses:

"My diagnoses were disc protrusions L4-5 and L5-S1 causing left leg radiculopathy. That's been pretty much all along I've been using that diagnosis.

Second diagnosis was discitis which is infection of the disc and disc space at the L4-5 level post-diskogram and associated L4 and L5 osteomyelitis. Those are the vertebral bodies, L4 and L5, status-post L4-5 discectomy.

Next diagnosis was persistent back pain with instability status-post anterior and posterior lumbar fusions L4-5 and L5-S1 with instrumentation.

My final diagnosis was failed back syndrome." (Volarich 3/11/04 Dp. pg. 13)

The doctor explained his diagnoses:

"Again (discitis is) a bacterial infection of the disc itself. It's a very serious infection. It's one of the most difficult to treat because the disc is such a deep seated area in the body. Because it has very poor blood supply, it's difficult to provide appropriate antibiotic therapy to clear up the infection and almost always osteomyelitis occurs because you can't get control of the infection in the disc space. When that happens, basically you need to do an incision and drainage procedure which was basically the discectomy that was performed. And if that doesn't work or if there's continuing breakdown, then a fusion has to be performed.

"Osteomyelitis means bone infection. It's a bacterial infection in bone. It's again another very serious infection. It never goes away. You can get control of it, but there's always a component of infection in the bone that becomes chronic. At times it reoccurs, flares up, and causes another active form of infection. Again, a very serious infectious process.

"Failed back syndrome means that with all the intervention that was done and all of the attempts to improve her condition, she's no better and, in fact, she's worse. It's not to fault the surgeon or the people providing treatment. It's just she had an extremely poor outcome from all that was done." (Volarich 3/11/04 Dp. pp. 13-14)

Dr. Volarich was asked whether or not these diagnoses were substantially caused by the accident of September 16, 1997, and the doctor answered:

"It's my opinion the work accident that occurred 9/16/97 when Ms. Jennings tripped and fell on a walkway

while entering the workplace at Station Casino St. Charles is the substantial contributing factor causing the disc herniations and protrusions at L4-5 and L5-S1 that required extensive medical care.

As part of her diagnostic workup, she underwent a diskogram and post-diskogram developed discitis, which is a disc space infection, at the L4-5 level that progressed to osteomyelitis at L4 and L5. As a result of this complication, she required two separate surgical repairs culminating in anterior and posterior fusions at L4-5 and L5-S1.” (Volarich 3/11/04 Dp. pg. 15)

The doctor was asked his opinion of disability for Jennings from the 9/16/97 accident at the time of the November 26, 2003 exam:

“In my opinion, there’s a seventy-five percent permanent partial disability of the body as a whole rated at the lumbosacral spine due to the disc protrusions at L4-5 and L5-S1 causing lower extremity radiculopathy.

The rating accounts for the complication of discitis and osteomyelitis that developed as a result of her diagnostic workup all of which required two separate surgical repairs culminating in an L4-5 and L5-S1 fusion with instrumentation.

The rating accounts for her failed back syndrome which continues to cause significant low back pain, lost motion, and bilateral lower extremity radiculopathy. There’s some additional disability in the low back as well.” (Volarich 3/11/04 Dp. pp. 16-17)

Dr. Volarich continued his opinion of preexisting diagnoses prior to the September 16, 1997 accident for Jennings of “minor lumbar syndrome secondary to a disc bulge at L4-5 to the left” and “left pubic ramus fracture well-healed.” (Volarich 3/11/04 Dp. pg. 16) The doctor also had the same opinion of permanent partial disability as to these preexisting diagnoses of “...twelve point five percent permanent partial disability of the body as a whole rated at the lumbosacral spine due to the historic strain/sprain injuries and disc bulging at L4-5 to the left”, and “(D)isability referable to her pelvic fracture was not found since those symptoms resolved”. (Volarich 3/11/04 Dp. pg. 18)

The doctor was asked his opinion as to whether or not Jennings would be able to engage in any substantial gainful activity due to her various injuries:

“It’s my opinion that she was unable to engage in any substantial gainful activity, nor could she be expected to perform in an ongoing working capacity in the future.

It’s my opinion she could not be reasonably expected to perform on an ongoing basis eight hours a day, five days a week throughout the work year.

It was also my opinion that she was unable to continue in her line of employment that she last held as a cocktail server for the Station Casino St. Charles, nor could she be expected to work on a full-time basis in a similar job.” (Volarich 3/11/04 Dp. pp. 18-19)

Dr. Volarich was asked to testify as to his opinion of whether Jennings was permanently and totally disabled as a result of her injuries:

“I had some concerns about just saying that she was permanently and totally disabled based on just my medical assessment primarily because of her age. Because of that, I recommended she undergo a vocational assessment to determine how she might best return to the open labor market in the greater St. Louis Metropolitan area. I noted when I saw her in November of ’03 that she was forty-five years old, which is considered a younger individual, has an education that’s limited to graduation from high school, had worked only clerk and waitress type jobs over the majority of her work career, and had been unable to get back to work since about March 23 of ’02.

If that assessment was able to identify a job for which she was suited, I have no objection with her attempting to return to work based on the limitations at the end of my report. If, however, a vocational assessment was unable to identify a job for which she was suited, then it was my opinion that she was permanently and totally disabled as a result of the work-related injury of 9/16/97.

She obviously had some disability in the low back prior to 9/16/97 as a result of the disc bulge at L4-5 and minor recurrent symptomatology that required treatment, but the injury of 9/16/97 and its complications far outweigh the pre-existing lumbar disability.” (Volarich 3/11/04 Dp. pp. 19-20)

Dr. Volarich discussed the restrictions he had recommended for Jennings.

The doctor was asked his opinion as to whether Jennings would benefit from any future medical treatment attributable to the 9/16/97 accident:

“In general, I recommended that she’d require some ongoing care for her pain syndrome using modalities including, but not limited to, the narcotic and non-narcotic medications such as the non-steroidal anti-inflammatory drugs, muscle relaxants, physical therapy, and similar treatments as directed by current standard of medical practice for the symptomatic relief of her condition.

I also recommended that she be seen and evaluated at a pain clinic to help better control her pain syndrome. Epidural steroid injections, trigger point injections, foraminal blocks, nerve root blocks, TENS units, and possibly even a spinal cord stimulator would benefit her condition.” (Volarich 3/11/04 Dp. pg. 22)

Dr. Volarich was asked his opinion of whether or not Jennings was a candidate for surgery when he last saw her:

“When I saw her, I didn’t think that additional surgery was needed on that day. But I did make some notes that because of all the hardware that was placed in her low back, she could have a problem with that hardware, become reinfected as I talked about a little earlier, loosen or fail, and those pieces of hardware would need to be removed or replaced. The decision to perform any additional surgery on her back should be made in conjunction with her wishes, change in symptoms, and expert surgical opinion.” (Volarich 3/11/04 Dp. pp. 22-23)

On cross examination by the employer/insurer, Dr. Volarich stated that in his first report of 5/15/98 “as far as treatment considerations, that she would need something for her pain syndrome periodically and I listed those.....At that point, you know, because the studies that were done at that time did not demonstrate surgical pathology, I didn’t see an indication for recommending surgery at that time”. (Volarich 3/11/04 Dp. pg. 25) The doctor agreed that subsequent to that, the claimant through her attorney wrote him and asked him to elaborate on the treatment considerations and he had indicated it would be appropriate for her to get some epidural injections, and dependent upon how that went, then maybe consideration of a post-myelogram and CT scan. In my 1999 evaluation report, Dr. Volarich said, I felt the treatment should be about the same. The doctor further stated: “As far as additional diagnostic studies, I just mentioned treatment for pain, manipulation type things, physical therapy, but I didn’t recommend any additional scanning procedures, for example”. (Volarich 3/11/04 Dp. pg. 26) When queried, in your review of records of Drs Sedgwick, Wayne, Guy and Levin did any of these doctors recommend that Jennings undergo a diskogram, Dr. Volarich responded – “No. Nobody said that.” (Volarich 3/11/04 Dp. pg. 27) The doctor was asked if at either of his exams had he recommended Jennings to undergo a diskogram, and Dr. Volarich answered: “At that time, I wasn’t recommending diskograms”. (Volarich 3/11/04 Dp. pg. 27) Dr. Volarich agreed that at the time of his 5/15/98 and 9/7/99 exams, it was his opinion that as a result of he September 16, 1997 accident alone, Jennings had sustained disability to the low back of thirty percent of the body as a whole.

During cross examination, Dr. Volarich agreed that the history relayed to him by Jennings was that she had received no treatment from 5/1/98 through 3/23/2000. The doctor agreed that during the time period of 1999 and March of 2002, Jennings was employed for approximately a year and a half at the St. Charles Princess and at Wal-Mart. While employed at these two places, the doctor was queried, there was no indication that Jennings missed extensive time from work. “She didn’t report to me that she missed significant time”, the doctor responded. (Volarich 3/11/04 Dp. pg. 30)

Dr. Volarich stated, during cross examination, that he did not have an opportunity to view the films of the additional studies Dr. Gornet had done. “I just had the reports, Dr. Volarich stated. (Volarich 3/11/04 Dp. pg. 30) These reports indicated mild protrusions at L4-5 and L5-S1, so Dr. Gornet’s initial assessments were consistent with the diagnosis he had previously made, Dr. Volarich agreed. The doctor agreed that when Dr. Gornet initially saw Jennings there was nothing in Dr. Gornet’s record or report that would have changed his opinion in regards to disability. Dr. Gornet ultimately decided that it would be appropriate to perform a diskogram, Dr. Volarich agreed. Dr. Volarich stated that he did not review the films of the diskogram, just the reports, and testified to the findings of the diskogram:

“The diskogram showed a tear at L4-5. There was some extravasation of contrast at L5-S1 that was indicative of degenerative change, but there was no extravasation at that level. And he did not report any significant concordant pain that happened with the performance of the diskogram. That’s what you’re looking for is reproduction of the pain.” (Volarich 3/11/04 Dp. pg. 31)

Dr. Volarich agreed that with the diskogram results, Dr. Gornet did not recommend any surgical intervention. It was noted that up to this point, Jennings had been seen by Dr. Wayne, by himself on two occasions, by Dr. Sedgwick, Dr. Guy, Dr. Levin and Dr. Wagner; Dr. Volarich was asked if any of these physicians, including himself, had recommended the discogram that was performed by Dr. Gornet. “No”, Dr. Volarich answered. (Volarich 3/11/04 Dp. pg. 32) Dr. Volarich stated that the bacterial infection he had discussed, the discitis, came from the performance of the diskogram; the doctor agreed that by the time the infection was discovered the vertebrae had eroded, and this bone destruction was one of the sources of the instability in Jennings’ spine that ultimately led to the fusion. The doctor agreed that therefore: no diskogram, no discitis and no erosion of the bone, no fusion, and no increase in disability. Dr. Volarich agreed that it would be fair to say of the seventy-five percent permanent partial disability of the body he had assessed for Jennings subsequent to the September 16, 1997 event, he would break it out thirty percent due to that initial event and forty-five percent to the complications of the diskogram. The doctor was queried - so, it was not the fall on September 16, 1997 in and of itself that caused the infection or the instability. Dr. Volarich answered: “No. That’s correct. I think we’ve established that already. The fall, the problems with the disc protrusions as I’ve described, 4-5 and 5-1, and the symptoms associated, everything else now is the complications of the diagnostic study.” (Volarich 3/11/04 Dp. pg. 35) The doctor was queried wasn’t it true that as of 5/15/98 and 9/7/99 it was his opinion the September 1997 incident at work didn’t cause a need for a diskogram, and Dr. Volarich responded:

“At that point, I didn’t think anything was needed. Again, I didn’t see her at that the time. Dr. Gornet did again to see

what change in her symptoms had occurred. You know, that's one of the next steps in the diagnostic process. When a patient still has back pain radiating into the leg with an MRI, for example, that doesn't show an obvious frank herniation, the diskogram is a very specific test for that level." (Volarich 3/11/04 Dp. pg. 35)

Dr. Volarich agreed, during cross examination, that repetitive activities cause a deterioration in one's back. The doctor was asked if Jennings' work activities at St. Charles Princess for a year and half and Wal-Mart for three years affected her low back condition. Dr. Volarich answered:

"Well, I asked her that question specifically, if she had any new injuries or any new problems and she didn't report anything new. She said that everything was just slowly getting worse as time went by. She had no new injuries. She denied new injuries in fact." (Volarich 3/11/04 Dp. pg. 36)

Dr. Volarich was queried if it was correct that he did not have a copy of the self-reporting health questionnaire that Jennings filled out at the time she was first seen by Dr. Gornet. "I do not", Dr. Volarich answered. (Volarich 3/11/04 Dp. pg. 44)

The doctor was asked, during cross examination, why he had put restrictions on Jennings the first time he saw her, and Dr. Volarich responded – "To attempt to prevent further injury". (Volarich 3/11/04 Dp. pg. 36) The doctor said that he did not know if Jennings had operated outside of his recommended restrictions at either St. Charles Princess or Wal-Mart as he did not ask her that question directly. "I think she probably worked within the weight limit, but she may have been upright more than thirty minutes at a time", the doctor said. (Volarich 3/11/04 Dp. pg. 37) The doctor said that he did not know if Jennings had engaged in repetitive bending, twisting, lifting, pushing, pulling carrying, etc. at either St. Charles Princess or Wal-Mart. Dr. Volarich agreed that repetitive activities over time can produce disability. Dr. Volarich agreed that, according to Dr. Gornet's records, the history was that Jennings worsened between the time he had seen her in 1999 and the time she went to Dr. Gornet. Dr. Volarich stated that he disagreed with Dr. Gornet who had stated on September 11, 2003 Jennings was not in need of any pain management. "I think she needs some pain management", Dr. Volarich said. (Volarich 3/11/04 Dp. pg. 38)

On redirect, Dr. Volarich explained why he felt Jennings needed pain management, testifying:

"Because of the ongoing problems she has. She has a severe injury to the back. She's got a fusion. And because of instability and bone destruction. She's got severe losses in motion. She still has radicular pain. She's taking several medications to control those symptoms. She's on Darvon which is a narcotic. She's on Diazepam which is Valium, the best muscle relaxant. She's on another muscle relaxant as well, Flexeril. She's taking Fioricet which is also used for pain and at times for headaches. So she still needs pain management." (Volarich 3/11/04 Dp. pg. 39)

The doctor was asked his opinion as to whether the work Jennings had performed at St. Charles Princess or Wal-Mart caused or aggravated her condition. Dr. Volarich answered: "I don't think it did. It's my opinion that it did not cause any new problems." (Volarich 3/11/04 Dp. pg. 39) Dr. Volarich then gave the following testimony:

Q. You indicated earlier on that in 1999 she was beginning to have problems in her right leg as well: correct?

A. Yes.

Q. What is the significance of that in the overall picture here

A. Well, again I think it shows that there's still ongoing difficulties from the original accident. Some progression of symptoms, more pressure on the L4-5 nerve root, and more centrally now rather than just being localized to the left side.

Q. And what would cause that problem in the right leg to develop?

A. Just life's activities I think could make it progress to some degree. I think it's just some ongoing progression of the original process, the original injury with two different disc levels being involved. (Volarich 3/11/04 Dp. pg. 40)

The doctor was asked to explain his testimony at the first deposition – that Jennings was as good as she was going to get based upon the treatment she had received to date:

"I mean based on everything that had been done up to the point that I saw her the second time in 1999, which was the MRI scans, the pain management that she had had with Dr. Guy, everything conservative that had been done to that point which was basically conservative treatment for her discogenic pain, you know, she was as good as she was going to get. There's nothing more to really do. I wouldn't have made a recommendation that she get a pain stimulator, for example, because there was not that kind of a problem with her back or her legs at that time. I wouldn't recommend that she be on narcotic medications at that time because she didn't have the severity of the pain.

So again, from what had been done from day one of the accident up to the time that I saw her in '99, it was all appropriate treatment. It was all reasonable treatment. It was all attempts to improve her symptoms. And she had more or less plateaued." (Volarich 3/11/04 Dp. pp. 41-42)

**Dr. John R. Wagner, M.D.** a board certified orthopedic surgeon, testified by deposition on behalf of the employer/insurer

on October 26, 2001 (Employer/Insurer's Exhibit No. 1). The doctor stated that he first saw Jennings on March 19, 2001. Jennings' relayed history was discussed by the doctor, including her September 16, 1997 work related injury and the subsequent treatment including injections in the lumbar spine, the second of which didn't help. Jennings stated that she has good days of light pain in the low back area near the sacrum, and bad days where there is pain like a knife stab and it shoots down both entire legs. The claimant's past history of medication and abdominal area problems were discussed. It was noted that Jennings relayed she was currently working as a cashier at Wal-Mart and also worked the floor, and been doing this for a year and a half; Jennings relayed that when she tries to sit or stand for an hour, she has back pain, the doctor noted. Physical exam findings on March 19, 2001 were discussed; Dr. Wagner stated that that he took x-rays on that date and reviewed the actual films, and discussed the results. The doctor noted that he reviewed medical records and films of prior radiographic studies. Dr. Wagner was asked to testify to the medical significance of the information and findings of his evaluation:

"Well, her examination is excellent. She has normal motion. She has excellent muscle relaxation. She has a normal neurological exam. Tugging on the nerves was straight leg raising and the knee flip test, so she has a normal examination and all of the films that I reviewed, except for that first film which showed a slight concave, are absolutely normal including her MRI." (Wagner 10/26/01 Dp. pp. 14-15)

Dr. Wagner testified that based on his March 19, 2001 evaluation, Jennings was "capable of working", and "there was no restriction in her activity". (Wagner 10/26/01 Dp. pg. 15) The doctor further opined that he felt no further treatment was indicated for Jennings, that she was "at maximum medical improvement". (Wagner 10/26/01 Dp. pg. 16) Dr. Wagner further opined that based on his March 19, 2001 evaluation, that as a result of the September 16, 1997 work related incident "there is no evidence of any disability in the lumbar spine. She has zero percent disability secondary to the injury of 9-16-97". (Wagner 10/26/01 Dp. pg. 17)<sup>[4]</sup>

**Dr. John R. Wagner, M.D.**, testified by deposition again on behalf of the employer/insurer on May 13, 2004 (Employer/Insurer's Exhibit No. 2). Dr. Wagner stated he had previously been deposed in this case on October 26, 2001, and had reviewed his previous testimony and his opinions had not changed.

Since the first deposition I have evaluated Cheryl Jennings again on March 17, 2003, the doctor said. Jennings' relayed interim history was discussed by Dr. Wagner, including that since he had seen her on 3-19-01, she had continued to complain of back pain and was treated by Dr. Gornet and had had a discogram of the lumbar spine performed and had low back pain for several days and then severe pain in her back for about six weeks and was treated in the emergency room three times with injection because of her severe pain. Dr. Wagner continued with the interim history:

"At five weeks after the discogram, the diagnosis of an infection was made. The patient then underwent open biopsy of the disc and this confirmed the diagnosis. She was seen by Dr. L'Ecuyer....., the infectious disease specialist who treated her with IV antibiotics for a bout six weeks. Then in September of 2002 she had an anterior lumbar fusion and a posterior lumbar fusion with pedicle screws and cages anteriorly. The pedicle screws, of course, were put in posteriorly and the cages were put in anteriorly. The fusion was at L4-5 and L5-S1. She stated afterwards she was treated with antibiotics with a PIC line....which collapsed her left lung. She was then treated with a chest tube for about four days and then that cleared up." (Wagner 5/13/04 Dp. pg. 6)

Jennings' present complaints were noted by Dr Wagner to be: low back pain, bilateral buttock pain, bilateral pain don to the bottom of the feet with paresthesias to the bottom of both feet; symptoms are worse with sitting and doing increased activities; occasional headaches. Her present medications are: Neurontin, Vioxx, Ultram, Valium and Lioricet.

Dr. Wagner was requested to explain a discogram, and stated that it "is a dye study with a needle put into the disc itself", and that it can show "cracks in the rim of the disc with leaking of the dye" and "various anomalies in the disc itself". (Wagner 5/13/04 Dp. pg. 7) Dr. Wagner noted that a discogram is usually quite painful and is not a procedure he uses in his office because patients don't like it. "Secondly, the results of the discogram are so mixed that it doesn't give me enough information to suggest surgery", the doctor said. (Wagner 5/13/04 Dp. pg. 8)

Examination findings for Jennings on March 17, 2003 were discussed by Dr. Wagner, and included: capable of walking without limp but walked slowly throughout the examining room, and there is a slight to the left; 30 degrees of forward flexion, 5 degrees of lateral flexion, and no, or zero degrees, extension; knee flip test is negative; can heel and toe walk, deep knee bend, stand on one leg without any evidence of weakness of hip, knee or ankle muscles; has excellent pulses; straight leg raising is negative; calf circumferences equal right and left, and has very thin lower extremities.

Agreeing that he had had an opportunity to review medical records and diagnostic studies, Dr. Wagner noted that Jennings had the discogram on April 23, 2002 and had follow-up MRI's and follow up notes from Dr. Gornet's office indicated that she was treated with antibiotics and then an open biopsy was done to obtain culture which showed a strep infection of the L4-5 disc, and this was treated with IV antibiotics and then oral antibiotics. Then an operation was performed, the doctor said, and further noted that "the CT scan with the discogram showed a tear of the disc annulus at L4-5". (Wagner 5/13/04 Dp. pg. 10) The doctor was asked

the significance he had attached to the CT scan finding, and Dr. Wagner gave the following testimony:

“Well, as I said, those findings are extremely common in normal population. And that I do not think is an indication for surgery as it is so common in normal population. And rehabbing patients is the way to handle that. There was no evidence of any extravasation, which means that the dye material at 5-1 did not come to the outside. The MRI of 3-29 showed no herniated disc, slight degenerative changes at 4-5, otherwise completely within normal limits.

The materials provided to me indicate that prior to her injury in 1997 she had a fracture of the pelvis and a black eye secondary to domestic violence. She was admitted to a hospital and at that time she was evaluated because of psychiatric problems. And she admitted to being addicted to Fioricet and Valium. She also was transferred from the initial hospital after her injury to St. John’s because of an apparent historical psychiatric reaction. And at that time, she was incidentally evaluated for a urinary tract infection. Also, there was an extensive array of films were reviewed including films of an MRI taken on 10-24-2000. These films were personally reviewed by me, and if I see my prior note of 3-19-01 the MRI – I had requested to review these films – the MRI of 10-24-2000 is absolutely within normal limits. There was no sign of any degenerative disc disease. There was no sign of a herniated disc. There was no sign of any facet problems. The asymmetrical disc seen by the radiologist in his report, reading that MRI, is simply a matter of the whole spine being slightly asymmetrical at that level. The disc, however, is absolutely within normal limits.

In view of the absolutely normal MRI of October, 24<sup>th</sup>, 2000, except for the slight asymmetry, which was positional, in other words, the position of the patient in the tube, it would seem to me that the injury of 1997, if it had any significance at all, would have resulted in changes in her MRI three year from the time of her injury. therefore, I think there is no evidence on an MRI of any injury that occurred three years previously. There would have been plenty of time for a slight degenerative disc to have appeared. In other words, from the injury of ’97 to the MRI of 2000 if she had an injury to that disc it would have appeared in the MRI, and it would have appeared as a degenerative disc.

Additional films were reviewed. These include films I had previously reviewed taken in our office 3-19-01. they’re completely within normal limits. The next set of films available for review are June 4<sup>th</sup>, 2002, Scott films taken at the operation for biopsy of the infection at L4-5. MRI of 8-5-2002 shows marked bony changes at L4-5 and L5-S1. There was no sign of any herniated disc. There was no sign of any disc changes outside of the disc at 4-5 and 5-1, meaning – that statement is a little confusing. Other than the discs at 4-5 and 5-1, in other words, the other discs in the lumbar spine are noted. No degenerative disc is noted. There’s a large bony defect at L5-S1, obviously secondary to an abscess, with these marked changes in the end plates and bodies of L5-S1. There are moderate changes at L4-5 with bony end plate changes. The next set of films is a CT scan of 8-20-02 which show the collapse of the disc at...L4-5, L5-S1, secondary to the infection with end plate changes at both 4-5 and 5-1. Larger end plate changes at both 4-5 and 5-1. Larger end plate changes with the bony defect was noted at L5-S1.

The next set of films is September 19<sup>th</sup>, 2002. It’s a set of lumbar spine films that show the pedicle screws at 4,5 and 1 with a transverse bar fixation between the right and left. The cages at 4-5 and 5-1 are protruding from the anterior margin of the vertebral bodies and I still see the previously noted bony changes.

The CT scan of 10-30-02 show a pedicle screw at 4 and a pedicle screw at 5 with the connecting bar. The cages at 4-5 and 5-1 again protrude anteriorly from the bony margins. There s no evidence of any healing of either 4-5 or 5-1. There is previously noted bony defects again at 5-1. Similar CT scans taken on 12-27-02 and 3-10-0(3) again showed... the cages in the same position anteriorly and the pedicle screws posteriorly. There was no evidence of any healing bone at 5-1. It’s possible healing at 4-5 on the most recent CT scan of 3-10-03, although all CT scans were reviewed and compared.

At this time, it appears as if Cheryl Jennings had an absolutely normal workup, but she had subjective complaints. Please see my review of the materials regarding her past complaints and hospitalizations. She had no objective evidence of any disease in her lumbar spine on her MRI of 10-24-00. She then had further workup with a discogram which was complicated by an infection. She had obviously infection at two levels. One level was biopsied or drained. This was done on 6-4-02. Three months later, she had a second operation to fuse these levels and she is in the process of healing. There is a possibility of a nonunion at L5-S1, as I saw her on 3-17-03. There may be some healing though definite at L4-5.” (Wagner 5/13/04 Dp. pp. 10-14)

Dr. Wagner stated that he did not know why the L4-5 disc level was biopsied and drained, and the L5-S1 level was not biopsied or drained when there was infection at both levels. “(T)hat’s probably why she had the bony defects at 5-1 that were worse than the bony defects at 4-5 where she had infection at both levels and why she probably has some delayed healing because of that problem at 5-1.” (Wagner 5/13/04 Dp. pg. 15)

The doctor was asked, based on his evaluation, what was his opinion as to the cause of the infections he had seen. “In my opinion, the cause was the discogram”, Dr. Wagner answered. (Wagner 5/13/04 Dp. pg. 15) The doctor was asked his opinion as whether or not the discogram that was performed was indicated or required as a result of the work related injury of 1997. Dr. Wagner answered:

“In my opinion, the discogram was not indicated. She had a normal examination. She had a normal MRI. She had subjective complaints. And one must not do things that harm patients. And this discogram obviously harmed this lady. And you have to have a good reason to do any test, either a discogram or a blood test or so on, there’s got to be a good reason. Because I don’t care what you do, there’s always bad side effects. And this is a classic example of a

discogram or a test that was, in my opinion, not indicated and the patient got in terrible trouble because of it. So in my opinion the discogram was not indicated and she had a terrible complication from that discogram. She had an excellent physical examination and she had no sign on her MRI, which is an excellent test for this kind of problem, three years after her injury. So if she had a significant injury in 1997, she certainly would have had a change on her MRI in three years.” (Wagner 5/13/04 Dp. pp. 15-16)

Dr. Wagner gave the following opinion as to whether he thought the discogram was either reasonable or necessary as a result of the injury of 9/16/97: “The discogram was not reasonable and it was not necessary as a result of the injury of 1997.” (Wagner 5/13/04 Dp. pg. 16) Dr. Wagner agreed that upon a request from the employer/insurer for his opinion as to whether it was appropriate for Jennings to undergo any additional pain management, he had recommended pain management with Dr. Graham, but further agreed that he did not have a personal opinion at that point in time as to whether pain management treatment was appropriate or not. “But if somebody deemed that she should go to a pain doctor, that would be the one that I would choose”, Dr. Wagner added. (Wagner 5/13/04 Dp. pg. 17) The doctor was asked what would be the cause of the need for pain management if Jennings needed it, and Dr. Wagner answered: “It would be the infection after her discogram and then subsequent surgeries. And she certainly didn’t need it before her discogram.” (Wagner 5/13/04 Dp. pg. 17)

On cross examination by the claimant, Dr. Wagner agreed that he is an orthopedic surgeon and does not have any expertise in vocational rehabilitation. “Although, as an orthopedic surgeon I send people back to work on a regular daily basis – after evaluating their situation. But I’m not a vocational counselor”, the doctor added. (Wagner 5/13/04 Dp. pg. 18) Dr. Wagner was queried as to the cause of Jennings’ headaches, and the doctor answered:

“I haven’t the faintest idea. I can’t relate that at all. She never had, you know, like a dural leak or anything that...would related to a headache. So I can’t put that together. She had – remember she was taking Fioricet and Valium for a long, long time, so I presume – Fioricet classically is prescribed for headaches, so she had Fioricet before she got hurt, so I presume that it was an ongoing problem with her, although I don’t have a response from her to indicate that.” (Wagner 5/13/04 Dp. pg. 20)

Dr. Wagner agreed, during cross examination by the claimant, he had indicated that the normal method of treatment of a tear of a disc annulus was to rehab the patient; when asked if he had ordered any rehab for Jennings, Dr. Wagner responded – “No. I was not authorized treatment.” (Wagner 5/13/04 Dp. pg. 22) It was noted by Dr. Wagner that on direct he had testified he had not seen on the CT scan of March 10, 2003 solid evidence of healing at 4-5 or at 5-1; “(B)ut there appeared to be more evidence of lack of healing at 5-1, and 4-5 could have been solid”, the doctor added. (Wagner 5/13/04 Dp. pg. 23) The doctor agreed that could have been healing since arch of 2003. Dr. Wagner was asked what was the reason for the nonfusion as of March 2003, which was six months after the fusion. Stating that there are several reasons for this, Dr. Wagner noted that Jennings smokes cigarettes and that can slow down healing. “But ii think the infection would also slow down healing”, the doctor added. (Wagner 5/13/04 Dp. pg. 23) Dr. Wagner stated that he has not seen any studies or medical reports since his exam of March 17, 2003.

**Dr. Wayne A. Stillings, M.D.** testified by deposition on behalf of the employer/insurer. (Employer/Insurer’s Exhibit No. 3) Board certified in psychiatry, Dr. Stillings stated that he met with the claimant for evaluation on January 25, 1999. The evaluation included taking a history from Jennings concerning her family, social, educational, occupational and legal information, a past medical history, a review of some medical records, a mental status exam of Jennings, and a MMPI test administered to the claimant. The mental status exam findings were discussed by Dr. Stillings:

“Ms. Jennings was an alert, cooperative, polite, casually attired white female,. There was n evidence of psychomotor retardation or acceleration. Her speech was normal in rate and rhythm. There was no formal thought disorder. She did not appear to be insignificant pain; nor was she preoccupied with pain. No psychological distress nor physiologic reactivity was manifested in regard to the work incident or its sequelae. Her affect was appropriate. Her mood was euthymic, meaning she was not depressed. She laughed and joked easily and appropriately. She did not appear generally concerned about her subjective complaints. She denied hallucinations, delusions, obsession, compulsions, phobias, suicidal and homicidal ideation. She was oriented to time, place and person. Recent and remote memory functions were intact. Her cognitive functions were intact. Her verbal comprehension and concentration were very good. Her general fund of knowledge was commensurate with her educational level. Proverb interpretation was appropriate. Her intellectual function is in the normal range. Insight and judgment are intact.” (Stillings Dp. pg. 21)

The doctor discussed his interpretation of the claimant’s MMPI results:

“This is a valid profile. This person has a histrionic construct to her personality structure. She is likely to report subjective complaints well beyond those which can be physically or organically objectively confirmed. She is prone to use these complaints to garner secondary gain. All scales relevant to pain, including the low back pain scale, are elevated into the functional/exaggeration region. She is likely to present with a variety of vague and unusual complaints. Focusing on her physical symptoms often represents a means of organizing her thoughts or a way of dealing with everyday stresses of life. Unfortunately, her ability to effectively deal with the every day stresses of life and anxiety is quite limited. She is likely to have interpersonal relationships marked by considerable distances and alienation. She will

distrust others. She has a tendency to express inner psychic conflict as physical subjective complaints. She has excessive needs for attention and affection, but emotional dependency is a source of inner conflict for her. The PD-S scale is elevated. There is a conspicuous absence of mood and anxiety disorders. (Stillings Dp. pp. 22-23)

Dr. Stillings agreed that he performed a substance abuse panel on Jennings, and stated that “(H)er panel was positive for barbiturates”. (Stillings Dp. pg. 24) The doctor stated that he had indicated the substance abuse panel was consistent with the use of Valium or Fioricet. (**Ruling:** Second Injury Fund’s objection on grounds of the doctor’s chemical knowledge background is overruled. Stillings Dp. pg. 24)

Dr. Stillings testified as to his diagnoses after evaluation of Jennings on January 25, 1999: “Number one, other conditions that may be a focus of clinical attention, that being histrionic personality traits. Number two, relational problems, not otherwise specified with a history of emotional and physical abuse. Number three rule out substance dependence.” (Stillings Dp. pg. 25) Explaining his diagnoses in layman’s terms, Dr. Stillings testified:

“Clearly, her personality is histrionic, which means, really, If you look at the MMPI, it’s a good description of a histrionic person. She has a tendency to express her interpersonal and intrapsychic and life psycho social stressors as physical complaints. Okay. And she has a tendency to do so in a fashion subconsciously where she will attempt to garner something personal for herself through the expression of physical complaints.

Her relational problems, her life is replete with relational problems. Almost all of her relationships as an adult have been abusive, emotionally and physically. Chronically. It’s a chronic problem. Her substance dependence has been severe.” (Stillings Dp. pp. 25-26)

Dr. Stillings testified as to his opinion on causation in relation to Jennings’ diagnoses and the September 16, 1997 work related accident: “Ms. Jennings has no psychiatric illness causally related to nor aggravated by the 9/16/97 work accident.” (Stillings Dp. pg. 28). (**Ruling:** Second Injury Fund’s objection on grounds of mischaracterizing the doctor’s opinion is overruled. Stillings Dp. pg. 27)

With regard to the September 16, 1997 work related accident and the psychiatric condition, there are no restrictions placed upon Jennings’ ability to work, the doctor said. When queried, with regard to the September 16, 1997 work related accident and the psychiatric condition was Jennings in need of any treatment as a result of the work accident, Dr. Stillings responded: “My opinion is that Ms. Jennings does not need and has never needed psychiatric treatment in relation to the 9/16/97 work injury.” (Stillings Dp. pg. 29) The doctor was asked his opinion of whether or not Jennings had any permanent partial psychiatric disability as a result of the September 16, 1997 work related accident. “Ms. Jennings has sustained 0 percent permanent partial psychiatric disability related to the 9/16/97 work accident”, Dr. Stillings testified. (Stillings Dp. pg. 30). (**Ruling:** Second Injury Fund’s objections are overruled. Stillings Dp. pp. 29 and 30)

Dr. Stillings discussed his review of additional medical records concerning Jennings sent to him in 2004. When asked if any of his opinions regarding Jennings’ psychiatric diagnoses changed after this review of additional information, the doctor answered – “Not really”. (Stillings Dp. pg. 32) Dr. Stillings stated that, based on his evaluation and review of all of the medical evidence, he had an opinion of whether Jennings had any psychiatric disability from any cause and testified:

“I have three opinions. Number one, Ms. Jennings has a 15 percent preexisting permanent partial psychiatric disability in relation to her first diagnosis of relational problems NOS multiple with a history of emotional and physical abuse.

Opinion No. 2 is that Ms. Jennings has a 15 percent preexisting permanent partial psychiatric disability related to diagnosis number two, which is histrionic personality traits.

Opinion No. 3 is Ms. Jennings has a preexisting permanent partial psychiatric disability of 5 percent related to diagnose number three, which is substance abuse by history.” (Stillings Dp. pg. 33)

Explaining how Jennings’ psychiatric problems were disabling, Dr. Stillings testified:

“Well, the disabling aspect, let’s just break this down into three components. In terms of her relational problems, she has a pattern of being abused and a pattern of being dependent in relationships. And – ....

Pattern of dependency and abuse in relationships. And that has occupational disabilities associated with it. People don’t function well in the workplace. It’s well documented that people who are in abusive relationships have diminished capacity to occupational functioning for multiple reasons because of their associated depressed feeling with this, their inability to develop appropriate self-esteem to get ahead in the workplace and things of that nature.

Component No. 2 is that she has histrionic personality traits. And people who are histrionic, of course experience a lot of stress and have very limited ability to cope with normal occupational stress, and that creates a certain degree of disability as well.

And No. 3 I think is pretty common sense. People who are abusing substances don’t do well in the workplace.” (Stillings Dp. pp. 34-35). (**Ruling:** Second Injury Fund’s objections are overruled. Stillings Dp. pg. 34)

Opining as to how all three of these diagnoses come together, Dr. Stillings stated: “Well, they really have a synergistic phenomenon in that it’s what we call co-morbidity. In other words, having three problems like this is worse than their simple sum.” (Stillings Dp. pg. 35). (**Ruling:** Second Injury Fund’s objection is overruled. Stillings Dp. pg. 35)

On cross examination by the claimant, it was noted that Dr. Stillings had testified about a co-morbidity in the way his three diagnoses worked with each other, and the doctor was queried, if there was a synergistic effect between the psychiatric diagnoses and the claimant’s work related back injury. Dr. Stillings answered stating that there was a co-morbidity in the fact that Jennings has both psychiatric problems and a back injury so that she is worse off. The doctor further testified:

“The principle of co-morbidity is applicable in psychiatry. It is also applicable between the presence of physical diseases in combination with psychiatric disorders, in that when you have both, you have a synergistic effect, and it is harder to treat the individuals and their outcomes are much poorer than if you have a person with just a single disorder.

“Say for Ms. Jennings, with her histrionic personality – let’s just take one of the three psychiatric disorders. Her histrionic personality feature will cause her not to do as well physically. She will not feel as well. She will report higher levels of pain. She’ll be functionally more limited in terms of her capacity from a physical standpoint due to that personality feature.” (Stillings Dp. pp. 37 and 38). (**Ruling:** Second Injury Fund’s objections are overruled. Stillings Dp. pp. 37 and 38)

Dr. Stillings was queried during cross examination by the claimant, when he said the claimant had histrionic complaints was he saying this was an intentional faking or malingering situation. The doctor answered:

“No, absolutely not. It just means this is her personality style. If she has an injury, her reaction and emotion to that injury is going to enhance the injury. It’s going to be a greater injury than if she didn’t have this personality. It’s a subconscious process. It’s not something that she’s aware of.” (Stillings Dp. pg. 38)

On cross examination by the Second Injury Fund, Dr. Stillings agreed that when he saw Jennings it was his opinion that the three psychiatric diagnoses he felt she had, none of these diagnoses would restrict her from working. The doctor was queried if it was true that his opinion was Jennings’ psychiatric diagnoses did not seem to be affecting her job at the casino (where she suffered her work related injury). Dr. Stillings answered: “Clearly that is wrong. My answer is clearly, the premise in your question is wrong. The defective logic is very, very straightforward here. She got fired for substance abuse....She was abusing substances. I’m sure that her psychiatric diagnoses were impairing her occupationally. I’m absolutely positive.” (Stillings Dp. pg. 45) It was noted that the claimant had told the doctor that she enjoyed her job (at the casino), enjoyed her work, and Dr. Stillings was queried if the claimant had given him any indication that she was impaired previously while working at the casino. The doctor answered: “She lacks total insight into her impairments and into her psychiatric disorders so she would never come in and say, oh, Doctor, I’m really impaired psychiatrically. She has no insight, no understanding of what’s wrong with her.” (Stillings Dp. pg. 47)

During cross examination, Dr. Stillings stated that he was aware that the claimant had had back fusion surgery after the work related injury of September 16, 1997, and acknowledged that the medical records reflected that she had pain problems since the injury due to her back. When queried wouldn’t chronic pain affect your work and cause one who had the propensity to be depressed to be even more so, Dr. Stillings responded – “Possibly.” (Stillings Dp. pg. 48) The doctor was asked if it was still his opinion that the claimant suffered zero psychiatric disability as a result of the primary injury. “Well, without a chance to reevaluate her, I really don’t have an opinion on that”, the doctor answered. (Stillings Dp. pg. 48) Dr. Stillings agreed that it had been five years since he had seen the claimant.

Date: December 7, 2004

Made by: /s/ LESLIE E. H. BROWN  
LESLIE E. H. BROWN  
Administrative Law Judge  
Division of Workers' Compensation

A true copy: Attest:

/s/ GARY ESTENSON  
GARY ESTENSON  
Director  
Division of Workers' Compensation

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[\[1\]](#) It should be noted that a Temporary Award was previously entered by Administrative Law Judge Joann Karll who is no longer with the Division.

[\[2\]](#) **Summary of the Evidence** and rulings on the evidence begin on page 25.

[\[3\]](#) See, *Dilallo v. City of Maryland Heights*, 996 S.W.2d 675, 677 (Mo.App. E.D.1999) in which the Court noted:

“Temporary or partial awards are not subject to the principles of either claim or issue preclusion. They are not final judgments on the merits but are subject to modification. *Korte v. Fry-Wagner Moving & Storage Co.*, 922 S.W.2d 395, 397-98 (Mo.App.1996). A temporary or partial compensation award "may be modified from time to time to meet the needs of the case, and the same may be kept open until a final award can be made...." Section 287.510 RSMo (1994). This language recognizes that the final award may differ from the temporary or partial award. *Welch v. Eastwind Care Center*, 890 S.W.2d 395, 398 (Mo.App.1995). ‘The legislature clearly contemplated that the ALJ may render a decision in a final hearing which differed from that of the temporary or partial award.’ *Id.*”

[\[4\]](#) Claimant withdrew Seven Day Rule objections at the November 28, 2001 hearing. See Wagner 10/26/01 Dp. pp. 16 and 17.