

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

Injury No.: 01-124687

Employee: Doris Lacy
Employer: Federal Mogul
Insurer: St. Paul Travelers Company
Additional Party: Treasurer of Missouri as Custodian
of Second Injury Fund

Date of Accident: May 17, 2001

Place and County of Accident: Dunklin County, Missouri

The above-entitled workers' compensation case is submitted to the Labor and Industrial Relations Commission (Commission) for review as provided by section 287.480 RSMo. Having reviewed the evidence and considered the whole record, the Commission finds that the award of the administrative law judge is supported by competent and substantial evidence and was made in accordance with the Missouri Workers' Compensation Act. Pursuant to section 286.090 RSMo, the Commission affirms the award and decision of the administrative law judge dated November 13, 2006, and awards no compensation in the above-captioned case.

The award and decision of Administrative Law Judge Lawrence C. Kasten, issued November 13, 2006, is attached and incorporated by this reference.

Given at Jefferson City, State of Missouri, this 10th day of September 2007.

LABOR AND INDUSTRIAL RELATIONS COMMISSION

CONCURRING OPINION FILED

William F. Ringer, Chairman

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 and 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 as a partner with Evans and Dixon. However, recognizing that there may exist the appearance of impropriety because of my previous status with the law firm of Evans and Dixon, I had 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 because 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. 1988).

Having reviewed the evidence and considered the whole record, I join in and adopt the award and decision of the administrative law judge denying benefits.

William F. Ringer, Chairman

DISSENTING OPINION

After a review of the entire record as a whole, and consideration of the relevant provisions of the Missouri Workers' Compensation Law, I believe the decision of the administrative law judge should be reversed.

The administrative law judge found that employee failed to prove that her cervical and lumbar conditions were a result of her work related injury. However, competent and substantial evidence shows that employee did suffer aggravation of her cervical condition as well as a back injury on May 17, 2001.

The administrative law judge found that these issues boil down to a question of credibility and neither the medical records nor the other evidence corroborated employee's assertion that her back condition and worsened cervical condition were a result of the accident on May 17, 2001. The administrative law judge called employee's credibility into question because he believed that employee was inconsistent in reporting her injury.

However, employee consistently reported symptoms following her May 17, 2001 injury, including back pain as well as an increase in the intensity of the pain in her neck. The medical records and injury reports do in fact corroborate employee's version of the May 17th accident. As a result, I find employee to be credible and worthy of belief.

Employee's initial injury report states that employee sustained injuries to her neck and back while she was in the course of performing her usual and customary work duties. Employee testified that she reported the injury to her supervisor promptly after the accident. Another co-worker witnessed the slip and fall accident and was present when she reported the injury to employer. Employee provided consistent testimony with regard to her injury stating that she slipped and fell at work and felt immediate discomfort in her back and neck. The administrative law judge made reference to a delay in seeking treatment for her conditions; however, employee sought treatment within a month of the injury.

Employee testified that she sought treatment from her treating family doctor, Dr. Campbell, who then referred employee to neurosurgeon, Dr. Yingling. Employee reported the injury to her treating doctors and underwent an MRI of the cervical spine which revealed a bulging disc at C4-5. Dr. Yingling recommended physical therapy and prescribed her pain medication. Employee testified that she requested medical treatment from employer during this time period which was denied. The medical record shows that employee complained of low back pain in July of 2001 and continued to report problems with her back thereafter. Employee went to Dr. Burns, a pain management specialist who treated her for her condition. Employee had never sought treatment for back problems before the 2001 accident. The medical record supports employee's assertion as it does not reference any complaints regarding back problems prior to May 17, 2001.

The record shows that employee had a pre-existing cervical condition, a cervical fracture as a result of a motor vehicle accident on March 12, 1999. However, aggravation of a pre-existing condition is compensable if employee establishes a direct causal link between her job duties and the aggravated condition. *Smith v. Climate Engineering*, 939 S.W.2d 429, 433-34 (Mo.App. E.D. 1996) (overruled on other grounds).

Employee received medical care and treatment for her pre-existing cervical condition; however, employee's work-related injury clearly caused her established cervical condition to worsen. Employee continued to work for a period of five months including overtime following her cervical fracture. As a result of her 2001 slip and fall injury, employee experienced a change in her condition. Employee experienced an immediate onset of pain after her 2001 injury, and reported the accident to employer the same day. The symptoms produced as a result of her injury, primarily intense pain, prevented employee from performing the job duties that she had been able to perform prior to her 2001 injury. Employee subsequently sought care from multiple physicians for her exacerbated cervical condition. Employee testified that she had never felt pain with regard to her neck similar to that which she experienced following her 2001 injury.

Employee's testimony was supported by the expert opinion of employee's treating doctor, Dr. Campbell, who testified that employee's chronic pain was made worse by level and intensity after the May 2001 event. He testified that employee required stronger and probably more frequent medication following the 2001 accident. Additionally, Dr. Volarich testified that as a result of the May 17, 2001 accident, employee suffered a 20% permanent partial disability to the body as a whole rated at the cervical spine as well as a 20% permanent partial disability to the body as a whole rated at the lumbosacral spine.

Competent and substantial evidence establishes that employee is entitled to permanent total disability benefits. Under the Missouri Workers' Compensation Law employee is considered totally disabled if he is unable to return to any employment, not merely the employment in which he was engaged at the time of the accident. § 287.020.7, RSMo. The test for permanent-total disability is whether employee is able to competently compete in the open labor market given his condition and situation. *Reiner v. Treasurer of State of Missouri*, 837 S.W.2d 363, 367 (Mo.App. E.D. 1992).

Employee's vocational expert, Ms. Shea, as well as employer's vocational expert, Mr. England, both testified to the fact that employee was not employable in the open labor market. In addition, Dr. Volarich, placed restrictions on employee that would prevent employee from competing in the open labor market, including the need to change positions frequently to maximize comfort as well as resting in a supine fashion if needed. The record clearly shows that employee meets the standard for permanent total disability.

Furthermore, employer had notice of employee's accident and injuries and failed to offer employee medical treatment. Employer thus waived its right to direct medical care and treatment and is responsible for any treatment sought by employee to cure and relieve the symptoms of her injuries. Employer is also responsible for future medical treatment. Dr. Campbell testified that employee was in constant need of pain medication. Dr. Volarich opined that employee's condition would require ongoing treatment for her pain syndrome including, but not limited to anti-inflammatory medications, muscle relaxants, physical therapy and similar treatments. He recommended ongoing treatment at a pain clinic with trigger injections, epidural steroid injections and similar treatments to control her myofascial pain syndrome. This constitutes competent and substantial evidence demonstrating the need for future medical care which justifies the award of future medical benefits.

Therefore, employee has met her burden by establishing that she suffered a work-related injury on May 17, 2001, that her condition is medically causally related to the work-related injury, and that she is permanently totally disabled as a result. Employee has also established entitlement for associated unpaid medical costs, as well as, the need for ongoing treatment justifying an award of future medical benefits. Accordingly, I would reverse the decision of the administrative law judge and award compensation.

For the foregoing reasons, I respectfully dissent from the decision of the majority of the Commission to deny compensation.

John J. Hickey, Member

AWARD

Employee: Doris Lacy

Injury No. 01-124687

Employer: Federal Mogul

Additional Party: Second Injury Fund

Insurer: St. Paul Travelers Company

Hearing Date: Commenced October 26, 2005
Completed August 4, 2006

Checked by: LK/kh

SUMMARY OF FINDINGS

1. Are any benefits awarded herein? No.
2. Was the injury or occupational disease compensable under Chapter 287? No.
3. Was there an accident or incident of occupational disease under the Law? No.
4. Date of accident or onset of occupational disease? N/A
5. State location where accident occurred or occupational disease contracted: N/A
6. Was above employee in employ of above employer at time of alleged accident or occupational disease? Yes.
7. Did employer receive proper notice? N/A
8. Did accident or occupational disease arise out of and in the course of the employment? No.
9. Was claim for compensation filed within time required by Law? Yes.
10. Was employer insured by above insurer? Yes.

11. Describe work employee was doing and how accident happened or occupational disease contracted: N/A.
11. Did accident or occupational disease cause death? N/A
12. Parts of body injured by accident or occupational disease: N/A.
13. Nature and extent of any permanent disability: N/A.
14. Compensation paid to date for temporary total disability: None.
15. Value necessary medical aid paid to date by employer-insurer? N/A.
16. Value necessary medical aid not furnished by employer-insurer? N/A.
17. Employee's average weekly wage: \$529.50.

18. Weekly compensation rate: \$353.00 for total disability. \$314.26 for permanent disability.

19. Method wages computation: By Agreement.
20. Amount of compensation payable: None.

TOTAL: None.

Second Injury Fund liability: None.

Future requirements awarded: None.

Said payments to begin (see findings) and 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: N/A.

FINDINGS OF FACT AND RULINGS OF LAW

On October 26, 2005, the employee, Doris Lacy, appeared in person and by her attorney, Joe Rice, for a hearing for a final award. The employer-insurer was represented at the hearing by its attorney, David Reynolds. The Second Injury Fund was represented by Assistant Attorney General Debra Ledgerwood. At the time of the hearing, the parties agreed on certain undisputed facts and identified the issues that were in dispute. These undisputed facts and issues, together with the findings of fact and rulings of law, are set forth below as follows:

UNDISPUTED FACTS:

1. Federal Mogul was operating under and subject to the provisions of the Missouri Workers' Compensation Act and its liability was fully insured by St. Paul/Travelers Insurance Company.
2. On or about May 17, 2001, Doris Lacy was an employee of Federal Mogul and was working under the Workers' Compensation Act of Missouri.
3. The employee's claim was filed within the time allowed by law.
4. The employee's average weekly wage was \$529.50. The rate of compensation for temporary total and permanent total disability is at the rate of \$353.00. The rate of compensation for permanent partial disability is \$314.26.
5. The employer-insurer has not paid any medical aid under workers' compensation.
6. The employer-insurer has not paid any temporary total disability under workers' compensation.

ISSUES:

1. Accident or occupational disease.
2. Notice.
3. Medical causation.
4. Previously incurred medical benefits. (Withdrawn as an Issue on August 4, 2006)
5. Claim for medical mileage.
6. Claim for additional or future medical aid.
7. Nature and extent of disability.
8. Liability of the Second Injury Fund.
9. Direct medical fee dispute of Dr. Campbell.
10. Credit for payments under the long-term disability plan.

EXHIBITS:

Employee's Exhibits

- A. Medical records of Dr. Yingling
- B. Medical records of Orthopedic Associates
- C. Medical records of Dr. Mays
- D. Medical records of Dr. Campbell
- E. Medical records of Cape Radiology Group, Inc. admitted November 18, 2005
- F. Medical records of Orthopedic Associates
- G. Medical records of Dr. Shakil (admitted January 26, 2006)
- H. Medical records of St. Francis Medical Center
- I. Medical records of Dr. Jordan
- J. Not offered
- K. Report of Dr. Volarich
- L. MRI of Cape Radiology Group (admitted November 18, 2005)
- M. Medical Records of St. Francis Medical Center
- N. Social Security Administration records – "Not admitted" (Offer of proof made)

- O. Record of mileage expenses
- P. Average weekly wage
- Q. Susan Shea's Vocational Assessment report. (Objections were made to the admission of this exhibit. The ruling on the admissibility was taken under advisement. The objection is overruled and the exhibit is admitted into evidence.)
- R. Not offered
- S. Records of Dr. Campbell
- T. Records of Cape Radiology Group
- U. Medical records of Scott City Medical Clinic.
- V. Letter from Dr. Campbell
- W. Deposition of Allen Blume
- X. Deposition of Tim Moore
- Y. Accident/Incident investigation report date of accident May 27, 2001.
- Z. Accident and Sickness Form dated June 18, 2001.
- AA. Form control document of accident/incident investigation report
- BB. Accident and sickness form dated March 12, 1999
- CC. Accident/incident investigation reports date of accident of May 17, 2001 and signed on October 31, 2001
- DD. Dr. Campbell's off work orders
- EE. Accident and sickness form dated November 13, 2001
- FF. Accident and sickness form dated November 20, 2001
- GG. Accident and sickness form dated September 11, 2001
- HH. Not offered
- II. Deposition of Susan Shea
- JJ. Deposition of Dr. Campbell
- KK. Deposition of Dr. Volarich
- LL. Deposition of Tony Campbell
- MM. CV of Susan Shea
- NN. Deposition of Johnna Barnes
- OO. Deposition of Cindy Hayes
- PP. Medication count form.
- QQ. Total medication used by employee 1996-2003.
- RR. 2001 days worked by the employee.
- SS. Medical bills
- TT. Medical records of Dr. Critchlow (admitted on November 18, 2005)
- UU. Paychecks of the employee
- VV. Missed days in 2000
- WW. Prescriptions of Dr. Yingling 1999-2001

Note: The employee's husband prepared Exhibits PP, QQ, RR, VV and WW. These exhibits were compilation of various records. There were objections made to these exhibits. The rulings on these exhibits were taken under advisement. The objections were overruled and the exhibits were admitted into evidence. Based on my review of the records of Dr. Campbell in 2001 in conjunction with the portion of Exhibit QQ regarding the medication prescribed in 2001, I find that there are several errors in Exhibit QQ. All of these exhibits (PP, QQ, RR, VV and WW) were not important factors in my decisions in this case.

Employer-Insurer's Exhibits

1. Deposition of Dr. Wagner
2. September 30, 2005 letter – not admitted
3. Medical report of Dr. Wagner dated June 23, 2003
4. Absentee records of the employee from Federal Mogul
5. Report of James England dated October 26, 2005 (Admitted November 18, 2005)
6. Deposition of James England (Admitted November 18, 2005)
7. Federal Mogul long-term disability payments and summary plan description. (Admitted November 18, 2005.)
8. Federal Mogul accident and sickness benefit plan summary and Federal Mogul pension plan (Admitted April 17, 2006)

Witnesses:

- Dr. Campbell – October 26, 2005
- Ron Lacy – October 26, 2005 and November 18, 2005
- Lance Lacy – November 18, 2005
- Doris Lacy – November 18, 2005

Briefs: The Second Injury Fund filed its brief on April 13, 2006. The employee filed its brief on April 14, 2006. The employer-insurer filed its brief on April 17, 2006.

The first hearing was held on October 26, 2005. A continuation of the hearing was held on November 18, 2005. The record was left open for additional exhibits to be introduced into evidence. After submission of those exhibits, the employer-

insurer requested that the record remain open for an additional exhibit with regard to alleged credit for medical bills previously paid by Federal Mogul under Issue 4. The employee agreed and the Second Injury Fund did not object. There were several additional requests by the employer-insurer requesting additional time for the record to remain open. At the end of June of 2006, the employer-insurer's attorney requested an additional period of time and the employee's attorney objected. A telephone conference was held on July 7, 2006. It was agreed that the record would remain open for the deposition of a witness. A letter was received on August 4, 2006 stating that the parties agreed that the record could be closed. The parties agreed to withdraw Issue 4. A follow-up letter was received on September 13, clarifying the agreement.

SUMMARY OF THE EVIDENCE:

EVIDENCE PRIOR TO MARCH 12, 1999:

The employee started working at Federal Mogul in the late 1980's. The employee has been treated by Dr. Campbell a general family practice doctor since the 1970's. She testified that prior to March of 1999, she had migraine headaches and when she had them her neck would also hurt. Dr. Campbell was unable to locate his records for the employee prior to 1995. Dr. Campbell treated her for migraines prior to March of 1999, and prescribed medicines including Fioricet, Demerol, Imitrex, and Vistaril for migraines. The medicines included narcotics and analgesics. Both the employee, her husband, and son testified that prior to March of 1999, that other than her migraines she had no other health problems. She would periodically miss work.

1995 and 1996: Dr. Campbell prescribed medication including Demerol, Vistaril, and Imitrex for the employee's migraine headaches. He also prescribed Xanax and Fioricet. In November of 1996, Dr. Campbell recommended that the employee have a neurology evaluation and made an appointment with Dr. Deshazo at Semmes-Murphy Clinic in Memphis.

1997: Dr. Campbell prescribed Demerol and Fiorinal for severe pain, Restoril, Vistaril and Xanax for her nerves. In May, the employee had neck pain. She had severe pain in July and August. The employee testified that she does not remember having neck pain prior to 1999 but when she had migraines they affected her neck.

1998: During 1998, Dr. Campbell prescribed Vistaril, Xanax, Restoril, Fioricet, Demerol, Fiorinal, Imitrex, and Nubain. The employee had migraine headaches. In February, the employee seemed clearly depressed and was taken off work for several weeks. Dr. Campbell added Valium and Paxil. Several times during the year the records show that the employee had severe pain. In July Dr. Campbell took the employee off work due to her being emotionally unable to work. Accident and Sickness Forms were filled out in July and September.

1999: Dr. Campbell prescribed Imitrex, Nubain, Fioricet, Fiorinal, Resotril, and Xanax.

EVIDENCE FROM MARCH 12, 1999 TO MAY 17, 2001:

On March 12, the employee had a motor vehicle accident where she was thrown upward and struck her head. The employee was admitted to the intensive care unit at St. Francis Medical Center and treated by Dr. Yingling. A CT scan of the neck showed a fracture at C2. The employee was placed in a halo immobilization. She was discharged from the hospital on March 15. On March 30, the employee signed an accident and sickness form for short-term disability. Dr. Yingling filled out the physician's statement with a diagnosis of a C2 fracture and a chief complaint of neck pain.

The employee continued to be treated by Dr. Yingling. He prescribed Lorcet Plus and Flexeril. On June 3, a follow up CT scan showed that the C2 fracture was healing. The employee's halo and halo vest were removed and she was placed in a soft collar. At the end of June, Dr. Campbell prescribed Restoril, Xanax, Fiorinal, and Fioricet. In July the employee continued to have muscle spasms and decreased range of motion. Dr. Yingling prescribed Skelaxin for the spasms. X-rays showed moderate degenerative changes of the cervical spine. Dr. Campbell testified that degenerative changes would be common in a 43-year-old woman.

At the end of July, Dr. Yingling noted that the employee felt a pop in her neck and developed severe pain in the right side of her neck. She went to the emergency room and was given a pain injection. She had fairly severe neck pain and continued to have spasms, loss of motion, muscular stiffness and soreness. Dr. Yingling ordered therapy, continued to prescribe Lorcet Plus and later prescribed Motrin.

In October, Dr. Yingling noted that the employee had significant spasms of her neck muscles and poor flexion. Dr. Yingling referred her to Dr. Shakil for her chronic neck pain. Dr. Shakil noted that the employee had significant neck pain and headaches which radiated to both shoulders. The range of motion was restricted. Dr. Shakil prescribed Vioxx, Neurontin, Lorcet and ordered therapy.

Dr. Shakil performed a cervical epidural steroid injection at C5-6 in November due to neck pain with radiation to the shoulder secondary to cervical radiculitis and myofascial pain. The shot helped but she continued to have pain in her upper neck and her range of motion was restricted. Dr. Shakil's diagnosed posttraumatic neck pain with C2 cervical fracture with cervical radiculitis and migraine headaches.

Dr. Campbell treated the employee throughout 1999 for various conditions including migraine headaches, neck pain with spasms, anxiety and depression. He prescribed Fiorinal with codeine due to severe neck pain, Xanax, Paxil, Restoril, Nubain, Vistaril, Fioricet, Imitrex, Prozac, Demerol, Neurontin, Vioxx, and Depo-medrol.

2000:

In January, Dr. Shakil performed a cervical facet rhizotomy at C2-3, C3-4 and C5-6 due to post-traumatic neck pain, C2 cervical fracture, and facet arthropathy. Dr. Campbell testified that the cervical rhizotomy was done to help with pain by severing or sectioning nerves. Dr. Campbell stated that the employee continued to have severe neck pain following the procedure.

The employee returned to work from the automobile accident on January 13. The employee testified that after going back to work she did not have any problems performing her job duties. She had neck problems after working overtime. She had neck complaints from the cervical fracture and with migraines but was able to function. Ron Lacy testified that the employee still had severe neck pain and other problems but did her job and worked overtime. She could take a pain pill and do activities like she did before. Lance Lacy testified that when she went back to work, she went back to doing things she had done before.

In mid-January, Dr. Campbell stated that the employee was anxious, tense, and her neck had clearly multiple spasms. Dr. Campbell prescribed Xanax, a Medrol dose pack, Flexeril, and Fiorinal #3 for severe pain.

In early February, the employee requested a shot due to pain. Dr. Campbell prescribed Depo-medrol, Restoril, and Flexeril. Dr. Campbell noted that the employee continued to have neck pain since her C2 fracture one year ago. He instructed the employee to use ice to her neck as needed and to use Tylenol for pain. He prescribed Xanax, Flexeril for muscle spasms, Fiorinal #3 for severe pain, and Imitrex.

In March, the employee's neck was painful. Dr. Campbell prescribed Depo-medrol, Flexeril, and Fiorinal for severe pain, and Xanax. In May, the employee continued with neck pain. Dr. Campbell prescribed Depo-medrol, Fiorinal #3 for severe pain, Xanax, Flexeril for muscle spasms, Restoril and Imitrex. Dr. Shakil continued to prescribe Lorcet Plus and Vioxx through May of 2000.

In June, Dr. Campbell prescribed Flexeril for muscle spasm, Fiorinal #3 for severe pain, and Xanax. In July, the employee had neck pain. Dr. Campbell prescribed Fiorinal, Depo-medrol, Imitrex, Nubain, Vistaril, and Restoril.

In September the employee requested a shot for a migraine. Dr. Campbell prescribed Flexeril, Fiorinal, Xanax, Nubain, and Vistaril. In early October, the employee's neck was stiff, tense and painful. She was stressed and had a high level of anxiety. Dr. Campbell advised her to get adequate rest and that she would need to consider a restricted program or medical sick leave in the future if she failed to respond adequately. She was prescribed Flexeril and Depo-medrol. In mid-October, the employee was in distress. Fiorinal, Imitrex, and Flexeril were prescribed.

In December the employee had severe neck pain that went down her right arm into her elbow, wrist, hand and her first three fingers. She was wearing a splint at night. Dr. Campbell prescribed Depo-medrol and Deadron; and Nubain with Vistaril was injected. During the rest of December Dr. Campbell prescribed Xanax, Fiorinal #3, Flexeril, and Restoril. She received a Nubain/Vistaril injection.

2001:

The employee testified that in the couple of months before May of 2001, she was doing everything she had done before and was doing well. She had no problems with her job and had no low back problems.

From early to mid-January of 2001, Dr. Campbell prescribed 100 Fiorinal #3, 60 Xanax 1 mg, and 60 Flexeril 10 mg. On January 23, the employee had severe neck pain and a migraine headache. The employee was in a darkened room and crying markedly. She stated that the stress in the work place and home was about to get her down. She was requesting a shot for her neck and for a migraine headache. Dr. Campbell mentioned to her an evaluation to see if she needed a higher level of diagnostic testing or other treatment other than self-prescribed injections. She was given injections for her neck and migraine as requested and was given an off work slip. He prescribed 50 more Fiorinal #3 to be taken every 6 hours and 60 more Restoril 30 mg.

On January 26, Dr. Campbell noted that the employee had many interpersonal and family problems. She had difficulty concentrating and resting and cried a lot. Dr. Campbell counseled her due to her clear depression. Dr. Campbell started her on Paxil 14 day sample starter pack and prescribed 30 Valium 10mg ½ to be taken every 6 hours for tension. Dr. Campbell testified that some of those medications she was taking were for her neck problems. Flexeril is a muscle relaxant and Fiorinal is an analgesic pain medicine. She was on Restoril due to the employee having a sleep disturbance due to neck pain.

On January 29, the employee saw Dr. Campbell for neck pain. The employee's neck and shoulder girdles were tense and she had cervical paraspinal muscle spasms. She was unable to go to work, and was holding her neck and crying. She spoke at length about the stress in her life involving her son and other family members. He counseled her and she declined psychiatric or psychological counseling or referral. Dr. Campbell stated that the employee had no particular etiological event for the flare up of her neck pain. She was status post cervical vertebral fracture and had chronic pain which was not unusual. She had moderate degenerative changes. Dr. Campbell stated that due to the degenerative changes in the fracture of her cervical spine, it would not be unusual to have a flare up of neck pain. Dr. Campbell prescribed 30 Flexeril 10 mg taken every 8 hours and Depo-medrol 40 mg. He prescribed 30 Lortab every 6 hours for pain, and told her to discontinue Fiorinal and change to the Lortabs. The employee was off work on intermittent family medical leave on January 23-24, 26-27, and 29th.

In February, Dr. Campbell prescribed 30 Lortab every 6 hours, 14 10 mg and 14 20 mg Paxil samples, 30 Valium 10 mg ½ tablet every 6 hours, 30 Flexeril 10 mg, to be taken every 8 hours, and 50 Fiorinal #3, to be taken every 6 hours. The employee was on intermittent family medical leave from February 6 through February 9, and was on voluntary layoff from February 12-March 7.

On March 5, Dr. Campbell noted that the employee was in a better mood and well focused. There were no cervical muscle spasms as she often had. Dr. Campbell prescribed 50 Fiorinal #3 one every 6 hours, 30 Lortabs one every 6 hours, and samples of 7 Paxil 10 mg and 7 Paxil 20 mg. On March 12, the employee had a migraine headaches and Dr. Campbell prescribed a shot of Nubain 20 mg with Vistaril 50 mg. On March 26, Dr. Campbell prescribed Depo-medrol 40 mg. The employee had ongoing headaches and stress from domestic matters.

During March, Dr. Campbell prescribed the following additional medication of 90 Valium 10 mg ½ tablet every 6 hours, 50 Fiorinal #3 every 6 hours, 30 Flexeril 10 mg every 8 hours, and 30 Lortabs every 6 hours for pain. The employee was on intermittent family medical leave on March 26, March 27, part of March 28, and April 4.

Dr. Campbell stated on Monday, April 9, that the employee had been having neck pain for 3 or 4 days. The employee had paraspinal cervical neck muscle spasms and her head was somewhat dorsiflexed at the cervical spine. The muscles bilaterally in the cervical area were tense with limited range of motion in all directions. Dr. Campbell's assessment was paraspinal cervical neck muscle spasm status post cervical fracture. The employee was very distressed and near to tears. Dr. Campbell noted that the employee's prognosis was discussed and while it is not perhaps bad it is not without guard. Dr. Campbell stated that he meant that the quality of life or her future for having difficulty was questionable due to her chronic neck complaints. The employee was taken off work for a few days and was prescribed 30 Lortabs every 6 hours for pain. The employee testified that she had neck problems including tense muscles and muscle spasms due to working overtime.

The employee was on intermittent family medical leave on April 9, April 11, April 23 and part of April 24. During April, Dr. Campbell prescribed the following additional medication of 30 Lortabs every 6 hours, 60 Flexeril 10 mg every 8 hours, 30 Valium 10 mg ½ every 6 hours, 30 Restoril 30 mg to rest, and 150 Fiorinal #3 every 6 hours.

In early May, Dr. Campbell prescribed the following additional medications of 30 Valium 10 mg ½ every 6 hours, Paxil 7 10 mg and 7 20 mg, Depo-medrol 40 mg and 30 Lortabs every 6 hours.

On May 10, Dr. Campbell noted that the employee was crying and extremely upset due to the health of one of her brothers. She had chronic neck and head pain which was presumably from the fractured cervical vertebra. Dr. Campbell testified that on May 10 seven days before the alleged injury, the employee had continuing head and neck pain that he characterized as chronic pain. The employee was absent from work on intermittent family medical leave on Friday May 11, Monday May 14, and Tuesday May 15.

On May 14, Dr. Campbell stated that the employee had neck pain from her former cervical spine fracture and had a headache. She was very tense secondary due to the illness of her mother and brother among other things. Dr. Campbell excused her from work on Friday, May 11 and on Monday, May 14, and Tuesday, May 15. Dr. Campbell's assessment was chronic anxiety/depression, status post c-spine fracture with pain, and chronic headaches. Dr. Campbell prescribed 30 Flexeril one every 6 hours, 50 Fiorinal #3 every 6 hours as needed for pain, 30 Valium 10 mg ½ every 6 hours for anxiety/tension, 30 Restoril 30 mg at bedtime to rest, and injected Depomedrol 40 mg IM for neck pain. The employee was to return to see Dr. Campbell as needed or if she had new concerns.

The employee testified that she never asked for ice pack at work for migraines, no other employee had ever gotten her an ice pack for her neck, and she did not use ice packs prior to May 17. The employee's supervisor, Tony Campbell testified that prior to the accident, the employee had complained of migraine headaches. He had gone to the first aid room and got her ice packs for her neck. There were several times he noticed her with an ice pack on the back of her neck with a towel wrapped around it while she worked.

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EVIDENCE AFTER ALLEGED MAY 17, 2001 ACCIDENT:

The employee testified that in May of 2001, she was going to get cardboard to put down on the floor due to water. On the way back, there was a mixture of oil/water on the floor. Her right foot went out. She fell and landed on her buttocks on the concrete. A co-employee, Alan Bloom, went to help her up. She had a real sharp pain in her neck that went up to the right side of her head. She thought that she had rebroken her neck. Her supervisor, Tony Campbell, came up and asked what happened. She told him and that she hurt her back and neck. He said he would get an accident report if she needed it in future. She went back to work and thought she would be okay. She continued to have pain in her low back and neck but finished her shift. An accident report was not filled out that day. She went back to work the next day and her neck got a little worse everyday.

Allen Blume testified that he saw the employee fall. His testimony corroborated the employee's testimony about the fall. One of the supervisors, Tony Campbell came up and talked to her. After talking to Tony, the employee went back to work. Mr. Blume heard Tony ask if the employee was okay. Mr. Blume spoke to the employee a couple times to see if she was okay. She said that she hurt, but thought it was an initial hurt from falling down and that she would be okay. The week following the accident, she told Mr. Blume that her back and neck was hurting. He got ice bags for her when she was hurting badly. If the room was not open, she would go to Tony to open it. Mr. Blume told Tony that he was getting ice for her due to her neck and back hurting. He cannot remember getting ice for her prior to the fall.

Tony Campbell testified that he did not see her fall. When he first saw her after the fall, she was standing up talking to Allen Blume. The employee stopped him and told him that she had slipped and fallen. Tony asked her if she was okay and the employee said yes. He asked her if she needed to see a first responder and go to the doctor. She said she was okay and thought she was fine. Allen Blume told him that he witnessed the employee falling.

An accident/incident investigation report was signed by Human Resources Assistant Johnna Barnes on May 31, 2001. The employee testified that she gave Tony Campbell the information and he filled out the accident report including the pain diagram. Mr. Campbell testified that he filled out the report except for the dates and the other people's signatures. The date of accident was originally put down appeared to be either May 13 or May 15. That date was then scratched out and May 27 was put in it's place. The employee and her supervisor, Tony Campbell signed it. The date that was originally put down as being signed by the employee and Tony appeared to be May 15th. The signature date was scratched out and May 27 was put in the space. The employee, Tony Campbell, and Johnna Barnes did not know who changed the date. The report stated that the accident/incident did not cause an injury. The parts of the body that were involved are listed as neck and lower back. The low back and neck were circled on the body diagram as parts of the body that were affected. No first aid was given and the employee did not go anywhere for treatment.

Tony Campbell testified that the report was not filled out on the day of the accident and thought it was filled out and signed within a week after the fall. He put the report in the slot on the door of human resources on the day it was filled out. Johnna Barnes testified that she saw the accident and investigation report at the end of May. The employee told her that she was not seeking medical treatment. Ms. Barnes thought that the employee had not injured herself in the fall because she did not request to or see a doctor and the accident report stated that she was not injured.

Cindy Hayes, the human resources manager, testified that she spoke to Tony Campbell about the incident probably within a day or two after it happened. Ms. Hayes also remembers a conversation that she and the employee had about the employee having neck problems again. She does not remember when the conversation occurred and does not remember the exact conversation with the employee. It was something about that the employee had jerked her neck or was having problems with her neck again, and thought she had aggravated it.

Tim Moore worked with the employee from February of 1996 until he left Federal Mogul on June 4, 2001. He did not see the employee fall. He remembers the employee wearing ice packs on her neck but he does not remember if it was before or after she fell. He did not remember her complaining of pain before the fall but he remembered her complaining of neck pain just before he left.

Allen Blume testified that the employee talked to him about her pain and that is the reason he went to get the ice packs. Before she quit, he was getting her ice packs a couple times a week. He does not believe he ever went and got an ice pack prior to the fall.

After the fall, Tony Campbell saw the employee with an ice pack and a towel on her neck while she worked. Allen Blume asked him to get ice and also got a key from him to get ice for the employee. Tony Campbell testified that after the fall, she continued to have problems 2 or 3 times a week with her neck or migraine headaches. The employee's problems and the use of the ice pack were not any more frequent after the fall than before. Her complaints basically stayed the same

and he did not notice anything differently.

The employee testified that after the fall she had low back pain which she had not had prior to May 17. Her neck pain became more constant than before the fall. She did her job okay but had to ask her foreman to get ice packs for her. She took new medication she had not taken prior to May 17. In the 6 months after fall took more medicine than prior to the fall. She thought that Dr. Campbell increased the dosage of the same medication including Lortab and prescribed different medication such as MS Contin. After the fall, she stopped doing yard work, shopping and housework. She does not lift anything over 5 pounds and started sleeping in a recliner. She started using cane right after she fell at the suggestion of Dr. Campbell or Dr. Burns.

The employee's husband testified that after May 17, she had severe head and neck pain. The pain after the fall was different in that it would not go away. Prior to May 17, she could take a pain pill and go on to work. She continued to work for a little while but then she took so much medication that she could not function. Within 30 days after the fall she could not function. Lance Lacy testified that he moved in with his parents in the middle of 2001 to help his mother since she could not anything for herself.

The employee's payroll records show that for the time period ending May 20, she worked 42 hours; for the time period ending May 27, she worked 57.5 hours; and for the time period ending June 3, she worked 53.5 hours.

Dr. Campbell testified that on June 2, he did not see the employee, but she went to his office where she was prescribed 50 Fiorinal #3 to be taken every 6 hours.

The employee testified that the first time she saw Dr. Campbell after the accident she told him about slipping and falling at work and told him about her neck injury and her low back problems.

The June 4 records of Dr. Campbell show that the employee had an acute migraine headache and she was examined in the backseat of the car. Dr. Campbell assessed an acute headache and possible migraine. He injected her with Nubain 20 mg and Vistaril 50 mg in the car. He suggested that the employee go home, pull the shades, and miss her work shift. He faxed a letter to the employer to that effect. The employee was on absent from work on intermittent family medical leave on June 4 and June 5.

Dr. Campbell testified that June 4 was the first time he saw the employee after May 17. Dr. Campbell testified that he attempted to be a pretty meticulous note taker and made it a point to take down the details when someone is seeing him. Dr. Campbell stated that the notes from June 4 do not show any history of a work injury occurring on May 17 or that the employee was having any neck or low back pain. Dr. Campbell testified that although he did not put it in his notes, he had a recollection that she related a history of an accident to him. He remembered a visit with the employee where she described where she slipped in some oil and went flat down on her buttocks and she had immediate severe pain in her neck and head. He thought she also told him about back pain but he was focused on the neck due to her pain. Although that history is not in his notes it is in his memory. He cannot explain why it was not in his notes since he always prided himself on taking pretty good historical information and documentation. When asked if the history of the fall could have been a different time frame he answered that it happened sometime in 2001 and was right adjacent to the fall.

On June 12 Dr. Campbell refilled 30 Flexeril 10 mg, 30 Restoril 30 mg, Paxil 7, 10 mg and 7 20 mg, and 30 Lortabs as needed for severe pain. Dr. Campbell testified that those medications were the same that he had been prescribing to her before the May 17 incident. There was no change compared to what was prescribed on May 14.

On June 13, Dr. Campbell injected 22.5mg of Nubain with 57.5mg of Vistaril. In the narrative, Dr. Campbell noted that the employee's husband had called in the morning. The employee had cried all night with a headache and neck ache and had to leave work early the evening before. He had requested an injection for pain and nausea. The nurses gave the employee an injection in her car. Later, Dr. Campbell examined the employee which was essentially negative. Special attention was given to the neurological exam but it was also normal. Dr. Campbell advised them that she had significant symptomology and recommended further diagnostic. He offered a direct referral to a neurologist or to Dr. Yingling, the neurosurgeon who had treated her fractured cervical spine, or an MRI. An MRI was scheduled.

Dr. Campbell testified that there was an increase in medication. However, when he compared the medicines prescribed on June 13, compared with the medications on May 14, he stated that there was not an increase. Dr. Campbell stated that in the records from June 13, there is not a history of a work injury occurring on May 17 and not a history of any low back pain.

On June 14, 50 Fiorinal #3 to be taken every six hours, and 30 Valium at 10mg to be taken ½ for every six hours was prescribed by Dr. Campbell. Dr. Campbell took the employee off work. A June 14 MRI of the cervical spine showed diffuse bulging of the annulus and focal midline discogenic bulge at C4-5 with no evidence of nerve root impingement and no spinal stenosis.

On June 18, the employee saw Dr. Campbell. The employee's current prescription medications were Flexeril, Restoril, Paxil and Lortabs. Dr. Campbell reviewed the MRI of the cervical spine and due to some questionable areas; it was his advice to be referred back to Dr. Yingling. Dr. Campbell stated the employee continued with headaches, had a high level of anxiety, had neck pain with shoulder pain and felt that she was unable to work. Dr. Campbell's assessment was chronic headache and neck pain, precise type unknown; anxiety/stress/depression; and status post C spine injury with abnormal MRI. Dr. Campbell prescribed 30 Lortab one to be taken every six hours. He gave her Depomedrol 40mg and Paxil 20mg samples. He set up an appointment with Dr. Yingling and put the employee on sick leave.

Dr. Campbell testified that the June 18, records do not mention any history of a work injury occurring on May 17 or any low back pain. He recommended a referral to Dr. Yingling because he thought that he had nothing else to offer her and she needed a higher level of treatment due to persistent severe pain both in the head and the neck. It was Dr. Campbell's opinion that there was an alarming difference in the intensity of her pain. When asked why the change was not in his notes, Dr. Campbell stated that was something he just remembered.

On June 18, the employee signed a short-term disability accident and sickness form. In the employee's statement, the date of disability is listed as June 12. The type of disability was injury from an automobile accident on March 13, 1999. Dr. Campbell filled out and signed the physician's statement on June 20. The diagnosis was neck pain due to the due to the March 15, 1999, automobile accident.

On June 25, Dr. Campbell prescribed 50 Fiorinal #3 to be taken every six hours and 30 Valium 10mg to be taken every six hours. .

On June 28, Dr. Yingling saw the employee and noted that she was having persistent pain in the posterior right neck particularly since she slipped, fell and landed in the sitting position at work two weeks before. The employee occasionally gets numbness of all the fingers of the right hand and wakes up at night "crying with pain" in her hands which radiates up to her forearms and elbow. She had spasms of the posterior cervical muscles. The range of motion of her neck was quite limited. X-rays of the cervical spine showed mild to moderate degenerative changes with decreased range of motion presumably due to muscle spasms. Dr. Yingling noted that the June 14 MRI showed evidence of some bulging of the disc at C4-5 but did not show any compressive lesions. Dr. Yingling stated that the employee had persistent worsening problems with pain and spasms in her neck muscles, right greater than left. Dr. Yingling stated that between the migraines and the neck pain, the employee was taking a fair amount of Lorcet and Fiorinal which he thought was most likely responsible for some memory problems she was having. Dr. Yingling thought the employee had carpal tunnel syndrome. He ordered physical therapy, splints for both wrists and 60 Relafen 500 mg. with three refills to help her presumed carpal tunnel syndrome as well as her neck pain and migraines. He recommended a referral to a neurologist for an evaluation of her neck pain, migraines and forgetfulness.

On July 3, Dr. Campbell prescribed 50 Fiorinal #3 to be taken every six hours, 30 Flexeril 10mg to be taken every 8 hours, 30 Lortabs to be taken every 6 hours, and 30 Restoril 30mg to be taken at bedtime.

On July 3, the employee saw Dr. Mays due to neck, shoulder and arm pain. The employee stated that she had neck pain since an automobile accident in 1999. She had done reasonably well, had been able to work, and had not had any difficulty until mid June of 2001 when she slipped and fell at work. The employee was taking Flexeril, Lortab, and Fiorinal for headaches. The employee hurt all over but her most specific and severe pain is in the neck and upper shoulder girdle. The range of motion of her cervical spine was limited in all planes and there was some sustained spasm. Dr. Mays stated that the employee was taking a very large amount of narcotic medication which was not in her best interest. Dr. Mays thought the employee had fibromyalgia, which was unrelated to her neck problem. Dr. Mays recommended that she be detoxified off narcotics, have a complete work up by a neurologist and be put on more appropriate medication. He performed an epidural injection of her neck.

On July 12, Dr. Campbell prescribed an additional 30 Lortabs to be taken every 6 hours for severe pain, and 30 Valium 10 mg to be taken every 6 hours. Dr. Campbell noted the employee was having neck pain for two days. The employee was having a lot of edema with generalized fluid retention. Dr. Campbell thought that she might have had a reaction to the Relafen that was prescribed by Dr. Yingling. On July 13, Dr. Campbell saw the employee and continued her on the medication.

On July 16, the employee was complaining of neck and head pain. Dr. Campbell noted the employee had a major concern about the return of the neck pain and asked him whether or not the bulging disc in her cervical spine could have come from the fall she sustained recently at work. Dr. Campbell stated that he was unable to address that. Dr. Campbell continued the same approach and took her off a few days. He prescribed 30 Flexeril 10mg to be taken every 8 hours for neck and other muscle spasms. He prescribed Depo-medrol 40mg. Dr. Campbell testified that he was unable to address

whether the bulging disc could have come from the fall.

On July 16, the employee signed a short term disability accident and sickness form. In her statement, the employee showed the date of disability as May 17, 2001. The type of disability indicated was a work related injury with a date of accident May 17, 2001. Dr. Campbell did not sign and date this document until November 14, 2001. The chief complaint was back pain and the diagnosis was back pain, lumbar spine, and disc trauma. Ms. Barnes signed the form on November 20, 2001.

On July 19, Dr. Campbell prescribed 30 Lortabs to be taken every 6 hours. On July 23, Dr. Campbell noted that the employee had a very worried appearance and she was somewhat tearful. The employee's neck had a good range of motion. The employee's low back was painful and but there was nothing overt and evident on the exam.

On July 26, the employee had a severe headache and was requesting an injection without being seen. Dr. Campbell prescribed 22.5mg of Nubain with 67.5mg of Vistaril. On July 27, the employee called stating that she was better but not well enough to go to work. She continued to have a blinding headache. Dr. Campbell noted there was no reason to think it was different from ordinary. Dr. Campbell prescribed an injection of 22.5mg of Nubain with 67.5mg of Vistaril.

Dr. Campbell saw the employee on August 1, with continued neck pain. The assessment was chronic neck pain status post C2 fracture and to rule out other. The prescriptions were without change and as usual. The employee was given a refill of 30 Lortabs to be taken every six hours. On August 3, the employee requested the following which were refilled: 50 Fiorinal #3 tablets to be taken every six hours and 30 Restoril 30mg. Dr. Campbell testified he wrote down his assessment as chronic neck pain status post C2 fracture and to rule out other. He did not put in his notes, status post May 17 accident, but it could have been inferred that her neck pain was exacerbated.

On August 7, Dr. Campbell noted that the employee was complaining of neck pain and headache. She was given an injection of Nubain 20mg and 50mg of Vistaril.

The employee testified that her low back pain started after she fell at work. She testified that after doing housework on Saturday, her back started hurting really bad, and her husband took her to the emergency room. She told the hospital what had happened at work. The hospital records show that the employee went to the emergency room in the late evening of Saturday, August 11. The records noted that the employee fell on concrete and was complaining of right lower back pain. The history was that she fell on the ground when she tripped 2 months ago and landed on her buttocks. She has had lower back pain off and on since then which was worse with activities. The employee would have occasional shooting pains down her right buttocks with ambulation. She had tenderness to palpation in the low back with a positive straight leg raise on the right. She was given morphine. Dr. Marble's assessment was sciatica and ordered a lumbar MRI. She was prescribed Lortabs, Flexeril and Ibuprofen.

The August 14, MRI showed at L3-4 a slight bulging disc with no evidence of herniated disc, spinal stenosis or neuroforaminal narrowing. At L4-5 there was a minimal bulging disc with no evidence of a herniated disc, annular tear, spinal stenosis or neuroforaminal narrowing. There was mild hypertrophy of the facet joints.

On August 14, Dr. Campbell prescribed 30 Lortabs to be taken every six hours.

On August 16, the employee saw Dr. Campbell's nurse practitioner due to right hip and low back pain. It was noted that the employee worked on Saturday and had right hip and lower lumbar area pain. An additional 30 Lortabs to be taken every six hours for severe pain was prescribed. Dr. Campbell testified that he thought that the employee had been complaining all along about her back pain but the first time that appeared in his notes was August 16. On August 17, Dr. Campbell prescribed 60 Flexeril 10mg tablets to be taken every eight hours.

On August 22, Dr. Campbell noted that the employee complained of neck pain, headache, and back pain. He presumed that she had strains with essentially normal and negative MRI of the lumbar spine. He prescribed Depo-medrol 40mg.

On August 27, Dr. Campbell prescribed 30 Lortabs 7.5/500 to be taken every 6 hours for pain. On August 30, the employee was complaining of severe headaches and neck aches in addition to her general state of agitation. He injected 20 mg of Nubain and 50mg of Vistaril. Dr. Campbell also prescribed Depo-medrol 40mg IM, 50 Fiorinal #3, and 60 Valium 10mg. Dr. Campbell noted that the prescriptions were the same as before. The assessment was anxiety/depression and status post C2 fracture with pain.

On September 10, the employee was complaining of an intense migraine headache and was crying uncontrollably. The nurse practitioner instructed the employee to go home and go to bed in a dark and quiet room. An injection of 20mg of Nubain and 50mg of Vistaril was done. Later that day the employee's son called and stated that the employee was still in severe pain and wanted another shot to be injected at home and a refill on the Fiorinal. She was given 20mg of Nubain and 50mg of Vistaril and refilled the Fiorinal #3 with 50 to be taken every six hours.

The employee went back to see Dr. Campbell on September 11 due to extreme neck pain and headaches which had been going on for 24-36 hours. The employee had a decreased range of motion of the cervical spine related to muscle spasms. Dr. Campbell's assessment was status post C2 fracture with neck pain and decreased range of motion. Prescribed was Depo-medrol with Dexamethasone. Dr. Campbell prescribed 20 Vioxx 25 mg to be taken 2 per day for 3 days and then 1 per day. It was noted that the employee had frequent visits due to both her neck and back, which had most recently been injured in an incident at work.

Ms. Barnes testified that September was when she first became aware that the employee was alleging that the fall resulted in an injury. It was when the employee requested a copy of the accident report. To her knowledge, prior to September 12, the employee had not requested a copy of the accident or incident report. The employee signed the short-term disability accident and sickness form on September 17. In the employee's statement, it states that the date of disability was May 17, 2001 due to a May 17, 2001 work related injury. In the physician's statement signed by Dr. Campbell on October 7, 2001, he stated that the disability began on May 17. The chief complaint was back pain, and the diagnosis was back pain, lumbar spine, and disc trauma.

From September 17-20, Dr. Campbell prescribed 30 Lortabs 7.5/500mg to be taken every 6 hours, 30 Flexeril 10mg to be taken every 8 hours, 30 Restoril 30mg to be taken at bedtime, and 50 #3 Fiorinals to be taken every 6 hours.

The employee saw Dr. Campbell on September 21, due to the low back pain. She had a degree of a headache. The employee had a restricted range of motion of her cervical spine. The lumbar spine had bilateral muscle spasms at L1-S1 in particular. Dr. Campbell noted that the employee had a continual complaint to her low back since sometime in springtime perhaps mid May, when she sustained an injury or fall at work of the sitting down type. It had been an ongoing thing sometimes overridden by headaches and cervical spine pain. Dr. Campbell's assessment was low back strain and rule out discogenic disease and traumatic disc degeneration; and cervical spine pain with reduced range of motion and muscle spasms. Dr. Campbell administered an injection of Aristocort 40mg with Dexamethasone 4mg. At her request, the employee was also supplied with an injection of Nubain 20mg with Vistaril 50mg to administered by a qualified injectionist in the event of one of her severe headaches. The employee was also given 30 Lortab 6.5/500mg every 6 hours. Dr. Campbell testified that with regard to the note regarding that the injury or fall happened perhaps in mid May that was not a new report by the employee but something he had not written down earlier.

On September 25, the employee was requesting a refill on Lortabs and stated that her husband had been taking hers. She was given 30 Lortabs to be taken every 6 hours.

On October 2, the employee was prescribed another 30 Lortabs, and 30 Flexeril 10mg to be taken 8 hours. On October 3 the employee saw Dr. Campbell complaining of a severe migraine headache and requested a shot. She was prescribed a shot of Nubain 20 mg with Vistaril 50mg. The employee was crying, was unable to speak coherently, and was holding her head. Dr. Campbell noted that there was no evidence to indicate that this was anything other than usual and frequent type of headache.

Dr. Campbell, on October 4, prescribed Nubain 20mg with Vistaril 50mg and Depo-medrol 40mg. On October 8, the employee was requesting double amount Fiorinal #3 "because of the war", 100 Fiorinal #3 were given with a note of the next refill not being until November 1.

On October 9, the employee saw Dr. Campbell with severe neck pain, headache and back pain. The neck pain was across both shoulders with the inability to freely move her cervical spine. The back pain in the lumbar area was fairly diffuse, but had started radiating down both the back of her legs. There were muscle spasms in the cervical, trapezius and upper back muscles and the lower lumbar spine muscles. Dr. Campbell's assessment was headaches/neck pain with muscle spasms and low back pain with radiation and rule out disc disease. She was prescribed Depo-medrol 40mg with Dexamethasone 4mg IM and 15 Lortabs 7.5/650mg.

In mid October, Dr. Campbell prescribed 30 Lortabs 7.5/500mg to be taken every 6 hours, 30 Flexeril 10mg to be taken every 8 hours, Depo-medrol 40mg IM to go, and Demerol 25mg with Vistaril 75mg.

On October 22, Dr. Campbell noted that the employee was having chronic neck and low back pain which had been exacerbated for some unknown cause for around three days. Dr. Campbell noted that he could not rule out degenerative changes as a complicating feature. Prescribed was Depo-medrol 40mg with Dexamethasone 4 mg. Since the employee's husband had a high level of concern about her general ability to function both at home and in the workplace, Dr. Campbell referred her to Dr. Burns a Physiatrist.

In late October, Dr. Campbell prescribed Depo-medrol 40mg, Demerol 25mg with Vistaril 75mg, 30 Lortabs 7.5/500mg every 6 hours, 30 Flexeril 10mg every 8 hours, and 60 Valium 10mg ½ every 6 hours.

On October 30, the employee saw Dr. Burns for neck and low back pain. The employee stated that the onset of her symptoms dated back to a motor vehicle accident in 1999 where she suffered a C2 fracture. She returned back to work with occasional neck pain and occasional migraines. The employee stated that on May 17, she slipped and fell at work and reported an increase in neck and intrascapular pain, and low back pain with radiation down the right leg. The lumbar MRI

showed a bulging disc at L3-4 and L4-5 and mild degenerative changes primarily at the L4-5 facets. Dr. Burns assessment was myofascial pain secondary to fall and mild degenerative disc and sleep disturbance secondary to the myofascial pain. Dr. Burns performed trigger point injections. He changed her Flexeril to Skelaxin. He also prescribed Ambien and Celebrex. He noted that the employee could continue on the pain medications per Dr. Campbell.

The employee testified that between May 17 and Oct 31, she kept getting worse. She asked Johnna Barnes for the accident report but she was unable to find it. The employee testified that the date of May 17, 2001 was figured out to be the day of the accident by Johnna Barnes and Cindy Hays. A second accident/incident investigation report for the May 17 injury was filled out and signed on October 31. The report stated that the accident/incident resulted in an injury to the neck and lower back.

On November 1, Dr. Campbell saw the employee who was sobbing and had a headache. She was given Nubain 15mg/Vistaril 75mg. In early November, the employee was prescribed 2 Depo-medrol 40mg, 50 Fiorinal #3, 30 Lorcet 75mg/650mg, and 50 Fiorinal #3 for every 6 hours. It was noted that the employee was doubling up on her prescriptions.

On November 12, Dr. Campbell noted that the employee was in obvious distress. There were paraspinal muscle spasms from C1 or so down to L5. The assessment was anxiety/depression probably situational and not clinical. In mid and late November, the employee was prescribed three Depo-medrol 40mg, 60 Prozac 20mg, 60 Fiorinal #3, one Nubain 15mg with Vistaril 75mg injection, and 60 Lortabs 7.5/650mg. The employee saw Dr. Campbell on November 29 who assessed low back injury, status post cervical spine injury and anxiety/tension.

On December 5, the employee had chronic headaches, neck pain, back pain, and anxiety/depression. The assessment was cervical muscle spasms; status post cervical fracture; lumbar spine muscle spasms presumed to be secondary to injury sustained a few months back due to a fall at work; and major acute and chronic anxiety and cannot rule out major depression. Dr. Campbell applied a lumbosacral brace and dispensed 60 Flexeril 10 mg tablets, 30 Lortabs 7.5/650mg 30 to be taken every 6 hours, and 50 Fiorinal #3 to be taken 6 hours when not taking the Lortabs.

In mid December, Dr. Campbell prescribed 60 Lortabs 7.5/650mg, every 6 hours, 100 Fiorinal #3 every 6 hours and two Depo-medrol 40mg. Two injections of Nubain 15mg with 75mg of Vistaril were given.

On December 20, Dr. Burns stated that the neck pain was triggering migraines. He diagnosed mechanical lower back pain which was questionably related to the fall and ordered a CT myelogram of the cervical spine due to progressive pain and scheduled L4-5 lumbar epidurals. The employee saw Dr. Campbell on December 24 for neck and back pain that had been worse for 3 days. The employee was given Depo-medrol 40mg, Nubain 20mg/Vistaril 15mg. On December 26, Dr. Campbell prescribed 30 Lortabs every 6 hours, 35 Fiorinal #3 every 6 hours but not to be taken with Lortabs, and 30 Restoril 30mg.

The employee had a cervical myelogram and CT scan on December 28. The myelogram showed mild degenerative disc disease at C5-6 and minimal disc bulges at C4-5, C5-6 and C6-7. The CT scan findings showed the healed cervical fracture at C1-2. At C2-3, there was mild degenerative disc disease. At C3-4 there was minimal spurring with a disc bulge slightly to the right. At C4-5 there was a small central disc protrusion abutting the ventral surface of the spinal cord without causing definite mass effect. At C5-6, there was degenerative disc disease with anterior spurring. At C6-7 there was mild spondylosis.

On December 31, the employee was seen by Dr. Campbell who assessed chronic back pain, neck pain and anxiety/depression.

2002:

In mid-January, Dr. Burns noted that the employee was developing significant features of chronic pain syndrome with significant adjustment in her lifestyle to cope with pain. He referred her to Dr. Stigers who performed two lumbar epidural steroid injections. The employee continued to be treated by physicians including Dr. Campbell in 2002 and continuing through 2005. The first prescription of MS Contin was not until April 17, 2002.

Medical Opinions:

Dr. Campbell stated that prior to May 17, 2001, the employee had chronic neck pain after her cervical spine fracture, had degenerative changes and would have had periodic increased neck pain. The employee had a long-standing history of using medication up to the fall. It was Dr Campbell's opinion that after the fall the level and intensity of the employee's chronic neck pain was much worse. It was his further opinion that the employee's condition was exacerbated, made much worse, and has rendered her almost with the inability to function. Dr. Campbell stated that the employee's needed medication was greater, and that the records would reflect that the frequency and dosage of the medication that he prescribed was increased.

It was Dr. Burns's opinion that the employee's mechanical lower back pain was questionably related to the fall.

It was Dr. Volarich's opinion that the employee had a pre-existing 20% permanent partial disability of the body as a whole rated at the cervical spine due to the C2 fracture and migraines that take into account the neck pain, loss of motion and headaches. It was Dr. Volarich's opinion that the incident on May 17, 2001, where the employee fell and landed on her buttocks which jarred her neck and low back was the substantial contributing factor in causing injuries including cervical syndrome which includes a disc protrusion at C4-5; aggravation of degenerative disc disease, degenerative joint disease, and migraine headaches; and lumbar syndrome which includes a disc bulge at L4-5 with intermittent right leg sciatica. As a result of those injuries, she also developed myofascial pain syndrome. It was Dr. Volarich's opinion that as a result of the accident, the employee sustained a 20% permanent partial disability of the body as a whole rated at the cervical spine and a 20% permanent partial disability of the body as a whole rated at the lumbosacral spine.

Dr. Volarich stated that the employee's history to him was that her problems worsened considerably after May 17, 2001, and she had more pain and was on more medication. Dr. Volarich stated that from May 14 through June 13, there was not a lot of change in the records with regard to any significant increase or change in her complaints, symptoms or pathology. The records were very similar after the fall when compared to before. The medicines prescribed on June 12, were all medications that the employee had been on prior to the fall and were given on the same schedule and same doses as before.

Dr. Volarich stated that the employee told him that in the fall her neck and low back were jarred. He stated that he would expect a person who had such an incident who went to a doctor and discussed their physical complaints and problems to relate the fall and the complaints to the doctor. Dr. Volarich agreed that the records when the employee first contacted Dr. Campbell (June 2) and first saw Dr. Campbell after the accident (June 4) contain nothing about a new accident or injury and nothing about the neck and low back. In the June 13 records, there is nothing in the history of an accident or injury having occurred in May, and nothing recorded regarding any complaints or difficulty to the low back. A month after the alleged injury there was not a single reference to an accident that caused any neck or low back complaints in the medical records of her family doctor that she had been seeing for a long time and had seen on a number of occasions after the alleged injury. Dr. Volarich stated that it was possible that would raise some questions in his mind about the causal connection between the accident and the employee's complaints.

Dr. Wagner reviewed Dr. Campbell's records and stated that his notes are quite good so he would presume that if she would have told Dr. Campbell about the accident, he would have put it in his notes. Dr. Wagner stated that Dr. Campbell's records did not mention an incident at work until July even though she saw the doctor several times after the alleged injury. Dr. Wagner stated that if someone has a significant injury with pain right away, they would not wait two months to complain of the pain. This is especially true with the employee coming in on a regular basis to see her doctor about pain. Dr. Wagner stated that it was significant that the employee did not go to her doctor who she sees on a regular basis and complain of the fall. Dr. Wagner stated that on June 13, there were not any changes in the medication that she was taking prior to May 17 and no history of complaints or injury problems related to her low back.

It was Dr. Wagner's opinion that prior to May of 2001, the employee had degenerative disease in her cervical spine and lumbar spine and had classic degenerative disease complaints in her lower cervical spine with the neck and trapezius pain. Dr. Wagner stated that after the May 17, 2001 fall she had no acute symptoms but just ongoing pain which she had previously and her employee's complaints remained the same. It was his opinion that her complaints and condition are not related at all to her fall. It was Dr. Wagner's opinion that the employee's fall did not cause and did not accelerate the degenerative changes.

It was his opinion that at most she may have sustained an extremely minimal or mild sprain injury which has healed and which did not cause any permanent disability to her neck, back or other body parts. It was Dr. Wagner's opinion that the employee did not sustain an injury on May 17, 2001, and sustained no permanent partial disability either to her cervical or lumbar spine.

FINDINGS OF FACT AND RULINGS OF LAW:

Issue 1: Accident and Issue 3: Medical Causation

The employer-insurer has denied that the employee sustained an accident on May 17, 2001 and denied that the employee's injuries and need for medical treatment were medically causally related to the alleged accident.

The employee has the burden of proving both that there was an accident and that there is a medical causal relationship between the accident, the injuries, and the medical treatment for which she is seeking compensation. See Dolan v. Bandera's Café and Bar, 800 S.W.2d 163 (Mo. App. 1990). It has long been accepted that there is a distinction between an accident and an injury. The employee must prove that not only did she have an injury, but an injury which was caused by an accident, which arose out of and in the course of her employment. Thus, the "accident" is the cause, and the "injury" is the result. See Errante v. Fisher Body Div., General Motors Corp., 374 S.W. 2d 521 (Mo. App. 1964). In Anderson v. Electric Storage Battery Company, 433 S.W.2d 73 (Mo. App. 1968), the Appellate Court upheld the denial of a claim where the employee slipped while lifting a battery but did not aggravate a pre-existing condition. Therefore there can be a showing that an incident occurred at work but no resulting injury.

Section 287.020.2 RSMO states that an accident is an unexpected or unforeseen identifiable event happening suddenly and violently and producing at the time objective symptoms of an injury. An injury is compensable if it is clearly work related and an injury is clearly work related if work was a substantial factor in the cause of the resulting medical condition or disability. An injury is not compensable merely because work was a triggering or precipitating factor.

Section 287.020.3 defines the term "injury" as an injury which has arisen out of and in the course of employment. The injury must be incidental to and not independent of the relation of employer and employee. An injury shall be deemed to arise out of and in the course of the employment only if: (a) It is reasonably apparent, upon consideration of all the circumstances, that the employment is a substantial factor in causing the injury; and (b) It can be seen to have followed as a natural incident of the work; and (c) It can be fairly traced to the employment as proximate cause; and (d) It does not come from a hazard or risk unrelated to the employment to which workers would have been equally exposed outside of and unrelated to the employment in normal non-employment life.

I find that there is not sufficient evidence to refute the employee's claim that she fell at work and landed on her buttocks. However, given the applicable case law and the required statutory findings of accident and injury, there are numerous evidentiary problems which support a finding that the employee has failed to meet her burden of proof that she sustained a compensable accident and injury and that the employee's injuries and her medical treatment were medically causally related to the fall. The evidentiary problems are summarized as follows:

1. The initial injury report does not support a finding that the employee sustained an injury as a result of the May 17, 2001 fall. The initial injury report was signed by the employee on May 27, 2001. The employee gave Tony Campbell the information that was included in the report. The report stated that the employee did not receive first aid, the employee did not get any treatment, and that the accident/incident did not cause an injury.

2. The fact that the employee continued to work overtime for over two weeks after the fall does not support a finding that the employee sustained an injury as a result of the fall. The employee is claiming that the fall caused an injury to her low back, that she aggravated her pre-existing problems in her neck and head, and thought she had broken her neck again. However, the employee continued to work overtime after the fall. For the period ending May 20, the employee worked 42 hours. For the period ending May 27, she worked 57.5 hours, and for the period ending June 3, she worked 53.5 hours. This overtime work makes it difficult to find that the employee sustained an injury as a result of her fall.

3. The initial accident and sickness form signed by the employee does not support a causal relationship between the fall and the employee's injuries. The initial short term disability accident and sickness form was filled out and signed by the employee on June 18, 2001, one month after the fall. It stated that the employee's disability was a result of the March 1999 motor vehicle accident where the employee fractured her neck. There is no mention that her disability had anything to do with the fall in May of 2001. Dr. Campbell, the employee's personal physician who had treated her several times after May 17, stated that the employee's neck pain was due to the March 1999 motor vehicle accident, and did not mention the May 2001 fall. He further did not list any problems with the employee's low back. He signed the form on June 20. The fact that as of June 18, the employee did not believe that the problems she had with her neck had anything to do with the May fall, makes it difficult to find that the employee's problems are causally related to the fall.

4. The employee's delay in seeking medical attention does not support a causal relationship between the employee's fall and her injuries. The employee testified that when she fell she thought she had rebroken her neck. The employee did not request first aid or medical treatment on the day of the fall. When the injury report was signed by the employee on May 27, the employee still did not request medical treatment. When she talked to Johnna Barnes at the end of May, she was not seeking medical treatment. The first contact after the fall with any doctor's office was June 2. She did not see a physician but Dr. Campbell's office prescribed her usual medication that she previously had been taking. It was not until June 4, two weeks and four days after the fall, that the employee sought medical attention from a doctor. Dr. Wagner stated that it was significant that the employee, who went to a doctor on a regular basis and who had a fall and allegedly had an injury with immediate pain, would wait to go to a doctor. This has a negative impact on the employee's claim that her injuries were related to her May 17 fall.

5. The lack of contemporaneous corroborating medical history concerning problems to the employee's neck and about a fall at work to the initial medical provider does not support a causal relationship between the fall and her injuries to her neck and head. In the first visit to Dr. Campbell after the fall which was June 4, the employee only complained of an acute headache/migraine. The first mention of any neck pain was to Dr. Campbell on June 13, which was almost one month after the fall. There is nothing in Dr. Campbell's medical records about the fall until July 16, almost two months after it happened. The first report of the fall contained in the medical records is the visit to Dr. Yingling on June 28 which is almost a month and a half after the fall.

6. The lack of contemporaneous corroborating medical history concerning problems to the employee's low back and about a fall at work to the initial medical providers does not support a causal relationship between the fall and her problems to her low back. There are no low back complaints in the initial records of Dr. Campbell, the June 28 record of Dr. Yingling and the July 3 record of Dr. Mays. The first medical record that mentions that the employee was having any low back problems was in Dr. Campbell's record of July 19, which is more than 2 months after the fall. The next mention of the low back after July 19 is on August 11. The August 11 emergency room records is the first mention that the employee's fall caused any low back problems which is almost three months after the fall. The employee testified that prior

to going to the emergency room, she had performed housework which caused her back to hurt worse. The August 16 records from Dr. Campbell mentioned that her low back started hurting badly after doing work. The first mention in Dr. Campbell's records about the fall causing problems with her low back was on September 11, almost 4 months after the fall. This makes it difficult to support a causal relationship between the fall and her low back problems.

7. The fact that the employee is unsure of the exact date of such an allegedly traumatic fall that she is claiming has led to so many problems does not support a causal relationship between the fall and the employee's problems to her neck, head and low back. When the first report of injury was filled out, the date of the injury was initially listed as either May 13 or May 15. That date was changed to May 27. On June 28, the employee reported to Dr. Yingling that the fall was two weeks before which would be in mid-June. On July 3, the employee reported to Dr. Mays that the fall was in mid June. During the August 11, emergency room visit, the employee stated the fall was 2 months ago, which would have been in mid-June. When the employee testified on direct, she stated she had the fall in May but did not give a specific date. The employee then testified Johnna Barnes and Cindy Hays determined that the fall occurred on May 17. It was not until July 16 when the employee signed a short term disability form that listed May 17 as the date of the injury.

8. The employee's testimony has several inconsistencies with the other evidence. The employee testified that prior to the fall, she did not use ice packs and no one had gotten an ice pack for her at work. In early February of 2000, Dr. Campbell instructed the employee to use ice on her neck due to her continued neck pain. Tony Campbell testified that several times prior to May 17, 2001, he observed the employee with an ice pack on the back of her neck with a towel wrapped around it while she worked and that he had gotten ice packs for her neck

The employee testified that on April 9, 2001, she was having neck problems due to working overtime. The employment records show that the only time in 2001 prior to April 9, that the employee worked more than 37.5 hours was the week ending April 1, when she worked 41 hours. The records show that she only worked 34 hours for the week ending April 8.

The employee testified that after the fall, she had low back and neck pain, and that her neck pain was more constant. Tony Campbell testified that after the fall, the employee continued to have problems with her neck or migraine headaches 2-3 times a week and her problems and the use of an ice pack were not any more frequent after the fall than before. Her complaints stayed the same and he did not notice anything differently. Dr. Volarich stated that the employee's history to him was that her problems worsened considerably after May 17, 2001, in that she had more pain and was on more medication. Dr. Volarich stated that from May 14 through June 13, there was not a lot of change in the records with regard to any significant increase or change in her complaints, symptoms or pathology. He stated that the records after May 17, 2001 were very similar to the records before the fall. The medicines prescribed on June 12, were all medications that she had been on prior to May 17, 2001, and were given on the same schedule and same doses as before.

The employee testified that the first time that she saw Dr. Campbell after the accident she told him about slipping and falling at work and told him about her neck and her low back. The medical records from the first visit to Dr. Campbell on June 4 did not mention a fall at work and did not mention neck or low back pain.

It is important to discuss the credibility of Dr. Campbell's testimony regarding the employee informing him of the fall. Dr. Campbell testified that even though his records did not mention that the employee fell and injured her neck and low back, he remembered a visit when the employee told him she had slipped in some oil and went down on her buttocks with immediate pain in head and neck. He believes that he remembers the back pain but was focused on the neck. He testified that he tried to be a pretty meticulous note taker; he made it a point to put down the details, and always prided himself on taking good historical information. However, he cannot explain why the fall is not mentioned in his notes the first time he saw the employee. Dr. Wagner stated that Dr. Campbell's records are quite good. Dr. Wagner presumed that if the employee told Dr. Campbell about the accident Dr. Campbell would have put it in his notes. It is also important to note that in addition to the May 17 fall not being in Dr. Campbell's records, when he filled out the short-term disability form on June 20, the May 17 fall is not mentioned. I find that Dr. Campbell's testimony regarding the history in his records regarding a fall and symptoms is neither credible nor persuasive.

The employee testified that in the months before May of 2001, she was doing well and had no problems with her job. The medical evidence and off work records show otherwise, which is discussed in detail in the following section.

These inconsistencies have an adverse affect on the employee's credibility.

9. The employee had been undergoing treatment for pain in her neck and migraine headaches for several years prior to May 17, 2001, and the treatment continued until immediately prior to her fall. The employee had been treated for severe migraine headaches since prior to 1995 with a variety of prescriptions medicines including Demerol, Vistaril, Imitrex, Fioricet, Fiorinal, Nubain, Restoril, Valium, Paxil and Xanax. The employee had a severe motor vehicle accident in March of 1999 where she fractured her neck, was placed in a halo, and missed work for 10 months. As a result of that accident, she had neck pain, muscle spasms, cervical radiculitis and had a loss of range of motion. She was treated with Vioxx, Neurontin, Lorcet Plus, Lortab, Flexeril, Prozac, and Skelaxin. She also had cervical epidural steroid injections, and injections of Depo Medrol, an anti-inflammatory steroid injection. In January of 2000, a rhizotomy was performed on

several levels of her cervical spine due to posttraumatic neck pain and C2 cervical fracture. In December of 2000, the employee was still experiencing severe neck pain that radiated down her right arm, elbow, wrist and the first three fingers of her right hand.

In late January of 2001, she had severe neck pain, cervical muscle spasms, and migraine headaches. Dr. Campbell recommended a possible evaluation and a higher level of diagnostic testing or other treatment. She was given injections. She was diagnosed with status post cervical fracture and chronic pain. The employee was off work 5 days due to her chronic neck and head problems. She continued to be treated in February and March. In early to mid April, the employee had neck pain, cervical muscle spasms, tense neck muscles, and limited range of motion. Dr. Campbell stated that her quality of her future life was questionable due to her chronic neck complaints. The employee was taken off work and put on Family Medical Leave for several days. Dr. Campbell testified that just prior to May 17, the employee had chronic headaches and chronic neck pain from her cervical spine fracture and degenerative changes. The employee had periodic increased neck pain. Dr. Volarich stated that the employee had chronic headaches, chronic neck pain, and loss of motion from the fracture, degenerative disc disease and degenerative joint disease. Immediately prior to May 17, Dr. Campbell prescribed Lortab, Fiorinal #3, Flexeril, Restoril, Valium, and Paxil. The employee had been given an injection of Depo-medrol as an anti-inflammatory steroid injection for neck pain.

10. The medicine prescribed by Dr. Campbell in the 4 ½ months prior to the fall and the 4 ½ months after the fall, are very similar in type and amount. The employee and her husband testified after the fall she took more medicine and took different medication than before the fall. Dr. Campbell, Dr. Wagner, and Dr. Volarich testified that the medicines prescribed on June 12 and June 13 were the same ones, same amount and on the same schedule as had been prescribed before. The records from Dr. Campbell on August 1 note that the prescriptions were without change. Dr. Campbell testified that the medicines that he prescribed in late August were the same as he had prescribed before.

I reviewed Dr. Campbell's medical records and compared the amount and type of medicines prescribed to the employee during the 4 1/2 months prior to the fall (January 1-May 16, 2001) with the 4 1/2 months after the fall (May 17-September 30, 2001). The only new type of medicine prescribed in the 4 ½ months after the fall, was Vioxx an anti-inflammatory which was not prescribed until September 11, and had also been prescribed prior to the fall. The only different medicine of the same type was Aristocort/Dexamethasone a steroid which was not prescribed until September 21. With regard to the other medicine that was prescribed both before and after, the amount was very similar and there was not a significant change. This supports a conclusion that the employee's fall did not have a significant impact on the employee's preexisting neck problems, pre-existing headaches or low back.

11. The medical evidence after May 17 supports a conclusion that the employee's fall did not have a significant impact on the employee's preexisting neck problems, pre-existing headaches or low back problems. The employee testified that after the fall, she started having low back and her neck pain was more constant. Her husband testified after the fall, the employee's neck and head pain was different as it would not subside.

The employee's pain in her neck, shoulder, arm, elbow and hand in late June and early July were similar to her complaints prior to the May 17 fall. The employee was diagnosed with myofascial pain both before and after her fall.

Dr. Campbell initially testified that the employee's neck pain was more intense after the fall and that on June 18, the employee had an alarming increase in the intensity of her pain. When he was confronted with the fact that the change was not contained in his notes, he stated it was something he remembered. Dr. Campbell testified that he thought that the employee had been complaining all along about her low back pain but the low back is not mentioned in his records until July 19. As stated previously, Dr. Campbell's testimony regarding what he remembered which contradicts what is in his records is neither credible nor persuasive. Dr. Campbell's records on July 27 and October 3 state that the employee's migraine headache was her usual and ordinary type of headache. Although on June 13, Dr. Campbell recommended additional diagnostics, he had also recommended the same thing in late January of 2001.

Dr. Volarich stated that the employee told him that her problems and pain had worsened considerably after May 17. Dr. Volarich testified in his review of the May 14 through June 13 record; there was not any significant increase or change in her complaints, symptoms or pathology. The records after the fall were very similar when compared to the records before the fall.

This medical evidence supports a conclusion that the employee's fall did not have a significant impact on the employee's preexisting neck problems, pre-existing headaches or low back problems.

12. There is insufficient medical evidence to support a finding that the employee's fall was a substantial factor in either causing the employee's injuries or aggravating her pre-existing conditions. It was Dr. Volarich's opinion that the employee's fall was the substantial contributing factor in causing the employee's C4-5 disc protrusion; aggravation of degenerative disc disease, degenerative joint disease, and migraine headaches; and the employee's L4-5 disc bulge with intermittent right leg sciatica; and the myofascial pain syndrome. Dr. Volarich stated that the fact that there is no mention in the initial medical records of a fall that caused any neck or low back complaints could raise questions in his mind regarding his causation opinion.

In July of 2001, Dr. Campbell was unable to address whether the employee's fall could have caused the employee's bulging disc in the cervical area. It was Dr. Campbell's opinion that after the fall, the employee's pre-existing neck condition was exacerbated and has rendered her almost with the inability to function. His opinion is based on an assumption that after the fall, the level and intensity of the employee's chronic neck pain was much worse and the employee required stronger and more frequent medication. It was Dr. Burns's opinion was that the employee's mechanical lower back pain was questionably related to the fall.

The opinions of Dr. Volarich, Dr. Campbell, and Burns are all substantially affected by the numerous evidentiary problems that are stated above.

It was Dr. Wagner's opinion that after the fall, the employee had no acute symptoms, and that her complaints and pain that she had from her pre-existing degenerative disease in her cervical spine remained the same and that her complaints and condition are not related to her fall. It was further his opinion that the fall did not cause and did not accelerate the degenerative changes and that the employee did not sustain any permanent injury or permanent disability to her cervical or lumbar spine.

I find that the opinion of Dr. Wagner is more credible than the opinions of Dr. Campbell, Dr. Volarich, and Dr. Burns.

Conclusion:

I find that the employee has failed to satisfy her burden of proof on the issues of accident and medical causation. Under the detailed definitions of accident and injury as set forth in Section 287.020 RSMo., and the case law, the evidence does not support a finding that the employee sustained a compensable work related accident and injury on May 17, 2001 or that the employee's medical conditions are medically causally related to the alleged accident.

Employee: Doris Lacy

Injury No. 01-124687

I find that the employee's fall on May 17, 2001 was not a substantial factor in causing the employee's low back condition or aggravating the employee's pre-existing neck and head condition. I further find that the employee has failed to prove that her fall caused an injury that was clearly work related and that the fall was a substantial factor in the cause of the resulting medical conditions or disability. I find that the employee's medical conditions did not follow as a natural incident of the fall at work and cannot be fairly traced to the fall at work as the proximate cause. I further find that the employee's medical conditions and need for treatment were not medically causally related to the fall sustained by the employee on May 17, 2001.

The employee's claim for compensation is denied against both the employer-insurer and the Second Injury Fund. Given the denial of the employee's claim on the issues of accident and medical causation, the remaining issues are moot and will not be ruled upon.

In addition to the employee's claim, a medical fee dispute was filed by Dr. Campbell. Based on the denial of the employee's claim for compensation against the employer-insurer and Second Injury Fund, the medical fee dispute filed by Dr. Campbell must also be denied and dismissed.

Date: _____

Made by:

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

A true copy: Attest:

Ms. Patricia "Pat" Secrest
Director

