

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

Injury No.: 98-174856

Employee: Linda Lawrence
Employer: Home Advantage
Insurer: Wausau Insurance Companies
Additional Party: Treasurer of Missouri as Custodian
of Second Injury Fund (Open)
Date of Accident: On or about July 15, 1998
Place and County of Accident: East Prairie, 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 associate administrative law judge (AALJ), as modified, 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 associate administrative law judge dated December 8, 2004, as modified. The award and decision of Associate Administrative Law Judge Lawrence C. Kasten, issued December 8, 2004, is attached and incorporated by this reference.

The Commission finds that the AALJ correctly weighed and evaluated the lay and medical testimony in reaching his conclusions, including those as to disability, accident and causation. *Reese v. Gary & Roger Link, Inc.*, 5 S.W.3d 522 (Mo. App. E.D. 2002), *Sullivan v. Masters Jackson Paving Co.*, 35 S.W.3d 879 (Mo. App. S.D. 2001), *Landman v. Ice cream Specialties, Inc.*, 107 S.W.3d 240 (Mo. banc 2003).

The Commission affirms the award of the AALJ as to future medical to cure and relieve from the effects of this injury as authorized by section 287.140 RSMo. However, the Commission reverses that portion of the award purporting to allow for the retention of jurisdiction by the Division of Workers' Compensation (Division) or the Commission. While it is well established that an award of ongoing medical care may be entered (*Kaderly v. Race Brothers Farm Supply*, 993 S.W.2d 512, (Mo. App. S.D. 1999)) the Division or Commission is without jurisdiction to enforce such an order. The sole statutory tool for enforcement of an award is found in section 287.500 RSMo requiring the acts of a Circuit Court. *Taylor v. St. John's Regional Health Center*, 161 S.W.3d 868 (Mo. App. S.D. 2005). Further, the Division or Commission can not invest itself with authority not granted in the statutory scheme. *Derby v. Jackson County Mo. Circuit Court*, 141 S.W.3d 413 (Mo. App. W.D. 2004).

This award is subject to a lien in favor of the Department of Social Services, Division of Medical Services.

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

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

Given at Jefferson City, State of Missouri, this 22nd day of July 2005.

William F. Ringer, Chairman

Alice A. Bartlett, Member

Attest: John J. Hickey, Member

Secretary

TEMPORARY OR PARTIAL AWARD

Employee: Linda Lawrence Injury No: 98-174856

Employer: Home Advantage

Insurer: Employers Insurance of Wausau

Hearing Date: April 18, 2000 Checked by: JHK/HO

FINDINGS OF FACT AND RULINGS OF LAW

1. Are any benefits awarded herein? Yes
2. Was the injury or occupational disease compensable under Chapter 287? Yes
3. Was there an accident or incident of occupational disease under the Law? Yes
4. Date of accident or onset of occupational disease: July 15, 1998
5. State location where accident occurred or occupational disease was contracted: Mississippi County, Mo.
6. Was above employee in employ of above employer at time of alleged accident or occupational disease? Yes
7. Did employer receive proper notice? Yes
8. Did accident or occupational disease arise out of and in the course of the employment? Yes
9. Was claim for compensation filed within time required by Law? Yes
10. Was employer insured by above insurer? Yes
11. Describe work employee was doing and how accident occurred or occupational disease contracted: Employee was working as a registered nurse for Home Advantage and injured her back while carrying two small whirlpool foot tubs from a patient's home to her car.
12. Did accident or occupational disease cause death? No
13. Part(s) of body injured by accident or occupational disease: Back
14. Compensation paid to-date for temporary disability: \$4,420.00
15. Value necessary medical aid paid to-date by employer-insurer? \$4,917.00

16. Value necessary medical aid not furnished by employer-insurer? Undetermined

Employee: Linda Lawrence

Injury No: 98-174856

17. Employee's average weekly wages: \$1,083.05

18. Weekly compensation rate: \$562.67 TTD/\$294.73 PPD

19. Method wages computation: By agreement

20. Amount of compensation payable:

Unpaid medical expenses: Undetermined – employer-insurer directed to provide additional medical aid (see findings)

15 4/7 weeks of temporary total disability at the rate of \$562.67 per week (\$8,761.57)

15 3/7 weeks of temporary partial disability at the rate of \$562.67 per week (\$8,681.19)

TOTAL: \$17,442.76

Each of said payments to begin (see findings) and be subject to modification and review as provided by law. This award is only temporary or partial, is subject to further order, and the proceedings are hereby continued and the case kept open until a final award can be made.

IF THIS AWRAD IS NOT COMPLIED WITH, THE AMOUNT AWARDED HEREIN MAY BE DOUBLED IN THE FINAL AWARD, IF SUCH FINAL AWARD IS IN ACCORDANCE WIT THIS TEMPORARY AWARD.

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.

Mr. Joe Fuchs

Additional note:

1. The employer-insurer is directed to provide additional medical aid pursuant to Section 287.140 RSMo. (See additional findings under Issue 4).
2. The employer-insurer is directed to pay to the employee's attorney, Mr. Joe Fuchs, the sum of \$4,360.69 (25% of compensation awarded), as the reasonable cost to recovery under Section 287.203 RSMo. (See additional findings under Issue 6).

FINDINGS OF FACT and RULINGS OF LAW:

Employee: Linda Lawrence

Injury No: 98-174856

Employer: Home Advantage

Insurer: Employers Insurance of Wausau

Checked by: JHK/HO

On April 18, 2000, the employee, Linda Lawrence, appeared in person and by her attorney, Mr. Joe Fuchs, for a hearing for a temporary award. The employer-insurer was represented at the hearing by its attorney, Ms. Laura Newberry. Following the initial hearing on April 18, 2000, the administrative law judge suggested that the employee file a motion to

submit additional evidence on the issue of medical causation. The employee's motion was filed on April 25, 2000. Based on that motion the hearing was continued and the record left open for the purpose of allowing both the employee and the employer-insurer to submit additional medical evidence in the form of medical depositions. On June 16, 2000, the Division received the employee's deposition testimony of Dr. C. P. McGinty. On September 5, 2000, the Division received faxed correspondence from the employer-insurer's attorney advising that no additional evidence would be submitted by the employer-insurer. Based on that correspondence the record was closed and the hearing completed as of September 5, 2000.

At the time of the initial hearing on April 18, 2000, the parties agreed on certain undisputed facts and identified the issues that were in dispute. These undisputed facts and issues, together with a summary of the evidence and the Findings of Fact and Rulings of Law, are set forth below as follows:

UNDISPUTED FACTS:

1. On or about July 15, 1998, Home Advantage was a covered employer operating under and subject to the provisions of the Missouri Workers' Compensation Act, and its liability was fully insured by Employers Insurance of Wausau.
2. On or about July 15, 1998, Linda Lawrence was an employee of Home Advantage, and was working under the provisions of the Missouri Workers' Compensation Act.
3. The employee's claim for compensation was filed within the time allowed by law.
4. The employee's average weekly wage was \$1,083.05 per week. The employee's rate of compensation for temporary total disability is \$562.67 per week and her rate of compensation for permanent partial disability is \$294.73 per week.
5. The employer-insurer furnished medical aid to the employee in the amount of \$4,917.00. These temporary total disability benefits were paid at the rate of \$562.67 per week for a total of 7 6/7 weeks, and ended on September 13, 1999. The employee indicated that she was not claiming any additional temporary total disability benefits prior to September 13, 1999.

ISSUES:

1. **Accident or occupational disease.**
2. **Notice.**
3. **Medical causation.**
4. **Additional medical aid.**
5. **Nature and extent of disability.**
6. **Cost of recovery under Section 287.203 RSMo.**

SUMMARY OF THE EVIDENCE:

At the time of the hearing the employee testified that she was 58 years old, and had been employed for several years as a registered nurse for a variety of different employers. Prior to starting with Home Advantage in November of 1995, the employee had worked as a nurse in hospitals, a school nurse, an occupational health nurse, and a nurse in the U. S. Navy Hospital Corps. and the Army Reserves. Immediately prior to starting her job with Home Advantage, the employee had worked approximately five years as the director of nursing for Pyramid Home Care. After transferring to Home Advantage in November of 1995 the employee indicated that her duties included home visits with mostly elderly patients in which she did IV therapies, wound care injections and other nursing responsibilities. The employee's area of responsibility included Mississippi County, New Madrid County and part of Scott County. The employee was paid approximately \$28.00 per visit plus mileage, and testified that her 1998 income was in the forty-six to forty-eight thousand dollar range.

At the time of her accident on July 15, 1998, the employee testified that she was assisting an elderly patient at her home in East Prairie, Missouri. This particular patient had diabetic wounds on her feet, and the employee saw her on a daily basis to do whirlpool treatments for her feet. The employee described the whirlpool tubs as being approximately three feet long with a motor on one end. At the time of her accident the employee testified that she was carrying two of these tubs as well as other items from the patient's house out to her car. While carrying the tubs the employee testified that they started slipping and she was afraid she was going to drop them. To keep them from falling, the employee stated that she went down on her left knee and when she tried to get up she twisted her back. The employee felt immediate pain in her mid back area approximately three inches above her belt line. The employee emphasized that she did not fall, but used her left knee to try to keep the tubs from falling.

After her accident on July 15, 1998, the employee continued working and completed her duties for the day. Two days later the employee reported her accident to Brenda Wells, who was her supervisor and was employed as the Director of Nursing for Home Advantage. She recalled that Ms. Wells had her fill out papers, and told her if she needed to see a doctor to let her know. After filling out the report and handing it to Ms. Wells, the employee testified that Ms. Wells put the report

in her file but she never saw it again and did not know what happened to the report.

After reporting her injury, the employee testified that she continued to work for several months without seeking medical attention until she finally mentioned it to her family doctor, Dr. Neal Gardner, who practices in Bernie, Missouri. The employee recalled that she told Dr. Garner that she had injured her back, but she thought it would go away without treatment. The employee testified that she was taking prescription pain medication that she had received for migraine headaches, and was therefore able to continue working. The employee emphasized, however, that she was in constant pain for a solid year, but was able to continue working because of the medication she was taking. She also noted that she adjusted her job because of the difficulty she was having with her back. The employee stated that she was around her supervisor and coworkers on a daily basis, and also attended weekly meetings. The employee emphasized that both her new Director of Nursing, Donna Stevens, and the other nurses employed by Home Advantage knew that her back was hurting and were aware that she was having a difficult time doing her job. The employee recalled that during this time period she had a heavy load of whirlpools, and asked her supervisor if they could have someone else do some of the whirlpools. In addition to the pain medication she was taking, the employee also carried a lumbar roll in her car which she used to help with her low back symptoms.

The medical records from Dr. Neal Garner confirm that starting in February of 1998 he had prescribed Fiorinal for treatment of the employee's migraine headaches, and had seen the employee on two or three occasions prior to her accident in July of 1998. None of the medical records from Dr. Garner indicate that the employee had any prior complaints of back pain before July 15, 1998. The first visit with Dr. Garner which occurred after her July 15, 1998, accident was recorded on July 29, 1998. At the time of that visit Dr. Garner's records indicate the employee was suffering from depression as a result of having been through a divorce and unrelated problems that her son was having. Dr. Garner diagnosed the employee as having situational depression and prescribed Prozac. After two additional entries in September in which Dr. Garner authorized refills for Prozac and Fiorinal, the employee's second recorded visit with Dr. Garner after her accident occurred on February 3, 1999. At the time of that visit Dr. Garner noted that the employee was running a fever, had a sore throat, and was not feeling good. He also recorded that the employee was complaining of a "strained back". In a typed entry Dr. Garner's medical records add that "she also states this A.M. that she strained her back, but we talked about that, and what she's talking about is that she's noticed over the past several months her posture is not as good as it had been. I'm not sure if that is a problem we need to deal with today. She does have probably a strep throat and we are going to deal with that." (See Joint Exhibit 1-3).

In a follow-up visit on March 9, 1999, the employee was complaining of a cold and cough, but also gave a more detailed medical history regarding her back pain. At the time of her March 9, 1999, visit Dr. Garner recorded the following:

Linda has described some back discomfort, she does a lot of lifting with her work and she was moving some whirlpool tubs, and she states that one started to slip and she tried to catch it and she kind of twisted a little. That was back in the summer time and she has dealt with this off and on for a while. (See Joint Exhibit 1-2).

After Dr. Garner did what he described as a "strain-counter strain" technique, the employee indicated that she was feeling better. Dr. Garner also noted that she had been wearing a back brace and encouraged her to continue wearing the back brace while she was working.

In her next visit with Dr. Garner on June 10, 1999, the employee continued to complain of some back pain. Dr. Garner's records indicate that he repeated the "strain-counter strain" technique, and diagnosed the employee as having chronic migraines, depression, and a somatic dysfunction in the sacroiliac region. Dr. Garner then prescribed Prozac, Inderal, Atrohist and Fiorinol.

Eight days later on June 18, 1999, the employee returned to Dr. Garner reporting that she was tired, having a really bad headache, and noted that her back was "really giving her a fit". Based on her complaints Dr. Garner gave the employee a note keeping her off work, and suggested that she needed an injection, which he allowed her to give herself since she was a nurse. (See June 18, 1999, entry in Joint Exhibit 1-3).

By June 29, 1999, the employee's headaches were better, but her back was still bothering her. After ordering x-rays, Dr. Garner diagnosed a possible compression injury at the L1, L2 and L3 levels. He noted that "it is difficult to determine age, I don't think it is anything recently". Dr. Garner then made the following entry regarding the employee's low back injury:

We want her out of work until she is seen by Dr. Miller, in fact, she just needs to be out the rest of the week. She wonders if what we are noticing now could be related to an injury that she had in her work. That would be in July of last year. She had two whirlpool tubs that were plastic, they weren't very heavy,

but she was carrying both of those under her left arm and she was trying to get in her car and she states that when she did, they started to fall and she didn't want them to fall and break, so she used her left leg to kind of brace them and she kind of twisted and that is when it felt like a tight rubber band and it felt like it broke almost. She didn't really think too much about it at that time, but probably two or three months after that, she started having pain pretty severe. Really she has been dealing with that off and on since that period of time. (See Joint Exhibit 1-3).

In a follow-up visit on July 2, 1999, Dr. Garner reviewed the x-rays and confirmed a compression fracture of the T9 and L1 level. He also noted that there were some disc bulges, and recommended the employee see Dr. Ray, who is a neurosurgeon. Dr. Garner also diagnosed the employee as having possible osteoporosis, and referred the employee to Dr. Joel W. Ray of Cape Girardeau Neurological Associates PC.

The medical records of Dr. Ray indicate that he saw the employee on July 14, 1999, and prepared a letter summarizing his conclusions which was mailed to Dr. Neal Garner. In that letter Dr. Ray concluded that the employee had a "50% compression fracture secondary to a work related injury on July 20, 1998". After considering both nonsurgical and surgical options, Dr. Ray recommended that the employee see Dr. Burns for rehabilitative treatment, as well as undergo a therapy program in Sikeston. Dr. Ray recommended that she undergo this conservative treatment for approximately one month to see if her symptoms would improve sufficiently to avoid possible surgical stabilization. (See July 14, 1999, report of Dr. Ray set forth in Joint Exhibit 1-2). In his report Dr. Ray also concluded that "given all of the above, however, she was able to work until July 1, 1999, but with progressive symptoms, has stopped". (Joint Exhibit 1-2).

During the same time period when the employee was being seen by Dr. Joel Ray, the employer-insurer also had the employee seen by Dr. David A. Pfefferkorn and by Dr. Joseph Miller. Dr. Pfefferkorn is an M. D. family practitioner who practices at the Ferguson Medical Clinic in Sikeston, Missouri, and Dr. Joseph Miller is a neurosurgeon with Simms Murphy Neurological Spine Institute in Memphis, Tennessee. The medical record of Dr. David A. Pfefferkorn was admitted as Joint Exhibit 1-4. In a report dated July 21, 1999, Dr. Pfefferkorn recorded a history in which the employee indicated that her original back problem started in July of 1998. Dr. Pfefferkorn's entry indicates that the employee was bending over to help a client use a whirlpool bath on his feet at the time of her injury. After reviewing the employee's x-rays Dr. Pfefferkorn agreed that the employee had at least one compression fracture at the L1 level, and agreed that she may have another compression fracture at the T9 level. Dr. Pfefferkorn felt the employee was suffering from symptomatic osteoporosis, and concluded that "I see no way she can continue to do her job. I think she will always have back problems from this. As far as I can tell, she needs to be off work permanently". (See January 21, 1999, report in Joint Exhibit 1-4).

In addition to the one visit with Dr. Pfefferkorn, the employer-insurer also authorized the employee to see Dr. Joseph Miller. The employee testified that she saw Dr. Miller a total of three times, two of which were in Poplar Bluff and one in Memphis, Tennessee. The x-rays and MRI performed at Lucy Lee Hospital at the request of Dr. Miller indicate that the employee was diagnosed as having an "old compression fracture involving the L1 vertebral body as well as having a slight gibbous deformity at the T12 L1 level associated with the old compression fracture." It should be noted that this MRI was completed approximately one year after the employee's alleged accident date. The MRI report also indicates the employee had some mild annular disc bulging at the L2 L3, L3 L4 and L4 L5, but did not confirm the presence of a disc herniation or spinal canal stenosis. (See June 29, 1999, MRI report in Joint Exhibit 1-1).

In a follow up report dated August 9, 1999, a radiologist who had conducted a bone scan confirmed that the employee was suffering from a compression fracture at the L1 level with a mild posterior protrusion of a portion of the vertebral body into the spinal canal. This bone scan also indicated the employee had diffuse bulging disc at the T12 L1 level, the L1 L2 level and the L3 L4 level, as well as mild degenerative arthritis. (See August 9, 1999, bone scan in Joint Exhibit 1-5).

In a follow up MRI performed by a radiologist at Simms Murphy, Dr. Mark Weatherly reported that the employee was suffering from a compression deformity of the L1 vertebral body of approximately 50%, but he concluded that it did not appear to be "acute", and there was no canal compromise. (Joint Exhibit 1-6). Based on his review of these additional tests Dr. Miller prepared a final report for a senior claims adjuster at Wausau dated August 31, 1999. In that letter Dr. Miller concluded that the employee was suffering from "an old fracture", with persistent pain. Dr. Miller stated that "it was our opinion that no type of operative procedure would help her, and I did not feel a brace was indicated at this point." (Joint Exhibit 1-6). At that point Dr. Miller indicated the employee had asked him about doing some light work which he felt would be satisfactory, but he did not feel she was capable of doing any heavy work. Dr. Miller then prepared an addendum in which he gave the employee a permanent partial disability rating of 7% of the body as a whole. (Joint Exhibit 1-6).

Following this release and rating by Dr. Miller, the employee testified that her temporary total disability benefits were terminated as of September 13, 1999. The employee indicated, however, that she was not able to return to work, and sought additional treatment on her own from Dr. Kapp of Orthopedic Associates in Cape Girardeau, Missouri. The only medical record from Orthopedic Associates was admitted as Joint Exhibit 1-8. This one page entry indicates that Dr. Kapp saw the

employee on October 22, 1999, and diagnosed the employee as having an L1 compression fracture. At the time of that visit Dr. Kapp indicated that the employee was “totally incapacitated at this time”, and referred her for an additional evaluation by Dr. Kee B. Park, who is a neurosurgeon with Cape Neurological Surgeons, P.C. In an office note dated October 28, 1999, Dr. Kapp recorded that:

“Ms. Lawrence is a 58 year old female who reports on July 20, 1998, while she was working, she twisted her back and landed on her knee and sustained a compression fracture of T9 and L1. She was treated by Dr. Joe Miller and was released for work. However, because of persistent pain she is seeking my help. Pain is nearly constant. It is a 7/10. It is an aching weakness in her mid lower back. It is made worse by any kind of activity. It is made better by resting. She denies any significant leg symptoms.” (See Joint Exhibit 1-9).

After performing a neurological examination and reviewing her x-rays and MRI, Dr. Park concluded that the employee was suffering from a “significant compression deformity of L1 with approximately 60% loss of anterior vertebral body height with significant kyphosis”. Dr. Park then made the following recommendation:

“Ms. Lawrence has persisted in chronic back pain from her compression fracture at L1. Given the chronic nature of this and her inability to get the relief of her symptoms, I believe at this time it will be reasonable to perform a posterior instrumentation with fusion. In addition, attempts should be made to try to correct the kyphosis. However, this may not be successful given that her fracture was over a year and a half ago. However, this is offered to her at this time. I will be waiting to hear back from her should she want to proceed”. (See Joint Exhibit 1-9).

Following this recommendation for surgery by Dr. Park, the employer-insurer responded by referring the employee for a medical evaluation by Dr. Allen H. Morris, who is an orthopedic surgeon in St. Louis, Missouri. In a medical report dated November 16, 1999, Dr. Morris diagnosed the employee as having a compression deformity at the L1 level with secondary kyphosis at the thoracolumbar level, as well as having “osteopenia”. At the time of this November 16, 1999, report Dr. Morris recommended that a bone density test be performed to determine if the employee was suffering from osteoporosis. On the question of causation Dr. Morris made the following comments:

A compression fracture is present at L1 with deformity producing a mild kyphosis. It is certainly old. The question as to whether this compression fracture actually occurred on July 15, 1998, and then if it did occur at that time, allowed Ms. Lawrence to continue to work for a year during which time visits to Dr. Garner did not bring about any specific complaints of thoracolumbar back pain, would make this examiner question if in fact, the compression fracture did really occur on July 15, 1998. (See Joint Exhibit 1-10).

Dr. Morris then concluded that he felt it was “problematic” to consider that a compression fracture of the employee’s L1 vertebra occurred in July of 1998. He did feel that the employee was suffering from “generalized back pain”, which could have been caused by symptomatic osteoporosis”, and for which she should have “appropriate evaluation and treatment”. (See Joint Exhibit 1-10).

Based on the recommendation of Dr. Morris, a bone mineral density test was performed at Missouri Baptist Medical Center on February 3, 2000. This bone density test indicated the employee had a bone density in the range which was “75% of the peak bone mineral density with a standard deviation of minus 1.9.” According to the radiology report, this represented diminished bone density in the osteopenic range, which Dr. Morris concluded was bordering on osteoporosis. (Joint Exhibit 1-11). In a final report dated March 7, 2000, Dr. Morris made the following observations:

In reviewing this patient’s case, it seems unlikely, to this examiner, Ms. Lawrence would have sustained a compression fracture on July 15, 1998, and then gone for a year without treatment. She then saw her primary care physician, who did not treat her for back pain. And, in fact, Ms. Lawrence continued to work. It is my experience with patients sustaining a compression fracture that they will have severe pain with limitation of activity and inability to perform most activities of daily living without significant pain. Bending and lifting would generally be impossible early after these injuries. (See Joint Exhibit 1-12).

Dr. Morris then concluded that the employee had reached her maximum level of medical recovery and gave her a 5%

permanent partial disability rating. As to her July 15, 1998, accident Dr. Morris diagnosed the employee as having "lumbar back pain", with a possible soft tissue injury.

In regard to the compression fracture Dr. Morris then added the following comment:

The exact date when this compression fracture occurred could well have been before that date or after that date. Based upon her history, as I stated above, it is unlikely this compression fracture actually occurred on July 15, 1998. (Joint Exhibit 1-11).

Dr. Morris then concluded his report by stating that after reviewing the employee's outside medical records and performing an examination, he found "no indications for surgery". (Joint Exhibit 1-11).

The last medical record offered at the time of the hearing was an April 13, 2000, disability certificate signed by Dr. Neal Garner. This certificate indicates that Dr. Garner felt the employee was still totally incapacitated as of April 13, 2000, as a result of her compression fracture to the T9 and L1 levels. (See Joint Exhibit 1-12).

In addition to the medical records, the employee also testified at the hearing that after being release by Dr. Miller on September 13, 1999, she had not been employed. Up until January of 2000 the employee testified that she was unable to work at all, but starting in January of 2000 she was forced to work one day a week because she had no other income. During her direct examination and through additional cross examination it was determined that the employee was working through a referral from "Staff Builders", in which she worked one day a week with a ten hour shift at the rate of \$15.00 an hour. The employee indicated that she was initially filling in with Staff Builders when other nurses were not available by watching a five year old disabled child. The employee emphasized that she was giving the child medication in an IV and turning the child while he was lying in bed. After a few weekly visits with this five year old child, the employee's testimony during her direct examination established that she was working on a private duty job one day a week watching a four year old child who had cerebral palsy. The employee indicated the child had no muscle control, and stayed on the couch. She indicated she was watching this child for a working mother, and was not required to do any lifting. The employee emphasized that she had not been able to do any other work either as a registered nurse or otherwise because of continued back pain. The employee added that she did not feel she was able to work at the time of the hearing because of continued severe pain in her back. She noted that she is not able to lift, and has problems sitting or standing for any significant time period. The employee also noted that prior to July 15, 1998, she had never missed work, and had never had any problems with back pain.

When questioned about her current symptoms, the employee stated that she was experiencing a constant ache in the middle of her back. She noted that if she exerts herself at all the pain gets much worse and she gets "out of breath". She also indicated that her left leg occasionally feels numb and the numbness runs down to the heel of her left foot. The employee added that to control her symptoms she is still taking the prescription pain medication prescribed by Dr. Garner for her migraine headaches.

At the conclusion of her direct examination the employee indicated that she was requesting an award for additional medical treatment. She specifically wants to have the surgery recommended by Dr. Park, but indicated that she is willing to consider going to any competent physician.

The employee also added that other than her one day of work per week starting in January, she has had no other source of income since September of 1999. The employee then noted that if she does any other strenuous activities such as housework, vacuuming, sweeping, carrying groceries or laundry, it causes a significant increase in her pain. The employee noted that she is able to bend in the waist if she has support, but she cannot lift anything heavy from the ground. She also noted that she has problems climbing steps or ladders, and is only able to walk approximately one half block before she feels exhausted and has to lean on things. The employee felt that her condition is gradually getting worse, and she is now starting to increase her pain medication.

The employee then emphasized that since she had entered the medical field she had never been unemployed for any length of time, and was frequently working two jobs. The employee added that she was eventually terminated by Mr. Glenn Beussink of Home Advantage, and that termination occurred on the same day that the workers' compensation paperwork had been filled out.

In addition to her request for additional medical aid, the employee also indicated at the conclusion of her direct examination that she was asking for an award of temporary total disability benefits from September 14, 1999, through the date of the hearing. She also requested an award of attorneys fees under Section 287.203 RSMo., and identified a 25% contingent fee agreement with her attorney which was admitted as Claimant's Exhibit A.

During cross examination the employee admitted that from November of 1995 until July of 1999 she had worked full time with Home Advantage. She also acknowledged that she had worked approximately one year after her accident doing her regular duties and working her regular hours. Although she agreed that she had continued to work and do all of the driving required by her job, she emphasized that she was required to modify the way she did her job, particularly in regard to

lifting. During additional cross examination the employee also admitted that after reporting her accident to her supervisor, she had never requested medical treatment until sometime in the summer of 1999.

When questioned about the medical entry of Dr. Garner in February of 1999 in which he mentioned a back strain, the employee specifically denied having any additional accident in which she injured her back after July 15, 1999. During redirect examination the employee added that any reference made to a back strain or back injury in Dr. Garner's notes from February, 1999 would have been in reference to her July, 1998 accident, since she had not had any other injuries to her back.

After the initial hearing on April 18, 2000, the hearing was continued and the employee subsequently submitted additional medical evidence in the form of a report and medical deposition from Dr. Charles P. McGinty, Sr. Dr. McGinty is a retired general surgeon in Cape Girardeau, Missouri who now performs workers' compensation evaluations. Dr. McGinty first examined the employee on April 20, 2000, and prepared a report dated May 5, 2000, which was admitted as Employee's Deposition Exhibit B and attached to Claimant's Exhibit B. Based on his review of the medical records and his physical examination of the employee Dr. McGinty diagnosed the employee as having a compression fracture at the T12 L1 level with possible osteopenia. Dr. McGinty noted that the employee's thoracic spine showed an obvious gibbous deformity, which he described as an abnormal angulation where a bony prominence is actually visible in the lower thoracic and upper lumbar region. (Claimant's Exhibit B, page 12). Dr. McGinty also observed that the employee was suffering from kyphosis, which he indicated was nicknamed "hunchback" with a forward flexion of the spine.

Dr. McGinty was then questioned about whether he felt the employee's current back condition and need for additional treatment were related to her July 15, 1998, accident in which she fell and twisted her back while carrying the whirlpool equipment. In response to this question Dr. McGinty stated "my opinion is that they were definitely related". (Claimant's Exhibit B, page 22). Dr. McGinty then added that it was possible that she might have had a degree of osteopenia at the time, but noted that she had no previous record or indication that she had a symptomatic problem up until the date of the July 15, 1998, accident.

Dr. McGinty then testified that he felt the employee was "in definite need of further medical or surgical treatment for the condition in her low back". (Claimant's Exhibit B, page 23). Dr. McGinty then added that he did not feel the employee had been able to work because of her present condition, and felt that she was totally disabled at the time of his evaluation. (Claimant's Exhibit B, page 23).

Dr. McGinty was then questioned extensively about the delay between the employee's date of injury and her first recorded request for medical treatment. Dr. McGinty indicated that he did not feel this was unusual given the fact that she was a registered nurse and was also experiencing a difficult time in her life due to social and family problems. He indicated that it was apparent to him that the employee, as a registered nurse, had decided to treat herself with heat and compresses and Fiorinal, and had deferred seeking medical treatment until it became apparent that her self treatment was not going to resolve the problem. Dr. McGinty also emphasized that the findings from the x-rays, MRI's and bone scans which confirm that the employee's fractures were "old", was consistent with a one year delay between the employee's accident and the diagnostic testing. He then noted that he did not feel the employee's possible osteoporosis had been caused by her fall, but felt that she was a good candidate to have some degree of osteoporosis because of her prior loss of her estrogen source following her hysterectomy. Dr. McGinty then clarified the difference between osteopenia and osteoporosis by noting that osteopenia was a condition in which the patient was beginning to lose ground, and is basically a predecessor of the more severe condition of osteoporosis. (Claimant's Exhibit B, pages 23, 24).

During cross examination by the employer-insurer's attorney Dr. McGinty acknowledged that approximately 95% of his evaluations and ratings are performed at the request of attorneys representing employees.

Following the completion of Dr. McGinty's deposition, the employer-insurer advised the Court that it would not be submitting additional medical evidence. The record was then closed and the hearing completed as of September 5, 2000. Prior to that date both the employee and the employer-insurer had submitted trial memorandums on the disputed issues. The employee's memorandum was received on April 25, 2000, and the employer-insurer's memorandum was received on May 10, 2000.

EXHIBITS:

The following exhibits were offered and admitted into evidence:

Joint Exhibits:

1 – X-ray reports from Dr. Joseph Miller dated June 29, 1999.

- 2 – Medical report from Dr. Joel W. Ray dated July 14, 1999.
- 3 – Office notes and medical records of Dr. Neal Garner.
- 4 – Medical report of Dr. David A. Pfefferkorn dated July 21, 1999.
- 5 – Bone scan report dated August 9, 1999.
- 6 – MRI, chest x-rays and additional report from Dr. Joseph Miller.
- 7 – Form 9 Surgeon's report from Dr. Kenneth McVey dated August 31, 1999.
- 8 – Off work record from Orthopedic Associates dated October 22, 1999.
- 9 – Medical record from Dr. Kee B. Park.
- 10 – Medical report and evaluation from Dr. Allen H. Morris.
- 11 – Bone density report and additional medical report from Dr. Allen H. Morris.
- 12 – Off work slip from Dr. Neal Garner dated April 13, 2000.

Claimant's Exhibits:

- A – 25% contingent fee agreement.
- B – Medical deposition of Dr. Charles P. McGinty, Sr.

Employer-Insurer's Exhibits:

None offered.

FINDINGS OF FACT AND RULINGS OF LAW

Issue 1 – Accident

Although the employer-insurer disputed accident at the time of the hearing, the employer-insurer has offered no evidence to refute the employee's claim that she sustained an accident which arose out of and in the course of her employment on or about July 15, 1998. The employee's testimony on the issue of accident was credible, and was also corroborated by most of the medical histories taken by various treating physicians. It is significant to note that the employer-insurer also came close to admitting the employee's accident in the answer to the employee's claim for compensation by stating that "the employer and insurer admit the employee sustained or reported the alleged work injury on or about 7/15/98". Following this answer, it is also significant to note that the employer voluntarily paid 7 6/7 weeks of temporary total disability and \$4,917.00 in medical expenses.

Given the employee's credible testimony on this issue and failure of the employer-insurer to offer any contradictory evidence, I find that on or about July 15, 1998, the employee did sustain an accident which arose out of and in the course of her employment.

Issue 2 - Notice

The employer-insurer has also denied the employee's claim on the issue of notice. Notwithstanding this denial, both the employee's testimony, the answer to the claim for compensation and the report of injury filed by the employer-insurer confirm that the employer did have actual notice of the employee's accident within the time allowed by the statute. The employee testified that two days after her accident she reported her injury to her supervisor, and the employer-insurer offered no evidence to contradict the employee's testimony on this issue. As previously indicated, the employer-insurer also admitted in their answer that the employee reported her alleged work injury on or about July 15, 1998. In addition to the answer filed by the employer-insurer, it is also important to note that the report of injury filed by the employer-insurer confirms that the employer was notified of the employee's accident on July 15, 1998. Although this report of injury was not prepared until July 15, 1999, the report specifically indicates the employer was notified of the accident on July 15, 1998. Based on these admissions together with the credible testimony of the employee I find that the employer did have actual notice of the employee's accident within two days of her July 15, 1998, injury.

Although Section 287.420 RSMo., generally requires written notice of the time, place and nature of the injury be provided within 30 days after the accident, both the statute and the relevant cases excuse the requirement of written notice if the claimant makes a showing of good cause or if the employer is not prejudiced by the lack of such notice. Although the claimant has the burden of showing that the employer was not prejudiced, a prima facie case of no prejudice is made if the claimant shows the employer had actual notice of the injury. **Pattengill v. General Motors Corporation**, 820 S.W. 2d 112, 113 (Mo. App. 1991). In this case the employer offered no testimony or other evidence to indicate that it was somehow prejudiced by the employer's failure to provide written notice. Based on this conclusion, I find that the employer-insurer did have adequate notice as required under Section 287.420 RSMo.

Issue 3 – Medical causation

The employee testified in this case that she had never experienced any low back problems or symptoms prior to her July 15, 1998, accident. She also testified that she had no additional injuries to her back between the date of her accident and

the time that she was subsequently diagnosed as having compression fractures at the L1 and possibly the T9 levels. Although the medical evidence supports a conclusion that the employee has osteopenia or a borderline case of osteoporosis, there is no evidence to support a finding that this condition was either symptomatic or disabling prior to the employee's July 15, 1998, accident. Most of the medical records together with the medical reports of Dr. Ray and Dr. Park and the deposition testimony of Dr. McGinty also support a finding that there is a direct causal relationship between the employee's current back complaints and her July 15, 1998, accident.

The employer-insurer's first argument on the issue of medical causation relies on the fact that the employee did not ask for or seek medical treatment for an extended time period after her July 15, 1998, accident. As previously indicated, the employee acknowledged that she did not request medical treatment from her employer until approximately one year after the date of her accident. The medical records of Dr. Garner also confirm that she did not mention any complaints of back pain until February of 1999, and did not seriously pursue treatment options until June of 1999. Although this "gap" in medical treatment clearly creates a concern which justified further investigation by the employer-insurer, there is no evidence to support a denial of the employee's claim merely because of a gap between the date of injury and the date of treatment. Although hindsight indicates the employee's failure to seek medical treatment may have been a mistake, this delay is understandable given the peculiar facts and circumstances involved in this case. As a registered nurse who had worked for nearly ten years as an occupational nurse for Noranda Aluminum, the employee certainly had extensive experience with cases involving back injuries, and was undoubtedly convinced that her back injury was a strain or sprain which would improve with the passage of time. Since the employee was already receiving regular prescriptions of a strong pain medication for migraine headaches, it is understandable and even predictable to expect that she would elect to treat her own back injury without seeking the assistance of a physician. In this case, the employee gave her employer immediate notice of the accident, which mitigates any concern that she may have fabricated this accident to generate workers' compensation benefits. Since the employer did have adequate notice of the employee's accident, and the statute of limitations has not run, the mere fact that there was a gap between the date of her accident and her subsequent decision to seek medical treatment is not a defense to the employee's claim for compensation. In this case the employee's explanation for that delay is credible, and the employer-insurer has offered no credible evidence to indicate that any type of intervening event occurred which would relieve the employer-insurer of further responsibility for medical treatment.

As part of this "gap theory", the employer-insurer has also emphasized that the employee saw Dr. Garner approximately two weeks after her accident and was treated for depression, but failed to mention her back injury. First, it should be noted that although Dr. Garner did not record any mention of a back injury, the employee testified that she did mention her back to Dr. Garner at some time relatively soon after the accident, but they decided nothing needed to be done at that time. Even if she did not mention her back complaints, given the fact that she was suffering from depression as a result of problems with her marriage and her son, it is not surprising that neither she nor Dr. Garner focused on what she thought at the time was a back strain or sprain. The medical records are consistent, however, with the employee's testimony that her back condition gradually got worse to the point where she finally mentioned it to Dr. Garner and began to ask for treatment. Once again, this gap between the accident and the first recorded medical entry regarding back complaints is not sufficient, standing alone, to justify a denial of the employee's claim.

In addition to the "gap defense", the employer-insurer has also relied heavily on the fact that the employee was able to continue to work and perform her regular duties for almost one year after the alleged accident date. The employer-insurer, through the report of Dr. Morris, argues that if the employee had really suffered a compression fracture in July of 1998 she would not have been able to perform those type of activities.

In response to this argument, the employee clearly testified that she continued to experience pain in her back, but was able to perform her duties by modifying the way she did her job. The primary flaw with this argument, however, is exposed by the results of the diagnostic testing performed in August of 1999. Both the MRI's and the bone scans confirm that the employee's compression fracture was not a new injury, but was rather the result of a "old fracture". As confirmed by Dr. McGinty, this diagnostic evidence is consistent with the fact that the employee's compression fracture was not the result of a recent injury, and corroborates the employee's version of an accident which occurred one year prior to the diagnostic testing.

This flaw in the employer-insurer's medical causation defense was clearly exposed through the contradictory statements of Dr. Allen Morris. On one hand, Dr. Morris testified that based on his experience with compression fractures, the employee would not have been able to work for over a year and perform her regular duties with a compression fracture. This conclusion obviously "flies in the face", of the diagnostic test result which confirms that the employee's compression fracture was not the result of a new injury. Dr. Morris then contradicted himself by doing an about face and stating that the compression fracture may have occurred either before or after her June 15, 1998, accident. Dr. Morris failed to offer any reasonable explanation to support this statement, and failed to explain why the compression fracture might have occurred before or after June 15, 1998, but could not have occurred as a result of her work related accident.

In conclusion, since the diagnostic evidence confirms that the employee's fracture was not a new injury, Dr. Morris's theory that she injured her back after July 15, 1998, as a result of some intervening accident is not believable. Conversely, his theory that her accident may have happened before July 15, 1998, is not supported by either the medical records nor the employee's testimony. On the issue of medical causation, I therefore find that Dr. Morris's opinion is neither credible nor persuasive.

The employer-insurer has also made a point of emphasizing that on February 3, 1999, the employee gave a history of “straining her back that morning”. (See Employer-Insurer’s post trial brief). The employer-insurer’s interpretation of the March 3, 1999, medical record, however, is not accurate. The March 3rd entry from Dr. Garner does not say that the employee strained her back this morning. The exact language used by Dr. Garner was that “she also states this A.M. that she strained her back . . .”. The correct grammatical construction of this sentence would be to identify “A.M.” as an adverb, which modifies the verb “states”. In other words, the employee apparently had a morning appointment, and at the time of her appointment stated that she had strained her back. To support the employer-insurer’s interpretation the sentence would have been structured to state “she also states that she strained her back this A.M.”.

Although this phrase may be somewhat ambiguous, there is absolutely no other evidence to indicate the employee suffered a new accident or injury to her back on February 3, 1999. This conclusion is supported by the remainder of the entry by Dr. Garner because he indicated that the employee was talking about noticing problems with her posture and her back over the past several months. This additional sentence is not consistent with the employer-insurer’s interpretation that she suffered the initial injury to her back on the morning of February 3, 1999. It is also significant to note that the next two medical histories taken by Dr. Garner were identical to the employee’s testimony at trial. Both of these corroborating medical histories were given to Dr. Garner several months before the employee’s claim for compensation was filed in September of 1999.

Another argument made by the employer-insurer relates to the allegedly inconsistent medical history which the employee subsequently gave to Dr. David Pfefferkorn. In his July 21, 1999, entry Dr. Pfefferkorn reported that the employee’s back problem began in July of 1998 while she was helping a client use a whirlpool bath on his feet. Although this statement is slightly inconsistent with the employee’s testimony, both the date and the mention of a whirlpool bath are consistent, and in a broader sense there is no question that the employee had, in fact, previously used the whirlpool baths to help bathe the patient’s feet. The mere fact that Dr. Pfefferkorn did not specifically indicate that the accident occurred when she was carrying the whirlpool baths out to the car does not create an irreconcilable conflict. It is also important to note that this entry by Dr. Pfefferkorn occurred after the employee had given two consistent medical histories to Dr. Neal Garner. Based on these facts, it does not appear that the slight variance between Dr. Pfefferkorn’s history and the prior medical histories taken by Dr. Garner create any inference that the employee’s testimony at the time of her hearing was not credible.

In conclusion, none of the employer-insurer’s arguments on the issue of medical causation appear to justify a denial of the employee’s claim. With the exception of Dr. Morris’s medical report, all of the other medical evidence supports a conclusion that the employee’s current back problems are medically causally related to her July 15, 1998, accident. Both the medical records of Dr. Joel Ray and Dr. Park, as well as the deposition testimony of Dr. McGinty, clearly indicate that the employee’s accident on July 15, 1998, was a substantial factor in causing the employee’s compression fracture and her resulting need for medical treatment. The employer-insurer obviously agreed with this assessment initially, and paid for all of the employee’s medical treatment and temporary total disability benefits up until the date of her release by Dr. Morris. It was not until the employee sought treatment on her own and was facing the possibility of additional surgery that the employer-insurer belatedly decided to send the employee to Dr. Allen Morris and deny the claim on the issue of medical causation.

After reviewing all of the medical evidence and the testimony of the employee I find that the employee’s July 15, 1998, accident was a substantial factor in causing the compression fractures and other diagnosed injuries to the employee’s back. Although the employee may also have some degree of osteoporosis, there is no evidence to support a finding that this condition was symptomatic or disabling prior to the date of her accident. Although the employee’s mild osteoporosis may have also contributed to her injury, both the testimony of the employee and the medical evidence support a finding that the July 15, 1998, accident was the primary and substantial contributing factor in causing the compression fractures and her current need for additional treatment.

Issue 4 – Medical aid

The employee has requested an award for additional medical aid under Section 287.140 RSMo. The medical evidence confirms that the employee has suffered a compression fracture at the L1 level which has resulted in a fifty to sixty percent loss of her disc space. Of the employee’s treating physicians, both the medical records of Dr. Ray and Dr. Park support a conclusion that the employee is in need of additional medical treatment to cure and relieve her from the effects of her injuries. Although Dr. Ray only saw the employee on one occasion, his detailed medical report clearly indicates that if conservative treatment failed to improve the employee’s condition surgery would be a viable option. Although Dr. Park expressed some concern about the length of time that had elapsed since the date of the compression fracture, his report unequivocally supports the employee’s request for surgical intervention. Dr. Park’s recommendation for a surgical fusion is also implicitly supported by the fact that Dr. William Kapp, of Orthopedic Associates, referred the employee to Dr. Park to consider the possibility of surgery.

Of the employee’s treating physicians, the only one who did not recommend surgery was Dr. Joseph Miller. Although Dr. Miller’s August 31, 1999, letter indicates he did not feel any type of operative procedure would help the employee, he failed to elaborate or offer any explanation to support this conclusion.

In addition to the report from Dr. Miller, the employer-insurer has also relied on the opinion of Dr. Allen Morris. Although Dr. Morris spent most of his time attempting to explain why the compression fracture occurred either before or after July 15, 1998, he also concluded that the employee did not need additional medical treatment. His opinion on this issue was limited to the statement that "I found no indications for surgery". As was the case with Dr. Miller's records, Dr. Morris offered no explanation to support this opinion. Dr. Morris did not indicate why he felt the surgery that had previously been recommended by Dr. Park would not be appropriate.

To contradict the opinion of Dr. Morris, the employee relied both on the medical reports of Dr. Joel Ray and Dr. Park as well as the medical deposition testimony of Dr. C. P. McGinty. After examining the employee and reviewing all of the medical records Dr. McGinty concluded that the employee was in need of further medical or surgical treatment.

After reviewing all of the medical evidence I find that the opinions of Dr. McGinty and Dr. Park on the issue of additional medical treatment are more credible than the opinions of Dr. Miller and Dr. Morris. Based on this conclusion I further find that the employee is in need of additional medical treatment to cure and relieve the employee from the effects of the compression fracture and other diagnosed injuries related to her July 15, 1998, accident. The employer-insurer is therefore directed to furnish additional medical aid in accordance with Section 287.140 RSMo.

Since the employer-insurer has previously denied medical treatment, I further find that the employer-insurer has waived its right to select and approve the treatment physician. **Emmert v. Ford Motor Company**, 863 S.W. 2d 629 (Mo. App. 1993). The employer-insurer and the employee are therefore directed to confer and attempt to agree on the selection of an authorized treating physician. If the parties cannot agree, the question of which doctor should be authorized to treat the employee shall be resolved with input from the Administrative Law Judge in a telephone conference call or at an additional prehearing conference.

Issue 5 – Nature and extent of disability

The employee has requested an award for additional temporary total disability starting on September 14, 1999, and continuing through the date of the hearing. The employer-insurer has argued that the employee is not entitled to additional temporary total disability, and that the employee's claim is ready for a final award which would include an award for permanent partial disability.

Based on the prior decision to award additional medical aid, the employer-insurer's request for a final award on the issue of permanent partial disability is denied.

The test for temporary total disability was restated by the Eastern District Court of Appeals in 1996 in the case of **Brookman v. Henry Transportation**, 924 S.W. 2d 286 (Mo. App. 1996). The Court of Appeals noted that temporary total disability benefits are intended to cover the hearing period, and are unwarranted beyond the point at which the employee is capable of returning to work. The Court also noted that temporary disability benefits are not intended to compensate the employee after his condition has reached the point where further progress is not expected. See also **Williams v. Pillsbury Company**, 694 S.W. 2d 488, 489 (Mo. App. 1985). In **Brookman**, the Court of Appeals noted that "the pivotal question in determining whether an employee is totally disabled is whether any employer, in the usual course of business, would reasonably be expected to employ the claimant in his present physical condition". **Brookman** I.d. at 290.

In the **Brookman** case, the employee had performed light duty in some other work during the time he was receiving treatment. The Court of Appeals noted that "the fact that employee performed some work during the period of his temporary disability is not controlling on whether employee was temporarily totally disabled. Total disability does not require that an employee be completely inactive or inert. **Brookman I.d. at 290.** [Citing **Reiner v. Treasurer of the State of Missouri**, 837 S.W. 2d 363, 367 (Mo. App. 1992).] The Court in **Brookman** concluded that "despite employee's limited employment following the accident, there was competent evidence establishing that he was unable to compete in the open labor market and that, with proper medical care, his condition was one for which progress could be expected". **Brookman** I.d. at 290, 291.

When these established standards for determining temporary total disability benefits are applied to the facts of this case, it is clear that the employee has been either temporarily totally disabled or temporary partially disabled from September 14th through the date of the hearing. The employee has stipulated that she had either worked or received temporary total disability benefits through September 13, 2000. The employer-insurer also stipulated that temporary total disability benefits were paid at the rate of \$294.73 per week for a total of 7 6/7 weeks, and that those benefits ended as of September 13, 1999. The employee also testified that she was not able to work at all from September 14, 1999, through December 31, 1999. Starting in the year 2000, however, the employee indicated she was forced to try and work one day each week to generate some income. The employee testified that she had been working one ten hour shift at the rate of \$15.00 per hour to assist in the care of a disabled child. The employee testified that this job did not require any lifting, but emphasized that she had not been able to return to work on a more regular basis because of her continuing back complaints.

The employee's testimony on this issue is supported by the medical records and opinions from a number of physicians. Dr. Garner, Dr. Pfefferkorn, Dr. Kapp, Dr. Park and Dr. McGinty all indicated that the employee was totally

disabled and was not able to work. On the issue of temporary total disability, I find that the opinions of these doctors are more credible than the opinions of Dr. Miller and Dr. Morris.

Based on this medical evidence and the testimony of the employee I find that the employee was temporarily and totally disabled from September 14, 1999, through December 31, 1999, for a total of 15 4/7 weeks. I further find that from January 1, 2000, through the date of the hearing on April 18, 2000, the employee was temporarily and partially disabled for a total of 15 3/7 weeks. As previously stipulated, the employee's temporary total disability rate is equal to the statutory maximum rate of \$562.67 per week. This rate of compensation was based on an agreed average weekly wage of \$1,083.05 per week.

Pursuant to Section 287.180 RSMo., I find that commencing on January 1, 2000, the employee, through the exercise of reasonable diligence, was able to earn \$150.00 per week. This determination was made in view of the nature and extent of the employee's injuries and her limited ability to compete in the open labor market. As specified in Section 287.180, the employee's rate of compensation for temporary partial disability shall be sixty-six and two-thirds of the difference between her average earnings prior to the accident and the amount she was able to earn during her period of temporary partial disability. The amount of the temporary partial disability rate is still subject to the statutory maximum in effect at the time of the employee's accident, which is defined in Section 287.180.1 (4) as one hundred and five percent of the state average weekly wage (\$562.67 per week as of July 15, 1998).

Under the facts in this case, the employee's temporary partial disability rate will be limited to the statutory maximum of \$562.67 per week. The difference between the employee's average earnings prior to the accident of \$1,083.05 and her temporary partial disability earnings of \$150.00 per week is \$933.05. Two-thirds of this difference is \$622.03, which exceeds the statutory maximum rate for temporary partial disability of \$562.67. In this case, the employee's temporary total disability rate and temporary partial disability rate are both limited to the maximum rate of \$562.67.

Based on these conclusions, the employer-insurer is directed to pay to the employee a total of 15 4/7 weeks of temporary total disability at the rate of \$562.67 per week for a total award of temporary total disability equal to \$8,761.57. The employer-insurer is further directed to pay to the employee a total of 15 3/7 weeks of temporary partial disability at the rate of \$562.67 per week for a total award of temporary partial disability equal to \$8,681.19. The total amount of temporary total disability and temporary partial disability that will have accrued prior to the hearing date is therefore equal to \$17,442.76.

Issue 6 – Cost of recovery under Section 287.203 RSMo.

The employee has alleged that she is entitled to an award for the reasonable cost of recovery under Section 287.203 RSMo. Under this "hardship hearing" section, if an employer has provided compensation under Section 287.170, 287.180 or 287.200 and terminates such compensation, and the employee dispute this termination and requests a hardship hearing, Section 287.203 provides that "reasonable cost of recovery shall be awarded to the prevailing party". In **P. M. V. Metro Media Steak Houses Company, Inc.**, 931 S.W. 2d 846 (Mo. App. 1996), the Eastern District Court of Appeals held that the phrase "cost of recovery", includes an award of attorney's fees. In a related footnote the Court of Appeals also noted that the attorney's fee of 25% of the underlying judgment was a standard fee in workers' compensation cases. I.d. at 848.

Although the employee in this case has not submitted any litigation expenses, the employee has requested an award for attorney's fees based on the standard 25% contingent fee agreement. Based on the statutory phrase "shall be awarded", and the holding in the **Metro Media Steak Houses** decision, I find that the employee, as the prevailing party, is entitled to an award for the cost of his recovery, including attorney's fees. Based on these findings, the employer-insurer is directed to pay to the employee's attorney, Mr. Joe Fuchs, the sum of \$4,360.69. This award of attorney's fees is based on 25% of the total compensation awarded under the provisions of this temporary award (25% of \$17,442.76 equals \$4,360.69).

INTEREST:

Interest on compensation awarded hereunder shall be paid in accordance with Section 287.160 RSMo.

Date: _____

Made by: _____

Jack H. Knowlan, Jr.

*Chief Administrative Law Judge
Division of Workers' Compensation*

A true copy: Attest:

Mr. Lawrence D. Leip
Director
Division of Workers' Compensation