

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

Injury No.: 99-091115

Employee: Stephanie Meyer-Linquist
Employer: Shugart, Thomson & Kilroy
Insurer: Federal Insurance Company

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 August 12, 2008. The award and decision of Chief Administrative Law Judge Kenneth J. Cain, issued August 12, 2008, is attached and incorporated by this reference.

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 1st day of July 2009.

LABOR AND INDUSTRIAL RELATIONS COMMISSION

William F. Ringer, Chairman

Alice A. Bartlett, Member

John J. Hickey, Member

Attest:

Secretary

FINAL AWARD

Employee: Stephanie Meyer-Linquist

Injury No. 99-091115

Dependents: N/A

Employer: Shughart, Thomson & Kilroy

Insurer: Federal Insurance Company

Additional Party: N/A

Hearing Date: May 21, 2008; final briefs filed July 14, 2008

Checked by: KJC/pd

FINDINGS OF FACT AND RULINGS OF LAW

- 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: January 1999.
- 5. State location where accident occurred or occupational disease was contracted: Kansas City, Jackson County, Missouri.
- 6. Was above employee in employ of above employer at time of alleged accident or occupational disease? Yes.
- 7. Did employer receive proper notice? Yes.
- 8. Did accident or occupational disease arise out of and in the course of the employment? Yes. (See additional findings of fact and rulings of law)
- 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, while in the course and scope of his employment as a legal assistant for Shughart Thomson law firm was required to use her hands and arms in a repetitive manner. As a result of doing keyboard work in a repetitive manner for 6 hours per day for several weeks, she developed right carpal tunnel syndrome. Employee also sustained other impairments as a result of authorized treatment.
- 12. Did accident or occupational disease cause death? No. Date of death? N/A
- 13. Part(s) of body injured by accident or occupational disease: Right hand and wrist, right eye, neck and

body as a whole.

14.. Nature and extent of any permanent disability: Right carpal tunnel syndrome, Horner's syndrome of right eye, hemilaminectomy from C4 to C7.

15. Compensation paid to-date for temporary disability: \$81,051.39

16. Value necessary medical aid paid to date by employer/insurer? \$610,774.12.

17. Value necessary medical aid not furnished by employer/insurer? Undetermined.

- Employee's average weekly wages: \$705.62.
- Weekly compensation rate: \$470.43/\$294.73
- Method wages computation: By agreement of the parties..

COMPENSATION PAYABLE

21. Amount of compensation payable:

Unpaid Medical expenses: Undetermined; See additional Findings of Fact and Rulings of Law.

200 weeks of permanent partial disability benefits @ \$294.73 per week = \$58,946

See additional findings of Fact and Rulings of Law for temporary total disability benefits owed. Employer is granted a credit for the \$81,051.29 previously paid.

0 weeks awarded for disfigurement.

22. Second Injury Fund liability: None

TOTAL: See additional Findings of Fact and Rulings of Law.

23. Future requirements awarded: See additional Findings of Fact and Rulings of Law.

Said payments to begin as of date of award 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 percent of \$58,946 in favor of the following attorney for necessary legal services rendered to the Claimant as well as 25 percent of the value of all future medical benefits awarded: Mr. Frederick Bryant

FINDINGS OF FACT and RULINGS OF LAW

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Prior to the hearing, the parties entered into various admissions and stipulations. The remaining issues were as follows:

- o whether the Employee sustained an occupational disease arising out of and in the course and scope of her employment;
- o liability of the Employer for \$26,141.80 for past temporary total disability benefits;
- o liability of the Employer for \$6,899.14 based on an alleged underpayment of temporary total disability benefits;
- o liability of the Employer for future medical benefits;
- o the nature and extent of the disability sustained by the Employee;
- o whether in the past the Employee was noncompliant with her medical treatment pursuant to Section 287.140.5 and whether the alleged noncompliance was an unreasonable refusal and whether the alleged unreasonable refusal enhanced, aggravated or increased the Employee's need for medical treatment or disability; and
- o whether the Employer is entitled to a credit for temporary total disability benefits paid during those periods the Employee was allegedly working and receiving temporary total disability benefits.

At the hearing, Ms. Stephanie Meyer-Linquist (hereinafter referred to as Claimant) testified that she was born on May 11, 1970 and that she had B.A. degree in criminal justice from the University of Missouri-Kansas City. She also stated that she had taken computer courses and been trained as a certified fraud examiner and private investigator.

Claimant testified that she had worked as a checker at a grocery store, receptionist at a law firm, secretary, paralegal, private investigator and that she had done bail bonding work. She stated that in September 1998 she was hired as a legal secretary for the law firm of Shughart, Thomson & Kilroy (hereinafter referred to as STK). She stated that her job at STK required her to transcribe tapes, prepare pleadings, answer the telephone, file, enter time sheets and do trial preparation work. She stated that she transcribed tapes about 6 hours a day.

Claimant testified that her workstation was modified in January 1999. She indicated that afterwards the equipment on her desk was further back from the seat and that her keyboard was about shoulder level, requiring her to sit on her legs and to reach up to shoulder height to type.

Claimant testified that after about a month of working at her new work station she began to develop tingling and numbness in her fingers at night and pain and a pinched nerve type feeling in her shoulders. She stated that she had a dull ache in her elbows.

Claimant testified that she had been under treatment for her injuries since April 1999. She admitted that in 1990 she had bilateral carpal tunnel releases but indicated that she was not experiencing any problems with her hands and wrists when she went to work for STK.

Claimant testified that she had not experienced any shoulder, neck or psychological problems prior to September 1998. She admitted that she was on medication for depression in 1998 when she had a hysterectomy, her father died and she was involved in divorce proceedings. She stated that she stopped taking the medication in April 1998.

Claimant also admitted that she was involved in a WaveRunner accident in the summer of 1999 when it flipped over and tossed her into the lake. She admitted that she experienced generalized pain all over her body after the accident. She stated that she was not prescribed any additional therapy due to any injuries she sustained in the accident.

Claimant testified that STK paid for her carpal tunnel release surgery in September 1999. She also stated that she quit her job at STK in September 1999 and began working as a private investigator for Pinkerton Investigations. She stated that as a private investigator she did workers' compensation surveillance in alleged fraud cases, patent infringement work, and that she worked on cases involving the illegal use of computer software. She stated that the surveillance jobs lasted from four to twelve hours. She stated that she did a substantial amount of driving which aggravated her upper extremity complaints.

Claimant admitted that she worked part-time at Gilio Bail Bonding at the same time as her employment as a private investigator. She stated that she did paperwork duties for the bonding company but did not apprehend alleged criminals. She stated that she was still receiving physical therapy during that period.

Claimant testified that STK next referred her to Dr. Finley, who diagnosed her condition as thoracic outlet syndrome. She stated that Drs. Satterlee and Stark agreed with the diagnosis. She stated that on May 23, 2000, Dr. Stark, a vascular surgeon and another authorized physician, performed surgery for the thoracic outlet syndrome in the form of a right rib resection.

Claimant testified that the surgery did not improve her condition. She stated that she woke up in the recovery room in extreme pain. She stated that her right arm was numb due to the anesthetic. She stated that she was next referred to a neurologist who ordered a total of 20 stellate blocks in her neck. She stated that the blocks only provided temporary relief. She stated that she was diagnosed with reflex sympathetic dystrophy (RSD).

Claimant testified that in July 2000 Dr. Stark performed a cervical sympathectomy on her and that during the procedure he cut the nerves to her arm. She stated that her pain became almost unbearable. She stated that she developed Horner's syndrome or a droopy eye.

Claimant testified that her doctor then recommended a spinal cord stimulator. She stated that he inserted an epidural catheter in her back which became infected and that she developed a cervical abscess from C2 to C7 causing temporary paralysis from her neck down her right side.

Claimant testified that Dr. Reintjes, a neurosurgeon, performed a hemilaminectomy to remove the abscess. She stated that the surgery by Dr. Reintjes was her fourth and that all of the surgeries were by authorized treating doctors.

Claimant testified that in 2001 her employer authorized pain management treatment with Dr. Simon. She stated that she sought a second opinion on her own with Dr. Charapata, a pain management specialist. She stated that both doctors were treating her at the same time. She admitted that both were prescribing medications for her and that neither knew about the other doctor's prescriptions. She denied that she took the medications as prescribed by both doctors, but she admitted that she got the prescriptions filled.

Claimant testified that Dr. Charapata implanted the spinal cord stimulator and later an intrathecal morphine pump. She stated that her workers' compensation insurer approved the pump. She stated that the pump later dislodged necessitating another surgery and that she developed an infection at the pump's site. She stated that she was still using the pump but not getting morphine through it.

Claimant testified that she was still taking the Actiq suckers initially prescribed by Dr. Simon. She stated that she was

taking about nine medications for pain control, with increased dosages over time.

Claimant testified that she did not believe that she could use her right arm to do a full day's work. She stated that she sometimes required assistance with dressing. She stated that she did her housework while sitting down. She stated that she was able to prepare quick meals. She stated that she was getting social security disability, although it took her three years to just complete the application. She alleged problems in using her right hand to write.

Claimant admitted that she wrote a "few" bail bonds in 2001. She admitted that she was a licensed bail bondsperson. She also stated that her husband did not have a license but worked with her in the bail bonds business. She stated that she and her husband operated Linquist Bail Bonds. She stated that he ran the day-to-day operations of the business.

Claimant testified that she did no apprehensions of alleged criminals while in the bail bonds business. She stated that her duties consisted primarily of calculating fees for the agents and the company, billing work, and clerical, administrative and financial duties. She stated that she did not go to the courthouse and write bonds.

Claimant admitted that she and her husband set up an office for their company in 2002. She admitted that that at its peak her company had five or six subagents. She stated that all the subagents could write bonds. She stated that her husband was also a bounty hunter. She stated that they closed the bail bonding business in February 2003.

Claimant stated that she had neck and upper extremity problems during the period while her business was in existence. She stated that she was on narcotic medications. She stated that she could only drive on a limited basis and only when her medications were not affecting her. She stated that she stayed at home in bed three or four days in a given week.

Claimant testified that she last worked in the bail bonding business in 2002. She related that her last job involved an incident at the DeWalt house in September of that year. She stated that she and her husband had been at a NASCAR race and that while she was driving home they received a phone call from a bounty hunter advising them that Steven DeWalt, who had failed to appear for his court proceeding, was at his mother's house. She stated that she then drove to the DeWalt house.

Claimant testified that she and her husband met the bounty hunters a few houses down from Ms. DeWalt's. She stated that when they reached the house, Steven ran inside. She stated that the bounty hunters then ran inside the house to effectuate the arrest. She stated that Ms. DeWalt attacked her and that Richie Vessels, one of the bounty hunters, pulled Ms. DeWalt off of her. She stated that Ms. DeWalt struck her on the head and grabbed her right arm. She stated that Mr. Vessels not only struck Ms. DeWalt but also broke her arm.

Claimant denied that she sustained any injuries in the incident. She stated that criminal charges were filed against Mr. Vessels. She stated that as a result of a criminal investigation against her and her husband, they pled guilty to obstructing an investigation.

Claimant testified that the insurance company referred her back to Dr. Simon in July 2006. She admitted that while being treated by Dr. Simon she failed a urinalysis. She stated that the failed urinalysis resulted from a mistake in which her husband two days prior to the test had inadvertently given her some of his prescription medication. She stated that in 2007 she was referred to the Lemon Center for behavioral pain management.

Claimant testified that she did not receive any temporary total disability benefits for the period September 2003 to September 24, 2004. She stated that she was unable to work during that period due to significant pain and problems with her pump. She stated that during that period she had memory problems and that she could not sleep, required lots of breaks and had to lie down.

Claimant testified that she believed that she was permanently and totally disabled due to her pain, which was tolerable but irritating, her memory loss, an inability to concentrate, an inability to sleep, and the need to take multiple breaks during the day. She stated that she could only sleep for 35 to 40 minutes at a time. She stated that her numerous medications were causing her to experience a dry mouth and to lose her teeth.

On cross-examination, Claimant admitted that she saw Dr. Koprivica on several occasions at the request of her attorney. She stated that Dr. Koprivica's office was about a 25-minute drive from her home. She stated that she had an appointment with Dr. Koprivica for an examination on June 4, 2002.

Claimant admitted that she told Dr. Koprivica that she had overwhelming pain. She acknowledged that Dr. Koprivica had indicated at the time that her pain was so extreme that he chose not to do a physical examination. She acknowledged that Dr. Koprivica had indicated that due to her extreme right hand pain that he did not believe that she could use it to insert a key and turn a car's ignition. She acknowledged that Dr. Koprivica concluded that she could not drive due to her right hand.

Next, while on cross-examination, Claimant's employer played a videotape of surveillance of Claimant on June 4, 2002, immediately prior to the examination by Dr. Koprivica. The videotape showed that Claimant drove a large Ford Explorer SUV to Dr. Koprivica's office. The videotape showed that she used her right hand to insert the key and to turn the ignition to the vehicle and that she used her right hand and arm to drive the vehicle.

The videotape also showed that Claimant stopped at a gasoline station while en route to Dr. Koprivica's office. She used her right hand to remove the nozzle from the pump. She used her right hand to insert the nozzle into her vehicle. She used her right hand to pump gasoline into her vehicle. She used her right hand to enter information into the pump. She used her right hand to twist open and to twist close the gas cap on her vehicle. She used her right hand to put trash in a container. She used her right hand to shut the doors of her vehicle. She used her right hand to put a clip in her hair. She adjusted her shirt with her right hand. She walked at what appeared to be a normal pace, swinging both her right and left arms.

The videotape showed that Claimant appeared to have no problems in getting in and out of her truck. The videotape showed that after leaving Dr. Koprivica's office she was able to back the large vehicle out of the parking space, using both arms and to drive off. She also opened the vehicle's door with her right hand and she held her purse in her right hand.

Claimant admitted that she drove herself to the hearing. She admitted that she was a "good" student in college. She reiterated that she wrote a few bonds in 2001 for Mr. Peak, the general agent for Linquist Bail Bonds.

Claimant described the bail bonding business as being similar to the AMWAY business. She stated that there was a pyramid and that Mr. Peak was at the top of it. She stated that Linquist Bail Bonds was at the next level and that its subagents were on the lower level. She stated that a percentage of any money made by the subagents went to her company and to Mr. Peak's company.

Claimant admitted that in 2001 she wrote a couple of bonds per week for her company when the subagents were not available. She admitted that the bonding company was liable for the entire amount of the bond in forfeiture cases. She stated that she disagreed with Mr. Peak's testimony that Linquist Bail Bonds did bonding work in 2003.

Claimant admitted that she owed Mr. Peak a substantial amount of money due to various loans. She stated that there was a dispute as to the exact amount of the loans. She admitted that he had a deed of trust on their house for over \$36,000.

Claimant admitted that she worked 40 to 60 hours per week as a private investigator. She admitted that she was working 20 hours per week for Gilio Bail Bonds at the same that she did the private investigation work.

Claimant admitted that she received temporary total disability benefits from May 31, 2000 to February 4, 2002. She testified that she could not recall whether she told Dr. Simon when she saw him in October 2001 that she was writing bail bonds. She admitted that she told Dr. Simon that she was not working.

Claimant admitted that in her application for social security disability benefits filed in 2003 she stated that she last worked in May 2000. She admitted that she worked after that date. She acknowledged that Dr. Lemon's records from 2006 showed that she provided a history of not working since May 2000. She admitted that although she received temporary total disability benefits from May 23, 2000 to February 4, 2002, she was working in the bail bonding business for at least part of that period.

Claimant admitted that Linquist Bail Bonds advertised, sponsored a soft ball team, and had Yellow Pages Advertisements from 2001 to 2006. She stated that the company stopped doing business in 2003 and that they had attempted to no avail to get the advertisements removed from the Yellow Pages.

Claimant next admitted that she sent correspondence to Tom Peak about Linquist Bail Bonds' expenses in September 2004. She admitted that she had discussed with him the need for a business plan in September 2001. She admitted that she received temporary total disability benefits based on an allegation of being unable to work despite actually working. She admitted that she did not tell anyone at Chubb Insurance Company about her work activities while she was receiving temporary total disability benefits.

Claimant also admitted that on June 14, 2002 she was signing subcontract agreements on behalf of Linquist Bail Bonds with various agents. She admitted that she drafted the subcontract agreements. She admitted that paperwork for Linquist Bail Bonds in October 2002 listed her as the 100 percent owner of the company. That was six months subsequent to when she had earlier testified that she stopped working for the company.

Claimant admitted that on June 20, 2007 her Employer offered to provide treatment at the Cleveland Clinic's detoxification program. She admitted that her employer offered to pay to her temporary total disability benefits once she enrolled in the program. She admitted that the Cleveland Clinic was one of three she had agreed to accept for detoxification treatment. She stated that she declined to participate in the program because her doctor did not believe that it was in her best interest.

Claimant acknowledged that Dr. Simon's records showed that on the day of her failed urinalysis she had initially left his office and later returned with her husband and with a sample for testing. She admitted that Dr. Simon's office told her that the sample was invalid and that she would have to provide a sample while on the premises. She admitted that when she provided that sample she failed the urinalysis.

Claimant acknowledged that Dr. Finley's records indicated that the doctor believed that Claimant was showing signs of symptom magnification. She acknowledged that Dr. Hancock had stated in his records that she was at times being half truthful and at other times telling "outright falsehoods."

Claimant admitted that Richie Vessels was an employee of Linquist Bail Bonds. She described Mr. Vessels as about 6 feet tall and over 300 pounds. She admitted that prior to going to the DeWalt house she knew that a physical confrontation could occur. She alleged that Ms. DeWalt attacked her and grabbed her right arm. She denied seeing Mr. Vessels twist Ms. DeWalt's arm behind her back or hearing him say, "Bitch, if you don't tell where your son is, I

will break your arm.”

Claimant admitted that she ran out of the DeWalt house. She admitted that she ran down the steps and that she ran up the street to her car. She admitted that Mr. Vessels had accused her in his criminal proceeding of telling him to lie about possessing an ASP and striking Ms. DeWalt with it. She admitted that during his criminal trial she exercised her Fifth Amendment right not to provide any testimony which could possibly incriminate her. She admitted that she pled guilty to a misdemeanor crime of obstructing an investigation. She admitted that she was originally charged with perjury.

On recross-examination, Claimant acknowledged that her tax returns for the year 2001 showed that her occupation was none. She admitted that the statement was incorrect.

Claimant testified at her deposition taken in the civil lawsuit filed by Ms. DeWalt that when she saw Ms. DeWalt's son on the porch, she “took off running” towards the house. She admitted that she signed a subagent agreement with Tom Peak to write bail bonds on July 20, 2001. She admitted that Linquist Bail Bonds had a clerical employee. She stated that she handled the financial end of the business.

Claimant's Employer also offered into evidence the videotaped deposition testimony of Helen DeWalt. Ms. DeWalt testified that she had retired in May 2002 from the State of Kansas Employment Security Division. She stated that she worked 32 years for the State. She stated that in May 2002 there were only two houses on her street and that the other belonged to her son Mark.

Ms. DeWalt testified that she lived at the bottom of a steep hill on a dead-end street. She stated that her grandson and granddaughter lived with her. She indicated that she stopped associating with her son Steven about 15 years earlier because she did not agree with his activities.

Ms. DeWalt testified that in 2002 she was harassed on numerous occasions by Claimant's bonding company. She stated that at about 3:00 a.m. in late May or early June 2002 she was awakened by pounding on her door and the screaming of “Bondsmen.” She stated that she opened her door and that Claimant was one of the five people standing on her porch. She stated that they tried to force their way into her house. She stated that when her son Mark came outside he was told that one of the bondsmen had a gun and that he needed to go back into the house. She stated that her son's wife called the police.

Ms. DeWalt testified that the more serious confrontation occurred on September 29, 2002, when Claimant and four other individuals ran down the hill to her house and forced their way into her home. She stated that Mr. Vessels physically assaulted her. She denied that she struck Claimant. She stated that she told her grandson to call the police and that when he went near the phone Mr. Vessels approached her grandson. She stated that she was afraid that Mr. Vessels was going to attack her grandson and that she stepped between them, thinking that he would not strike a woman.

Ms. DeWalt testified that Mr. Vessels had a weapon, which she described as a police baton. She stated that Claimant stood by the front door with a police scanner in her right hand held up to her ear. She stated that Claimant was listening to the police scanner during the entire incident. She stated that she did not talk to Claimant. She stated that she told all of the intruders to get out of her house.

Ms. DeWalt testified that after she stepped between Mr. Vessels and her grandson that he began beating her with the police baton. She stated that after he knocked her to the floor, he grabbed her right arm and began twisting it. She stated that she screamed, “You're breaking my arm.. She stated that he said, “I'm going to break your arm, Bitch,” and broke her right arm.

Ms. DeWalt testified that Claimant was standing by the front door while Mr. Vessels was attacking her. She stated that Claimant never put the police scanner down. She stated that Claimant never tried to stop Mr. Vessels from attacking her. She stated that both Claimant and Claimant's

husband were close enough to hear Mr. Vessels threaten to break her arm. She stated that Claimant saw the whole incident. She stated that even after Mr. Vessels broke her arm Claimant did nothing to remove Mr. Vessels from her. She stated that during the entire beating Claimant just held the police scanner to her ear.

Ms. DeWalt testified that during the incident the bounty hunters ransacked her house, broke doors, furniture, and tore her closets up. She stated that eventually Claimant screamed, "We got to go. We got to go," and that Claimant and the others ran out the front door and ran up the hill and got into their vehicles shortly before the police arrived. She stated that she specifically saw Claimant running across the yard and running up the hill. She stated that it did not appear that Claimant had any trouble running up the hill. She stated that Claimant did not appear to be winded as she ran up the steep hill and that Claimant received no assistance from anyone as she did so. She stated that she heard Claimant telling Richie Vessels as they were running that "Richie, you messed up. Your broke her arm."

On cross-examination, Ms. DeWalt admitted that she had settled a civil lawsuit arising out of the assault and that Mr. Peak's insurer had paid the settlement money. She stated that she had no physical contact with Claimant during the assault. She described the assault by Mr. Vessels as a "vicious beating."

Claimant's Employer also offered into evidence various video surveillance tapes of Claimant. The videos were essentially cumulative of the other evidence. The video in July 2004 showed Claimant walking in what appeared to be a normal pattern, swinging her right arm. She did not appear to be guarded in her walking or in the use of her arm. The only videotape where she appeared to be slightly guarded in her walking was after she had parked in a handicapped parking space in a Target grocery store parking lot. Other videotapes showed Claimant getting in and out of her truck and using her right hand to open the vehicle's door and both hands to turn the steering wheel and to drive. In one video, she opened the garage door to her home with both hands. In one, she trotted up the steps to her house.

Ms. Mary Ecklund, a 16-year employee of STK, testified on Claimant's Employer's behalf. She stated that she had managed STK's legal assistants since 1998 or 1999. She stated that she was the manager when Claimant worked for STK.

Ms. Ecklund testified that Claimant's job did not require Claimant to reach or work at shoulder height or above. She identified photographs of the workstation, which she related depicted the work areas as they existed when Claimant worked for the company.

Ms. Ecklund testified that the desk tops in the workstations were 29 to 30 inches from the floor. She reiterated that legal assistants did not work with their arms at breast height or above. She stated that it was impossible for the keyboard to be at chest or shoulder height. In fact, she stated that an ergonomic analysis completed after Claimant complained about her workstation showed that Claimant's keyboard tray was slightly too low.

Claimant's Employer also offered into evidence Richie Vessels' testimony from his criminal trial. He testified that he was employed by Linquist Bail Bonds in September 2002. He stated that during the incident at the DeWalt household he heard Claimant screaming for help and that he observed Ms. DeWalt attacking Claimant. He stated that he pulled Ms. DeWalt off of Claimant. He stated that he was instructed to lie to the police about having a baton in his possession during the incident.

Claimant also offered into evidence numerous and voluminous other exhibits. Claimant's Exhibit B was the cross-examination deposition testimony of P. Brent Koprivica, M.D. The deposition was taken on October 15, 2002. Claimant, as part of her §287.210 submission, had offered the written reports of Dr. Koprivica as set out in Exhibit D.

In his July 30, 2007 report, Dr. Koprivica noted that he continued to believe that Claimant was permanently and totally disabled. He stated that the side effects from her medications for the chronic pain problems resulted in the total disability. He stated that Claimant would need ongoing medical treatment for her "chronic pain situation." He stated that the treatment Claimant had received was reasonable and necessary.

In his October 30, 2005 report, Dr. Koprivica stated that even if Claimant had been capable of working as a bail bondsperson in 2001 “on a limited basis,” her current disability was such that it precluded her from doing those activities. On August 23, 2005, Dr. Koprivica noted that Claimant was 5 foot 5-1/4 inches tall and that she weighed 205 pounds. He stated that she had overwhelming pain. He stated that she had extreme allodynia of the right upper extremity. He stated that she had some discoloration and some subtle shininess of the right upper extremity. He noted that he did not find any atrophy.

Dr. Koprivica concluded that Claimant’s work activities at STK had caused her carpal tunnel syndrome and were a substantial factor in the development of her thoracic outlet syndrome. He stated that her complex regional pain syndrome (CRPS) resulted from the surgery for the thoracic outlet syndrome. He stated that Claimant had RSD or CRPS in both lower extremities as well as her upper extremities. He concluded that Claimant was at maximum medical improvement. He stated that Claimant was limited to sedentary physical demand level activities and that she could not use her right upper extremity for “useful vocational activities.”

Dr. Koprivica’s June 4, 2002 report was cumulative of his other reports. He noted that Claimant complained of overwhelming pain. He noted that she alleged pain in her face and into both of her legs. He stated that she complained of pain so severe that she could hardly chew. He stated that Claimant’s presentation was so extreme and, with her history of a need for additional treatment including a spinal cord stimulator, he chose not to perform a physical examination.

On cross-examination, Dr. Koprivica concluded that Claimant’s initial carpal tunnel syndrome had evolved into thoracic outlet syndrome and, ultimately, RSD. He admitted that neither condition was an expected complication from a carpal tunnel release. He also stated that due to significant complications from her stellate ganglion blocks Claimant required a cervical sympathectomy.

Dr. Koprivica concluded that Claimant had also developed significant complications from the placement of an epidural catheter, resulting in a life-threatening abscess or infection, requiring a decompressive laminectomy of the cervical spine. He stated that she had complications from the implantation of the spinal cord stimulator.

Dr. Koprivica admitted that some of Claimant’s medications were addictive and had a high potential for abuse. He admitted that some of Claimant’s behavior was indicative of a person with a significant pain medication dependency problem. He admitted that some of Claimant’s behavior was indicative of pain medication abuse.

Dr. Koprivica admitted that Claimant’s medical records showed that Drs. Hancock and Siwek had recommended against a spinal cord stimulator. He acknowledged that Dr. Simon had recommended an inpatient detoxification program at MidAmerica and that the doctor was concerned that Claimant was going to emergency rooms to get “fixes of Toradol and Demerol and Vistaril via ID’s.”

Claimant’s Exhibit C was the April 28, 2008 cross-examination deposition testimony of Dr. Koprivica. Much of the testimony was cumulative of his earlier deposition testimony. Dr. Koprivica admitted in his 2008 testimony that none of his income was derived from treating patients. He admitted that he had never prescribed Actiq. He admitted that his board certification was in emergency medicine.

Dr. Koprivica admitted that he was not a specialist in pain management, neurology, anesthesiology, psychiatry or psychology. He stated that he had refrained from examining Claimant on June 4, 2002 due to her presentation of “overwhelming pain.” He stated that Claimant complained of pain in her face, both legs, and that she had been vomiting for a couple of days. He stated that she complained that her pain was so severe that she could “hardly” chew.

Dr. Koprivica indicated that in June 2002 he did not believe that Claimant could even complete his three-page intake sheet. He admitted that he believed that Claimant was capable of doing paper and telephone work, appearing at the courthouse, and doing bookkeeping and accounting activities associated with the bail bonding business in November 2002 as Dr Charapata had concluded.

Dr. Koprivica admitted that on August 23, 2005 he had noted that Claimant was an excellent historian. He agreed that it did not appear that her medications were impairing her cognitive ability. He admitted that the information Claimant provided to him was very detailed. He agreed that in most instances RSD was not a lifelong condition. He admitted that thoracic outlet syndrome was usually caused by working at shoulder or chest height or above. He admitted that he was not sure as to what Claimant did in her jobs other than bookkeeping in the bail bonding business.

Dr. Koprivica testified that Claimant's carpal tunnel syndrome had resulted in a permanent partial disability of 10 to 20 percent at the 200-week or forearm level. He stated that his rating did not include any disability from her RSD or any other conditions. He indicated that based on the history Claimant provided to him he believed that she would have trouble putting a key into a lock.

Dr. Koprivica admitted that Claimant was on an enormous amount of narcotic medications. He acknowledged that Claimant's medical records indicated that by 2007 Claimant was getting 900 milligrams of oral morphine per hour. He acknowledged that 900 milligrams of oral morphine per hour translated to 21,600 milligrams of oral morphine per day.

Dr. Koprivica admitted that Actiq suckers were more potent than Claimant's narcotic medications taken orally. He admitted that when he rendered his opinions he was not aware that Claimant had her own bail bonds company in 2002 and 2003. He admitted that the history Claimant provided to him was not consistent with someone participating in the apprehension of an alleged criminal. He admitted that if Claimant were working as a bail bonds person that would change his opinion about her alleged temporary total disability during the period 2001 to 2004. He admitted that he based his opinion on Claimant's allegation that she had not worked since May 2000.

Finally, Dr. Koprivica concluded that Claimant was permanently and totally disabled as of 2005 due to the amount of medication she was taking. He admitted that it would be reasonable for Claimant to be weaned off the medications. He admitted that Claimant's high dosages of medications were greater than what would usually be appropriate for terminally ill patients. He admitted that he had concluded that Claimant's work had caused her alleged thoracic outlet syndrome based on her allegation that she had to reach up to do her typing at work.

On examination by Claimant, Dr. Koprivica reiterated that in his opinion Claimant's work at STK was a substantial factor in causing her to develop carpal tunnel syndrome, thoracic outlet syndrome and RSD. He stated that her RSD was a consequence of the thoracic outlet syndrome surgery.

Numerous other medical reports and records and depositions were admitted into evidence. Exhibit E was the deposition testimony of Steven Simon, M.D., taken on Claimant's Employer's behalf. Dr. Simon defined the term "allodynia" as when a non-painful touch was interpreted as pain. He stated that most people walked with their arms swinging. He stated that a person with allodynia involving an arm would not walk in that manner in an effort to protect the arm. He stated that such a person would hold the arm close to the body to prevent it from making contact with anything. He stated that on some examinations Claimant did not guard her arm and walked with a normal arm swing, while in others she guarded her arm.

Dr. Simon testified that he terminated his treatment of Claimant in December 2006 due to a failed drug screening. He stated that Claimant had Oxycodone, an opiate medication, in her system that he had not prescribed. He stated that Claimant told his staff when a urine sample was requested that she could not urinate and left his office but returned with her husband and with a urine sample. He stated that his office advised Claimant that the sample was invalid because she had left the premises. He stated that Claimant then provided a sample without leaving the premises and failed it. He stated that she told his staff that she had accidentally taken some of her husband's Oxycodone two weeks earlier. He stated that she began arguing. He stated that he discontinued his treatment of her.

Dr. Simon testified that Claimant asked him whether there was any way she could correct the error because with a failed urinalysis her workers' compensation benefits would be terminated. He stated that if Claimant had taken

Oxycodone by mistake two weeks prior to the test, it would not have been present in her urine when she took the test in his office. He stated that Oxycodone would not remain in a person's system for two weeks.

Dr. Simon admitted that in his October 2005 report he had indicated that Claimant was capable of working. He stated that on September 27, 2006 he concluded that Claimant was not capable of working.

Dr. Simon agreed that Actiq was a very strong opioid medication. He stated that he cautioned people not to drive while taking it. He stated that when he last saw Claimant she was being prescribed as many as five 1600 microgram Actiq suckers per day. He stated that he would not necessarily agree that an inpatient detox facility to wean Claimant off her oral opioid medications would be a reasonable alternative for Claimant.

Dr. Simon testified that oral transmucosal medications, such as the Actiq suckers, were designed to treat episodes of rapid onset, high-intensity or breakthrough pain. He denied that Actiq was to be principally used for terminal cancer patients. He stated that the recommended maximum dosage for terminal patients of Actiq was four units as high as 1600 micrograms per dose.

Dr. Simon admitted that he had been paid money by Abbott or Cephalon, the makers of Actiq, for giving advice to the company and for speaking on the benefits of Actiq.

On examination by Claimant's attorney, Dr. Simon testified that he was board certified in physical medicine and rehabilitation. He indicated that he specialized in pain management. He stated that he had published in the area of breakthrough pain. He stated that it would not be reasonable to suddenly discontinue the use of Claimant's intrathecal pump.

Dr. Simon testified that Horner's syndrome involved an impairment to the sympathetic nerve system and that it was typical in cases involving chronic pain syndrome. He stated that Claimant's Horner's syndrome was caused by her cervical sympathectomy. He stated that he concluded that Claimant was permanently and totally disabled in September 2006 due to the effects of her medications and the inability to control her pain.

Claimant's Exhibit F contained Dr. Simon's reports, which were essentially cumulative of his testimony. On September 14, 2006, Dr. Simon noted that Claimant's walk was "robot-like, very slow." On July 28, 2006, he noted that Claimant held her right arm against her body and that she was only able to raise it about 40 degrees on her own. On July 6, 2006, he noted that she had normal hair growth on her upper extremities with no discoloration or cooling.

Jim G. Lemons, Ed.D., a licensed psychologist and the director of the Pain Management Program at the Lemons Center, stated that Claimant was not employable in the open labor market. His office noted on November 6, 2007 that Claimant was reluctant to participate in the program and that she had expressed "grave concerns" about how she could not be open and honest, because the insurance company would use such information against her in her workers' compensation case. Dr. Lemons noted that Claimant told him that she did not want to go to the detoxification program at the Cleveland Clinic because it was "just to detox me." He stated that Claimant expressed fear that the program would not help her cope with her pain.

Claimant's Exhibit J contained the reports and correspondence of Steven D. Charapata, M.D., an anesthesiologist and specialist in pain management. In a report dated August 16, 2007 and addressed to Claimant's attorney, Dr. Charapata stated that Claimant had RSD or CRPS of the right upper extremity. He stated that the conditions were work-related and dated back to March 1999.

Dr. Charapata recommended a behavioral pain management program and the continuation of her opioid medications. He stated that Claimant was not employable in the open labor market due to her chronic pain syndrome and the side effects of her medications. He stated that the treatment Claimant had received was reasonable and necessary.

Claimant's Exhibit K was the cross-examination deposition testimony of Dr. Charapata. The doctor admitted that he had expressed some concern about long-term opioid treatment. He admitted that he had stated that opioids were not "extremely" effective in relieving Claimant's type of pain. He admitted that he had stated that medications taken by

mouth tended to decrease in effectiveness over time due to the patient developing a tolerance for the medication.

Dr. Charapata admitted that the records showed that Claimant was doubling up on her narcotic medications by getting prescriptions from him and Dr. Simon at the same time. He admitted that the records showed that Claimant was getting additional pain medications at that time by going to the emergency room and requesting pain medications. He admitted that such behavior could be characterized as narcotic abuse. He agreed that a detoxification program for Claimant was reasonable. He stated that a goal should be to get Claimant off the Actiq.

Dr. Charapata indicated that although he agreed with the diagnosis of RSD, Claimant did not have the symptoms associated with that disorder. He admitted that she had no atrophy of her right hand or any other signs of the condition. He stated that Claimant's complaints of back and leg problems were "probably" more related to the spinal cord stimulator than the alleged RSD. He stated that he had no problem with Claimant attempting to perform her work as a bail bonds person.

Claimant's Exhibit L was the April 22, 2008 cross-examination deposition testimony of Dr. Charapata. Much of the testimony was cumulative. He stated that Claimant had tolerated her pain medications very well. He stated that she was never confused. He stated that she never slurred her words. He stated that she never staggered around.

Dr. Charapata admitted that Claimant was still in need of behavioral pain management to decrease her narcotic medications. He admitted that some doctors did not believe that thoracic outlet syndrome even existed. He admitted that he had been paid money by the makers of Actiq and Medtronic.

On examination by Claimant, Dr. Charapata testified that Claimant reached maximum medical improvement as of October 11, 2005. He stated that Claimant became unemployable in the open labor market as of August 2007. He stated that Claimant was in need of future medical treatment in the form of pain medications and possibly a nerve block.

Volumes 2 and 3 of Claimant's medical records were essentially cumulative of the other evidence. Dr. Charapata noted in several records that Claimant was asking for an increase in the fusion rate of the intrathecal pump. In an August 27, 2001 report addressed to Chubb Group of Insurance Companies, Dr. Dan Hancock, M.D., stated that he had advised Claimant that he was no longer going to treat her except in a life-threatening emergency. He stated that, "Quite frankly, the longer I have cared for Stephanie, the more difficult and noncompliant she has become. Each clinic visit over the past several months, whether or not her husband is in attendance, has become increasingly confrontational and argumentative. Quite clearly, I have discovered Stephanie to be portraying many half-truths and some outright falsehoods. She has been noncompliant with her medications and has increasingly relied upon emergency department visits for supplemental pain medications."

In addition, Dr. Hancock noted that Claimant often failed to appear for clinic appointments or arrived late and that she often made urgent calls to the clinic insisting on a same day appointment allegedly because she had run out of medications.

The psychological assessment of Neal B. Deutch, Ph.D., was also included as a deposition exhibit. He noted that Claimant provided a history of both of her parents being disabled. He stated that she told him that her father was on disability prior to his death. He stated that she told him that her mother had a morphine pain pump.

Dr. Deutch noted that Claimant had failed to appear for two previous appointments. He stated that tests results showed that individuals with Claimant's profile tended to persist in pursuing medical treatment

for problems with a questionable organic basis. He stated that such individuals often failed to respond to any type of treatment. He stated that Claimant would likely lose interest in psychological treatment.

Claimant offered the May 16, 2005 report of John D. Graham, M.D., of the Pain Treatment Center, Inc., in St. Louis, Missouri into evidence. Her employer offered his deposition testimony into evidence. Dr. Graham noted that he had performed an independent medical examination of Claimant on her employer's behalf. He stated that he was an anesthesiologist who limited his practice to pain management.

Dr. Graham indicated that he based his conclusions on his examination of Claimant and his review of her numerous medical records and the job description for her position at STK. He noted in his report that Claimant had advised him that she last worked in May 2000. He noted that on physical examination Claimant walked without a limp. He stated that she changed positions with ease and without assistance. He stated that she had a slight droop of the right eyelid and a normal range of motion of her neck.

Dr. Graham stated that Claimant's sensory and motor functions were intact in her upper extremities. He indicated that she had no changes in skin color or texture. He stated that there were no changes in her nails or hair. He stated that there were no changes in temperature. He stated that there was no allodynia. He stated that there was no sweating, swelling or atrophy. He stated that examination of her back and lower extremities was unremarkable. He stated that neurologically she was intact.

Dr. Graham concluded that Claimant's case was a textbook demonstration of what could happen when subjective complaints were treated without any objective findings. He stated that although multiple nerve conduction studies showed no evidence of carpal tunnel syndrome, her doctor performed a right side carpal tunnel release. He stated that objectively there was no indication for the carpal tunnel surgery and that it failed to provide any benefit to her.

He stated that Claimant was diagnosed with bilateral thoracic outlet syndrome and had her first rib removed; although, again, the objective test results did not confirm any abnormality. He questioned why Claimant was diagnosed with a bilateral condition when she had no symptoms or complaints on the left side. He stated that thoracic outlet syndrome resulted from using the arms at shoulder height or above. He stated that Claimant's job requirement at STK did not require any extensive overhead work. He stated that there was no indication that Claimant needed surgery based on her complaints which were interpreted to represent thoracic outlet syndrome.

Dr. Graham testified that there was no evidence that Claimant ever had RSD. He stated that the diagnosis was apparently made based strictly on Claimant's subjective complaints, despite the lack of any supporting objective evidence such as allodynia, atrophy, color changes, temperature changes, sweating, and changes in skin texture, nails and hair. He stated that the three phase bone scan was unremarkable for any findings consistent with RSD.

Dr. Graham wrote that there was no need for the stellate ganglion blocks administered to Claimant, which were prescribed due to her alleged RSD. He stated that the ganglion blocks ultimately led to the cervical sympathectomy, which resulted in the chronic Horner's syndrome. He stated that despite any relief from the alleged pain after the initial blocks, Claimant's doctor prescribed an additional 21 blocks.

Dr. Graham indicated that there was no objective evidence showing that Claimant needed the cervical catheter. He stated that the decision to insert it was based strictly on Claimant's subjective complaints without any corresponding objective evidence showing the need for it. He stated that the cervical catheter became infected and resulted in the hemilaminectomy from C4 to C7.

Dr. Graham stated that he saw no objective indication for a dorsal column stimulator. He stated that

Claimant's psychological test results were a strong contraindication for a dorsal column stimulator. He stated that there was no objective evidence showing that Claimant needed an intrathecal pump. He stated that it was implanted based strictly on Claimant's subjective complaints. He stated that Claimant was on a "mind boggling" enormous amount of narcotic medications for subjective complaints without any objective findings to support the complaints.

Dr. Graham recommended that Claimant be weaned off her medication. He stated that Claimant's work activities at STK had not resulted in any of her complaints. He stated that all of her diagnoses were a direct result of the complications of the treatments she received. He reiterated that there was no objective evidence that Claimant needed any of the treatment. He stated that Claimant was at maximum medical improvement for her alleged physical injuries but not due to her drug dependency.

Finally, Dr. Graham stated that Claimant was capable of working in the open labor market. He stated that "I would give her a 10 pound weight restriction, and limited lifting, bending and twisting due to the multi-level hemilaminectomy that was required to address the cervical abscess from the epidural catheter that I would not have recommended." He also stated that he found it interesting that Claimant denied doing any work after May 2000 but was involved in an altercation in late 2002 while she and her husband were working on a potential bond forfeiture case.

Dr. Graham's testimony was cumulative of his report. He stated that neurogenic thoracic outlet syndrome was caused by working with the arms in an elevated position above shoulder height. He stated that the condition was typically found in individuals who did duct work for heating and air conditioning or installed mufflers on cars. He stated that someone holding their hands above their head for a few seconds in an eight-hour day would not get thoracic outlet syndrome. He stated that the entire medical community did not recognize that such a condition as thoracic outlet syndrome even existed.

Dr. Graham testified that Claimant did not have an extra cervical rib which could have caused the irritation resulting in the diagnosis of neurogenic thoracic outlet syndrome. He stated that Claimant had none of the 11 criteria established by the American Medical Association for RSD. He stated that a person with allodynia would not be able to use the affected right upper extremity to steer an automobile, shift gears or use a key to manipulate locks. He stated that a person with that condition would not be able to raise her arm above her head to "fix" her hair.

Dr. Graham testified that Horner's syndrome was a cosmetic problem and would not impact a person's ability to work. He stated that there was no evidence that Claimant had a cervical radiculopathy. He stated that Claimant's work activities at STK could not have caused thoracic outlet syndrome. He stated that her work activities at STK were not a substantial factor in her alleged development of thoracic outlet syndrome, RSD, CRPS or the need for the cervical sympathectomy. He stated that Claimant's carpal tunnel release was not a substantial factor in the development of the alleged thoracic outlet syndrome, CRPS or a cervical radiculopathy. He concluded that Claimant could do sedentary work.

Finally, Dr. Graham testified that as of November 2007 Claimant's medical records showed that she was taking approximately 20,000 milligrams of oral morphine per day as prescribed by Dr. Charapata. He stated that Claimant's daily narcotic intake had increased by 200 times. He stated that Dilaudid, one of her prescriptions, was about 3 to 5 times the strength of morphine. He stated that it had a very high euphoric effect and that one dose would put a person in "la-la-land." He stated that when he saw Claimant in May 2005 she was on 7.5 milligrams of intrathecal Dilaudid per day. He stated that three years later she was on 15 milligrams per day. He stated that she was taking 1600 micrograms of Fentanyl per day in the Actiq suckers.

Dr. Graham testified that Claimant's hourly dosage of oral morphine was 900 milligrams. He stated

that if anyone in the room during the deposition were to be given 900 milligrams of oral morphine over the next hour they would die. He stated that 900 milligrams would be enough to cause respiratory arrest in the person within half an hour, if not sooner, and that the person would simply quit breathing. He stated that 900 milligrams per hour would kill a 300-pound person several times over.

Dr. Graham testified that long-term use of too much narcotic medication could cause respiratory and bowel problems, as well as a hyperanalgesia. He stated that narcotics were supposed to blunt the body's response to pain, but the opposite occurred with hyperanalgesia. He stated that the body after being exposed to too much narcotics for long periods of time could become more sensitive to pain with hyperanalgesia.

Dr. Graham testified that Actiq had not been approved by the FDA for CRPS. He stated that a mixture of Dilaudid and Clonidine as prescribed for Claimant had not been approved by the FDA for CRPS.

Dr. Graham recommended that Claimant enter a detoxification program for her narcotic use. He stated that it was likely that Claimant was going to die from the enormous amounts of medications if she were not weaned off of them.

On cross-examination by Claimant, Dr. Graham admitted that he had occasionally seen patients on a referral from Chubb Insurance Company. He admitted that he was not board certified in any specialty. He stated that he had passed the written board certifications but had never taken the oral boards.

Dr. Graham admitted that he had never published in the areas of anesthesia or pain management nor lectured on the subjects. He stated that about 5 percent of his practice involved examining patients at the request of insurance companies. He admitted that although he would not operate on a patient without a positive EMG, he would defer to a hand surgeon on that issue.

Dr. Stephen Siwek, M.D., noted on October 8, 2001 that he recommended against a spinal cord stimulator for Claimant. He stated that he found no significant symptoms of CRPS. On May 4, 2000, Karl R. Stark, M.D., of Kansas City Vascular, P.C., noted that Claimant's EMG's of February 17, 2000 and July 1999 were normal. He stated that her chest x-rays showed no cervical ribs. He admitted that he had decided to do the thoracic outlet surgery despite the lack of any positive objective findings and noted: "A great worry is that her EMG is totally normal in all occasions."

On March 30, 2000, the consulting orthopedic surgeon at Disco, Fee & Parkins concluded that Claimant had thoracic outlet syndrome despite the negative EMG findings. The doctor noted that there was a concern that Claimant was addicted to narcotic medications.

Claimant's employer also offered into evidence medical depositions and voluminous reports and records. Richard M. Dubinsky, M.D., an associate professor of neurology at the University of Kansas Medical Center, testified by deposition on Claimant's employer's behalf on May 13, 2008. Dr. Dubinsky testified that he taught and was in charge of the intern program in the neurology department. He stated his students were taking post-graduate courses. He also stated that he was nearing his twentieth year as a professor and that he also worked as a consulting neurologist.

Dr. Dubinsky testified that that he was fellowship trained and board certified in psychiatry, general neurology, electrodiagnostic medicine, and neurophysiology. He acknowledged that his curriculum vitae was over 32 pages and that he had authored about 90 peer-reviewed articles. He stated that in reaching his conclusions in Claimant's case he reviewed her medical records, the medical depositions and her job description at STK. He stated that he had treated patients with carpal tunnel syndrome, thoracic outlet syndrome, CRPS and cervical radiculopathies.

Dr. Dubinsky testified that it was not possible for Claimant's job at STK to have caused thoracic outlet syndrome based on the job description. He stated that her job did not require her to work for prolonged periods with her arms at shoulder height or above. He questioned the diagnosis of thoracic outlet syndrome and stated that results from the vascular study were not sufficient to make the diagnosis.

Dr. Dubinsky testified that a person could not develop thoracic outlet syndrome from carpal tunnel syndrome. He concluded that Claimant's work activities at STK were not a substantial factor in her developing thoracic outlet syndrome. He stated that there was no evidence that her employment at STK or her carpal tunnel release was a substantial factor in her development of the alleged CRPS. He stated that there was no evidence that Claimant's cervical radiculopathy was related to her carpal tunnel syndrome. He stated that Claimant's job at STK was not capable of causing thoracic outlet syndrome, CRPS or a cervical radiculopathy.

Dr. Dubinsky testified that Claimant's long-term, high-dose narcotics use could result in respiratory distress, brain damage hyperanalgesia, a narcotic bowel and even death. He stated that long-term, high-dose narcotic use was not effective in treating thoracic outlet syndrome, CRPS or a cervical radiculopathy. He recommended a non-narcotic regime and a detoxification program.

Dr. Dubinsky testified that Dilaudid and Clonidine were not FDA approved to be used in combination for chronic and non-cancer pain. He stated that Actiq was not FDA approved for chronic non-cancer pain.

On cross-examination by Claimant, Dr. Dubinsky acknowledged that he did not personally examine Claimant. He acknowledged that it was not unreasonable for Drs. Finley, Satterlee and Stark to have diagnosed Claimant with thoracic outlet syndrome. He stated that due to the numerous risks associated with a first rib resection procedure that he could not fully answer the question of whether Claimant's surgery was reasonable. He stated that there was a controversy in the medical community as to whether such a condition as thoracic outlet syndrome even existed.

The medical reports offered into evidence by Claimant's employer were essentially cumulative of the other evidence. On September 30, 2003, Dr. Steven Hendler, M.D., stated that Claimant was at maximum medical improvement. He stated that she could perform her duties as a bail bonds person as long as she was not physically "arresting" people. On August 10, 2000, Dr. James S. Zarr, M.D., recommended weaning Claimant off her narcotics. He stated that he discussed such a program with Claimant and that she was not willing to comply.

Dr. Timothy P. Laird, M.D., Claimant's family doctor, noted on March 10, 1999 that Claimant had complained when her prescriptions for Prozac were changed from 40 to 20 milligrams per day. Claimant alleged in her application for social security disability benefits filed in 2003 that she had not worked since May 23, 2000.

The vocational evidence in the case consisted of the April 29, 2008 deposition testimony of Michael J. Dreiling, who testified on Claimant's behalf. He stated that he was a certified vocational vendor for the State of Kansas and that he was a Diplomat for the American Board of Vocational Experts.

Mr. Dreiling testified that he evaluated Claimant on October 17, 2005 and that in reaching his conclusions he considered her education, the medical reports and records, her work history, job skills, his personal evaluation of her and the physical requirements for various jobs. He indicated that he authored an addendum to his report on April 1, 2008.

Mr. Dreiling testified that Claimant was highly educated with significant job skills. He stated that based on

the medical opinions, other than those of Dr. Graham, Claimant would not be employable in the open labor market. He stated that in his opinion Claimant was not employable due to her chronic pain and the chronic medications, which had impacted her overall level of functioning. He stated that pain appeared to be the significant issue with Claimant.

On cross-examination by Claimant's Employer, Mr. Dreiling admitted that he did not do any vocational testing of Claimant. He admitted that Claimant's allegation of memory problems appeared to be contradicted by Dr. Koprivica's conclusion that she was an excellent historian. He acknowledged that other doctors besides Dr. Graham had indicated that Claimant could work. He acknowledged that at some point both Drs. Simon and Hendler had concluded that Claimant could work.

Employer/Insurer's Exhibit 3 showed that on January 10, 2007 Claimant pled guilty to Obstruction of Legal Process in a misdemeanor case. Employer/Insurer's Exhibit 9 was a letter from Chubb Insurance Group to the attorney for the Employer stating that TTD/PPD benefits had been paid to Claimant in the amount of \$101,346.50 as of May 19, 2008. The total paid in medical benefits was \$610,774.12.

Employer/Insurer's Exhibit 49 was the deposition testimony of Thomas R. Peak taken on August 10, 2005. Mr. Peak indicated that he was a general agent in the bail bonding business and that Linquist Bail Bonds was under his umbrella of companies or agents. He stated that he issued a 1099 to Claimant in the year 2001 in the amount of \$4,379.50. He stated that Claimant and/or Linquist Bail Bonds issued a 1099 to him for the year 2002 based on monies paid to him. He stated that he did not believe that he had received any 1099's from Claimant for the year 2003.

Mr. Peak testified that he had made loans to Claimant and her husband in the range of 30 to \$40,000. He stated that Claimant could have worked as late as May 2003 when Linquist Bail Bonds ceased doing business. He admitted that he understood that on one occasion Claimant and her husband had issued a bond on an Eric Sharp and that they had to "hunt him down" and that they cornered him and had him arrested. He stated that about 10 percent of all bonds written involved a recovery effort. He stated that Linquist Bail Bonds had seven subagents.

On cross-examination by Claimant's attorney, Mr. Peak testified that Linquist Bail Bonds "went down the tubes" due to a change in Jackson County's policies requiring greater assets by the bonding company and due to Claimant's deteriorating health.

Employer/Insurer's Exhibit 55 was a lawsuit filed by a James D. Johnston against Claimant and Linquist Bail Bonds and Thomas Peak Bail Bonds alleging an attempt to defraud him out of additional monies over and above the amount needed to cover his bond.

Employer/Insurer's Exhibit 58 involved a lawsuit filed by Reconstruction Specialists, Inc., against Claimant alleging fraud by Claimant in connection with work done on her home. The lawsuit alleged that Claimant had received insurance payments to cover the work done on her home but misrepresented and alleged that she had not received any such payments.

Employer/Insurer's Exhibit 59 contained the 2001 Income Tax Return for Claimant and her husband. The return showed that the income was \$47,601 and it was signed by Claimant and listed her occupation as none. It listed her husband's occupation as a superintendent. It did not list any income Claimant received from her bail bond work.

The April 30, 2004 deposition testimony of Jerry A. Linquist from the DeWalt civil lawsuit was admitted into evidence. He testified that Linquist Bail Bonds grossed approximately \$55,000 in 2002. He stated that their expenses were in excess of that amount. He stated that they started Linquist Bail Bonds around July 20, 2001 and ceased doing business in May 2003. He stated that one of the reasons they ceased doing business was that Tom Peak failed to invest the money he had promised and the amount needed for sufficient capitalization and to operate a successful business.

Claimant testified at her deposition that although STK had once offered her a position as a paralegal, she turned it down because she was only interested in working on employment or medical malpractice cases. She admitted that she believed that her job doing surveillance at Pinkerton where she was carrying cameras aggravated her shoulders and the pain in her shoulders.

The other exhibits admitted into evidence were cumulative.

LAW

After considering all the evidence, including the two depositions each of Drs. Koprivica, Charapata, and Simon, the depositions of Drs. Graham and Dubinsky, the numerous medical reports and records, the deposition of Mr. Dreiling, the vocational expert, the videotaped deposition of the fact witness, the other depositions, the other videotapes, the other exhibits, the testimony at the hearing, and observing the appearance and demeanor of Claimant and the other witness at the hearing, I find and believe that Claimant met her burden of proving that she sustained an occupational disease, which arose out of and in the course and scope of her employment with the law firm of STK.

I find that Claimant did not prove her employer's liability for any additional temporary total disability benefits. I find that she did prove her need for future medical treatment to cure and relieve her from the effects of her injuries. Her employer is hereby ordered to provide the future medical aid as set out in the Award.

I find that Claimant failed to prove that she was permanently and totally disabled. She did prove that she sustained a permanent partial disability of 50 percent to the body as a whole due to her work-related injuries and the complications from authorized treatment. At a rate of \$294.73 per week for 200 weeks, her employer is liable for \$58,946. Her employer is ordered to pay that amount to Claimant less the credits due it.

Finally, I do not find that Claimant's employer proved that Claimant's alleged noncompliance with medical treatment enhanced or aggravated her alleged disability. I find that Claimant's employer did prove that it paid temporary total disability benefits to Claimant during periods when Claimant was either working or capable of working. Claimant's employer is thus entitled to a credit for any benefits it paid during such periods as set out in the Award.

Occupational Disease

Claimant had the burden of proving all material elements of her claim. Fischer v. Archdiocese of St. Louis-Cardinal Ritter, Inst., 703 S.W. 2d 196 (Mo. App. E.D. 1990); overruled on other grounds by Hampton v. Big Boy Steel Erection, 121 S.W. 3d 220 (Mo. banc 2003); Griggs v. A.B. Chance, Co., 503 S.W.2d 697 (Mo. App. W.D. 1973); Hall v. Country Kitchen Restaurant, 936 S.W.2d 917 (Mo. App. 1997); overruled on other grounds by Hampton. She met her burden of proof as set out above.

The applicable statutes define occupational disease as follows:

§287.067. Occupational disease defined – loss of hearing, radiation injury, communicable disease, others.

- In this chapter the term “occupational disease” is hereby defined to mean, unless a different meaning is clearly indicated by the context, an identifiable disease arising with or without human fault out of and in the course of the employment. Ordinary diseases of life to which the general public is exposed outside of the employment shall not be compensable, except where the diseases follow as an incident of an occupational disease as defined in this section. The disease need not to have been foreseen or expected but after its contraction it must appear to have had its origin in a risk connected with the employment and to have flowed from that source as a rational consequence.

An occupational disease is compensable if it is clearly work related and meets the requirements of an injury which is compensable as provided in subsections 2 and 3 of Section 287.020. An occupational disease is not compensable merely because work was a triggering or precipitating factor.

§287.020. Definitions.

2. The word "accident" as used in this chapter shall, unless a different meaning is clearly indicated by the context, be construed to mean an unexpected or unforeseen identifiable event or series of events happening suddenly and violently, with or without human fault, and producing at the time objective symptoms of an injury. An injury is compensable if it is clearly work related. 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.
3. (1) In this chapter the term "injury" is hereby defined to be 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. Ordinary, gradual deterioration or progressive degeneration of the body caused by aging shall not be compensable, except where the deterioration or degeneration follows as an incident of employment.
- (2) An injury shall be deemed to arise out of and in the course of 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 a 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 nonemployment life.

Credibility

Claimant did not make a credible witness. Her testimony was replete with contradictions, inconsistencies and inaccurate statements. There were numerous examples and concrete proof that she could do activities, which she alleged that she could not do due to her alleged injuries. She went to Dr. Koprivica's office on June 4, 2002 and complained of overwhelming pain. She complained that her pain was so severe that she could hardly chew food. Based on her complaints and medical history, Dr. Koprivica chose not to even do an examination. He concluded that she was so disabled that she could not even use her right hand to insert a key into a lock or, as she testified on cross-examination, to turn the ignition in a motor vehicle.

Claimant's employer had performed video surveillance on Claimant on the same day as Dr. Koprivica's examination. The video clearly showed that Claimant was doing activities inconsistent with her complaints to Dr. Koprivica. The video showed that while driving to Dr. Koprivica's office, Claimant stopped at a gasoline station and clearly used her right hand in a manner inconsistent with the history and complaints she provided to the doctor. She used her right hand to remove the gasoline hose from the pump. She used her right hand to pump gasoline. She used her right hand to twist open and shut the gasoline cap on her vehicle. She used her right hand to carry trash to a receptacle and to put a clip in her hair. She used her right hand to open her vehicle's door, insert the key and turn the ignition. She used her right hand and arm to turn the steering wheel and drive a large Sports Utility Vehicle. Those activities were clearly contrary to her complaints to Dr. Koprivica. Those activities clearly demonstrated questions about her credibility.

There were other examples in the record showing that Claimant was not a credible witness. There were periods where she worked but at the same time received temporary total disability benefits based on an allegation that she could not work. She stated in her tax returns that she was not employed when she was clearly employed. She did not report income in her tax returns. She told the Social Security Administration when she applied for disability benefits that she had not worked since May 2000. The most credible competent evidence clearly showed that she worked until May 2003 when her company ceased doing business due to undercapitalization and not due to any of her alleged physical injuries.

Claimant was doubling and tripling up on her medications. She did not tell either Drs. Simon or Charapata, pain management specialists, that she was being treated by the other doctor and that the other doctor was prescribing medications for her. Her explanation that she got the prescriptions filled as ordered by the two doctors, but did not take the medication was not credible. She was also getting prescriptions for narcotic medications from emergency room doctors at the same time that Drs. Simon and Charapata were prescribing essentially the same narcotic medications for her.

She failed a urinalysis as ordered by Dr. Simon. Initially, when asked to provide a sample, she stated that she could not do so. She then left the premises and returned with her husband and with a sample. She was advised that the sample was invalid because she had left the premises. She was advised that she had to provide a sample on the premises. She failed that sample.

The failed urinalysis showed drugs in her system which were not prescribed by Dr. Simon. Her explanation that her husband had mistakenly given her some of his drugs was not credible. Dr. Simon testified that if she had mistakenly taken a drug two weeks prior to the test, as she told him, the drug would not have been in her system when the test was ordered. She testified at the hearing that the mistake was made two days prior to the test. Either way, her explanation was not credible. The failed urinalysis was further proof of her lack of credibility.

Claimant was accused by one of her employees of telling him to lie in his criminal proceeding about possessing and using a weapon during the assault of Ms. DeWalt. Claimant initially exercised her Fifth Amendment right to not incriminate herself during the criminal proceeding and later pled guilty to the crime of a misdemeanor obstruction of justice. The original charge was perjury.

Dr. Finley, an orthopedic surgeon, noted that Claimant showed signs of malingering. Dr. Hancock noted that he stopped treating Claimant because, "Quite clearly, I have discovered Stephanie to be portraying many half truths and some outright falsehoods. She has been noncompliant with her medications and has increasingly relied upon emergency department visits for supplemental pain medications."

More importantly, Claimant alleged numerous impairments and severe disabling pain, restrictions and limitations. She alleged severe problems in using her upper and lower extremities. She alleged severe back pain. She alleged pain so severe that she had difficulty in dressing herself. She alleged pain so severe

that she could not chew food at times. She alleged pain so severe that she had to guard and protect her right hand and arm and that she had essentially no use of either. Her activities at the DeWalt house in September 2002 and in the videotapes as set out earlier were clearly contrary to her allegations of severe pain and a severe disability.

Claimant admitted that she had attended a NASCAR race on the day of the DeWalt incident. She admitted that she went directly from the NASCAR race to the DeWalt house and that she drove the vehicle. She admitted in her deposition taken in the civil lawsuit by Ms. DeWalt that when she believed that she saw Ms. DeWalt's son on the porch, she took off "running". That behavior was not indicative of a severely disabled individual. Her ability to run was also clearly contrary to her testimony and complaints at the hearing. The ability to apprehend alleged criminals and essentially work as a bounty hunter also contradicted her allegation that she was permanently and totally disabled

The uncontroverted evidence further showed that despite Claimant's allegation of being totally disabled, she owned a bail bonding company and that she was clearly performing work in furtherance of it when she was out apprehending alleged criminals as demonstrated by the DeWalt incident.

Claimant admitted that she went to the DeWalt house to effectuate the apprehension of an alleged criminal. She admitted that she knew that there could be a physical confrontation at the DeWalt house. She admitted that she stood at the front door while the other bounty hunters searched the house and one guarded the back door of the house. The only reasonable inference was that Claimant's job was to make sure that the alleged criminal did not escape the premises through the front door.

Claimant testified that she could not use her right hand. Ms. DeWalt, who made a credible witness, testified that Claimant held a police scanner in her right hand up to her ear during the whole incident. Claimant did not deny or dispute Ms. DeWalt's testimony on that issue.

Claimant alleged at the hearing that she was in so much pain that she had trouble walking and standing; yet she admitted that she ran from Mr. DeWalt's house, ran down Ms. DeWalt's steps, and that she ran up a steep hill to get to her vehicle shortly before the police arrived. Those were not the activities of a severely disabled person. Those were activities which further detracted from Claimant's credibility.

In addition, Claimant stood a few feet away and watched as one of her employees, a 300-pound man, beat a 63-year old grandmother with a weapon and then broke the grandmother's arm with his bare hands because the grandmother would not disclose the whereabouts of her son. That, as noted above occurred during a period where Claimant claimed that she was temporarily and totally disabled.

Claimant testified on several occasions that she only did administrative and office type duties for Linquist Bail Bonds. That was contradicted by the incident referred to above where she was clearly working outside the office and participating in the attempted apprehension of an alleged criminal. Claimant admitted that apprehending alleged criminals was the most dangerous and physically taxing aspect of the bail bonding business.

The incident involving the attempted apprehension of an alleged criminal by Claimant referred to above was not the only such incident participated in by Claimant. She did not deny Ms. DeWalt's testimony that on a previous occasion about three months earlier Claimant had come to her house at 3:00 a.m. in an attempt to apprehend Ms. DeWalt's son. Claimant did not deny Mr. Peak's testimony that on one occasion Claimant and her husband had "cornered" an alleged criminal and telephoned the police to effectuate the arrest. Thus, the record clearly showed that Claimant had attempted to apprehend alleged criminals on three known occasions. That behavior was not indicative of the behavior of a severely disabled permanently and totally disabled person.

Finally, Claimant was evasive in her testimony. She was evasive in describing what she did in her business and the nature of her work. She was evasive in her testimony as to the number of agents she employed in her business. She was evasive as to exactly when she worked, when the business ceased operations and why it did so. Claimant clearly did not make a credible witness.

Alleged Occupational Diseases

Claimant alleged several occupational diseases or impairments. She alleged carpal tunnel syndrome, thoracic outlet syndrome, RSD/CRPS and various other conditions. The only one that she proved that her work was a substantial factor in causing was the right carpal tunnel syndrome. The uncontroverted evidence showed that Claimant did repetitive activities in her job at STK. The uncontroverted evidence showed that she used a keyboard on a repetitive basis for approximately six hours during the work day for several weeks prior to when she began complaining of carpal tunnel type symptoms.

The EMG studies of her right hand were negative. Dr. Thomas, the authorized treating physician, however, diagnosed carpal tunnel syndrome based on his clinical findings. Drs. Koprivica, Simon and Charapata agreed that she had right carpal tunnel syndrome. Their opinions were credible. The evidence supported their opinions. Claimant proved that she had right carpal tunnel syndrome and that her work at STK was a substantial factor in causing it.

Claimant not only failed to prove that her work was a substantial factor in causing her alleged thoracic outlet syndrome, but there was an issue as to whether she even had the condition. Her EMG studies were negative. All the objective tests results were negative. She did not have an extra cervical rib, which the doctors testified was often removed as treatment for the condition. Dr. Stark, who performed the thoracic outlet surgery, expressed concern over doing it based on the negative studies.

Drs. Graham and Dubinsky, who testified on Claimant's employer's behalf, made credible witnesses. Both explained in a thorough, clear and concise manner that neurogenic thoracic outlet syndrome, the diagnosis made for Claimant's condition, was caused by using the hands and arms at shoulder height or above on a repetitive basis for an extended period of time. Both explained that there was no evidence in the record that Claimant used her hands or arms on a repetitive basis at shoulder height or above in her job at STK.

Dr. Graham testified that the condition was commonly seen in patients who did duct work for heating and air conditioning systems or who installed mufflers on cars. Both doctors, while noting the dispute in the medical community as to whether the condition even existed, concluded that Claimant's work at STK was not a substantial factor in causing Claimant's complaints diagnosed by her treating doctors as thoracic outlet syndrome.

The evidence clearly supported Drs. Graham and Dubinsky's opinions. There was no credible, competent or objective evidence which showed that Claimant used her hands and arms at shoulder height or above on a repetitive basis in performing her job at STK. Claimant's allegation that due to the height of her desk and keyboard that she had to sit on her legs and type with her hands and arms at shoulder level was not credible. The record was completely void of any credible supporting evidence. Claimant offered no evidence showing that any such desk at that height even existed. She offered no evidence that any workstation or desk was set up in such a manner that a 5-foot 5-inch worker had to type with her arms extended out at nearly a 180-degree angle from the shoulders due to the height of the desk as she alleged.

In contrast, Claimant's employer offered photographs of Claimant's workstation. The photographs clearly contradicted Claimant's testimony. Also, Ms. Ecklund, an employee of STK who testified on Claimant's

employer's behalf, indicated that the desk tops were 29 to 30 inches from the floor and that the keyboards were either a few inches lower or higher depending on whether the employee used a keyboard tray. A desk top 29 to 30 inches from the floor would not require a 5 foot 5 inch worker to type with her hands and arms at shoulder height.

In addition, Ms. Ecklund testified that after Claimant complained of carpal tunnel type symptoms STK commissioned an ergonomics study and that the findings showed that Claimant's keyboard was slightly too low and not that it was so high that Claimant had to sit on her legs to reach the keyboard or that she had to type with her hands at shoulder height. Ms. Ecklund was credible in her testimony.

Claimant clearly failed to prove that her work was a substantial factor in causing what was diagnosed as thoracic outlet syndrome. She did, however, prove that her authorized treating doctors diagnosed the condition and that her employer authorized Dr. Stark, a vascular surgeon, to perform surgery for it in the form of a first rib resection. She proved that her employer chose to authorize surgery despite the lack of any objective evidence showing that she had the condition. It chose to authorize surgery despite a notation in the surgeon's records expressing concern about the benefit of any surgery due to the lack of any objective evidence showing that Claimant had the condition. It chose to authorize a first rib resection when the evidence showed that Claimant did not have an extra cervical rib, which according to the medical evidence often served as the source for the complaints diagnosed as thoracic outlet syndrome.

Claimant did prove that she developed numerous complications as a result of the thoracic outlet surgery. Her employer, while not liable for her complaints or the condition diagnosed as thoracic outlet syndrome, is liable for the consequences of the authorized treatment. See Schumacher v. Leslie, 232 S.W. 2d 912 (Mo. 1950) where the Court noted that an injured employee's rights against her employer under the Workers' Compensation Act embraced compensation for an aggravation of the employee's primary injury through malpractice by a physician selected by an employer. The Court noted that such malpractice was a natural consequence of the primary original injury. *Id.*

See also Wilson v. Emery Bird Thayer Co., 403 S.W. 2d 953 (Mo. App. 1966) where the Court noted that where without the fault of the employee her original compensable injury was aggravated by medical or surgical treatment, there was such a causal connection between the original injury and the resulting disability due to the aggravation caused by the medical or surgical treatment that the aggravation was also compensable.

The evidence clearly showed that Claimant sustained an original injury, carpal tunnel syndrome. The evidence clearly showed that due to Claimant's other right upper extremity complaints, her employer authorized additional treatment. The evidence clearly showed that Claimant developed additional problems as a result of that treatment. Her case is clearly analogous to what happened in Schumacher and Wilson.

Claimant alleged that as a complication of the authorized treatment including the first rib resection, she developed RSD/CRPS, required a cervical sympathectomy during which a nerve to her arm was severed, developed Horner's Syndrome, and that she was prescribed more than 20 stellate ganglion blocks. She alleged that she developed an infection due to the ganglion blocks and that she required a hemilaminectomy from C4 to C7 to remove the abscess.

The evidence clearly showed that Claimant developed each of the conditions listed above as a complication of the thoracic outlet surgery other than the alleged RSD/CRPS. Drs. Graham and Dubinsky, who as noted earlier made very credible witnesses, concluded that Claimant did not have RSD/CRPS. The evidence clearly supported their opinions. Dr. Graham specifically testified that Claimant had none of the 11 criteria as established by the American Medical Association for diagnosing RSD/CRPS.

The uncontroverted evidence showed that Claimant did not have any atrophy of any of her muscle groups. All the doctors who offered an opinion agreed that atrophy would have been expected if Claimant had RSD/CRPS. In addition, the most credible evidence showed that Claimant did not have any sweating, or shininess, or changes in color or temperature, or changes in her nails, hair or skin texture. Those symptoms should have been present if she had RSD/CRPS. Dr. Charapata, who testified on Claimant's behalf, also agreed that Claimant had none of the indications of RSD/CRPS.

In addition, the evidence clearly showed that Claimant was able to use her right upper extremity in a manner inconsistent with a diagnosis of RSD/CRPS as demonstrated by her activities at the DeWalt house. The videotape evidence also showed that she was able to use her right upper extremity in a manner clearly inconsistent with the RSD/CRPS diagnosis. Those doctors who made the diagnosis did so strictly based on Claimant's subjective complaints. Their opinions were vague and inconsistent. Their opinions clearly ignored the overwhelming contrary evidence. Claimant did not prove that she had RSD/CRPS.

The uncontroverted evidence did show that Claimant developed the other complications from the authorized treatment as set out above. Those complications included the Horner's syndrome, the need for the cervical sympathectomy, and the abscess resulting in the hemilaminectomy from C4 to C7. Her employer is liable for the treatment and the disability resulting from those conditions. Schumacher; Wilson.

Nature and Extent

Claimant alleged that she was rendered permanently and totally disabled due to her occupational disease and the complications from the authorized medical treatment. She did not, however, prove that she was permanently and totally disabled.

Section 287.020 (7) RSMo.1994 defines total disability as the inability to return to any employment and not merely . . . inability to return to the employment in which the employee was engaged at the time of the accident. The terms "any employment" mean "any reasonable or normal employment or occupation." Fletcher v. Second Injury Fund, 922 S.W. 2d 402 (Mo. App. 1996); Crum v. Sachs Electric, 768 S.W. 2d 131 (Mo. App. 1989); Kowalski v. M-G Metals and Sales, Inc., 631 S.W. 2d 919 (Mo. App. 1982); Groce v. Pyle, 315 S.W. 2d 482 (Mo. App. 1958).

To prove her entitlement to permanent total disability benefits, Claimant needed to show that she was unable to compete in the open labor market. See Fletcher; Cearcy v. McDonnell Douglas Aircraft, 894 S.W.2d 173 (Mo. App. 1995); Reiner v. Treasurer, 837 S.W.2d 363 (Mo. App. 1992); Brown v. Treasurer, 795 S.W. 2d 478 (Mo. App. 1990).

Missouri courts have also held that various factors may be considered in determining whether a person is permanently and totally disabled including the person's physical and mental condition, age, education, job experience and skills. Tiller v. 166 Auto Auction, 941 S.W. 2d 863 (Mo. App. 1997); Olds v. Treasurer, 864 S.W.2d 406 (Mo. App. 1993); Brown v. Treasurer, 795 S.W. 2d 439 (Mo. App. 1990); Patchin v. National Supermarkets, Inc. 738 S.W. 2d 166 (Mo. App. 1987); Laturno v. Carnahan, 640 S.W. 2d 470 (Mo. App. 1982).

Claimant clearly failed to prove that she was permanently and totally disabled. As noted earlier, she was not a credible witness. Her lack of credibility made it impossible to determine the legitimacy of her numerous complaints. The evidence did, however, clearly show that she was still able to do her job in the bail bonding business and that she could do at a minimum other sedentary jobs.

Claimant is a young lady. She is only 38 years old. She is highly educated. She has a B.A. degree from the University of Missouri-Kansas City. She was a good student, maintaining a 3.1 grade point average in

college. She has done sedentary work. She has run her own business. There was no credible evidence that she could not continue to run that business or other businesses.

In fact, the most credible evidence showed that she was operating her business as late as May 2003. She quit her job at STK in 1999. The most credible evidence further showed that her business ceased operations due to undercapitalization and not due to her inability to do the job based on some alleged injury. She offered no credible evidence showing any change in her physical or mental condition subsequent to May 2003 when she stopped working which supported her allegation that she was no longer capable of working as a bail bonds agent or running a bail bond business or doing other jobs.

Claimant's vocational expert admitted that she had transferable job skills. He admitted that her prior jobs showed that she had the ability to communicate with people. He admitted that Claimant's age, education and job skills were positive factors. Drs. Graham, Dubinsky and Hendler concluded that she could work. The evidence clearly supported their opinions. She was clearly working nearly four years after she quit her job at STK. Claimant clearly failed to prove that she was permanently and totally disabled.

In addition, Claimant's own testimony provided evidence that she was not permanently and totally disabled. As noted earlier, she admitted at the hearing and in her deposition taken in the civil suit filed by Ms. DeWalt that in September 2002 she was searching for Ms. DeWalt's son as part of her job at Linquist Bail Bonds. She admitted in the deposition that when she thought she saw Ms. DeWalt's son on the front porch she "took off running" towards Ms. DeWalt's house. That was not behavior indicative of a permanently and totally disabled person. She admitted that she was able to run out of the house and up a steep hill to avoid the police after her employee had assaulted Ms. DeWalt.

The videotapes showed that Claimant could use her right hand in a manner clearly inconsistent with her testimony and her complaints to the doctors. Claimant's activities were clearly not those of a severely disabled person who had impairments in her ability to walk, run and use her right hand to even turn a key in a lock. Her activities were not those of a person who was so disabled that she could not dress herself. She clearly failed to prove that she had any impairment to her right hand or any other part of her body which would preclude her from working.

Finally, the allegation that Claimant could not work due to the alleged side effects from her medications was not credible. She was on numerous and strong narcotic medications while she was running her bail bonding business. She was on numerous and strong narcotic medications on the three occasions noted in the record when she was attempting to apprehend alleged criminals.

Dr. Koprivica admitted that Claimant was an excellent historian. He admitted that she was able to provide her history in great detail. He admitted that the medications had not affected her cognitive abilities. Dr. Charapata admitted that the medications had not affected Claimant's cognitive abilities. He admitted that Claimant had tolerated the medications "very well." He stated that she was never confused. He stated that she never slurred her words. He stated that she never "staggered around." He admitted that he had never cautioned her not to drive.

Claimant demonstrated no problems at the hearing with her memory, concentration or affect. She admitted that she drove herself to the hearing. The hearing lasted three days. She again testified in great detail. There was no credible evidence which supported her allegation as to disabling side effects from the medications. She clearly failed to prove that she was rendered permanently and totally disabled due to either the side effects from her narcotic medications or the side effects in combination with her alleged physical injuries.

In addition, the most credible, competent evidence clearly showed that Claimant did not need to be permanently on the staggering amounts of narcotic medications being prescribed by Dr. Charapata. Dr. Graham testified that Claimant was taking more than 21,000 milligrams of strong narcotic medications per day based on the prescriptions. All the doctors who offered an opinion admitted at some point that Claimant needed to be weaned off the narcotic medications. Dr. Graham testified that Claimant would likely die if not weaned off the staggering amounts of narcotic medications prescribed for her.

Permanent Partial Disability

Claimant did prove that she sustained permanent disability as a result of her occupational disease and the complications from authorized treatment. She proved that her work at STK was a substantial factor in causing her right carpal tunnel syndrome for which she had surgery and that as a result of complications from authorized treatment she developed Horner's syndrome and required the cervical sympathectomy and a cervical hemilaminectomy from C4 to C7.

Based on the most credible, competent evidence, including the opinions of all the doctors, her subjective complaints, the video surveillance and the results from the numerous examinations and objective tests, I find that Claimant proved that she sustained a permanent partial disability of 50 percent to the body as a whole. At a rate of \$294.73 per week for 200 weeks, she is entitled to \$58,946 in permanent partial disability benefits. Her employer is hereby ordered to pay that amount to her. Her employer is also entitled to a credit in the amount of \$20,295.11 based on advanced payments made to her against her employer's liability for permanent disability benefits as set out later in the Award.

Liability for Additional Temporary Total Disability Benefits.

Claimant's employer paid \$81,051.39 in temporary total disability benefits. It paid temporary total disability benefits for the period May 30, 2000 to February 4, 2002 at the rate of \$433.75 per week. It restarted the temporary total disability benefits on December 3, 2002 and paid the benefits, other than for one week, through September 4, 2003. It again paid temporary total disability benefits for the period September 23, 2004 through October 26, 2005 and from November 29, 2007 through December 11, 2007 at the rate of \$433.75 per week.

Claimant's employer also paid what it labeled as permanent partial disability benefits to Claimant for the period October 27, 2005 to March 1, 2006 at the rate of \$294.73 per week. It paid benefits with the same label and at the same rate for the period July 6, 2006 through May 4, 2007, June 15 to June 30, 2007 and July 1 to July 19, 2007. The payments equaled \$20,295.11 and represented 68 6/7ths weeks of benefits. Claimant did not prove that she was temporarily and totally disabled during any of those periods. Thus, her employer was entitled to a credit for the \$20, 295.11 previously paid in permanent partial disability benefits.

Claimant alleged that her employer was liable for an additional \$26,141.80 in temporary total disability benefits for the period September 4, 2003 to September 29, 2004 and that her employer was liable for an underpayment of temporary total disability benefits in the amount of \$6,899. The parties stipulated that the proper compensation rate was \$470.43 per week. Thus, there was an underpayment of \$36.68 per week in the benefits owed by Claimant's employer for the weeks Claimant was temporarily and totally disabled. Claimant's argument, however, that she was entitled to an underpayment in benefits for 188.09 weeks lacked merit.

In fact, Claimant did not prove her employer's liability for any additional temporary total disability benefits. Claimant was vague and evasive in her testimony about when Linqvist Bail Bonds was started and when it went out of business. The most credible evidence showed that, and as Claimant admitted in her brief, she

began writing bail bonds effective with March 23, 2001. Therefore, she was no longer temporarily and totally disabled as of that date.

The evidence also showed that the Claimant established Linquist Bail Bonds in September 2001. The company had Yellow Page Advertisements in 2001. In September 2001, she was discussing business plans with Mr. Peak, the general agent. She admitted that she did sedentary work and accounts receivables type duties. The most credible evidence clearly showed that her company remained in business until May 2003. The most credible evidence showed that her business failed due to undercapitalization rather than her inability to do the work based on some alleged disability. Her husband admitted in his deposition that the business was undercapitalized. Mr. Peak testified that one of the reasons Claimant's business ceased operations was that Jackson County changed its capitalization requirements for writing bail bonds in the county and that Claimant's business could not meet the requirements.

Claimant offered no credible evidence showing that she was temporarily and totally disabled for any period for which she did not receive temporary total disability benefits. The most credible evidence showed that effective with March 23, 2001 she was working and she offered no credible competent evidence that she became temporarily and totally disabled after that date or after May 23, 2003 when her company ceased doing business due to undercapitalization.

Claimant, however, received temporary total disability benefits from May 30, 2000 through February 4, 2002, even though she had worked as a bail bonds agent since at least March 23, 2001. Based on the most credible evidence, her employer proved that it was entitled to a credit for the temporary total disability benefits paid from March 23, 2001 through February 4, 2002. The credit was substantially more than the \$6,899.14 she alleged as the underpayment.

Similarly, Claimant offered no credible evidence that she was temporarily and totally disabled for any period for which she did not receive benefits. She received benefits as noted above for numerous weeks after she began working as a bail bonds agent and failed to disclose to her employer that she was working. Instead of being liable for additional temporary total disability benefits, Claimant's employer was clearly entitled to a credit based on the benefits it paid while Claimant was working.

Claimant alleged that she was entitled to temporary total disability benefits for the period September 2003 to September 2004. There was no credible evidence supporting her allegation. There was no credible evidence that she could not have worked as a bail bonds agent during that period. She offered no credible evidence showing any change in her condition after May 2003 when her business ceased operations or any evidence which showed that she could not work as of May 2003 or on any date thereafter. She clearly failed to prove her employer's liability for any additional temporary total disability benefits.

Credit for Temporary Total Disability Benefits Paid

Claimant's employer asked for a credit for those weeks for which it paid temporary total disability benefits and during which Claimant was working. Claimant worked until May 23, 2003. The most credible evidence as noted above showed that she began writing bail bonds on March 23, 2001 and that she started her own bail bond business on September 4, 2001. She received temporary total disability benefits from May 30, 2000 to February 4, 2002. Thus, her employer was entitled to a credit for all benefits paid from March 23, 2001 to February 4, 2002.

Claimant received temporary total disability benefits from December 3, 2002 through September 4, 2003 other than for a one-week period. Her employer did not show which days it failed to pay the benefits or whether the days occurred prior to or after Claimant's business ceased operations on May 23, 2003. Thus,

based on the most credible evidence available, Claimant's employer proved that it was entitled to a credit for the benefits paid from December 3, 2002 to May 16, 2003, which takes into account the one week for which benefits were not paid.

Thus, Claimant's employer's credit for temporary total disability benefits covered the period March 23, 2001 to February 4, 2002 and from December 3, 2002 to May 16, 2003. The credits may be deducted from Claimant's employer's liability for the \$58,946 in permanent partial disability benefits. The credit shall also be reduced by the amount of the underpayment of temporary total disability benefits paid to Claimant for those periods prior to March 23, 2001 and during which Claimant's employer paid benefits at the rate of \$433.75 per week instead of the proper rate of \$470.43 per week.

Claimant's employer did not ask for any credits based on any other periods for which it paid benefits and for which Claimant may not have been temporarily and totally disabled. Therefore, no specific findings are made as to whether Claimant's employer is entitled to a credit for any such periods.

Future Medical Aid

The statute provides that the employer must provide all future medical aid, including medicines as may be reasonably required to cure and relieve the employee from the effects of her injuries. §287.140 RSMo. 1994. It also provides that the employer has the right to direct the medical treatment. *Id.*

Claimant testified and Dr. Charapata admitted that he was prescribing four Actiq suckers per day for Claimant for pain relief. She has an intrathecal pump. She is on numerous other pain medications. Dr. Graham testified that Claimant was taking 900 milligrams of narcotic pain medications per hour which, according to the doctor, equaled more than 21,000 milligrams per day. Neither Claimant nor Dr. Koprivica, who testified on her behalf and discussed Dr. Graham's conclusions, disputed Dr. Graham's testimony.

Drs. Graham and Dubinsky testified that Claimant was on an enormous amount of pain medications and that she needed to be weaned off the medications. All of Claimant's treating doctors at some point during their treatment of her indicated that she needed to be weaned off the medications. Dr. Koprivica agreed that Claimant needed to be weaned off the pain medications. Dr. Graham indicated that Claimant was at a high risk for death if she remained on the enormous dosages of the medication.

The evidence showed that Claimant needed to be weaned off the medications in a gradual and appropriate manner. Thus, she proved that she needed future medical aid in the form of medications to cure and relieve her from the effects of her work-related conditions and those caused by the authorized treatment. Her employer is therefore ordered to provide such treatment and to continue to do so for so long as she remains in need of it.

The statute provides that her employer has the right to direct the medical treatment. *Id.* Therefore, her employer is not required to continue to provide treatment with Dr. Charapata who is prescribing the enormous amounts of narcotic pain medications for Claimant. Also, her employer has clearly shown that a detoxification program would constitute reasonable and necessary medical treatment. Claimant is ordered to enroll in such a detoxification program if her employer chooses to send her to one.

Claimant, although agreeing to such a program in 2007, refused to enroll in the program after her employer chose one that both the Employer and Claimant had agreed was acceptable. If Claimant refuses to enroll in such a program as ordered by this Award, such a refusal would constitute an unreasonable refusal to submit to medical treatment. See §287.140.5. The statute provides that no compensation shall be payable if the employee refuses to undergo reasonable and necessary medical treatment if and insofar as the death or disability may be caused, continued or aggravated by any unreasonable refusal to submit to any medical or

surgical treatment. Id. The statute further clearly indicates that medical treatment is considered compensation. Id.

Thus, if Claimant refuses to enroll in the detoxification program as ordered in this Award, her employer may, pursuant to the statute, stop the payment of compensation or, in Claimant's case, medical treatment. If she refuses but later agrees to comply, the compensation or medical aid shall be reinstated and continued for so long as she remains in need of it and as long as she continues to comply with the reasonable and necessary medical treatment.

Whether Claimant was noncompliant with medical treatment in the past and whether such alleged noncompliance was unreasonable and whether it enhanced, aggravated or increased her need for medical treatment or her disability

Claimant was clearly noncompliant with medical treatment when she refused to accept treatment at the Cleveland Clinic's detoxification program. Claimant's employer's remedy, as noted above, was to stop providing compensation at that time and to continue to do so until Claimant agreed to accept reasonable and necessary medical treatment.

Claimant's employer offered no evidence showing that Claimant's refusal to accept the reasonable medical treatment enhanced or aggravated her disability. Therefore, Claimant's employer has not shown that Claimant's permanent disability benefits may be reduced or lowered due to her disability being caused, enhanced or aggravated by her unreasonable refusal to accept medical treatment.

Date: _____

Made by: _____

Kenneth J. Cain

Chief Law Judge

Division of Workers' Compensation

A true copy: Attest:

Jeffrey Buker

Director

Division of Workers' Compensation