

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

Injury No.: 06-022475

Employee: Tammy Stroud
Employer: Health Management Associates
d/b/a Poplar Bluff Regional Medical Center
Insurer: Liberty Insurance Corporation
Additional Party: Treasurer of Missouri as Custodian
of Second Injury Fund

This workers' compensation case is submitted to the Labor and Industrial Relations Commission (Commission) for review as provided by § 287.480 RSMo. Having read the briefs, reviewed the evidence, and considered the whole record, we find that the award of the administrative law judge allowing compensation is supported by competent and substantial evidence and was made in accordance with the Missouri Workers' Compensation Law. Pursuant to § 286.090 RSMo, we affirm the award and decision of the administrative law judge with this supplemental opinion.

Discussion

Permanent total disability

Employee argues she is permanently and totally disabled owing to a combination of the effects of her primary low back injury and her preexisting conditions, which include chronic obstructive pulmonary disease and psychiatric disability. We note that, with the exception of Dr. Bassett (a psychiatrist who testified for employer), each of the experts rendered the opinion that employee is permanently¹ and totally disabled owing to a combination of her preexisting conditions and the effects of the work injury. The administrative law judge, however, found these opinions lacking credibility on the rationale that employee lacked credibility regarding her own limitations and abilities, and thus the experts who relied on employee's subjective reporting of her limitations and abilities did not have an accurate factual basis from which to form their opinions on the issue of permanent total disability.

After carefully reviewing the testimony from each of the experts in conjunction with employee's testimony, we ultimately must agree with the administrative law judge on this point. We note that employee changed her testimony about her activities before and after the injury. Specifically, we note that employee initially described doing jumping jacks, step aerobics, tightrope balancing, and going from a squatting to standing position quickly, all while playing the Nintendo Wii Fit video game before her work injury. But when confronted on cross-examination with a post-injury release date

¹ Dr. Guidos (a physical medicine and rehabilitation specialist who testified for employer) opined employee was "completely disabled" as of the date employee reached maximum medical improvement from the effects of the work injury, but offered the caveat that she was not opining as to the permanency of employee's complete disability. See *Transcript*, 1553.

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for that video game, and after the matter was extensively pursued on re-direct and re-cross-examination, employee essentially acknowledged that if the game did in fact come out in May 2008, she must have played it after her work injury. *Transcript*, page 200-204. We find that, contrary to her initial testimony, employee did in fact play the Nintendo Wii Fit video game following her work injury, and that this activity involved performing jumping jacks, step aerobics, tightrope balancing, and going from a squatting to standing position quickly.

Employer and the Second Injury Fund argue that employee's changing her testimony on this point means she lacks any credibility whatsoever, and that we should accordingly find she failed to prove an accident and deny her claim. We are not persuaded. We find employee's testimony with regard to the issue of accident credible. But we share the administrative law judge's concern that employee's testimony is not reliable about her present abilities and limitations.

Notably, although certain of the treating and evaluating doctors found employee's subjective complaints to be inconsistent with their objective findings, none of the experts who ultimately testified in this case diagnosed any conscious or deliberate symptom magnification on employee's part. This includes employer's rating psychiatrist Dr. Bassett, who testified, "I was not prepared to make an accusation of malingering in this case." *Transcript*, page 1668. Employee's inconsistent testimony regarding her physical abilities strikes us as more likely a product of employee's psychiatric difficulties rather than a deliberate attempt to misrepresent the nature or extent of her disability.

With that said, we concur with the administrative law judge that where employee's testimony as to her post-injury abilities and limitations is demonstrably unreliable, we are less inclined to credit the testimony from her experts (and Dr. Guidos) on the issue of permanent total disability. It's not that employee's ability to play a video game following the work injury demonstrates that she is able to compete for gainful employment; rather, it's her inconsistency on the subject that leads us to question the true nature and extent of her disability. Because of these doubts, and because we otherwise agree with the administrative law judge's findings, analysis, and conclusions on the issue, we affirm the award of permanent partial, rather than permanent total disability benefits, against both employer and the Second Injury Fund.

Corrections

We are convinced the administrative law judge capably analyzed this factually complex and exhaustively litigated claim, and we ultimately agree with the findings, analysis, and conclusions in his well-reasoned and thorough award. But upon careful review of the record, we noted that several of the administrative law judge's factual findings are inaccurate. We hereby correct those findings as follows.

On page 22 of his award, the administrative law judge states that Dr. Volarich testified that employee was off work following the injury because of peripheral vascular disease. Dr. Volarich actually testified that the diagnosis of peripheral vascular disease was initially considered when employee sought treatment for her pulmonary complaints in June 2006, but noted that diagnosis was ruled out after treating doctors reviewed the

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results of an angiogram. *Transcript*, page 395-97. Accordingly, we do not adopt the administrative law judge's finding that Dr. Volarich agreed employee was off work following the work injury for peripheral vascular disease.

On page 32 of his award, the administrative law judge characterizes employee's pulmonary condition as having significantly deteriorated following the work injury; the administrative law judge listed this factor as affecting his analysis of the issue of permanent total disability. We are not convinced that the expert medical testimony supports a finding that employee's pulmonary condition worsened so significantly as to affect the analysis of permanent total disability. Dr. Volarich did testify that employee's pulmonary condition worsened "a little bit" following the work injury, but qualified that testimony when he explained that one would expect temporary flare-ups with employee's condition and that her post-injury treatment did not necessarily mean employee's underlying asthma and pulmonary function had permanently worsened. *Transcript*, page 428-29. Accordingly, we do not adopt the administrative law judge's finding that employee's COPD and asthma conditions worsened following the work injury, or his analysis listing that factor as affecting the issue of permanent total disability.

On pages 29 and 34 of his award, the administrative law judge recites testimony from Roger Barton, a security consultant who employer hired to follow employee and observe her activities. The administrative law judge avers that Mr. Barton testified he saw employee going up some "steps" outside a law office without difficulty. But Mr. Barton did not so testify, and indicated only that there may have been a single step. *Transcript*, page 259. Accordingly, we do not adopt these findings from the administrative law judge regarding employee negotiating steps outside a law office in view of Mr. Barton.

On page 37 of his award, the administrative law judge finds "credible" the opinions of Drs. Tolentino and Burns as part of his rationale for determining employee is not permanently and totally disabled. We note that these doctors were not identified as experts and did not testify in this matter. Employee argues the administrative law judge improperly credited these non-testifying doctors, and points out employee did not have an opportunity to cross-examine them. It's clear to us that the administrative law judge meant that the medical records and treatment notes authored by Drs. Tolentino and Burns rendered the opinions from the testifying Drs. Volarich, Guidos, and Stillings (and the vocational expert Ms. Gonzales) less credible on the issue of permanent total disability, and that his language assigning "credibility" to the opinions of non-testifying doctors was merely an unfortunate choice of words. But in any event, we wish to make clear that our findings on the issue of permanent total disability are not a product of our choosing to credit any non-testifying doctor. Instead, our findings reflect employee's failure to persuade us to credit the expert testimony suggesting she is permanently and totally disabled. In other words, we believe employee has simply failed to meet her burden of proof on the issue. Accordingly, we do not adopt the administrative law judge's language "crediting" the non-testifying doctors. Instead, we find that the

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treatment notes from Drs. Burns and Tolentino detract from the credibility of the opinions of the experts who testified employee is permanently and totally disabled.²

Finally, on page 35 of his award, the administrative law judge states employee testified she “delivered food” as part of her activity in helping out at Cyndi’s Restaurant in the week prior to the first hearing date. The evidence on this point was somewhat unclear. Employee initially testified that she did not carry any trays of dishes. *Transcript*, page 82. On cross-examination, employee initially agreed that she “delivered food” but then appeared to qualify that answer when she testified, “I took napkins and crackers, I think.” We do not adopt the administrative law judge’s finding that employee “delivered food,” and instead find that she delivered napkins and crackers to customers in the parking lot.

Conclusion

The Commission affirms and adopts the findings, conclusions, decision, and award of the administrative law judge to the extent they are not inconsistent with this supplemental opinion.

The award and decision of Chief Administrative Law Judge Lawrence C. Kasten, issued April 10, 2012, is attached and incorporated by this reference.

We approve and affirm 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 16th day of January 2013.

LABOR AND INDUSTRIAL RELATIONS COMMISSION

V A C A N T
Chairman

James Avery, Member

Curtis E. Chick, Member

Attest:

Secretary

² We also note that on page 30 of his award, the administrative law judge states that he found “credible” the opinions of Drs. Tolentino and Burns on the issue whether employee sustained more than a low back strain; for obvious reasons, employee has not challenged this finding. However, in the interest of consistency, we do not adopt the administrative law judge’s language on page 30 “crediting” a non-testifying doctor. Instead, we find that the records of Drs. Tolentino and Dr. Burns lend weight to Dr. Volarich’s testimony that employee sustained more than a low back strain.

ISSUED BY DIVISION OF WORKERS' COMPENSATION

FINAL AWARD

Employee: Tammy Stroud Injury No. 06-022475
Dependents: Undetermined.
Employer: Health Management Associates d/b/a Poplar Bluff Regional Medical Center
Additional Party: Second Injury Fund
Insurer: Liberty Insurance Corporation
Appearances: Colleen Vetter, attorney for employee
Fielding Poe, attorney for employer-insurer
Jon Lintner, Assistant Attorney General for the Second Injury Fund.
Hearing Date: Commenced July 6, 2011
Completed August 19, 2011
Checked by: LCK/rf

SUMMARY OF FINDINGS

1. Are any benefits awarded herein? Yes.
2. Was the injury or occupational disease compensable under Chapter 287? Yes.
3. Was there an accident or incident of occupational disease under the Law? Yes.
4. Date of accident or onset of occupational disease? March 14, 2006.
5. State location where accident occurred or occupational disease contracted: Butler County, Missouri.
6. Was above employee in employ of above employer at time of alleged accident or occupational disease? Yes.
7. Did employer receive proper notice? Yes.
8. Did accident or occupational disease arise out of and in the course of the employment? Yes.

9. Was claim for compensation filed within time required by law? Yes.
10. Was employer insured by above insurer? Yes.
11. Describe work employee was doing and how accident happened or occupational disease contracted: The employee was transferring a patient and injured her low back.
12. Did accident or occupational disease cause death? No.
13. Parts of body injured by accident or occupational disease: Body as a whole referable to low back and psychiatric condition.
14. Nature and extent of any permanent disability: 12.5% of the body as a whole referable to the low back and 5% of the body as a whole referable to the psychiatric condition.
15. Compensation paid to date for temporary total disability: \$2,920.94.
16. Value necessary medical aid paid to date by employer-insurer: \$21,463.74.
17. Value necessary medical aid not furnished by employer-insurer: N/A
18. Employee's average weekly wage: \$705.52.
19. Weekly compensation rate: \$470.35 for temporary total and permanent total disability and \$365.08 for permanent partial disability.
20. Method wages computation: By agreement.
21. Amount of compensation payable against employer-insurer:

\$25,555.60 for permanent partial disability.
\$7,008.58 for temporary disability.

Total: 32,564.18
22. Second Injury Fund liability: \$8,670.65.
23. Future requirements awarded: Future medical-See Rulings of Law.

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

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

FINDINGS OF FACT AND RULINGS OF LAW

On July 6, 2011 and August 19, 2011, the employee, Tammy Stroud appeared in person and with her attorney, Colleen Vetter for a hearing for a final award. The employer-insurer was represented by its attorney Fielding Poe. The Second Injury Fund was represented at the hearing by Assistant Attorney General Jon Lintner. At the time of the hearing, the parties agreed on certain undisputed facts and identified the issues that were in dispute. These undisputed facts and issues, together with the findings of fact and rulings of law, are set forth below as follows:

UNDISPUTED FACTS

1. The parties agreed to have the hearing in Cape Girardeau County.
2. Health Management Associates d/b/a Poplar Bluff Regional Medical Center was operating under and subject to the provisions of the Missouri Workers' Compensation Act, and its liability was fully insured by Liberty Mutual Insurance Company.
3. On March 14, 2006 Tammy Stroud was an employee of Health Management Associates d/b/a Poplar Bluff Regional Medical Center and was working under the Workers' Compensation Act.
4. The employer had notice of the employee's alleged accident.
5. The employee's claim was filed within the time allowed by law.
6. The employee's average weekly wage was \$705.52. The rate of compensation for temporary total and permanent total disability is \$470.35 per week. The rate of compensation for permanent partial disability is \$365.08 per week.
7. The employer-insurer paid \$21,463.74 in medical aid.
8. The employer-insurer paid \$1,876.24 in temporary total disability for 4 2/7 weeks from March 15, 2006 through April 13, 2006 at the rate of \$437.79 per week. The employer-insurer paid \$1,044.70 in temporary partial disability for 3 2/7 weeks from April 14, 2006 through May 6, 2006.

ISSUES

1. Accident.
2. Medical causation.
3. Previously incurred medical expenses.
4. Future medical treatment.
5. Additional temporary disability benefits.
6. Nature and extent of permanent disability against the employer-insurer.
7. Liability of the Second Injury Fund for permanent partial disability or permanent total disability.
8. The employee is alleging a violation of 287.120.4 RSMo.
9. The employer-insurer is alleging a violation of 287.120.5RSMo.
10. Dependency under Schoemehl v. Treasurer of the State of Missouri.
11. The employee is requesting attorney's fees and costs under Section 287.560 RSMo.
12. The employer-insurer is requesting attorney's fees and costs under Section 287.560 RSMo.

EXHIBITS

The following exhibits were offered and admitted into evidence:

Employee

- A. Deposition of Dr. Volarich including his report and CV.
- B. Deposition of Dr. Stillings including his CV, report and correspondence.
- C. Deposition of Ms. Gonzalez including her report and CV.
- D. Medical records of Tinsley Medical Clinic.
- E. Medical records of Brain and Neurospine Clinic.
- F. Medical records of Orthopaedic Associates.
- G. Medical records of Poplar Bluff Regional Medical Center.
- H. Medical records of Poplar Bluff Regional Medical Center.
- I. Medical records of Dr. John Woods.
- J. Medical records of Dr. Randy Woods.
- K. Medical records of Advanced Pain Center.
- L. Medical records of Advanced Pain Center.
- M. Medical records of Bloomfield Clinic.
- N. Medical records of Advanced Health Care.
- O. Medical records of Dr. Critchlow.
- P. Medical records of Poplar Bluff Medical Center.
- Q. Medical records of Missouri Southern Health Care.
- S. September 20, 2007 letter from employee's attorney to employer-insurer's attorney.
- T. E-mails regarding requests for medical treatment.
- U. June 25, 2010 letter from employee's attorney to employer-insurer's attorney.
- V. Medical bills of Dr. John Woods, Dr. Randy Woods and Dr. Naushad.
- W. Letters between Second Injury Attorney and employee's attorney.
- X. Employee's attorney's statement of expenses.
- Y. November 23, 2010 letter and recorded statement of the employee by insurance company adjuster (The employer-insurer and the Second Injury Fund objected to the admission of this exhibit. The ruling on the admissibility of the exhibit was taken under advisement. The objections are overruled and the exhibit is admitted into evidence.)
- Z. Medical Records of Orthopedic Associates.
- AA. Medical Bills from Dr. John Woods, Dr. Randy Woods, and Dr. Naushad.

Employer-Insurer Exhibits:

- 1. Deposition of Dr. Guidos with her reports and CV.
- 2. Deposition of Dr. Bassett with his report and CV.
- 3. Medical Records of Dr. Burns.
- 4. Medical Records of Orthopaedic Associates.
- 5. Medical Records of Orthopaedic Associates.
- 6. Medical Records of Iron County Hospital.
- 7. Withdrawn.

8. Medical Report of Dr. Burns.
9. Poplar Bluff Regional Medical Center Policy/Procedure.
10. Accident Investigation Report.
12. Subpoena Duces Tecum for Norris Blair
13. Subpoena Duces Tecum for Blair Group Security Solutions
14. Letter dated June 30, 2011 from employee attorney to employer-insurer attorney
15. Medical records of Ozark Physical Therapy (functional capacity evaluation)
16. Employer general orientation schedule
17. Job description for Nurses Aide for the employee.

Second Injury Fund

- I. Medical Records of St. John's Clinic.
- II. Withdrawn.

The following exhibits were not admitted into evidence:

Employee Exhibit R: Birth certificate of Ray Womble (This exhibit was objected to on hearsay grounds because it was an uncertified copy. The ruling on this exhibit was taken under advisement. The objection is sustained and the exhibit was not admitted. This exhibit shall be part of the Division's file for appellate purposes.)

Employer-Insurer Exhibit 11: Printout from internet regarding release date of Wii Fit (This exhibit was not admitted into evidence but an offer of proof made at the hearing. This exhibit shall be part of the Division's file for appellate purposes)

Judicial notice of the contents of the Division's files for the employee was taken.

WITNESESS: Tammy Stroud, the employee, Lora Clark, a representative of the employer, and Roger Barton, for the employer-insurer.

Blair Norris appeared on July 6, 2011 to testify on behalf of the employer-insurer. Due to the employee alleging that he violated Section 287.120.3(6) RSMo, Mr. Blair was advised by the Court to consult with an attorney prior to testifying. On August 19, 2011 Mr. Blair stated that he had consulted with one or more attorneys, and that based upon the advice of the attorneys he would not be voluntarily answering any questions. Mr. Blair did not testify.

BRIEFS: The employee, employer-insurer, and Second Injury Fund's briefs were received October 19, 2011.

FINDINGS OF FACT

The employee testified that she is married and her last name is now Smith. She is 42 years old and lives in Lesterville, Missouri. She has two children. Kimberly was born on March

10, 1988 and Raymond Womble, Jr. who was born on November 12, 1990. She has worked as a waitress, a clerk in insurance sales, a water district office manager, and a certified nurse's aide.

Pre-Existing Conditions:

The employee testified that prior to her work accident she was depressed due to bad marriages. She has been married 6 times. She has been prescribed Wellbutrin and Xanax, and other medications by her family doctors. Prior to the work accident, she had not seen a psychologist or psychiatrist. She had a breathing condition and was diagnosed with COPD and severe asthma. She was born with asthma, and has had treatment over the years with inhalers, and other medications. She has missed time from work due to breathing problems.

The employee saw Dr. Critchlow in September of 2002 for lifelong asthma which had gotten worse in the past year or two. She was at the point that she could not walk 20 feet without getting short of breath and cannot walk 50 feet without having to stop. She had been hospitalized for asthma six times including twice in the last six years. She was taking Advair, Singulair, Albuterol inhaler, and Xopenex. On exam there were diffuse wheezes. A pulmonary function test showed mild obstruction. Dr. Critchlow diagnosed severe allergic asthma and a history of recurrent sinusitis, and stated that it was absolutely necessary for her not to be exposed to smoke. He continued Advair, Singulair, and Xopenex, and placed the employee on an Atrovent inhaler.

The employee was admitted to Missouri Southern Healthcare Hospital from October 3, until October 9, 2002 for acute asthma exacerbation. The employee had worsening shortness of breath and a history of asthma and COPD. The employee was advised to quit smoking. She was started on Ativan for anxiety. A chest x-ray showed evidence of old granulomatous disease. The discharge diagnosis was improved asthma exacerbation and anxiety disorder. The employee was admitted to Missouri Southern Healthcare on October 15, 2002 for shortness of breath and cough. The employee was in tears during her hospitalization and was pre-occupied with financial and social issues. Dr. Majid-Agha noted a psychological component and Zolofit was prescribed. A chest x-ray showed probable bronchitis. The diagnosis was asthma exacerbation with severe bronchitis. The employee was discharged on October 16 with a diagnosis of improved asthma exacerbation, anxiety, and depression.

In November of 2002, Dr. Critchlow noted that the employee had social problems. She had an injection of steroids two days ago for asthma. Among the diagnoses were asthma and acute sinusitis. The employee was easily dyspneic with any exertion. A pulmonary function report showed mild obstructions and reduced inspiratory flow.

On December 9, 2002 a pulmonary function report showed early obstructive pulmonary impairment. Dr. Critchlow sent a letter to the Asthma Clinic at Washington University for an evaluation of the employee's asthma including shortness of breath and wheezing. On December 13 Dr. Critchlow wrote a letter to the social security disability office stating that the employee has a history of unremitting problems with severe asthma resulting in frequent hospitalizations and the frequent use of systemic corticosteroids for control. It has been a life-long problem which has been worse in the past couple of years.

The employee testified that she applied for social security in 2002 through Dr. Critchlow which was denied. She was on Elavil to help her sleep.

The employee was admitted to Missouri Southern Healthcare on May 27, 2003 for shortness of breath and asthma. She was in moderate respiratory distress with diffuse wheezing. The employee had a life long history of asthma and chronic bronchitis. The employee was on several medications including inhalers. She was discharged on May 28.

Dr. Critchlow in September of 2003 noted she had been doing well with her asthma. The employee told him she had quit smoking but when he told her he saw cigarettes in her purse she told him she didn't smoke much. In October, Dr. Critchlow noted that the employee's asthma was good but she had been under a lot of family stress due to her daughter wanting to quit school and her 13 year old son wanting to live with his father. The employee was taking Xanax and asked about increasing it. A November pulmonary function test showed the mild obstruction was significantly improved. In November and December of 2003 and January of 2004, Dr. Critchlow performed Xolair therapy.

Dr. Critchlow in February of 2004 performed a Xolair injection. He noted that the employee did not take her medication and the next day she was coughing, had difficulty breathing and swelling in her ankles. Dr. Critchlow prescribed Wellbutrin. In April of 2004, Dr. Critchlow performed Xolair injections. In May of 2004, Dr. Critchlow noted that the employee had been working at a desk job in a tax/insurance office which was not physically demanding. She had a recent onset of fatigue and day time drowsiness. Xolair injections were performed. In June of 2004, Dr. Critchlow put her on Prednisone for exacerbation of the asthma, and added inhalers. In August, the employee discontinued Xolair therapy due to her job.

In January of 2005, Dr. Newell ordered home oxygen for COPD and asthma. A respiratory assessment was done in February of 2005 due to chest pain from coughing and bilateral wheezing. In September of 2005 the employee went to the emergency room at Missouri Southern Healthcare for wheezing and shortness of breath, and it was noted the employee was on home oxygen.

On September 18, 2005 the employee went to the emergency room at Poplar Bluff Regional Medical Center with shortness of breath and a history of asthma/COPD. The employee had constant severe wheezing and was in moderate respiratory distress. The employee persisted in crying in the room and had an episode of unresponsiveness which was revolved with an ammonia capsule. The clinical impression was acute bronchitis. Augmentin and Albuterol were prescribed. The employee had a flat affect, was lying on a stretcher, eyes open, and was not talking until the doctor stimulated the patient.

The employee testified that her prior husbands were mentally and physically abusive, and contributed to missing work and leaving the job; and she was depressed due to unhappy marriages. She had sexual abuse by an uncle-in-law when she was 5 or 6, and later in life she chose to ignore it. All of her relationships were either physically and some sexually abusive. Prior to the accident, she had depression due to marital abuse, and was prescribed Xanax and

Wellbutrin, and she lost work due to her depression. Her marital abuse affected her work. She had occasional nightmares prior to her back injury, and had panic attacks when she was around her uncle. When she was married to Mr. Lawson, he kicked her legs. She received counseling from the hospital and doctor. Her first husband, Mr. Womble beat her several times a week. All of her husbands committed marital rape. She missed work due to breathing problems; had occasional sleep problems and sometimes her legs gave out due to circulation problems.

The employee saw Dr. Daniels, a pulmonologist on March 13, 2006. In a patient questionnaire she noted she could not breathe which kept her from sleeping. For twelve years it has felt like there is a heavy weight on her chest. She has difficulty in falling asleep and frequently wakes up during the night. She did not feel refreshed and rested after a night's sleep. She gets sleepy during the day and falls asleep at inappropriate times such as while driving, watching TV or at work. She had an overwhelming urge to take a nap during the day. Medical disorders listed were asthma and chronic bronchitis. She had a lot of allergies and was smoking a pack of cigarettes daily. She slept with oxygen. Dr. Daniels noted that the employee has developed increasing dyspnea; and has asthma and chronic bronchitis. On physical examination she had diffuse wheezing. Dr. Daniels recommended smoking cessation; prescribed Wellbutrin, a nicotine patch, and Spiriva; and ordered a chest CT and a pulmonary function test.

The employee testified that prior to the March 14, 2006 accident she worked without restrictions or accommodations and worked overtime. She was able to perform her duties except when she had breathing problems. She did not have pain in her back, buttocks, or legs that interfered with work; and she did not have to lie down.

The employee testified that she was last employed by Poplar Bluff Regional Medical Center from November of 2005 until September of 2006. She was a general certified nurse's aide.

Primary Accident:

The employee testified that on March 14, 2006, she was working on the 4th floor in the critical care unit. A person named Loretta, who was the transporter and brought patients from the emergency room to the floor, asked her to help transfer a female patient that weighed 300 pounds from a stretcher to a hospital bed. Loretta went back to the emergency room. There was another employee named Cora Brown and another nurse was called in. The other employees were pulling the sheet and the employee was on the stretcher on her knees. There was a hump between the bed and stretcher because it was not on the same level. Her job was to lift the patient up and over the stretcher as the other two were holding and pulling the sheet. As she was lifting the patient one of the other two nurses let the sheet go. The patient was not on the bed, and if she let go, the patient would fall in between the bed and stretcher. As she was lifting her across the bed she felt a twinge with immediate burning and tearing pain mostly in the left low back below the waist. She finished her shift despite the low back pain. After the accident, she told her supervisor, Mike about the accident.

The employee testified that prior to the accident she had never transferred anyone on a stretcher and was never trained on transferring. She always tried to practice safe lifting. She had watched other employees do transfers and observed an ER nurse lift while on a stretcher. She was not disciplined for the accident and did not know if the other employees got into trouble. At the time of the accident, a nurse did not fill out a form about how the patient was going to be transferred and it was not normal to do that before the transfer. On the critical care floor, there were two wings with generally two nurses per floor and there usually were not enough aides to take care of the patients. They were working short and there was not enough aides to care for patient as per state law although she cannot remember the number of aides required by state law and based it upon what the nurses said.

In her statement to the adjuster, the employee said a patient was being moved from the emergency room to her floor. There was a sheet underneath the employee and they were pulling the sheet to remove her from the stretcher to the bed and the employee was on the stretcher lifting her over the hump to the bed. The other girls thought she was on the bed enough but the employee could see that she was going to hit a rail. The employee had to quickly decide to drop the patient and let her back hit the rail or hang onto to her. The other girls let go and she injured her back. Both of the other girls let go at the same time because they thought the patient was on the bed. The employee said she was doing the major part of the lifting. The employee testified that the statement to the adjuster is accurate and she was kneeling on a stretcher.

Lora Clark testified. She is the Manager of Occupational Medicine Center for the employer and has been employed for 18 years. She has been in her present position since October of 2010. She is familiar with the policies of the hospital including the safety policy. She is over all new hires and their orientation, and manages all workers' compensation claims.

Ms. Clark testified that what the employee told Dr. Burns on September 26, 2006 about the injury would be a safety violation. Ms. Clark testified that if there were not enough people to lift then a transfer device such as a Hoyer Lift should have been used. In addition, when transferring patients, employees should have both feet flat on the floor and that kneeling would be a violation. The Safe Patient and Material Handling Policy was instituted on March 1, 2005. The purpose of the policy is to prevent injury to the employees and give guidelines on safe transferring. A mechanical lift device is a Hoyer Lift which is used regularly on bigger patients to perform a safe transfer. She was not aware if the employee was disciplined for failure to follow procedures. The employee would have received notice of the safety policy during the new hire orientation, when they get to the floor, it is part of the job description, and is reviewed annually in skill fair. When the employee was hired, she would have general orientation which would be done by a physical therapist and also during staff meetings. The employees are required to have training before going to the floor; and a Hoyer Lift was demonstrated on the floor during competency assessment.

The employee testified that she was not trained on the Hoyer lift and if the employer had a policy about the use of the Hoyer lift, she has not seen it. In her November of 2005 orientation, she was trained in policy and procedure but she is not aware of being certified with how to use a Hoyer lift. She does not know if a Hoyer lift was available. There was not one on the floor and

was never told about one in the alcove. She knew about a Hoyer lift on other floors but never used one.

The Safe Patient/Material Handling Policy and Procedure states that mechanical lift devices are a key component in the effort to have safe transfers/lifting and handling. Staff that fail to use the proper safe handling equipment or safety devices will be subject to disciplinary action up to and including termination of employment. In the Patient Handling Section Provision 5 states that that staff will secure equipment or proper assistance of the appropriate number of staff members. Provision 6 states that lifting and transfer devices will be used as often as deemed necessary to insure patient safety and reduce the potential for employee injury. Provision 7 states in instances when equipment is not feasible, staff will use proper positioning of their body, use the large muscle groups of the legs and arms and maintain a base support with a neutral/lordotic spine while holding the patient.

Ms. Clark testified that policy is still in effect. When asked what efforts are made to let employees know about the policy, Ms. Clark testified that during general new hire orientation one of the main policies discussed was safe patient handling and training. It is available on the intranet website and any update or review is in the up-to-date book on each unit. She has heard about the policy being enforced but has never seen it. There were reasonable efforts to make the policy known. Ms. Clark believes that the employee violated the safety policy that was in effect March 1, 2005. The employee was not employed on March 1, 2005, was not handed a copy of the policy but was expected to read it in a policy and procedure manual that was kept in the nurses' station. Ms. Clark does not know if the employee ever read the policy. Ms. Clark did not know why the Hoyer Lift was not used and did not know if it was available on the floor at the time of transfer. There were 3 Hoyer Lifts in the 154 bed facility and a Hoyer Lift was supposed to be in the alcove between the floors. Being trained on the use of the Hoyer Lift was part of their competency but Ms. Clark did not know for sure if the employee was trained with the Hoyer Lift on the floor. The policy does not include words Hoyer Lift or standing on the floor.

Ms. Clark testified that an RN is supposed to fill out a form on how a patient was transferred in nursing assessment. The RN should be called and should be in the room when the patient arrives. She does not think the RN was present during the transfer which violates policy. She does not know if the RN was disciplined. The other employee should have waited until the RN was there. On March 14, 2006, the day of the accident, on the fourth floor there were 15 patients and there were 17 in the critical care unit. There was 1 nurse to 3.5 patients and the goal was 4 nurses per patient.

The employee testified that there was no RN there when they moved the patient, and the general rule was that an RN would be in after the patient got to the floor. An RN filled out the form after the patient was in bed and comfortable. When they transferred the patient she did not see a RN on the floor. She could not recall being disciplined for transferring the patient to the bed. On the day of the accident, the employee was told by Loretta to do as she did. During general orientation, she went through training.

The Nurse Aide Job Description includes a section in the essential job functions to adhere to the nursing safety plan (i.e. fall prevention, body mechanics, universal precautions, medication administrations, etc) when implementing care. The last page is an employee job description notification that was signed by the employee on November 14, 2005 acknowledging receipt of the job description and to familiarize herself with the information in the document. The employee testified that she wrote and signed her name on November 14, 2005.

There was a document entitled General Orientation that was signed by the employee on November 21, 2005 when she attended general orientation that day, and was given information and an opportunity to ask questions to verify understanding. The all day orientation included a two hour back safety/body mechanics section. The employee testified that she wrote and signed her name on November 21, 2005, and was shown back safety and body mechanics.

The Report of Injury was filed on March 24, 2006. It was noted that on March 14, 2006, the employee injured her low back while transferring a patient and the employer was notified on the same day.

The Accident Investigation Form has a front and back. The front showed that the employee had the accident on March 14, 2006 and it occurred approximately at 10:00 a.m. The employee sustained back pain and the witnesses were listed as Cora Brown, Loretta and Vicky. It stated that the employee was not doing something other than required duties at the time of the accident. Checked was schedule safety training for actions that has or will be taken to prevent recurrence. The supervisor signed and dated the report on March 14, 2006. The back part of the form is the Supervisor Investigation Report. The Supervisor was to determine whether the injury was a result of inadequate job safety training, a physical hazard or unsafe work practice. The Unsafe Work Practice lists 7 questions to be answered including if there were safety rules and procedures that existed for the job being performed and if they were followed. The back was left blank and not filled out.

The employee testified that her supervisor sent her to Dr. Tinsley on March 15, 2006.

On March 15, 2006, the employee told Dr. Tinsley that she had pain radiating down her right leg. She gave a history of transferring a 300 pound patient when she felt a pull in her low back. Dr. Tinsley prescribed Ultram and Flexeril. On March 17 the employee told Dr. Tinsley that she got on the stretcher to help lift a patient. The other helpers let go during the lift and she hurt her back.

On March 20, 2006, the employee reported low back pain and tingling and numbness in both feet. Dr. Tinsley noted the employee was able to heel and toe walk with less difficulty; continued medications; and ordered an MRI.

The March 23, 2006 lumbar MRI showed degenerative disc disease at the L5-S1 level with posterior disc bulging with a very small broad based midline area of asymmetric bulging or contained disc herniation with underlying annular tear which abutted the anterior margin of both the originating right and left S1 nerve roots but which produced no neural impingement;

degenerative disc disease at the L4-5 level with very mild posterior disc bulging; and degenerative disc disease at the L3-4 level with very mild posterior disc bulging. The bulging disc and osseous degenerative changes from L3 through S1 resulted in bilateral neural canal narrowing but the nerve roots appeared to exit without impingement.

Due to the positive MRI, Dr. Tinsley referred the employee to a neurosurgeon. The employer-insurer sent the employee to Dr. Tolentino on March 30, 2006. The employee gave a history of transferring a patient that weighed over 300 pounds from an emergency room stretcher to a bed when she felt pain in her lower back. She had bilateral pins and needles that ran down her legs in a multi-dermatomal pattern; and had numbness especially in the S1 dermatome pattern worse on the right and hip pain worse on the right. Dr. Tolentino stated that the MRI showed evidence for a small central annular tear at L5-S1 which appeared acute to subacute but did not appear to have any significant mass effect on the S1 nerve roots. He recommended an EMG, physical therapy, lumbar epidural steroid injections, a lumbar corset, and allowed her to work with a 15 pound work restriction with no repetitive bending, stooping or twisting, and no overhead work. Given the time course of the employee's symptoms, her lack of prior back or leg problems, and the acute to subacute nature of the annular tear at L5-S1, Dr. Tolentino felt that her symptoms were work-related.

On April 3, 2006 Dr. Daniels noted that the pulmonary function test revealed COPD with a significant response to bronchodilators. Dr. Daniels diagnosed COPD, tobacco use, depression, and anxiety; and he adjusted her medication.

The employee went to Advanced Pain Center on April 13, 2006 for low back pain. On March 14, 2006 she was lifting a patient with assistance and injured her low back. The assessment was spondylosis; arthritis; lumbar or lumbosacral disc without myelopathy; and degenerative disc disease. The employee was put on restricted duties and prescribed Hydrocodone.

On April 20, 2006, Dr. Stahly performed an EMG/NCS which was normal. On April 25, a lumbar epidural steroid injection was performed at Advanced Pain Center. Dr. Tolentino saw the employee on April 27 with bilateral leg pain radiating in an apparent S1 dermatomal pattern. After the epidural steroidal injection the employee had an increase of bruising type back pain but no leg pain. The employee was very motivated to return to work and asked to be released without restrictions. She was using Darvocet and a TENS unit to alleviate pain symptoms. Dr. Tolentino ordered work conditioning for four weeks and gave a 25 pound lifting restriction with no repetitive bending, twisting, or stooping and no overhead work.

Dr. Tolentino saw the employee on June 6, 2006 and diagnosed a lumbar strain while transferring an ER patient from a bed to stretcher. She returned to worked for two weeks without restrictions and continued to use a TENS unit. She reported an incident the day before where she had been sitting for about two hours on rocks while her family was fishing. When she got up her left leg was numb and she fell. She denied any injury in the fall and her sensation returned quickly. She was pleased with her return to work and her performance during that time. Dr. Tolentino stated there was some evidence for a lumbar strain with some disease noted at L5-S1

but no clear neurologic deficits; returned her to work to full duty without restrictions; and stated she had reached maximum medical improvement and released her from care.

The employee testified that she asked Dr. Tolentino to release her to full duty because her mother and father were in bad financial shape, and went back to work even though she was still hurting. At the end of August, she was off work for a couple of weeks due to lung spasms and breathing problems. When she told her employer about her breathing problems, the supervisor told her to get better and come back to work. A few days later she was terminated. Her back and legs were hurting all the time.

On July 10, 2006 the employee saw Dr. Daniels who noted she had chest pain and had been diagnosed with pneumonia. Dr. Daniels noted that the employee was asleep when he entered the room and asleep in the waiting room. On exam, there was diffuse expiratory wheezing. Dr. Daniels stated the employee had obstructive sleep apnea with daytime sleepiness and would plan on scheduling a sleep study once her insomnia was under control and to treat her acute exacerbation. Dr. Daniels diagnosed chronic obstructive pulmonary disease with acute exacerbation; and again recommended smoking cessation. Dr. Daniels prescribed Prednisone and Ambien for insomnia.

On July 24, 2006 Dr. Daniels noted the shortness of breath had improved but she still had a cough; and her lungs were clear. Dr. Daniels diagnosed insomnia and prescribed Lunesta. He continued the asthma medications.

The employee returned to Dr. Critchlow on August 16, 2006 due to reduced peak flow and had lost 3 days of work in the past two weeks. The employee was working as a nurse's aide. On exam, the employee had diffuse expiratory wheezes. Dr. Critchlow diagnosed allergic asthma, COPD, and chronic leg pain. Medications were adjusted.

On August 30, 2006 the employee saw Dr. Critchlow for breathing problems. She had been on medical leave and was terminated. She had been on oxygen since February and cannot walk from her car to the office without dyspnea. She cannot do housework and stays in bed much of the day. Dr. Critchlow diagnosed COPD/chronic bronchitis, and anxiety. He recommended counseling. On September 6, Dr. Critchlow wrote Dr. Daniels stating that the employee was emotional and in some respiratory distress; and had advised the employee to see a counselor because she cannot afford to rely on cigarettes to relieve her stress.

On September 8, 2006 Dr. Daniels wrote to Dr. Critchlow noting that the employee told him that she had been put on a leave of absence for work for shortness of breath and wheezing. The employee has been started on oxygen due to dyspnea; and was currently on Spiriva, Advair, Xopenex inhaler alternating with Albuterol and Atrovent inhalers. The employee continued to smoke; and had continued wheezing.

On September 13, 2006 Dr. Critchlow noted that the employee was having breathing problems and could barely walk. Her legs were shaking walking in from the parking lot. The employee had not seen a counselor, did not have a job and cannot work. The employee cannot

walk more than several yards before having to rest and her left leg hurts. There was no peripheral edema. Dr. Critchlow diagnosed severe allergic asthma, COPD, and anxiety/depression.

On September 14, 2006 the employee saw Dr. Daniels and stated that she had dyspnea on exertion. After walking just a short distance she gets shortness of breath; and has weakness in her legs. She attributed the weakness to shortness of breath. Dr. Daniels diagnosed a history of asthma, tobacco dependency, and dyspnea on exertion which was multi-factoral including obstructive lung disease. The employee had a component of chronic obstructive pulmonary disease; obesity and deconditioning which are the main reasons for the shortness of breath. Dr. Daniels recommended a pulmonary exercise test but the employee could not afford it. Dr. Daniels continued the current medications.

On September 26, 2006, the employer-insurer sent the employee to Dr. Burns for continued low back pain. The employee told Dr. Burns that she had a low back injury in March of 2006. She described a patient transfer from a stretcher to a bed with a sheet transfer. She was kneeling on the stretcher when the excess of 300 pound patient started to fall. The three other people helping prevented the patient from falling. The employee continued to have left leg pain with numbness and has had some falls but no injuries. She had increased pain with prolonged sitting of any kind; had increased pain with lying flat; and side lying with flexion of the hips and knees significantly reduced low back and leg pain. An MRI showed a L5-S1 sequestered disc herniation with mild lateralization to the left and a L5-S1 annular tear. Dr. Burns stated the Ultram and Ultracet prescribed by Dr. Wilson provided some benefit. She was working full duty in June but limited to light work secondary to increased low back pain. Dr. Burns noted reluctance to make eye contact, inappropriate laughter, and moderate pain behavior. She had crutches but had well preserved left lower extremity strength. Dr. Burns found diffuse paraspinous muscle tenderness without atrophy. She had no radicular findings with straight leg raise and well preserved left lower extremity strength. She had an antalgic gait when walking without crutches and pain behavior moving on and off the exam table. The employee generated 50% of normal lumbar motion, refused to do any lumbar extension, and side bending and rotation were restricted to 75% of normal. Dr. Burns diagnosed mechanical lower back pain, ordered physical therapy, and prescribed Ultracet and Ambien. He gave restrictions of light work lifting no more than 15 pounds, no sitting or standing greater than 2 hours, and no bending, squatting or twisting.

On October 11, 2006 Dr. Critchlow noted that the employee had good and bad days with asthma. With vacuuming the floor she was worn out and had shortness of breath. She uses oxygen and sleeps poorly. The employee was depressed and was worried that the stabbing chest pain is cancer. She had low back pain and left leg pain. X-rays showed an incomplete fracture of her left 10th rib. Dr. Critchlow noted that the employee had lower lumbar pain with numbness in both legs due to an injury in March and was using a cane. Dr. Critchlow diagnosed severe allergic asthma and COPD. He sent a letter to Dr. Daniels noting the employee was doing very poorly and her peak flow had gone down. He put the employee on Prednisone and was going to renew Xolair therapy. On October 17, 2006, the employee went to Bloomfield Medical Clinic with lumbar and right leg pain; right leg tingling; wheezing and using a cane.

On November 1, 2006, Dr. Burns diagnosed musculoskeletal spinal injury with decreased insight medically. He found paraspinous muscle tenderness with no focal atrophy. He continued Ultracet and started Skelaxin and physical therapy. Dr. Burns noted that the employee could continue to work on light duty with no lifting over 15 pounds. Dr. Burns stated that there was not a surgical repairable lesion.

On January 2, 2007 Dr. Critchlow noted that the employee's chest felt heavy for two to three weeks and she was out of breath walking. She was using oxygen off and on during the day and awakes several times at night with dyspnea. He diagnosed severe allergic asthma, COPD, chronic low back pain and anxiety. On January 5, the employee felt very drained, had insomnia, and had pain in the back and hips. Tylenol did not help and she was afraid of being addicted to Oxycontin. The employee appeared to be depressed. Dr. Critchlow diagnosed severe allergic asthma, COPD, chronic low back pain, and chronic anxiety/insomnia.

On January 11, 2007, Dr. Critchlow noted that the employee was tired and awoke several times a night. The Celebrex for back pain helped some. Dr. Critchlow diagnosed severe asthma, COPD, chronic low back pain, depression, and insomnia. On January 18, the employee told Dr. Critchlow that her asthma was not good. The employee had diffuse wheezing and appeared very depressed. Dr. Critchlow increased Prednisone for a week. On February 15, the employee told Dr. Critchlow that she cannot walk within her house due to shortness of breath and was having trouble sleeping. She had wheezing and was having severe pain in the left upper chest and was worried it was cancer. A CT scan of the chest was negative. The employee went to Bloomfield Medical Clinic on February 27, 2007 for medication refills. She was still off work due to wheezing and back pain.

On March 30, 2007, Dr. Burns noted that the employee continued to demonstrate a guarded spinal exam due to musculoskeletal tightness, a positive straight leg raise, and bilateral equivocal long tract signs. Dr. Burns found no focal atrophy and there was diffuse paraspinous muscle tenderness. Dr. Burns stated progressive symptoms suggested radicular pain with radicular pain distribution. Dr. Burns ordered a lumbar MRI; therapy; and prescribed Hydrocodone for pain.

The April 10, 2007 MRI showed mild degenerative disc changes at L3-4 and L4-5. At L5-S1 there was disc degeneration with minimal indentation of the thecal sac which represented primarily an annular bulge more than disc herniation which did not create any thecal sac or nerve root compression. Dr. Critchlow noted on April 10, 2007 the employee was on Oxycontin for her back and was on long term disability. The employee did not sleep particularly well due to asthma and did not sleep in the daytime. Her son was rebellious and the employee did not take the prescribed medicine. Dr. Critchlow diagnosed severe allergic asthma; chronic insomnia; depression and anxiety; and chronic low back pain. Dr. Critchlow instructed the employee to stop smoking or her lung disease will never get better.

On April 11, 2007 the employee contacted Dr. Burns' office and reported that the 5 mg of Oxycodone was not touching the pain and requested 10 mg which was denied.

On April 27, 2007, Dr. Burns stated the physical examination was remarkable for diffuse paraspinous muscle tenderness, positive straight leg raise with pain in both legs, normal strength and reflexes in the lower extremity with no muscle atrophy. He continued his diagnosis of musculoskeletal spinal injury and added chronic pain syndrome. Dr. Burns stated that given the negative response from conservative treatment and the lack of a surgical lesion that the employee was probably at maximum medical improvement. Dr. Burns increased the Hydrocodone and recommended a FCE evaluation to recommend a more objective return to work. Dr. Burns noted that the employee cannot function at all but examination in the room demonstrated no clear limitations and the employee was self-limiting in a lot of ways. She had fairly significant improved gait pattern after she leaves the examination room. He would see her in a month after the FCE and stated it was reasonable to expect her to return to work. She would need a drug screen randomly during the next month. The return to work records showed continued off work until the FCE.

On May 30, 2007 the employee called Dr. Burns' office and stated that her pain medication was not helping. The employee was instructed to take over the counter ibuprofen between pain medication doses.

On June 6, 2007, Dr. Burns noted that a neurologist appointment was scheduled for June 14, 2007 with Dr. Stahly. The examination showed well preserved lower extremity reflex and strength with no muscle atrophy. She had a very guarded motion quality with some pain behavior. The gait pattern was very unusual and did not demonstrate a consistent step to gait nor is there significant consistent asymmetry with gait pattern. She ambulated with a straight cane. Dr. Burns stated that the employee had a musculoskeletal injury, some degenerative changes, and secondary sleep and mood disturbance. The compliance with medication has been problematic and the employee denied performing a requested drug screen. Dr. Burns assessed chronic pain syndrome, stated there was a failure of patient/physician relationship and her care was terminated. The return to work record showed off work until her neurology appointment.

A form dated July 23, 2007 was sent from the insurance company requesting a statement of medical necessity for medication. Dr. Burns filled out the form showing the need for Hydroco/Apap Tab 10-325 mg and Ultram for continued low back pain for an unknown length of time. Dr. Burns noted the employee had been released from his care.

The employee testified that the insurance company stopped paying for the Ultram. After he released her, she continued with numbness and tingling in her feet and legs after sitting and when walking a certain way. She had situational depression due to the break-up of her marriage; and the first time she saw a psychologist or psychiatrist was Dr. John Woods in August of 2007.

The employee saw John Woods, a clinical psychologist, beginning August 20, 2007. The employee was taking Xanax for anxiety and was having panic attacks due to stress from finances, a pending workers' compensation claim for her back, worries about her two teenage children, and problems with her husband. Her health problems included COPD and asthma. The employee was on a variety of medications and she wanted to go back to work but cannot. She planned on going back to school in the spring. Dr. Wood diagnosed panic disorder.

On August 22, 2007, a functional capacity evaluation was performed by Chad Casey a physical therapist/certified FCE evaluator. He stated that the employee is able to work at the sedentary physical demand level for an 8 hour day which does not qualify the employee for her current job as a nurse's aide. Mr. Casey noted signs of symptom exaggeration on her questionnaire packet with high marking and percentage on the inappropriate symptoms, Oswestry, McGill, activity and MSPQ. Ms. Stroud has inappropriate extrapolation comparisons with her static and dynamic lifting indicating decreased effort on dynamic performance. Given the failure of the validity testing the results of the FCE test were considered invalid.

The employee told Dr. John Woods on September 19 that she was having trouble with her husband.

Dr. Burns signed a return to work record dated October 4, 2007. He diagnosed lumbar strain, and chronic pain, with no structural abnormality. The employee was to return to work with no limitations based on the recent FCE and previous visits.

The employee was sent to Dr. Cleaver for pain management on October 8, 2007 by the employer-insurer. She had an aching-type pain along her lower back; burning and numbness in the right posterior and anterior thigh; aching and burning along the posterior calves; and pins and needles in the feet. Dr. Cleaver noted the prior MRI showed signal abnormalities at L3-4, L4-5 and L5-S1 with loss of disc height at L5-S1 and an annular tear. Dr. Cleaver found negative straight leg testing; some mild decreased sensation light touch and sharp challenges along the right lateral femoral cutaneous nerve distribution and along distal L5-S1 distribution; tenderness over the SI joints bilaterally to palpation; and midline lower lumbar tenderness to palpation with somewhat exaggerated response to minor pressure. Dr. Cleaver diagnosed neuropathic pain in the lower extremities right greater than left; and low back pain with etiology potentially related to L5-S1 disc protrusion versus meralgia paresthetica or possible metabolic disorder. Dr. Cleaver thought that there was some suggestion of radicular components of her pain but there was normal neurodiagnostics and the absence of obvious nerve root impingement on the MRI scan. Dr. Cleaver stated the employee should be evaluated by a pain psychologist or psychiatrist to determine any underlying risk factors which may limit her response to treatment and/or likely recover. Dr. Cleaver diagnosed mechanical low back pain and lower extremity neuropathic pain, etiology not entirely clear with possible lumbar radicular contribution. The employee would potentially benefit by addressing her neuropathic pain initially with Neurontin and consideration for Cymbalta and/or Lyrica. Dr. Cleaver stated the FCE recommended sedentary work and he thought in her current condition that would be the maximum that she would be able to perform. Dr. Cleaver recommended Neurontin, a Serum B12 level, a lumbar myelogram followed by CT and repeat EMG/nerve conduction study, and neuraxial steroids. The summary report stated that she was under treatment related to an alleged work-related accident and could not return to work.

On October 10, 2007, Dr. John Woods noted that the employee had been having family problems including her husband. Her mother had moved away and was trying to move back but cannot help like she would like to. Dr. Woods added depressive disorder as a diagnosis.

The employee saw Dr. Randy Woods on November 1, 2007. He assessed bronchitis, allergies, COPD, vasomotor instability, and neuropathy. The employee was taking Neurontin for her back problem and was on supplemental oxygen. Dr. Woods provided medications for her pre-existing breathing problems. The employee called on November 7 and requested Xanax for anxiety. On November 8 Dr. John Woods noted the employee was having problems with her husband. He diagnosed panic disorder and major depressive disorder.

A CT and lumbar myelogram were performed on November 9, 2007. The myelogram showed a mild L3-4 disc bulge causing mild central stenosis, mild L4-5 disc space narrowing and small osteophytes, and no nerve root sleeve filling defects. The CT scan showed moderate central stenosis at L3-4; and mild stenosis at L4-5 and L5-S1; and multilevel foraminal stenosis. At L5-S1 there was a small concentric bulge that contacted both S1 nerve roots as they exit the thecal sac but did not displace them.

The employee was admitted to Poplar Bluff Regional Medical Center on November 10, 2007 and was discharged on November 15. The discharge diagnosis was major depressive disorder; rule out mood disorder and painkiller dependence; and rule out cluster-B personality traits. It was noted there was limited support, financial problems and family problems. The employee was admitted on a voluntary basis secondary to intensive back pain, emotional distress and acute suicidal ideations. The employee was to follow up with her counselor.

Dr. John Woods noted on November 20, 2007, that the employee had depression of mood and feelings of worthlessness and was requested to stay in therapy.

The employee was admitted to Poplar Bluff Regional Medical Center on December 1, 2007 and was discharged on December 5 for depression. The employee's admission diagnosis was depression, asthma, COPD, and chronic back pain. The discharge diagnosis was major depressive disorder; rule out mood disorder and prescription medication abuse; and rule out cluster-B personality traits. The employee had a history of chronic back pain and was admitted on a voluntary basis secondary to depression and suicidal ideations. The employee was to continue with pain management.

On December 6, 2007, the employee saw Dr. Randy Woods for lower back and left leg pain. She had a significant psychiatric history with major depressive disorder and chronic back pain. A MRI showed a L4-5 bulging disc and other degenerative changes. The employee reported tenderness over the lumbar spine and had positive straight leg raise. She needed refills on pain medications which were prescribed.

On December 12, 2007, Dr. John Woods noted the employee felt abandoned because her mother and father moved to a different town and went to work. Dr. Woods recommended the employee go to the emergency room to be screened for admission. The employee was admitted to Poplar Bluff Regional Medical Center on December 12, 2007 and was discharged on December 14 for depression and pain. The discharge diagnosis was major depressive disorder; mood disorder; rule out prescription medication abuse; and Class B personality traits.

On December 20, 2007, Dr. Cleaver noted the employee reported a worsening of swelling in her lower extremities. She had recently been in the emergency room due to pain and swelling in her lower extremities but it was not felt to be cardiac in nature. Dr. Cleaver noted initially the employee was sitting in a wheelchair without any distress and was engaging in conversation. When Dr. Cleaver reported the results of the tests he said she immediately became tearfully distraught and concerned about the source and future of her pain issues. The pain description was patchy in nature and not dermatomal. The employee had significant edema in her lower extremities. Dr. Cleaver stated that in light of her current physical status and normal studies showing no nerve root impingement he would not recommend steroid injections. He would ask Dr. Tolentino to review the radiologist's opinions and if no significant findings were noted the employee will be referred to Dr. Guidos for evaluation. He kept her off work until the final rating by Dr. Guidos.

On December 21, 2007, the employee saw Dr. Randy Woods for leg pain and swelling. The Lasix had not significantly reduced the symptoms. Dr. Woods diagnosed edema, venous stasis disease; and vasomotor instability. He prescribed Toradol for leg pain.

On January 3, 2008 the employee had low back pain and tenderness. Dr. Randy Woods diagnosed degenerative disc disease and back pain; and prescribed Vicodin, ibuprofen, Ultram, and Toradol. He diagnosed depression and continued Cymbalta and Klonopin. In February, July, and August of 2008, Dr. Randy Woods prescribed medication for back and leg pain.

The employee went to Iron County Hospital in December of 2008 due to a motor vehicle accident injury to her right upper extremity. She had pain to the neck, right shoulder, elbow and wrist. On exam, the employee had muscle spasms of the neck but no back tenderness. X-rays were taken of the neck, left elbow, right wrist, and right elbow. The impression was fracture of the left elbow radial head and an abrasion to the left knee.

The employee testified that as a result of the motor vehicle accident she fractured her elbow but did not hurt her back. In April of 2009, she was punched and shaken which hurt her back but she did not tell a doctor because she did not want to admit to her problems.

The employee went to St. John's Clinic in January of 2010 and was diagnosed by Dr. McCaul with back pain, COPD, and asthma. Her medications had not been filled since March and she requested that they be filled including an inhaler. The employee had shortness of breath and wheezing, back pain and headaches; and was in respiratory distress. Dr. McCaul diagnosed COPD with acute exacerbation and prescribed medications including inhalers. In March of 2010, Dr. McCaul stated that the asthma was poorly controlled and she was non-compliant with medication due to costs.

The employee testified that she went back to Dr. Naushad in February of 2010 on her own after the employer-insurer stopped authorizing treatment. She was taking a lot of Ibuprofen and was not getting relief.

The employee went to Dr. Naushad at Advanced Pain Center in February of 2010 as a self-referral for low back pain with radicular symptoms in the lower extremities in the L4-5 and L5-S1 dermatomes. She used a cane off and on for assisted ambulation. In March of 2010, the medications were adjusted and a lumbar epidural spinal injection was performed. In April and June two more lumbar epidural steroid injections at L5-S1 were performed. In July the employee was stable. Her primary care physician had prescribed an anti-depressant. Facet joint injections at L3-4, L4-5 and L5-S1 were performed in August, September and October of 2010. Dr. Naushad performed radiofrequency of lumbar medial branch levels at L3-4, L4-5 and L5-S1 in November of 2010. In April of 2011, Dr. Naushad reported the radiofrequency gave her 85% relief for four months. The last time he saw her in October of 2010, the employee was on the truck with her husband. The employee received an SI joint injection in April of 2011 and a lumbar epidural steroid injection in May of 2011. On June 20, 2011, a lumbar epidural steroid injection was considered for her back and left leg pain or possible radiofrequency ablation if pain comes back.

The employee testified that the medical bills in Employee Exhibits AA and V are for psychological treatment by Dr. John Woods and for medical treatment of Dr. Randy Woods and Dr. Naushad. She did not ask the insurance company to send her to Dr. Woods. She went back to Dr. Naushad on her own.

The medical bills for Dr. John Woods begin on August 20, 2007; for Dr. Randy Woods on November 1, 2007; and for Dr. Naushad on April 26, 2010. On September 20, 2007, the employee's attorney sent a letter to the employer-insurer's attorney making a demand for further medical treatment. On January 10, 17, and 29, 2008 the employee's attorney demanded psychological treatment recommended by Dr. Cleaver to the insurance company adjuster. On June 25, 2010, the employee's attorney sent a letter to the employer-insurer's attorney requesting pharmacotherapy recommended by Dr. Bassett.

Opinions:

The employee saw Dr. Volarich on May 8, 2009. His deposition was taken on November 20, 2009. Dr. Volarich noted that calf strength and extensor hallucis longus reflexes were difficult to assess due to breakaway. The sensory exam was difficult to interpret due to a variable response to pinprick in both upper and lower extremities. The employee's exam showed objective signs of some impingement of the S1 nerve root to the right lower extremity with the Achilles reflexes being 1/4 on the right and 2/4 on the left. There was a 20% loss in flexion and side bending and 36% loss in extension. The employee was unable to toe walk, could heel walk with poor balance; was only able to squat about 1/2 of normal due to back discomfort; and she held on to the exam table to help steady herself to maintain balance. Dr. Volarich measured straight leg raising to 10 degrees on the left and 20 degrees on the right. He attempted to elevate beyond those levels but was unable to do so because of the increase of back pain. He reported no radicular symptoms in the legs but there needed to be at least 60 to 70 degrees to put adequate stretch on the sciatic nerve to see if it is irritated.

Dr. Volarich stated that the employee moved slowly and carefully when she was barefoot and flatfoot on his examination room floor. The employee was unable to toe walk at all and could not heel walk due to poor balance. The employee was able to stand on each foot about four seconds before losing his balance; and tandem walk 3 or 4 steps but it took almost 30 seconds to do so. Dr. Volarich stated that the employee had multiple Waddell's signs including superficial tenderness, non-anatomic tenderness, positive complaint of pain with simulated rotation and overreaction. The Waddell's signs he found were the same as just about everybody else that examined her; and are abnormal or non-physiologic responses to maneuvers done on physical examination.

Dr. Volarich diagnosed lumbar syndrome with radicular features secondary to disc bulge with annular tear at L5-S1 and lesser disc bulges at L3-4 and L4-5; and myofascial pain syndrome, with an additional diagnosis of probable depression. It was Dr. Volarich's opinion that the work accident that occurred on March 14, 2006 was the substantial contributing factor as well as the prevailing or primary factor in the causing the annular tear and disc bulge at L5-S1 as well as the mild bulging at L3-4 and L4-5 that has caused a severe back pain syndrome with myofascial and radicular features. The annular tear can cause back pain as well as radiating pain to the lower extremities. It was Dr. Volarich's opinion that as a direct result of the March 14, 2006 injury that the employee sustained a 30% permanent partial disability to the body as a whole rated at the lumbosacral spine. Dr. Volarich stated no additional disability occurred to the low back due to the December of 2008 motor vehicle accident.

Dr. Volarich diagnosed pre-existing moderately severe asthma/COPD that required recurrent courses of steroid treatments. It was Dr. Volarich's opinion the pre-existing to March 14, 2006 the employee had a 35% pre-existing permanent partial disability of the body as a whole rated at the pulmonary system due to moderately severe COPD and asthma requiring daily medications to control wheezing. It was his opinion that the condition was a hindrance to her employment or reemployment. It was his opinion that the combination of her disabilities created a substantially greater disability than the simple sum or total of each separate injury or illness and a loading factor should be added.

Dr. Volarich recommended that the employee undergo vocational evaluation and assessment to determine how she might best return to the open labor market in any capacity. Dr. Volarich noted that the employee is 40 years old and is a younger individual, has an education that includes graduation from high school as well as some college course. Dr. Volarich stated if vocational assessment was able to identify a job for which she is suited, he had no objection for the employee attempting to return to work based on limitations. It was his opinion that if vocational evaluation and assessment did not identify a job for which the employee was suited, she is permanently and totally disabled as a result of the work related injury in combination with her pre-existing medical conditions.

Dr. Volarich opined the employee required ongoing treatments for her pain syndrome, including narcotics and non-narcotic medications, muscle relaxants, and physical therapy. She would benefit from treatment at a pain clinic and consideration of a trial of a spinal cord stimulator. Surgical repair was not indicated at the time of his evaluation.

Dr. Volarich put spine restrictions of avoiding all bending, twisting, lifting, pushing, pulling, carrying, climbing and other similar tasks to as needed basis; not handle weight greater than 15 pounds and limit to occasional basis; not handle weight over head or away from body, and not carry weight over long distances or uneven terrain; not to remain in a fixed position for any more than about 20-30 minutes including sitting and standing; and to change positions frequently to maximize comfort and rest when needed including resting in a recumbent fashion. Dr. Volarich put pulmonary restrictions to avoid weather extremes and sudden changes in temperature; avoid all odors, fumes, and other elements that could trigger attack of bronchospasm; limit vigorous or strenuous activities particularly pushing, pulling and extreme emotional stress; and to stop smoking cigarettes

Dr. Volarich testified the degenerative condition on her MRI would not have developed so soon after the accident. The employee was off work post-injury because of peripheral vascular disease not related to the alleged work injury and which could cause numbness, muscular pain, an altered walking gait, cause a person to fall, and contribute to pain. The employee was on medical leave in June of 2006 for her respiratory problems which were unrelated to her back injury. Her asthma has progressed and worsened a little bit. Dr. Volarich acknowledged that someone with a cane or a walker, on first impression, would appear to have a greater disability than someone who does not use such a device.

Ms. Gonzalez is a vocational rehabilitation counselor and evaluated the employee on July 21, 2009. Her deposition was taken on April 23, 2010. The employee graduated from high school, attended Three Rivers Community College in 2000 and 2008 and earned 32 hours of credit. She earned 600 hours in Office Technology at Sikeston Vocational School. Ms. Gonzalez stated the employee does not have transferrable skills within her residual functional capacity given her restrictions of not to handle any weights greater than 15 pounds and to limit tasks to an occasional basis; avoid remaining in a fixed position for any more than about 20 to 30 minutes at a time including both sitting and standing; to change positions frequently to maximize comfort; and rest when needed, including resting in a recumbent fashion. It was Ms. Gonzales' opinion that due to the restrictions, the employee is not able to work competitively and her current residual functional capacity is less than sedentary work.

Ms. Gonzales said the medical evidence corroborates continued significant, residual complaints that present a chronic hindrance to the employee's ability to perform basic work functions and some activities of daily living. It was her opinion that the employee was unable to perform her past job or any job on the open labor market and her impairments have severely compromised her ability to return to her past relevant job or to perform even sedentary work on a sustained basis. The employee has a combination of adverse vocational factors as a result of her primary and pre-existing conditions that would preclude employment. It was her opinion that the employee is not employable in the open labor market and is not capable of any competitive work for which there is a reasonably stable job market. She would not benefit from vocational rehabilitation and her restrictions are so severe that she would not be able to perform sedentary, light, medium, heavy or very heavy work as a result. It was her opinion that the employee would not be employable because of her current conditions including her breathing condition, psychiatric issues, and the physical aspects of her back condition. A competitive job on the open

labor market requires one to be able to work without accommodation. In a competitive job a worker would not be able to lie down several times throughout the day.

Ms. Gonzales took into consideration the opinions of Dr. Volarich and Dr. Guidos. Ms. Gonzales stated that her opinion was based upon work restrictions and that Dr. Tolentino had returned the employee to work without any restriction. No other doctor, other than Dr. Volarich, advised the employee to be in a recumbent position occasionally. The employee was 41 at the time she saw her which is considered to be a younger individual and her age would not limit her to the jobs she has done in the past in terms of employment. Ms. Gonzales has known people more severely disabled than the employee who are gainfully employed. Her opinions take into account the employee's physical limitation, and if those complaints and limitations are not completely accurate, that could alter her opinion.

Dr. Stillings, a psychiatrist, examined the employee on July 20, 2009. His deposition was taken on January 13, 2010. Dr. Stillings noted that the employee appeared to be in some pain and occasionally changed her position and stood twice during the evaluation. Her mood was distraught and she was unable to stop crying throughout most of the evaluation. It was Dr. Stillings opinion that the employee had a mood disorder with a major depressive-like episode due to a general medical condition which was the March 14, 2006 work injury; a pain disorder associated with psychological factors and a general medical condition which was the March 14, 2006 work injury and a panic disorder due to a general medical condition which was the March 14, 2006 work injury. Due to the work injury she has developed panic attacks that included shortness of breath, chest pain, nausea, sweating, numbness and tingling in her fingertips and palpitations. The employee told him she has been very depressed since the work injury and is characterized by chronic low moods, poor concentration, fatigue, disorganized thinking, initial and middle insomnia, feelings of hopelessness, helplessness, worthlessness, uselessness, despairing and morbid thoughts, and suicidal ideation but no active suicidal plans.

Prior to the work injury, the employee had generalized anxiety and association with excessive worry, restlessness, and muscle tension. Dr. Stillings diagnosed pre-existing psychiatric disorders/disabilities of sexual abuse victim; partner relational problems from 5 abusive ex-husbands; generalized anxiety disorder; and a personality disorder with histrionic borderline and dependent personality traits. The employee was prescribed psychotropic medication, Xanax, in the 1990's for generalized anxiety disorder; and took Xanax on and off for general anxiety disorder and multiple marital problems. In 2004 her primary care physician prescribed several antidepressants including Zoloft, Wellbutrin and Amitriptyline for generalized anxiety disorder and marital problems.

Dr. Stillings reported the employee's complex marital history including six marriages and five divorces when she was emotionally, physically, and sexually abused. She frequently changed jobs and received multiple reprimands at work due to these stressors. Dr. Stillings stated the findings on the MMPI was a high rating for hypochondriasis and hysteria opinion, the employee's chronic pain and physical debility caused those scales to be elevated because she is very unhappy about her physical problems. She would focus on physical problems, pain problems, and related complaints; and she has a high rating for hysteria. Dr. Stillings said the

employee did not show a pattern of over reporting of her pain. Her elevated depressive scale and mania scale flow from her chronic pain, her limiting physical factors, her back condition limits her with the work restrictions, her inability to work and return to her former job, and was consistent with her injury history.

It was Dr. Stillings' opinion that the March 14, 2006 work injury was the prevailing factor in causing the employee to have a mood disorder with an associated 20% permanent partial psychiatric disability of the body as a whole; a pain disorder with an associated 10% permanent partial psychiatric disability of the body as a whole and an anxiety disorder with an associated 5% permanent partial psychiatric disability of the body as a whole.

It was Dr. Stillings' opinion that the employee had the following pre-existing permanent partial psychiatric disability: Victim of sexual abuse with an associated 7.5% body as a whole permanent partial psychiatric disability; spousal abuse with an associated 7.5% body as a whole permanent partial psychiatric disability; generalized anxiety disorder with associated 5% body as a whole permanent partial psychiatric disability; and a personality disorder with associated 5% body as a whole permanent partial psychiatric disability. It was his opinion that the pre-existing conditions were a hindrance or obstacle to re-employment. It was his opinion that the employee's pre-existing psychiatric conditions and disabilities combine with her primary injury in a synergistic fashion creating a total disability greater than the simple sum and rendered the employee permanently and totally disabled from gainful employment on a psychiatric basis. It was his opinion that the employee would benefit from psychiatric care causally related to the work injury that would primarily consist of psychotropic medication to prevent deterioration in her clinical psychiatric condition and add some stability to her clinical state. She is not a particularly good candidate for psychotherapy and would need psychotropic medication for a minimum of two years. Dr. Stillings found her to be a forthright reporter. The employee's depression noted since the work injury were her assessment and not his. Dr. Stillings stated that if his information from the employee or other sources were incorrect or inaccurate, it could change his opinion.

The employee was evaluated by Dr. Bassett, a psychiatrist, on April 4, 2010. His deposition was taken on June 18, 2010. The employee had a prior history of sexual abuse as a child; six marriages and five divorces; and physical and emotional abuse by her husbands. Dr. Bassett reported that the employee shifted positions frequently throughout the evaluation and regularly stood up and stretched. At times she stood in place and shifted her weight from one foot to the other which she stated made her back and her leg cramps feel better. Dr. Bassett reported that the employee has to lie down several times a day in order to relieve her back discomfort. She stated the hardest thing is not being able to work and is frustrated by the fact she has to find new ways to do things.

Dr. Bassett said the employee was being treated by a Dr. Naushad, a pain management doctor, who was prescribing Amitriptyline, Hydrocodone/Acetaminophen and Naproxen. The Amitriptyline can help with sleep and as an antidepressant. The employee is not crying as much as she used to about not working and she no longer feels worthless. She feels guilty about not being able to financially help her family and has days when she is so depressed that she does not

want to eat. The employee denied having any long lasting psychiatric or emotional difficulties subsequent to being sexually molested; denied undergoing marital counseling or treatment prior to the injury; and stated her first treatment with a mental health professional was after the work accident. Prior to the work accident she was treated by her primary care provider for depression and took Wellbutrin, Paxil, Effexor and another medication. The employee would take the medications for a couple of weeks, feel better, and stop taking them.

Dr. Bassett diagnosed mild to moderate depressive symptoms. At times, the employee has tearfulness and is frustrated with what she perceived as lack of ability to be as physically active to the degree she was prior to the injury. She has some sleep difficulties but he did not know if they were due to depressive symptoms or pain. It was Dr. Bassett's opinion that the pain and the subsequent alleged reduced physical functioning flowing from the injury of March 14, 2006 is the prevailing factor in the development of depressive symptoms which he characterized as adjustment disorder with depressed mood. Her depressive symptoms, at least on the day he saw her, are more recently of lower intensity than the past. He thought that the Amitriptyline, an antidepressant medication that has pain reducing effects, might be accounting for some of her improvement. The passage of time and the employee's development of some perspective with regard to her condition may have also contributed to how she appeared.

It was Dr. Bassett's opinion that the employee has a pre-injury history of a mood disorder and made reference to depressive or bi-polar type symptoms, secondary to corticosteroid (Prednisone) that she took for asthma. It is a powerful anti-inflammatory and is psychoactive and can cause a manic and a depressed state, and insomnia. It was his opinion that the employee had a pre-injury adjustment disorder with depressed mood, history of sexual abuse, history of partner relational problems, and symptom amplification noted on psychological testing. Dr. Bassett diagnosed a pre-existing pre-injury personality disorder of histrionic traits which is an over the top individual who is kind of the center of attention; and may be prone to symptom amplification but not necessarily conscious. Dr. Bassett found an injured-related adjustment disorder and a propensity to somatize. Somatoform disorder is a psychiatric condition characterized by complaints of physical symptoms either in the absence of or in excess of findings upon physical examination and/or diagnostic testing. Individuals sometimes will hurt or suffer without being able to find a reason or they will hurt or suffer more than one would expect, given the level of illness. They can have some symptom amplification which is often non-conscious. Victims of sexual molestation have a higher likelihood of having a somatoform disorder.

It was Dr. Bassett's opinion that from a purely psychiatric perspective and in reference to the March 14, 2006 injury, she is psychiatrically able to work and was at maximum medical improvement. He gave an overall 10% permanent partial psychiatric disability as a consequence of both pre-injury and injury related factors and which takes into account the symptom amplification. He attributed half to the pre-injury psychopathology and the other half to the permanent partial psychiatric disability due to the injury of March 14, 2006.

Dr. Bassett testified her current medications should be continued if it accounts for her recent uptick in mood. It is Dr. Bassett's opinion that the March 14, 2006 accident is the prevailing factor causing the need for further medication in the form of Amitriptyline. Dr.

Bassett explained that non-conscious symptom amplification as a symptom of somatoform disorder refers to unintentional symptom amplification. Dr. Bassett was not prepared to make an accusation of malingering in this case. Dr. Bassett noted that the employee did not need to lie down at all during the 143 minute examination. The employee appeared to be stiff and uncomfortable but did not appear overly dramatic. She stood and stretched and ambled around the room from time to time in a manner consistent with chronic back pain. The employee was less distressed and appeared to have gotten better from the way she appeared in late 2007.

Dr. Guidos evaluated the employee on behalf of the employer-insurer on January 17, 2008. The employee's medical history included asthma, and very significant chronic obstructive pulmonary disease requiring intermittent oxygen and oxygen at nighttime. The employee had a history of chronic pain and multiple comorbidities including severe pulmonary disease and history of psychiatric issues severe enough to be admitted to the hospital three times over the last several months. The employee has confounding psychiatrist overlays on examination and a history of requesting narcotic medication for pain management. Dr. Guidos found symptom magnification on examination. Dr. Guidos stated that the employee would benefit from additional rehabilitation and psychiatrist intervention which are not work related. The work injury was a musculoskeletal strain that occurred while transferring a patient and she was at maximum medical improvement for that injury. It was Dr. Guidos' opinion that the employee had 7% permanent partial disability of the whole person. Dr. Guidos noted that the employee is completely disabled but there are compounding factors that contribute to her total disability including her severe COPD and underlying psychiatric illness.

In a separate January 17, 2008 letter Dr. Guidos stated that the employee is considered disabled secondary to a multiplicity of factors not fully related to her work injury. The employee is completely disabled on the basis of her severe COPD, asthma, and underlying psychiatric issues in association with her history of lumbosacral strain. The employee is considered to be at maximum medical improvement from her work related injury and could work at a sedentary level as per the FCE of August 22, 2007, if she did not have the compounding factors of her other medical conditions.

In November 2008, Dr. Guidos stated that the initial medications were a result of the work related injury, and the employee was now at maximum medical improvement for her work related lumbar strain and no further treatment was needed. She should continue with treatment for her underlying psychiatric issues, pain behavior and overall medical care but her work related lumbar strain was felt to be at maximum improvement.

Dr. Guidos' deposition was taken on April 16, 2010. The employee had a musculoskeletal strain which occurred while transferring a patient. There was a lack of any type of objective testing on physical examination and on radiographic/electrodiagnostic studies. Dr. Guidos diagnosed mechanical low back strain, stated that the employee had undergone sufficient and extensive treatment for that condition and was at maximum medical improvement as of January 17, 2008. The employee needed to continue treatment for her underlying psychiatric issues and pain behavior. It was her opinion that the employee was disabled due to her other non work related injuries which includes a history of severe COPD and underlying psychiatric illness.

The employee should continue with her medications for her treatment of her underlying psychiatric illness which includes her pain behavior.

Dr. Guidos stated that if the employee did not have her other factors, she could work at a sedentary level due to her work related back injury and agreed with the functional capacity evaluation. The employee had inconsistency on physical examination for pain behaviors. One of the factors was constantly requesting medications. Using a wheelchair, walker or cane is not typical of what one would expect for someone who has a low back strain.

Dr. Guidos was unable to obtain an accurate back assessment on examination due to things the employee could or would not do. The employee would not bend forward as asked because she said she would fall. The employee walked with a cane but was concerned her leg would give out on her but was able to walk several feet with assistance. The employee continued to ask for narcotics throughout the entire examination and then expressed displeasure when Dr. Guidos would not obtain narcotics for her. There were psychological overlays on examination, and inconsistencies in the way the patient responded. The employee's cooperation on examination was very limited. The pain and sensation problems in her legs were inconsistent with the physical examination and inconsistent to some extent with objective testing. The employee had a negative straight leg raise in both legs which showed at that time no radiculopathy. The employee had normal muscle strength in all of her major muscle groups of the lower extremities. If the employee had nerve damage from radiculopathy, it could cause weakness in her ability to raise her foot. The employee had inconsistencies in her symptoms with what was found on examination and in testing, and the employee had some symptom magnification issues. Dr. Guidos stated that the employee's objective findings did not match her subjective complaints and that the use of a cane or a wheelchair was not medically indicated.

Additional testimony of the employee and Ms. Clark:

The employee testified at the hearing that prior to March 14, 2006, she used Wii Fit for exercise including using the Wii Fit board for step aerobics, balance, ski jump, tight rope, and went from squatting to standing quickly. She has not used the Wii Fit since March 14, 2006 because she thought it would hurt her. She did not know when the Wii Fit was released in the stores. In her deposition, she testified that she played a lot of Wii Fit Games including the Wii Fit prior to March 14, 2006. Ms. Clark testified that she has had the Wii Fit game since December 25, 2009 and her grandchildren had one before she did. Ms. Clark remembered that her Aunt was going to have back surgery in November of 2008, and that prior to May of 2008, the Wii Fit was not available in the United States. During rebuttal the employee testified that after the accident, she used the Wii Fit maybe a couple of times but does not know if she played it more than twice. Prior to March 14, 2006, she was playing whatever games her sister had. If the Wii Fit game was not released until after the accident, she made a mistake in her deposition. After the accident, she does not know when she played Wii Fit.

The employee testified that she married Mr. Stroud before the work injury. He was physically abusive but she did not think that he ever injured her back. After the work injury, when he was physically abusive her back hurt worse but it did not cause any additional treatment.

After the work accident, she developed feelings of depression. She became upset and if her parents needed something or her children called and they needed money she could not provide it to them. It made her feel worthless since she could not take care of parents or children and she would cry. In 2007 she was treated inpatient in the psychiatric ward for a short period. She felt suicidal but would not act on it. The treatment helped somewhat until her parents or children would call again. Prior to March of 2006 she never felt suicidal and was never treated at an inpatient psyche ward. Since her work injury she has a feeling of having something sitting on her chest, her heart was pounding and racing, she gets really hot, and cannot breath due to her lungs. She has been more mentally stable since taking Amitriptyline.

The employee testified that she started at Three Rivers Community College in 2007 or 2008, but was only able to manage two semesters due to her back problems and the college would not accommodate her. Her back hurts when she does a lot of walking. She takes muscle relaxers, pain pills, Neurontin, and Amitriptyline; and does exercises, and uses a heating pad, massagers, and a TENS unit. She has to lay down at least once a day with a heating pad. She has learned how to adjust her life around her back. Sometimes she uses a cane and always keeps a cane in the car. On the first day of the hearing, she used a cane to get in the building because she had been sitting in her vehicle for too long but did not use the cane at the hearing. On the second day of the hearing, the employee was using a cane due to rain which makes her back worse.

The employee testified that since the accident she has not applied for a job, because no one would want her with taking narcotics, lying down, and moving around a lot. Her mother worked at Cyndi's Restaurant for a while but she has not applied there. If somebody stated she was taking orders, delivering food, giving someone a cracker, or sweeping there, she was not employed. She helped her mother at the restaurant twice and went in and talked to her while she was working. The two times she helped her mother her back hurt really bad and afterwards was in bed for several hours. She never cooked food or carried trays of dishes. The last time she took an order, delivered food, went out to the parking lot and took someone napkins and crackers, and swept the floor was a week ago last Saturday before the first hearing day.

The employee testified that most of the time she has no problems driving a car. Since her deposition was taken, she can drive longer, can bend better, and reach above her head better. She is on a lot stronger pain medication. She can walk longer than 100 feet and is more steady on her feet now. She can walk regularly without a cane and can negotiate small steps. She does not walk normally even if some people said she does. She can get in and out of the car okay. She currently lies down 2-4 hours due to back pain, and did not have to lie down before March 14, 2006. After the accident, her back pain affected her ability to sleep at times. She could not go all day without lying down. She uses a cane, walker and wheelchair, from time-to-time, but not every day. If there was surgery to relive her back and leg she would have it done. She was told it would be hard to find a doctor to do surgery due to her lungs. She used a walker after having nerve ablations in November of 2010 but presently did not need it. She might use the cane 2-3 days in a row, and then go a week without it. During the last two weeks of June she used the cane if she needed it.

Testimony of Roger Barton

Roger Barton testified. He has worked at Blair Group since May of 2004. He is a retired law enforcement officer and was a detective. He was hired by the insurance company to observe the activities of the employee, and was told that she had a back injury. He observed the employee for 5 days and saw her walking, driving, bending over, reaching, and getting in and out of an SUV. The first day he observed her was on June 16, 2011 in Lesterville, Missouri. He drove by her residence and saw her standing in the yard without using support such as a cane or walker. The second time he drove by she was near the front of the house and was bent over looking into a container that appeared to be a cooler. Each of those observations was several seconds. On June 20, he saw the employee driving a minivan in Centerville. On June 21, he obtained the permission of a neighbor to park on their property. He parked on the property for 3 or 4 days. On June 21, when he saw the employee drive past he drove to her residence. He saw the employee get out of her SUV carrying something and walking with a rather quick pace faster than normal toward the house. He saw no limping or hobbling, and saw her walking with no support and no problems. When he drove by and saw her standing at a table near the front door she was leaning forward.

Mr. Barton testified that on June 22, 2011 he was with Norris Blair the owner of the company driving north on Highway N toward the employee's residence. They saw the employee and her husband traveling south with the employee driving. They turned around and followed them 6-8 miles into Centerville. The employee pulled up to a law office, exited the vehicle, stepped out and walked briskly into the law office with no problems going up the steps. She was not limping or favoring her back and had no limitations. After several minutes, she came out of building and got back into the vehicle with no sign of limping or problems. Mr. Barton saw the employee walking about 10-15 feet which took several seconds when she went into the attorney's office. On June 23, he drove by the employee's residence, and saw her standing by a tree with both arms extending out like she was retrieving or getting something out of the tree. He observed her for several seconds. Later that day, he drove back and she was leaning forward; picking up something; and her body was not supporting her back when leaning over. He saw her for several seconds, and she was still bent over as he went out of sight. He was present for an additional 5 days after June 23 but never observed her again.

When he passed her house he was able to observe her for several seconds. The house was off the road a bit approximately 40 yards and there were trees along the road with large breaks in between the trees. Mr. Barton did not have any problems observing. Mr. Barton observed the employee both days of the hearing. He saw her getting out of her chair with difficulty at the hearing and it was different than when he saw her getting out her car. At the hearing she had to use her arms to push herself up and use a cane. When he observed her exit the vehicle she walked normally at a normal pace. On the second day of the hearing, he saw her sitting down in a chair in the lobby and she had difficulty doing that. That was completely different than observing how she got back into a vehicle.

RULINGS OF LAW

Issue 1. Accident.

The employee testified that on March 14, 2006, she was helping transfer a female patient that weighed 300 pounds from a stretcher to a bed. The employee was on her knees on the stretcher and was helping lift the patient over the stretcher as two other employees were pulling the sheet. One of the other employees let go of the sheet and the employee did everything she could to lift the patient across to the bed so the patient would not fall. The employee felt a twinge with immediate burning and tearing pain mostly in the left low back. The Report of Injury, the Accident Investigation Form, and the history in the various medical records including Dr. Tinsley, Dr. Tolentino, Advanced Pain Center and Dr. Burns are consistent with and corroborate the employee's testimony concerning the accident and injury.

Based on a review of the evidence, I find that on March 14, 2006, the employee sustained an accident arising out of and in the course of her employment.

Issue 2. Medical Causation.

Low Back:

Dr. Tolentino stated that the MRI showed a small central annular tear at L5-S1 which appeared acute to subacute but did not appear to have any significant mass effect on the S1 nerve roots. Based on the time course of symptoms, the lack of prior back or leg problems, and the acute to subacute nature of the L5-S1 annular tear, it was Dr. Tolentino's opinion that the employee's symptoms were work-related. Dr. Tolentino diagnosed the employee with a lumbar strain while transferring a patient with some disease noted at L5-S1 but no clear neurologic deficits. Dr. Burns stated that the MRI showed a L5-S1 disc herniation and annular tear and diagnosed mechanical lower back pain, a musculoskeletal spinal injury with some degenerative changes. Dr. Cleaver diagnosed mechanical low back pain and lower extremity neuropathic pain, etiology not entirely clear with possible lumbar radicular contribution. It was Dr. Guidos' opinion that the employee sustained a musculoskeletal strain while transferring a patient.

Dr. Volarich diagnosed lumbar syndrome with radicular features secondary to disc bulge with annular tear at L5-S1 and lesser disc bulges at L3-4 and L4-5; and myofascial pain syndrome. It was Dr. Volarich's opinion that the March 14, 2006 work accident was the prevailing or primary factor in causing the annular tear and disc bulge at L5-S1 as well as the mild bulging at L3-4 and L4-5 that has caused severe back pain syndrome with myofascial and radicular features.

I find that the opinions of Dr. Tolentino, Dr. Burns, Dr. Cleaver and Dr. Volarich more credible than the opinion of Dr. Guidos on whether the employee had sustained more than a low back strain. I find that the employee had a disc bulge with an annular tear at L5-S1 and mild disc bulges at L3-4 and L4-5.

Based on a review of all the evidence, I find that the March 14, 2006 work accident was the prevailing factor in causing an injury to the employee's low back. I find that the accident was

the prevailing factor in causing the disc bulge with a small annular tear at L5-S1 and mild disc bulges at L3-4 and L4-5; and caused the low back to become symptomatic and disabling; and caused the need for the medical treatment provided by the employer-insurer. I find that the employee's low back condition was medically causally related to the March 14, 2006 work accident.

Psychiatric Condition:

In the fall of 2007, Dr. Wood diagnosed the employee with panic disorder and major depressive disorder. The employee was admitted to the hospital three times in November and December of 2007 with a diagnosis of major depressive disorder; mood disorder, rule out prescription medication abuse, and Class B personality traits. It is important to note that during the fall of 2007, the employee noted non-work related stressors including problems with her teenage children and husband, and her parents moving away.

It was Dr. Guidos' opinion that the employee had psychiatrist overlays and the psychiatric intervention was not work related.

Dr. Stillings diagnosed pre-existing psychiatric disorders with permanent partial disabilities of sexual abuse victim; partner relational problems from five abusive ex-husbands; generalized anxiety disorder; and a personality disorder with histrionic borderline and dependent personality traits. Prior to the work injury the employee had generalized anxiety in association with excessive worry, restlessness, and muscle tension and was prescribed Xanax, Zoloft, Wellbutrin and Amitriptyline for generalized anxiety disorder and marital problems.

It was Dr. Stillings' opinion that the employee had a mood disorder with a major depressive-like episode; a pain disorder associated with psychological factors; and a panic disorder due to the March 14, 2006 work injury. It was Dr. Stillings' opinion that the March 14, 2006 work injury was the prevailing factor in causing the mood disorder; pain disorder; and anxiety disorder.

It was Dr. Bassett's opinion that the employee has a pre-existing mood disorder with depressive or bipolar type symptoms with insomnia. It was his opinion that the employee had a pre-injury adjustment disorder with depressed mood, history of sexual abuse and partner relational problems, and symptom amplification. Dr. Bassett diagnosed a pre-existing pre-injury personality disorder of histrionic traits and may be prone to symptom amplification.

It was Dr. Bassett's opinion that the employee had mild to moderate depressive symptoms and the pain and the subsequent alleged reduced physical functioning flowing from the injury of March 14, 2006 is the prevailing factor in the development of mild to moderate depressive symptoms which he characterized as adjustment disorder with depressed mood. It was Dr. Bassett's opinion that the employee had sustained an injury-related adjustment disorder and had a propensity to somatize. It was Dr. Bassett's opinion that the March 14, 2006 accident is the prevailing factor causing the need for further medication in the form of Amitriptyline.

With regard to the medical causation opinions concerning the employee's alleged psychiatrist conditions, I find that the opinion of Dr. Bassett is more credible and persuasive than the opinions of Dr. Guidos and Dr. Stillings.

Based on a review of all the evidence, I find that the March 14, 2006 work accident was the prevailing factor in causing the development of mild to moderate depressive symptoms of an adjustment disorder with depressed mood. I find that the employee's mild to moderate depressive symptoms of an adjustment disorder with depressed mood was medically causally related to the March 14, 2006 work accident.

Issue 6. Nature and extent of permanent disability against the employer-insurer and Issue 7. Liability of the Second Injury Fund for permanent partial disability or permanent total disability.

Permanent Total Disability

The employee has alleged that she is permanently and totally disabled. I find that there is not sufficient evidence to find that the employee is permanently and totally disabled either as a result of the March 14, 2006 accident and injury alone or a combination of the March 14, 2006 accident and injury and the pre-existing conditions at the time of the March 14, 2006 accident.

The employee's claim for permanent total disability is affected by the following:

After March 14, 2006 the employee's COPD/Asthma condition deteriorated.

On June 6, 2006, Dr. Tolentino returned the employee to work at full duty without restrictions and stated she was at maximum medical improvement for her low back. On July 10, 2006, Dr. Daniels diagnosed acute exacerbation of chronic obstructive pulmonary disease. On August 16, 2006, Dr. Critchlow noted that the employee had lost three days of work in the past two weeks. On August 30, 2006, the employee saw Dr. Critchlow for breathing problems and it was noted that she had been on medical leave. The employee could not walk from her car to the doctor's office without shortness of breath, cannot do housework, and stayed in bed much of the day. In September, Dr. Critchlow noted that the employee was in respiratory distress and Dr. Daniels noted that the employee had been put on a leave of absence from work for shortness of breath and wheezing. Dr. Critchlow noted that the employee was having breathing problems and could barely walk. Dr. Volarich stated that in 2006 the employee went out on medical leave for respiratory problems which was unrelated to her back injury and that her asthma had progressed and gotten worse.

After March 14, 2006 the employee continued to have non-work related stressors:

The employee had a pre-existing psychiatric condition from different stressors. After March 14, 2006, it is clear from the medical records that the employee continued to have non-work related stressors.

In the fall of 2006, the employee was seeing Dr. Critchlow for her breathing problems and was worried that her stabbing chest pain was cancer. In April of 2007 the employee told Dr. Critchlow that her son was rebellious. In August of 2007 the employee told Dr. John Woods that she was having anxiety and panic attacks due to stress from finances, her pending workers' compensation claim for her back injury, worries about her two teenage children, and problems with her husband. In October, the employee noted that she had been having family problems including her husband and her mother had moved away and could not help. In November, Dr. Woods noted the employee was having problems with her husband. When she was admitted to the hospital in November for depression it was noted that the employee had limited support, financial problems and family problems. In December of 2007, Dr. Woods noted the employee felt abandoned because her mother and father moved.

The subsequent deterioration of the COPD/asthma after March 14, 2006 and the subsequent non-work related stressors substantially affect the employee's claim for permanent total disability against the employer-insurer and the Second Injury Fund.

Alleged Severity of Back Symptoms:

There were numerous health care providers both treating and examining that questioned the severity of the employee's low back symptoms.

Dr. Burns, during his first examination, noted that the employee's reluctance to make eye contact, inappropriate laughter, and moderate pain behavior. She was on crutches but had well preserved left lower extremity strength. Dr. Burns found diffuse paraspinal muscle tenderness. The employee had no radicular findings with straight leg raise testing and well preserved left lower extremity strength. The employee had pain behavior moving on and off the exam table. The employee refused to do any lumbar extension. During a subsequent visit, Dr. Burns noted that even though the employee stated she could not function, the physical examination was remarkable for diffuse muscle tenderness and there were no clear limitations demonstrated and the employee was self-limiting in a lot of regards. The employee had fairly significant improved gait pattern after she left the examination room. A later examination showed well preserved lower extremity reflex and strength with no muscle atrophy but the employee had a very guarded motion quality with some pain behavior. The gait pattern was very unusual with no significant consistent asymmetry.

The functional capacity evaluation showed signs of symptom exaggeration and inappropriate symptoms and a failure of validity testing.

Dr. Cleaver noted that initially the employee was sitting without any distress and engaging in conversation and when he reported the test results, the employee immediately became tearfully distraught and concerned about the source and future of her pain issues. The pain description was patchy in nature and on examination the employee had exaggerated response to minor pressure.

Dr. Guidos found symptom magnification and psychiatric overlays on examination. Dr. Guidos was unable to obtain an accurate back assessment due to things the employee could or would not do. The employee continued to ask for narcotics throughout the entire examination and then expressed displeasure when Dr. Guidos would not obtain narcotics for her. There were inconsistencies in the way the employee responded. She had inconsistency on physical examination for pain behaviors that were out of character for someone having discomfort. The employee's cooperation on examination was very limited. The pain and sensation problems in her legs were inconsistent with the physical examination and with objective testing. The employee had inconsistencies in her symptoms with what was found on examination and in testing; and the employee had symptom magnification issues. Her objective findings did not match her subjective complaints; and the use of a cane or a wheelchair was not medically indicated.

Even the employee's rating physician, Dr. Volarich, noted that testing of calf strength and extensor hallucis longus reflexes were difficult to assess due to breakaway. The sensory exam was difficult to interpret due to a variable response to pinprick in upper and lower extremities. Dr. Volarich stated that the employee had multiple Waddell's signs including superficial tenderness, non-anatomic tenderness, positive complaint of pain with simulated rotation and overreaction. The Waddell's signs he found were the same as just about everybody else that examined her.

The credible testimony of Roger Barton affects the employee's claim for permanent total disability. Mr. Barton observed the employee for five days, two to three weeks prior to the first day of hearing. Mr. Barton saw the employee walking with a faster than normal pace with no limping or hobbling; the employee leaning forward; exit her vehicle; and walk briskly into an office with no problems going up the steps. The employee was not limping, was not favoring her back and she had no limitations. He observed her coming out of the office and get back into her vehicle with no signs of limping or problems. He saw her with both arms extending out like she was getting something out of a tree; saw her leaning forward and picking up something without her body supporting her back. He never saw her walk with a limp or use a cane or walker. Mr. Barton observed the employee both days of the hearing. On the first day of the hearing, Mr. Barton saw her getting out of her chair with difficulty including having to use her arms to push herself up and she had to use a cane. This was totally different than when he saw her get out of her vehicle and walk without a problem. On the second day of the hearing, he saw her sitting down in a chair in the lobby and had difficulty which was totally different when he had seen her getting back into the vehicle.

I observed the employee during both days of the hearing. On the first day, the employee was continuously moving around in her seat including at times standing up and sitting down. At one point, she leaned over the hearing room table and then leaned up against the wall. During the testimony of the other witnesses, the employee appeared to be sleeping. At the continuation of the hearing on the second day, the employee was walking gingerly with a cane. Based on a review of the evidence, I find that the employee's observed actions are not credible regarding the extent of her disability.

These observations substantially affect the employee's claim for permanent total disability. Based on a review of the evidence, I find that the employee's physical complaints and limitations are not as significant as her testimony indicated.

The following testimony of the employee affects her credibility with regarding the extent of her disability:

The employee testified that prior to March 14, 2006, she used the Wii Fit game but since that date has not used it because she thought it would hurt her. She testified that she used the Wii Fit game board for step aerobics, to balance, ski jump, tight rope, and a person had to go from squatting to standing quickly. In her deposition she testified that she played Wii Fit prior to March 14, 2006. Ms. Clark testified that the Wii Fit game was not available in the United States prior to May of 2008. I find that the Wii Fit game was not released until at least two years after the employee's accident and that the employee used the Wii Fit game at least a couple of times. The employee's testimony and participation in the Wii Fit game affects her credibility with regard to the extent of her disability.

I find the employee's testimony that approximately a week prior to the first hearing date while she was at Cyndi's restaurant that she took an order, delivered food, went out to the parking lot and took someone napkins and crackers, and swept the floor affects her credibility with regard to the extent of her disability.

Disability Opinions:

In June of 2006, Dr. Tolentino returned the employee to work full duty without restrictions. In October of 2007, Dr. Burns returned the employee to work with no limitations.

Dr. Volarich placed restrictions to the employee's spine of avoiding all bending, twisting, lifting, pushing, pulling, carrying, climbing and other similar tasks to an as-needed basis; not to handle weight greater than 15 pounds and limit to an occasional basis; not to handle weight over head or away from the body, and not to carry weight over long distances or uneven terrain; not to remain in a fixed position for any more than about 20-30 minutes including sitting and standing; and to change positions frequently; to maximize comfort and rest when needed including resting in a recumbent fashion. It was Dr. Volarich's opinion that as a direct result of the March 14, 2006 accident the employee sustained a 30% permanent partial disability to the body as a whole rated to the lumbosacral spine.

Dr. Volarich diagnosed pre-existing moderately severe asthma/COPD and it was his opinion that prior to March 14, 2006, the employee had a 35% pre-existing permanent partial disability of the body as a whole of the pulmonary system. Dr. Volarich put pulmonary restrictions to avoid weather extremes and sudden changes in temperature; avoid all odors, fumes, and other elements that could trigger an attack of bronchospasm; limit vigorous or strenuous activities particularly pushing, pulling and extreme emotional stress; and to stop smoking cigarettes. It was his opinion the condition was a hindrance to her employment or re-employment.

It was his opinion that the combination of her disabilities created a substantially greater disability than the simple sum or total of each separate injury or illness and a loading factor should be added. Dr. Volarich recommended that the employee undergo vocational evaluation and assessment to determine how she might best return to the open labor market in any capacity. Dr. Volarich noted that the employee is 40 years old, is a younger individual, graduated from high school, and has some college courses. Dr. Volarich stated if vocational assessment was able to identify a job for which she is suited, he had no objection to the employee attempting to return to work. If the vocational evaluation and assessment did not identify a job for which she is suited, it was his opinion that the employee is permanently and totally disabled as a result of the work related injury in combination with her pre-existing medical conditions.

It was Ms. Gonzales' opinion that due to the restrictions, the employee is not able to work competitively; and her current residual functional capacity is less than sedentary work. It was her opinion that the employee was unable to perform any job on the open labor market and her impairments have severely compromised her ability to perform even sedentary work on a sustained basis. The employee has a combination of adverse vocational factors as a result of her primary and pre-existing conditions that would preclude employment. It was her opinion that the employee is not employable in the open labor market and is not capable of any competitive work for which there is a reasonably stable job market. Her restrictions are so severe that she would not be able to perform sedentary work. It was her opinion that the employee would not be employable because of her current conditions including her breathing problems, psychiatric issues, and the physical aspects of her back condition. Ms. Gonzales stated that if her physical complaints and limitations are not completely accurate it could alter her opinion. Ms. Gonzales stated that she has known people more severely disabled than the employee who are gainfully employed.

It was Dr. Guidos' opinion that the employee had 7% permanent partial disability of the whole person referable to the low back. It was Dr. Guidos' opinion that the employee was completely disabled due to a multiplicity of factors not wholly related to her work-related injury. It was her opinion that the employee was completely disabled based upon severe COPD, asthma, and underlying psychiatric issues, in association with her lumbosacral strain. It was her opinion that the employee could work at a sedentary level as per the August of 2007 FCE, if she did not have the compounding factors of her other medical conditions. It was her opinion that due to her work related back injury alone she could work at a sedentary level based upon the functional capacity evaluation.

It was Dr. Stillings' opinion that as a result of the March 14, 2006 work accident and injury that the employee sustained a 20% permanent partial psychiatric disability of the body as a whole for the mood disorder; a 10% permanent partial psychiatric disability of the body as a whole for the pain disorder; and a 5% permanent partial psychiatric disability of the body as a whole for the anxiety disorder.

It was Dr. Stillings' opinion that the employee had pre-existing permanent partial psychiatric disability for sexual abuse of 7.5% of the body as a whole; for spousal abuse of 7.5% of the body as a whole; for generalized anxiety disorder of 5% of the body as a whole; and for

personality disorder of 5% of the body as a whole. It was his opinion that the pre-existing conditions were a hindrance or obstacle to re-employment. It was his opinion that the employee's pre-existing psychiatric conditions and disabilities combine with her primary injury in a synergistic fashion creating a total disability greater than the simple sum and rendered the employee permanently and totally disabled from gainful employment on a psychiatric basis. Dr. Stillings stated that if his information from the employee or other sources were incorrect or inaccurate, it could change his opinion.

It was Dr. Bassett's opinion from a purely psychiatric perspective the employee is able to work. It was his opinion that the employee had sustained an overall 10% permanent partial psychiatric disability of the body as a whole as a consequence of both pre-injury and injury related factors. He took into account the symptom amplification. He attributed half of her overall disability to the pre-injury psychopathology and the other half to the permanent partial psychiatric disability due to the injury of March 14, 2006.

The opinions of Dr. Volarich, Ms. Gonzales, Dr. Guidos, and Dr. Stillings as to permanent total disability are substantially affected by my findings that the employee's complaints and limitations are not as significant as she testified to and told the physicians and vocational examiner; the August of 2007 functional capacity evaluation which was not valid due to the failure of the validity testing; and after March 14, 2006, the employee's COPD/Asthma condition deteriorated and she continued to experience non-work related stressors.

I find that the opinions of Dr. Burns, Dr. Tolentino, and Dr. Bassett are persuasive and more credible than the opinions Dr. Volarich, Ms. Gonzales, Dr. Guidos, and Dr. Stillings.

Based on the evidence, I find that the employee has failed to satisfy her burden of proof on her claimed permanent total disability. I find that the employee is not permanently and totally disabled and unemployable in the open labor market either as a result of the primary March 14, 2006 accident or injury alone or from a combination of the March 14, 2006 accident and injuries and the pre-existing conditions at the time of the March 14, 2006 accident. The employee's request for an award of permanent total disability is denied.

Permanent Partial Disability

Employer-Insurer:

Based on the evidence, I find that the employee has sustained permanent partial disability as a result of the March 14, 2006 accident. I find that as a direct result of the March 14, 2006 accident the employee sustained a 12.5% permanent partial disability of the body as a whole referable to her low back and 5% of the body as a whole referable to the psychiatric condition. The employer-insurer is ordered to pay the employee 70 weeks of compensation at the rate of \$365.08 per week for a total award of permanent partial disability of \$25,555.60.

Second Injury Fund:

Based on the evidence, I make the following rulings:

Primary Injury: I find that the primary injury to the employee's low back and psychiatric condition resulted in a 17.5% permanent partial disability of the body as a whole for a total of 70 weeks of compensation.

Pre-Existing Psychiatric Condition: I find that the employee's pre-existing psychiatric condition was of such seriousness as to constitute a hindrance or obstacle to employment or obtaining re-employment. I find that the pre-existing psychiatric condition resulted in a 12.5% permanent partial disability of the body as a whole for a total of 50 weeks.

Pre-Existing Pulmonary Condition: I find that the pre-existing injury pulmonary condition was of such seriousness as to constitute a hindrance or obstacle to employment or obtaining re-employment. I find that the employee's pre-existing pulmonary condition resulted in a 17.5% permanent partial disability of the body as a whole at the 400 week level for a total of 70 weeks.

Conclusion:

I find that the employee's pre-existing psychiatric and pulmonary conditions and the last injury to the body as a whole referable to the low back and psychiatric condition combined synergistically to create a total disability of 213.75 weeks. This total disability is based on a loading factor of 12.5%. After deducting the percent of disability that existed prior to the last injury (120 weeks) and the disability resulting from the last injury, considered alone (70 weeks) from the total disability attributable to all injuries or conditions existing at the time of the last injury (213.75 weeks), the remaining balance to be paid by the Second Injury Fund is equal to 23.75 weeks. The Second Injury Fund is therefore directed to pay to the employee the sum of \$365.08 per week for 23.75 weeks for a total award of permanent partial disability equal to \$8,670.65.

Issue 5. Additional Temporary Disability Benefits.

The parties stipulated that if I ruled in favor of the employee on the issues of accident and medical causation that the employee is owed an additional \$139.54 for underpayment of temporary total disability for the time period of March 15, 2006 through April 13, 2006 due to the benefits being paid at the incorrect rate.

The parties stipulated that if I ruled in favor of the employee on the issues of accident and medical causation, that the employee is owed an additional amount for underpayment of temporary partial disability for the time period of April 14, 2006 through May 6, 2006. The parties were to agree on the exact amount in the briefs. In her brief, the employee is alleging that she is owed an additional \$190.25. The employer-insurer in its brief alleged that they owe an additional \$81.89. There is no question that the employee is owed a minimum of \$81.89.

The parties stipulated that if I ruled in favor of the employee on the issues of accident and medical causation, that the employee is owed additional temporary total disability in the amount of \$6,787.15 for the 14 3/7 week period of October 8, 2007 through January 17, 2008. That is from the time she started treating with Dr. Cleaver until the employee saw Dr. Guidos.

The employee is requesting an additional \$25,264.51 of temporary total disability for the 53 5/7 week period of September 26, 2006 through October 7, 2007. The employer-insurer is disputing temporary total disability for that period which is from the employee beginning treatment with Dr. Burns until Dr. Burns released the employee on October 4, 2007.

The employee has the burden to prove that she was unemployable in the open labor market as a result of the March 14, 2006 accident. The employee returned to full duty work at the employer on May 7, 2006. She continued to work until sometime in August as a result of the exacerbation of her pulmonary condition with shortness of breath and was on a leave of absence at work. When Dr. Burns saw her on September 26, 2006 he did not take her off work but put her on light duty. On April 27, 2007, Dr. Burns stated that given the negative response from conservative treatment and the lack of a surgical lesion that the employee was probably at maximum medical improvement. Dr. Burns thought it was reasonable for her to work but recommended an FCE evaluation. The return to work slip noted continued off until the FCE which was not done until August 22, 2007. On June 6, 2007, Dr. Burns terminated her care due to medication compliance problems, not submitting to a drug screen, and a failure of patient/physician relationship. The return to work record showed off work until an appointment with a neurologist scheduled on June 14, 2007 and which apparently did not take place. On October 4, 2007, Dr. Burns noted that the employee could work with limitations based on the recent FCE and previous visits. I find that the employee has failed to meet her burden of proof that she was unemployable in the open labor market from September 26, 2006 through October 6, 2007 as a result of her work accident. The claim for this additional period of temporary total disability is denied.

Based on the stipulations, the employer-insurer is ordered to pay the employee \$139.54 for underpayment of temporary total disability from March 15, 2006 through April 13, 2006; \$81.89 for underpayment of temporary partial disability from April 14, 2006 through May 6, 2006; and an additional \$6,787.15 in temporary total disability for the 14 3/7 week period of October 8, 2007 through January 17, 2008. The total amount of additional temporary total disability to be paid to the employee is \$7,008.58.

Issue 4. Claim for Future Medical Treatment.

Low Back:

In July of 2007 Dr. Burns filled out an insurance company form that indicated that the employee's need for Hydroco/Apap Tab 10-325MG and Ultram was for an unknown length of time. I find that is not sufficient specificity that she will need the medication in the future.

It was Dr. Volarich's opinion that the employee required ongoing treatments for her pain syndrome, including narcotics and non-narcotic medications, muscle relaxants, and physical therapy. He stated she would benefit from treatment at a pain clinic and consideration of a trial of a spinal cord stimulator. Dr. Volarich's opinion regarding future medical treatment is substantially affected by my rulings regarding the severity of the employee's low back complaints.

Dr. Tolentino in June of 2006 stated the employee had reached maximum medical improvement and released her from care. It was Dr. Guidos' opinion that the employee had undergone sufficient and extensive treatment for her low back and that the initial medications were a result of the work related injury but as of January 17, 2008, the employee was at maximum medical improvement and no further treatment was needed.

Based on a review of the evidence including my rulings on the credibility of the employee concerning the severity of her symptoms, I find that the opinions of Dr. Guidos and Dr. Tolentino are very persuasive and are more credible than the opinion of Dr. Volarich and the opinion in the form filled out by Dr. Burns regarding future medical treatment.

I find that the employee has failed to meet her burden of proof on the issue of future medical for her low back. The employee's claim for future medical on the low back is denied.

Psychiatric Condition:

The employee must establish through competent medical evidence that the medical care requested, "flows from the accident" before the employer-insurer is responsible. See Crowell v. Hawkins, 68 S.W.3d 432 (Mo. App. 2001), Landers v. Chrysler Corporation, 963 S.W.2d 275 (Mo. App. 1997); Modlin v. Sunmark, Inc., 699 S.W.2d 5, 7 (Mo. App. 1995); and Sifferman v. Sears, Roebuck and Company, 906 S.W.2d 823 (Mo. App. 1995).

The employee's burden of proof is complicated by and made more difficult by the fact that the employee had taken prescription medication for her psychiatric condition prior to the accident. Dr. Stillings, Dr. Guidos, and Dr. Bassett diagnosed the employee with pre-existing psychiatric conditions. The evidence shows that after the accident the employee had non-work related family stressors.

It was Dr. Stillings' opinion that the employee would benefit from psychiatric care causally related to the work injury primarily consisting of psychotropic medication but she was not a good candidate for psychotherapy. It was Dr. Guido's opinion that the employee would benefit from additional psychiatrist intervention and to continue with her medications for the treatment of her non-work related underlying psychiatric condition. Dr. Bassett testified her current medications should be continued if it accounts for her recent uptick in mood. It was his opinion that the March 14, 2006 accident is the prevailing factor causing the need for further medication in the form of Amitriptyline.

Based on a review of the evidence, I find that the opinion of Dr. Bassett is persuasive and

is more credible than the opinions of Dr. Guidos and Dr. Stillings with regard to what future medical that the employee needs for her psychiatric condition that flows from the March 14, 2006 accident.

I find that the employee is in need of additional psychiatric treatment to cure and relieve her from the effects of her March 14, 2006 work related injury. The employer-insurer is therefore ordered to provide the employee with the psychiatric care and medication set forth by Dr. Bassett.

Issue 3. Previously Incurred Medical Expenses.

The employee is claiming \$10,342.00 in previously incurred medical bills. The employer-insurer is disputing those bills with regard to authorization, reasonableness, necessity and causal relationship. The employee testified that the medical bills in Employee's Exhibits AA and V are for psychological treatment by Dr. John Woods; and for medical treatment of Dr. Randy Woods and Dr. Naushad.

With regard to the medical bills of Dr. John Woods, PhD., his treatment began on August 20, 2007, and ended on December 12, 2007. On January 10, 17, and 29, 2008 the employee's attorney demanded psychological treatment which are all after the treatment by Dr. John Woods ended. The medical records from Dr. John Woods put into question the medical causation of the treatment with the March 14, 2006 accident. The records note multiple non-work related stressors of family problems including her two teenage children and her husband; and feelings of abandonment by her parents. I find that the medical treatment by Dr. John Woods was not authorized and the employee did not meet her burden of proof that the treatment was medically causally related to the March 14, 2006 accident. I find that the employer-insurer is not liable for Dr. John Woods' bills.

With regard to the medical bills of Dr. Randy Woods, his treatment began on November 1, 2007. On September 20, 2007, the employee's attorney sent a letter to the employer-insurer's attorney making a demand for further medical treatment. The employer-insurer sent the employee for treatment with Dr. Cleaver.

With regard to the issue of authorization, Section 287.140 RSMo gives the employer the right to select the treating physician. The statute also gives the employee the option of selecting her own physician at her own expense. See Anderson v. Parrish, 472 S.W.2d 452 (Mo. App. 1971). I find that when the employee started seeing Dr. Randy Woods, the employer-insurer had been providing treatment with Dr. Cleaver. I find that the medical treatment by Dr. Randy Woods was unauthorized and the employee exercised her right under the statute to have treatment on her own. I find that the employer-insurer is not liable for the bills of Dr. Randy Woods.

With regard to Dr. Naushad's bills, those treatments for pain management began on April 26, 2010. The employee testified that she went back to Dr. Naushad on her own. As set forth in my ruling for future medical treatment, I found that the opinion of Dr. Guidos was very

persuasive and credible. It was her opinion that as of January 17, 2008, the employee was at maximum medical improvement and no further treatment was needed for her low back. Based on a review of the evidence including Dr. Guidos' opinion and my rulings on the credibility of the employee concerning the severity of her symptoms, I find that the medical treatment provided by Dr. Naushad starting on April 26, 2010 and continuing through July 18, 2011, was not necessary as a result of the March 14, 2006 accident and injury. I find that the employer-insurer is not liable for Dr. Naushad's bills.

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

Issue 8. The employee is alleging a violation of 287.120.4 RSMo.

Section 287.120.4 RSMo states, "Where the injury is caused by the failure of the employer to comply with any statute in this state or any lawful order of the division or the commission, the compensation and death benefit provided for under this chapter shall be increased fifteen percent."

To prevail on the 15% increase under Section 287.120.4, the employee must demonstrate the existence of the statute, its violation, and a causal connection between the violation and the compensated injury. See *McGhee v. W.R. Grace & Co.*, 312 S.W.3d 447, 458 (Mo. App. 2010).

The employee is claiming that the employer violated Section 197.289 RSMo. which states:

- "1. All hospitals and ambulatory surgical centers shall develop and implement a methodology which ensures adequate nurse staffing that will meet the needs of patients. At a minimum, there shall be on duty at all times a sufficient number of licensed registered nurses to provide patient care requiring the judgment and skills of a licensed registered nurse and to oversee the activities of all nursing personnel.
2. There shall be sufficient licensed and ancillary nursing personnel on duty on each nursing unit to meet the needs of each patient in accordance with accepted standards of quality patient care."

The employee has the burden to prove that the statute was violated because the needs of each patient were not being met due to inadequate nursing staffing including insufficient numbers of nursing personnel to meet the standards of quality patient care; and that due to violation of the statute that there was a causal connection between the violation and the injury.

I find that the statute is very ambiguous and not specific as to what is sufficient and adequate staffing. This lack of specificity makes it difficult to show a violation of the statute.

The employee testified that on the critical care floor there usually were not enough aides to take care of the patients as required by state law but she could not remember the number of

aides required by state law. Ms. Clark testified that on the day of the accident there were 1 nurse to 3.5 patients and the goal was 4 patients per patient on the fourth floor.

I find that the employee failed to meet her burden of proof that there was a violation of the statute and that there was a causal connection between the violation and the compensated injury. The employee's claim for a 15% penalty against the employer-insurer is denied.

Issue 9. The employer-insurer is alleging a violation of 287.120.5 RSMo.

Section 287.120.5 states: "Where the injury is caused by the failure of the employee to use safety devices where provided by the employer, or from the employee's failure to obey any reasonable rule adopted by the employer for the safety of employees, the compensation and death benefit provided for herein shall be reduced at least twenty-five but not more than fifty percent; provided, that it is shown that the employee had actual knowledge of the rule so adopted by the employer; and provided, further, that the employer had, prior to the injury, made a reasonable effort to cause his or her employees to use the safety device or devices and to obey or follow the rule so adopted for the safety of the employees."

The Safe Patient/Material Handling Policy and Procedure states that mechanical lift devices are a key component in safe transfers/lifting and handling. Staff that fail to use the proper safe handling equipment or safety devices will be subject to disciplinary action up to and including termination of employment. The provisions state that staff will secure equipment or proper assistance of the appropriate number of staff members; lifting and transfer devices will be used as often as deemed necessary to insure patient safety and reduce the potential for employee injury; when equipment is not feasible, staff will use proper positioning of their body, use the large muscle groups of the legs and arms and maintain a base support with a neutral/lordotic spine while holding the patient.

The employer-insurer has the burden of proof to show that the employee failed to obey the rules; that the employee had actual knowledge of the rules; and that prior to the injury the employer had made a reasonable effort to cause the employees to use the safety device or devices and to obey or follow the rules adopted for the safety of the employees.

It was Ms. Clark's opinion that the employee violated the safety policy because a Hoyer Lift should have been used because there were not enough people to lift the patient; and the employee should have had both feet flat on the floor when transferring the patient instead of kneeling on the stretcher.

I find that the employer's policy is extremely general and is not specific as to when to use transfer devices when lifting patients, what transfer device to use in different situations, how many employees are appropriate for different situations, and exactly what is proper positioning of the body. This lack of specificity makes it difficult to show a failure to obey the rules.

It is important to note that the employee was not disciplined for her allegedly violating the safety policy. The Accident Investigation Form which was signed on the day of the accident,

stated that the employee was performing the required duties at the time of the accident; and that to prevent a recurrence safety training would be scheduled. In the Supervisor Investigation Report, the supervisor was to determine whether the injury was a result of an unsafe work practice including whether there were safety rules and procedures for the job being performed and if they were followed. The supervisor left the form blank. The employee testified that she was not disciplined and Ms. Clark testified that she was not aware if the employee or any of the others were disciplined. The failure to discipline makes it difficult to show that the employee did not obey the rules.

The employee testified that she was not trained on the Hoyer Lift and had not seen any policy about the use of the Hoyer Lift. She did not know if a Hoyer Lift was available on the floor and had never used one. The employee had watched ER nurses kneel on stretchers to do lifting and was never trained on transferring. Ms. Clark testified generally about how employees would know about the safety policy and how they would have been trained but was not in her present job when the employee was hired or had her accident. She has heard about the policy being enforced but has never seen it enforced. Although she stated there were reasonable efforts to make the policy known, Ms. Clark testified that since the employee was not employed on March 1, 2005, when the policy was implemented, the employee was not handed a copy of the policy. The employee was expected to read the policy is a manual that was kept in the nurses' station but Ms. Clark does not know if the employee ever read the policy. Ms. Clark did not know if a Hoyer Lift was available on her floor at the time of transfer and did not know if the employee was trained with the Hoyer Lift.

The testimony of the employee and Ms. Clark makes it difficult to show the employee had actual knowledge of the rules adopted by the employer; and that prior to the injury the employer had made a reasonable effort to cause the employees to use the safety device or devices and to obey or follow the rules adopted for the safety of the employees.

I find that the employer-insurer did not meet its burden of proof that the employee failed to obey the rules, that the employee had actual knowledge of the rules adopted by the employer; and that prior to the injury the employer had made a reasonable effort to cause the employees to use the safety device or devices and to obey or follow the rules adopted for the safety of the employees. I find that the employer-insurer did not meet their burden of proof that there was a violation of the statute and a causal connection between the violation and the injury. The employer-insurer's claim for a penalty against the employee is denied.

Issue 11. The employee is requesting attorney's fees and costs under Section 287.560 RSMo; and Issue 12. The employer-insurer is requesting attorney's fees and costs under Section 287.560 RSMo.

Both the employee and the employer-insurer are requesting attorney's fees and costs under Section 287.560 RSMo. That section states that if the Division determines that any proceedings have been brought, prosecuted or defended without reasonable grounds, it may assess the whole cost of the proceedings upon the party who so brought, prosecuted or defended them. I find that the employee did not bring or prosecute the final hearing without reasonable grounds. The employer-insurer's request for costs under Section 287.560 RSMo is denied.

I find that the employer-insurer did not defend the final hearing without reasonable grounds. The employee's request for costs under Section 287.560 RSMo is denied.

Issue 10. Dependency under Schoemehl v. Treasurer of the State of Missouri.

Due to my ruling that the employee is not permanently and totally disabled, this issue is moot and shall not be ruled upon.

ATTORNEY'S FEE

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

Attorneys Lien for Fees and Expenses of Ron Little:

On July 11, 2011, the Division received a letter from the employee's attorney that she had agreed with the employee's former attorney, Ron Little, that his attorney lien for attorney fees and expenses was \$1,104.03. This attorney lien shall be paid out of Ms. Vetter's attorney's fee.

INTEREST

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

Made by:

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