

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

Injury No.: 03-065196

Employee: Zlata Uzicanin
Employer: Bethesda Town House
Insurer: Bethesda Health Group, Inc.
c/o Claims Management, Inc.
Additional Party: Treasurer of Missouri as Custodian
of Second Injury Fund (Open)
Date of Accident: April 9, 2003
Place and County of Accident: St. Louis City

The above-entitled workers' compensation case is submitted to the Labor and Industrial Relations Commission (Commission) for review as provided by section 287.480 RSMo. Having reviewed the evidence and considered the whole record, the Commission finds that the award of the administrative law judge is supported by competent and substantial evidence and was made in accordance with the Missouri Workers' Compensation Act. Pursuant to section 286.090 RSMo, the Commission affirms the award and decision of the administrative law judge dated August 10, 2007, and awards no compensation in the above-captioned case.

The award and decision of Administrative Law Judge John K. Ottenad, issued August 10, 2007, is attached and incorporated by this reference.

Given at Jefferson City, State of Missouri, this 4th day of December 2007.

LABOR AND INDUSTRIAL RELATIONS COMMISSION

William F. Ringer, Chairman

Alice A. Bartlett, Member

John J. Hickey, Member

Attest:

Secretary

AWARD

Employee: Zlata Uzicanin

Injury No.: 03-065196

Dependents: N/A

Employer: Bethesda Town House

Additional Party: Second Injury Fund (Open)

Insurer: Bethesda Health Group, Inc.
C/O Claims Management, Inc.

Hearing Date: April 3, 2007

Before the
Division of Workers'
Compensation
Department of Labor and
Industrial Relations of Missouri
Jefferson City, Missouri

Checked by: JKO

FINDINGS OF FACT AND RULINGS OF LAW

1. Are any benefits awarded herein? No
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: April 9, 2003
5. State location where accident occurred or occupational disease was contracted: St. Louis City
6. Was above employee in employ of above employer at time of alleged accident or occupational disease? Yes
7. Did employer receive proper notice? Yes
8. Did accident or occupational disease arise out of and in the course of the employment? Yes
9. Was claim for compensation filed within time required by Law? Yes
10. Was employer insured by above insurer? Yes
11. Describe work employee was doing and how accident occurred or occupational disease contracted: Claimant was employed as a housekeeper for Employer, and was struck in the head with a window as she was washing them.
12. Did accident or occupational disease cause death? No Date of death? N/A
13. Part(s) of body injured by accident or occupational disease: Head—Body as a Whole
14. Nature and extent of any permanent disability: 0% of the Body as a Whole
15. Compensation paid to-date for temporary disability: \$0.00
16. Value necessary medical aid paid to date by employer/insurer? \$114.00

Employee: Zlata Uzicanin

Injury No.: 03-065196

17. Value necessary medical aid not furnished by employer/insurer? (allegedly) \$3,143.85
18. Employee's average weekly wages: \$314.22
19. Weekly compensation rate: \$209.49 for TTD/ \$209.49 for PPD
20. Method wages computation: By agreement (stipulation) of the parties

COMPENSATION PAYABLE

21. Amount of compensation payable:

Unpaid medical expenses: \$0.00

0 weeks of permanent partial disability from Employer \$0.00

22. Second Injury Fund liability: Open

TOTAL: **\$ 0.00**

23. Future requirements awarded: None

Said payments to begin immediately and to be payable and be subject to modification and review as provided by law.

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

FINDINGS OF FACT and RULINGS OF LAW:

Employee:	Zlata Uzicanin	Injury No.: 03-065196
Dependents:	N/A	Before the Division of Workers' Compensation
Employer:	Bethesda Town House	Department of Labor and Industrial Relations of Missouri
Additional Party:	Second Injury Fund (Open)	Jefferson City, Missouri
Insurer:	Bethesda Health Group, Inc. C/O Claims Management, Inc.	Checked by: JKO

On April 3, 2007, the employee, Zlata Uzicanin, appeared in person and by her attorney, Mr. Frank J. Niesen, for a hearing for a final award on her claim against the employer, Bethesda Town House, and its insurer, Bethesda Health Group, Inc. C/O Claims Management, Inc. The employer, Bethesda Town House, and its insurer, Bethesda Health Group, Inc. C/O Claims Management, Inc., were represented at the hearing by their attorney, Mr. E. Thomas Liese. The Second Injury Fund is a party to this case, but was not present or represented at the hearing, since the parties agreed to leave that portion of the Claim open. Also present and participating in the hearing was Violet Niesen, who was serving as a Bosnian translator for these proceedings. At the time of the hearing, the parties agreed on certain stipulated facts and identified the issues in dispute. These stipulations and the disputed issues, together with the findings of fact and rulings of law, are set forth below as follows:

STIPULATIONS:

- 1) Zlata Uzicanin (Claimant) sustained an accidental injury arising out of and in the course of employment on or about the date of injury of April 9, 2003.
- 2) Claimant was an employee of Bethesda Town House (Employer).
- 3) Venue is proper in the City of St Louis.

- 4) Employer received proper notice.
- 5) The Claim was filed within the time prescribed by the law.
- 6) At the relevant time, Claimant earned an average weekly wage of \$314.22, resulting in applicable rates of compensation of \$209.49 for total disability benefits and \$209.49 for permanent partial disability (PPD) benefits.
- 7) Employer has not paid any temporary total disability benefits to date.
- 8) Employer paid medical benefits totaling \$114.00.

ISSUES:

- 1) Are Claimant's injuries and continuing complaints, as well as any resultant disability, medically causally connected to her accident at work on or about April 9, 2003?
- 2) Is Employer liable for past medical expenses of an undetermined amount?
- 3) Is Claimant entitled to receive future medical care related to this injury?
- 4) What is the nature and extent of Claimant's permanent partial disability attributable to this injury?

EXHIBITS:

The following exhibits were admitted into evidence:

Employee Exhibits:

- A. Deposition of Dr. David T. Volarich, with attachments, dated March 21, 2007
- B. Deposition of Dr. Edwin Wolfgram, with attachments, dated March 20, 2007
- C. Certified medical treatment records of Dr. Alexander Rudoj
- D. Certified medical treatment records of Dr. Alexander Rudoj
- E. Medical treatment records of Dr. Richard A. Head
- F. Certified medical treatment records of St. Anthony's Medical Center
- G. Certified medical treatment records of St. Anthony's Medical Center
- H. Medical treatment records of Unity Corporate Health
- I. Certified medical treatment records of Forest Park Hospital
- J. Medical bill from Internal Medicine, LLC (Dr. Rudoj) in the amount of \$74.00
- K. Medical bill from St. Anthony's Medical Center in the amount of \$1,127.00
- L. Medical bill from South County Radiologists, Inc. in the amount of \$165.00
- M. Medical bill from Metropolitan Neurology, LTD. (Dr. Head) in the amount of \$210.00
- N. Claim for Compensation date-stamped July 15, 2003
- O. Letter from Claimant's attorney to Employer's attorney dated November 19, 2004
- P. Letter from Claimant's attorney to Employer's attorney dated March 10, 2005

Employer/Insurer Exhibits:

1. Deposition of Dr. Patrick A. Hogan, with attachments, dated March 13, 2007
2. Certified medical treatment records of St. Anthony's Medical Center
3. Medical treatment records of Dr. Edward A. Hengel (Chiropractor)

Notes: 1) Unless otherwise specifically noted below, any objections contained in these Exhibits are overruled and the testimony fully admitted into evidence.

2) Some of the records submitted at hearing contain handwritten remarks or other marks on the Exhibits. All of these marks were on these records at the time they were admitted into evidence and no other marks have been added since their admission on April 3, 2007.

FINDINGS OF FACT:

Based on a comprehensive review of the evidence, including Claimant's testimony, the expert medical opinions and depositions, the medical records and bills, and the testimony of the other witness, as well as based on my personal observations of Claimant and the other witness at hearing, I find:

- 1) **Claimant** is a 47-year old female who was born in Novi Sad, Yugoslavia (Serbia). She has been married to Mujo Uzicanin for 27 years. They have one son who is 26, and who still lives with them. Claimant had 14 years of schooling in Yugoslavia, and worked for 2 years as a Kindergarten teacher. She left Yugoslavia (Serbia) just before the war, so she was not involved in it. After stays in Austria and Germany, she eventually landed in the United States, and has lived in St. Louis since 1998.
- 2) Claimant testified she has had three jobs here, all with Employer. She has worked in housekeeping, in the restaurant, and in laundry. She last worked for Employer in January 2007. Her employment ended for Employer when she was discharged (fired) by them. She testified that she lost the job because she would forget things and she was not good with communicating with her supervisors and co-workers. Before April 9, 2003, Claimant denied any problems with headaches, depression, anxiety or anything else.
- 3) On April 9, 2003, the date of the injury, Claimant was washing windows as a part of her normal job duties for Employer as a housekeeper. She was washing the bottom half of the window, and another employee was washing the upper half. Claimant was bent down, and when a resident opened the door to come into the room, the upper half of the window fell on her head. It struck her on the right side of the head, higher up near the top. She did not lose consciousness. She described immediate complaints of shaking, and lost concentration. She said she felt bad, and she had to sit down on the ground. She said she just could not stand anymore. She reported the injury to her supervisor. She said the older lady and the other worker explained what had happened. She received some ice on her head, but no other first aid.
- 4) Claimant testified that her manager, Betty Altman, drove her to the company doctor. Claimant said there was no translator, so her manager was explaining things for her to the doctor. She was only able to show where things were hurting by pointing with her hand. No X-rays were taken. Claimant said her manager then drove her home.
- 5) The medical records from **Unity Corporate Health** (Exhibit H) document a visit on April 9, 2003. The record contains a consistent history of the window falling and striking her on the right side of the head. According to the record, Claimant denied loss of consciousness, visual disturbances, nausea, or headaches. Physical examination revealed no swelling, discoloration, and no break in the skin. Her vision and neuromuscular testing was all normal. She was diagnosed with a contusion to the right side of the head. The record characterized the injury as "very minor." She was released from care without restrictions. The report notes that permanency is not anticipated.
- 6) Regarding her continuing complaints in the days and weeks following the accident, Claimant testified that she had a bruise on her head for awhile. Later, her nose started bleeding. She said she was taking Tylenol every day for the pain on the top of her head. She said her head was hurting all the time.
- 7) On cross-examination, Claimant confirmed that she worked the next day after this accident, and in fact, worked from April 9, 2003 until she saw Dr. Rudoi for the first time in July 2003. During this time though, she indicated that she did have the bleeding nose and she was waiting to be sent to the doctor.
- 8) Claimant testified that she eventually went to the secretary and asked her about going back to the doctor. Claimant testified that they never sent her back. She said her problems with headaches were getting worse and she could not work as quickly as before. She testified that she eventually went to see her own doctor, Dr. Rudoi, after they did not respond to her requests for medical treatment. Dr. Rudoi sent her for a head scan and gave her some pills. She said she was also sent to a neurologist, Dr. Head, who gave her some medications for her headaches. Claimant testified that it helped ease the pain, but the pain was still there.
- 9) Following her initial visit to Unity Corporate Health on the day of the accident, the next medical treatment record is from **Dr. Alexander Rudoi** (Exhibit C), and is dated July 7, 2003. Her chief complaint at that time was a headache. She gave a history of the window falling on her. She also complained that she now had blurry vision in the right eye. Dr. Rudoi referred her to **Dr. Richard Head** (Exhibit E), a neurologist, for further evaluation. Dr. Head first saw her on July 24, 2003. Because of the language barrier, he was not able to get a good history from her. She complained of headaches for the last 2 to 3 months that were continuous, 24 hours a day. He was unable to definitively conclude if there was a visual disturbance on the right side. He did find an elevated blood pressure, which she apparently attributed to the headache. Dr. Head gave her pain medication and recommended a CAT scan of the head. The CAT scan taken on July 18, 2003 was read as normal. In a letter from Dr. Head to Claimant dated August 6, 2003, he confirmed that "there are no signs of anything serious going on" in her head. He again notes her elevated blood pressure and recommends that she follow-up with Dr. Rudoi for that condition. She next saw Dr. Rudoi on September 26, 2003 and was still complaining of a headache.

- 10) Claimant submitted medical bills for this treatment into evidence in this case. A bill from **Internal Medicine, LLC (Dr. Rudoj)** showed a charge for the July 7, 2003 visit of \$74.00, which was reduced by his insurance contract by \$16.78, leaving a balance due of \$57.22. (Exhibit J) A bill from **St. Anthony's Medical Center** for the July 18, 2003 CAT scan totaled \$1,127.00. (Exhibit K) It was reduced by insurance payments and adjustments of \$876.53, leaving a balance due of \$250.47. A bill from **South County Radiologists, Inc.** for the reading of the CAT scan totaled \$165.00. (Exhibit L) It was reduced by an insurance adjustment of \$83.09 and an insurance payment of \$65.53, leaving a balance due of \$16.38. Finally, a bill from **Metropolitan Neurology, LTD. (Dr. Head)** totaled \$210.00. (Exhibit M) It was reduced by an insurance adjustment of \$54.91, leaving a balance due of \$155.09. The initial total for all of these bills is \$1,576.00. However, after taking into account the insurance payments and adjustments, the amount still outstanding is \$479.16.
- 11) Claimant filed her **Claim for Compensation** for this accident on July 15, 2003. (Exhibit N) On the Claim in the additional statements section, Claimant wrote, "Claimant is in need of medical care. Her supervisors have told her to 'see your own doctor', which she is doing, but it sounds as though the insurer will still claim this is 'unauthorized', as this is the usual M.O." Claimant's attorney also sent Employer's attorney correspondence on November 19, 2004 and March 10, 2005 demanding medical treatment per Dr. Volarich's and Dr. Wolfgram's reports. (Exhibits O and P)
- 12) Claimant described that she also began to notice some emotional changes after a few months. She said she was crying a lot. She avoided friends and did not want to communicate with them. She testified it was hard to work. She was always taking pills. She said she started to forget things, like turning off the stove. She would close the door, but forget the keys, or she would leave her wallet. At work, she said she would forget what her supervisors told her to do. She also described problems at home. Claimant said that her husband makes her nervous, and her son also makes her nervous by asking questions. She said she has been more aggressive with her husband by yelling at him.
- 13) Claimant testified that she went on a trip to Bosnia for 27 or 28 days, from July 31, 2003 until September 2, 2003. She described the trip as a vacation. She testified that her husband has a child there, and he went to visit his child. She said she went along because she is more comfortable with him there, than without him.
- 14) In December 2003 she said that she had chest pain for which she went to St. Anthony's. She testified that she had the chest pains because of her headaches and nervousness. She said that her head hurt so badly that she believed it caused the pain in her chest.
- 15) Medical records from **St. Anthony's Medical Center** (Exhibit G) document an admission on December 10, 2003 for a complaint of chest pain, and increased blood pressure. The notes indicate that she has a history of hypertension and migraine headaches. Physical examination revealed that she was severely hypertensive. Claimant was given a full cardiac work-up, but all the tests were negative for a heart attack. She was discharged with diagnoses of atypical chest pain, hypertension, and migraines.
- 16) Claimant testified that her attorney sent her to Dr. Volarich, and then she was referred to Dr. Wolfgram. She testified that Dr. Wolfgram gave her medications to ease her nervousness. She said he talked to her quietly and slowly. She felt he was trying to help her. She said that she had a translator 2 or 3 times, and the rest of the time with Dr. Wolfgram, they communicated with gestures or speaking slowly. She also sometimes called her son to translate questions.
- 17) The deposition of **Dr. David T. Volarich** was taken by Claimant on March 21, 2007 to make his opinions in this case admissible at trial. (Exhibit A) Dr. Volarich is an osteopathic physician who examined Claimant at the request of Claimant's attorney, but who provided no treatment.
- 18) Dr. Volarich first examined Claimant on October 12, 2004. She provided a consistent history of being struck in the head with the window. She described a wide array of complaints from this injury, including constant daily headaches increased by changes in the barometric pressure, lack of energy, nervousness, occasional left arm numbness, diminished vision, sensitivity to noise, an inability to distinguish between multiple people talking at the same time, and poor sleep. She reported no difficulty driving. Dr. Volarich was unable to perform a physical examination on that date because she was anxious and under a great deal of emotional stress. He nonetheless diagnosed a closed head trauma with posttraumatic headaches, and significant anxiety with possible depression as a result of the injury on April 9, 2003. He did not believe she was at maximum medical improvement, did not provide ratings of disability, and instead recommended psychiatric care.
- 19) Medical records from **St. Anthony's Medical Center** (Exhibit F) document an admission to the emergency room on November 12, 2004 with complaints of chest pain from the evening before and numbness in the left face, arm and leg as well. A CAT scan of the head from that date was read as normal. Although the doctor wanted to admit her to do further testing, she refused admission and instead wanted to go home.
- 20) Claimant was next examined by Dr. Volarich on May 12, 2005 at the request of her attorney. She continued to

complain of headaches. Dr. Volarich noted her additional visit to the hospital for chest pain and headaches. His physical examination of her head revealed no significant osseous deformity of the bony calvarium, a normal size and symmetry to the skull, and a scalp examination characteristic for her age without significant abnormality. The eyes, ears, nose and neck examinations were all normal. In fact, there were no objective abnormalities at all documented from the physical examination. Dr. Volarich also found that she was less anxious than at his first examination. He diagnosed an enclosed head trauma with posttraumatic headaches, and anxiety and posttraumatic stress related to the April 9, 2003 accident at work. He rated her as having 10% permanent partial disability of the body as a whole for her headaches, and deferred any rating of her anxiety (psychiatric disorder) to a psychiatrist. He recommended continued care for her anxiety, headaches, and hypertension. Dr. Volarich admitted that he based the diagnosis and rating solely on her subjective complaints, and he further admitted that his examination did not indicate any evidence of injury at the time he examined her in 2005.

- 21) The deposition of **Dr. Edwin Wolfgram** was taken by Claimant on March 20, 2007 to make his opinions in this case admissible at trial. (Exhibit B) Dr. Wolfgram is a board-certified psychiatrist, who first examined Claimant at her attorney's request on December 1, 2004. He met with her twice before issuing his first report dated December 30, 2004. In that report he documents (for the first time in the medical records) crying spells and poor memory, in addition to her headaches. He recommended studies to rule out brain damage, and commenced psychiatric treatment. He began psychotherapy and placed her on medications. He also recorded for the first time that she was fearful, frightened and had trouble being around co-workers. He continued to see her until December 7, 2005. He did issue a second report dated July 11, 2005 in which he diagnosed a pain disorder associated with both psychological factors and a general medical condition, chronic; anxiety disorder due to posttraumatic headaches; and medical diagnoses deferred to medical-neurological evaluations. He opined that the psychiatric diagnoses were the direct result of the accident on April 9, 2003. He indicated she was at maximum medical improvement. He opined that she would need monthly psychotherapy visits for the next five years with quarterly visits thereafter, and she would also need at least two psychoactive medications. Finally, he also rated Claimant as having 20% permanent partial disability of the body as a whole for her psychiatric conditions. Dr. Wolfgram testified that he believed her to be reliable in terms of her complaints and presentation. He also testified that his charges for her care were \$1,567.85.
- 22) On cross-examination, Dr. Wolfgram noted that he only had an interpreter present for the first visit, and thereafter they communicated in "feelings and tone" which he felt was adequate. He admitted that there were a lot of words he could not understand, and they gestured a lot. Employer's counsel also put into evidence the letters sent by Claimant's attorney to Dr. Wolfgram, including the first letter dated October 28, 2004, indicating that Claimant's attorney wanted to "discuss treatment options" with Dr. Wolfgram before he had even seen Claimant for the first time. Additionally, there was another different billing statement put into evidence which showed total charges of \$2,585.35, and further showed that Claimant's attorney had paid for some of the initial visits in the amount of \$1,117.85, leaving a balance of \$1,357.50.
- 23) Regarding her current complaints, Claimant testified that she has headaches every day. She said they get worse as the weather changes. She also testified that her emotional problems are just getting worse. She said she continues to forget things, and she is nervous around other people. She is not happy anymore. She does not feel like talking to family, and she avoids friends. She testified she does not drive on the highway anymore, and actually, only drives if it is necessary. She is afraid to wash windows at home. Claimant said her husband helps her with everything. Claimant also noted that she has an uneven spot on her head that hurts when she hits it as she is combing or doing her hair.
- 24) Claimant said that she was involved in a rear-end car collision with her husband in 2005. She was the passenger in the vehicle. She testified that her neck, back and head hurt a lot. She was initially seen at the St. Anthony's Emergency Room, and she followed up with a chiropractor. On cross-examination, she said she did not remember saying in the records that her headaches were from this car accident, but she said her son was filling out the paperwork for her. She admitted that it was her signature on the form in Exhibit 3, and she further admitted that she wrote in the date of August 16, 2005, but she insisted that her son and husband actually filled it out. Claimant testified that for about 3 weeks after the accident her headaches were very bad. She was unable to get up during this time. She said that she did not work for 3 weeks after this car accident. Then after that 3 weeks, her headaches returned to their normal baseline of complaints for her. Claimant acknowledged that her husband is pursuing a lawsuit for them to recover for the car accident. She said she thought it was settled, but her husband would have the details.
- 25) Medical records from **St. Anthony's Medical Center** (Exhibit 2) document her admission there to the emergency room on July 30, 2005 following her car accident. The notes indicate that she was a front-seat, restrained passenger who was rear-ended. She was complaining of headache and neck pain, but denied chest, abdominal and back pain. A CAT scan of the head was negative.
- 26) Claimant then sought treatment following the car accident from a chiropractor, **Dr. Edward Hengel**. (Exhibit 3) The patient information sheet filled out and signed by Claimant on August 16, 2005 indicates her complaints in her head and neck were from an auto accident on July 30, 2005. The next page of the exhibit that contains the

doctor's notes again indicates a date of onset of these complaints on July 30, 2005. There are spaces available on the form to indicate the "dates of same or similar symptoms" and whether or not another type of accident was involved, but those spaces are not filled in on the form. The headaches are described as severe at times and occurring every day. Then on page 3 of the exhibit, there is the specific question, "Have you ever injured this same area before?" The answer to that question clearly marked on the form is "No." She treated with Dr. Hengel through September 8, 2005. There is absolutely no indication in his records that Claimant had any prior problems with her head before the car accident, nor any mention of the prior injury at work at all.

- 27) Additional medical records from **Dr. Alexander Rudoi** (Exhibit D) document visits Claimant had with him for various conditions including head congestion, cough, and allergies from playing with stray cats between August 1, 2005 and November 10, 2005.
- 28) Claimant also described a low back injury at work in 2006. She testified that on September 11, 2006 she hurt her back when she was carrying out and lifting the heavy trash. She said she was out of work for about a month and a half because her back hurt.
- 29) The deposition of **Dr. Patrick A. Hogan** was taken by Employer on March 13, 2007 to make his opinions in this case admissible at trial. (Exhibit 1) Dr. Hogan is a board-certified neurologist who examined Claimant one time at the request of Employer.
- 30) Dr. Hogan examined Claimant on December 15, 2006. She provided a consistent history of injury. She described continued complaints of headaches 2 to 3 times per week, and major symptoms of anxiety and depression, for which she sees a psychiatrist and is on medication. She described occasional numbness in the left arm, but no difficulty with vision. On physical examination, Claimant complained of tenderness at the anterior vertex of the head, but during the eye examination, when Dr. Hogan elevated her eyelid and touched the same spot, she did not complain. There were no objective abnormalities found on the head, and in fact, no abnormalities documented from the examination at all. Dr. Hogan formed an impression of a head injury with a possible contusion, but no neurological disorder. He opined that Claimant had no permanent partial disability as a result of the accident on a neurological basis.
- 31) Claimant's husband, **Mujo Uzicanin**, testified on her behalf at the hearing. He said that he does not speak English and he only understands a little English. He testified that he never translated for his wife in speaking to any doctor. He thought he was there with her once, but he thought their son was there as well.
- 32) Mr. Uzicanin confirmed that his wife had no emotional problems or headaches prior to April 9, 2003. After April 9, 2003, he described "great differences" in her. He testified that within a few months after the injury, he noticed some changes in her. He said that she is very depressed and forgets things. He confirmed that she is in a lot of pain, and must take pills. He said she cannot work around the house, and so he and his son must do much more. He said that he or his son must be with her, since he does not think she should be by herself for a long time. He expressed this concern about leaving her alone because he said if she got a bloody nose that would not stop, then someone would need to take her to the emergency room. He testified that he changed jobs to be able to be with her more. He testified that she has become much more argumentative. He did not believe she could work a full 8 hour work day, because someone needs to be with her. He also testified that she has headaches and some dizziness. He said she spends most of her time laying down or resting. He testified that she is not the person now that she was before the injury. He described Claimant's personality changes including having no friends, being afraid of windows and doors, and being more withdrawn.
- 33) Regarding their trip to Bosnia, Mr. Uzicanin testified that he did not want to go, but someone had to go with her. He said her status then was the same as it is now. He testified that Claimant wanted to go to Bosnia to visit family because of her illness. He said she also wanted to see if doctors there could take a look at her. He noted that she was not in good emotional standing.

RULINGS OF LAW:

Based on a comprehensive review of the evidence described above, including Claimant's testimony, the expert medical opinions and depositions, the medical records, the testimony of Claimant's husband, and my personal observations of Claimant and the other witness at hearing, as well as based upon the applicable laws of the State of Missouri, I find the following:

Issue 1: Are Claimant's injuries and continuing complaints, as well as any resultant disability, medically causally connected to her accident at work on or about April 9, 2003?

Under **Mo. Rev. Stat. § 287.020.2 (2000)**, an injury by accident is compensable if it is clearly work-related, and it is clearly work-related if work was a substantial factor in the cause of the resulting medical condition or disability.

Claimant bears the burden of proof on all essential elements of her Workers' Compensation case. *Fischer v. Archdiocese of St. Louis-Cardinal Ritter Institute*, 793 S.W.2d 195 (Mo.App.E.D. 1990) *overruled on other grounds by Hampton v. Big Boy Steel Erection*, 121 S.W.3d 220 (Mo. 2003). Claimant must establish a causal connection between the accident and injury. *Id.* at 198. The fact finder is charged with passing on the credibility of all witnesses and may disbelieve testimony absent contradictory evidence. *Id.* at 199.

In a Workers' Compensation case, expert medical testimony is not necessarily needed to establish the cause of the injury, if causation is a matter within the understanding of laypersons. *Knipp v. Nordyne, Inc.*, 969 S.W.2d 236 (Mo.App.W.D. 1998) *overruled on other grounds by Hampton v. Big Boy Steel Erection*, 121 S.W.3d 220 (Mo. 2003). When the condition presented in a case is a sophisticated injury that requires surgical intervention or highly scientific technique for diagnosis, and especially when there is a serious question of pre-existing disability, then the proof of causation is not within the realm of lay understanding. *Id.* at 240.

In this case, there is no dispute that an accident occurred and that Claimant was struck in the head as a result of the accident. What is disputed is whether the alleged continued headaches and the alleged anxiety and depression are medically causally related to this accident.

Considering the evidence listed above, I find that Claimant has failed to meet her burden of proving that the headaches and the alleged anxiety and depression are medically causally related to the accident at work on April 9, 2003. This conclusion is based specifically on the findings that Claimant did not provide competent and credible testimony on her own behalf, and that the opinions of Dr. Wolfram were not competent, credible or persuasive when compared to those of Dr. Hogan and those contained in the medical treatment records.

In reviewing Claimant's testimony and comparing it to that of her husband, as well as comparing it to the medical records and reports in evidence, I find that Claimant is not credible. On the one hand, Claimant testified that she was experiencing worsening emotional problems following this accident, and further noted that her husband made her nervous, she avoided friends, and did not feel like talking to family. But on the other hand, she traveled with her husband to Bosnia for over a month to specifically visit with his family there, indicating that she was more comfortable with him than without him. Regarding the trip to Bosnia, Claimant testified that her husband has a child there and he went to visit his child, so she just went along. However, when her husband was asked under oath why they traveled to Bosnia, he said Claimant wanted to go visit her family because of her illness and also wanted to see if the doctors there could take a look at her. Even setting aside the inherent conflict between going to visit family when she testified she does not want to see or talk to family, Claimant and her husband do not give consistent answers to the simple question of why they went to Bosnia in the first place.

In comparing Claimant's testimony to the medical records, I find additional discrepancies that further call into question Claimant's credibility. Claimant testified that immediately after being struck by the window, she experienced headaches, shaking and lost concentration. None of those complaints are reported to Unity Corporate Health on the day of the accident when she is first examined. Although she did not have a translator at that appointment, according to other medical records, she was apparently able to communicate complaints and problems to other physicians. There is then a three-month gap in treatment and only in July 2003 is a headache complaint reported for the first time. There is then the whole list of complaints in Dr. Volarich's and Dr. Wolfram's reports that are documented nowhere else in the records despite seeing a number of different physicians between the date of her accident and these later examinations with her experts. Then in Dr. Hogan's examination findings, he noted an inconsistency when she complained about tenderness on a spot on her head where she was struck, but when he later touched the same spot during the eye examination, she voiced no complaint. In fact, she testified about an uneven spot on her head that hurt when combing her hair, but the doctors found no such uneven spot on their physical examinations.

Finally, there are the chiropractic records from Dr. Hengel following her car accident in 2005 that raise questions regarding Claimant's credibility. Claimant reported to Dr. Hengel that she was having headaches following the car accident for which she needed to receive treatment. She apparently never reported the prior injury to Dr. Hengel as a potential cause for her headaches, because the prior injury is not mentioned at all in his reports. Additionally, she denied, on the patient form, ever injuring this part of her body before the car accident. All of these discrepancies taken together lead me to the conclusion that Claimant is not credible in the description of her complaints and their onset. When combined with the discrepancies above regarding her emotional state and her trip to Bosnia, I am left to conclude that Claimant is just not credible and her testimony cannot be used as a basis for an award of benefits in this case.

In addition to Claimant's lack of credibility, Dr. Wolfram's opinions are also not competent, credible or persuasive. Dr. Wolfram admittedly relied on Claimant's statements and complaints in formulating his opinions in this case. He found her to be reliable and he believed her in terms of her complaints and presentation. However, she reported symptoms and complaints to him that never before appeared in any of the medical treatment records. She reported crying spells and poor

memory, but never mentioned those things to Unity, Dr. Rudoi or Dr. Head. Additionally, Dr. Wolfgram admitted that an interpreter was only present for his first visit with her, and after that they communicated in “feelings and tone.” To the extent that Dr. Wolfgram was not able to fully communicate with Claimant at any of his subsequent visits, and based on his admission that he relied on her statements and complaints in formulating his opinions (which I have now found were not credible), Dr. Wolfgram’s opinions are based on an inadequate foundation, and are thus fatally flawed. Therefore, Dr. Wolfgram’s opinions are not competent, credible or persuasive, and cannot be used as a basis for an award of benefits in this case.

In contrast to Dr. Wolfgram’s opinion, I find the opinions of Dr. Hogan are competent, credible, persuasive, and consistent with the medical treatment records and testing. Dr. Hogan’s report contained a consistent history of the injury. His physical examination revealed no objective abnormalities on the head, and in fact, no abnormalities at all. His lack of findings is supported by the three CAT scans performed since her injury, which all were read as normal. He ultimately formed an impression of a possible head contusion, but no neurological disorder. His impression agrees with the Unity diagnosis of a head contusion, and Dr. Head’s assessment that he could find nothing serious going on in her head. In short, Dr. Hogan’s opinions are more consistent with the overwhelming weight of the competent and credible medical evidence, and are thus more competent, credible and persuasive than the opinions of Dr. Wolfgram.

Since Claimant failed to provide credible testimony on her own behalf, and since Claimant’s expert (Dr. Wolfgram) provided no competent, credible or persuasive testimony on her behalf to support her claim, I find that Claimant has failed to meet her burden of proving that the headaches and the alleged anxiety and depression are medically causally related to the accident at work on April 9, 2003.

Issue 2: Is Employer liable for past medical expenses of an undetermined amount?

Issue 3: Is Claimant entitled to receive future medical care related to this injury?

Under **Mo. Rev. Stat. § 287.140.1 (2000)**, “the employee shall receive and the employer shall provide such medical, surgical, chiropractic and hospital treatment...as may reasonably be required after the injury or disability, to cure and relieve from the effects of the injury.” Just as Claimant must prove all of the other material elements of her claim, the burden is also on her to prove entitlement to future medical treatment. ***Dean v. St. Luke’s Hospital***, 936 S.W.2d 601, 603 (Mo.App. 1997) *overruled on other grounds by Hampton v. Big Boy Steel Erection*, 121 S.W.3d 220 (Mo. 2003). Claimant is entitled to an award of future medical treatment if she shows by a reasonable probability that future medical treatment is needed to cure and relieve the effects of the injury. ***Concepcion v. Lear Corporation***, 173 S.W.3d 368, 372 (Mo.App. 2005).

Given the findings above that Claimant has failed to prove that her headaches and alleged anxiety and depression are medically causally related to her injury at work on April 9, 2003, I find that Claimant is not entitled to recover any of her outstanding medical bills, nor receive any future medical treatment on account of this injury.

The additional, unpaid medical bills submitted into evidence are all related to treatment Claimant obtained as a result of her alleged headaches and her alleged anxiety and depression. As noted above, whether or not those alleged conditions are medically causally related to her accident at work on April 9, 2003 depends on Claimant providing credible testimony in that regard and also depends on Claimant having credible medical testimony to support her position. Since she did not offer credible testimony herself, and since she failed to provide that credible medical evidence, she failed to meet her burden of proof on medical causation. Thus, if she has failed to prove the conditions are medically causally related to work, she is not entitled to recover for the medical expenses she amassed attempting to treat those non-causally related conditions.

Similarly on the future medical issue, Dr. Wolfgram opines that she is in need of future medical treatment to treat her alleged anxiety and depression. The same findings of Dr. Wolfgram’s lack of credibility apply to this issue as they did above. Thus, as noted above, Claimant failed to prove those conditions were medically causally related to the accident, and so she is not entitled to receive future medical treatment for conditions she has failed to prove are related to the accident.

Accordingly, I find Claimant has failed to meet her burden of proving that she is entitled to recover for any of the past or future medical treatment or bills for her alleged headaches or alleged anxiety and depression. Claimant’s claim for the payment of past medical bills and for future medical treatment is denied.

Issue 4: What is the nature and extent of Claimant’s permanent partial disability attributable to this injury?

Under **Mo. Rev. Stat. § 287.190.6 (2000)**, “‘permanent partial disability’ means a disability that is permanent in nature and partial in degree...” The claimant bears the burden of proving the nature and extent of any disability by a reasonable degree of certainty. ***Elrod v. Treasurer of Missouri as Custodian of Second Injury Fund***, 138 S.W.3d 714, 717 (Mo. banc 2004). Proof is made only by competent substantial evidence and may not rest on surmise or speculation. ***Griggs***

v. A.B. Chance Co., 503 S.W.2d 697,703 (Mo.App. 1973). Expert testimony may be required when there are complicated medical issues. *Id.* at 704. Extent and percentage of disability is a finding of fact within the special province of the [fact finding body, which] is not bound by the medical testimony but may consider all the evidence, including the testimony of the Claimant, and draw all reasonable inferences from other testimony in arriving at the percentage of disability. *Fogelsong v. Banquet Foods Corp.*, 526 S.W.2d 886, 892 (Mo. App. 1975) (citations omitted).

In addition to Dr. Wolfgram's opinions (which have already been found to not be credible), Claimant also submitted the medical opinion of Dr. Volarich on the issue of nature and extent of permanent partial disability for this injury. Dr. Volarich documented no objective abnormalities in Claimant's physical examination in his report, and he admitted that his examination in 2005 did not reveal any evidence of the injury. He admitted that he based his rating of disability on Claimant's subjective complaints of the headaches. The sole basis of Dr. Volarich's rating of disability, are the incredible statements from Claimant regarding her complaints, and thus Dr. Volarich's opinion is fatally flawed. To the extent that Dr. Volarich's opinions relied on Claimant's complaints (which I have already found were not credible), then, similar to my findings regarding Dr. Wolfgram's opinions, I find that Dr. Volarich's rating lacks a proper foundation and is not competent, credible or persuasive.

Since Claimant's testimony regarding her complaints was not credible, and since Dr. Wolfgram's and Dr. Volarich's opinions are also not credible to the extent they relied on Claimant's statements, Claimant has no competent, credible or persuasive evidence in the record to support a finding of any amount of permanent partial disability attributable to this accident.

The only competent and credible evidence left in the record on the issue of permanent partial disability is in the report and testimony of Dr. Hogan, and in the records of Unity Corporate Health. Both document no permanent partial disability on account of the injury. The Unity record from the date of injury indicates no permanency is expected. Dr. Hogan found no objective abnormalities on the head and no other abnormalities in the examination to show any residual evidence of the injury. Therefore, he opined Claimant suffered from no permanent partial disability as a result of this accident.

These opinions on the lack of permanency associated with this injury are also bolstered by the medical treatment records and testing showing no residual objective abnormalities. There was never any break in the skin or any loss of consciousness reported in connection with the window striking Claimant's head. There was no residual, lump, bump, swelling or bruise found. All three CAT scans were read as completely negative. Neither neurologist (Dr. Hogan or Dr. Head) was able to find anything neurologically wrong with her. Quite simply, other than Claimant's incredible complaints, there is nothing in the record to document any continuing effects or disability from this bump on the head.

Based upon all of these findings, I find that Claimant has failed to meet her burden of proof that she has any permanent partial disability related to the accident at work on April 9, 2003. In fact, I find that she has no permanent partial disability associated with the accident, and thus, her claim for permanent partial disability benefits from this accident is denied.

CONCLUSION:

Claimant had a compensable accident on April 9, 2003 when a window she was cleaning fell and struck her on top of the head. However, Claimant has failed to meet her burden of proving that her alleged headaches and alleged anxiety and depression are medically causally related to this accident. Similarly, she has failed to meet her burden of proving entitlement to payment for past medical bills or future medical treatment for those conditions. Finally, Claimant has failed to meet her burden of proving any amount of permanent partial disability attributable to this accident on April 9, 2003. Accordingly, while this was a compensable accident, no benefits are awarded by the terms of this award.

Date: _____

Made by: _____

JOHN K. OTTENAD
Administrative Law Judge
Division of Workers' Compensation

A true copy: Attest:

Jeffrey W. Buker

Director

Division of Workers' Compensation