Issued by THE LABOR AND INDUSTRIAL RELATIONS COMMISSION

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

Injury No. 12-100528

Employee: Cynthia G. Null

Employer: Albany Medical Center, a/k/a
Northwest Medical Center Association

Insurer: Hospital Association Team

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 awarding 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 (ALJ) with this supplemental opinion.

Discussion

The disputed issues in this case are:

- Future medical treatment
- Past medical expenses of $41,407.04

Employer/insurer filed an application for review, citing the following errors in the ALJ's award:

- The ALJ erred in allowing future medical benefits based on aggravation of employee's pre-existing condition. The ALJ misapplied the law by not requiring that employee's work injury be the "prevailing factor", as defined in § 287.020.3 (1), causing employee's need for future medical treatment.
- The ALJ erred in relying on Dr. Hill's report, because Dr. Hill relied on incorrect information regarding employee's pre-existing conditions and was not furnished employee's extensive medical history.
- The ALJ erred in awarding future and past medical benefits based on a finding that employee was credible, in that the records includes clear instances where employee misled or plainly misinformed her treating physicians.

Employee's Burden of Proving a Need for Future Medical Treatment

Section 287.140 RSMo provides, in pertinent part:

> In addition to all other compensation paid to the employee under this section, 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. . . .

Section 287.800, as amended in 2005, requires that the Commission construe the provisions of the chapter strictly. "[A] strict construction of a statute presumes nothing that is not expressed. . .[and] means that everything shall be excluded from its operation which does not clearly come within the scope of the language used." *Allcorn v. Tap Enters.* 277 S.W.3d 823, 828 (Mo. App. 2009). The plain language of § 287.140 does not require an employee who sustains a compensable injury to prove the injury is the "prevailing factor" in causing his or her need for future medical treatment. This is in contrast to the stricter standard for medical causation of a compensable condition and disability specifically set out in § 287.020.3(1)[1].

In this case, employer stipulated that the employee sustained an injury by accident arising out of and in the course of her employment on December 24, 2012. *Transcript,* 8. Employer does not dispute that employee injured her left foot, left ankle, and right knee as a result of falling on ice in employer's parking lot that day. Prior to hearing, employee and employer settled all issues relating to permanent disability for $120,000.00. As of the date of hearing, employer had paid $281,070.75 in medical aid related to the injury, including pain management treatment by Dr. Blacher and psychiatrist Dr. Hu, counseling by Dr. Jura and psychiatric treatment by Dr. Pronko.

In *Tillotson v. St. Joseph Medical Center*, 347 S.W. 3d 511 (Mo. App. 2011), the court held:

> The existing case law at the time of the 2005 amendments to The Workers' Compensation Law instructs that in determining whether medical treatment is "reasonably required" to cure or relieve a compensable injury, it is immaterial that the treatment may have been required because of the complication of pre-existing conditions, or that the treatment will benefit both the compensable injury and a pre-existing condition. . .Rather, once it is determined that there has been a compensable accident, a claimant need only prove that the need for treatment and medication flow from the work injury. . .The fact that the medication or treatment may also benefit a non-compensable or earlier injury or condition is irrelevant. . .*Id.* at 519 (citations omitted).

In *Greer v. Sysco Food Servd.*, 475 S.W.3d 655, (Mo. 2015), the Supreme Court confirmed that an employee "needs only to show a reasonable probability that the future treatment is necessary because of his work-related injury." In *Armstrong v. Tetra Pak, Inc.,* 391 S.W.3d 466 (Mo. App. 2012), the court of appeals clarified that *Tillotson* standard for awarding future medical does not apply where an employee fails to prove a compensable injury. Because employer/insurer concedes that the employee sustained injury to her left foot, left ankle and right knee as a result of her December 24, 2012, work injury, the *Armstrong* exception does not apply.

As a matter of law, we reject employer's argument that the ALJ erred in failing to require that the employee prove that her compensable work injury was the "prevailing factor" causing her need for future medical treatment for depression, psychological injury and chronic pain management. Consistent with the legislature's strict construction mandate, and judicial interpretation of § 287.140 in *Tillotson, supra,* we find that the ALJ properly concluded that the employee needed only to show a reasonable probability that future treatment was necessary because of her work-

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[1] § 287.020.3(1) provides "An injury by accident is compensable only if the accident was the prevailing factor in causing both the resulting medical condition and disability. **'The prevailing factor'** is defined to be the primary factor, in relation to any other factor, causing both the resulting medical condition and disability."

related injury and that the need for future medical treatment and medication flowed from the injury.

Sufficiency of Evidence in Support of ALJ's Award of Disputed Past Medical Treatment and Future Medical

Employer argues that the ALJ erred in basing his award of disputed past medical treatment in the amount of $41,407.04 and future medical on the report of Dr. Todd Hill. Dr. Hill, an emergency room psychiatrist, treated employee at North Kansas City Hospital on March 8, 2017. Dr. Hill opined in a report documenting his consultation with employee on that date that employee suffered from depression and chronic pain as a result of her December 24, 2012, work injury. Employer asserts that Dr. Hill's opinions are not credible because they were based on the employee's statement that she "had no psychiatric issues" prior to her December 24, 2012, work injury and because Dr. Hill failed to independently review employee's past medical history.

We agree that the medical history employee gave Dr. Hill at the time of her emergency admission to North Kansas City Hospital on March 6, 2017, was incomplete. We disagree with employer's suggestion that Dr. Hill's evaluation of employee's medical condition, based on her presentation in the hospital emergency room that day, is not credible. Dr. Hill noted:

> It does appear that Psychiatry has been prescribing her 200 mg of trazodone with 120 mg of Cymbalta and Xanax for anxiety *where the workman's comp doctors is also putting her on muscle relaxers as well as some pain medication.* . . .The patient at this point is having significant side effects it appears from all of her medications. She is on multiple medications that are prescribed not only by her psychiatrist, *but by the workman's comp pain physician*, all of which can cause significant drug interactions. (emphasis added) *Transcript*, 1156, 1158.

The above findings and conclusions did not stem from Dr. Hill's reliance on employee's self-reported health history.

With respect to employer's suggestion, the ALJ placed "undue weight" on Dr. Hill's opinion as the basis for his award of future medical, we note the ALJ also relied on the opinion of licensed psychologist Dr. Allan Schmidt. On March 16, 2016, after a comprehensive review of the employee's medical records, Dr. Schmidt conducted a four-hour evaluation of the employee in his office. We credit Dr. Schmidt's opinion, based on his independent medical evaluation, that the employee's December 24 2012, work injury caused her need for future medical treatment for major depression and chronic pain disorders. We affirm the ALJ's finding that Dr. Schmidt's opinion is more credible and persuasive than the opinions of employer's experts Drs. Pronko and Rosenthal.

ALJ's Reliance on Employee's Credibility as a Basis for Awarding Future and Past Medical Benefits

Employer asserts the ALJ erred in relying on employee's testimony in his award, without acknowledging or explaining less than entirely consistent statements regarding her health history.

The ALJ found:

> Claimant *credibly described her symptoms and complaints* since the December 24, 2012 work injury. She has had continuing and ongoing physical and psychological symptoms and complaints caused by her compensable work injury. The evidence demonstrates she has continued to receive treatment, and has continued to have prescriptions filled for her left ankle and psychological injury caused by the work accident. Her work injury is permanent. The evidence supports the conclusion that Claimant will continue to need treatment in the future to treat her work injury. The fact that the medication or treatment may also benefit a non-compensable or earlier injury or condition is irrelevant. (emphasis added). *Award*, p. 53.

As a factual matter, we adopt the ALJ's finding that employee was credible with respect to her description of symptoms and complaints she has experienced since her December 24, 2012, compensable injury.

North Kansas City Hospital's March 6, 2017, admission history documents employee's report that "most of the time she just feels like she can't think straight." *Transcript,* 1147. We reject employer's theory that the employee deliberately intended to mislead Dr. Hill. We find employee's less than entirely accurate accounts of her multiple diagnoses and past medical treatment were attributable to the complexity of her medical history as well as the mental confusion she experienced due to side effects of multiple medications, including those prescribed for her work injury.

Award

We affirm and adopt the award of the administrative law judge as supplemented herein.

The award and decision of Administrative Law Judge Robert B. Miner, issued October 26, 2017, is attached and incorporated herein to the extent not inconsistent with this supplemental decision.

We approve and affirm the ALJ's allowance of attorney's fee herein as being fair and reasonable.

Given at Jefferson City, State of Missouri, this 20th day of December 2018.

LABOR AND INDUSTRIAL RELATIONS COMMISSION

Robert W. Cornejo, Chairman

Concurring Opinion Filed
Reid K. Forrester, Member

Curtis E. Chick, Jr., Member

LABOR & INDUSTRIAL RELATIONS COMMISSION OF MISSOURI SEAL

Attest:

Secretary

Employee: Cynthia G. Null

SEPARATE CONCURRING OPINION

Employer is entirely reasonable in objecting to an award of future medical benefits where, as here, the employee's work injury is clearly not the prevailing factor causing the need for such treatment. Employee's long history of physical and mental ailments predating her December 24, 2012, work injury included depression, anxiety, and chronic pain disorder. It is unfair to require employer to assume ongoing responsibility for future treatment of these pre-existing conditions because a slip and fall in its parking lot resulted in injury to employee's left foot, left ankle and right knee.

Psychiatrist Dr. Pronko, who treated employee following her work injury, conceded that she suffered from somatic symptom disorder and major depression but found that these conditions were *not* new symptoms caused by her work injury. Dr. Rosenthal agreed with this assessment, stating that employee suffered from "a decades long history of chronic pain and a lifelong history of Somatic Symptom Disorder." *Transcript, 3914.* Even employee's expert, Dr. Schmidt, conceded, "If I would have seen her before this [accident], I would have recommended she have psychological and psychiatric treatments as well." *Transcript*, 214.

Regrettably, § 287.140 of the Act, which specifically addresses an employer's obligation to provide future medical treatment, does not specifically incorporate the "prevailing factor" medical causation standard required to prove a compensable injury set out in § 287.020.3(1). The precedent of *Tillotson v. St. Joseph Medical Center*, 247 S.W. 3d 511 (Mo. App. 2011) also muddies the water with respect to what constitutes future medical treatment reasonably necessary pursuant to § 287.140 "to cure and relieve *from the effects of the injury.*" (emphasis added)

Employer correctly observes the employee made numerous inconsistent statements relating to her health history; that her husband lacked credibility in denying that she needs psychiatric treatment; and that the credibility of Dr. Hill's report, heavily relied on by the ALJ, was marred due to Dr. Hill's failure to review employee's past medical records and his reliance on employee's inaccurate denial of any past psychiatric treatment.

Unfortunately, employer's authorization of psychiatric treatment after employee's work accident and its stipulation that employee sustained an injury arising out of and in the course of her employment mitigates against its contention that employer should not be required to continue this type of treatment in the future. For this reason, and without foreclosing consideration of application of the prevailing factor standard to the issue of future medical treatment in a case with clearer facts, I regrettably concur.

Reid K. Forrester, Member

AWARD

Employee: Cynthia G. Null

Injury No.: 12-100528

Employer: Albany Medical Center, a/k/a Northwest Medical Center Association

Additional Party: The Treasurer of the State of Missouri as Custodian of the Second Injury Fund

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

Insurer: Hospital Association Team, c/o Cannon Cochran Management Services

Hearing Date: July 25, 2017

Checked by: RBM

FINDINGS OF FACT AND RULINGS OF LAW

1. Are any benefits awarded herein? Yes.

2. Was the injury or occupational disease compensable under Chapter 287? Yes.

3. Was there an accident or incident of occupational disease under the Law? Yes.

4. Date of accident or onset of occupational disease: December 24, 2012.

5. State location where accident occurred or occupational disease was contracted: Albany, Gentry 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 occurred or occupational disease contracted: Employee slipped on ice and fell in the employee parking lot of Employer.

12. Did accident or occupational disease cause death? No.

13. Part(s) of body injured by accident or occupational disease: Left ankle, knees, head, body as a whole, including psychological injury.

14. Nature and extent of any permanent disability: See agreements of the parties regarding payments to be made for permanent disability set forth later in this Award.

15. Compensation paid to-date for temporary disability: $38,757.10.

16. Value necessary medical aid paid to date by employer/insurer? $281,010.75.

17. Value necessary medical aid not furnished by employer/insurer? $41,407.04

18. Employee's average weekly wages: $788.40

19. Weekly compensation rate: $525.60 for temporary total disability, $525.60 for permanent total disability, and $433.58 for permanent partial disability.

20. Method wages computation: By agreement of the parties.

COMPENSATION PAYABLE

21. Amount of compensation payable:

Unpaid medical expenses: $41,407.04.

Permanent disability benefits: $120,000.00.

Employer is directed to authorize and furnish additional medical treatment to cure and relieve Claimant from the effects of her December 24, 2012 injury, in accordance with section 287.140, RSMo., including chronic pain management, monitoring and providing medications for Claimant's chronic pain, maintenance, repair, replacement and modification of Claimant's pain stimulator, psychological counseling, and medication for Claimant's depression and psychological injury.

22. Second Injury Fund liability:

For permanent disability: $60,000.00.

23. Future requirements awarded: As awarded.

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, including, but not limited to attorney's fees of $27,150.22 (which is 25% of $120,000.00 after deduction of expenses of $11,399.12) and expenses of $11,399.12 from the award against Employer/Insurer in the amount of $120,000.00 regarding permanent disability, and attorney's fees of $15,000.00 from the award against the Second Injury Fund in the amount of $60,000.00 for permanent total disability, in favor of the following attorney for necessary legal services rendered to the claimant: Athena M. Dickson.

FINDINGS OF FACT and RULINGS OF LAW:

Employee: Cynthia G. Null

Injury No.: 12-100528

Employer: Albany Medical Center, a/k/a Northwest Medical Center Association

Additional Party: The Treasurer of the State of Missouri as Custodian of the Second Injury Fund

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

Insurer: Hospital Association Team, c/o Cannon Cochran Management Services

Hearing Date: July 25, 2017

Checked by: RBM

PRELIMINARIES

A final hearing was held in this case on Employee's claim against Employer and The Treasurer of the State of Missouri as Custodian of the Second Injury Fund on July 25, 2017 in St. Joseph, Missouri. Employee, Cynthia G. Null, a/k/a Cindy Null, appeared in person and by her attorney, Athena M. Dickson. Employer, Albany Medical Center, a/k/a Northwest Medical Center Association, and Insurer, Hospital Association Team, c/o Cannon Cochran Management Services, appeared by their attorney, Daniel L. Doyle. The Second Injury Fund appeared by its attorney, Maureen T. Shine. Athena M. Dickson requested an attorney's fee of 25% from all amounts awarded. It was agreed that post-hearing briefs would be due on August 25, 2017.

STIPULATIONS

At the time of the hearing, the parties stipulated to the following:

1. On or about December 24, 2012, Cynthia G. Null, a/k/a Cindy Null ("Claimant") was an employee of Albany Medical Center, a/k/a Northwest Medical Center Association ("Employer") and was working under the provisions of the Missouri Workers' Compensation Law.

2. On or about December 24, 2012, Employer was an employer operating under the provisions of the Missouri Workers' Compensation Law and was fully insured by Hospital Association Team, c/o Cannon Cochran Management Services ("Insurer").

3. On or about December 24, 2012, Claimant sustained an injury by accident in Albany, Gentry County, Missouri, arising out of and in the course of her employment.

4. Employer had notice of Claimant's alleged injury.

5. Claimant's Claim for Compensation was filed within the time allowed by law.

6. The average weekly wage was $788.40, the rate of compensation for temporary total disability is $525.60 per week, the rate of compensation for permanent total disability is $525.60 per week, and the rate of compensation for permanent partial disability is $433.58 per week.

7. Employer/Insurer has paid $38,757.10 in temporary total disability at the rate of $525.60 per week.

8. Employer/Insurer has paid $281,010.75 in medical aid.

9. Venue was proper in St. Joseph, Buchanan County, Missouri for the July 25, 2017 hearing.

10. Claimant and Employer/Insurer stipulated pursuant to Exhibit Y, as amended by Court's Exhibit 1:

> The Claimant and Employer have entered into a settlement as to the issue of permanent disability. The Claimant and the Treasurer/Second Injury Fund have also entered into an agreement, which will be memorialized and presented for judicial approval separately.
>
> As far as the agreement between the Employer/Insurer and Claimant Cynthia Null, the Employer/Insurer agrees to pay a lump sum of $120,000, which includes attorney's fees of $27,150.22 and expenses of $11,399.12, leaving a balance of $81,450.66, closing out all issues regarding permanent disability. This payment is not for medical treatment, only for permanency.
>
> Ms. Null was 50 years old at the time temporary total disability payments ceased, in October 2015. At that point, Ms. Null's remaining life expectancy was 33.24 years, based on Social Security Actuarial Life Table of 2013. Therefore, even though compensation was documented, the Employee's benefit on this compromise settlement shall be considered to be $47.12 per week, or $204.20 per

month, paid in advance pursuant to R.S.Mo. §287.250(9) for 398.88 months, commencing as of July 25, 2017.

The issue of future medical treatment and past medical treatment remain open and are to be determined after a presentation of evidence to Administrative Law Judge Miner. With regard to past medical treatment, the parties agree that the Claimant has received medical treatment that was not authorized by the Employer/Insurer, however due to the nature and the necessity of the medical treatment the parties have agreed to have Judge Miner determine what bills are to be paid by the Employer/Insurer and what bills are not the responsibility of the Employer/Insurer. But notwithstanding the decision by Judge Miner, Employer/Insurer do agree to pay a one-time lump sum of $10,000 to the Claimant to reimburse her for unauthorized medical care. In the event that Judge Miner does find in the Claimant's favor regarding any of the past unauthorized medical treatment, the Employer/Insurer will receive a credit for the $10,000 voluntarily paid.

With regard to future medical treatment, the parties agree to submit to Judge Miner for a ruling regarding the Employer/Insurer's responsibility for specific future medical treatment.

The ruling by Judge Miner to all issues regarding medical treatment, both past and future, will be appealable by the parties, notwithstanding the fact that the permanency has been agreed upon by the parties.

11. Claimant and the Second Injury Fund stipulated that Claimant's claim against the Second Injury Fund be settled for a total of $60,000.00 for alleged permanent total disability. Claimant and the Second Injury Fund stipulated pursuant to Exhibit Z, as amended by Court's Exhibit 1:

This lump sum settlement in the amount of $60,000 includes attorney's fees in the sum of $15,000 and no expenses leaving a balance of $45,000.00 which is compensation for permanent impairment that will affect Cynthia Null for the rest of her life. Ms. Null was 50 years of age when temporary total disability (TTD) benefits were stopped in October 2015 and at that point employee's remaining life expectancy was 33.24 years based upon and listed in the Social Security Actuarial Life Table. Therefore, even though compensation was paid as documented, the employee's benefit on this compromised settlement shall be considered to be $26.03 per week

and $112.81 per month, paid in advance pursuant to RSMO 287.250 (9) for 398.88 months, commencing July, 2017.

ISSUES

The parties agreed that there were disputes on the following issues:

1. What is Employer's liability for additional medical aid?

2. What is Employer's liability, if any, for past medical expenses in the claimed amount of $41,407.04?

Claimant testified in person. Claimant's husband, Robert Null, also testified. In addition, Claimant offered the following exhibits which were admitted in evidence without objection:

A- Rating Report of P. Brent Koprivica, M.D.
B- Psychological Evaluation of Allan Schmidt, Ph.D.
C- Deposition of Allan D. Schmidt, PhD
D- Vocational Report of Michael J. Dreiling
E- Deposition of Michael J. Dreiling
F- Northwest Medical Records
G- Orthopedic & Sports Medicine Center Records
H- St. Joseph Center for Outpatient Center Records
I- Hanger Clinic Records
J- Center for Pain Management Records
K- Samaritan Counseling Center Records
L- Dickson-Diveley Midwest Ortho Records
M- KU Medical Center Records
N- Pain & Wellness Clinic Records
O- Albany Clinic East Northwest Medical Center Records
P- Pain & Wellness Center Records
Q- Pain & Wellness Clinic Records
R- North Kansas City Hospital Records
S- Performance Appraisal Caregiver Assessments
T- Deposition of Cindy Null
U- Mayo Clinic Records
V- Research Psychiatric Center Records
W- Itemized billing statements for NKC hospitalization
X- Medical expense breakdown for NKC hospitalization
Y- ER Addendum
Z- SIF Addendum

Employer offered the following exhibits that were admitted in evidence without objection:

1- Northwest Medical Center Medical Records
2- Research Medical Center Psychiatric Records
3- Deposition of Dr. Anne Rosenthal with Exhibits
4- Deposition of Dr. Michael J. Pronko with Exhibits
5- Deposition of Terry Cordray with Exhibits

Court's Exhibit 1, emails between the Court and the attorneys for the parties, relating to agreed corrections in Employer/Insurer's Addendum to Stipulation for Compromise Settlement, Exhibit Y, and the Second Injury Fund's Addendum, Exhibit Z, was admitted in evidence on October 21, 2017.

Any objections not expressly ruled on during the hearing or in this award are now overruled. To the extent there are marks or highlights contained in the exhibits, those markings were made prior to being made part of this record, and were not placed thereon by the Administrative Law Judge.

The Post-Hearing Briefs have been considered.

Findings of Fact

Claimant was injured on December 24, 2012 when she slipped on ice and fell in Employer's parking lot. She first received treatment at Northwest Medical Center for a left ankle and left foot injury where she had x-rays and a CT, and received medication. She saw Dr. Trease on December 26, 2012. Dr. Trease performed surgery for an ankle fracture on December 27, 2012. He placed a plate and screws in Claimant's left ankle. She used a boot. She had therapy that did not help.

Dr. Horton performed a second surgery on October 25, 2013 and removed the hardware in Claimant's left ankle. Claimant is not aware of any hardware in her ankle.

Claimant continued to receive treatment for her ankle. She had pain medication prescribed by Workers' Compensation doctors. Dr. Blachar prescribed medications. She was on multiple pain medications, including Dilaudid and Fentanyl. Later, Claimant had pain management with Dr. Hu. She had taken Lyrica for fibromyalgia before her work injury.

Claimant received treatment for psychological problems under Workers' Compensation. She first saw Dr. Jura, a psychiatrist, in St. Joseph who provided

counseling and prescribed medication after the work accident. Dr. Jura started her on Cymbalta. He treated her for her pain, a sense of failure, a sense of loneliness, and feeling not needed.

Claimant's treatment was changed from Dr. Jura to Dr. Pronko in Kansas City. Dr. Pronko provided counseling and continued Cymbalta. She saw Dr. Pronko weekly, then bi-weekly, and then every three months. Dr. Pronko provided phone therapy in between appointments. He continued medication during therapy. The treatment with Dr. Pronko ended in July 2016. Claimant had no problems scheduling appointments with Dr. Pronko before July 2016. After July 2016, Claimant tried to set appointments and was told in October 2016 that he was too busy. Claimant was told she had to do treatment on her own. Dr. Pronko was not refilling medication. She needed medication and went to her endocrinologist for medication.

Claimant testified she began having problems blacking out after Claimant's work injury in December 2012. She would lose track of time. She would stare into space. She could not remember conversations. She was having blackouts two to three times per week. She discussed the blackouts with Dr. Hu. Her blackouts continued and happened multiple times until she went to North Kansas City where she was told they were due to medication.

Claimant went to North Kansas City Hospital on March 6, 2017 for a routine appointment with her endocrinologist who was treating her for diabetes and thyroid. A nurse was walking Claimant to her bone scan when the room starting spinning. She felt like she was going to pass out. She was put in a wheelchair. Her endrocologist, Dr. Pothuloori, came out and sent her to be admitted to the hospital. She was admitted to North Kansas City Hospital on March 6, 2017. She was not "with it' when she was admitted to the hospital.

Claimant stayed in the hospital for eight days and was discharged on March 13, 2017. She testified she treated for spells while in the hospital. She had a full heart work-up. She was seen by a psychiatrist, Dr. Hill, a pain management doctor, and an endocrinologist at North Kansas City Hospital.

Claimant has not had blackouts since she left North Kansas City Hospital.

Prior History

Claimant testified at the hearing that she took psychiatric medication before her December 24, 2012 injury. She was on an antidepressant during the months before the Workers' Compensation injury of December 24, 2012. She had a difficult home life

before December 24, 2012. She had problems with her father. She was raped when she was eighteen and did not receive psychological treatment for that.

Claimant testified that she could put the problems she had behind her before the December 24, 2012 accident. She wanted to be a better person. After the work accident, she was totally knocked down. She testified that she does not know how to get back up.

Claimant was asked at the hearing about Dr. Schmitt's report, Exhibit C. She told Dr. Schmitt she grew up all over and did not have any confidence as a child. She saw her father arrested and taken away. Her father went to the penitentiary. She started working at McDonalds when she was fourteen. She finished high school. Her family had her write bad checks to pay bills occasionally when she was a child.

Claimant was abducted in her last year of school. She was raped by a black man who had a gun. She jumped out of the car going 35 miles an hour. The police were called. Claimant had occasional nightmares. She continues to be frightened when she is around black men, but that is getting better. She still has nightmares, but less often. Her body locks up when she sees a gun.

When Claimant was in her first semester of college, she attended Ford Christian College. She did not finish the semester. She had a meltdown. She froze up and went to the hospital for a short time. Her mother came and got her from school. She is not sure how long she was at school before she left. She does not know why she froze up. She did not get medication. She testified she did not think she was in the hospital due to a mental condition.

Claimant acknowledged at the hearing that she was taking Celexa and Darvocet on July 31, 2006, she was taking Clozapine for headaches on July 7, 2007, and she saw a doctor on March 21, 2007 and was diagnosed with stress, anxiety, depression and received Wellbutrin. Claimant agreed she was diagnosed with fibromyalgia and depression in 2009 and she took Prozac, Lyrica, Soma, and Percocet. She agreed that on December 20, 2009, she was taking multiple medications. She agreed on April 29, 2012 she was taking Percocet and Robaxin for headaches and back pain, and on June 20, 2012, she was prescribed pain medication. She was not on Dilaudid or Fentanyl patches prior to December 24, 2012.

One year before the December 24, 2012 accident work injury, Claimant went to the Emergency Room at Albany Hospital and was then transferred to Research for treatment. She had been running around the house in her bra and underwear while her father-in-law was there. Her voice was slurred. That behavior was unlike her. Her thyroid was low and her medication was changed. She did not have a repeat of those symptoms after her medication was changed.

Claimant testified at the hearing that she went to Research because of slurred speech, not blackouts.

Claimant agreed she had prior psychological counseling before December 24, 2012. She did not believe the treatment at Research, a psychiatric hospital, was for a psychological condition. She testified that she was at Research Hospital for her thyroid. She said her mental status change was because her thyroid was off. Claimant had diabetes for ten to eleven years and had had thyroid issues for fourteen years.

Claimant testified at the hearing that her headaches did not affect her work before her December 24, 2012 work accident. She worked full-time before her December 24, 2012 work accident. She went out socially and went on vacations.

Claimant's Deposition Testimony Regarding Prior Health Conditions and Treatment

Claimant testified in her deposition, Exhibit T, that she was in a motor vehicle accident in 1981 or 1982 and had some treatment. She said she did not go to the hospital and was not given work restrictions and she recovered from that. (*Id.* at 33). She did not have any psychological treatment after being abducted and jumping out from a moving vehicle in 1982. (*Id.* at 34) She had scrapes from that. She did not get medication for that.

Claimant was in a motor vehicle accident in 1990, but she did not have any physical injury in the accident. (*Id.* at 35-36). In 1991, some cabinets fell on her head and she had some treatment. She went to the Mayo Clinic in February 1993 because of pain. She was diagnosed with fibromyalgia. (*Id.* at 36). She was put on Amitriptyline and later Lyrica for fibromyalgia. (*Id.* at 37). She mostly had pain in her upper back from fibromyalgia. That did not cause her problems at work. (*Id.* at 38). Claimant agreed she had pain when she went to the Mayo Clinic in 1993. She was asked if it ever went away and she replied, "off and on, yes." (*Id.* at 102).

Claimant was self-employed from December 1990 until October 2005 and did not have problems working because of fibromyalgia. (*Id.* at 38). When she started working for Employer, the fibromyalgia did not cause her to call in sick or miss work. (*Id.* at 38).

Claimant had a motor vehicle accident in 1995 but did not have an injury from that and had no treatment due to that accident. (*Id.* at 39). She had uterine cancer in 2005 and a partial hysterectomy, but she recovered and had no problems from that. (*Id.* at 39). She had a partial thyroidectomy in February before her hysterectomy. (*Id.* at 39). She was put on thyroid medication after that surgery. (*Id.* at 40).

Claimant testified she was hospitalized at Western Missouri Mental Health before working for Employer because her thyroid was abnormal. Her medications were adjusted. (*Id.* at 40-41). As far as she knew, they did not diagnose any psychological problems for her at that time or put her on any psychotropic medication. (*Id.* at 41).

Claimant was diagnosed with diabetes in 2005 and was put on medication for that. Diabetes did not cause her any problems on the job before December 2012. (*Id.* at 41-42).

Claimant testified that any possible psychiatric issues did not affect her on the job at all before December 2012. (*Id.* at 42). She was never depressed or upset to the point where she was not working before the December 2012 work injury. (*Id.* at 43).

Claimant testified she was able to do all of her household activities before the December 2012 work injury. (*Id.* at 48).

Claimant testified that she talked to Dr. Schmidt about having suicidal thoughts or plans, but she denied any attempt to follow through. She was not having those suicidal thoughts or plans before the injury of 2012. She said it was because of the pain she was having currently. (*Id.* at 62). She testified in her deposition that her fibromyalgia comes and goes and she has good days and bad days. (*Id.* at 102). When she has a bad day, she has fatigue and it hurts a lot. (*Id.* at 103). She testified in her deposition that she was not still taking Lyrica. (*Id.* at 103).

Claimant was asked in her deposition about treatment records, Claimant Deposition Exhibits 2 through 24, which document treatment Claimant received at Northwest Medical Center, Albany, Missouri, on various dates between 2006 and June 2, 2012. She did not recall certain complaints described in the treatment records.

Claimant Deposition Exhibit 2 references angina in 2006. (*Id.* at 107). Claimant Deposition Exhibit 3 references left arm, shoulder and pain impingement syndrome on June 20, 2006. (*Id.* at 108). Claimant did not remember anything about that. Claimant Deposition Exhibit 4 is a CT evaluation of the pelvis for pelvic pain. Claimant said she did not have any treatment besides the CT scan. (*Id.* at 111).

Claimant Deposition Exhibit 5 is a Bone Scan dated October 24, 2006 and notes a history of back and leg pain. (*Id.* at 111). Claimant did not recall having that issue or having the bone scan performed. Claimant Deposition Exhibit 6 is a physical therapy discharge note dated December 18, 2006 stating a diagnosis of left arm pain, impingement syndrome. (*Id.* at 113). It notes she had five treatments. She did not recall having those issues. She remembered they applied ice in her office.

Claimant Deposition Exhibit 7 is a Patient History Form dated March 7, 2007. It notes the reasons for seeing the doctor were "continuous headaches, blurred vision, occasional numbness. She believed she was having issues with her diabetes. (*Id.* at 114). Exhibit 8 is a Consultation dated March 21, 2007 for follow-up for evaluation of her headaches. The record notes an MRI study of the brain was unremarkable. She was on Verapamil for headache. The record also notes in part, "She is also having stress, anxiety and depression issue [*sic*]. The plan is to put her on Wellbutrin SR 150 mg every day." (*Id.* at 115).

Claimant was asked about Claimant Deposition Exhibit 9, a History and Physical dated December 20, 2008. (*Id.* at 117). Claimant had complaints of severe headache and nausea and diarrhea along with dizziness. She rated her pain 10 out of 10 on a 0 to 10 pain scale. She was put on Meclizine and that seemed to resolve the issues. (*Id.* at 118).

Claimant Deposition Exhibit 10 is a Progress Note dated December 21, 2008 of Dr. Soghrati. It notes Claimant was in supine position in her bed complaining of headache. She did not take off work for that. (*Id.* at 119).

Claimant Deposition Exhibit 11 is a report dated December 20, 2008 that notes certain medications Claimant was taking. They included Nalbuphine, which is a medication Claimant testified she was taking for pain. She was also taking Soma for depression on December 20, 2008. (*Id.* at 122).

Claimant Deposition Exhibit 12 is a record dated December 24, 2008 noting vertigo and neck pain. Claimant testified she got the vertigo under control, but she did not recall the neck pain. (*Id.* at 123-124).

Claimant Deposition Exhibit 13 is an X-ray Report dated January 17, 2009, which is an MRI of the brain. The history given is for headaches, worsening recent episode of pupil dilation, dizziness. No abnormality was found. She does not recall that. (*Id.* at 124).

Claimant Deposition Exhibit 14 is an Emergency Room Note dated September 7, 2009. Claimant's chief complaint was back pain. She remembered that she slipped and almost fell, but did not fall. She had pain of 10 over 10. (*Id.* at 124). Claimant said that lasted a couple of days, maybe a week. (*Id.* at 125). Claimant Deposition Exhibit 14 also notes that Claimant was complaining of headache. Claimant did not have any memory of that. (*Id.* at 127). Claimant Deposition Exhibit 14 also notes in part that Claimant had a history of fibromyalgia, chronic low back pain, and depression.

Claimant Deposition Exhibit 15 is an Out-patient record dated January 2, 2010. Present medications were noted to include Prozac daily, Lyrica daily, and Percocet prn. (*Id.* at 115).

Claimant Deposition Exhibit 16 is a Progress Report that contains records of Northwest Medical Center dated January 14, 2010. The record notes, "Prozac to Cymbalta". Claimant did not know if Prozac was changed to Cymbalta. She was taking Prozac in January 2010 for depression. The record also notes Darvocet. She did not remember Dr. Miller prescribing her Darvocet at that time. (*Id.* at 130).

Claimant Deposition Exhibit 17 is an MRI of the cervical spine. It notes a history of bilateral arm pain and tingling. Claimant did not recall exactly what happened. (*Id.* at 133).

Claimant Deposition Exhibit 18 is a record dated March 19, 2011. It notes in part present medication of Cymbalta 60 mg daily. Claimant testified she was taking that for depression. (*Id.* at 135).

Claimant Deposition Exhibit 19 is record dated June 16, 2011. It references Elavil. Claimant testified she was being prescribed Elavil. She agreed it is a depression medication. (*Id.* at 136). Claimant did not recall having migraine problems on June 15, 2011, though the record notes educational handouts regarding migraine were provided.

Claimant Deposition Exhibit 20 is a Physician Order diagnosing migraine and chest pain. (*Id.* at 135).

Claimant Deposition Exhibit 21 is a record dated December 16, 2011 noting Claimant had gone to bed "not feeling right." She was noted to be not acting right. The discharge plan notes, "Decreased confusion then return home with husband." (*Id.* at 139).

Claimant Deposition Exhibit 22 is a record dated December 16, 2011 that states Claimant's complaint was "weak and disoriented slurred speech." Claimant believed that visit was for the time that she was transferred because of her thyroid. (*Id.* at 139).

Claimant Deposition Exhibit 23 is a Progress Note dated December 16, 2011 of Dr. Jackie Miller. Claimant believed that referred to when her thyroid was acting up. (*Id.* at 142). Claimant was sent to a psych hospital in Kansas City, Tri-County or probably Western Missouri Mental Health Center. The only thing that helped was getting her thyroid on track. (*Id.* at 143).

Claimant Deposition Exhibit 24 is Patient Registration Form of Northwest Medical Center dated June 2, 2012. The record notes the reason for admission was "chronic back pain, migraine." Claimant did not remember being treated for chronic back pain or migraine in June 2012. (*Id.* at 144).

Claimant admitted that she decided to quit the on again, off again antidepressants and just took them before the injury on the ice. (*Id.* at 148).

Current Condition

Claimant still sees Dr. Hu. She last saw him two months before the July 25, 2017 hearing. She had another appointment set with Dr. Hu on August 21, 2017. Dr. Hu inserted a spinal cord stimulator in Claimant in December 2014. He tried another medicine that did not work. Dr. Hu primarily provides pain medication and pain management. He currently prescribes Mobic and a Fentanyl patch. The patch is changed every three days. He also prescribed Dilaudid, Trazodone, and Gabapentin. Claimant understands she is to continue the medications prescribed by Dr. Hu. They have not been stopped. She has taken them since they were first prescribed.

Claimant is treating with Dr. Pothuloori at North Kansas City Hospital since being in the hospital there. Claimant also takes Cymbalta for pain and depression that was prescribed by Dr. Pronko. Claimant's endocrinologist and primary care doctor currently prescribe her medications, including Cymbalta.

Claimant is currently no longer able to go to church as often as she did before December 24, 2012. She now goes to church about one-third of the time. She has withdrawn from society. She is in a lot of pain. She cannot drive. Pain affects her depression and makes it worse. Her headaches come and go.

Past Medical Expenses

Claimant testified the itemized bills relating to the North Kansas City Hospital hospitalization, Exhibit W, were all related to her Workers' Compensation injury. She testified Exhibit X, a summary of her bills, is an accurate summary of those bills. Claimant is asking for the North Kansas City Hospital bills and the bills in Exhibit W be paid by Workers' Compensation.

Future Medical

Claimant testified she is interested in getting outpatient psychotherapy for depression and anxiety and pain. She feels she needs a new psychiatrist. She feels she was dropped by Workers' Compensation as to antidepressant medication.

Claimant's spinal stimulator gives her a problem. It hurts her lower back. She understands the stimulator is to remain in her. She requests the medical treatment to remain open for her spinal cord stimulator.

Claimant requests future medical treatment relating to her back, left ankle, left foot and pain management and for medications for pain to continue. She requests whatever the pain management doctors recommend. She requests treatment for maintenance of her spinal stimulator. She requests for psychiatric treatment and medication. She requests the Court to continue Cymbalta be covered by Workers' Compensation. She requests that the psychologist who she is now seeing be paid by Employer.

Claimant does not request any additional treatment for her knee.

I find Claimant's testimony to be credible unless discussed otherwise later in this Award.

Claimant's husband, Robert Null, testified that he and Claimant were married in 1987. He testified Claimant went to Research one year before the December 24, 2012 accident because her thyroid level was a problem. She did not go for mental health. He was not aware of a psychiatric health diagnosis. He did not think Claimant needed psychological treatment. He testified she has never had a mental problem. She has had headaches.

I find Robert Null's testimony that he did not think Claimant needed psychological treatment and that Claimant has never had a mental problem is not credible.

Medical Treatment Records

Exhibit G contains records of Dr. Corey Trease. Dr. Trease treated Claimant for her left ankle injury after she fell on ice at work. His December 26, 2012 Progress Note states he recommended surgical stabilization. Dr. Trease's December 27, 2012 Operative Note states his pre-operative and post-operative diagnosis was left bimalleolar equivalent ankle fracture. Dr. Trease performed an open reduction internal fixation of the ankle.

Dr. Trease also performed a diagnostic right knee arthroscopy with arthroscopic partial medial and lateral meniscectomies on April 8, 2013. His pre-operative and post-operative diagnosis was right knee medial and lateral meniscus tears.

Dr. Trease's March 8, 2013 Progress Note states that an MRI was reviewed and revealed medial and lateral meniscus tears of her right knee. He thought the prevailing factor in her developing her meniscal tears is a work related injury.

Exhibit M contains records of KU Medical Center and Dr. Greg Horton. Claimant saw Dr. Michael Tilley at KU on August 19, 2013. His record notes that Claimant returned for a follow-up of her left foot and ankle. She was taking Percocet and OxyContin. He assessed late effects left ankle fracture and planovalgus deformity with posterior tibial insufficiency that had failed brace treatment. He recommended she see Dr. Horton and consider operative solutions.

Dr. Horton's October 25, 2013 record notes Claimant's chief complaint was, "Late effects left ankle fracture, pain and deformity. They discussed surgery. An October 25, 2013 Operative Report of Dr. Horton notes that he performed "left ankle arthroscopy with debridement of the tibial plafond. Debridement of left posterior tibial tendon and secondary repair with augmentation utilizing flexor digitorum longus. Secondary lateral ankle ligament reconstruction using a modified Brostrom technique." Dr. Horton's post-operative diagnosis was severe chondromalacia of the left tibial plafond, left posterior tibial tendinopathy, and left lateral ankle ligamentous instability.

Dr. Trease's May 14, 2013 Progress Note states in part that Claimant "says that her ankle is still giving her quite a bit of grief." Dr. Trease thought she had done reasonably well from her knee arthroscopy. He was concerned about her ankle. He thought they needed to get Claimant into a foot and ankle specialist. He thought Dr. Greg Horton would be an optimal choice. He thought the prevailing factor in developing this problem was her work related ankle fracture.

Claimant saw Dr. Horton on February 11, 2014. She continued to have pain in the medial aspect of her ankle that she described as a burning, throbbing pain. The pain awakened her at night. She was taking OxyContin and Percocet. Dr. Horton noted Claimant inquired about pain management. Dr. Horton thought, "that getting her plugged in with pain management would be reasonable to manage this. She is taking Lyrica, and I have encouraged to stay on it."

Exhibit J contains records of Center for Pain Management at Mosaic Life Care of St. Joseph. Claimant saw Dr. Alejandro Blachar on March 6, 2014 to discuss her left ankle and foot pain. Claimant rated "her pain at 8/10 sharp, throbbing, burning, ache" rates. Dr. Blachar noted an onset due to a fall on December 24, 2012. Dr. Blachar was aware that Claimant had seen Dr. Trease and later Dr. Horton. He noted she underwent left ankle arthroscopy with debridement by Dr. Horton, including ankle ligament reconstruction. He noted Claimant has had persistent pain since that surgery. Dr. Blachar also noted, "She has associated nausea, sleeplessness, anger, irritability, depression, loss of appetite and loss of concentration accompanying the pain." Current medications included acetaminophen-hydrocodone, Ambien, ibuprofen, Lexapro, Lyrica, and OxyContin.

Dr. Blachar's March 6, 2014 Office/Clinic Note states in part:

Impression

1. Generalized Pain (780.86)
2. Chronic Foot Pain, left (729.5)
3. Neuropathic pain versus complex regional pain syndrome
4. Anxiety and depression
5. Status post trauma, ankle fracture December 24, 2012, with 2 subsequent ankle surgeries
6. Fibromyalgia
7. History of uterine cancer, hypothyroidism, hypertension, obesity and GERD (gastroesophageal reflux disease)

Plan

1. The patient is currently on OxyContin and Norco as chronic opioid medications. I would increase them for improved pain control. Monitor for sedation, constipation and nausea.
2. She also continues to be on Lyrica, which I think is a good choice, as an adjunctive neuralgic pain medication.
3. I will also prescribe a topical compounded ketamine cream which has been found useful for relief of neuropathic pain in the distal limbs especially.
4. Given the fact that I believe she has associated depression and possible symptom magnification related to this, I believe it would be reasonable to increase her Lexapro to 40 mg daily. However, I would leave this up to her primary care provider. I believe this is actually Dr. Martin now since she is her workman's compensation physician.
5. It is unclear whether or not the patient does have complex regional pain syndrome at this time. She does meet some of the criteria such as allodynia and erythema at times, but other criteria are not present. I believe in order to sort this out, it would be reasonable to proceed with diagnostic left lumbar sympathetic block in order to determine whether or not her left foot pain is sympathetically mediated. If not, then we are mainly dealing with a neuropathic pain syndrome and/or possibly a mechanical pain syndrome, which is exacerbated with weight bearing and use.
6. Apart from medical management of her pain complaints, ultimately she may be a candidate for spinal cord stimulator trial if she passes appropriate psychological testing.
7. We will set her up for diagnostic left lumbar sympathetic block pending workman's compensation insurance authorization.

Dr. Horton's April 22, 2014 record notes that he saw Claimant for re-evaluation. She had pain with weight bearing. She complained of swelling and color changes. She stated she had a lot a lot of coldness in her toes. She continued Lyrica that did not seem to help her. She had one sympathetic block but stated she got no relief with it. She had gone to the pain specialist twice and had another appointment in a month.

Dr. Horton stated that it seemed the bulk of her symptoms were nerve related more than anything else. His record notes in part: "I certainly don't see anything from a mechanical standpoint that is going to offer her much in the way of relief. She will continue use of her Tubigrip. She can discontinue physical therapy at this point. I also think that use of her boot at least situationally would be reasonable. I have spent the majority of our 15-minute encounter today counseling Cynthia G. Null with regard to my findings and recommendations. She is at MMI from an orthopedic standpoint."

Dr. Blachar's April 30, 2014 Office/Clinic Note states that Claimant's chief complaint was, "Patient here today to discuss her pain. She rates her pain 7/10, burning, sharp, throbbing pain." The record notes that Claimant was then on chronic doses of OxyContin 40 mg every 12 hours as well as Dilaudid 4 mg three times daily as needed. The record notes she uses Ambien at night for sleep but it is not very helpful. The record notes that Dr. Horton had released Claimant from his care and stated she had reached maximum medical improvement from an orthopedic standpoint, and he had turned over further care to Dr. Blachar. Dr. Blachar's record notes that Claimant appeared "very emotional and quite distraught."

Dr. Blachar's April 30, 2014 Office/Clinic Note states in part:

> Her prognosis is guarded and is actually unknown. I do believe, however, that she will not improve if she does not get a handle on her emotional state and on the psychological factors which affect her physical condition. I believe she is quite depressed and anxious over the fact that she may have to live with severe chronic left lower extremity pain for the rest of her life. I have told this patient that she may have chronic pain forever, but I am hopeful that the chronic pain syndrome would be muted and tolerable going forward.

Dr. Blachar's April 30, 2014 Office/Clinic Note dated sets forth the following Impression and Plan:

Impression

1. Pain, Lower/Upper Extremity (729.5), left lower
2. Neuropathic left lower extremity pain

3. Status post workman's compensation injury with ankle fracture and 2 subsequent ankle surgeries

Plan

1. I believe the patient's chief diagnosis is neuropathic left lower extremity pain. However, the patient may have some component of complex regional pain syndrome, even though she did not get benefit from lumbar sympathetic block. I think, however, that this is the more unlikely diagnosis at this time.
2. We will put the patient on Topamax as an adjunctive neuralgic pain medication.
3. We are in the process of establishing a pain psychologist in our practice. I believe she would be an excellent candidate for this individual to see in order for coping skills and help, and for the pain psychologist to help Cindy live with her pain in a more reasonable fashion if possible.
4. In addition, I think she would be an appropriate candidate for referral to a psychiatrist for manipulation of antidepressants and possibly sleep medications, which are not habit forming. I will try to set her up with Dr. James Jura, who is an excellent psychiatrist in general.
5. I have counseled her to go down to Kansas City in order to see this other pain physician, which may give her some benefit. As far as I know, radiofrequency ablation would allow her to obtain possible relief for some period of time, but it certainly is not a cure for her ailment. She needs to be aware of the fact that there may not be a cure for her chronic pain syndrome. She understands this.

Exhibit K contain records of Samaritan Counseling Center and Dr. James Jura, M.D. Dr. Jura saw Claimant on June 9, 2014. Dr. Jura's record notes Claimant feels very depressed since breaking her foot. Dr. Jura's record notes that when he first saw Claimant, she was taking several medications, including OxyContin, Topamax, Lexapro, Lyrica, Nexium, Ambien, and Dilaudid. Dr. Jura assessed depression, major, severe recurrence, and post-traumatic stress disorder.

Claimant saw Dr. Jura again on July 21, 2014. His record notes she continued to feel depressed and anxious. Dr. Jura assessed depression, major, severe recurrence and post-traumatic stress disorder. He prescribed Cymbalta and Trazadone.

Exhibit L contains records of Dixon-Diveley Midwest Ortho, Dr. Stanley Bowling, M.D. Dr. Bowling saw Claimant on July 11, 2014. Her chief complaint was evaluation

of the left foot and ankle as a second opinion. He noted she was on OxyContin, Dilaudid, and Lyrica for the pain. He recommended an EMG of the bilateral extremities.

A record in Exhibit L notes Dr. Santos saw Claimant on August 1, 2014 and performed an EMG on that date.

Exhibit N contains records of Dr. Zhengyu Hu and Pain and Wellness Clinic, Inc. Claimant treated with Dr. Hu. Dr. Hu's record notes that he is a Board Certified Physiatrist. Dr. Hu first saw Claimant on May 7, 2014. Her chief complaint was left ankle/foot pain since December, 24, 2012. His record describes the history of the treatment she received after her fall. When Dr. Hu first saw Claimant, she was on Lyrica, Neurontin, Ambien, Dilaudid, OxyContin, and other medications. Dr. Hu examined Claimant. His note states in part: "Clinically, I don't think she has RSD." The record notes treatment options relating to her left ankle pain were discussed. The options included Lidoderm patches, cream, Cymbalta, peripheral nerve blocks, Synvisc injection and possibly spinal stimulator.

Dr. Bowling saw Claimant on August 8, 2014. His record notes multiple medications, including Lyrica, Trazodone, Dilaudid, Cymbalta, and OxyContin. Claimant's chief complaint was follow-up for EMG of the left lower extremity. The record notes the EMG showed possible atrophy in the extensor digitorum brevis, but no other nerve entrapment. Claimant continued to have hypersensitivity to light touch throughout the left lower extremity. Dr. Bowling assessed, "Status post-open reduction internal fixation of trouble or ankle fracture and reconstruction tendon transfer and ankle arthroscopy left ankle. Suspected nerve damage left lower extremity." Dr. Bowling noted that he did not feel there was any kind of surgical intervention warranted by himself and she may benefit from sympathic nerve blocks.

Records in Exhibit N note Dr. Hu saw Claimant throughout the period May 7, 2014 through September 2, 2015. The records include an Operative Report dated December 17, 2014 documenting dorsal column stimulator permanent placement. Dr. Hu monitored Claimant's medications and changed medications from time to time.

Exhibit 1 contains records of Northwest Medical Center, Albany, Missouri pertaining to Claimant. These include a History and Physical dated March 31, 2015 pertaining to Claimant's admission there on March 30, 2015. The record notes Claimant was admitted with a history of chronic pain syndrome. Claimant was found to have very slow mentation and appeared very lethargic.

Dr. Ewing's Consultation dated April 1, 2015 in Exhibit 1 notes that Nortriptyline was added about a month ago and it is possible she could be orally sedated by some of the drugs and that could be causing problems. He noted episodes of confusion which

apparently had been going on for six months. Claimant was discharged home. Dr. Ewing suggested Claimant have a Nortriptyline drawn.

Exhibit B contains records of Dr. Hu from September 30, 2015 through July 13, 2016. Claimant continued to have complaints of left ankle pain. She also complained of low back pain. Medications were adjusted.

Exhibit Q contains records of Dr. Hu from October 5, 2016 through March 1, 2017. Dr. Hu saw Claimant every few weeks during that period. He adjusted medications. Claimant continued to have left ankle pain and low back pain. On March 1, 2017, Dr. Hu increased Elavil and provided three scripts for Claimant's Fentanyl and Dilaudid.

Exhibit R contains records of North Kansas City Hospital for treatment Claimant received there between March 6, 2017 and March 13, 2017. Dr. Pothuloori's Discharge Summary dated March 13, 2017 sets forth the following History of Present Illness and Hospital Course:

> **History of Present Illness**
> Mrs. Null is a 52 year old female with poorly controlled type 2 diabetes, hypothyroidism, HTM, HL, GERD, vitamin D deficiency, and complex regional pain syndrome to include the left lower leg/foot. She presented to the office for routine follow-up regarding diabetes and hypothyroidism. She reported to me that she has "black out spells". She notes this has been occurring for an unknown amount of time but seems to be worsening and becoming more frequent. She states she does not know when they are going to occur. She tends to fall with these black out spells. She states her husband can occasional [*sic*] discern when this will happen because her speech becomes 'thick tongued.' She notes that her blood sugar has been checked during these spells and are never low but rather they are elevated. She denies shortness of breath, chest pain, dizziness, changes in vision or really anything prior to the spell. She states her husband tends to put her in bed and lets her "sleep it off" and this can take up to 1.5-2 days. She reports having had a cardiac and neurologic work-up but was unable to tell me what was done but states 'no one can figure out why I pass out.'
>
> During the walk from the exam room to the lab, within our office, the patient was ambulating with her cane and stated "I'm going to pass out." Her demeanor changed and she was staring into space, but did not have full syncope. She was helped into a chair. She was able to

tell me this is what happens when she ends up in bed for several days. Her blood pressure was 112/77 with a pulse of 88 and blood sugar was 320.

. . . . . .

In 12/20/12, she had a fall on the ice that lead to a severe left lower leg injury. She is currently taking multiple medications to manage the pain. These medications are Xanax, Cymbalta, Dilaudid, Amitriptyline, Fentanyl, Gabapentin, Mobic, Tizanidine, and Trazodone.

Hospital Course
The patient was admitted with altered mental status. She underwent imaging of the head that did not reveal acute pathology. It was eventually determined that the etiology of her altered mental status was polypharmacy.[1] The patient was initially seen by pain management for her dependence on pain medication and it was recommended not to stop any pain medications and that she follow up with her pain specialist. However, the patient was noted to have hypotension related to use of the pain medication, Tizanidine. After stopping the medication, her hypotension resolved. The patient was seen by Psychiatry, Dr. Hill, who modified her psychiatric medications and decreased the Xanax and changed it to scheduled Klonopin; with this change, she was more alert. Amitriptyline was stopped and Trazodone was lowered to 100 mg at HS. The fentanyl pain patch was also stopped. By the day of discharge the patient was more alert and pain was controlled. Dilaudid was also decreased as outlined in the medication list.

Dr. Miller's Cardiac Consultation note dated March 6, 2017 in Exhibit R states in part:

Assessment/Plan
1. Episodic feelings of detachment and "out of it" which are unrelated to blood sugars. This suggests some sort of metabolic neurologic or psychiatric disorder or some combination thereof
2. Symptoms near-syncope and syncope which is probably not cardiac related unless it is vagal.

[1] "Polypharmacy" is defined as "The administration of multiple drugs at the same time." *Stedman's Medical Dictionary (28th Edition).*

Dr. Robinson's Neurology Consultation note dated March 7, 2017 in Exhibit R states in part:

> CHIEF COMPLAINT: Spells of alteration of consciousness.
>
> HISTORY OF PRESENT ILLNESS: This is a 52-year-old woman who for the past couple of years has been having spells of alteration of consciousness. She estimates they happen once per week. Evidently, during these spell [*sic*] she either does totally pass out or acts in a confused manner.
>
> . . . . . .
>
> It is also conceivable to multiplicity of her medications, maybe causing some of the problem. It was noted that she was very hypotensive this morning here in the hospital and her medicines were actually held to a great degree. I will go ahead and order an MRI head scan as well as an EEG and further decisions can be made after these studies are back. If nothing shows up on these studies to indicate that she may be having seizures, it might be reasonable to either try to hold as many of her medications as possible to see if these spells abate or actually give her a trial of anticonvulsant medication, although if the test [*sic*] turn out negative I would favor attempting the former, namely with holding as many medications as possible to see if these spells go away.

Dr. Todd Hill, a psychiatrist, treated Claimant while she was hospitalized at North Kansas City Hospital in March 2017. Dr. Hill's Consultation Report dated March 8, 2017 in Exhibit R states in part:

> HISTORY OF PRESENT ILLNESS: The patient is a pleasant 52-year-old Caucasian female who was admitted to the hospital for episodes of what are described as "blackout" spells. These have been going on and off for the past two years that have increased over the past month. They have become more frequent and become worsening in severity. She will tend to fall when she has these blackouts spells. She doesn't know when they are going to happen and actually they come out of nowhere. She also will then have difficulty speaking. She is a diabetic and her sugars have been checked during these spells, and they appear to be for the most part normal. They are never extremely low. The patient while being examined at Endocrinology

on the day of admission felt like she was going to pass out. She started staring into space but did not have any full syncopal episode. She was helped to a chair and eventually recovered from the spell. She was subsequently admitted for further evaluation. Since admission she has been seen by Neurology. Neurology is considering that these could represent complex partial seizure type episodes. There is also some concern given her multiple medications that these may be a contributing factor as well. She has had an MRI and a [*sic*] EEG, although the results are pending at this point. Some of her medications are actually on hold as she is on multiple medications for her chronic pain disorder. Pain Management has been consulted. The patient reported that her complex regional pain syndrome has been "well-controlled," although this may not appear to be the case given her ongoing symptoms and she still has some significant pain issues. Pain management did not recommend decreasing any of her pain medications. The patient is being treated by a workman's comp pain doctor and it appears that Pain Management at this point did not feel comfortable making any adjustments to her medications because of this as well. Regardless, the patient has had multiple episodes of the above-mentioned syncope spells. The patient is on multiple medications, many of these medications may be interacting contributing to her symptoms. The patient has some depression and anxiety associated with her complex regional pain syndrome. Psychiatry was consulted for evaluation and treatment recommendations.

. . . . . .

The patient reports that she has had significant problems since 12/2012 since she fell on the ice at work. The patient was working at the hospital in Albany, Missouri. The patient actually at that time had developed their EMR and was basically in charge or running the EMR system for the hospital. The patient did suffer a lower extremity fracture. This resulted in surgery, I believe, at KU Medical Center. Apparently the surgery did not go well and she began to develop chronic pain issues in her lower extremity. This has now gone on for 4 years. She has been treated primarily by Pain Management doctor, Dr. Hu, who is retained by the workman's comp insurance company. She has been seeing Dr. Hu for several years as well. He apparently is prescribing many of her medications for pain. Although it does appear he is attempting to manage her pain symptoms, she still is struggling with a significant amount of pain in her lower extremity.

The pain is in her left foot. She has had again surgery on her left foot. She has mild deformity of her left ankle joint as well. The patient has been diagnosed with complex regional pain syndrome by an orthopedic physician as well as this being confirmed here at North Kansas City Hospital with Pain Management today. The patient indicates, however, that Dr. Hu is trying to 'avoid confirming this diagnosis.'

The patient has struggled significantly with depression following this accident.

. . . . . .

In terms of mood symptoms, the patient states her life has been 'turned upside down' from this accident. She is depressed more days than not. She feels helpless, hopeless, worthless and useless. She feels she is actually a burden to her family at times. She has had suicidal thoughts, although this is nothing that she would act on at least at this point.

. . . . . .

In terms of any anxiety symptoms, the patient does report she feels keyed up and on edge much of the time. She is worried about her ongoing medical problems and her chronic pain. The pain in her left lower extremity obviously makes her anxiety and her depression worse. She has nightmares at times during periods of anxiety and takes the Xanax at least every night.

PAST PSYCHIATRIC HISTORY: Prior to her injury in 12/2012, the patient denies any psychiatric issues. She states that she had possibly seen a counselor on one occasion but was never on any psychiatric medications again prior to the 12/2012 accident. The patient states that since the accident, workman's comp did send her to see a psychiatrist, Dr. Pronko. Dr. Pronko has put her on Cymbalta and Xanax for her depression and anxiety. He also started trazodone for sleep. It does appear that Psychiatry has been prescribing her 200 mg of trazodone with 120 mg of Cymbalta and Xanax for anxiety where the workman's comp doctor is also putting her on muscle relaxers as well as some pain medication. All of this may be contributing to some of her mental status decline as well. She does have what appears to be major depressive disorder and generalized anxiety disorder and pain

disorder. The pain disorder is associated with her complex regional pain syndrome.

IMPRESSION:
1. Somatic symptom disorder.
2. Generalized anxiety disorder.
3. Major depressive disorder, recurrent, moderate.
4. Complex regional pain syndrome.
5. Possible serotonin syndrome.
6. Hyponatremia.

RECOMMENDATIONS: The patient at this point is having significant side effects it appears from all of her medications. She is on multiple medications that are prescribed not only by her psychiatrist, but by the workman's comp pain physician, all of which can cause significant drug interactions. The combination of Elavil, Cymbalta and trazodone, especially at the doses that she is getting of the Cymbalta and trazodone can contribute to serotonin syndrome. This combined with pain medication and Xanax can all be contributing to a decline in not only her mental status but her ability to function on a daily basis. She states that when she did try to go back to work initially with some of these medications, she actually was falling asleep. There is as stated above in the ER note from 2013 where she was actually falling asleep during the day but was on the antipsychotic medication Seroquel. Regardless, I am in agreement with Neurology that many of these medications need to be limited for now, I am in agreement with stopping the Xanax during the day or at least making it as-needed. The amitriptyline will be discontinued. Tizanidine has been discontinued. I would continue the Cymbalta at this point. The trazodone has been discontinued, although the patient most likely will need something for sleep, this can be replaced with melatonin or possibly decrease the trazodone back to 100 mg. The patient reports that she has not seen a psychiatrist since November of last year. She has left messages, but apparently he has not returned her calls. The patient does need ongoing psychiatric medication management, and she especially needs behavioral pain management due to the devastating effect that her chronic regional pain syndrome has had on her life and quality of life. Behavioral pain management may help her at least adapt to this new level of dysfunction.
The patient was very tearful, very upset about her ongoing multiple medical problems primarily her pain. Prior to the accident, her diabetes was fairly well-controlled with oral medications, now she is

on insulin which is another frustrating factor for her. Her blood sugar has been running high, which also can be contributing to her severe depression. There are multiple factors going on with this patient, the majority of these do stem from polypharmacy. We will try to simplify her medications and see how she does. I will await EEG and MRI results as well as there may be actually some underlying seizure disorder.

Dr. Hill's March 10, 2017 Progress Note states in part:

I did reinforce the fact that her EEG was normal at this point she does not appear to have any underlying seizure disorder.

. . . . . .

The patient's husband had questions regarding the fentanyl patch, along with the as needed Dilaudid. I indicated that in my experience with neuropathic pain such as complex regional pain syndrome, opiates are not the drug of choice, and lead to further debilitation secondary to the side effects. These medications do significantly impair the patient's ability to function during the day, and to have any sort of quality of life.

The patient was tearful, she was anxious, she was still depressed over her current situation although slightly more hopeful regarding the fact that her medications were looked at in detail.

. . . . . .

Assessment and Plan
The patient will be taken off the daytime trazodone, will be changed to 100 mg and be given at night starting tomorrow night. She will be started on melatonin at bedtime as needed for sleep as well. She will continue on the Cymbalta twice daily, the low-dose of trazodone at night, with the possibility of even discontinuing the trazodone in the near future. I did recommend possibly restarting the ties Anna Dean only on a [*sic*] as needed basis which could be given in the evening. In terms of her fentanyl and Dilaudid, I did defer for pain management regarding this. Although the patient was seen by pain management here, they were reluctant to change any of her medications. She can follow up with her outpatient pain management doctor through Workmen's Comp., Dr. Hu. My opinion is that the Dilaudid is

making the patient too tired during the day, when combined with many of her other medications. There may be other options for her neuropathic pain. I did discuss with the patient and her husband at length behavioral pain management and there is a group in Liberty called the Center for Healing and Recovery, that is a psychotherapy group that deals with pain management, in terms of behavioral pain management, as well as helping the patient deal with the stress that this injury is [*sic*] caused her. The patient is very interested in getting this type of support as well.

After evaluating the patient, in reviewing her medications, I called pharmacy to help reconcile her medications. Apparently the patient's medications are still not correct. She does not take alprazolam, she takes clonazepam. She also is not taking trazodone 200 mg as an outpatient she is actually on trazodone 100 mg at bedtime. She does take clonazepam 1 mg at bedtime and 0.5 twice daily will be made as needed. We will see how the patient does over the weekend with these medication changes, follow-up on Monday, and make a referral for the behavioral pain psychologist.

Dr. Hill's March 13, 2017 Progress Note states in part:

She is extremely interested in getting outpatient psychotherapy for her pain as well as her depression and anxiety. She also states that she is needing not only a therapist but a new psychiatrist as her last psychiatrist, Dr. Pronko, apparently is no longer going to see her as an outpatient. I indicated that she may need to coordinate this through her workers comp case manager.

. . . . . .

IMPRESSION:
1. Major depressive disorder, recurrent, severe without psychotic features.
2. Generalized anxiety disorder.
3. Somatic symptom disorder.
4. Complex regional pain syndrome.

RECOMMENDATION: I did discuss the case with Endocrinology, who is managing her primary care while here in the hospital. They are concerned that she may go home and start taking her medications again that she was on, for example the amitriptyline and Tizanidine. I

> indicated that these medications can be canceled at the pharmacy, and I did discuss this with the patient, who agreed that she would not be taking the amitriptyline or the Tizanidine. She will remain on the Cymbalta, trazodone as needed and the Klonopin during the day as needed with the Klonopin at night for sleep. The patient would benefit from melatonin at night for sleep as well. In terms of her fentanyl and Dilaudid, I will defer to Pain Management regarding that, although it does not appear that again opiates are always the best choice in complex regional pain syndrome, as this is a lot of this is neuropathic pain. The patient is already on high doses of Neurontin and Cymbalta, however. From a psychiatric standpoint, she will also try to set up an outpatient psychiatric medication management as per the patient. She no longer has a psychiatrist.

Dr. Michael Pronko

The deposition of Dr. Michael Pronko, M.D. taken on April 24, 2017 was admitted in evidence as Exhibit 4. Dr. Pronko is a psychiatrist and has been practicing psychiatry for 53 years. (Pronko deposition, page 5). Dr. Pronko first treated Claimant on September 17, 2014. (Pronko deposition Exhibit 2). Dr. Pronko saw Claimant between September 17, 2014 and December 7, 2016. (*Id.* at 45-46).

Dr. Pronko saw Claimant for treatment at the request of one of the insurance companies. (*Id.* at 4). He was aware she had had ankle surgery times two and knee surgery. (*Id.* at 7).

Dr. Pronko testified when Claimant first came to see him, she was depressed and had a lot of pain that interfered with her functioning at work and at home. He noted she had a lot of side effects of pain medication that he thought interfered a lot with her functioning. (*Id.* at 8). He noted she ended up with a spinal cord stimulator implant that gave her some relief. (*Id.* at 9). Claimant did not give a previous history of psychological difficulties and said this was all related to her ankle injury. (*Id.* at 10).

Dr. Pronko was asked the following questions and gave the following answers at Pronko deposition, page 10:

> Q. So that's what she told you when you were treating her?
>
> A. Yes.
>
> Q. Do you now still believe that to be true?

A. No.

Q. Okay, And why not?

A. Well, because there are other medical records which indicates going throughout her life that she has had a multiplicity of emotional, psychological problems, starting with horrendous family history of turmoil and trauma, abuse, physical and sexual abuse, difficulties emancipating herself. She went away to school and decompensated and came back home.

Dr. Pronko noted Claimant was kidnapped and raped and had to jump out of a moving vehicle to get away from her attacker in 1982. (*Id.* at 12). He noted she had a diagnosis of viral myalgia since 1994. She was abducted at gunpoint and raped by a black man at age 17, and was frightened of black the rest of her life. (*Id.* at 13-14) Her brother and mother had depression. (*Id.* at 15). When she was younger, her brother was abusive to her physically and sexually. (*Id.* at 15). She saw her dad arrested and taken to prison. Her dad was a con man. They sometimes had her write bad checks. (*Id.* at 15-16).

Claimant was taking multiple medications for pain, dizziness, vertigo, back pain, headaches, and fibromyalgia. (*Id.* at 16). He testified she had a somatic system disorder since at least her 20's. (*Id.* at 17).

Dr. Pronko was asked the following questions and gave the following answers at Pronko deposition, page 21:

Q. But what I'm getting at is, what part of her psychological overall condition that preexisted the December, 2012 injury, what how does that play into her not working?

A. I think her current state is similar to what has been in the past. She has physical complaints which have interfered with her functioning at home, at work, at play, everywhere, and it has been compounded with this current injury.

Q. You say compounded. Would it be combined too?

A. Combined, yes.

Dr. Pronko agreed with Dr. Rosenthal's statement, "I think she has had chronic pain forever. I don't think that she has additional chronic pain because of this injury." (*Id.* at 23).

Dr. Pronko testified that he agreed with Dr. Rosenthal's statement that for this injury, the left ankle and the right knee, Claimant would have had medication for a finite, a defined period of time, and it would have ended and she would not have needed long-term pain management modalities. (*Id.* at 25.)

Dr. Pronko diagnosed Claimant with major depression. He said it was long-standing. He testified that she requires medication to treat pain and depression, and "that's for her lifelong difficulties and problem that she has." (*Id.* at 30).

Dr. Pronko was asked the following questions and gave the following answers at Pronko deposition, pages 43-44:

> Q. (By Mr. Doyle) We discussed earlier with Dr. Rosenthal's report where Dr. Rosenthal said that had it not been for the preexisting psychological overlay, that when the ankle injury occurred and the knee surgery occurred, that Ms. Null would have been on medication, pain medication for a finite period, then that would have been it. Correct? And you agreed with that?
>
> A. Yes, yes.
>
> Q. So the fact that she is currently taking pain medications and depression medications, what's the prevailing factor in taking those medications now? Is it because of her preexisting, or because of the work-related injury?
>
> A. It is primarily her preexisting lifelong dysfunction.

Dr. Pronko testified his opinions were given with a reasonable degree of medical certainty.

Dr. Pronko has provided records from the insurance company representing the Employer who had sent Claimant to him. (*Id.* at 48-49). The insurance company intermittently paid for the treatment he provided Claimant. (*Id.* at 49).

Dr. Pronko was asked the following questions and gave the following answers at Pronko deposition, pages 50-51:

Q. It looks like this is some documentation that you had filled out related to a medical request?

A. Yes.

Q. And if I look down on this date, this is July 5, 2016?

A. Yes.

Q. And you have Ms. Null's primary diagnosis as depression, correct?

A. Yes.

Q. As far as the specific factors impacting her return to work, you mention pain in her foot, correct?

A. Yes.

Q. Depression?

A. Yes.

Q. The side effects of the medication?

A. Yes.

Q. And sleepiness?

A. Yes.

Q. And decrease in concentration?

A. Yes, decreased concentration, yes.

Q. And that the restrictions that she should have is limited hours at work?

A. Yes.

Q. And that you also indicate that she is limited by pain and the side effects from the medication?

A. Yes.

Q. As far as the estimate on when the patient can return to work, you don't believe she can return to work, you have, "Never" under "Without restrictions," correct?

A. Yes.

Dr. Pronko testified that he indicated that he believed Claimant needed ongoing therapy and he believed that was trying to be set up. (*Id.* at 53).

Dr. Pronko testified that when he gave treatment to Claimant and when he submitted his bill to the insurance company, there was indication that the work injury was the current cause of the necessity for treatment. (*Id.* at 55). He thought Claimant is going to need treatment for a long time. (*Id.* at 56). He stated she requires ongoing psychotherapy and medication to treat pain and depression. (*Id.* at 56).

Dr. Pronko was asked the following questions and gave the following answers at Pronko deposition, pages 57-58:

A. Yes.

Q. And you mention that these are not new symptoms, correct?

A. Yes.

Q. As far as a new symptom, her not working would have been a new symptom that happened post 12/24/2012, correct?

A. I don't know that not working is a symptom. I suppose it is of dysfunction.

Q. Or having the ability to work?

A. Right.

Q. And your knowledge from your treatment of her is that she was working full-time prior to that date, correct?

A. No, she was not working full-time.

Q. Prior to 12/24/2012?

A. 12/24, yes, she was.

Q. She was working on a full-time basis?

A. Yes.

Dr. Pronko did not have any information indicating Claimant was having a problem performing her job satisfactorily before December 24, 2012. (*Id.* at 58).

Dr. Pronko agreed that Claimant's hospitalization at Research Hospital in January 2012 was the only psychiatric hospitalization prior to December 24, 2012. He agreed her confusion and mental status changes cleared up after they took her off Viibryd or Ativan. (*Id.* at 61).

Dr. Pronko testified Claimant had been taking medication throughout her life, at different periods, "and whether she took them day after day or quit them for a time, I really don't know." (*Id.* at 62).

Dr. Pronko was asked the following question and gave the following answer at Pronko deposition, pages 66-67:

> Q. So it is possible that that's also going on here with Ms. Null, correct? The fact that she had serious injuries, she had to have treatment for it, three surgeries in all, plus a wound infection, lots of physical therapy, and then a spinal cord stimulator implanted, certainly that would cause her to have pain and possible depression, correct?
>
> A. Yes, could contribute to that, yes, absolutely.

Dr. Pronko was asked the following question and gave the following answer at Pronko deposition, page 71:

> Q. Okay. But it is your opinion that the December 24, 2012 injury to the left ankle did exacerbate and increase her pain and possibly any psychiatric problems that she may have had prior to that day, correct?
>
> A. I think it increased it, yes. But it is also another episode in her life of her response to a happening.

Dr. Pronko was asked the following question and gave the following answer at Pronko deposition, page 74:

Q. And Dr. Schmidt gave the opinion that it is the December 24, 2012 injury to the left ankle and the right knee which has significantly aggravated any prior psychiatric or psychological problems that Ms. Null has had. He said that's the prevailing factor, that December 24, 2012 injury is the prevailing factor in the exacerbation of any prior psychological or pain complaints she has had. You don't have any reason to disagree with that, do you?

A. No. I think it did exacerbate things.

Dr. Pronko's April 1, 2017 report states in part:

She needs to use her spinal cord stimulator.

. . . . . .

I have reviewed Dr. Anne Rosenthal's report of March 31, 2017. Dr. Rosenthal's thorough, detailed report evaluating Cynthia Null concludes she has Somatic Symptom Disorder. A decades long history of chronic pain and pre-existing psychological conditions combine with her last injury to result in greater disability. Dr. Rosenthal's report substantiates and confirms my conclusions.

Dr. Koprivica's examination and written report concludes longstanding psychological difficulties best diagnosed as Somatic Symptom Disorder and Major Depressive Disorder. This supports and substantiates the same conclusions reached in my March 20, 2017 evaluation and review of medical records of Cynthia Null. She is in need of psychotherapy and medication to alleviate her symptomatology. Psychotherapy is needed to help her find other ways of resolving her problems through expression of feelings rather than limiting herself to physical presentations of her internal psychic distress.

. . . . . .

These conclusions have been reached with a reasonable degree of medical certainty.

Dr. Pronko's March 20, 2017 report states in part:

> After this ankle injury she had increased difficulty working due to side effects of pain medication that she took for relief and somatic problems. It does seem at the present time from her most recent hospitalization March 2014 at North Kansas City Hospital that Ms. Null is totally disabled at this time. With ongoing therapy and medication, she could resolve some of the issues that have hampered her and caused her difficulties throughout her life. This last injury alone would not have caused her permanent total disability if not for her preexisting psychiatric overlay.
>
> . . . . . .
>
> Cynthia Null's psychiatric history and psychiatric overlay have always had the potential to combine with a work related injury to cause a greater degree of disability than would have resulted without it. Ms. Null's psychiatric history up to the time of her work related fracture of her ankle did not preclude her from working but did present a hindrance or obstacle to her employments.
>
> . . . . . .
>
> From the 4th Edition AMA guide to Evaluation of Permanent Impairment.
>
> Cynthia Null has a class 3 to class 4 psychiatric impairment.
>
> . . . . . .
>
> These conclusions have been reached with a reasonable degree of medical certainty.

Dr. Pronko's April 1, 2017 report states in part:

> She [Claimant] is in need of psychotherapy and medication to relieve her symptomology.

Prior Treatment Records

The medical treatment records in evidence record Claimant had numerous doctor visits before her December 24, 2102 injury. She was also hospitalized before December 24, 2102. These records note Claimant complained of pain on numerous occasions and received medications for pain. She was diagnosed with and treated for fibromyalgia and

depression before December 24, 2012. Some notable entries in the records, in addition to those discussed earlier in this Award relating to Claimant's deposition, are discussed below.

Exhibit U contains records of Mayo Clinic. The records note that Claimant was admitted there on February 1, 1993 and was discharged on February 4, 1993. The General History notes that Claimant was evaluated for long standing myofascial-like chronic pain. The record notes her discomfort primarily involved a dorsal back area and dorsal lumbar junction area and was quite intermittent. Medications included Lodine, Zoloft, and Equajesic." The record notes in part: "I believe this borders on chronic pain disorder."

Exhibit 1 contains records from Northwest Medical Center, Albany, Missouri. A Northwest Medical Center Consultation Note dated March 7, 2007 states that Claimant had been noticing severe headaches for a long time. The note records Clonazepam medication every night for six months for sleep.

An Emergency Room Note of Northwest Medical Center dated September 7, 2009 notes Claimant's chief complaint was back pain. The records note she had a history of fibromyalgia, chronic low back pain, and noninsulin-dependent diabetes mellitus. The record notes medications of Gemfibrozil, Prozac, Lyrica, Synthroid, Soma, Avandamet, and Nexium. The Clinical Impression notes a history of fibromyalgia, gastroesophageal reflux disease, depression, Dyslipidemia, and noninsulin-dependent diabetes mellitus.

The Northwest Medical Center records include a Discharge Summary dated December 29, 2009. The final diagnosis was intractable migraine headache, exacerbation of back pain, anemia, a chronic disease, history of fibromyalgia, depression, noninsulin-dependent diabetes mellitus, gastroesophageal reflux disease and dyslipidemia. Home medications included Prozac, Lyrica, Percocet for pain, ibuprofen, and Diazepam for insomnia.

Exhibit V contains records of Research Psychiatric Center. The Discharge Summary notes Claimant was admitted on December 17, 2011 and discharged December 20, 2011. The record notes the Reason for Admission was: "Mental status changes and depression."

Dr. Wade Hachinsky's Psych Report dated December 19, 2011 in Exhibit V notes Claimant had been struggling with some depression and anxiety for some period of time and had been on Viibryd for about three months. The record notes she was prescribed some Clonazepam by her primary care doctor. The record states in part: "In any case, she took those and had what appears to be a reaction to that medication. She experienced confusion, slurring of her speech, ataxia, and she had amnesia for the day." The record

notes work-up was negative and states that Claimant does not feel like she needs to be in the hospital. The record notes that CA Scan is negative and the drug scene was negative.

The Discharge Summary notes Claimant had received a dose of Clonazepam, "which was relatively high dose given her nativity to Benzodiazepines as well as lack of other substance abuse." The record notes she experienced side effects of confusion, slurring speech, ataxia, and some amnesia. Dr. Hachinsky stopped Claimant's Viibryd and started her on Cymbalta. She was discharged to home in improved condition without suicidal or homicidal thoughts on December 22, 2011. The Discharge Diagnosis was:

AXIS I:
1. Depressant disorder, not otherwise specified.
2. Anxiety disorder, not otherwise specified.
3. Status post Benzodiazepine intoxication.

AXIS II: None.

AXIS III:
1. Hypothyroidism.
2. Diabetes Mellitus.
3. History of uterine cancer.
4. Hypertension.

A Northwest Medical Center record dated September 17, 2012 notes Claimant had pain in the right side of her abdomen. An Emergency Room Note dated April 29, 2012 reports Claimant came to the emergency room with severe headache and severe lower back pain. She was given Demerol, Vistaril IM, and Toradol, and was given a prescription for Percocet.

Medical Evaluations

Dr. P. Brent Koprivica

Dr. P. Brent Koprivica evaluated Claimant on October 3, 2015 at the request of Claimant's attorney. He reviewed records, took a history, and performed an examination of Claimant.

Dr. Koprivica's October 3, 2015 report, Exhibit A, states in part, beginning at page 29:

> Ms. Null continues to have overwhelming hindfoot [*sic*] pain.
> Clinically, I believe there is a neurogenic component to that ongoing

pain, although I would not diagnosis a regional pain syndrome with the data that is available. Ms. Null has certainly not progressed to the atrophic phase of complex regional pain syndrome, despite the duration of time since the injury.

I do believe there are likely psychological factors involved in the overall disability presentation regarding this chronic pain. Those issues would be best addressed by a mental health care expert.

A consideration would be one of a possible somatic symptom disorder as part of the presentation along with separate mood disorder.

The mental health care expert will need to address whether or not apportionment of disability is appropriate psychologically as well in looking at the overall disability from the primary injury on December 24, 2012, in isolation, and separate from the synergism of combining the pre-existent disabilities.

.....

4. I would consider Ms. Null to be at maximal medical improvement regarding the primary injury claim sustained on December 24, 2012.

. . . . . .

7. Clinically, I believe a multi-disciplinary approach to chronic pain management is warranted in this presentation.

I would also point out that Ms. Null needs appropriate monitoring of her spinal cord stimulator in particular.

The need to replace the power pack is something that would be expected in the future.

. . . . . .

Ms. Null needs to use her spinal cord stimulator. Historically, she is using it 90 percent of the time.

Dr. Koprivica stated if it is deemed Claimant is employable by a vocational expert, he would apportion a "seventy-five (75%) permanent partial disability of the left lower extremity above the ankle (155 week level) as representing the disability based on the residuals involving the left lower extremity, including chronic pain issues and the need for spinal cord stimulator placement." He would also apportion a twenty (20%) permanent partial disability at the level of the right lower extremity of the knee (160 week level), which is a forty (40%) permanent partial disability to the body as a whole for the primary injury of December 24, 2102, separate from any considerations for psychological/psychiatric impairment and resultant disability.

Dr. Koprivica also assigned a fifteen (15%) percent permanent partial disability to the body as a whole for Claimant's fibromyalgia at the time of the December 24, 2012 work injury.

Dr. Anne Rosenthal, M.D.

The deposition of Dr. Anne Rosenthal taken on April 13, 2017 was admitted in evidence as Exhibit 3. Dr. Rosenthal identified her March 31, 2017 report pertaining to her evaluation of Claimant, Deposition Exhibit 2.

Dr. Rosenthal testified she did not see anybody who gave Claimant a diagnosis of complex regional pain syndrome. (Rosenthal deposition, page 10).

Dr. Rosenthal noted Claimant's present symptoms were: "She talked about extreme pain, depression, confusion, inability to sleep. She said her left foot and ankle has the worst pain. She complained of back pain and she said the spinal cord stimulator zaps and hurts her back when it is on." Dr. Rosenthal testified Claimant's complaints of confusion, fibromyalgia, headaches, major depression, blackouts, and thyroiditis all pre-dated her work related injury. (*Id.* at 12).

Dr. Rosenthal noted that Claimant was on pain medicines, including Dilaudid, Meloxicam, Gabapentin, Trazodone for sleep, Clonazepam, Cymbalta, and Fentanyl patches. (*Id.* at 13). She noted Claimant was on Cymbalta, Lortab, Diclofenac, ibuprofen and Abilify, four of which are pain medicines, on June 15, 2011. (*Id.* at 16).

Dr. Rosenthal testified that Claimant did not get complex regional pain syndrome for this injury. (*Id.* at 25).

Dr. Rosenthal was asked the following question and gave the following answer at Rosenthal deposition, page 26:

Q. All right. And why is that important:

> A. Because she had the spinal cord stimulator not for complex regional pain syndrome, but she had it for the preexisting chronic pain syndrome. And so what I stated, in fact - - it would just be easier for me to read it, that while she did undergo a spinal cord stimulator placement for her left foot and ankle pain, if she did not have the preexisting chronic pain syndrome, she would not have ended up with a spinal cord stimulator. She has taken pain medications for years and but for this history of chronic pain and somatization disorder, her physicians would have been able to control her pain with pain medication for a finite period of time after her injury and surgeries and she would have not needed long-term pain management modalities.

Dr. Rosenthal testified that she gave Claimant a 25% at the 155-week level rating of the left upper extremity for the ankle injury and also stated in her report: "Please note that she has chronic pain in a somatization disorder and this has an impact on her symptomatology and her perception of disability, and I have not apportioned a rating due to that condition." Dr. Rosenthal deferred talking about Claimant's psychological overlay to the psychiatrist, Dr. Pronko, and the psychologist, Dr. Schmidt. (*Id.* at 29-30). She testified her opinions and her reports and her testimony had been given with a reasonable degree of medical certainty. (*Id.* at 36).

Dr. Rosenthal testified that she thought Claimant had chronic pain forever. She testified, "I don't think she has additional chronic pain because of this injury." (*Id.* at 68).

Dr. Rosenthal agreed that Claimant was not on Dilaudid before the work injury. (*Id.* at 69).

Dr. Rosenthal agrees that Claimant had increased pain and major depression following this December 24, 2012 injury. (*Id.* at 70). Dr. Rosenthal agreed Claimant was not taking Fentanyl patches or Gabapentin before December 24, 2012. (*Id.* at 75).

Dr. Rosenthal's March 31, 2017 report states Claimant's permanent partial disability for the December 24, 2012 injury is 25% as the 155 week level of the left lower extremity for the ankle injury and 10% at the 160 week level of the right lower extremity for the right knee injury. Dr. Rosenthal notes Claimant has chronic pain and somatization disorder that has an impact on her symptomatology and her perception of her disability, and she has not apportioned a rating due to that condition.

Dr. Rosenthal's March 31, 2017 report states in part:

> Ms. Null's pre-existing psychological conditions, as diagnosed by Dr. Schmidt and Dr. Pronko, had the potential to combine with the last injury to result in more permanency. Her decades long history of chronic pain and her psychological diagnoses have made her much worse. She has been on medication for decades for chronic pain and chronic pain history. Please note that Ms. Null may need psychiatric treatment, but even with combining her pre-existing conditions with the 12/24/12 injury, she can work at least a five to six hour day.
>
> . . . . . .
>
> Her somatic symptom disorder and her anxiety and depression combine with her chronic pain disorder/fibromyalgia. . . .

Evaluation of Dr. Allan Schmidt, PhD

The deposition of Dr. Allan Schmidt, PhD, taken on September 15, 2016 was admitted in evidence as Exhibit C. Dr. Schmidt evaluated Claimant on February 3, 2016. Approximately one-third of his practice is spent evaluating individuals in workers' compensation or personal injury cases. (Schmidt deposition, page 6).

Dr. Schmidt was aware of Claimant's past medical history before December 24, 2012 injury. Claimant had described bouts of depression, a history of being abducted at gunpoint, raped, after which she did not get any treatment. He noted she has a history of being diagnosed with fibromyalgia in approximately 1995, reported taking antidepressants on and off, and had seen a counselor a couple of times approximately 15 years ago. (*Id.* at 8).

Dr. Schmidt diagnosed Claimant with major depressive disorder, recurrent, and a pain disorder associated with both psychological factors and a general medical condition. (*Id.* at 11). Dr. Schmidt testified he cannot determine if Claimant had a pain disorder before December 2012. He testified, "She certainly has - - has developed it since then, and this is a disorder that is a focus on pain. It is a psychological condition." (*Id.* at 11). He noted that the pain disorder in this particular case indicates Claimant does have some medical problems that would produce pain and that she manifests these pain problems and experiences to a much higher degree than the average individual. (*Id.* at 12). Dr. Schmidt did not believe was malingering. He believes she was experiencing the problems as she presented them. (*Id.* at 14).

Dr. Schmidt testified that the injury of December 24, 2012 was the prevailing factor in causing the aggravation of Claimant's major depression disorder and in causing the chronic pain disorder. He testified that the pain management program for Claimant

would be caused by the December 24, 2012 injury. (*Id.* at 40). He testified the aggravation that was caused by the December 24, 2012 injury of Claimant's psychological condition and the need for treatment is due to the December 24, 2012 injury. (*Id.* at 41).

Dr. Schmidt agreed that Claimant was not taking Trazodone, Nortriptyline, Neurontin, Dilaudid, and Morphine Sulfate prior to the December 24, 2012 injury. (*Id.* at 33). He understood that she had two major surgeries to her ankle and one surgery to her knee and that she complained of a stabbing and aching pain due to her foot/ankle trauma and some due to fibromyalgia, and as far as he knew, she was not taking those narcotic pain medications before the work injury. But as far as he knew, that is what she reported as a result of the injury. He was aware she has a pain implant stimulator and she did not have that before the work injury. (*Id.* at 35).

Dr. Schmidt's psychological evaluation report dated February 10, 2016, Schmidt Deposition, Exhibit 2, notes he evaluated Claimant between 10:00 o'clock a.m. and 2:00 o'clock p.m. on February 3, 2016. The interview took approximately one and one-half hours and the remainder of that time was for completing questionnaires and tests. Dr. Schmidt's report sets forth the treatment records he reviewed, and also notes the record of Dr. Brent Koprivica. The report describes Claimant's medical history. Claimant had described her pain as "excruciating."

Dr. Schmidt's report sets forth Claimant's psychiatric history, family social history, current function, test results and conclusions. The report states in part: "She is highly focused on her pain. She reports that 'most of my pain is stabbing and aching, some is due to foot and ankle trauma, and some is due to fibromyalgia.' She described her pain level as being an 8 on a scale of 0 to 10 at the time of the evaluation. She has an implanted stimulator which she believes helps but does not take away all of her pain."

Dr. Schmidt's February 10, 2016 report states in part:

> **Conclusions:** There is evidence of significant pre-existing psychological problems for Ms. Null. She was abducted at gunpoint and raped as a teenager. She was encouraged to write bad checks as a teenager. She reports having no sense of security as a child and teen. She reports feeling inadequate and unsupported as a child. She has had episodes of depression as an adult that have interfered with her ability to work at times. She has had unusual physical reactions that include being unable to walk and have her "body shut down" as well as an incident of acting bizarrely which was attributed to her thyroid condition.

Her injury, and the resulting physical limitations she experienced, was the prevailing factor in the aggravation of her pre-existing psychological condition. As a result of this injury she has become significantly more depressed and has developed a pain disorder.

She should continue with consultation with her psychiatrist quarterly for the next 2 years and will likely need psychiatric medication indefinitely. The psychiatric treatment that she has had to date has been reasonable. She should be treated by a therapist who is experienced in dealing with complicated pain disorders. This therapy should be weekly for 4 months. She would benefit from a behaviorally-based pain management program that would include participation of family members. Psychiatric care would be approximately $175 per visit, while counseling would be $150 per visit.

Her need for these services is the direct result of her injury and the significant aggravation of her pre-existing psychological condition. It is unlikely that Ms. Null would be able to function full time in the workplace when considering the combined effect of her physical and psychological condition.

. . . . . .

Using AMA Guidelines Edition 2 as a reference, combined with my education, training and experience, it is my opinion that Ms Null has a current total psychological disability rating of 25%, a psychological disability rating of 15% prior to her injury, and a 10% psychological disability rating as a result of her injury.

All conclusions contained in this report were reached using the materials provided by Ms. Dickson., [*sic*] my interview and testing of Ms. Null, my education and experience. These conclusions have been reached with a reasonable degree of psychological certainty.

Diagnostic Impression: (Both DSM IV and DSM V are reported below)
DSM IV

Axis I: Major depressive disorder, recurrent Pain disorder associated with both psychological factors and a general medical condition.

. . . . . .

Rulings of Law

Based on the substantial and competent evidence, the stipulations of the parties, and the application of the Workers' Compensation Law, I make the following Rulings of Law:

1. What is Employer's liability, if any, for additional medical aid, and does Claimant currently need medical treatment to cure or relieve her of the effects of her December 24, 2012 injury?

Claimant requests an award of additional medical aid.

Section 287.800, RSMo[2] provides in part that administrative law judges shall construe the provisions of this chapter strictly and shall weigh the evidence impartially without giving the benefit of the doubt to any party when weighing evidence and resolving factual conflicts.

Section 287.808, RSMo provides:

> The burden of establishing any affirmative defense is on the employer. The burden of proving an entitlement to compensation under this chapter is on the employee or dependent. In asserting any claim or defense based on a factual proposition, the party asserting such claim or defense must establish that such proposition is more likely to be true than not true.

Section 287.020.2, RSMo provides:

> The word 'accident' as used in this chapter shall mean an unexpected traumatic event or unusual strain identifiable by time and place of occurrence and producing at the time objective symptoms of an injury caused by a specific event during a single work shift. An injury is not compensable because work was a triggering or precipitating factor.

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[2] All statutory references are to RSMo 2006 unless otherwise indicated. In a workers' compensation case, the statute in effect at the time of the injury is generally the applicable version. *Chouteau v. Netco Construction,* 132 S.W.3d 328, 336 (Mo.App. 2004); *Tillman v. Cam's Trucking Inc.*, 20 S.W.3d 579, 585-86 (Mo.App. 2000). *See also Lawson v. Ford Motor Co.,* 217 S.W.3d 345 (Mo.App. 2007).

Section 287.020.3, RSMo provides in part:

> 3. (1) In this chapter the term 'injury' is hereby defined to be an injury which has arisen out of and in the course of employment. An injury by accident is compensable only if the accident was the prevailing factor in causing both the resulting medical condition and disability. 'The prevailing factor' is defined to be the primary factor, in relation to any other factor, causing both the resulting medical condition and disability.
> (2) An injury shall be deemed to arise out of and in the course of the employment only if:
> (a) It is reasonably apparent, upon consideration of all the circumstances, that the accident is the prevailing factor in causing the injury; and
> (b) It does not come from a hazard or risk unrelated to the employment to which workers would have been equally exposed outside of and unrelated to the employment in normal nonemployment life.
> (3) An injury resulting directly or indirectly from idiopathic causes is not compensable.
>
> (5) The terms 'injury' and 'personal injuries' shall mean violence to the physical structure of the body. . . .

Section 287.030.2, RSMo provides: "Any reference to the employer shall also include his or her insurer or group insurer."

The workers' compensation claimant bears the burden of proof to show that her injury was compensable in workers' compensation. *Johme v. St. John's Mercy Healthcare*, --- S.W.3d ----, 2012 WL 1931223 (Mo.) *(citing Sanderson v. Producers Comm'n Ass'n,* 360 Mo. 571, 229 S.W.2d 563, 566 (Mo. 1950).

"In a workers' compensation case, the claimant carries the burden of proving all essential elements of the claim." *Fischer v. Archdiocese of St. Louis*, 793 S.W.2d 195, 198 (Mo.App. 1990), *overruled in part on other grounds by Hampton v. Big Boy Steel Erection,* 121 S.W.3d 220, 230 (Mo.banc 2003)[3]. The employee must establish a causal connection between the accident and the claimed injuries. *Thorsen v. Sachs Elec. Co.,* 52

[3]Several cases are cited herein that were among many overruled by *Hampton* on an unrelated issue (*Id.* at 224-32). Such cases do not otherwise conflict with *Hampton* and are cited for legal principles unaffected thereby; thus *Hampton*'s effect thereon will not be further noted.

S.W.3d 616, 618 (Mo.App.2001); *Williams v. DePaul Ctr,* 996 S.W.2d 619, 625 (Mo.App. 1999); *Decker v. Square D Co.*, 974 S.W.2d 667, 670 (Mo.App. 1998); *Fischer*, 793 S.W.2d at 198.

The testimony of Claimant or other lay witnesses as to facts within the realm of lay understanding can constitute substantial evidence of the nature, cause, and extent of disability when taken in connection with or where supported by some medical evidence. *Pruteanu v. Electro Core, Inc.*, 847 S.W.2d 203, 206 (Mo.App. 1993), 29; *Reiner v. Treasurer of State of Mo.*, 837 S.W.2d 363, 367 (Mo.App 1992); *Fischer*, 793 S.W.2d at 199. The trier of facts may also disbelieve the testimony of a witness even if no contradictory or impeaching testimony appears. *Hutchinson, 721 S.W.2d* at 161-2; *Barrett v. Bentzinger Brothers, Inc.*, 595 S.W.2d 441, 443 (Mo.App. 1980). The testimony of the employee may be believed or disbelieved even if uncontradicted. *Weeks v. Maple Lawn Nursing Home*, 848 S.W.2d 515, 516 (Mo.App. 1993).

The Court in *Silman v. William Montgomery & Assocs.*, 891 S.W.2d 173 (Mo. App. 1995) stated at 175-76:

> The testimony of a claimant or other lay witness can constitute substantial evidence of the nature, cause, and extent of disability when the facts fall within the realm of lay understanding. However, an injury may be of such a nature that expert opinion is essential to show that it was caused by the accident to which it is ascribed. Where the condition presented is a sophisticated injury that requires surgical intervention or other highly scientific technique for diagnosis, and particularly where there is a serious question of pre-existing disability and its extent, the proof of causation is not within the realm of lay understanding nor--in the absence of expert opinion--is the finding of causation within the competency of the administrative tribunal. (citations omitted)

Where there are conflicting medical opinions, the fact finder may reject all or part of one party's expert testimony which it does not consider credible and accept as true the contrary testimony given by the other litigant's expert. *Kelley v. Banta & Stude Constr. Co. Inc.*, 1 S.W.3d 43, 48 (Mo.App. 1999); *Webber v. Chrysler Corp.*, 826 S.W.2d 51, 54 (Mo.App. 1992)), *overruled on other grounds by Hampton v. Big Boy Steel Erection,* 121 S.W.3d 220, 229 (Mo. banc 2003); *Hutchinson v. Tri-State Motor Transit Co.*, 721 S.W.2d 158, 162 (Mo.App. 1986). The Commission's decision will generally be upheld if it is consistent with either of two conflicting medical opinions. *Smith v. Donco Const.*, 182 S.W.3d 693, 701 (Mo.App. 2006). The acceptance or rejection of medical evidence is for the Commission. *Smith,* 182 S.W.3d at 701; *Bowers v. Hiland Dairy Co.*, 132 S.W.3d 260, 263 (Mo.App. 2004).

The Commission may not arbitrarily disregard and ignore competent, substantial, and undisputed evidence of witnesses who are not shown by the record to have been impeached and the Commission may not base its findings upon conjecture or its own mere personal opinion unsupported by sufficient and competent evidence. *Cardwell v. Treasurer of State of Missouri,* 249 S.W.3d 902, 907 (Mo.App. 2008), citing *Copeland v. Thurman Stout, Inc.,* 204 S.W.3d 737, 743 (Mo.App. 2006).

The Court in *Knipp vs. Nordyne, Inc.*, 969 S.W.2d 236 (Mo.App 1998), states at 239:

> Mrs. Knipp is correct that expert medical testimony is not necessary to establish the cause of an injury if causation is a matter within the understanding of lay persons. *Quilty v. Frank's Food Mart*, 890 S.W.2d 360, 364 (Mo.App.1994). If medical causation is not within common knowledge or experience, however, then:
>
> > an injury may be of such a nature that expert opinion is essential to show that it was caused by the accident to which it is ascribed. When the condition presented is a sophisticated injury that requires surgical intervention or other highly scientific technique for diagnosis, and particularly where there is a serious question of pre-existing disability and its extent, the proof of causation is not within the realm of lay understanding nor—in the absence of expert opinion—is the finding of causation within the competency of the administrative tribunal.
>
> *Silman v. William Montgomery & Assoc.*, 891 S.W.2d 173, 175–76 (Mo.App.1995) (citations omitted). *See also Brundige v. Boehringer Ingelheim*, 812 S.W.2d 200, 202 (Mo.App.1991).

Mental and psychological injuries can be compensable under Missouri Law. *Tibbs v. Rowe Furniture Corp.,* 691 S.W.2d 410 (Mo.App. 1985). *See also Higgins v. The Quaker Oats Co.*, 183 S.W.3d 264 (Mo.App. 2005); *Bloss v. Plastic Enterprises*, 32 S.W.3d 666 (Mo.App. 2000); *Fischer v. Montgomery County,* (Missouri LIRC June 15, 2010, Injury No.: 04-052344).

The Court states in *Tibbs,* 691 S.W.2d at 412-13:

> Mental conditions are compensable under the Worker's Compensation Law provided they are shown to have been directly and proximately

> caused by the accident. *Wilhite v. Hurd,* 411 S.W.2d 72, 78 (Mo.1967).

Section 287.140, RSMo requires that the employer/insurer provide "such medical, surgical, chiropractic, and hospital treatment ... as may reasonably be required ... to cure and relieve [the employee] from the effects of the injury." This has been held to mean that the worker is entitled to treatment that gives comfort or relieves even though restoration to soundness [a cure] is beyond avail. *Greer v. SYSCO Food Servs.,* 475 S.W.3d 655, 2015 WL 8242710 (Mo. banc 2015); *Bowers v. Hiland Dairy Co.*, 132 S.W.3d 260, 266 (Mo.App. 2004). Medical aid is a component of the compensation due an injured worker under Section 287.140.1, RSMo. *Bowers,* 132 S.W.3d at 266; *Mathia v. Contract Freighters, Inc.*, 929 S.W.2d 271, 277 (Mo.App. 1996). The employee must prove beyond speculation and by competent and substantial evidence that his or her work related injury is in need of treatment. *Williams v. A.B. Chance Co.*, 676 S.W.2d 1 (Mo.App. 1984). Conclusive evidence is not required. *Farmer v. Advanced Circuitry Division of Litton*, 257 S.W.3d 192, 197 (Mo. App. 2008); *Bowers*, 132 S.W.3d at 270; *Landers v. Chrysler Corp.*, 963 S.W.2d 275, 283 (Mo.App. 1997).

The Missouri Supreme Court in *Greer,* -- S.W.3d --, 2015 WL 8242710 states:

> Greer need not present "conclusive evidence" that future medical treatment is needed to be entitled to an award of future medical benefits. *Null v. New Haven Care Ctr., Inc.*, 425 S.W.3d 172, 180 (Mo.App.E.D.2014). Instead, Greer needs only to show a reasonable probability that the future treatment is necessary because of his work-related injury. Id. Future medical care should not be denied simply because an employee may have achieved maximum medical improvement. *Pennewell v. Hannibal Reg'l Hosp.*, 390 S.W.3d 919, 926 (Mo.App.E.D.2013).

It is sufficient if Claimant shows by reasonable probability that he or she is in need of additional medical treatment. *Tillotson v. St. Joseph Medical Center*, 347 S.W.3d 511, 524 (Mo.App. 2011); *Farmer*, 257 S.W.3d at 197; *ABB Power T & D Co. v. Kempker*, 236 S.W.3d 43, 53 (Mo. App. 2007); *Bowers*, 132 S.W.3d at 270; *Mathia*, 929 S.W.2d at 277; *Downing v. Willamette Industries, Inc.,* 895 S.W.2d 650, 655 (Mo.App. 1995); *Sifferman v. Sears, Roebuck and Co.*, 906 S.W.2d 823, 828 (Mo.App. 1995). "Probable means founded on reason and experience which inclines the mind to believe but leaves room to doubt." *Tate v. Southwestern Bell Telephone Co.,* 715 S.W.2d 326, 329 (Mo.App. 1986); *Sifferman* at 828. Section 287.140.1, RSMo does not require that the medical evidence identify particular procedures or treatments to be performed or administered. *Tillotson,* 347 S.W.3d 525*; Forshee v. Landmark Excavating & Equipment*, 165 S.W.3d 533, 538 (Mo. App. 2005); *Talley v. Runny Meade Estates, Ltd.*,

831 S.W.2d 692, 695 (Mo.App. 1992); *Bradshaw v. Brown Shoe Co.*, 660 S.W.2d 390, 394 (Mo.App. 1983).

The type of treatment authorized can be for relief from the effects of the injury even if the condition is not expected to improve. *Farmer*, 257 S.W.3d at 197; *Bowers*, 132 S.W.3d at 266; *Landman v. Ice Cream Specialties, Inc.*, 107 S.W.3d 240, 248 (Mo.banc 2003). Future medical care must flow from the accident, via evidence of a medical causal relationship between the condition and the compensable injury, if the employer is to be held responsible. *Bowers v. Hiland Dairy Co.*, 188 S.W.3d 79, 83 (Mo.App. 2006). Once it is determined that there has been a compensable accident, a claimant need only prove that the need for treatment and medication flow from the work injury. *Id; Tillotson*, 47 S.W.3d 519.

The court in *Tillotson* states at 347 S.W.3d 519:

> The existing case law at the time of the 2005 amendments to The Workers' Compensation Law instructs that in determining whether medical treatment is "reasonably required" to cure or relieve a compensable injury, it is immaterial that the treatment may have been required because of the complication of pre-existing conditions, or that the treatment will benefit both the compensable injury and a pre-existing condition. *Bowers v. Hiland Dairy Co.*, 188 S.W.3d 79, 83 (Mo.App. S.D.2006). Rather, once it is determined that there has been a compensable accident, a claimant need only prove that the need for treatment and medication flow from the work injury. *Id. The fact that the medication or treatment may also benefit a non-compensable or earlier injury or condition is irrelevant. Id. (Emphasis added).*

The court in *Tillotson* states at 347 S.W.3d 524:

> To receive an award of future medical benefits, a claimant need not show 'conclusive evidence' of a need for future medical treatment." *Stevens,* 244 S.W.3d at 237 (quoting *ABB Power T & D Co. v. Kempker,* 236 S.W.3d 43, 52 (Mo.App.W.D.2007)). "Instead, a claimant need only show a 'reasonable probability' that, because of her work-related injury, future medical treatment will be necessary. A claimant need not show evidence of the specific nature of the treatment required. *Id.*

The court in *Tillotson* also states at 525:

> In summary, we conclude that once the Commission found that Tillotson suffered a compensable injury, the Commission was required to award her compensation for medical care and treatment reasonably required to cure and relieve her compensable injury, and for the disabilities and future medical care naturally flowing from the reasonably required medical treatment.

8 CSR 50–2.010(14) states in part, "Prior to hearing, the parties shall stipulate uncontested facts and present evidence only on contested issues." Such stipulations "are controlling and conclusive, and the courts are bound to enforce them." *Hutson v. Treasurer of Missouri as Custodian of Second Injury Fund*, 2012 WL 1319428 (Mo.App. 2012) (*citing Boyer v. Nat'l Express Co.*, 29 S.W.3d 700, 705 (Mo.App. 2001)).

The evidence is undisputed that Claimant sustained an injury by accident on December 24, 2012 while working for Employer.

The parties stipulated that on or about December 24, 2012, Claimant sustained an injury by accident in Albany, Gentry County, Missouri, arising out of and in the course of her employment.

Claimant has had chronic left ankle pain since the accident. She developed depression and anxiety after the accident as a result of the chronic pain caused by the accident. The medical treatment records discussed previously in this Award describe Claimant's history of her December 24, 2012 injury and the treatment for the injury. The treatment records in evidence record ongoing treatment for her chronic pain and depression since the accident.

I find and conclude that on December 24, 2012, Claimant was injured when she slipped and fell in Employer's parking lot. I find and conclude that this was an unexpected traumatic event identifiable by time and place of occurrence and producing at the time objective symptoms of an injury caused by a specific event during a single work shift, and was an accident under the Workers' Compensation Law, section 287.020.2, RSMo. I find and conclude that on December 24, 2012 Claimant sustained a compensable left ankle injury and a psychological injury by accident arising out of and in the course of her employment for Employer and that the accident was the prevailing factor in causing both the left ankle injury and disability and a psychological injury and disability.

I find and conclude that Claimant's current chronic left lower extremity pain and depressive condition is medically causally related to the work accident of December 24, 2012.

I also find and conclude Claimant will need future chronic pain management, including monitoring and providing medications for Claimant's chronic pain, maintenance, repair, replacement and modification of Claimant's pain stimulator, psychological counseling, and medication for Claimant's depression and psychological injury in the future to treat her compensable physical and psychological injury.

Factors that support my conclusion that Claimant will need additional medical treatment to cure and relieve Claimant from the effects of her December 24, 2012 work injury include the following.

Claimant credibly described her symptoms and complaints since the December 24, 2012 work injury. She has had continuing and ongoing physical and psychological symptoms and complaints caused by her compensable work injury. The evidence demonstrates she has continued to receive treatment, and has continued to have prescriptions filled for her left ankle and psychological injury caused by the work accident. Her work injury is permanent. The evidence supports the conclusion that Claimant will continue to need treatment in the future to treat her work injury.

The treatment records and medical reports describe Claimant's ongoing severe left ankle pain and depression following the accident. Dr. Trease and Dr. Horton operated on Claimant's left ankle. Dr. Horton noted on February 11, 2014 that Claimant had burning, throbbing pain in her ankle that awakened her at night. He thought getting Claimant "plugged in with pain management would be reasonable to manage this." He noted she was taking Lyrica, and he encouraged to stay on it.

Dr. Koprivica, Dr. Rosenthal, and Dr. Schmidt have concluded Claimant sustained permanent partial disability as a result of her December 24, 2012 work injury, and I find that she did.

The evidence establishes that Claimant had treatment for depression and fibromyalgia prior to her work injury, and was taking medication for those conditions prior to her work injury. I agree with Dr. Pronko's opinion that Claimant's psychiatric history and psychiatric overlay have always had the potential to combine with a work related injury to cause a greater degree of disability than would have resulted without and presented a hindrance or obstacle to her employments. I agree with Dr. Koprivica that Claimant had permanent partial disability relating to her preexisting fibromyalgia at the time she sustained her December 24, 2012 work injury. I agree with Dr. Schmidt that

Claimant had permanent partial disability relating to her preexisting psychological condition at the time she sustained her December 24, 2012 work injury.

Nevertheless, Claimant was able to work full-time without restrictions before her work injury. She was not in counseling due to pain or depression. She was active and able to perform her activities of daily living. She did not have difficulty with sleep.

Claimant's condition significantly changed after her December 24, 2012 work injury. She has suffered very severe and debilitating left ankle pain that has resulted in her receiving pain management with Dr. Blacher and Dr. Hu. The medications that Claimant has been taking since the work injury are different from the medications that she took before the work injury. She has had a pain stimulator implanted and continues to treat with that. She has been prescribed and has taken a variety of opioid pain medications to treat her chronic pain and she continues to do so. The dosages of her medications have been monitored and changed from time to time. Her treating doctors have noted her pain has caused her to have depression and anxiety.

Dr. Blachar noted on March 6, 2014 that he believed Claimant had associated depression related to her chronic foot pain. Dr. Blachar noted on April 30, 2014 that Claimant was there that day to discuss her pain. She rated her pain "7/10, burning, sharp, throbbing pain." Dr. Blachar noted Claimant was then on chronic doses of OxyContin 40 mg every 12 hours as well as Dilaudid 4 mg three times daily as needed. Dr. Blachar's record notes that Claimant appeared "very emotional and quite distraught."

Dr. Blachar's April 30, 2014 record states:

> Her prognosis is guarded and is actually unknown. I do believe, however, that she will not improve if she does not get a handle on her emotional state and on the psychological factors which affect her physical condition. I believe she is quite depressed and anxious over the fact that she may have to live with severe chronic left lower extremity pain for the rest of her life. I have told this patient that she may have chronic pain forever, but I am hopeful that the chronic pain syndrome would be muted and tolerable going forward.

Dr. Blachar's April 30, 2014 record also states in part:

> 3. We are in the process of establishing a pain psychologist in our practice. I believe she would be an excellent candidate for this individual to see in order for coping skills and help, and for the pain psychologist to help Cindy live with her pain in a more reasonable fashion if possible.

> 4. In addition, I think she would be an appropriate candidate for referral to a psychiatrist for manipulation of antidepressants and possibly sleep medications, which are not habit forming. I will try to set her up with Dr. James Jura, who is an excellent psychiatrist in general.

I find these opinions of Dr. Blachar are credible.

Employer authorized a psychiatrist, Dr. Jura, to treat Claimant's depression resulting from her work injury. Claimant saw Dr. Jura on July 21, 2014. His record notes she continued to feel depressed and anxious. Dr. Jura assessed depression, major, severe recurrence and post-traumatic stress disorder. He prescribed Cymbalta and Trazadone.

Later, Employer authorized Dr. Pronko to treat Claimant's depression due to the work injury.

Dr. Hu, a Board Certified Physiatrist, has treated Claimant since 2014. He has monitored and prescribed pain medications. He has noted Claimant has continued to have left ankle pain and low back pain. On March 1, 2017, Dr. Hu increased Elavil and provided three scripts for Claimant's Fentanyl and Dilaudid.

Employer has paid for treatment provided by Dr. Blacher, Dr. Hu, Dr. Jura and Dr. Pronko. Employer's attorney stipulated at the hearing that Employer/Insurer had paid $281,070.75 in medical aid in this case as of the date of hearing.

Dr. Hill, a psychiatrist who treated Claimant at North Kansas City Hospital, noted Claimant needs ongoing psychiatric medication management and behavioral pain management. Dr. Hill wrote on March 8, 2017:

> . . . . . .
>
> The patient has been diagnosed with complex regional pain syndrome by an orthopedic physician as well as this being confirmed here at North Kansas City Hospital with Pain Management today.
>
> . . . . . .
>
> The patient has struggled significantly with depression following this accident.
>
> . . . . . .

In terms of mood symptoms, the patient states her life has been 'turned upside down' from this accident. She is depressed more days than not. She feels helpless, hopeless, worthless and useless.

. . . . . .

The pain in her left lower extremity obviously makes her anxiety and her depression worse.

. . . . . .

She does have what appears to be major depressive disorder and generalized anxiety disorder and pain disorder. The pain disorder is associated with her complex regional pain syndrome.

. . . . . .

IMPRESSION:

1. Somatic symptom disorder.
2. Generalized anxiety disorder.
3. Major depressive disorder, recurrent, moderate.
4. Complex regional pain syndrome.
5. Possible serotonin syndrome.
6. Hyponatremia.

RECOMMENDATIONS:

. . . . . .

The patient does need ongoing psychiatric medication management, and she especially needs behavioral pain management due to the devastating effect that her chronic regional pain syndrome has had on her life and quality of life. Behavioral pain management may help her at least adapt to this new level of dysfunction.

. . . . . .

There are multiple factors going on with this patient, the majority of these do stem from polypharmacy.

Dr. Hill noted on March 10, 2017:

> I did reinforce the fact that her EEG was normal at this point she does not appear to have any underlying seizure disorder.
>
> . . . . . .
>
> I did discuss with the patient and her husband at length behavioral pain management and there is a group in Liberty called the Center for Healing and Recovery, that is a psychotherapy group that deals with pain management, in terms of behavioral pain management, as well as helping the patient deal with the stress that this injury is [*sic*] caused her. The patient is very interested in getting this type of support as well.

Dr. Hill's March 13, 2017 Progress Note states in part:

> She is extremely interested in getting outpatient psychotherapy for her pain as well as her depression and anxiety. She also states that she is needing not only a therapist but a new psychiatrist as her last psychiatrist, Dr. Pronko, apparently is no longer going to see her as an outpatient. I indicated that she may need to coordinate this through her workers comp case manager.

I find these opinions of Dr. Hill are credible and persuasive. He is a treating psychiatrist. He was not retained by an attorney to evaluate Claimant.

Dr. Schmidt testified Claimant's pain disorder developed after the December 24, 2012 work injury indicates Claimant does have some medical problems that would produce pain and that she manifests these pain problems and experiences to a much higher degree than the average individual. Dr. Schmidt did not believe Claimant was malingering. I find these opinions of Dr. Schmidt are credible and persuasive.

Dr. Schmidt testified that the injury of December 24, 2012 was the prevailing factor in causing the aggravation of Claimant's major depression disorder and in causing the chronic pain disorder. He testified that the pain management program for Claimant would be caused by the December 24, 2012 injury. He testified the aggravation that was caused by the December 24, 2012 injury of Claimant's psychological condition and the need for treatment is due to the December 24, 2012 injury. I find these opinions of Dr. Schmidt are credible and persuasive.

Dr. Schmidt's September 10, 2016 report states in part:

> Her injury, and the resulting physical limitations she experienced, was the prevailing factor in the aggravation of her pre-existing psychological condition. As a result of this injury she has become significantly more depressed and has developed a pain disorder.
>
> She should continue with consultation with her psychiatrist quarterly for the next 2 years and will likely need psychiatric medication indefinitely. The psychiatric treatment that she has had to date has been reasonable. She should be treated by a therapist who is experienced in dealing with complicated pain disorders.

I find these opinions of Dr. Schmidt are credible and persuasive.

Dr. Koprivica evaluated Claimant in October 2015. He noted then that she continued to have overwhelming foot pain. He believed there were likely psychological factors involved in the overall disability presentation regarding this chronic pain and that those issues would be best addressed by a mental health care expert. He also believed a multi-disciplinary approach to chronic pain management was warranted. He also stated Claimant needs appropriate monitoring of her spinal cord stimulator and needs to use her spinal cord stimulator. He felt the need to replace the power pack is something that would be expected in the future. I find these opinions are credible and persuasive.

Dr. Pronko agreed with Dr. Rosenthal's statement, "I think she has had chronic pain forever. I don't think that she has additional chronic pain because of this injury." I find this opinion is not credible or persuasive.

Dr. Pronko testified that he agreed with Dr. Rosenthal's statement that for this injury, the left ankle and the right knee, Claimant would have had medication for a finite, a defined period of time, and it would have ended and she would not have needed long-term pain management modalities. I find this opinion is not credible or persuasive.

Dr. Pronko testified that Claimant requires medication to treat pain and depression, and "that's for her lifelong difficulties and problem that she has." I find this opinion is not credible or persuasive.

Dr. Pronko testified:

> Q. So the fact that she is currently taking pain medications and depression medications, what's the prevailing factor in taking those

medications now? Is it because of her preexisting, or because of the work-related injury?

A. It is primarily her preexisting lifelong dysfunction.

I find this opinion is not credible or persuasive.

Dr. Pronko diagnosed Claimant with major depression. Dr. Pronko believed Claimant needed ongoing therapy. Dr. Pronko thought the December 24, 2012 injury to the left ankle did increase her pain and possibly any psychiatric problems that she may have had prior to that day. I find these opinions are credible and persuasive.

Dr. Rosenthal testified, "She [Claimant] has taken pain medications for years and but for this history of chronic pain and somatization disorder, her physicians would have been able to control her pain with pain medication for a finite period of time after her injury and surgeries and she would have not needed long-term pain management modalities." I find this opinion is not credible or persuasive.

Dr. Rosenthal testified that she thought Claimant had chronic pain forever. She testified, "I don't think she has additional chronic pain because of this injury." I find these opinions are not credible or persuasive.

Dr. Rosenthal noted Claimant discussed extreme pain, depression, confusion, inability to sleep. She said her left foot and ankle has the worst pain. She complained of back pain and she said the spinal cord stimulator zaps and hurts her back when it is on." Dr. Rosenthal agreed that Claimant had increased pain and major depression following this December 24, 2012 injury.

Based on competent and substantial evidence and the application of the Missouri Workers' Compensation Law, I find and conclude that Claimant has offered persuasive evidence that she has a need for additional medical treatment that flows from the December 24, 2012 compensable work accident. I find and conclude that Claimant showed a reasonable probability that, because of her December 24, 2012 compensable work-related injury, additional medical treatment for her left ankle condition and psychological condition is necessary. I find and conclude that the treatment recommended by Dr. Hu, Dr. Hill, Dr. Koprivica, Dr. Schmidt, and Dr. Pronko will give relief to Claimant from the effects of the December 24, 2012 injury. I find and conclude that Claimant needs additional medical aid to cure and relieve her from the effects of her December 24, 2012 compensable injury.

I direct Employer to authorize and furnish additional medical treatment to cure and relieve Claimant from the effects of her December 24, 2012, in accordance with Section

287.140, RSMo., including chronic pain management, monitoring and providing medications for Claimant's chronic pain, maintenance, repair, replacement and modification of Claimant's pain stimulator, psychological counseling, and medication for Claimant's depression and psychological injury.

2. What is Employer's liability, if any, for past medical expenses?

Claimant requests an award for $41,407.64 for past medical expenses.

"Employee had the burden of proving his entitlement to benefits for care and treatment authorized by § 287.140.1, i.e., that which is reasonably required to cure and relieve from the effects of the work injury." *Bowers v. Hiland Dairy Co.*, 132 S.W.3d 260, 266 (Mo.App. 2004); *Rana v. Landstar TLC*, 46 S.W.3d 614, 622 (Mo.App. 2001). Meeting that burden requires that the past bills be causally related to the work injury. *Bowers*, 132 S.W.3d at 266; *Pemberton v. 3M Co.*, 992 S.W.2d 365, 368-69 (Mo.App. 1999).

The employee must prove that the medical care provided by the physician selected by the employee was reasonably necessary to cure and relieve the employee of the effects of the injury. *Chambliss v. Lutheran Medical Center*, 822 S.W.2d 926 (Mo.App. 1991); *Jones v. Jefferson City School District*, 801 S.W.2d 486, 490-91 (Mo.App. 1990); *Roberts v. Consumers Market*, 725 S.W.2d 652, 653 (Mo.App. 1987); *Brueggemann v. Permaneer Door Corporation*, 527 S.W.2d 718, 722 (Mo.App. 1975). The employee may establish the causal relationship through the testimony of a physician or through the medical records in evidence that relate to the services provided. *Martin v. Mid-America Farm Lines, Inc.*, 769 S.W.2d 105 (Mo. 1989); *Meyer v. Superior Insulating Tape*, 882 S.W.2d 735, 738 (Mo.App. 1994); *Lenzini v. Columbia Foods*, 829 S.W.2d 482, 484 (Mo.App. 1992); *Wood v. Dierbergs Market*, 843 S.W.2d 396, 399 (Mo.App. 1992).

The *Martin* court states at 769 S.W. 2d 111-12:

> In this case, Martin testified that her visits to the hospital and various doctors were the product of her fall. She further stated that the bills she received were the result of those visits. We believe that when such testimony accompanies the bills, which the employee identifies as being related to and the product of her injury, and when the bills relate to the professional services rendered as shown by the medical records in evidence, a sufficient factual basis exists for the commission to award compensation. The employer, of course, may challenge the reasonableness or fairness of these bills or may show that the medical expenses incurred were not related to the injury in question. In this age of soaring medical costs it no longer serves the purposes of the Act to

> assume that medical bills paid by an injured worker are presumed reasonable (because they were paid), while those which remain unpaid, very probably because of lack of means, must be proved reasonable and fair.

The medical bills in *Martin* were shown by the medical records in evidence to relate to the professional services rendered for treatment of the product of the employee's injury. *Martin*, 769 S.W.2d at 111.

The law in Missouri provides that while the employer has the right to name the treating physician, it waives that right by failing or neglecting to provide necessary medical aid to the injured worker. *Emert v. Ford Motor Co.*, 863 S.W.2d 629, 631 (Mo.App.1993); *Shores v. General Motors Corp.*, 842 S.W.2d 929, 931 (Mo.App.1992); *Herring v. Yellow Freight System, Inc.*, 914 S.W.2d 816, 822 (Mo.App. 1995); *Hawkins v. Emerson Elec. Co.*, 676 S.W.2d 872, 879 (Mo.App. 1984). The Court in *Shores* stated at 931-932:

> The case law under §287.140(1) establishes the employer's right to provide medical treatment of its choice, however, this right is waived when the employer fails to provide necessary medical treatment after receiving notice of an injury. *Wiedower v. ACF Indus., Inc.*, 657 S.W.2d 71, 74 (Mo.App.1983). 'Where the employer with notice of an injury refuses or neglects to provide necessary medical care, the [claimant] may make his own selection and have the cost assessed against the employer.' *Id.*
>
> In the present case, there is substantial evidence which supports a finding that employer had notice of claimant's injuries and refused to provide medical treatment. On the day she was injured, and thereafter whenever the pain made it difficult to work, claimant reported to the plant dispensary to receive medical aid. At some point, a nurse at the dispensary informed claimant that she was no longer welcome and should consult her own doctor for further treatment.

An employer may be liable for payment of necessary medical services selected by the employee with an opportunity and without prior notice by the employee to the employer in emergency situations. *Farmer-Cummings v. Future Foam, Inc.*, 44 S.W.3d 830 (Mo.App. W.D.2001). *See Roberts v. Consumers Market*, 725 S.W.2d 652 (Mo.App. S.D.1987) and *Schutz v. Great American Insurance Co.*, 231 Mo.App. 640, 103 S.W.2d 904 (1937).

The Court in *Farmer-Cummings,* 44 S.W.3d states at 837:

> Moreover, a significant portion of Ms. Cummings medical bills incurred after January 1993, were also a result of her continued need for emergency medical treatment, and thus it would not have been possible for Personnel Pool to select the health care provider.

The Court in *Sheehan v. Springfield Seed and Floral, Inc.,* 733 S.W.2d 795 (Mo.App. 1987) states at 798:

> In general, only when an employer has notice that a claimant needs treatment or demand is made on the employer to furnish medical treatment and he neglects to provide needed treatment, will the employer be held liable for medical treatment for the employee. *Hawkins v. Emerson Electric Co.,* 676 S.W.2d 872, 880 (Mo.App.1984).
>
> [4] [5] [6] Implicit in the above rule is knowledge by the employee that he has suffered a job related disability. Where an employee does not know at the time that he or she receives medical treatment that he or she has suffered a compensable injury, and the employee contracts for medical services without the employer's knowledge, the employer is not relieved from liability for necessary medical services. *Beatty v. Chandeysson Electric Co.,* 238 Mo.App. 868, 190 S.W.2d 648, 656 (1945).

The court in *Farmer-Cummings v. Personnel Pool of Platte County*, 110 S.W.3d 818 (Mo.banc 2003) states at 822:

> As previously noted, the aim of Missouri's workers' compensation law is to remedy the losses incurred by an employee as a result of a compensable injury. *Bethel,* 551 S.W.2d at 618. To award Ms. Farmer-Cummings compensation for medical expenses for which she has no liability would result in a windfall rather than compensation. On the other hand, to reduce Ms. Farmer-Cummings' award when she may still be held liable for those reduced amounts vitiates the policy behind workers' compensation-to place upon the shoulders of industry the burden of workplace injury. *See id.* Personnel Pool must reimburse Ms. Farmer-Cummings for all medical expenses incurred as a result of her workplace injury. Moreover, Personnel Pool should not receive an advantage for failing to timely pay medical bills incurred in such

> treatment at Ms. Farmer-Cummings' expense.
> Ms. Farmer-Cummings had the burden and has produced documentation detailing her past medical expenses and has testified to the relationship of such expenses to her compensable workplace injury. *See Martin v. Mid-America Farm Lines, Inc., 769 S.W.2d 105, 111-12 (Mo. banc 1989)*; *Esquivel v. Day's Inn,* 959 S.W.2d 486, 489 (Mo.App.1998). It is a defense of Personnel Pool, as employer, to establish that Ms. Farmer-Cummings was not required to pay the billed amounts, that her liability for the disputed amounts was extinguished, and that the reason that her liability was extinguished does not otherwise fall within the provisions of section 287.270. *See Martin, 769 S.W.2d at 112*; *Esquivel,* 959 S.W.2d at 489.

The medical records in evidence contain a history of Claimant's care and treatment relating to her December 24, 2012 injury, including her hospitalization at North Kansas City Hospital in March 2017.

Claimant was admitted to North Kansas City Hospital on March 6, 2017. Dr. Pothuloori's Discharge Summary dated March 13, 2017 notes:

> She presented to the office for routine follow-up regarding diabetes and hypothyroidism. She reported to me that she has "black out spells". She notes this has been occurring for an unknown amount of time but seems to be worsening and becoming more frequent. She states she does not know when they are going to occur. She tends to fall with these black out spells.
>
> . . . . . .
>
> During the walk from the exam room to the lab, within our office, the patient was ambulating with her cane and stated 'I'm going to pass out.' Her demeanor changed and she was staring into space, but did not have full syncope. She was helped into a chair. She was able to tell me this is what happens when she ends up in bed for several days.
>
> . . . . . .
>
> **Hospital Course**
> The patient was admitted with altered mental status. She underwent imaging of the head that did not reveal acute pathology. *It was eventually determined that the etiology of her altered mental status was polypharmacy.* The patient was initially seen by pain

management for her dependence on pain medication and it was recommended not to stop any pain medications and that she follow up with her pain specialist. (*Emphasis added*).

Dr. Hill, a psychiatrist who treated Claimant at North Kansas City Hospital, wrote on March 8, 2017:

Regardless, the patient has had multiple episodes of the above-mentioned syncope spells. The patient is on multiple medications, many of these medications may be interacting contributing to her symptoms. The patient has some depression and anxiety associated with her complex regional pain syndrome. Psychiatry was consulted for evaluation and treatment recommendations.

. . . . . .

She has been treated primarily by Pain Management doctor, Dr. Hu, who is retained by the workman's comp insurance company. She has been seeing Dr. Hu for several years as well. He apparently is prescribing many of her medications for pain. Although it does appear he is attempting to manage her pain symptoms, she still is struggling with a significant amount of pain in her lower extremity. The pain is in her left foot. She has had again surgery on her left foot. She has mild deformity of her left ankle joint as well. The patient has been diagnosed with complex regional pain syndrome by an orthopedic physician as well as this being confirmed here at North Kansas City Hospital with Pain Management today.

. . . . . .

She does have what appears to be major depressive disorder and generalized anxiety disorder and pain disorder. The pain disorder is associated with her complex regional pain syndrome.

. . . . . .

IMPRESSION:
1. Somatic symptom disorder.
2. Generalized anxiety disorder.
3. Major depressive disorder, recurrent, moderate.
4. Complex regional pain syndrome.

5. Possible serotonin syndrome.
6. Hyponatremia.

RECOMMENDATIONS: The patient at this point is having significant side effects it appears from all of her medications. She is on multiple medications that are prescribed not only by her psychiatrist, but by the workman's comp pain physician, all of which can cause significant drug interactions.

. . . . . .

There are multiple factors going on with this patient, the majority of these do stem from polypharmacy.

Dr. Hill noted on March 10, 2017:

I did reinforce the fact that her EEG was normal at this point she does not appear to have any underlying seizure disorder.

I find these opinions of Dr. Hill are credible and persuasive.

I find and concluded that Dr. Pothuloori's and Dr. Hill's opinions that the etiology of Claimant's altered mental status at North Kansas City Hospital was polypharmacy are credible and persuasive. I find the polypharmacy was caused by the medications Claimant was taking to treat her compensable work injury.

Claimant credibly testified the itemized bills relating to the North Kansas City hospitalization, Exhibit W, were all related to her Workers' Compensation injury. She credibly testified Exhibit X, a summary of her bills, is an accurate summary of those bills. Claimant is asking for the North Kansas City Hospital bills and the bills in Exhibit W be paid by Workers' Compensation.

Exhibits R and W contain treatment records and billing records relating to the care provided to Claimant at North Kansas City Hospital in March 2017. These records and Claimant's testimony establish that Claimant incurred these bills for treatment of her December 24, 2012 injury. I find these bills were a product of the injury she sustained from a compensable accident while working for Employer. The medical bills which Claimant requests be paid by Employer are in the total amount of $41,407.04.

Like Ms. Cummings in *Farmer-Cummings v. Future Foam, Inc.*, the treatment Claimant received at North Kansas City Hospital in 2017 was obtained under emergency circumstances. Thus, even had Claimant provided Employer written notice of her medical

condition and had Employer been directing her medical treatment, Employer would not have directed her emergency care.

I find and conclude the medical bills in evidence were shown by the medical records in evidence to relate to the professional services rendered for treatment of the product of Claimant's injury. I find and conclude that the medical care Claimant received North Kansas City Hospital in March 2017 that is represented by the medical bills and treatment records in evidence (Exhibits W and R) was reasonably necessary to cure and relieve her of the effects of her December 24, 2012 injury that arose out of and in the course of her employment for Employer.

I have previously found that Claimant's December 24, 2012 compensable accident while working for Employer was the prevailing factor in causing her left ankle injury and psychological injury and resulting disability.

Employer did not pay Claimant's medical expenses for which she seeks payment. The evidence documents that Claimant received the treatment for the injury that is represented by the expenses for which she seeks payment. Employer offered no evidence that the charges were not fair and reasonable and usual and customary and offered no credible evidence that showed that the medical expenses incurred were not related to the injury in question.

Employer offered no evidence that Claimant was not required to pay the billed amounts, that her liability for the disputed amounts was extinguished, and that Claimant has ceased to be liable to healthcare providers for write-offs and fee adjustments. I find Employer failed to prove that Claimant was not required to pay the billed amounts, failed to prove that her liability for the disputed amounts was extinguished, and failed to prove that Claimant has ceased to be liable to healthcare providers for write-offs and fee adjustments.

I find and conclude that Claimant met her burden of proof regarding Employer's liability for past medical expenses of $41,407.04. I find that the medical expenses incurred in this case in the amount of $41,407.04 were fair, reasonable, and necessary expenses to cure and relieve the effects of the injury that Claimant sustained in the course of her employment on December 24, 2012 while she was working for Employer.

I find and conclude that the medical bills incurred to treat Claimant's December 24, 2012 injury in the amount of $41,407.04 should be paid by Employer. I award the sum of $41,407.04 in favor of Claimant against Employer for these past medical expenses.

Employer's Liability for Permanent Disability Benefits

Claimant and Employer/Insurer stipulated that Claimant's claim against the Employer/Insurer be settled for a total of $120,000.00 for alleged permanent disability. Claimant and Employer/Insurer stipulated pursuant to Exhibit Y, as amended:

> As far as the agreement between the Employer/Insurer and Claimant Cynthia Null, the Employer/Insurer agrees to pay a lump sum of $120,000, which includes attorney's fees of $27,150.22 and expenses of $11,399.12, leaving a balance of $81,450.66, closing out all issues regarding permanent disability. This payment is not for medical treatment, only for permanency.
>
> Ms. Null was 50 years old at the time temporary total disability payments ceased, in October 2015. At that point, Ms. Null's remaining life expectancy was 33.24 years, based on Social Security Actuarial Life Table of 2013. Therefore, even though compensation was documented, the Employee's benefit on this compromise settlement shall be considered to be $47.12 per week, or $204.20 per month, paid in advance pursuant to R.S.Mo. §287.250(9) for 398.88 months, commencing as of July 25, 2017.

I therefore award the sum of $120,000.00 in favor of Claimant and against Employer/Insurer for permanent disability. I find this lump sum of $120,000.00 includes attorney's fees of $27,150.22 and expenses of $11,399.12, leaving a balance of $81,450.66, which is not for medical treatment, only for permanency. I find Claimant was 50 years old at the time temporary total disability payments ceased, in October 2015. At that point, Claimant's remaining life expectancy was 33.24 years, based on Social Security Actuarial Life Table of 2013. Therefore, even though compensation was documented, Claimant's benefit on this compromise settlement shall be considered to be $47.12 per week, or $204.20 per month, paid in advance pursuant to R.S.Mo. §287.250(9) for 398.88 months, commencing as of July 25, 2017.

Second Injury Fund's Liability for Permanent Disability Benefits

Claimant and the Second Injury Fund stipulated that Claimant's claim against the Second Injury Fund be settled for a total of $60,000.00 for alleged permanent total disability. Claimant and the Second Injury Fund stipulated pursuant to Exhibit Z, as amended:

> This lump sum settlement in the amount of $60,000 includes attorney's fees in the sum of $15,000 and no expenses leaving a

balance of $45,000.00 which is compensation for permanent impairment that will affect Cynthia Null for the rest of her life. Ms. Null was 50 years of age when temporary total disability (TTD) benefits were stopped in October 2015 and at that point employee's remaining life expectancy was 33.24 years based upon and listed in the Social Security Actuarial Life Table. Therefore, even though compensation was paid as documented, the employee's benefit on this compromised settlement shall be considered to be $26.03 per week and $112.81 per month, paid in advance pursuant to RSMO 287.250 (9) for 398.88 months, commencing July, 2017.

I therefore award the sum of $60,000.00 in favor of Claimant and against the Second Injury Fund for permanent total disability. I find her lump sum settlement in the amount of $60,000.00 includes attorney's fees in the sum of $15,000.00 leaving a balance of $45,000.00 which is compensation for permanent impairment that will affect Claimant for the rest of her life. Claimant was 50 years of age when temporary total disability (TTD) benefits were stopped in October 2015 and at that point employee's remaining life expectancy was 33.24 years based upon and listed in the Social Security Actuarial Life Table. Therefore, even though compensation was paid as documented, Claimant's benefit on this compromised settlement shall be considered to be $26.03 per week and $112.81 per month, paid in advance pursuant to RSMO 287.250 (9) for 398.88 months, commencing July, 2017.

Attorney's Fees

Claimant's attorney is entitled to a fair and reasonable fee in accordance with Section 287.260, RSMo. An attorney's fee may be based on all parts of an award, including the award of medical expenses. *Page v. Green*, 758 S.W.2d 173, 176 (Mo.App. 1988). During the hearing, and in Claimant's presence, Claimant's attorney requested a fee of 25% of all benefits to be awarded. Claimant did not object to that request. I find Claimant's attorney is entitled to and is awarded an attorney's fee of 25% of all amounts awarded for necessary legal services rendered to Claimant. This award for attorney's fees includes, but is not limited to attorney's fees of $27,150.22 (which is 25% of $120,000.00 after deduction of expenses of $11,399.12) and expenses of $11,399.12 from the award against Employer/Insurer in the amount of $120,000.00 regarding permanent disability, and attorney's fees of $15,000.00 from the award against the Second Injury Fund in the amount of $60,000.00 for permanent total disability. The compensation awarded to 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 Claimant: Athena M. Dickson.

Issued by DIVISION OF WORKERS' COMPENSATION

Re: Injury No.: 12-100528
Employee: Cynthia G. Null

I certify that on 10-26-17, I delivered a copy of the foregoing award to the parties to the case. A complete record of the method of delivery and date of service upon each party is retained with the executed award in the Division's case file.

By _____

Made by: _____
Robert B. Miner
Administrative Law Judge
Division of Workers' Compensation