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Issue Date: 11 April 2012

CASE NO.: 2011-LHC-01249

OWCP NO.: 07-184573

IN THE MATTER OF

**CARLA STALLWORTH,
Claimant**

v.

**HUNTINGTON INGALLS, INC., f/k/a NORTHROP GRUMMAN SHIPBUILDING,
INC.,**

Employer

DECISION AND ORDER GRANTING BENEFITS

This is a claim for benefits under the Longshore and Harbor Workers' Compensation Act, as amended, 33 U.S.C. § 901, *et seq.*, (the Act), brought by Claimant against Huntington Ingalls, Inc., (Avondale Operation) f/k/a Northrop Grumman Shipbuilding, Inc., (Employer).

The issues raised by the parties could not be resolved administratively, thus the matter was referred to the Office of Administrative Law Judges for hearing. A formal hearing was held on December 8, 2011, in Covington, Louisiana. All parties were afforded a full opportunity to adduce testimony, offer documentary evidence, and submit post-hearing briefs. Claimant exhibits (CX) 1-24 were offered and admitted into evidence. Employer exhibits (EX) 1-21 were offered and admitted into evidence. This decision is based upon a full consideration of the entire record.

STATEMENT OF THE CASE

Claimant sustained a work injury to her shoulder, arm and neck on December 11, 2008 when she fell through a floorboard. Later, she developed RSD¹ (Reflex Sympathetic Dystrophy), as a result of those injuries. Claimant also allegedly developed psychological injuries flowing

¹ RSD (Reflex Sympathetic Dystrophy) and CRPS (Complex Regional Pain Syndrome) are used interchangeably throughout this opinion.

from her constant pain. She has treated with multiple doctors, and asserts that she is totally disabled. Employer argues Claimant is only partially disabled.

The Parties stipulated that 1) an injury occurred on December 11, 2008 to Claimant's left shoulder, arm and neck; 2) the injury was in the course and scope of her employment; 3) an employer/employee relationship existed; 4) employer was timely advised; 5) a timely notice of controversion was filed; 6) compensation for temporary total disability was paid from January 6, 2009 to June 21, 2009 and Claimant performed temporary light duty work from June 22, 2009 to September 21, 2009; 7) compensation for permanent partial disability was paid from September 22, 2009 through present based upon a post-injury wage earning capacity of \$320/week; and 8) total compensation paid is \$17,014.72, and medicals paid \$82,109.50. (ALJ-1).

The issues for the Court to decide are 1) nature and extent of disability (Claimant contends she is totally disabled from September 22, 2009 through present, and Employer contends she is partially disabled. Employer paid temporary total disability from September 22, 2009, but claimed an overpayment after a retroactive labor market survey contending Claimant was partially disabled.); 2) date of MMI; 3) reasonableness and necessity of certain recommended medical treatment and the relationship to Claimant's injury; 4) average weekly wage (AWW); 5) attorney's fees; and 6) Employer's credit for compensation and wages paid. (ALJ-1).

Summary of the Testimony

Testimony of Claimant

Claimant testified at the formal hearing on December 8, 2011. (Tr.). She is 40 years old, single, and divorced. (Tr. 18). Claimant has three children, graduated high school, and attended the Tampa School of Business for two years. Her work history includes: prep work and cleaning at a restaurant, customer service, call center representative, medical billing and coding for a pathology center, and a sheet metal clerk. (Tr. 18-24).

Claimant worked for Employer from 2002-2006, and resigned due to migraine headaches. (Tr. 22-23). She returned to Employer in April 2008. (Tr. 24). She took some time off to determine the cause of her headaches in July, August, and up to December 2008. She was working as a cleaner. (Tr. 24-25). Starting the week of May 4th, Claimant only worked 20 hours, and subsequent weeks she worked 30, 30, 39, 40, 40, 40, 40, and 23 hours. Starting the week of July 20th and until September 21st, Claimant worked no hours, then worked 10 hours the week of September 21st. (Tr. 25). She worked 38 hours the week of September 28th, 5 hours the week of October 5th, and missed the weeks of October 12th, October 19th, October 26th, and up until the week of December 7th. The week of December 7th Claimant worked only 10 hours. (Tr. 26).

Before the accident, Claimant suffered from migraines, had a partial hysterectomy, and tonsillectomy. She pulled her back cleaning up after the storm, and later found out she had a moderate slipped disc. Dr. Washington told her it would slip back in and it never bothered her

after that. (Tr. 27-28). Claimant never had prior treatment for her left arm, left shoulder, or neck. (Tr. 28).

On December 11, 2008, Claimant was cleaning the bilges. She was supposed to pick the boards up, but the carpenters would place them back down. (Tr. 28). However, whoever was supposed to put them down did not. Claimant was putting down the boards and walked across one; the board toppled and cracked, and she fell in. She fell three feet into a hole; half of her body was stuck. She was pulled out of the hole and taken to the foreman's office to report the injury. (Tr. 29). Claimant's shoulder struck the hole, along with her pinky finger and right knee; her neck was stuck between a beam. (Tr. 29-30). After the report was filled out, Claimant declined going to the hospital and stated "I just want to go home and lay down." She started hurting in the middle of the night, but went to work the next day and her arm would not lift. She reported to Sheila that her arm was getting worse, but finished the day out. Claimant's left arm was aching, burning, and throbbing all the way down. (Tr. 30-31).

Claimant first went to the hospital on her own around the 21st or 22nd of December, and was told by Northrop Grumman to go straight to their doctor on January 5th when she reported back to work. (Tr. 32). Claimant had tests run, then chose Dr. Black who did an MRI; the MRI revealed a torn rotator cuff. (Tr. 32-33). First, Claimant went to therapy, then surgery was performed on March 18, 2009. (Tr. 33). She went to therapy at Singing River Hospital then PT Solutions. Claimant explained to Dr. Black that her knee was injured, but he wanted to take care of the shoulder first. Her knee is still messed up, and was "never tended to." (Tr. 34).

Claimant testified that her physical therapist told Dr. Black the therapy was hurting more than helping Claimant. She would take medication at 3 or 4 in the morning, and then sleep through therapy. (Tr. 34). She would miss therapy, but would call them and let them know. (Tr. 34-35). "I was in agony." Dr. Black recommended a second surgery for her shoulder, and Claimant went to Dr. Fontana for a second opinion, who agreed with Dr. Black. She did not want the surgery because it could help her or make it worse. "There was no guarantee of which one it would do." (Tr. 35). Dr. Fontana thought Claimant had evidence of RSD because her arm was freezing yet burning, and her fingertips were cold. She went back to Dr. Black. (Tr. 36).

Dr. Black sent Claimant to Dr. Terry Smith, a neurosurgeon. He never touched her, but told Claimant nothing was wrong, and the burning was normal. Dr. Smith gave Claimant some pain patches. (Tr. 36). Dr. Black then sent Claimant to Dr. Elmore, another neurologist. Dr. Elmore could not determine where the nerve damage came from. Claimant was having muscle spasms which Dr. Smith had attributed to swelling. Dr. Black sent Claimant to Dr. Tsang for pain management. (Tr. 37).

Employer finally allowed Claimant to see Dr. Millette, who took one look at her arm and diagnosed her with RSD; her arm was swollen and a purplish color. Claimant told Dr. Millette this had been going on for over year, and he said it was too late to do anything for it, they could just try to make her comfortable. Claimant received injections for the pain, which were later rejected by Employer. Dr. Tsang began Stellate Ganglion nerve blocks. (Tr.38). However, those were also stopped by Employer, and Claimant's pain has been "nothing but hell" since.

Dr. Black was told by Employer to release Claimant to work for at least 90 days, so he released her. She would do partial days and leave at 10:00 to go to therapy. The period was approximately from June 21, 2009 to September 22, 2009. (Tr. 39). Her work restrictions included no climbing, no pulling, no reaching, and she could lift up to 10 pounds. However, Claimant never had to lift anything. (Tr. 40). Claimant was put in the office doing paperwork, but she could only sit for about 20 minutes due to the muscle spasms. At the end of 90 days, Employer wanted Dr. Black to release Claimant; however, she was in agony so he would not do it. (Tr. 41). She was laid off at the end of the 90 days, but got compensation until February of 2009, about \$316.00/week.

Claimant had an injection with Dr. Tsang in January, but did not attend her March injection; therefore, Employer said she “abandoned” the injection. (Tr. 43). She explained to them that she was there hooked up to an I.V., but did not have someone to drive her, so they could not do it. A lady from Dr. Tsang’s office sent an e-mail to Employer stating “Ms. Stallworth was there, but we cancelled the injection until the following week.” Furthermore, Employer claimed she abandoned her therapy. (Tr. 44). Claimant stated she did not abandon physical therapy, but it hurt more than helped her.

From approximately February 24, 2010 to May 2011, Claimant did not receive compensation. She received a check for \$7.56 in April, then has received \$173.00 every two weeks. (Tr. 45). Dr. Black had Claimant out of work from September 23, 2009 to August 12, 2010. (Tr. 55). On August 12, 2010, Dr. Black assigned Claimant permanent work restrictions of no pulling, no lifting more than 5 pounds, no climbing, crawling, or standing. She took her restrictions to Employer, who said they had no work for her with those restrictions. (Tr. 46-47).

On November 3, 2010, Claimant interviewed with Employer’s vocational expert. He stated, “There’s no reason to go any further if she’s off work under the care of a doctor.” Dr. Tsang had Claimant out of all work. (Tr. 48-49). The vocational expert later proposed some jobs for Claimant, but Dr. Tsang had Claimant off work throughout that time and at the time of the hearing. She needed injections which Employer would not pay for, and a cardiologist and psychiatrist. (Tr. 49-50). Claimant had an appointment scheduled post-hearing with Dr. Masong, a psychiatrist.

Twice, Claimant was hospitalized at Singing River Hospital due to pain. She thought she was having a heart attack, but was treated with Xanax for a possible anxiety attack. Her blood pressure was high. (Tr. 50). She also has had periods of extremely low blood pressure. Dr. Tsang had Claimant taking Opana, Lortab, Ambien and Trazadone for sleeping, Phenergan for her stomach, Lidaderm and Flector patches for muscle spasms and pain, Somas for muscle relaxers, Lyrica for the burning, Mobic for swelling, and at one point high blood pressure pills. (Tr. 51-52). Claimant testified she cannot function without her medications, and her pain will be a 9 out of 10 on a scale of 1 to 10, which causes panic attacks. With medicine, her pain may be a 6 or 7. (Tr. 52). Claimant’s skin forms blisters as a side effect of the RSD. (Tr. 53).

Dr. Millette told Claimant she was non-functional in her left arm, because she had gone untreated for so long. He recommended Claimant continue to see Dr. Tsang and apply for disability. (Tr. 54).

Claimant used to cook, but with the medication she forgets what she is doing and burns her food. Her hand goes numb and she drops dishes, she gets muscle spasms if she tries to vacuum, and her daughter helps her bathe and comb her hair. (Tr. 55). She used to go to family functions, but now cannot go. She used to go to the gym and jogging track; she used to read but can no longer comprehend; she is losing her memory. She does not have a sex life, because she has blisters everywhere. She is not the person she used to be. She used to do a lot with her kids, but now has anger and takes it out on them. Claimant started crying, and stated she cannot purchase food for her children. (Tr. 57).

Employer made Claimant an appointment to see Dr. Patricia Boltz. (Tr. 57). Claimant saw her twice, the second time on November 30, 2011. Dr. Boltz confirmed the RSD, and thought Claimant had chronic neck and myofascial pain. (Tr. 58).

On April 29, 2011, Mr. Rowe performed a FCE (Functional Capacity Examination) on Claimant at Physical Therapy Center of Ocean Springs. (Tr. 58). She was in so much pain, she could not complete the examination; Claimant went straight to the doctor and found out her blood pressure was extremely high. The doctor put her on bed rest for ten days. Dr. Tsang sent a letter entitled "medical excuse letter" directly following the FCE for ten days of bed rest. He told Claimant not to return to the second day of the FCE. (Tr. 59-60).

Claimant was denied Social Security disability benefits twice, and was waiting on a hearing. She tried to lift her arm for the judge, and could only lift it to around 90 degrees. Claimant testified she lets her arm stay at her side in a locked position because when it hangs she gets muscle spasms. (Tr. 61-62). Claimant stated her upper arm was hot, but the lower part cold. (Tr. 62).

On cross-examination, Claimant testified she was on the Dean's list at Florida School of Business. (Tr. 63). She studied medical office assistant management. Claimant worked at Statewide Physical Therapy but the business was shut down for fraud. (Tr. 64). She stated in interrogatories that she worked there from 2000-2002, but Claimant testified that was not full time. She also worked at Driftwood Nursing Home for a year or less. (Tr. 65). There were times in the last ten years that Claimant was unemployed, for medical reasons. She was having abdominal pains when she left Driftwood. (Tr. 66). In her first stint with Employer, her doctor thought the migraines could be caused by noise; she was moved inside, then quit when she was supposed to be moved back outside. (Tr. 67). Claimant left Odyssey because it was an unprofessional atmosphere and they were not paying her enough. In eight years, Claimant had four jobs, and left at least two of them for health reasons. (Tr. 68).

Dr. Black thought Claimant had a low pain threshold and needed to push through. He told Claimant she needed to be more active. Two weeks following surgery, Claimant agreed Dr. Black told her to work her arm for range of motion. (Tr. 71). Claimant stated Dr. Smith never touched her, even though his records report checking her reflexes. (Tr. 72-73). She did not get the injection which Dr. Smith had recommended, because she was concerned about a needle in her spine. (Tr. 73). She allowed Dr. Tsang to give her the injection because he explained it in a way that made her more comfortable with the idea.

Claimant chose not to have a second surgery because Dr. Black told her he did not think it would help her. “You have a low pain tolerance and I don’t think you would do well with a second surgery.” (Tr. 78). Dr. Black wrote “I did put some of the blame on her for her lack of productivity in the early post-operative period.” (Tr. 79). Also, the notes from physical therapy stated Claimant cancelled eight visits and no-showed eight visits. However, Claimant testified if she slept through an appointment, she would always call and apologize.

Claimant went to the hospital on August 17, 2011 because the pain had gotten so bad. She testified that even though she had visited Dr. Tsang the day before, Employer was delayed in approving her pain medications. (Tr. 81-83). Claimant testified that since she worked 90 days of light duty for Employer, she had not tried to apply for any jobs; Dr. Tsang has had her off work. (Tr. 83). Claimant testified Dr. Black never treated her knee, but in the medical records he gave her an injection. (Tr. 89).

On redirect, Claimant testified she could not do her old jobs because they required two hands to type, and required long sitting which gives her muscle spasms. She cannot hold a phone with her left arm or use it for a long time because it starts to burn. (Tr. 90-91). Dr. Black notified FARA that Claimant’s lack of compliance was not as much of a problem as her low pain threshold. (Tr. 92). Claimant testified that Dr. Tsang puts her to sleep to give her injections, while Dr. Smith would not. (Tr. 92). Claimant stated she has not applied for jobs because of the pain, she cannot function, and she cannot drive due to the muscle spasms; also, she lost her car because she could not pay for it. Since October 22, 2010, Dr. Tsang has not approved for Claimant to do any type of work. However, Claimant did make calls to some of the positions recommended by Mr. Sanders. (Tr. 94-95).

Claimant called about positions at Express Check Advance, Thousand Trails, Lifeline, and Check Into Cash. She stated that when she inquired, none of the employers were hiring. (Tr. 96-97).

On re-cross, Claimant admitted she discussed her physical condition with the employers that she called. (Tr. 99).

Medical Evidence

Singing River Hospital

On December 23, 2008, Claimant presented at Singing River Hospital with left shoulder and hand pain, approximately a week following her accident. She stated her pain was a 10 on a scale of 1 to 10. A left shoulder and hand x-ray did not reveal any acute dislocations. The doctor recommended Claimant see an orthopedist. (CX-19, pp. 4-5). An MRI obtained on December 26, 2008 revealed a partial thickness tear involving the inferior articular surface of the supraspinatus tendon near its insertion site, with a joint effusion. (CX-19, p. 9).

On August 3, 2011, Claimant presented with chest pain, but a stress test was negative. A CT of the chest was negative; Claimant also had chronic left shoulder pain. She was diagnosed with accelerated hypertension, anxiety, and chronic pain. (CX-19, p. 13).

On August 17, 2011, Claimant returned to the hospital. She complained of chronic neck and shoulder pain that was constant but worse with movement. She was diagnosed with intractable shoulder pain, chronic shoulder pain, RSD, hypertension, and anxiety. Claimant was released with enough Percocet to last until she could see either Dr. Millette or Dr. Tsang. (CX-19, p. 28).

On September 1, 2011, Claimant returned to the hospital with chest complaints. She stated the pain was intermittent and sharp; it felt like someone was sitting on her. She had left arm numbness, dry mouth, a lump in her throat, and had shortness of breath. The doctor diagnosed Claimant with chest pain and gastroesophageal reflux disease; Claimant was prescribed over-the-counter medications such as Maalox, Zantac, or Prilosec. (CX-19, pp. 39-40).

Dr. Arthur D. Black, M.D.

Claimant first saw Dr. Black on January 5, 2009. She reported that she went to the emergency room 10 days following her accident, and x-rays taken of her finger and left shoulder were negative. An MRI taken of her left shoulder on December 26, 2008 revealed a supraspinatus tendon tear. (CX-17, p. 1, 5). Claimant's past medical history was back trouble, migraines, and anemia. She presented with complaints of right medial knee pain in the seated position, stiffness in the left fifth finger, and strain on the left side of her neck with intermittent numbness; she had paraesthesias down the left upper extremity and into her hand and elbow. She listed her medications as Topamax, Inderal, Xanax, and Lortab. On physical examination, Dr. Black noted stiffness in her neck especially bending to the right and chin down in flexion, and tenderness in the left shoulder subacromial space; he could only lift her arm somewhere near 90 degrees with 20 degrees of external rotation. There was mild swelling at the PIP joint of her fifth finger, with tenderness and stiffness. Her right knee exhibited no fusion, full range of motion, guarding in flexion, and medial compartment tenderness. All x-rays were normal. Dr. Black diagnosed Claimant with cervical strain, possible partial thickness supraspinatus tendon tear of her left shoulder with stiffness, left fifth finger sprain, and right medial knee pain. (CX-17, p. 1). He planned for an MRI of the right knee and cervical spine, and physical therapy for her neck, left hand, left shoulder, and right knee. He prescribed Claimant Lortab, Soma, and Feldene. (CX-17, p. 2).

Claimant's MRI of her cervical spine taken on January 20, 2009 was normal. (CX-17, p. 6). For her knee, the MRI revealed grade II chondromalacia involving the medial femoral condyle, grade II degenerative signal intensity within the posterior horn of the medial meniscus, and minimal suprapatellar effusion. (CX-17, p. 7).

Claimant returned to Dr. Black on January 23, 2009. She presented with complaints of shoulder pain and a hard time lifting overhead; her shoulder would catch and lock, and she had the same radiating pain. Her right knee would bother her when she sat for a long time, but not as

much as her shoulder. On physical exam, Dr. Black noted stiff neck and soreness on the left side, and 120 degrees of elevation of her shoulder but with pain and guarding. She was tender over the anterior and the lateral subacromial space. Claimant's right knee was normal, but had weakness secondary to pain. He diagnosed her with cervical strain with radiculopathy on the left side, knee aggravation with a possible chondral injury, and a partial thickness rotator cuff tear and impingement on the shoulder. He planned to perform a subacromial decompression if workmen's compensation approved. Dr. Black restricted Claimant from work, recommended therapy, and prescribed her Lortab and Ultram. (CX-17, p. 8).

On March 2, 2009, Claimant presented with the same complaints, and Dr. Black wrote "[i]t is almost pain out of proportion." She denied numbness or paraesthesias. Dr. Black was able to get her left shoulder up to 140 degrees of elevation. He diagnosed her with left shoulder impingement, AC arthrosis, tendinopathy, and a full versus partial tear. He planned for a left shoulder arthroscopy, subacromial decompression; he planned to do a rotator cuff repair if needed. He prescribed Claimant Lortab, Soma, Feldene, Bactrim, and Phenergan. (CX-17, p. 9).

On March 18, 2009, Dr. Black performed a left arthroscopy on Claimant's shoulder. He found synovitis in the flenohumeral joint, a significant partial thickness tear on the articular side and also on the bursal side of the supraspinatus tendon, and it had flaps hanging down into the joint. On the bursal side, she had a very prominent anterior acromion and an arthritic AC joint. The following day, Claimant presented with moderate pain. Dr. Black planned for her to start therapy that Monday, and he explained the importance of getting full range of motion. She was prescribed and dispensed a left shoulder abduction pillow and sling to be worn for six to eight weeks. (CX-17, pp. 10-12).

On April 4, 2009, Claimant presented to Dr. Black with complaints of soreness. On physical examination of her left shoulder, she got 10 degrees external rotation and 145 degrees of elevation. Her x-ray revealed effects of acromioplasty. Dr. Black planned to continue therapy, add a cortisone shot, and renew analgesics as needed. (CX-17, p. 13).

On April 20, 2009, four and a half weeks out of surgery, Claimant presented with improvement. She got 150 degrees of elevation with her left shoulder and 30 degrees of external rotation. Dr. Black thought Claimant was behind yet making progress. He wanted to focus on passive range of motion and wanted Claimant to wean herself off the sling; he restricted her from work. (CX-17, p. 14).

On May 11, 2009, Claimant presented with improved pain since before her surgery. On physical examination, Dr. Black noted 140 degrees of passive elevation, and external rotation of 50 degrees. Claimant had internal rotation to her belt line. Dr. Black discussed active use of the arm with Claimant, and he thought she was progressing. He planned for her to work on internal rotation and active motion, but kept Claimant off work. He prescribed her Lortab, Soma, and Mobic. (CX-17, p. 15).

On June 8, 2009, Claimant presented to Dr. Black with pain complaints and tightness in the shoulder; the worst pain was along the shoulder blade and into her neck. He thought she had shoulder pathology. On physical examination, Claimant had 160 degrees of elevation passively,

145 actively, and 25 degrees of external rotation. Claimant was tight on internal rotation, had positive arc of pain, tenderness on the medial border of the scapula, and tightness in her neck. Dr. Black reported slow progress, and planned for her to see a neck specialist. He allowed her to return to work on June 22, 2009 with no ladder climbing, no overhead work, no lifting more than 10 pounds, and sedentary work. Claimant was to continue therapy twice a week. (CX-17, p. 16).

On July 20, 2009, Claimant presented to Dr. Black with pain in the left side of her neck, left trap, left shoulder, and down the left arm. She also had difficulty raising her arm; it got stuck in the morning. She complained of coldness in her hand all the time, and was crying at the appointment. On physical exam, her left shoulder was sensitive to the touch. She had 80 degrees of active elevation, but he took her to 120 degrees of passive elevation. She had 40 degrees of external rotation. Her left hand was cooler than the right hand, and she was tender over her trap and had stiffness in her neck with pain. Dr. Black thought she was not doing well, and behind schedule. He believed Claimant had some type of radiculopathy in her neck, and thought she was developing some signs of CRPS (Complex Regional Pain Syndrome). He planned for Claimant to see a nerve or neck specialist. He requested that she get a second opinion for her shoulder. He wanted to continue rehab, but if she did not get better, then do a revision surgery. (CX-17, p. 19).

On August 17, 2009, Dr. Black continued Claimant's work status, and requested to see her written second opinion on the shoulder surgery. (CX-17, p. 21). On September 1, 2009, Claimant presented with shoulder pain; she had seen Dr. Andre Fontana, who thought she had cervical radiculopathy. He suggested an MR of the shoulder and a neurology consult. She had an EMG nerve conduction study that was normal in the left upper extremity. However, she had continued disability, stiffness, and pain. Dr. Black thought Claimant had left shoulder adhesive capsulitis, possible recurrent tear, though doubtful, and cervical radiculopathy. He suggested a neurosurgery consult with Dr. Terry Smith, pain management consult with Dr. Joe Chen, and an MR arthrogram to evaluate rotator cuff healing. He wanted her to return after an EMG nerve conduction study, and to continue physical therapy. (CX-17, p. 25).

On September 29, 2009, Claimant told Dr. Black she was about the same, but had seen Dr. Terry Smith, a neck specialist. He recommended an epidural block, and thought she had inflammation of her nerve and neck. On physical exam, Claimant's left shoulder had 90 degrees of motion. The MR arthrogram did not show a re-tearing of the rotator cuff. Dr. Black planned to proceed with pain management and to hold therapy until after her shoulder injection. (CX-17, p. 27).

On October 8, 2009, Claimant presented with left shoulder pain, soreness, and stiffness. She planned to get an epidural injection. On physical examination, Dr. Black noted her range of motion was 0 to 110, and Claimant was tender in the subacromial space and weak secondary to pain. Dr. Black wanted Claimant to get the injection, and placed her out of work. (CX-17, p. 28).

On November 17, 2009, Claimant had the same complaints, but she had not gotten an epidural because she could not tolerate the procedure; she planned to get it in the future. Dr.

Black wanted Claimant to get a cortisone shot, and noted the possible necessity of another surgery. (CX-17, p. 29).

On December 15, 2009, Claimant presented with the same symptoms. On exam, her left shoulder had 125 degrees of elevation and 20 degrees of external rotation; she had pain and tenderness in the subacromial space. He gave Claimant a cortisone shot, and recommended that she continue therapy on her shoulder. (CX-17, p. 30).

On January 26, 2010, Claimant continued to have the same problems. On exam, her left shoulder had 100 degrees of elevation. She had tenderness around her neck. Dr. Black noted Claimant was going to get her epidural and get treated by her neck specialist. (CX-17, p. 31).

On March 2, 2010, Claimant still had pain, soreness, and stiffness in her left shoulder. She had one epidural, and was going to get another. She was following up with her pain management doctor and neck specialist. Dr. Black continued to discuss another surgery for her shoulder. (CX-17, p. 32).

On April 12, 2010, Claimant presented to Dr. Black with similar complaints, but had puffiness and swelling in her neck. She was released by Dr. Smith. On exam, her left shoulder had 70 degrees of active elevation, 110 degrees of passive elevation, 40 degrees of external rotation, and internal rotation to T11. She had tenderness in the subacromial space with puffiness in her left trap. He diagnosed Claimant with post-operative stiffness in the left shoulder and radicular symptoms in the neck; Dr. Black did not know if it was related to the shoulder. He gave Claimant several options, including being released with a permanent partial impairment, seeking a second opinion, or he would do the left shoulder subacromial decompression. He wrote, "I do not expect her to do remarkably well." (CX-17, pp. 33-34).

On April 26, 2010, Dr. Black reported that Claimant wanted a second opinion. He wanted her to return to him as needed. (CX-17, p. 35).

On July 29, 2010, Claimant returned to Dr. Black and presented with pain in the left shoulder. She thought she had a pinched nerve in her back, could not lift her shoulder above 90 degrees, and it was painful to sleep on it. On physical examination, her left shoulder had 90 degrees of elevation with pain, and she was tender in the subacromial space and posterior joint line. Dr. Black assigned Claimant a maximum medical improvement (MMI) date, and planned to assess her permanent partial impairment and permanent work restrictions at a later date. (CX-17, p. 36). On August 12, 2010, Dr. Black determined her permanent partial impairment of the left upper extremity was 20%. Her permanent work restrictions included sedentary work, no lifting over 5 pounds, no pulling, and no climbing. He stated she could return to work on August 12, 2010. (CX-17, pp. 37-38).

On September 21, 2010, FARA sent Dr. Black a letter. He responded that if Claimant had been more compliant with his treatment, she would *not* have reached MMI any sooner, nor would she have been able to return to full duty. He wrote that her lack of compliance was not so much of an issue as her low pain threshold and inability to maximize her therapy due to pain. (CX-17, p. 40). Furthermore, Dr. Black agreed with the treatment plan from Dr. Boltz. (CX-17,

p. 41). On November 23, 2010, Dr. Black stated in a letter to Claimant's attorney that he would refer Claimant to Dr. Terry Millette who treated CRPS. Also, he opined that Dr. Tsang should treat Claimant's shoulder and her cervical regions from a pain management standpoint. (CX-17, p. 42). Furthermore, he pulled Claimant from work between September 23, 2009 and August 12, 2010. (CX-17, p. 43). FARA then sent Dr. Black a letter. Dr. Black responded and agreed that Claimant would have been able to work, with restrictions of no ladder climbing, no overhead work, and no lifting more than 10 pounds between September 22, 2009 to August 12, 2010. (CX-17, p. 44).

Dr. Terry C. Smith, M.D.

Dr. Black referred Claimant to see Dr. Smith, a neurologist, on September 26, 2009. (EX-9). She presented to Dr. Smith with a history of her accident, and pain complaints in the left neck, headaches in the back of her head, and pain and numbness going down her arm to her hand. Her shoulder swelled, and hurt in the morning. She also has some right shoulder pain. She reported to Dr. Smith that physical therapy was not helping. On physical examination, Dr. Smith noted pain to extension and left tilt of the neck. He found non-anatomic sensation loss in her left arm. (EX-9, p. 1). He recommended a (CESI) cervical epidural steroid injection.

On November 20, 2009, Dr. Smith reported Claimant would not receive the epidural because she was afraid of needles. She presented to him with complaints of pain in the right side of her neck going into her shoulder, which was worse when she turned to the left. She had tenderness to palpation over her neck and shoulder, but normal strength, sensation, reflexes, and gait. Dr. Smith stated that he had nothing to offer Claimant if she would not receive the injection. (EX-9, p. 4).

On November 25, 2009, in response to a letter from Employer, Dr. Smith assigned Claimant an MMI date of November 20, 2009 and stated she had no permanent restrictions. (EX-9, p. 5).

On January 2, 2010, Dr. Smith stated Claimant returned to him even though he released her. She reported pain in her upper back and right shoulder, and she rescheduled her injection. On examination, Claimant was tearful and stated that she "mentally can't take the pain any more." She had tenderness to palpation over her neck. He prescribed Claimant a muscle relaxer and offered home treatment tips. (EX-9, p. 6).

On February 17, 2010, Claimant returned after her epidural steroid injection. She stated that it helped for 3 to 4 days. Her pain was in both sides of her upper back, and her left neck and shoulder were swelling. She reported pain to left tilt of her neck. She stated she wanted a second injection. Dr. Smith noted Claimant said she did not drive anymore and had to get transportation because she could not turn her head. (EX-9, p. 7).

On March 23, 2010, Claimant presented to Dr. Smith with a report that her second injection helped more than the first. She still stated that she had constant pain in the left neck and worried about the swelling in her vertebral pomenas area and left scapula, which she described as "knots". She reported her medications from Dr. Tsang to Dr. Smith. Claimant

jumped when Dr. Smith touched her anywhere over her neck and shoulders. He offered a myelogram to determine if they missed anything, but she refused because of the needles involved. She expressed displeasure that she had to “live like this”. He prescribed Claimant Lidoderm patches. (EX-9, p. 9).

On March 24, 2010, Dr. Smith responded to a letter from Employer stating Claimant could return to full duty. (EX-9, p. 10). On April 6, 2010, Dr. Smith responded to another letter, claiming that Claimant needed no further CESIs, because they were not medically necessary based on lack of findings and a normal duty release. (EX-9, p. 11).

Dr. Andre Fontana, M.D.

On August 13, 2009, Claimant went to Dr. Fontana for a second opinion on her shoulder. (CX-18, pp. 17-18). Claimant presented with left shoulder pain, and hot and cold sensations. She had limited range of motion in her left shoulder. Dr. Fontana noted that Claimant had rotator cuff surgery, and that Dr. Black had recommended a second surgery. Furthermore, Dr. Black was referring Claimant to a neurologist for the cervical radiculopathy down her left arm. On physical examination, Dr. Fontana found forward flexion to 90 degrees in her left shoulder, abduction to 80 degrees, external rotation of 30 degrees, and internal rotation to 100 degrees. In her hand, Dr. Fontana found decreased sensation in the radial nerve distribution, and she had tightness and restricted range of motion in her neck. He diagnosed Claimant with cervical radiculopathy and a possible recurrent tear. He recommended a neurologist, and an MRI of the shoulder to evaluate the rotator cuff repair; he continued Claimant on light duty work, and no work at all with her left arm. (CX-18, p. 19).

Dr. Todd Elmore, M.D.

On August 26, 2009, Claimant presented to Dr. Elmore with similar complaints. He took her history, and on physical examination noted some deltoid weakness, limitation due to pain, weakness in her left hand grip, decreased sensation to light touch over her entire left hand, and limited range of motion in her left shoulder. Dr. Elmore could not determine what was wrong with Claimant; he opined her problems were muscular tenderness and joint related. He thought that she may have a peripheral nerve injury, but could not tell what nerve was involved. He stated that her symptoms did not really sound like radiculopathy. He considered a trial of Lyrica, but thought that aggressive therapy and pain management may be what Claimant needed. An EMG/NCV performed the following day was normal. (CX-18, pp. 24-25).

Dr. Patricia Boltz, M.D.

Dr. Boltz saw Claimant on September 1, 2010. (EX-11). Claimant presented with complaints of chronic neck and bilateral shoulder pain, left arm pain, and headaches since her December 2008 accident. Claimant told Dr. Boltz the pain was constant, her left arm was weak and cold, and the pain was cramping and burning with swelling and stiffness. Claimant reported that she was on so much medication she had no energy, and had to take Phenergan and Prilosec because the medications made her sick. On physical examination, Claimant’s left hand grip was weak, and cooler than the right hand. Cervical range of motion created pain, and there was

swelling on the left side of her neck. Dr. Boltz diagnosed Claimant with chronic neck pain, and chronic left arm and shoulder pain with some radicular features of the upper extremity, and possible RSD. Dr. Boltz stated that Claimant was on so much medication she could barely function. She recommended another CESI, but a reduction in medications. (EX-11, pp. 1-4).

Dr. Boltz agreed with Dr. Black that Claimant needed another shoulder surgery. Because Claimant did not want surgery, Dr. Boltz did not know what else could be done; she recommended a FCE. (EX-11, p. 5).

On November 14, 2011, Claimant returned to Dr. Boltz for a second medical opinion. She presented with pain complaints in her left arm, shoulder, fingers, left upper back, and intermittent pain in the right shoulder. Claimant was tearful throughout the exam. She complained of burning and freezing cold down the left arm, and breaking out on her body, including on her face. Claimant reported an unchanged history to Dr. Boltz. On physical examination, Dr. Boltz noticed significant temperature differences between Claimant's left and right hands. Claimant would not put forth effort to test the strength. She had multiple palpable trigger points, but Dr. Boltz did not notice any blisters or rashes. Claimant guarded her arm but "several times throughout the visit, she would use the arm somewhat and forget." Dr. Boltz saw evidence of allodynia and hyperesthesia. (EX-11, pp. 6-7). Dr. Boltz assessed Claimant with left arm pain with probable RSD, and temperature change during the visit. Furthermore, she had chronic neck pain and myofascial pain, and opioid dependence. Dr. Boltz counseled Claimant and recommended she use her left arm if she wanted to get better; also, she continued to believe Claimant was on too many medications. Dr. Boltz felt Claimant was not giving a full effort. (EX-11, p. 8).

On November 18, 2011, Dr. Boltz wrote a second medical opinion, reporting what she observed in her two visits with Claimant. She opined that Claimant was overmedicated, and should be seen by a behavioral psychologist. She reviewed the FCE which Claimant did not complete the second day, and determined there was symptom magnification and inconsistencies, which she stated she saw in her visit with Claimant in November 2011. Dr. Boltz thought Claimant was self-limiting her behavior, which resulted in muscle spasms. Dr. Boltz agreed with Dr. Black's July 2010 work restrictions. (EX-11, pp. 9-10).

On December 5, 2011, Dr. Boltz wrote that she did not feel Claimant needed a dermatologist, because she had seen no blisters or rashes on Claimant. Moreover, she did not think Claimant needed a cardiologist because she thought that was unrelated to the work accident. She did, however, believe that Claimant needed to see a behavioral psychologist for "behavior modification in helping this patient deal with the reality that she needs to use her arm, and if there is ever any hope of moving forward and decreasing pain." (EX-11, p. 11).

Dr. Brian K. Tsang, M.D.

On January 14, 2010, Claimant presented to Dr. Tsang with radiating shoulder pain and numbness. He took a history, did a physical examination, and diagnosed Claimant with chronic cervical radiculopathy and chronic pain in the shoulder joint; he also noted she was taking a combination of opioid drugs. A cervical ESI was scheduled. (CX-15, pp. 4-6). On January 26,

2010, Claimant presented with complaints of depression because she could not do her household chores, migraines from her neck pain, and a sharp, burning, throbbing, tingling, shooting, and electric-like pain originating from the back of her neck down that spread into her left arm. Also, her left hand went numb from time to time. She stated that her pain was more severe while doing housework, grocery shopping, walking or jogging, and working. (CX-15, p. 8). Claimant's diagnosis was the same, and she was prescribed Paxil for depression, Lortab for short term neck and shoulder pain relief, Opana ER and Zanaflex for neck and shoulder pain along with her muscle spasms, Mobic for neck and shoulder inflammation, Trazodone for neuropathic pain in the neck and shoulder, and Nuerontin. (CX-15, p. 10). Claimant received a CESI on January 27, 2010. (CX-15, p. 11).

On January 27, 2010, Claimant presented with similar complaints. She was diagnosed with cervical radiculopathy, cervical myofascial pain, and cervical discogenic pain. She was to continue her prescribed medications. (CX-15, p. 14-15). On February 19, 2010, Claimant had the same diagnosis, but with pain in the shoulder joint, her medications were continued. (CX-15, pp. 17-18). On March 10, 2010, Dr. Tsang continued her medications. (CX-15, pp. 19-21). Claimant received another cervical epidural injection, without IV sedation. Although it was originally scheduled for March 3, 2010, she showed up without a driver over 18 and had to reschedule for March 10. (CX-15, pp. 22-23, 27).

On March 16, 2010, Claimant was prescribed the same drugs, with the addition of Nucynta for better pain control. (CX-15, p. 26). On April 13, 2010, Claimant stated she had increased swelling and inflammation at the site of her pain, and that her neck pain and associated headaches had worsened. Dr. Tsang continued her medications. (CX-15, pp. 32-34). On May 11, 2010, Dr. Tsang continued Claimant's medications. (CX-15, p. 37). He also continued them on June 8, 2010, and ordered a Cervical MRI and MRI of her left shoulder to evaluate the increased pain, swelling, and inflammation. (CX-15, p. 40). On June 29, 2010, and July 30, 2010, Claimant made same complaints and received the same diagnosis. On August 27, 2010, Dr. Tsang also diagnosed Claimant with long term use of high-risk medications. (CX-15, pp. 66-70).

From September 24, 2010 through February 11, 2011, Claimant made similar complaints to Dr. Tsang. (CX-19, pp. 57-66). On March 15, 2011, Claimant presented to Dr. Tsang with a recent diagnosis of CRPS from Dr. Millette. (CX-15, pp. 55-57). On March 30, 2011, Dr. Tsang administered a Stellate Ganglion block to reduce RSD symptoms of the left upper extremity. (CX-15, p. 54). On April 12, 2011, Claimant presented with similar symptoms, including radiating left shoulder pain, fatigue, sleep disturbance, chest pain, nausea, vomiting, joint, back, or neck pain, muscle aches, skin feeling hot and cold and painful to touch, headaches, tingling, and nervousness. (CX-15, pp. 53-54).

On April 29, 2011, Claimant returned to Dr. Tsang ten days earlier than scheduled due to severe pain in her left shoulder and arm. She attended a FCE the day prior, which caused severe increased symptoms. Thus, she could not make it to the second day of the FCE. After picking up a box, the pain became unbearable, and she broke down and cried. She told Dr. Tsang that she was unable to sleep at that point, and had heart palpitations and panic attacks; Claimant did not feel like she could cope with the depression from feeling so much pain. Her arms and hand

turned fire red. Dr. Tsang prescribed her Roxicodone, Lidoderm to the skin and Flector Patch-Diclofenac. (CX-15, pp. 51-53).

On May 5, 2011, Dr. Tsang administered a Stellate Ganglion block with IV sedation. (CX-15, pp. 50-51). On May 10, 2011, Claimant reported that the Stellate Ganglion block only relieved her pain for 3-4 days, and that epidural injections were more effective. (CX-15, p. 49). On June 21, 2011, Claimant presented with little changes since her last visit. She noted that she switched positions constantly for the pain, and that weather affected her pain level. Dr. Tsang added Nuerontin to help manage Claimant's pain. (CX-15, pp. 87-89).

On July 19, 2011, Dr. Tsang recommended that Claimant continue Cervical ESI for pain management, in a series of three injections to suppress irritation and inflammation over the next six months. (CX-19, pp. 91-93). On August 16, 2011, Claimant presented to Dr. Tsang with extremely low blood pressure and feeling faint. He told her to immediately go to the ER and not to take her current medications until being evaluated. (CX-15, pp. 95-97).

On September 13, 2011, Claimant presented to Dr. Tsang with left hand, arm, and leg electric-like pain, burning on her left side, and blisters forming on the left side. Claimant stated she was bedridden. Her muscle spasms had increased in frequency and her muscle relaxer was not working. Dr. Tsang continued her medications, but discontinued Percocet for Hydrocodone. Neurontin was discontinued for ineffectiveness. (CX-15, pp. 98-100). On October 11, 2011, Dr. Tsang scheduled trigger point injections for her shoulder in order to address the nerve pain secondary to radiculopathy. (CX-15, p. 101-103).

On October 31, 2011, Claimant made similar complaints and Dr. Tsang continued her medications. (CX-15, pp. 104-106).

In a patient referral letter that Dr. Tsang wrote on October 31, 2011, Claimant continued to have left shoulder pain and had RSD, which caused blisters to form on her face. Furthermore, her feet were swollen, hands and feet felt like ice, and she had no energy. Claimant could not sit or drive long periods, and had muscle spasms starting in her shoulder and radiating down her back. She also had anxiety and depression with severe headaches. (CX-15, pp. 44-47).

Dr. Terry Millette, M.D.

On March 4, 2011, Claimant presented to Dr. Millette with her history and complaints of left arm pain. On physical examination, she was tearful and guarded her left arm. Claimant's hand was cool and her fingers were swollen. Dr. Millette thought she had rotator tendonopathy, post successful surgical repair, and residual neuropathic pain, consistent with CRPS. He planned to take photographs and her temperature. (CX-16, p. 2).

On March 4, 2011, Dr. Millette expressed his opinion to FARA that Claimant had RSD, but some compliance problems with meeting appointments and attending therapy. He thought that a FCE was reasonable, and reasonable for Claimant to pursue disability acquisition. (CX-16, p. 4). On March 28, 2011, Claimant received a letter to show up at Physical Therapy Center of Ocean Springs for a FCE on April 28 and April 29, 2011. (CX-16, p. 6).

On April 29, 2011, Claimant phoned and left a message for Dr. Millette that her left shoulder burned all the way to her feet and she was having suicidal thoughts, which she had been having for some time. She wanted Dr. Millette to refer her to a psychiatrist. (CX-16, p. 10).

On November 23, 2011, Dr. Millette sent a letter to Claimant's counsel to clarify that she had a case of RSD in her left arm, and could only use the left arm in a limited fashion. He wrote that "the patient could conceivably be allowed to return to work but would only effectively be able to use her right arm." (CX-16, p. 24).

Physical Therapy Records

Singing River Rehab Records

Claimant attended rehab at Singing River Hospital from January 6, 2009, to July 1, 2009. In summary, Claimant complained of left shoulder pain, and received moist heat to the left shoulder followed by active and passive ROM/strengthening exercises and functional activities. (CX-21).

Physical Therapy Solutions Records

Claimant reported to therapy on July 21, 2009. She gave her history, and complained of swelling in the left side of her neck, pain along the left shoulder blade, shooting pain down her elbow, coldness and numbness in her left hand, pain along the left side of her back while driving, and sleep problems due to spasms of her left shoulder blade. She reported increased pain while wearing a bra. After performing a physical exam, the physical therapist opined that Claimant's symptoms were consistent with posterior-lateral cervical disc derangement in combination with RSD, complicating post-surgical recovery. The goal was to improve her RSD symptoms, rehabilitate her shoulder and back, gain improved active and passive shoulder range of motion, and improve cervical extension range of motion. (CX-20, p. 4).

On August 18, 2009, Claimant had completed 8 out of 18 ordered visits, and missed 2 scheduled visits. (CX-20, p. 12). On August 21, 2009, Claimant reported decreased coldness in the hand, but complained of neck, arm, and hand pain; she made modest gains with range of motion. (CX-20, p. 15).

On October 28, 2009, Claimant had completed 12 out of 18 ordered and approved visits from 7/21/09 through 9/21/09. Claimant complained of right shoulder pain, and her left shoulder feeling stiffer; however, she reported that she had been performing her weight carrying exercises. (CX-20, p. 24). On February 15, 2010, the physical therapist reported that Claimant had trouble with attendance. She completed 11 out of 12 ordered and approved visits, but had cancelled 8 visits and no showed for 8 visits. She was not in treatment between January 7 and February 15, 2010 as a result. Claimant reported tearfully that she had been without medication during that time. She reported tightness and stiffness in her neck and upper back, daily headaches, more pain on the right side of her neck, and pain along the left side. She reported that she spent most

of her time in bed and could not sit up longer than 45 minutes. “Her emotional state is a significant barrier to her participation in therapy.” (CX-20, p. 43).

Physical Therapy Center of Ocean Springs, Functional Capacity Evaluation

Claimant attended a FCE on April 28, 2011. (CX-16, p. 11-15). She demonstrated an unwillingness to attempt use of her left upper extremity; thus, it was determined she could do sedentary to light work with the right upper extremity. “However, if the client were to fully cooperate and participate with the testing procedure, it is within reasonable medical probability that her abilities would far exceed those demonstrated during the test.” Claimant was reported as engaging in self limited performance, exaggerated pain behaviors, and inconsistent use of her left upper extremity. (CX-16, p. 11). Claimant only showed up for the first day of the FCE. Claimant gave full effort on 5 out of 14 tests, and self restricted on 9 tests. (CX-16, p. 12).

Psychological Evidence

Dr. Stofan Massong, Ph.D.

On January 9, 2010, Dr. Massong examined Claimant. (CX-23). Dr. Massong wrote that Claimant gave her best effort during the three hour exam, and that the results were valid. He took a personal and medical history, and reviewed Claimant’s prescribed medications. (CX-23, p. 1). Dr. Massong found Claimant to be at least average intellectual capacity and generally realistic in her medical agenda. However, “her judgment, psychological insight, problem-solving capacities and adaptational resources appear somewhat compromised and inefficient in the face of her immediate situational factors.” He found that she exhibited symptoms of reactive depressive disorder, and Claimant described depressed mood with anhedonia, withdrawal, rumination, guilt, loss of self-esteem, and inefficient mental status. (CX-23, p. 2).

Dr. Massong opined Claimant felt she had no one to confide in, and was overwhelmed by the chronic pain and helplessness in the face of the medical and rehabilitative challenges confronting her. She has become withdrawn and detached from her family and emotional support system. (CX-23, p. 2). Dr. Massong recommended six to eight visits of psychotherapy. Moreover, he thought Claimant could benefit from Prozac, Wellbutrin, or Cymbalta, and he suggested the Remeron be discontinued. (CX-23, p. 3).

On January 23, 2012, in an addendum to his January 9 report, Dr. Massong opined that Claimant was not at the present time capable of any competitive employment due to the effects of her major clinical depressive disorder and chronic, intractable pain syndrome. (CX-24).

Dr. John Davis, Ph.D.

Dr. Davis examined Claimant post-hearing at the request of Employer. (EX-21). In a letter from Employer dated January 25, 2012, Dr. Davis responded that there was no way Claimant could work with the amount of medication she was taking, and that she was receiving too much medication. (EX-21, p. 2). Furthermore, he stated that he did not think Claimant would benefit from psychological treatment. (EX-21, p. 3).

On January 31, 2012, Dr. Davis met with Claimant. Claimant reported to Dr. Davis that she injured her left rotator cuff and left knee, and that the knee and neck injuries were untreated. She presented with a burning sensation attributable to RSD, and reported chronic headaches, sleep problems, depression, and panic attacks. (EX-21, p. 4). Claimant stated to Dr. Davis that walking and sitting causes her pain, and her left arm does not work. (EX-21, p. 5). Dr. Davis noted that Claimant was tearing up and complained of pain during the interview, and told him that she gained 40 pounds since 2008. He stated her mood was generally one of depression, and she had some anxiety and depression about herself. He found no concentration or memory difficulties, and she knew the President but not the Governor or Mayor. (EX-21, pp. 6-7). She reported that she does not sleep well, and does limited housekeeping and cooking. Overall, Dr. Davis felt Claimant put forth her best effort, thus his results were a “reliable and valid estimate of this patient’s current level of intellectual functioning.” (EX-21, p. 7). He opined the results were consistent with her education, vocational background, and social judgment. She obtained a Full Scale IQ of 82, which placed her overall level of functioning in the Low Average range. (EX-21, p. 8).

For her personality profile, Dr. Davis stated the results of his MMPI showed a high F scale which suggested that Claimant was not reading the items, disoriented, or trying to emphasize physical problems for treatment purposes or secondary gain. (EX-21, p. 9). He found no indications of psychotic or delusional thinking, but stated she was malingering and had developed a pattern of withdrawal and detachment. Claimant showed boredom, lethargy, fatigue, passivity, and daily monotony. He opined her eccentric personality style revealed an absence of normal experiences, emotions, and connections to others. “She seems to have given up on the need for intimate relationships, friendships, camaraderie or involvement with others. She has a disconnected, hazy, empty, or indifferent self-image.” (EX-21, p. 9). He felt she was dependent on prescribed narcotic medication. (EX-21, p. 10).

Dr. Davis diagnosed Claimant with malingering, poly-substance abuse, situational depression, and personality disorder. He opined her medication needed adjusting and controlling, and if she was not taking any pain medication there would be no restrictions. He noted that she could need drug rehabilitation to get control of the pain medications. (EX-21, p. 10).

Vocational Evidence

Report of Tommy Sanders and the Labor Market Surveys

On December 14, 2010, Mr. Sanders completed a vocational report. (EX-17). Mr. Sanders was asked to complete two reports using Dr. Black’s restrictions. The first request was for current jobs within the sedentary limitations, and also jobs on or about July 29, 2010. The second request was for a retroactive hypothetical survey for jobs on or about September 22, 2009. Mr. Sanders met with Claimant at Employer’s attorney’s office. (EX-17, p. 1). She had no problems with the law, and had no current hobbies although she used to swim, walk, and go to the gym.

Claimant graduated from high school where she could type 65 words per minute. She is familiar with Word and Excel. She attended Medical Office Management and received her certificate after nine months from Florida School of Business in Tampa; her courses included medical billing, medical terminology, and word processing. Claimant reported past work history which was consistent with her testimony at the formal hearing, and she gave a medical history to Mr. Sanders. On August 13, 2010, Dr. Black determined Claimant could work in a sedentary job with no pulling, no climbing, and no lifting over five pounds. (EX-17, p. 2).

Mr. Sanders determined that Claimant's work activity was unskilled to semi-skilled involving sedentary to heavy physically demanding occupations. He opined that Claimant was qualified for entry level unskilled to semi-skilled jobs, and he found the following for current jobs available or jobs available since July 22, 2010:

The position of customer service representative paid \$8.00/hour. The job required frequent sitting and routine lifting of one to two pounds; it required light cleaning such as sweeping and vacuuming.

The position of appointment setter paid \$7.25/hour. The job was sedentary.

The position of telemarketer paid \$8.00/hour plus commission. The job was sedentary.

The position of customer service representative paid \$8.00/hour and was sedentary. The position required frequent sitting, occasional walking, and routine lifting of one pound or less.

The position of call center operative paid \$8.00/hour and was sedentary and required applicant to be able to operate a computer system, speak clearly, and handle multiple phone lines.

The position of customer service representative paid \$8.00/hour, required frequent sitting, occasional walking and standing, and routine lifting of one to two pounds. (EX-17, pp. 3-4)

For jobs available on or about September 22, 2009, the position of telephone collector paid \$8.00/hour and was sedentary.

The position of night auditor trainee paid \$7.25/hour and primarily required sitting, with negligible lifting.

In October 2009, the position of telephone answering service operator paid \$7.50/hour and was sedentary.

In February 2010, the position of customer service representative paid \$8.00/hour and included frequent sitting, and occasional walking and standing.

In March 2010, the position of retention clerk paid \$8.00/hour and was sedentary.

In April 2010, the position of insurance claims coordinator paid \$8.00/hour and was sedentary.

In May 2010, the position of customer service representative paid \$8.00/hour and required frequent sitting with occasional walking and standing. Mr. Sanders stated that the positions were found assuming Claimant was capable of sedentary employment. (EX-17, pp. 4-5).

A second labor market report and survey was completed on November 2, 2011, using the same history Claimant had given Mr. Sanders.

The position of customer service representative paid \$8.00/hour and required light cleaning, vacuuming, and emptying trash. Employees would also be required to pass out business cards once weekly. The job required frequent sitting, occasional walking/standing with infrequent bending, twisting, and squatting. The applicant would lift up to five pounds infrequently, and routinely one pound or less. (EX-17, p. 6).

The position of reservation clerk paid \$8.00/hour and was sedentary with lifting one pound or less. (EX-17, p. 6).

The position of telemarketer paid \$7.25/hour plus commission. The duties included selling mops, brooms, T-shirts, and other products. The job was sedentary with negligible lifting.

The position of customer service representative paid \$8.00/hour and required frequent lifting of one to two pounds, and allowed frequent sitting, occasional standing, and infrequent bending or squatting. (EX-17, p. 7).

DISCUSSION

It has been consistently held that the Act must be construed liberally in favor of the claimant. *Voris v. Eikel*, 346 U.S. 328, 333 (1953); *J.B. Vozzolo, Inc. v. Britton*, 377 F.2d 144 (D.C. Cir. 1967). However, the United States Supreme Court has determined that the “true-doubt” rule, which resolves factual doubt in favor of the claimant when the evidence is evenly balanced, violates Section 7(c) of the Administrative Procedure Act, 5 U.S.C. § 556(d), which specifies that the proponent of a rule or position has the burden of proof. *Director, OWCP v. Greenwich Collieries*, 512 U.S. 267 (1994), *aff’g* 990 F.2d 730 (3d Cir. 1993).

In arriving at a decision in this matter, it is well-settled that the fact-finder is entitled to determine the credibility of the witnesses, weigh the evidence and draw his own inferences from it, and is not bound to accept the opinion or theory of any particular medical examiner. *Todd Shipyards v. Donovan*, 200 F.2d 741 (5th Cir. 1962); *Banks v. Chi. Grain Trimmers Ass’n*, 390 U.S. 459, 467, *reh’g denied*, 391 U.S. 928 (1968).

In the instance case, Employer argues that Claimant lacks credibility due to her alleged inconsistencies, exaggerations, and malingering. In their post-hearing brief, Employer points to

excerpts from certain doctors revealing their opinions of Claimant. For example, Dr. Boltz stated Claimant was malingering on her FCE. However, Dr. Boltz agreed with Dr. Black that Claimant needed another surgery for her left shoulder. Moreover, she determined Claimant had symptoms of RSD, a year before Dr. Millette's diagnosis of RSD for Claimant. Thus, Dr. Boltz's opinion is inconsistent in that she acknowledges Claimant had injuries requiring treatment, but still determined Claimant was malingering. Dr. Massong believed Claimant's psychological issues were directly related to the pain and hopelessness she felt, and Dr. Black opined that Claimant's main issue was her low pain threshold. Thus, any malingering or inconsistencies can be explained by Claimant's fragile mental state and inability to deal with the pain she felt. This court finds Claimant to be consistent with her pain complaints and a credible witness.

It is also noted that the opinion of a treating physician may be entitled to greater weight than the opinion of a non-treating physician under certain circumstances. *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 830, 123 S.Ct. 1965, 1970 n.3 (2003)(in matters under the Act, courts have approved adherence to a rule similar to the Social Security treating physicians rule in which the opinions of treating physicians are accorded special deference)(citing *Pietrunti v. Director, OWCP*, 119 F.3d 1035 (2d Cir. 1997)(an administrative law judge is bound by the expert opinion of a treating physician as to the existence of a disability "unless contradicted by substantial evidence to the contrary")); *Rivera v. Harris*, 623 F.2d 212, 216 (2d Cir. 1980)("opinions of treating physicians are entitled to considerable weight"); *Loza v. Apfel*, 219 F.3d 378 (5th Cir. 2000)(in a Social Security matter, the opinions of a treating physician were entitled to greater weight than the opinions of non-treating physicians).

Here, Claimant was and is treated by multiple doctors rendering opinions. While she has treated with Dr. Tsang for a long period of time, she also treated with Dr. Black on a regular basis, and has different types of doctors for her different medical needs. She is currently treating with a psychologist. Therefore, this Court will review the medical record in its entirety, and not give greater weight to any particular physician.

Compensable Injury

Section 2(2) of the Act defines "injury" as "accidental injury or death arising out of and in the course of employment, and such occupational disease or infection as arises naturally out of such employment or as naturally or unavoidably results from such accidental injury" 33 U.S.C. 902(2). Section 20(a) of the Act provides a presumption that aids the Claimant in establishing that a harm constitutes a compensable injury under the Act. However, before an administrative law judge may properly apply the Section 20(a) presumption, the claimant must establish a *prima facie* case. *Murphy v. SCA/Shayne Bros.*, 7 BRBS 309 (1977).

Claimant's Prima Facie Case

Claimant has sustained a physical harm and pain as a result of her 2008 work accident. Claimant claims injuries to her left shoulder and neck, right pinky finger, knee, and left arm. Thereafter, the left shoulder and neck injury caused RSD/CRPS to develop. In their post-hearing

brief, Employer did not dispute these injuries. Thus, this Court finds Claimant has the above compensable injuries.

Claimant's Secondary Injuries

The Fifth Circuit has held that the presumption of causation does not apply to subsequent, non-work-related conditions that follow an initial work injury. *Amerada Hess Corp. v. Director, OWCP*, 543 F.3d 755 (5th Cir. 2008). Such subsequent conditions are compensable under the Act only if the claimant's condition "naturally or unavoidably" resulted from the treatment for his work-related injury. *Amerada*, 543 F.3d at 762 (citing 33 U.S.C. § 902(2)). The standard, therefore, is that an employer is liable for all disability and medical expenses which are the natural or unavoidable result of a claimant's work injury.

Thus, in the present case, Claimant must establish that her psychological injury "naturally or unavoidably" resulted from her physical injuries sustained in the December 11, 2008 work accident. Employer contests that Claimant's psychological condition was related to her work accident. In support of this, Employer states that Dr. Davis diagnosed Claimant with malingering, poly substance abuse, situational depression and personality disorder cluster B. Dr. Davis recommended that Claimant's medications be reviewed and controlled. Despite writing that Claimant would not benefit from psychological treatment, Dr. Davis diagnosed Claimant with situational depression and even noted the necessity of rehab. While he suggested that Claimant was malingering, inconsistently he also determined that Claimant put forth her best effort, and his results were a "reliable and valid estimate of this patient's current level of intellectual functioning." (EX-21, p. 7). Thus, this Court does not find that Dr. Davis' opinion is conclusive evidence Claimant's psychological injury was not work-related.

Also as evidence that Claimant did not sustain a psychological injury, Employer states that Dr. Boltz opined Claimant did not need to see a psychologist. However, Dr. Boltz actually opined that Claimant *would* benefit from a psychologist, in complete contradiction to what Employer cited in their brief. "I do . . . feel that [Claimant] would benefit from seeing a behavior psychologist for behavior modification." Dr. Boltz determined Claimant needed therapy in order to move forward with her left arm recovery. (EX-11, p. 11). Moreover, Claimant's own psychologist, Dr. Massong, stated that Claimant was overwhelmed by the chronic pain and helplessness in the face of the medical and rehabilitative challenges confronting her. Thus, Dr. Boltz and Dr. Massong connected Claimant's psychological problems to her injuries, and even Dr. Davis acknowledged that any psychological problems Claimant had were a result of medicine prescribed *for* her work-related injuries. This Court finds that Claimant, based on the medical record, proved that her psychological injury flowed "naturally or unavoidably" from her other work-related injuries. Thus, Claimant established a compensable psychological injury.

Nature and Extent of Disability

Having found that a claimant suffers from compensable conditions, the burden of proving the nature and extent of the disability rests with him. *Trask v. Lockheed Shipbuilding Constr. Co.*, 17 BRBS 56, 59 (1985). "Disability" is defined under the Act as "incapacity because of injury to earn the wages which the employee was receiving at the time of injury in the same or

any other employment” 33 U.S.C. § 902(10). Therefore, for a claimant to receive an award for disability, an economic loss coupled with a physical (and/or psychological) impairment must be shown. *Sproull v. Stevedoring Servs. of Am.*, 25 BRBS 100, 110 (1991).

Generally, disability is addressed in terms of its nature (permanent or temporary) and extent (partial or total). *Pool Co. v. Cooper*, 274 F.3d 173, 175 n.2 (5th Cir. 2001).

Nature of Disability

The permanency of any disability is a medical rather than an economic concept. Permanent disability is a disability that has continued for a lengthy period and appears to be of lasting or indefinite duration, as distinguished from one in which recovery merely awaits a normal healing period. *Watson v. Gulf Stevedore Corat*, 400 F.2d 649, *pet. for reh'g denied sub nom. Young & Co. v. Shea*, 404 F.2d 1059 (5th Cir. 1968) (per curiam), *cert. denied*, 394 U.S. 876 (1969); *SGS Control Services v. Director, OWCP*, 86 F.3d 438, 444 (5th Cir. 1996). A claimant's disability is permanent in nature if he has any residual disability after reaching maximum medical improvement (MMI). *Trask v. Lockheed Shipbuilding Constr. Co.*, 17 BRBS 56, 60 (1980). Any disability suffered by a claimant before reaching MMI is considered temporary in nature. *Berkstresser v. Washington Metropolitan Area Transit Authority*, 16 BRBS 231 (1984); *SGS Control Services*, 86 F.3d at 443.

The traditional method for determining whether an injury is permanent or temporary is the date of MMI. *See Turney v. Bethlehem Steel Corat*, 17 BRBS 232, 235 n.5 (1985). The date of MMI is a question of fact based upon the medical evidence of record. *Ballesteros v. Willamette Western Corat*, 20 BRBS 184, 186 (1988); *Williams v. General Dynamics Corat*, 10 BRBS 915 (1979). An employee reaches MMI when his condition becomes stabilized. *Cherry v. Newport News Shipbuilding & Dry Dock Co.*, 8 BRBS 857 (1978); *Thompson v. Quinton Enterprises, Ltd.*, 14 BRBS 395, 401 (1981).

Dr. Black placed Claimant at MMI on July 29, 2010, because she did not want to have a second shoulder surgery. Claimant's medical issues continued. Dr. Black admitted in a letter to Employer that Claimant's main issue was her low pain threshold, and referred her to a doctor for pain management. Thus, he placed her at MMI because he could no longer help Claimant, but he acknowledged that she could improve with other medical attention. Importantly, it was after that potential MMI date that Claimant finally was diagnosed with RSD. She subsequently treated with Dr. Tsang and others for her pain. Dr. Boltz and Dr. Massong feel that Claimant could benefit from psychological treatment, and that her psychological issues are likely a barrier to her physical improvement. Thus, because Claimant has the potential to improve with additional physical and psychological treatment, this Court finds that Claimant has not reached MMI for her December 2008 work injuries.

Extent of Disability

The question of extent of disability is an economic as well as a medical concept. *Quick v. Martin*, 397 F.2d 644 (D.C. Cir. 1968); *Eastern S.S. Lines v. Monahan*, 110 F.2d 840 (1st Cir. 1940); *Rinaldi v. General Dynamics Corporation*, 25 BRBS 128, 131 (1991). To establish a

prima facie case of total disability, the claimant must show that he is unable to return to his regular or usual employment due to his work-related injury. *Manigault v. Stevens Shipping Co.*, 22 BRBS 332 (1989); *Harrison v. Todd Pac. Shipyards Corat*, 21 BRBS 339, 342-43 (1988). A claimant need not establish that he cannot return to any employment, only that he cannot return to his former employment. *Elliot v. C&P Tel. Co.*, 16 BRBS 89 (1984).

To determine whether the claimant has presented a *prima facie* case for total disability, the claimant's present medical restrictions must be compared with the specific requirements of his usual or former job. *Curit v. Bath Iron Works Corat*, 22 BRBS 100 (1988). A physician's opinion that an employee's return to his usual work would aggravate his condition is sufficient to support a finding of total disability. *Care v. Wash. Metro. Area Transit Auth.*, 21 BRBS 248 (1988); *Boone v. Newport News Shipbuilding & Dry Dock Co.*, 21 BRBS 1 (1988); *Lobue v. Army & Air Force Exch. Serv.*, 15 BRBS 407 (1983).

Claimant cannot return to her former work. Even if this Court used Employer's suggested restrictions, those from Dr. Black, Claimant could not return to her former employment. Dr. Black assigned Claimant restrictions of possible sedentary work, no lifting over 5 pounds, no pulling, and no climbing. Furthermore, Employer allowed Claimant to work light duty for 90 days, at which point they told her they no longer had a light-duty position available. Thus, I find that Claimant cannot return to her usual employment at this time, and has established a *prima facie* case of total disability.

Suitable Alternative Employment

Once a *prima facie* case of total disability is established, the burden shifts to the employer to establish the availability of suitable alternative employment. *New Orleans (Gulfwide) Stevedores v. Turner*, 661 F.2d 1031, 1038 (5th Cir. 1981). In addressing the issue of job availability, the Fifth Circuit has developed a two-part test to meet this burden:

Considering a claimant's age, background, etc., what can he physically and mentally do following his injury (i.e., what types of jobs is he capable of performing or capable of being trained to do)?

Within the category of jobs that the claimant is reasonably capable of performing, are there jobs reasonably available in the community for which he is able to compete and which he reasonably and likely could secure?

Id. at 1042-43. *Turner* does not require that the employer find specific jobs for the claimant or act as an employment agency for the claimant; instead, the employer may simply demonstrate "the availability of general job openings in certain fields in the surrounding community." *P & M Crane Co. v. Hayes*, 930 F.2d 424, 431 (5th Cir. 1991); *Avondale Shipyards, Inc. v. Guidry*, 967 F.2d 1039, 1044 (5th Cir. 1992).

However, for the court to rationally determine if the claimant is physically and mentally capable of performing the work and that it is realistically available, the employer must establish the precise nature and terms of those job opportunities it contends constitute suitable alternative

employment. *Piunti v. ITO Corat of Baltimore*, 23 BRBS 367, 370 (1990); *Thompson v. Lockheed Shipbuilding & Constr. Company*, 21 BRBS 94, 97 (1988). The court must compare the jobs and requirements identified by the vocational expert with the claimant's physical (and mental) restrictions based on the medical opinions of record. *Villasenor v. Marine Maint. Indus., Inc.*, 17 BRBS 99 (1985). Failure to show suitable alternative employment results in a finding of total disability. *Manigault v. Stevens Shipping Co.*, 22 BRBS 332 (1989).

Employer hired Mr. Sanders to complete labor market surveys and a report based on Dr. Black's work restrictions. Employer maintains that according to Drs. Fontana, Black, and Smith, Claimant can return to work. Dr. Black placed Claimant at MMI and allowed her to return to work on August 12, 2010. He assigned her sedentary work, no lifting over 5 pounds, no pulling, and no climbing. Moreover, he stated in a letter he would have allowed Claimant to work with his restrictions between September 22, 2009 and August 12, 2010, had work been available. Employer produced a hypothetical labor market survey to show suitable alternative employment retroactively for those dates. However, Claimant was not properly diagnosed with RSD until Dr. Millette examined her in March 2011. This Court will not examine the retroactive jobs found for Claimant during the time when she was lacking a firm diagnosis, even though some doctors had acknowledged RSD-like symptoms. This would be speculative at the least, considering she may not have been assigned proper work restrictions and her pain was misunderstood.

Employer urges that this Court ignore Dr. Tsang's work restrictions and instead look to Drs. Fontana, Black, and Smith. First, Drs. Black and Smith have not recently examined Claimant, thus any work restrictions and opinions are not current. Even though Dr. Fontana agreed that Claimant could return to light duty work, most doctors with current knowledge of Claimant do not believe she can work at this time. Dr. Tsang has restricted Claimant from work. Dr. Massong, Claimant's psychologist, stated that she would not be capable in her current major clinical depressive state with chronic pain to secure competitive employment. Dr. Davis, Employer's choice for a second medical psychological opinion, opined there was no way Claimant could work on her current medications. Thus, given the great weight of the current medical opinions, this Court finds no suitable alternative employment, and finds Claimant to be temporarily totally disabled. This Court notes that with psychological and physical treatment, Claimant should be able to return to some type of work in the future.

Average Weekly Wage

Section 10 of the Act sets forth three alternative methods for calculating a claimant's average annual earnings, 33 U.S.C. § 910 (a)-(c), which are then divided by 52, pursuant to Section 10(d), to arrive at an AWW. The computation methods are directed towards establishing a claimant's earning power at the time of injury. *SGS Control Services v. Director, OWCP*, 86 F.3d 438, 441 (5th Cir. 1996); *Empire United Stevedores v. Gatlin*, 936 F.2d 819, 25 BRBS 26 (5th Cir. 1991); *Johnson v. Newport News Shipbuilding & Dry Dock Co.*, 25 BRBS 340 (1992); *Lobus v. I.T.O. Corp.*, 24 BRBS 137 (1990).

Section 10(a) provides that when the employee has worked in the same employment for substantially the whole of the year immediately preceding the injury, his annual earnings are computed using his actual daily wage. 33 U.S.C. § 910(a). Section 10(b) provides that if the

employee has not worked substantially the whole of the preceding year, his average annual earnings are based on the average daily wage of any employee in the same class who has worked substantially the whole of the year. 33 U.S.C. § 910(b). However, if neither of these two methods “can reasonably and fairly be applied” to determine an employee’s average annual earnings, Section 10(c) is appropriate. *Empire United Stevedore v. Gatlin*, 936 F.2d 819, 821 (5th Cir. 1991).

To determine average annual earnings, Section 10(a) and 10(b) both require a determination of an average daily wage to be multiplied by 300 days for a 6-day worker and by 260 days for a 5-day worker. To do this calculation under either Section 10(a) or 10(b) the number of days a claimant actually worked must be known. Claimant worked a 4-day week, and not substantially the whole of the year preceding her accident. Accordingly, neither Section 10(a) nor Section 10(b) can be applied.

Because neither Section 10(a) nor 10(b) of the Act can be applied, Section 10(c) is the appropriate standard under which to calculate AWW in this matter.

Section 10(c) of the Act provides:

If either [Section 10(a) or 10(b)] cannot reasonably and fairly be applied, such average annual earnings shall be such sum as, having regard to the previous earnings of the injured employee in the employment in which he was working at the time of the injury, and of other employees of the same or most similar class working in the same or most similar employment in the same or neighboring locality, or other employment of such employee, including the reasonable value of the services of the employee if engaged in self-employment, shall reasonably represent the annual earning capacity of the injured employee.

33 U.S.C § 910(c). The objective of 10(c) is to reach a fair and reasonable approximation of a claimant’s wage-earning capacity at the time of injury. *Story v. Navy Exchange Service Center*, 33 BRBS 111 (1999). The court has broad discretion in determining annual earning capacity under Section 10(c). *Fox v. West State, Inc.*, 31 BRBS 118 (1997); *Hicks v. Pacific Marine & Supply Co., Ltd.*, 14 BRBS 549 (1981).

In the instant case, Section 10(c) is applied. Claimant began work for Employer in May 2008. Until her accident in December of that year, Claimant only worked 15 weeks, due to migraine headaches unrelated to her employment. Thus, this Court finds that the most accurate determination of Claimant’s average weekly wage is her total earnings with Employer divided by the weeks worked, or \$5,597.88 divided by 15. (CX-11). This equals an average weekly wage of \$373.19.

Entitlement to Medical Care and Benefits

Section 7(a) of the Act provides that:

The employer shall furnish such medical, surgical, and other attendance or treatment, nurse and hospital service, medicine,

crutches, and apparatus, for such period as the nature of the injury or the process of recovery may require.

33 U.S.C. § 907(a).

The Employer is liable for all medical expenses which are the natural and unavoidable result of the work injury. For medical expenses to be assessed against the Employer, the expense must be both reasonable and necessary. *Pernell v. Capitol Hill Masonry*, 11 BRBS 532, 539 (1979). Medical care must also be appropriate for the injury. 20 C.F.R. § 702.402.

A claimant has established a prima facie case for compensable medical treatment where a qualified physician indicates treatment was necessary for a work-related condition. *Turner v. Chesapeake & Potomac Tel. Co.*, 16 BRBS 255, 257-258 (1984).

Section 7 does not require that an injury be economically disabling for claimant to be entitled to medical benefits, but only that the injury be work-related and the medical treatment be appropriate for the injury. *Ballesteros v. Willamette Western Corp.*, 20 BRBS 184, 187.

Entitlement to medical benefits is never time-barred where a disability is related to a compensable injury. *Weber v. Seattle Crescent Container Corp.*, 19 BRBS 146 (1980); *Wendler v. American National Red Cross*, 23 BRBS 408, 414 (1990).

An employer is not liable for past medical expenses unless the claimant first requested authorization prior to obtaining medical treatment, except in the cases of emergency, neglect or refusal. *Schoen v. U.S. Chamber of Commerce*, 30 BRBS 103 (1997); *Maryland Shipbuilding & Drydock Co. v. Jenkins*, 594 F.2d 404, 10 BRBS 1 (4th Cir. 1979), rev'g 6 BRBS 550 (1977). Once an employer has refused treatment or neglected to act on claimant's request for a physician, the claimant is no longer obligated to seek authorization from employer and need only establish that the treatment subsequently procured on his own initiative was necessary for treatment of the injury. *Pirozzi v. Todd Shipyards Corp.*, 21 BRBS 294 (1988); *Rieche v. Tracor Marine*, 16 BRBS 272, 275 (1984).

The employer's refusal need not be unreasonable for the employee to be released from the obligation of seeking his employer's authorization of medical treatment. See generally 33 U.S.C. § 907(d)(1)(A). Refusal to authorize treatment or neglecting to provide treatment can only take place after there is an opportunity to provide care, such as after the claimant requests such care. *Mattox v. Sun Shipbuilding & Dry Dock Co.*, 15 BRBS 162 (1982). Furthermore, the mere knowledge of a claimant's injury does not establish neglect or refusal if the claimant never requested care. *Id.*

Having found that Claimant suffered work injuries to her left shoulder and neck, right pinky finger, knee, left arm, and RSD and psychological injuries arising out of those, this Court finds that Employer must pay all related reasonable and necessary medical expenses. Claimant's psychological injuries are a natural and unavoidable result of her other work injuries. Thus, Employer must pay medical expenses pertaining to Claimant's anxiety and depression.

Employer asserts that they are not responsible for Claimant's cardiac related emergency room visit or future cardiac treatment. Employer argues Claimant did not request authorization before going to the emergency room for her low blood pressure. However, Dr. Tsang told Claimant during an appointment to go directly to the emergency room, thus this Court finds an emergency situation. Therefore, Claimant did not need to seek authorization and Employer is responsible. (CX-15, pp. 95-97). Furthermore, Dr. Tsang referred Claimant for a consultation concerning her low blood pressure. This Court finds it reasonable and necessary to evaluate Claimant's blood pressure in order to determine that medication and treatment for her injuries are proper. However, the extent of any treatment from a cardiologist should be restricted to an evaluation and regulation of Claimant's low blood pressure.

Employer also asserts that they are not responsible for any dermatological treatment requested by Claimant. However, Claimant's post-hearing brief did not request any payment for dermatology treatment. Thus, this Court finds Employer not responsible for any dermatological treatment for Claimant.

This Court notes that Employer asserts Claimant requires no more treatment for her knee and neck injured in December 2008. However, Claimant has not at this time requested such treatment, thus Employer is not responsible.

ORDER

Based upon the foregoing findings of fact, conclusions of law, and upon the entire record, the Court issues the following compensation ORDER:

Employer shall pay Claimant compensation benefits for temporary total disability from September 22, 2009 and continuing, based on an average weekly wage of \$373.19.

Employer shall pay Claimant for all reasonable and necessary medical expenses arising out of her work-related injuries pursuant to 33 U.S.C. § 907.

Employer shall pay Claimant interest on any sums determined due and owing at the rate provided by 28 U.S.C. § 1961.

Employer shall receive a credit for all compensation payments previously made to Claimant.

Claimant's counsel shall have twenty days from receipt of this ORDER to file a fully supported attorney's fee petition and to serve a copy on opposing counsel, who shall then have ten days to respond with objections thereto.

All computations of benefits and other calculations provided in this ORDER are subject to verification and adjustment by the District Director.

So ORDERED.

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LARRY W. PRICE
Administrative Law Judge