

Conversely, the respondent agrees with the ALJ that claimant failed to prove her entitlement to work disability but contends claimant's appropriate permanent partial general disability award should be 5 percent based on the permanent functional impairment opinion of Theodore L. Sandow, M.D., who was appointed by the ALJ to perform an independent medical examination of claimant.

Thus, the sole issue for Appeals Board (Board) review is the nature and extent of claimant's disability.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

After reviewing the record, considering the briefs and hearing the parties' arguments, the Board makes the following findings and conclusions:

On November 4, 1996, claimant started working for respondent as a diagnostic medical stenographer operating an ultrasound machine. As claimant was walking out of her office on October 6, 1998, claimant slipped on a freshly mopped floor and fell. The fall caused claimant to suffer injuries to her right hip, low back, right forearm and palm of her left hand.

Respondent first provided the claimant with medical treatment through its emergency department. The next day, October 7, 1998, claimant was seen by Kevin Komes, M.D., a physical medicine and rehabilitation physician. Dr. Komes saw claimant on six occasions for the period including October 7, 1998, through November 18, 1998. Dr. Komes' initial impression was soft tissue trauma in multiple areas of claimant's body. Dr. Komes treated claimant's injuries conservatively with physical therapy and medication. The claimant was returned to light duty work on October 12, 1998. Claimant's temporary restrictions were no lifting or pulling/pushing and alternate sitting and standing.

Claimant's condition improved and Dr. Komes released claimant for work without restrictions on November 11, 1998. The last time Dr. Komes saw claimant was November 18, 1998. At that time, claimant was performing her regular job of operating the ultrasound machine. Claimant still had some discomfort complaints in her right wrist, left elbow and right thigh. But claimant's physical examination showed she was able to flex forward and touch the floor, had normal back extension and side bending. She had full passive and active motion of flexion and extension of her right and left wrist. Claimant also walked with a normal gait. Dr. Komes discharged claimant from his care with no permanent restrictions and no functional impairment rating.

Although Dr. Komes had released claimant without permanent restrictions and claimant had exhibited only minor symptoms during her last visit, after claimant returned to work, she testified her symptoms continued to worsen to the point she gave respondent two

weeks notice and terminated her employment with her last day worked of March 5, 1999. Claimant also testified that her supervisor attempted to help her to continue to perform her job by hiring other employees to assist her. He also limited the amount of overtime she worked and her on-call time was limited from every week to every third week. Even with those accommodations, claimant testified that her pain caused her to have a lot of stress and she could no longer operate the ultrasound machine for the respondent.

Before claimant's October 6, 1998, accident, she was treated in 1997 by rheumatologist Michael E. Joseph, M.D. Dr. Joseph first saw claimant on July 1, 1997, with complaints of pain and stiffness in her neck, fatigue and insomnia. Dr. Joseph's initial diagnosis was osteoarthritis and fibromyalgia. He prescribed medication treatment for claimant's conditions which included anti-inflammatories, muscle relaxants and anti-depressants.

Dr. Joseph saw claimant on two additional occasions in 1997, on July 23, 1997, and September 3, 1997. During the September 3, 1997, visit, Dr. Joseph found claimant's fibromyalgia and osteoarthritis conditions as stable.

Other than to refill prescriptions, Dr. Joseph did not hear from claimant until after her October 6, 1998, accident on November 17, 1998, when claimant requested an appointment by telephone. Dr. Joseph then saw claimant on January 28, 1999. At that time, claimant again had complaints of pain and stiffness in her neck and shoulders. Dr. Joseph opined that claimant's fibromyalgia condition had been stable and based on the history of claimant's October 6, 1998, fall at work, that trauma aggravated and worsened her fibromyalgia condition. The doctor adjusted her medication by changing the anti-depressant medication and increasing the sleep disorder medication.

Dr. Joseph had not placed any restrictions on claimant's activities, but testified he would have restricted claimant from heavy lifting above her head, no excessive pulling, pushing, crawling, climbing, stooping, and bending. The claimant did not return to see Dr. Joseph for almost a year from January 28, 1999, to January 17, 2000. This was the last time that Dr. Joseph saw claimant for her continuing fibromyalgia condition. At that time, claimant had no neck and shoulder complaints but had for the first time, right hip pain.

Claimant last testified in this case at the April 6, 2000, regular hearing. At that time, claimant had a myriad of complaints including pain and discomfort in her right hip, neck, shoulders, and low back. Claimant testified she was in so much pain and discomfort that in order for her to get through the day she had to lay down three to four times per day. She also continued not to sleep well at night.

After claimant quit respondent's employment, she testified she looked for other employment including a less strenuous ultrasound machine operating job but was unable

to find one. The only job claimant found and attempted was to sell prepaid legal insurance. She attempted that only for a short period of time because she could not make any money selling the insurance. But claimant is presently involved and able to assist her family in finding volunteers and raising money to restore an old theater in downtown Pittsburg, Kansas. This includes working with the telephone, the computer, and having dinner with prospective volunteers and donors. For the six months before claimant testified at the regular hearing, she had not actively looked for employment.

Orthopedic surgeon Theodore L. Sandow, M.D., was appointed by the ALJ to perform an independent medical examination of claimant. Dr. Sandow saw claimant on one occasion on October 15, 1999. Dr. Sandow found it difficult to separate out claimant's symptoms from her preexisting fibromyalgia condition. He did relate her low back and right hip symptoms to the trauma of her fall at work. Dr. Sandow opined claimant had a 5 percent permanent functional impairment. He restricted claimant's activities to lifting of no more than 25 pounds and no repetitive bending, twisting, and reaching.

At claimant's attorney's request, she was examined and evaluated by orthopedic surgeon Edward J. Prostic, M.D. Dr. Prostic saw claimant on one occasion on April 30, 1999. Dr. Prostic found claimant with complaints over numerous areas of her body. He diagnosed claimant with evidence of carpal tunnel syndrome of the left wrist, chronic sprain and strain of her low back with possible S1 radiculopathy and trochanteric bursitis of the right hip. Utilizing the AMA Guides to the Evaluation of Permanent Impairment, Fourth Edition, Dr. Prostic opined claimant had a 12 percent permanent functional impairment of the body as a whole. Dr. Prostic imposed restrictions on claimant's activities of no lifting of greater than 40 pound occasionally, 10 pounds frequently, avoid frequent bending or twisting at the waist, avoid handwriting and/or keypunching more than 30 minutes per hour.

Claimant's attorney also had claimant examined and evaluated by physical medicine and rehabilitation physician Kenneth B. Reeves, M.D. Dr. Reeves saw claimant once on June 28, 1999. Dr. Reeves general diagnosis was fibromyalgia, work related low back strain and secondary trochanteric bursitis. Dr. Reeves opined that claimant's October 6, 1998, work related accident permanently aggravated her fibromyalgia condition. Based on the AMA Guides, Fourth Edition and the pain intensity-frequency grid located on page 310, Dr. Reeves opined that claimant had a 60 percent permanent functional impairment for pain alone associated with the permanent aggravation of claimant's fibromyalgia condition. Dr. Reeves determined claimant's chronic pain was measurable under the AMA Guides, Fourth Edition because the pain was at a level severe enough to interfere with claimant performing daily activities. The 60 percent permanent functional impairment rating does not include any component of permanent functional impairment based on the range of motion or injury model. Dr. Reeves also opined that 30 percent of his 60 percent functional impairment rating preexisted claimant's October 6, 1998, accident because of her preexisting fibromyalgia. Dr. Reeves recommended claimant restrict her activities to avoid continuous

reaching, frequent lifting and limited occasional lifting to 20 pounds. Sitting or standing should be alternated at 20 minute intervals and no repetitive reaching, stooping or bending.

Respondent's employee health coordinator, Lisa New testified in this case concerning claimant's return to work after the October 6, 1998, accident and the circumstances surrounding claimant's termination. Ms. New testified that claimant requested to return to her regular job of operating the ultrasound machine on November 9, 1998, three days before Dr. Komes released her, because claimant told Ms. New that she was fine. From the time claimant returned to her regular job on November 12, 1998, through the date that she quit, claimant made no complaints about any problems of performing her job. Ms. New testified that she was told by claimant's director and also respondent's human resource director that claimant had notified them that she was not quitting because of her injuries but because she had found a better job in Texas. Ms. New also counseled the claimant about employees being available to help claimant in her job if she needed help. Ms. New told claimant to notify her if claimant did not get the assistance she needed to perform the job. Claimant never notified Ms. New that she was having problems with the job or was not getting the needed assistance. Further, Ms. New testified she had observed claimant working after she had returned to her regular work and claimant was performing her job without any difficulties.

As noted above, claimant's only job she was able to find since March 5, 1999, the last day she worked for respondent, was the job for a short period of time of selling prepaid legal insurance. The last time claimant testified on April 6, 2000, at the regular hearing, she had not looked for employment for some six months. Thus, if claimant made a good faith effort to retain her employment with respondent¹ and then made a good faith effort to find appropriate employment after recovering from her injuries,² claimant's wage loss component of the work disability test would be 100 percent.³ Here, the ALJ, however, found that claimant left her employment with respondent voluntarily where accommodation was available for her to continue the employment. Thus, the ALJ found claimant did not have a wage loss and limited claimant's permanent partial general disability to her permanent functional impairment rating.⁴

¹ See Fouk v. Colonial Terrace, 20 Kan. App. 2d 277, 887 P. 2d 140 (1994), *rev. denied* 257 Kan. 1091 (1995).

² See Copeland v. Johnson Group, Inc., 24 Kan. App. 2d 306, 944 P.2d 179 (1997).

³ See K.S.A. 1998 Supp. 44-510e(a).

⁴ See K.S.A. 1998 Supp. 44-510e(a).

The claimant argues the record establishes that because of the work-related injuries she had to quit her job with respondent. Also, after she quit her job with respondent, claimant contends she made a good faith effort to find appropriate employment, but again because of her injuries she failed to do so.

The record contains conflicting testimony on the reason that claimant terminated her employment with respondent. Claimant claims that because of the continuing and worsening pain and discomfort she had to quit her job. But claimant does not testify that she notified respondent that her injuries were the reason she had to quit her job. Respondent through the testimony of Ms. New has contradicted claimant's position that she left the respondent's employment because of her injuries. Although the Board acknowledges that claimant did sustain both orthopedic injuries and an aggravation of her preexisting fibromyalgia condition, the Board based on the record as a whole, questions whether the work-related fall has resulted in the debilitating pain and discomfort claimant now describes. In fact, claimant's two treating physicians, Dr. Komes' and Dr. Joseph's medical records do not contain the multiple severe complaints of discomfort and pain that claimant now describes.

An employer is not required to offer a claimant accommodated work and a claimant is not required to request from the employer accommodated work. Whether claimant requested accommodated work is just one factor in deciding whether claimant made a good faith effort to retain or obtain appropriate employment.⁵ Here, the Board concludes that the more persuasive evidence contained in the record proves respondent made a good faith effort to accommodate claimant after her October 6, 1998, injury and would have continued to accommodate claimant's appropriate work restrictions if claimant had not quit her employment. Accordingly, the Board concludes the claimant has not suffered a wage loss because she could have continued to work for respondent at the same wage and therefore, claimant's permanent partial general disability benefits are limited to her functional impairment rating.

The ALJ found claimant was entitled to a 12 percent permanent partial general disability award based on Dr. Prostic's 12 percent permanent functional impairment rating. The Board finds, however, that although there is a large range of difference between the three physicians who expressed opinions on permanent functional impairment, none of those opinions were either discredited or otherwise proven to be unreasonable. The Board recognizes that Dr. Reeve's functional impairment rating, based on pain only from claimant's aggravated fibromyalgia condition, is a rating not normally expressed because in general, the impairment percent shown in the chapters of the AMA Guides, Fourth Edition that consider the various organ systems make allowance for the pain that may accompany

⁵ See Oliver v. Boeing Co., 26 Kan. App. 2d 74, 977 P. 2d, 288, *rev. denied* 267 Kan. 886 (1999).

the impairing conditions. But chronic pain, also called the chronic pain syndrome, is evaluated as described in Chapter 15 of the Guides.⁶ In formulating his opinion on claimant's functional impairment, Dr. Reeves utilized Chapter 15 and his interpretation of the method set out in the chapter to arrive at an appropriate rating based on chronic pain. The Board concludes that claimant's appropriate functional impairment rating lies somewhere between Dr. Reeves' 30 percent rating which took into consideration his opinion that 30 percent of the fibromyalgia condition was preexisting⁷ and Dr. Sandow's 5 percent permanent functional impairment rating. Therefore, the Board concludes that claimant is entitled to a 17.5 percent permanent partial general disability.

AWARD

WHEREFORE, it is the finding, decision, and order of the Board that ALJ Steven J. Howard's August 25, 2000, Award, should be, and the same is hereby, modified as follows:

WHEREFORE, AN AWARD OF COMPENSATION HEREBY MADE IN ACCORDANCE WITH THE ABOVE FINDINGS IN FAVOR of the claimant, Marsha Spenrath, and against respondent, Mount Carmel Medical Center, and its insurance carrier, Liberty Mutual Insurance Company, for an accidental injury which occurred October 6, 1998, and based upon an average weekly wage of \$693.60.

Claimant is entitled to 72.63 weeks of permanent partial general disability compensation at the rate of \$366.00 per week, for a 17.5 percent permanent partial general disability, making a total award of \$26,582.58, which is all due and owing and is ordered paid in one lump sum less any amounts previously paid.

Respondent is ordered to pay all reasonable and related medical expenses.

Claimant is entitled to an unauthorized medical allowance in the statutory maximum of \$500.

Claimant is entitled to future medical upon proper application and approval by the Director.

Claimant's attorney fees are approved subject to the provisions of K.S.A. 44-536.

All remaining orders contained in the Award are adopted by the Board.

⁶ AMA Guides to the Evaluation of Permanent Impairment, Fourth Edition, p. 9.

⁷ See K.S.A. 1998 Supp. 44-501(c).

IT IS SO ORDERED.

Dated this ____ day of June 2001.

BOARD MEMBER

BOARD MEMBER

BOARD MEMBER

c: William L. Phalen, Pittsburg, KS
John J. O'Connor, Pittsburg, KS
Steven J. Howard, Administrative Law Judge
Philip S. Harness, Director