STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS

PROVIDENCE, SC. WORKERS' COMPENSATION COURT

MARIANNE BOWDEN	)	
	)	
VS.	)	W.C.C. 98-07010
	)	
GATEHOUSE CATERING	)	

D E C I S I O N

OLSSON, J. This matter is before the court on the employee's Original Petition for workers' compensation benefits in which she alleges that she sustained multiple injuries on July 25, 1998 during the course of her employment with the respondent, which resulted in incapacity from July 26, 1998 and continuing. The petition was granted at the pretrial conference and the employee was awarded weekly benefits for partial incapacity from July 26, 1998 to October 22, 1998 for lumbar and cervical strains. The employee claimed a trial in a timely manner.

The employee, a 38 year old female, testified that she previously injured her low back in 1985 while lifting a bag of coins from a coin-operated copy machine. She also had complaints of pain in both legs at that time. She moved to Rhode Island from Connecticut shortly thereafter and began treating for the back injury with Dr. Paul Welch, a neurosurgeon. She had a myelogram and CT scan and Dr. Welch performed a lumbar laminectomy in March 1986. After the

surgery, she continued to have pain in the low back and right leg, but it was less severe. However, on cross-examination, she admitted that she continued to treat for pain in her back and both legs and even underwent another myelogram and facet blocks. During this time, Ms. Bowden was receiving workers' compensation benefits. She settled her case sometime in 1989. The employee continued to see Dr. Welch and remained out of work until 1989 or 1990.

At that time, Ms. Bowden began working at Filene's in the cosmetics department. Dr. Welch actually discharged her from his care with the recommendation of no heavy lifting. She left Filene's after about six (6) months and began working as the front desk manager for Athletic Clubs of America (Celebrity Courts in Warwick, Rhode Island). Ms. Bowden eventually moved up to full-time work as a sales manager and then was promoted to the general manager of the facility. She continued working there until the facility closed in 1994.

In November 1994, the employee was hired by Lombardi Chiropractic Center as a physician's assistant and receptionist. She explained that in the summer of 1995, she began to experience numbness and tingling in her forearms, particularly the right side. She discussed it with her employer and Dr. Lombardi began giving her manipulation treatments. However, Ms. Bowden developed pain in the neck and then the low back to the point where she could not use her arms anymore to do anything. She decided to see Dr. Welch again for her problems.

Dr. Welch sent her for some tests and then performed surgery, a cervical fusion, in late 1995, which relieved the pain in her arms. She was out of work for almost two (2) years. She also had low back pain radiating into her left leg during this time which was treated conservatively.

In July 1997, she took a position as office manager for the Shepherd of the Valley United Methodist Church. Although she continued to have some discomfort and tightness in her neck, some mild discomfort in her low back, and intermittent discomfort in both legs, she was still able to perform the job on a part-time basis. In September 1997, she took on another part-time job at the Velvet Dance Club. Ms. Bowden was responsible for hiring and firing personnel, opening and closing the club, keeping an inventory of the liquor stock, and producing reports of receipts. The club closed in November 1997 and she went to work at a restaurant, Grill 262, basically performing the same duties. She was working about 50 to 55 hours a week between the job at the church and the job at Grill 262.

From January to July 1998, Ms. Bowden was still under the care of Dr. Welch for low back pain radiating to her leg, and burning, numbness and tingling in her arms. She had another MRI and was taking Percocet and Vicodin intermittently. In May or June of 1998, Dr. Welch recommended that she see Dr. Beverly Walters for an evaluation.

In early July 1998, she began working for Gatehouse Catering and discontinued her employment at Grill 262. She was hired as an event manager

and also did cost and financial analysis of events catered by the company. Ms. Bowden indicated that she was required to travel to pick up flowers, produce and other items from vendors, travel to the catering sites, oversee the setup for the event, carry trays of food, and sometimes fill in for serving staff. She had worked there less than two (2) weeks when she was injured. The employee stated that at times, the pain was so bad in her neck, arms, back and legs that she had to lie down on a couch at the restaurant, but she continued working.

On July 25, 1998, she was in the kitchen at the Lippitt House when she slipped and fell backwards on her tailbone. She put her elbows back to break her fall and her elbows hit the cement floor and then the back of her head hit the floor. The employee stated that she felt a "shock" in her back and down her legs. She was taken by rescue to Rhode Island Hospital, examined and released.

The employee saw Dr. Welch within a few days. She had continued to treat with him and had just seen him on July 17, 1998. She complained of pain in her low back, both legs, her neck, both arms and both elbows. She also had constant severe headaches. The employee saw Dr. Walters shortly thereafter because she already had an appointment scheduled due to her previous problems.

In December 1998, the employee began treating with Dr. Frederick Burgess, a pain management specialist. He prescribed Methadone, Valium and Percocet, which she takes every day on a regular basis. Ms. Bowden has not worked since the fall in July 1998. She stated that since the fall at work, the

condition of her low back is worse in that the pain is constant and extremely painful.

Reverend William Flug, the senior pastor at the Shepherd of the Valley United Methodist Church, testified that the employee was hired in the middle of July 1997 to do office/clerical work such as word processing, answering the telephone, scheduling and mailing for twenty (20) hours a week. From January to June 1998, her hours increased somewhat and then were reduced in June because the church was less busy.

Ms. Bowden never complained to Reverend Flug of any physical problems and she rarely missed time from work for any reason. He never noticed that she was having any difficulty and she never indicated that she was unable to perform certain tasks. Ms. Bowden had continued to work for the church until she was injured on July 25, 1998. She has not returned to work since that date.

A document prepared by the treasurer of the church was introduced into evidence which lists the employee's gross wages for each week from July 27, 1997 to August 2, 1998.

Umberto Sorbo testified that he previously owned the Velvet Club and Grill 262. The employee worked for the Velvet Club beginning around September 1997 and then later worked for Grill 262. He explained that she was employed as a manager at Grill 262, which was a restaurant. She did bookkeeping and scheduling and oversaw the floor and employees. He indicated that the employee had to be on her feet most of the time and she worked at least forty (40) hours a

week. However, when Mr. Sorbo was confronted with copies of pay stubs from the business, he acknowledged that perhaps Ms. Bowden only worked about thirty (30) hours a week.

Mr. Sorbo stated that the employee stopped working for him in July 1998 after giving a two (2) week notice. He testified that the employee never complained to him about any physical problems or stated that she could not do certain tasks.

The medical evidence consists of records of Rhode Island Hospital, the affidavit and extensive records of Dr. Paul T. Welch, the affidavit and reports of Dr. Beverly C. Walters, the affidavit and reports of Dr. William Golini, the deposition and records of Dr. Frederick Burgess, and the deposition and records of Dr. A. Louis Mariorenzi.

Dr. Welch, a neurosurgeon, treated the employee initially for a back injury she sustained in 1985. Ms. Bowden underwent low back surgery, specifically a laminectomy at L4 on the left, on March 20, 1985. She continued to have problems with her back and her legs after the surgery, although the diagnostic testing at the time did not reveal any significant abnormalities. On July 25, 1988, Dr. Welch stated in a report that her functional impairment rating was seventy percent (70%) of the whole person and she was permanently totally disabled.

There is a gap in treatment for a number of years and then in May of 1995, the employee returned to Dr. Welch with complaints of pain in her low back radiating to her left knee and left leg weakness. She then developed increasing

discomfort in her forearms, wrists, hands and fingers bilaterally. At this time, she was receiving about fifty (50) Percocets a week from Dr. Welch. The employee eventually underwent surgery, an anterior discectomy and fusion at C6-7 in November 1995.

The employee's neck and back complaints continued and she saw Dr. Welch about once a month. Ms. Bowden began working at the church and then picked up some other part-time jobs as well. In March 1998, Dr. Welch gave her a referral to a pain clinic. In May of that year, she underwent EMG studies of her upper extremities and also another cervical MRI. The many diagnostic tests over the course of several years revealed a mild right C7 radiculopathy and a minimal disc bulge at L4-5 with scoliosis.

Ms. Bowden saw Dr. Welch for a regularly scheduled appointment on July 14, 1998. He noted that there was some question of whether she had a herniated C5 disc. Around this time, the doctor recommended that she have an evaluation by Dr. Beverly Walters, a neurosurgeon.

The employee fell at work on July 25, 1998. She saw Dr. Welch two (2) days later. He indicated that he did not detect any spasm or tenderness in the low back area and his diagnosis was a severe low back strain and probably a mildly contused sciatic nerve, greater on the left than the right. He recommended that she remain out of work for two (2) to three (3) weeks. The doctor also referred her to Dr. William Golini for EMG studies.

At the visit to Dr. Golini, the employee informed him that she had injured her neck as well as her low back when she fell at work. The results of the EMG studies were the same as those from April 1998, before the fall at work. An MRI of the lumbar spine revealed that the minimal disc bulge at L4-5 appeared the same, but there was now a disc protrusion at L1-2 to the left. An MRI of the cervical spine on August 27, 1998 was unchanged from a study done prior to the fall.

On September 25, 1998, the employee was evaluated by Dr. Beverly Walters. The only positive findings were limited straight leg raising bilaterally and restricted range of motion of the neck and back. The doctor's diagnosis was neck pain and bilateral hand and arm pain secondary to an aggravated pre-existing cervical and low back injury with a cervical disc herniation without myelopathy at C5-6. She prescribed pain medication.

The employee had some difficulty obtaining the pain medication through her insurance or the workers' compensation insurer. She did eventually purchase it on her own and tried it for a month with no improvement. When she returned to Dr. Walters on October 29, 1998, her complaints and examination were essentially the same. The doctor recommended that she try a pain control program. Dr. Walters also stated that the employee was unable to work due to her neck and back pain.

Ms. Bowden began seeing Dr. Frederick Burgess for her multiple pain complaints. At the time of her testimony, the employee was taking Valium and Methadone on a regular basis and Percocet for severe episodes of pain.

Dr. A. Louis Mariorenzi evaluated the employee on October 19, 1998 at the request of the insurer. The history recorded in his report indicates that the employee informed him that she had make a full and complete recovery from the 1984 back injury and she was having no difficulty whatsoever with her back or legs prior to July 1998. She further advised the doctor that she had right leg problems in 1984, not left leg, and that she had made a full recovery from the neck problems she experienced while working for a chiropractor. Ms. Bowden acknowledged that she had continued to see Dr. Welch, but they were merely routine evaluations and not for treatment. The physical findings did indicate a slight sensory deficit on the right in the C7 dermatome and some suggestion of a mild L5 nerve root irritation.

Dr. Mariorenzi pointed out that the cervical MRI studies from before and after the fall at work were identical, and the lumbar MRI studies before and after the fall were also identical. The doctor concluded that the employee likely sustained cervical and lumbar strains as a result of the fall in July 1998 and had fully recovered at the time of his examination. He testified that based upon his review of her prior medical records, she had returned to her pre-injury state and was capable of returning to her regular employment.

After careful consideration of all of the evidence which has been presented in this matter, I find that the employee sustained a cervical strain and a lumbar strain when she fell at work on July 25, 1998. This incident caused her to be partially disabled from July 26, 1998 through October 19, 1998. Any further incapacity is not the result of the incident at work on July 25, 1998.

It is obvious from the medical records of Dr. Welch that Ms. Bowden was treating for low back pain radiating to her left leg, neck pain, and bilateral shoulder and arm pain for three (3) years prior to the fall at work. She was seeing Dr. Welch immediately before the incident at work for these complaints and had undergone additional diagnostic testing within the last six (6) months. Her comments to Dr. Mariorenzi that she had fully recovered from all of her previous problems were entirely inconsistent with the medical records.

Dr. Golini, who took over the employee's care from Dr. Welch in 1999, noted in his January 14, 1999 report that he was referring the employee for an MRI of the brain "given the lack of explanation for her condition." Dr. Burgess testified that he was unable to sort out which source of pain he was treating exactly because Ms. Bowden had multiple problems and her current condition was the cumulative effect of all of her injuries.

Even Dr. Welch, the employee's treating physician for many years, expressed doubt as to the cause of the employee's ongoing complaints in a summary report dated January 11, 1999 which he provided at the request of the employee's first attorney:

> "Basically, the report of Dr. Louis Mariorenzi is clinically consistent with what I have outlined and his physical findings are essentially those which I have found. I agree with his evaluation on findings of the MRIs of both the cervical and lumbar spine studies. In addition, the electromyogram and nerve conduction studies have not changed significantly. The one aspect of her complaints is their persistence without being able to find adequate pathology to support the complaints. This raises a strong probability that there is a functional element present. I believe that she should have psychological help to cope with her problems, particularly to help her to discontinue the pain medication that she is demanding. Until this help is forthcoming, I find her totally disabled."

Although Dr. Welch states that the employee is totally disabled, he cannot say what is causing the disability. A review of the reports of the physicians who have seen Ms. Bowden all seem to have the same difficulty determining the cause of her severe and persistent complaints. None of the physical examinations have revealed any objective physical findings of any significance. The focus is basically on the employee's complaints of pain throughout various parts of her body, which no one can explain.

Dr. Mariorenzi pointed out the inconsistencies in the employee's history and the fact that the results of the diagnostic testing have not revealed any significant abnormalities, nor have they changed as compared to the results before the fall at work. Considering all of the evidence presented in this matter, I find the testimony and opinions of Dr. Mariorenzi to be the most persuasive and probative. The fall at work on July 25, 1998 caused only soft tissue injuries

which resolved by October 19, 1998, leaving the employee in the same physical condition she was in prior to the injury.

I, therefore, find as a fact:

1. That the employee sustained a personal injuries, specifically, a cervical strain and a lumbar strain, on July 25, 1998, arising out of and in the course of her employment with the respondent, connected therewith and referable thereto, of which the respondent had knowledge.

2. That the employee's average weekly wage is Seven Hundred Eighty-eight and 46/100 ($788.46) Dollars.

3. That the employee has received some Temporary Disability Insurance benefits.

4. That the employee received some weekly workers' compensation benefits pursuant to a Non-Prejudicial Agreement and the pretrial entered in this matter on January 6, 1999.

5. That the employee was partially disabled from July 26, 1998 through October 19, 1998 due to the effects of the work-related injury.

It is, therefore, ordered:

1. That the employer shall pay to the employee weekly benefits for partial incapacity from July 26, 1998 through October 19, 1998.

2. That the employer shall take credit for any weekly benefits paid to the employee pursuant to the Non-Prejudicial Agreement and the pretrial order entered in this matter.

3. That the employer shall reimburse the Temporary Disability Insurance Fund for any benefits paid to the employee during the period of disability noted above and shall take credit in that amount against any weekly workers' compensation benefits owed to the employee.

4. That the employer shall pay all reasonable charges for medical services rendered to the employee in order to cure, rehabilitate or relieve the employee from the effects of the work-related injuries she sustained on July 25, 1998.

5. That no witness fees, counsel fees, or costs are awarded as the employee has not obtained any additional benefits after trial than were awarded at the pretrial conference.

In accordance with Sec. 2.20 of the Rules of Practice of the Workers' Compensation Court, a decree, a copy of which is enclosed, shall be entered on

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D E C R E E

This cause came on for trial and upon trial thereon and in consideration thereof, the following findings of fact are made:

1. That the employee sustained a personal injuries, specifically, a cervical strain and a lumbar strain, on July 25, 1998, arising out of and in the course of her employment with the respondent, connected therewith and referable thereto, of which the respondent had knowledge.

2. That the employee's average weekly wage is Seven Hundred Eighty-eight and 46/100 ($788.46) Dollars.

3. That the employee has received some Temporary Disability Insurance benefits.

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5. That no witness fees, counsel fees, or costs are awarded as the employee has not obtained any additional benefits after trial than were awarded at the pretrial conference.

Entered as the decree of the court this day of .

ENTER: PER ORDER:

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Olsson, J.

I hereby certify that copies were mailed to Fred L. Mason, Esq., and James Rivello of Gallagher Bassett Services, on

_____