State of Wisconsin

Labor and Industry Review Commission

Twana Burris Applicant **Transit Express, Inc.** Employer **Twin City Fire Ins. Co.** Insurer Claim No. 2015-024870	**Worker's Compensation Decision**[1] **Dated and Mailed:** May 30, 2024 burritw_wsd.docx:190

Order

The commission **modifies** and **affirms** the decision of the administrative law judge. Accordingly, the application for benefits is dismissed.

By the Commission:

/s/
Michael H. Gillick, Chairperson

/s/
Georgia E. Maxwell, Commissioner

/s/
Marilyn Townsend, Commissioner

[1] **Appeal Rights**: See the yellow enclosure for the time limit and procedures for obtaining judicial review of this decision. If you seek judicial review, you **must** name the following as defendants in the summons and the complaint: the Labor and Industry Review Commission, and all other parties in the caption of this decision or order (the boxed section above). Appeal rights and answers to frequently asked questions about appealing a worker's compensation decision to circuit court are also available on the commission's website, http://lirc.wisconsin.gov.

Procedural Posture

This case is before the commission to consider the applicant's eligibility for worker's compensation benefits. The applicant filed a hearing application dated August 5, 2017, alleging that she sustained right knee, bilateral shoulder, back and neck injuries in a work incident where her vehicle was hit from behind on October 10, 2015. The employer and insurer (collectively, the respondent) conceded jurisdictional facts, an average weekly wage of $440.00, and that a work-related injury occurred. The respondent paid temporary total disability through November 30, 2015, and medical expenses listed on the WKC-3s. As part of a third-party agreement, the respondent was entitled to a credit in the amount of $13,951.12. An administrative law judge for the Department of Administration, Division of Hearings and Appeals (Division), Office of Worker's Compensation Hearings, held a hearing in the matter on April 25, 2023, and issued a decision dated August 25, 2023, finding that the applicant sustained only cervical, lumbar, and bilateral shoulder sprains and bilateral knee contusions in the work incident; and that the applicant was not entitled to additional temporary disability payments, medical expenses, or permanent disability. The applicant then filed a timely petition for commission review.

The issues are the nature and extent of the applicant's disability from the conceded work injury. The commission has considered the petition and the positions of the parties and has independently reviewed the evidence. Based on its *de novo* review, the commission modifies and affirms the decision of the administrative law judge and makes the following:

Findings of Fact and Conclusions of Law

As supplemented by the commission's memorandum opinion,[2] the commission makes the same findings of fact and conclusions of law as stated in the decision of the administrative law judge and incorporates them by reference, subject to the following:

Modification

On page 7 of the decision, in the first full paragraph, replace the second sentence with the following, "First, Dr. Chunduri's opinion is incomplete because he indicated that the basis for his assessment of permanent disability was to be determined."

Memorandum Opinion

The applicant, who was born in 1960, worked as a driver for a wheelchair van for the employer. She was injured when the parked van she was sitting in was sideswiped by another vehicle at the right rear passenger side. She alleges that she sustained injuries to her cervical and lumbar spine, bilateral shoulders, and bilateral knees in the car accident. As a result of her injuries, she claims temporary and permanent disability benefits, and a 20-25% loss of earning capacity. The respondent conceded a work injury and paid temporary total disability benefits through November 30, 2015, but it alleged that her injuries were minor and resolved by that date with no permanent disability or need for work restrictions. The administrative law judge credited and adopted the opinions of the respondent's medical expert and dismissed

[2] The commission's memorandum opinion may be the basis for more formal findings of fact. *Manitowoc Boiler Works v. Indus. Comm'n,* 165 Wis. 592, 594-95, 163 N.W. 172 (1917).

the applicant's hearing application, finding that the applicant was not entitled to additional temporary total disability payments, medical expenses, or permanent disability. The applicant then filed her timely petition for commission review.

The Applicant's Work Experience and Work Injury

The applicant worked as a home care companion in the 1980s and early 1990s, and then she worked as a cleaner in the mid to late 1990s. She then briefly worked for the employer from about 1998 to 2001. From 2002 to 2013, she worked for Milwaukee County as a correction officer. According to the applicant, she did not have any problems performing the physical aspects of her job. Her employment with the county ended in 2013 when she was convicted of a felony. After this, she returned to working for the employer as a driver of a wheelchair van. She also worked part-time as a home care health aide. According to the applicant, she did not have any problems performing any of this work prior to the work incident at issue in this case.[3]

As a driver of a wheelchair van for the employer, the applicant's duties were to transport elderly, handicapped, and physically disabled clients in wheelchairs to and from their destinations. She had to lift, pull, push, squat, and reach over her head to do this work. According to the job description, she needed to be able to lift 40 pounds.[4] Before the injury, she did not have any work restrictions, problems performing her activities of daily living, or difficulties performing any aspect of her position. She also testified that she was not on any medications for pain.[5]

However, the Wisconsin Prescription Drug Monitoring Program report showed the applicant's use of opioid medications prior to the work injury. This showed **hydrocodone prescribed by a Dr. Probst in October 2014; hydrocodone prescribed by a Dr. Schwartz in March 2015; and hydrocodone prescribed by the applicant's primary care provider, Dr. Nolan, in April and May 2015**.[6] When asked on cross-examination about this prior use of opioids, the applicant did not recall if she had filled the prescriptions for hydrocodone-acetaminophen in October 2014 or April and May 2015.[7] The applicant testified that she was not suffering from any neck or low back pain, pain in her shoulders, or pain in either knee, though on cross-examination, she did indicate that she had had shoulder pain previously. Before the injury, she had never had any injections in her neck or back, and she had never had any chiropractic treatments, except following a motor vehicle accident in 2001, from which she had completely healed. She never needed to walk with a cane, and she was not on any pain medications.[8] At the time of the work incident, she also did not have any plans to retire.[9]

On October 10, 2015, the applicant was transporting a client and the client's caregiver to Bayshore Mall. She noted that there was a police vehicle in the loading and

[3] Transcript of Proceedings dated April 25, 2023 (Tr.), pp. 13-16.
[4] Exhibit (Ex.) E.
[5] Tr., pp. 16-17, 21, 32.
[6] Ex. 11.
[7] Tr., pp. 57-58, 62-64.
[8] Tr., pp. 20-21, 27, 57, 64.
[9] Tr., p. 18.

unloading zone, and two vehicles were behind the police vehicle. The officer was talking to the person behind his vehicle who was sitting in a car. The client complained about the police vehicle being in the loading zone, and the applicant assured her that she could unload her safely behind the second parked car. The applicant indicated that she parked illegally because the police vehicle was in the loading zone. After the client and caregiver left the vehicle, she got back into the parked van to call in for her next assignment. Before she called in, the car was hit from behind by a van. According to the applicant, "The collision caused the upper half of [her] body to move in a jerking motion causing the bottom half of [her] body to slide forward forcing [her] knees into the dash." She was not wearing a seatbelt. She called the accident in to her employer and did not complete her next pickup for the workday. The van was still drivable, so she drove back to work and used her personal vehicle to go to urgent care.[10]

The police **accident report** noted that the airbag did not deploy and the applicant had **"no apparent injury."** It also noted that the applicant was illegally parked. The extent of the **damage noted was "Very Minor" on the rear driver side.** For the vehicle that hit the applicant's vehicle, the damage noted was "Minor" on the middle passenger side and rear passenger side. In the narrative, the officer noted, "Unit 1 was illegally stopped in marked pedestrian cross walk blocking entire cross walk and completely obstructing north bound traffic lane for several minutes, not actively loading or unloading. **Operator of Unit 2 side swiped Unit 1 while they were trying to get around Unit 1**."[11]

The van driven by the applicant was hit on the driver's side rear corner. The cost to fix the **damage to the vehicle was $659.75**, and the employer was reimbursed $653.19 by its insurance carrier.[12] John Doherty, the employer's vice-president for about 40 years, took photos of the damage, which is shown in Exhibit 14.[13] The photos show slight damage to the right rear side of the van above the bumper. The pain is scraped off on the right rear side, and there is a slight indentation on the side just above the bumper. There is no damage to the back of the vehicle that would indicate a rear-end collision. The applicant settled her claim against the driver of the vehicle, which included payments to the applicant and to the employer's insurance carrier, as well as a $13,951.12 balance to the applicant, which constituted a cushion against any additional claim under worker's compensation.[14]

The Applicant's Medical Treatment

On October 10, 2015, the applicant was seen in urgent care by Dr. Robert L. Schwartz, M.D. The medical assistant intake note indicates the applicant's right knee hit the dashboard and left knee hit the transmission radio. She complained of **neck pain and back pain along with shoulder burning pain**.[15] She was noted as feeling stiff. She was

[10] Tr., pp. 21-24, 51, 53.
[11] Ex. D; emphasis added.
[12] Tr., p. 68-69, 71; Exs. 14, 15.
[13] Tr., p. 70.
[14] Ex. 16.
[15] Ex. J.

prescribed hydrocodone-acetaminophen and was to follow up with her primary care provider.

The applicant treated with her primary care provider, Dr. Sara J. Nolan, M.D., on October 15, 2015. Dr. Nolan noted the applicant was treated at urgent care and given pain pills and muscle relaxants. The applicant's pain had gotten progressively worse, especially in her low back. "She now states that her **left leg is completely numb and tends to give out. She is using a cane to help her walk**." She also complained of **bilateral knee pain and neck pain. Dr. Nolan prescribed Percocet and referred the applicant for physical therapy** and a lumbar MRI. The applicant indicated that between October 10th and 15th, when she saw Dr. Nolan, her symptoms worsened, especially her lower back and knees. She was not able to walk, so she walked with a cane.[16] On October 23, 2015, Dr. Nolan noted the applicant continued to have moderate to severe pain. The applicant felt that the **pain had now spread from her low back to her hips.** She also complained of **knee pain and continual weakness in her left leg.** She had not been able to start physical therapy yet. Dr. Nolan referred the applicant to orthopedics.[17]

On October 29, 2015, the applicant saw Dr. Derek Orton, M.D., in orthopedics, at the request of Dr. Nolan. The applicant was complaining of **neck and low back pain that radiated into the bilateral lower extremities, more prevalent on the left. She also had numbness and tingling in the hand.** He noted that the applicant was "struck on the side/rear of her vehicle while parked." She did not require emergency care, but she had since reported pain radiating from the neck into the thoracic and lumbar spines. **There was numbness in the hands and legs bilaterally, and associated weakness in the legs.** There was no significant radicular pain. Her pain was constant and described as sharp, throbbing, aching, shooting, and burning. She now required a cane for ambulation and a back brace for her back pain. She also reported a loss of balance. The lumbar **MRI was reviewed. "There are mild degenerative changes to the discs and facet joints. No significant stenosis throughout the lumbar spine. No fractures. Not other significant findings." Dr. Orton discussed the "natural history" of the lumbar and cervical spondylosis and discussed treatment options.** He noted, **"I reassured the patient that there is no dangerous pathology in the lumbar spine. There is no significant stenosis in the lumbar spine to explain her lower extremity symptoms."** He recommended a cervical spine MRI. He also noted that per the police report, **"the incident was not high impact and airbags were not deployed."**[18]

On November 11, 2015, the applicant presented to urgent care. "She was see[ing] a physician yesterday afternoon as requested by her employer. The physician flexed her knee and hip, pushing her knee into her chest. She heard a 'pop' and felt sudden onset of pain in the left hip and posterior upper leg." The urgent care doctor suspected the applicant had a muscle strain of her left hamstring. She was given a dose of Toradol and told to continue her medications.[19]

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[16] Tr., p. 25.
[17] Ex. J; emphasis added.
[18] Exs. J, 3; emphasis added.
[19] Ex. R.

On November 17, 2015, Dr. Nolan saw the applicant for her left hamstring muscle strain. She recommended the applicant continue physical therapy. The **MRI of the cervical spine on November 27, 2015, showed mild to moderate degenerative changes, most prominent at the C7-T1 facets with mild right and moderate left foraminal stenosis**.[20]

On November 30, 2015, Dr. Orton saw the applicant for follow up. Her symptoms had not changed. He noted that in a recent independent medical evaluation, "the patient reports developing hip and lower extremity pain after feeling a pop in her hip." In reviewing the cervical **MRI, Dr. Orton noted that there was mild degenerative disc disease, most significantly at C7-T1, but there was no severe stenosis. He noted that there was no significant stenosis in the lumbar or cervical regions to explain her radicular symptoms. There was no severe disc disease or arthritis.** He found, **"No acute injuries noted throughout the cervical and lumbar spines. For this reason, from a spinal perspective, she may return to work with no specific restrictions. Ms. Burris is discharged from my care."** He **did encourage her to continue with formal physical therapy and noted that evaluation and management by a pain management specialist would be helpful. He found that the applicant had not sustained any permanent partial disability with respect to the cervical or lumbar regions as a result of her recent injury**.[21]

The applicant also saw Dr. Nolan on November 30, 2015, for migraines that the applicant indicated were well managed until the motor vehicle accident. She was having almost daily migraines. Dr. Nolan also saw the applicant for **her neck and low back pain**. She was noted as being in physical therapy and slowly improving.[22] According to the applicant, as of November 30, 2015, she was still in excruciating pain in her neck, shoulders, low back, and knees.[23] On December 17, 2015, **Dr. Nolan** saw the applicant for ongoing pain and weakness. She had tried physical therapy but now was not improving. She continued to have **numbness in her right upper arm and complained of bilateral leg weakness. Her pain was 8/10.** She was still having daily headaches. Dr. Nolan recommended she be seen in neurosurgery as well as physical medicine and rehabilitation.[24] Dr. Nolan prepared a letter called a "certificate of medical opinion," in which she stated that it was her professional opinion that the work incident caused the applicant's neuropathy and neck pain. **Although the MRI did not show any stenosis, she believed that the applicant may have permanent low back pain from the accident that would flare up every now and then. She stated that the applicant had completed physical therapy "and does not require further treatment."**[25]

The applicant had another lumbar spine **MRI on January 14, 2016, which found mild multilevel degenerative disc disease with areas of annular degeneration and small**

[20] Ex. J.
[21] Exs. J, 3.
[22] Ex. J.
[23] Tr., p. 32.
[24] Ex J.
[25] Ex. 12; emphasis added.

annular high intensity zone/tears associated with mild disc protrusions, but no significant stenosis. PA-C Jacob J. Finer called the applicant and indicated that it was the opinion of Dr. Orton and himself that "no acute injury was suffered by the spine during the worker's comp incident that was reflected on her recent lumbar MRI or clinical evaluation. "The patient requested that annular tears be put on her diagnosis list and that this was an acute finding. I explained that this was not the opinion of Dr. Orton or myself. Twana became very frustrated and did not agree with this. She stated that Dr. Orton and myself will be hearing from her soon and proceeded to hang up the phone."[26]

On January 21, 2016, Dr. Nolan noted that the applicant was coming in for acute and chronic issues. "She was involved in a very bad accident and then a subsequent fall this last winter." She was requesting a refill of Tramadol.[27]

On February 17, 2016, the applicant first treated with Dr. Krishna Chunduri, M.D., in pain management. Dr. Chunduri noted that applicant presented with pain in her lower back and right shoulder, as well as radiation down her left leg due to a work injury. She was sitting in her van when she was "suddenly rear-ended." She had had about 3 months of physical therapy but still had pain in her lower back and left leg. Her neck pain was nearly resolved. She also continued to have right shoulder pain. Her overall pain was rated as 8/10. Her leg symptoms would come and go and cause her to fall. She had weakness primarily in the left leg, but occasionally in the right. Her lower back pain was constant. The MRI of the right shoulder showed an extensive labral tear. The MRI of the lumbar spine revealed diffuse spondylitic changes with the disc bulge at L2-3 with facet hypertrophy and joint effusion. L4-5 had disc protrusions to the left side with also a small right protrusion. L5-S1 had bilateral facet hypertrophy. The MRI of the cervical spine showed some diffuse spondylitic changes with mild right and moderate left foraminal stenosis at C7-T1. Dr. Chunduri noted that the MRI did not show significant compression pathology to account for her paresthesias in her legs. Her EMG of her upper extremities was normal, but Dr. Chunduri ordered an EMG of the lower extremities.[28]

On March 2, 2016, Dr. Chunduri noted the applicant's pain was at 8/10 in her lower back radiating down her left leg, with pain, numbness, and tingling. She also continued to have shoulder pain. Dr. Chunduri noted that the EMG of the lower extremities showed some mild L5-S1 irritation, but no radicular injury. Dr. Chunduri advised an L5-S1 transforaminal injection, but the applicant did not wish to receive injections or surgery. "Therefore at this time, I advised her that she is at end of healing and maximal medical improvement." Dr. Chunduri ordered a functional capacity evaluation (FCE).[29] On March 23, 2016, the applicant had a Functional Capacity Evaluation (FCE) at Athletico Physical Therapy. The report noted the applicant gave consistent performance/acceptable effort 82% of the time. Based on her evaluation, she was only able to perform less than 35% of her job demands, which

[26] Ex. J; emphasis added.
[27] Exs. J, L.
[28] Ex. G.
[29] Ex. G; emphasis added.

was at the medium job level. The evaluation concluded that if the applicant were to be employed in the future, it would need to be in a sedentary position that had minimal standing, walking, and lifting. The therapist noted that the applicant was limited by her high levels of pain in her cervical spine, right shoulder, and lumbar spine. "She is also very deconditioned at this time and is unable to tolerate more than the most basic movements without a significant rise in heart rate."[30]

At a follow-up visit on March 30, 2016, Dr. Chunduri noted the applicant's pain was still 8/10. She was reporting right shoulder pain, and low back and left leg pain. After receiving the FCE, **Dr. Chunduri wrote permanent restrictions** of an 8-pound lifting, pushing, and pulling restriction. She should do no bending, squatting, kneeling, or twisting. Dr. Chunduri noted, "Her disability rating at this point appears to be approximately 6% when including the shoulder along with her lower back and neck symptoms and more specifically 5% for her lower back and leg symptoms and 2% for her shoulder, and 1% for her neck.[31]

The applicant continued to seek medical treatment. On May 5, 2016, the applicant was seen by APNP Karla M. Zilinski for neck pain and a back problem. She was referred by Dr. Nolan. The applicant **continued to have neck pain with a cracking sensation, and it hurt her to turn her head to both the left and right**. She continued to have **numbness in her hands in the morning. She also had pain in her low back that went down the left leg and affected the pelvic area.** She had recently been released from care by Dr. Chunduri to return to work "with full disability." **APNP Zilinski noted, "It is concerning that she has seen numerous providers over the last few months for the same complaints (concern for doctor shopping)." APNP Zilinski determined it was not appropriate for prescribing medications because her behavior was concerned for doctor shopping.** Her controlled substance risk assessment was in the high risk category. **"She insists that she needs pain medication today even though she indicates it is not helping her pain."** APNP Zilinski **discontinued Tramadol "as it is ineffective as evidenced by her pain being 10/10."** Gabapentin was also discontinued, but the applicant could continue Topamax.[32]

In a Medical Report on Industry Injury (WKC-16-E) form dated June 6, 2016, Dr. Orton diagnosed spondylosis of the lumbar region without myelopathy or radiculopathy and cervical spondylosis without myelopathy. He **checked the box "no," indicating that no permanent disability had resulted.** He also indicated that the healing period had ended and the applicant was discharged from treatment. Under the description for permanent disability, Dr. Orton wrote, "N/A." **Dr. Orton indicated that the applicant could return to work with no limitations as of November 30, 2015**.[33]

On July 6, 2016, Dr. Chunduri noted the applicant was seen for a follow up on her pain in her shoulders, worse on the right side, ongoing pain in her lower back radiating to her thighs, and back pain on both sides. He noted that after the FCE, she

[30] Ex. F.
[31] Ex. G.
[32] Exs. M, 9; emphasis added.
[33] Ex. 4.

tried to find work but was unable to do so. The applicant wanted to explore further options. Dr. Chunduri noted that the **MRI of the right shoulder did reveal a labral tear, and he recommended a shoulder cortisone steroid injection, which the applicant had**.[34] According to the applicant, the shoulder injection helped only for a short time, and the pain returned.[35] The applicant had a bilateral lumbosacral medial branch block at L4-5 and L5-S1 on August 3, 2016.[36] On August 17, 2016, Dr. Chunduri noted that the applicant continued to improve in her shoulder after the injection. Her lower back had improved temporarily with the diagnostic block. Dr. Chunduri noted, "**At this time it appears that possibly there is a different pain generator as her diagnostic block did not give her the appropriate amount of pain relief that one would expect**." Dr. Chunduri felt she may be suffering from radicular nerve irritation and recommended a bilateral L5 transforaminal epidural steroid injection.[37] According to the applicant, the bilateral lumbosacral medial branch block injections provided temporary relief in her lower back. The L5 bilateral transforaminal epidural injections also worked for a short period of time.[38]

On September 13, 2016, Dr. Nolan saw the applicant for ongoing moderate to severe pain. The **primary assessment was cervical degenerative disc disease and facet arthropathy, paresthesias/numbness, and spondylosis of the lumbar region without myelopathy or radiculopathy**. She was given a **limited amount of Percocet**.[39] She had a transforaminal epidural steroid injection bilaterally at L5 on September 14, 2016.[40] On October 4, 2016, APNP Miriam J. Colton noted the applicant's **primary reason for the visit was "to be continued on the medication her PCP started her on—Percocet**." She continued to have low back pain. "At times her feet will collapse with pain when she is stepping up or down on the stairs." She did not feel the medications they gave her were helpful for pain. **She discontinued all other medications when she received Percocet from her primary care provider.** "She was advised that we will not be prescribing narcotics to her as this was explained to her at multiple appointments. **She then asked for tramadol."** She was told this was a **narcotic and would not be prescribed. APNP Colton noted that "she rated her pain 10/10 while taking tramadol."** She also noted, **"I'm very concerned that this patient is merely drug-seeking and only returns to the clinic when she thinks that a provider will provide her with narcotics. She is informed once again that narcotics are not used to treat chronic pain and these will not be prescribed by our clinic."** The medication choices were severely limited because the applicant either refused to try medications, had side effects, or reported ineffectiveness. **APNP Colton recommended the applicant see the pain psychologist, but the applicant refused**. She noted **"Refusing treatments always puts into question the veracity of patient's pain complaints."** In her exam, APNP Colton noted that the applicant was using a cane: "Patient screams out in pain

[34] Ex. G.
[35] Tr., p. 39.
[36] Ex. P.
[37] Ex. G.
[38] Tr., p. 39.
[39] Ex. M.
[40] Ex. P.

and pushes my hand away with minimal palpation of the lumbar sacral area and exclaims, 'it hurts I'm in pain today.'"[41]

On October 20, 2016, Dr. Nolan again saw the applicant for her chronic pain. She continued to have significant pain in her neck and low back that radiated into her legs. She was **requesting a refill of Percocet**. Dr. Nolan advised the applicant that chronic narcotics is not the answer.[42]

On December 7, 2016, Dr. Rani J. Chovatiya, M.D., saw the applicant for body **pain at rest and with activities of 10/10**. **Pain was constant and located in the neck, shoulders, low back, buttocks, thighs, knees, legs, hands, and feet.** The **pain was burning, stabbing, electric shocks, spasming, sharp, aching, throbbing, radiating, and vice-like**. **Average pain level was 10/10. Of the medications she had tried in the past, Percocet was the most effective.** The applicant had followed up with multiple pain providers: **"she reports that they were not inclined to prescribe any opioid medications to her so she did not continue following up."** Dr. Chovatiya noted that **"Her primary goal is to establish herself with a provider who may continue to refill the Percocet medication, since her primary care physician is unable to do so."** Dr. Chovatiya discussed the importance of multimodal therapy for pain management, which would include physical therapy, behavioral therapy, interventional therapy, and medication management. **"The patient reports that she is only interested in continuation of opioid medications (specifically Percocet) at this time."** The applicant was not in agreement with the doctor's approach, so he provided her with a list of other pain providers.[43]

Though the applicant had been released from care, she indicated that she still sought treatment at Advanced Pain Management because she was "still in excruciating pain and wanted the pain to cease."[44] On January 26, 2017, the applicant first treated with **Dr. Hany R. Nosir, M.D.** She presented with a history of chronic low back pain that radiated intermittently to the lower extremity, and neck pain that referred to the shoulder area. He planned to schedule a right lumbar medial branch facet block at L2-5 and start physical therapy. He also **prescribed Percocet.** The applicant needed a disability assessment, but Dr. Nosir noted that he does not get involved in legal issues with injuries.[45] On April 13, 2017, Dr. Nosir saw the applicant for her back pain and neck pain. He felt the applicant would benefit from a lumbar medial branch facet block at L2-5. The goal of the procedure was to make the applicant less dependent on opioid medications. On the new patient evaluation form, the applicant indicated that her **pain was 10/10 at its worst and best**.[46]

On June 8, 2017, **Dr. Nosir saw the applicant for a "chief complaint of I want oxycodone." He noted, "patient is here today demanding OXYCODONE."** He noted that the applicant was **not interested in any other treatment modalities. "PATIENT**

[41] Exs. M, 2, 9; emphasis added.
[42] Ex. M.
[43] Exs. M, 9; emphasis added.
[44] Tr., p. 41.
[45] Ex. S.
[46] Exs. S, 1.

IS FIXATED ON OXYCODONE ONLY." The applicant declined to pursue management of pain with low dose opioid medication other than oxycodone. **She refused all other treatments.** He noted, "the patient refuses all of these treatments and she **will go to another provider by name of Dr. Mines as she heard from her relative that the Doctor gives Percocet to everyone**." **Dr. Nosir issued a one-time refill of Percocet.**[47] The applicant did not see Dr. Nosir again.

On August 14, 2017, Dr. Nolan noted that the applicant continued to have low back, neck, and right shoulder pain. **Dr. Nolan gave the applicant a limited amount of Percocet**. "She understands that further refills will be needed for pain management." On January 23, 2018, Dr. Nolan noted the applicant had a flare-up of her cervical neck pain. She was requesting a refill of cyclobenzaprine (muscle relaxant).[48]

The applicant also sought chiropractic care with Dr. Kelly G. Von-Shilling Worth at the Milwaukee Spine & Joint Institute during this time, from February 2, 2016, through November 22, 2016, for a total of approximately 51 visits. Dr. Von-Shilling Worth described the work injury and the applicant's initial medical treatment. The applicant was seen until June 2016, but stopped care because she was not getting the relief she wanted. She treated the next several months solely with Dr. Chunduri. She returned on November 22nd for a final examination and she was officially released. However, the applicant returned on January 18, 2017, at which time she was encouraged to get into the gym and start exercising and to stay active. Dr. Von-Shilling Worth summarized that the applicant was a healthy and active individual before the accident, but this changed. She now had to have assistance with daily chores and eating. She could not work any longer and had difficulty with transportation. She was not a surgical candidate, but the MRI exhibit positive annular tears and minor disc bulges. They were not causing myelopathies or neuropathies, "but rather deep constant internal pain that is localized within the lumbar and cervical spine." Given the change in her condition, Dr. Von-Shilling Worth opined that the mental and physical disabilities that the applicant was experiencing were directly related to the work accident. Dr. Von-Shilling Worth agreed with the FCE that she was limited to sedentary work.[49] According to the applicant, Dr. Von-Shilling Worth's treatments helped, but only for a short time, and then the pain returned.[50]

On January 29, 2019, the applicant sought treatment with **Dr. Roman Berezovski**, M.D., for pain. The **pain was localized to headaches, neck, bilateral shoulder, bilateral arms, bilateral hands/wrists, lower back, bilateral buttocks, bilateral hips, bilateral knees, right ankle/foot. The pain was described as aching, burning, constant, sharp, shooting, soreness, stiffness, and throbbing. At best, her pain was 5/10, and at worst, 10/10**. The pain was always present and varied. She had had a TENS unit and acupuncture for her pain. The physical therapy did not help. Dr. Berezovski did not prescribed opioids and wanted to wait for prior records. After opioid clearance, he

[47] Exs. S, 1; emphasis added.
[48] Ex. M.
[49] Exs. N, O.
[50] Tr., p. 37.

would consider Percocet. She was also to start physical therapy. He wanted to proceed with bilateral lumbar medial branch blocks, and possibly consider a radiofrequency ablation.[51] There are no further medical records with Dr. Berezovski.

The applicant never returned to work for her employer. As of the date of the hearing, she was still unemployed and not looking for work. She testified this was because, "I am disabled, and I am not able to work due to my injuries from the collision."[52] She was found disabled and receives SSDI benefits.[53] She has never received services from the Division of Vocational Rehabilitation.[54] She is still receiving care from the Center for Pain Management in the form of medication (oxycodone and a muscle relaxer) and her home goals program.[55] She finds that the prescription pain medications are the only thing that make her disabilities more tolerable. According to the applicant, she still has aching, burning, cracking, tingling sensations, spasms, and throbbing in her neck, lower back, and at times in both shoulders and both legs. She considers her neck and back problems to be the most significant, and she has some good days and some bad days. According to the applicant, she used a cane from 2015 to 2019.[56] She underwent 118 physical therapy sessions because she was in "excruciating pain," but the physical therapy did help.[57] She has a caregiver to help with personal cares and daily chores 5 days per week. For personal cares, the caregiver helps with showering, lotioning her lower extremities, putting cream on her back, and helping her to take medication. They also assist with preparing meals, making her bed, changing linen if necessary, vacuuming, doing laundry, and assisting her with walking up and down the stairs, getting groceries, and running errands.[58]

The Applicant's Medical Opinions

The applicant submitted the WKC-16-B of Dr. Chunduri dated April 13, 2016. Dr. Chunduri described the work incident as "Ms. Burris was at work sitting in her minivan when she was suddenly rear-ended." She has complaints of pain in her lower back and right shoulder, as well as down her left leg. He opined that the applicant had cervical spondylosis, cervicalgia, right shoulder pain, and lumbar spondylosis with left radiculitis. He opined that the work incident directly caused the applicant's disability and also that her work exposure was at least a material contributory causative factor in the onset or progression of her condition. Dr. Chunduri assessed 6% permanent partial disability, but indicated that the elements that constituted the disability were "TBD," or "to be determined." He anticipated that she would need further treatment of medications to control her symptoms, and possibly surgery if the disc protrusions worsened.[59]

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[51] Ex. 13.
[52] Tr., p. 18.
[53] Tr., p. 19. The record reflects the attorney stated on the record that there was no reverse offset on the claim.
[54] Tr., p. 59.
[55] The applicant's home goals program is exercising 3 times per week, including walking on a treadmill, lifting 5-pound weights, and riding an exercise bike. Tr., pp. 60-61.
[56] Tr., p. 27.
[57] Tr., p. 42; Exs. H, I, K.
[58] Tr., pp. 43-50, 59.
[59] Ex. A.

The applicant also submitted a WKC-16-B from Dr. Von-Shilling Worth dated January 25, 2017.[60] Dr. Von-Shilling Worth described the accident as the applicant sitting in her parked vehicle "awaiting her next assignment when suddenly her vehicle was struck from behind by a minivan. Patient states that the minivan seemed to attempt to drive away however, a witness 'flagged' the minivan over and an accident report was completed." Dr. Von-Shilling Worth opined that the work incident directly caused the applicant's disability and also precipitated, aggravated, and accelerated her preexisting degenerative condition beyond its normal progression. He assessed 7% permanent partial disability for the applicant's lower back and radiculopathy, 3% for the right shoulder, 2% for the left shoulder, 3% for the cervical spine, 1% for the right knee, and 1% for the left knee. The assessments were based on decreased range of motion for the lumbar and cervical spine and shoulders; subjective complaints that were moderate and a grade II-III neck and shoulder and grade IV for lumbar-sacrum; MRI findings with the lumbar and cervical spine; orthopedic tests for the right and left shoulder, lower back, and neck; digital palpation revealing objective evidence of ongoing pain through muscle spasms and "other"; and weakness with gait, core, and grip strength on the right. Dr. Von-Shilling Worth opined that the applicant would need ongoing care to assist with her pain, weakness, and muscle spasms, and she would periodically have her lower extremities give way causing her to fall and need care.

The Respondent's Medical Opinions

The respondent submitted an Independent Medical Evaluation and WKC-16-B from Dr. Stephen E. Barron, M.D., with a specialty in orthopedic surgery, dated December 1, 2015.[61] Dr. Barron described the work incident as the applicant's parked vehicle being hit from behind. "Her left knee hit the transmission radio, the right knee hit the dash. On impact she flexed and extended her cervical, thoracic, and lumbar spine. She developed pain in her cervical, thoracic and lumbar spine, bilateral shoulders, and bilateral knees." She noted she had recovered from a right shoulder injury in 2010. In reviewing the medical records back to 2001, Dr. Barron noted the applicant was involved in a prior motor vehicle accident on September 7, 2001, with injuries to her upper back, lower back, neck, right arm, and right leg. She subsequently had chiropractic treatment through 2002. Dr. Barron also reviewed the medical records for the work injury and noted her current pain complaints. For the examination, Dr. Barron indicated that the applicant was told to inform him of any acute increase in pain, and she did not. He told her to actively move her knees while in the supine position, and he found presentation of guarding and symptom magnification. As a result, he had her sit on the table and he examined her knees. Dr. Barron opined that the applicant sustained cervical, thoracic, lumbar, and bilateral shoulder sprains and bilateral knee contusions as a direct result of the work incident. He noted that she also had evidence of inconsistent exam findings, pain, symptom magnification, and guarding. He indicated it was "not applicable" that the incident aggravated a preexisting condition. Dr. Barron opined that the applicant had

[60] Ex. B.

[61] Ex. 6. On December 7, 2015, Dr. Barron provided a Supplemental Report to note typographical errors in his original report. Ex. 7.

not reached an end of healing and that all medical treatment to date had been reasonable and necessary. Further medical treatment would be necessary, and he felt she was a candidate for an MRI of her cervical spine. Until then, she should continue her physical therapy. "In my opinion, she most likely sustained soft tissue injuries to her cervical, thoracic, and lumbar spine, bilateral shoulders, and bilateral knees," which should reach a healing plateau within three months and require no further treatment. Until she had the MRI, she should not lift over 15 pounds and not do repetitive over-shoulder work, squatting, stairs, or ladders. Dr. Barron felt it was premature to assign any permanent disability.

Dr. Barron prepared another Independent Medical Evaluation and WKC-16-B dated September 25, 2018.[62] Dr. Barron reviewed numerous medical records, photos of the vehicle damage, the employee accident incident report, the first report of injury, and the job description. He reviewed the medical records through 2017. Dr. Barron attempted to examine the applicant, but she stated that "I am in too much pain and I do not want to be touched." She indicated that the last time she was there she wound up in the emergency room. As a result, he did not do a physical examination. In Dr. Barron's opinion, the applicant sustained cervical, thoracic, and lumbar, and bilateral shoulder sprains, and bilateral knee contusions as a result of the work injury. He opined that the incident did not precipitate, aggravate, or accelerate a preexisting degenerative condition beyond its normal progression. He also opined that she had reached an end of healing as of November 30, 2015, and that her treatment after that date was not reasonable or necessary to cure and relieve the effects of the work injury. He noted that the applicant did not cooperate with the examination, but based on his December 2015 evaluation, and further review of the medical records, he concluded that the applicant did not sustain any permanent disability as a result of the work injury and did not need any work restrictions as a result of the work injury.

According to the applicant, when she saw Dr. Barron the first time, he forced her left leg into her chest, and she heard a popping sound in her hip and yelled in pain.[63] Since he had caused her "pain and suffering and injury," the applicant was afraid to let him touch her again at the second evaluation.[64]

The respondent also submitted a record review and WKC-16-B from Dr. Michael C. Reineck, M.D., a board certified orthopedic surgeon, dated October 29, 2018.[65] Dr. Reineck reviewed numerous medical records and opinions and provided an extensive summary of the medical records. As a result of his review, Dr. Reineck opined that after giving the applicant the benefit of the doubt, he thought that her subjective complaints were due, at most, to nonstructural myofascial soft tissue contusions/sprains of her anterior knees, strain of her cervical spine and lumbar spine and contusion/sprain of her right shoulder. These were self-limited nonstructural injuries. He opined that regardless of cause, these resolved without functional

[62] Ex. 5.
[63] Tr., p. 29.
[64] Tr., p. 47.
[65] Ex. 10.

impairment on or before November 30, 2015, with no permanent functional impairment or need for work restrictions. Any medical treatment after this date was not reasonable or necessary to treat the work injury. Dr. Reineck noted that before the accident, the applicant had multiple level age-related degenerative cervical disc disease and facet arthropathies and age-related degenerative lumbar disc disease with facet arthropathies that were not structurally injured in the work accident. He opined that the accident did not aggravate or accelerate these conditions beyond their normal expected course, and they were not traumatic. In his opinion, her preexisting arthritis was naturally progressing and being made manifest by activities of daily living. He felt her numerous subjective complaints were being enhanced by symptom magnification and drug seeking behavior, unrelated to the work injury.

According to Dr. Reineck, the fact that the accident report showed that the vehicle had "very minor damage," and the applicant was not documented by the officer to have requested or sought medical attention following the accident, called into question what if any injuries the applicant may have sustained in the accident. He also noted that the injuries the applicant alleged were more likely to occur in a rear-end collision than in a side swiping injury. In his opinion, based on 45 years of orthopedic experience, he opined that nonstructural soft tissue strains/sprains typically resolve without functional impairment within 8 to 10 weeks from the onset of the injury. He felt that the applicant's subjective complaints to Dr. Nolan were far in excess of the objective findings. He noted, for instance, that the applicant's pain was reported to be spreading from her low back to her hips, which progression he found was non-anatomic and non-physiologic in progression. He noted that Dr. Orton even found that the applicant's cervical and lumbar spines did not show acute injuries. After giving the applicant the benefit of the doubt, Dr. Reineck agreed with Dr. Orton that the injuries the applicant sustained were at most temporary nonstructural myofascial soft tissue strains/sprains/contusions that resolved by November 30, 2015.

The Vocational Expert Reports

The applicant submitted a Vocational Expert Report from Michael J. Ewens, M.A., dated November 17, 2017.[66] Mr. Ewens interviewed the applicant and reviewed the medical records from Dr. Chunduri and the applicant's physical therapy records from Athletico. According to Mr. Ewen, the applicant's options for employment would be limited, given the restrictions assigned by Dr. Chunduri, to positions such as cashier, cafeteria worker-counter attendant, and possibly parking lot attendant. Given her age, lack of education and work skills, as well as her medical issues, he opined that she had sustained a 20%-25% loss of earning capacity.

The respondent provided a Vocational Expert Report from Mandy Krueger, MS, CRC, LPC, dated October 16, 2018.[67] Ms. Krueger interviewed the applicant and reviewed numerous medical records, Social Security earnings report, and medical opinions. In calculating the applicant's earning capacity, she did not include her wages as a corrections officer because the applicant could not return to that work following her

[66] Ex. C.
[67] Ex. 8.

felony conviction. Under Dr. Barron's and Dr. Orton's opinions that the applicant had no permanent disability or restrictions, the applicant would have no loss of earning capacity. Dr. Chunduri and Dr. Von-Shilling Worth did not provide allocation between the restrictions attributable to her scheduled versus unscheduled injuries, but assuming they were related to the unscheduled injury, Ms. Krueger opined that the applicant would sustain a 10% to 15% loss of earning capacity. In addition, Ms. Krueger considered that the applicant had not attempted vocational rehabilitation, which suggested that it would be premature to offer a loss of earning capacity.

Analysis

The issues are the nature and extent of the applicant's disability from the conceded work injury. The applicant has the burden of proving beyond a legitimate doubt all the facts necessary to establish a claim for compensation.[68] The commission must deny compensation if it has a legitimate doubt regarding the facts necessary to establish a claim, but not every doubt is automatically legitimate or sufficient to deny compensation.[69] Legitimate doubt must arise from contradictions and inconsistencies in the evidence, not simply from intuition.[70]

The Parties' Arguments

The applicant argues that the evidence shows that she did not reach an end of healing as of November 30, 2015. Though Dr. Orton released her from his care on this date, he still encouraged her to continue formal physical therapy and to seek management by a pain management specialist. Unfortunately, she was only able to attend two additional physical therapy sessions before her claim was denied, and she was not able establish further care at that time. However, after November 30, 2015, the applicant did continue to seek treatment for her injuries, including physical therapy, chiropractic sessions, injections, and various office visits. She argues that she suffered demonstrable injuries that were not present before the work injury. Dr. Chunduri reviewed the MRIs and opined that they showed an extensive right shoulder labral tear, an L2-3 disc bulge, an L4-5 disc bulge, and diffuse spondylitic changes and left foraminal stenosis at C7-T1. The EMG revealed L5-S1 nerve root irritation. The applicant did not suffer from any of these injuries prior to the work accident. Dr. Chunduri recommended injections, which the applicant ultimately had. He eventually sent her for an FCE, assigned permanent work restrictions, and put her at an end of healing on March 30, 2016. Even at this time, however, her pain had not resolved, and she continued to seek medical treatment. She treated with doctors in an attempt to alleviate her pain; she continues to treat and requires home care as a result of her injuries.

Though there were concerns that she was exhibiting drug seeking behavior, the applicant argues that there was a good reason for her seeking pain medication. She was not provided any pain medications at her 118 physical therapy sessions or 46

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[68] *Leist v. LIRC,* 183 Wis. 2d 450, 457, 515 N.W.2d 268 (1994); *Erickson v. DILHR*, 49 Wis. 2d 114, 118, 181 N.W.2d 495 (1970).

[69] *Erickson, supra,* at 119; *Leist, supra*, at 457.

[70] *Erickson, supra; Richardson v. Indus. Comm'n,* 1 Wis. 2d 393, 396-97, 84 N.W.2d 98 (1957).

chiropractic sessions. Though the administrative law judge found that there was no evidence that she had sustained cervicalgia, the applicant argues that she has been consistent since the day of the accident that she was suffering from neck pain. This is reflected in the medical records, and all of her treatment notes consistently mention her neck pain. These were demonstrable injuries as evidenced by the MRIs and EMGs.

The commission should not credit Dr. Barron and Dr. Reineck, according to the applicant, because Dr. Barron's opinions are not, in fact, consistent with Dr. Orton's opinion. Dr. Barron opined that the applicant required no further treatment for her work injuries and reached an end of healing in November 2015. Dr. Orton, on the other hand, recommended that the applicant continue with formal physical therapy and seek treatment with a pain management specialist. The applicant asserts that Dr. Orton only released her from his care as she did not require spine surgery. Since he recommended further treatment, the applicant argues that he obviously did not believe she should be done treating for her injuries. Dr. Barron's opinions are also in direct contrast to the opinions of Dr. Chunduri and Dr. Von-Shilling Worth, who the applicant argues were in the best position to make a determination as to the extent and duration of her injuries and are the doctors the commission should credit. They made their assessments on the results of the FCE. The commission should not credit Dr. Barron or Dr. Reineck because they could not explain why the applicant required the extensive care following her alleged end of healing in November 2015. Neither doctor can explain why she requires permanent work restrictions and the assistance of a personal care worker. As a result, the applicant asks the commission to review all of the evidence in the record and reverse the administrative law judge's decision.

The respondent responds and argues that the commission should affirm the administrative law judge's decision and not award compensation for the endless pain management that the applicant has pursued. Based on the weight of the evidence, the respondent argues that the commission should deny the applicant's claim. First, the respondent argues that the opinions of Dr. Barron and Dr. Reineck, and to an extent, that of Dr. Orton and Dr. Nolan, are more credible than those of Dr. Chunduri or Dr. Von-Shilling Worth. Dr. Barron's and Dr. Reineck's opinions are largely consistent with the opinions of the initial treating physicians. They both opined that the applicant reached an end of healing as of November 30, 2015, with no permanent disability. Dr. Orton provided the same opinions. Although he suggested that she see a pain specialist and complete physical therapy, he never endorsed the endless pain management she has pursued. Likewise, in May 2017, Dr. Nolan opined that the applicant required no further treatment.

The respondent also points out that the accident was relatively minor and caused about $653 in damage to the van. There is also little, if any, objective evidence of significant injury. According to Dr. Orton, the only orthopedist the applicant has seen, the MRI of the lumbar spine in October 2015 showed only mild degenerative changes of the discs and facet joints. He said there were no other significant findings and no significant stenosis to explain the lower extremity symptoms; and the cervical MRI showed only mild degenerative disc disease, and there was no significant stenosis to

explain the radicular symptoms. According to the respondent, Dr. Orton's opinions suggest that the applicant's complaints were not genuine.

Besides the lack of evidence for the applicant's complaints, the respondent asserts that the applicant has shown other signs of "doctor shopping" and "drug seeking" behavior. This is reflected in the medical records. The applicant sought pain medication from several clinics. Dr. Nosir noted that the applicant demanded "only oxycodone." When he recommended other treatment, the applicant stopped seeing him. She also refused non-opioid options recommended by Dr. Berezovski. According to the respondent, the applicant's behavior was not consistent with a legitimate claim. Although the applicant argues that her need for pain management stemmed from the October 2015 work injury, the respondent notes that she had several prescriptions for pain medications in the months before the accident. The respondent also disputes the treatment at the Center for Pain Management as not supported by a medical opinion. Regarding the applicant's loss of earning capacity claim, the respondent argues that the applicant has not established a genuine loss of earning capacity. Although Dr. Orton had released her to work with no restrictions, the applicant has not looked for work or sought assistance from the Division of Vocational Rehabilitation.

What is the extent of the applicant's disability from the work injury?

The commission finds that there are several things that create legitimate doubt that the applicant sustained the severe injuries and permanent disabilities that she is alleging. First, the accident was very minor. The applicant was sitting in a parked van near a loading zone in a parking lot of the mall when her vehicle was sideswiped by another vehicle trying to get past her. The pictures of the vehicle show that the rear driver's side of her vehicle was sideswiped. Her vehicle was not rear-ended in traffic. This is not a case where the applicant was sitting at a stop sign, for instance, and a car driving the speed limit rear-ended her with significant impact. The police report described the incident as sideswiping, and it noted that the applicant had no apparent injury and that the damage to the applicant's vehicle was "very minor" and the damage to the other vehicle was "minor." The fact that the vehicle sustained less than $700 in damage also shows that the incident was very minor. It is true that the applicant treated at urgent care on the same day, but no imaging was done. There was apparently no concern for fractures or serious injuries that required emergency care. She was prescribed an opioid and muscle relaxer and told to follow up with her primary care physician. The very minor nature of the accident and initial treatment is not consistent with the extensive injuries subsequently claimed by the applicant.

Also, the medical evidence does not support any acute injuries from the accident. Though the applicant reported numerous subjective pain locations and symptoms, when Dr. Orton reviewed the lumbar MRI, he found there was no significant stenosis, no fractures, and no significant findings. He reassured the applicant that there was no dangerous pathology of the lumbar spine, and he found there was no significant stenosis to explain her lower extremity symptoms. After the cervical MRI, he made similar findings that there was no significant stenosis in the cervical spine to explain her claimed radicular symptoms. There was no significant disc disease or arthritis. *From a spinal perspective,* he opined that the applicant could return to work with no

restrictions, and he discharged the applicant from care. Though the applicant requested that the annular tears be listed as an acute finding, PA-C Finer specifically told the applicant that this was *not* the opinion of Dr. Orton or him. He relayed that it was Dr. Orton's and his opinion that "*no acute injury was suffered by the spine*" during the accident. It is true that Dr. Orton encouraged the applicant to continue with physical therapy and pain management, but his records show that his opinion was clear that this was not causally related to the work injury. He specifically noted that the applicant had reached an end of healing as of November 30, 2015, and had no permanent disability.

Dr. Orton's opinion was confirmed by the treatment records of Dr. Chunduri. When the applicant saw Dr. Chunduri, her neck pain had nearly resolved, though she still had shoulder pain. Dr. Chunduri found that the MRI did not show significant compression pathology to account for her paresthesias in her legs, the EMG of the upper extremity was normal, and the EMG of her lower extremities show no radicular injury. He found that she had reached maximum medical improvement as of March 2016. He did recommend a cortisone injection in the shoulder, but the pain returned afterwards. When the applicant returned to Dr. Chunduri in August 2016, he considered whether there was a different possible pain generator since her diagnostic block did not give her the relief he expected. Dr. Chunduri did provide a WKC-16-B in which he opined the work incident directly caused the applicant's disability, but he described the incident as the applicant being "suddenly rear-ended," which is not entirely accurate, and he failed to provide the basis for his assessment of permanent partial disability. He merely stated that it was "TBD."[71]

The treatment providers' many concerns that the applicant was doctor shopping and drug seeking also call into question the applicant's subjective pain complaints. The record shows that the applicant had received prescriptions for opioids in the months prior to the work incident from three different doctors, including one from Dr. Nolan, though the applicant testified that she could not recall if she had filled those prescriptions. After the work incident, the applicant complained of 8/10 to 10/10 constant pain, despite taking opioid medications. APNP Zilinski specifically noted concern for doctor shopping since the applicant had seen several doctors over a few months for the same complaints. APNP Zilinski would not provide medications because of her concerns of doctor shopping. Even though the applicant indicated that the Tramadol was not helping her pain, for instance, the applicant continued to insist that she needed pain medication. That is why APNP Zilinski discontinued the Tramadol when the applicant insisted that her pain was still 10/10 on the medication. The applicant also continued to seek oxycodone from Dr. Nolan, even after Dr. Nolan had determined that the applicant did not require further treatment in December 2015. APNP Colton likewise expressed concerns about the applicant's drug-seeking behavior, noting that the primary reason for her medical visit was to get Percocet, and when that was not going to be provided, she requested Tramadol, another opioid. APNP Colton noted the applicant claimed her pain was 10/10 while taking the

[71] Dr. Nolan also incorrectly noted in her records that the applicant was involved in a "very bad accident," which was not correct. She also referred to a fall, which is not otherwise explained in the records.

Tramadol. When APNP Colton recommended the applicant see a pain psychologist, the applicant refused, which also caused APNP Colton to question the veracity of the applicant's pain complaints. Similarly, Dr. Chovatiya noted that the applicant's primary goal was to establish herself with a provider who would continue to fill Percocet medications. That was the applicant's only interest; she was not interested in any other treatment modalities, and Dr. Chovatiya then provided her a list of other pain providers. Most explicitly, Dr. Nosir noted that the applicant's chief complaint was "I want oxycodone" and that she was demanding oxycodone and was not interested in any other treatment modalities. He specifically noted that she was going to seek another doctor who "gives Percocet to everyone." These notations suggest that the applicant was only interested in seeking drugs and not in seeking any treatment that would provide relief from actual pain.

Based on the medical evidence, the commission finds Dr. Barron's opinion to be the most credible. As noted, Dr. Chunduri's opinion is based on a misunderstanding of the accident and his opinion is incomplete. Dr. Von-Shilling Worth did not address the concerns for doctor shopping or drug seeking. Also, Dr. Von-Shilling Worth assessed permanent disability for each of the applicant's knees, but there is no evidence that the applicant sustained anything other than bruises to her knees in the work incident. Dr. Barron, however, had an accurate understanding of the accident and had reviewed the accident report as well as the applicant's medical records prior to and after the work incident. He noted the inconsistent exam findings with the applicant's pain complaints and symptom magnification. His opinion that the applicant had reached an end of healing with no disability and no need for further treatment as of November 30, 2015, was also consistent with the opinion of Dr. Orton, the applicant's physician.[72] As a result, the commission credits Dr. Barron that the applicant sustained cervical, thoracic, lumbar, and bilateral shoulder sprains, and bilateral knee contusions as a result of the work injury; that the applicant reached an end of healing as of November 30, 2015; and that the applicant did not sustain any permanent disabilities as a result of the work injury. Accordingly, the administrative law judge's decision is affirmed.

cc: Atty. Jason Oldenburg
Atty. Eric Lengell

[72] The applicant argues that these two opinions were not consistent because Dr. Orton encouraged the applicant to continue physical therapy and seek pain management. However, as noted above, Dr. Orton was clear that he did not think the applicant sustained a spinal injury in the work accident, so any such recommendation was not for treatment causally related to the work injury.